Edited by
Dinesh Bhugra and
Kamaldeep Bhui

Textbook of Cultural Psychiatry

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Textbook of Cultural Psychiatry

Cultural psychiatry is concerned with understanding the impact of social and cultural differences and similarities on mental illness and its treatments.

A person's cultural characteristics can often lead to misunderstandings, influenced by language, non-verbal styles, codes of etiquette and assumptions. There may also be perceived misconceptions and differences in beliefs and values. In order to provide appropriate, sensitive and acceptable services for different cultural groups, all service providers need to take these factors into account.

Written by leading clinicians and academics from around the world, and integrating both practical and theoretical knowledge, the *Textbook of Cultural Psychiatry* provides a framework for the provision of mental healthcare in a multi-cultural/multi-racial society and global economy.

It will be essential reading for those providing mental healthcare, or who are involved in the organisation and management of services.

Dinesh Bhugra is Professor of Mental Health and Cultural Diversity, at the Institute of Psychiatry, King's College London.

Kamaldeep Bhui is Professor of Cultural Psychiatry and Epidemiology, at Barts and the London, Queen Mary School of Medicine and Dentistry.

Textbook of Cultural Psychiatry

Edited by

Dinesh Bhugra
and
Kamaldeep Bhui

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Contributors

Iqbal Ahmed
Department of Psychology
John A. Burns School of Medicine
University of Hawai'i at Manoa
1960 East-West Road
Honolulu HI 96822
USA

Paul Bebbington
UCL, Department of Mental Health Sciences
2nd Floor, Charles Bell House
67–73 Riding House Street
London WIW 7EJ, UK

John W. Berry
Psychology Department
Queen's University
62 Arch Street
Kingston Ontario K7L 3N6
Canada

Dinesh Bhugra
Mental Health and Cultural Diversity
Section of Cultural Psychiatry
Institute of Psychiatry
King's College London
De Crespigny Park
London SE5 8AF, UK

Kamaldeep Bhui
Department of Cultural Psychiatry and Epidemiology
Institute of Community Health Sciences

Queen Mary
London E1 4NS, UK

Nick Bouras
King's College London
Institute of Psychiatry
The Estia Centre
York Clinic – Guy's Hospital
47 Weston Street
London SE1 3RR, UK

Santosh K. Chaturvedi
Department of Psychiatry
National Institute of Mental Health and Neurosciences
Bangalore 560029
India

Chia-Hui Chen
Division of Mental Health and Substance
Abuse Research
National Health Research Institutes, 5th Floor
Second Campus, Tapiei City Psychiatric Center
309 Song-De Road
Taipei 110
Taiwan

Carl I. Cohen
Division of Geriatric Psychiatry
SUNY Downstate Medical Center
Box 1203
450 Clarkson Avenue
Brooklyn NY 11203
USA

Matthieu Crews
The Maudsley Hospital
Denmark Hill
London SE5 8AF, UK

Claudia Cooper
Royal Free and University College Medical School
UCL – Department of Psychiatry and Behavioural Sciences
Holborn Union Building, Archway Campus
Highgate Hill
London N19 5LW, UK

Joop T. V. M. de Jong
Vrije Universiteit Medisch Centrum Amsterdam
TPO
Keizersgracht 329
Amsterdam 1016 EE
The Netherlands

Padmal de Silva
Department of Psychology PO Box 77
Institute of Psychiatry
King's College
De Crespigny Park
London SE5 8AF, UK

Geetha Desai
Department of Psychiatry
Kasturba Medical College
Manipal
Karnataka
India

Nisha Dogra
University of Leicester
Greenwood Institute of Child Health
Department of Psychiatry
Division of Child Psychiatry
Westcotes House, Westcotes Drive
Leicester LE3 0QU, UK

William W. Dressler
Department of Anthropology
PO Box 870210
The University of Alabama
Tuscaloosa Alabama 35487-0210
USA

Horacio Fabrega Jr
257 Kenforest Drive
Pittsburgh PA 152136
USA

Larkin Feeney
Department of Psychiatry
St Vincent's Hospital
Fairview

Dublin 3
Ireland

Sarah A. Fortune
University of Oxford Centre for
Suicide Research
Department of Psychiatry
Warneford Hospital
Oxford OX3 7JX, UK

Alexander Friedmann
Psychiatric University Clinic Vienna
Währinger Gürtel 18–20
A-1090 Vienna
Austria

Keith Hawton
University of Oxford Centre for
Suicide Research
Department of Psychiatry
Warneford Hospital
Oxford OX3 7JX, UK

Assen Jablensky
School of Psychiatry & Clinical Neuroscience
University of Western Australia
MRF Building, 50 Murray Street
Mail Bag Delivery Point M571
Perth WA 6000
Australia

Janis H. Jenkins
Department of Anthropology
University of California, San Diego
9500 Gilman Drive
La Jolla CA 92093-053
USA

Niranjan Karnik
Division of Child and Adolescent Psychiatry
Stanford University
401 Quarry Road
Stanford CA 94305
USA

Shahe Kazarian
Department of Social and Behavioural
Sciences
American University of Beirut
PO Box 11-0236
Riad El Solh
Beirut 1107 2020
Lebanon

Brendan D. Kelly
Department of Adult Psychiatry
University College Dublin
Mater Misericordiae University Hospital
63 Eccles Street
Dublin 7
Ireland

Laurence J. Kirmayer
Culture and Mental Health Research Unit
Institute of Community and Family
Psychiatry
McGill University
4333 Côte Ste Catherine Road
Montreal
Quebec H3T 1E4
Canada

Robert Kohn
Butler Hospital
345 Blackstone Blvd
Providence RI 02906
USA

Arlene Laliberté
Centre for Research and
Intervention on Suicide and Euthanasia
Université of Québec in Montréal
Succursale Centre ville
Montreal, Quebec H3C 3P8
Canada

Keh-Ming Lin
Division of Mental Health and Substance
Abuse Research

National Health Research Institutes
5th Floor, Second Campus
Tapiei City Psychiatric Center
309 Song-De Road
Taipei 110
Taiwan

Shi-Kai Liu
Division of Mental Health and Substance
Abuse Research
National Health Research Institutes, 5th Floor
Second Campus, Tapiei City Psychiatric Center
309 Song-De Road
Taipei 110
Taiwan

Kate M. Loewenthal
Psychology Department
Royal Holloway
University of London
Egham
Surrey TW20 0EX, UK

Sheena MacKenzie
Old Age Psychiatry
West London Mental Health NHS Trust
Uxbridge Road
Southall
Middlesex UB1 3EU, UK

Malcolm MacLachlan
Centre for Global Health and Department of Psychology
Trinity College Dublin
Dublin 2
Ireland

Sieglinde McGee
School of Psychology
Trinity College Dublin
Dublin 2
Ireland

Harry Minas
Victorian Transcultural
Psychiatry Unit
Level 2, Bolte Wing
St Vincent's Hospital
14 Nicholson Street
Fitzroy VIC 3065
Australia

Paul Moran
Institute of Psychiatry
De Crespigny Park
Denmark Hill
London SE5 8AF, UK

Mervat Nasser
Eating Disorders Research Unit
Institute of Psychiatry
King's College (Guy's Campus)
5th Floor, Thomas Guy House
Guy's Hospital
London SE1 9RT, UK

Jean O'Hara
York Clinic
47 Weston Street
Guy's Hospital
London SE1 3RR, UK

Gwendolyn Portzky
Unit for Suicide Research
Department of Psychiatry
Ghent University
De Pintelaan 185
9000 Gent
Belgium

Pedro Ruiz
Department of Psychiatry and Behavioral Sciences
Medical School
University of Texas
1300 Moursund Street
Houston, Texas 77030
USA

Sue Salas
Mental Health Strategies
Emerson House

Albert Street
Eccles
Manchester M30 0BG, UK

Ajit Shah
John Connolly Unit
West London Mental Health NHS Trust
Uxbridge Road
Southall
Middlesex UB1 3EU, UK

Andrew Sims
formerly Department of Psychiatry
University of Leeds
Leeds, UK

Sisira Siribaddana
Sri Lankan Twin Registry Project
25a Temple Road
Thalapattiya
Nugegoda
Sri Lanka

Daryl Somma
Department of Public Health and Epidemiology
Swiss Tropical Institute
Socinstrasse 57
CH-4002 Basel
Switzerland

Thomas Stompe
Psychiatric University Clinic Vienna
Währinger Gürtel 18–20
A-1090 Vienna
Austria

John Strang
National Addiction Centre
Institute of Psychiatry
Kings College London
4 Windsor Walk
London SE5 8AF, UK

Athula Sumathipala
Section of Epidemiology
Institute of Psychiatry
King's College London
De Crespigny Park
London SE5 8AF, UK

Digby Tantam
Centre for the Study of Conflict and Reconciliation
School of Health and Related Research
University of Sheffield
30 Regent Street
Sheffield S1 4DA, UK

Jaideep Thoduguli
Department of Psychiatry
National Institute of Mental Health &
Neurosciences
Bangalore 560029
India

Michel Tousignant
Centre for Research and Intervention on Suicide and
Euthanasia
Université of Québec in Montréal
Succursale Centre ville
Montreal, Quebec H3C 3P8
Canada

Wen-Shing Tseng
Department of Psychiatry
University of Hawaii School of Medicine
1356 Lusitana Street
4th Floor
Honolulu HI 96813-2421
USA

Kees van Heeringen
Unit for Suicide Research
Department of Psychiatry
Ghent University
De Pintelaan 185
9000 Gent
Belgium

Panos Vostanis
University of Leicester

Greenwood Institute of Child Health
Department of Psychiatry
Division of Child Psychiatry
Westcotes House, Westcotes Drive
Leicester LE3 0QU, UK

Shamil Wanigaratne
National Addiction Centre
Institute of Psychiatry
Kings College London
4 Windsor Walk
London SE5 8AF, UK

Nasir Warfa
Centre for Psychiatry
Wolfson Institute for Preventive Medicine
Barts and the London Medical School
Queen Mary, University of London, UK

Mitchell G. Weiss
Department of Public Health and Epidemiology
Swiss Tropical Institute
Socinstrasse 57
CH-4002 Basel
Switzerland

Joseph Westermeyer
University of Minnesota Hospital
Department of Psychiatry
F282/2A Medical School
2450 Riverside Avenue South
Minneapolis MN 55454
USA

Shu-Han Yu
Division of Mental Health and Substance Abuse Research
National Health Research Institutes, 5th Floor
Second Campus, Taipei City
Psychiatric Center
309 Song-De Road
Taipei 110
Taiwan

Foreword

Pedro Ruiz, MD

Professor and Vice Chair, Department of Psychiatry and Behavioral
Sciences, University of Texas Medical School at Houston
President, American Psychiatric Association

It is for me a real pleasure and an honour to write the foreword for this impressive textbook edited by Professors Dinesh Bhugra and Kam Bhui. Based on my involvement in the field of Cultural Psychiatry for over four decades, I clearly envisage this textbook to be one of the most authoritative textbooks ever written on the topic of Cultural Psychiatry.

I base my assumption on a series of well-established facts. They are as follows:

1. This textbook has secured a cadre of authors who represent the best that the field of Cultural Psychiatry can offer at the present time. This cadre of authors encompasses over 40 experts from all regions of the world, each of them bringing to this textbook a rich set of knowledge and experiences in their respective assignments in this text. They are all highly respected scholars in their assigned topics. Undoubtedly, this is not a minor task and clearly symbolizes the respect that each of them has for Professors Bhugra and Bhui and what this textbook will have to offer to the field of Cultural Psychiatry for years to come.
2. The topics selected for this textbook represent very relevant subjects. Each of the critical areas of the field of Cultural Psychiatry is addressed in this textbook. They all signified the best curriculum within the field of Cultural Psychiatry. This compendium of highly important subjects will certainly offer the best advances and knowledge in this field to all professionals and trainees who

are or could be interested in the field of Cultural Psychiatry in the twenty-first century.

3. The six broad areas covered in this textbook address the most critical and relevant areas of the field of Cultural Psychiatry. They are (a) theoretical issues, (b) the relationship between culture and mental health, (c) the role of culture on mental disorders, (d) the theoretical aspects of the clinical management of patients across cultures, (e) the clinical managements of special groups such as children and adolescents, patients with learning disabilities, etc. and (f) the most recent and important research and training aspects in the field of Cultural Psychiatry.

Undoubtedly, no other current text shows the depth and the extension of this formidable textbook. My deepest appreciation goes to Professors Bhugra and Bhui and their outstanding cadre of collaborators in this project. This textbook will certainly make major contributions in the field of Cultural Psychiatry for several decades. I plan to keep this textbook handy and use it in my clinical, educational and investigative activities.

Preface

People eat, drink and breathe culture. Without any conscious awareness, we absorb culture; and as culture becomes an integral part of us we become acculturated and a part of culture. Although nearly a century ago cultural variations in the presentation of mental illness were noted, the impact of culture on distress, identification of symptoms and reaching diagnosis as well as pathways people follow into health care (be it statutory or non-statutory) have become clearly important in the last quarter of a century. It appears that cultural psychiatry is gradually taking over the role of social psychiatry. Cultural factors in aetiology, management and prognosis are being identified both as within cultures but also increasingly in a comparative style across cultures. The relationship of the clinician with the medical formulation on the one hand, and the cultural formulation on the other, has led to a creative tension which can be seen in this volume.

With ever-increasing globalization and the international flow not only of people but of physical resources too, it is essential that any clinician practising in the twenty-first century be aware of the cultural norms and variations. We have deliberately stepped away from one approach of cultural psychiatry (which relies on dealing with each individual cultural group as if it were isolated) to adopt one that emphasizes broad principles that can then be used to develop patient-based services rather than group or culture or ethnicity-based services.

The book is divided into six Parts. Starting with theoretical background, we move to the relationship between culture and mental health. The third Part deals with culture and mental disorders focusing on specific disorders, whereas the fourth Part provides an overview of theoretical aspects of management. We then move on to management with special groups and conditions. The last Part focuses on cultural research and training. There is no doubt that there are times when there is an overlap in the contents of various chapters, but this is inevitable in a volume of this size. We have deliberately left this in place so that each chapter can also be read independently of the others. The aim of the book is to be a textbook and also a source book that psychiatrists and other mental-health professionals will find user-friendly and helpful in clinical settings.

We are delighted at the responses of our authors who, in spite of their busy schedules, not only agreed to contribute to this volume but stuck to deadlines and were generous enough to accept critical comments from us in shaping their contributions. We are grateful to Professor Pedro Ruiz for his Foreword and his generous support of this project. Andrea Livingstone has done a splendid job in keeping the project moving smoothly – thanks are really inadequate words. Tajinder Kaur Bhui kindly permitted use of her painting for the cover illustration. Richard Marley, Betty Fulford and their team at Cambridge University Press have been supportive beyond the call of duty. Thanks to all of them.

Mike Thacker, Gurpreet Bhui and Arjan have as ever been patient supports. Thank you all.

Dinesh Bhugra
Kamaldeep Bhui
March 2007

PART I

Theoretical background

Cultural psychiatry in historical perspective

Laurence J. Kirmayer

EDITORS' INTRODUCTION

The evolution of cultural psychiatry over the last few decades has been an interesting phenomenon to observe. Psychiatry is perhaps one of the younger disciplines of medicine. The coming of age of psychiatry as a profession was clearly linked with the development of training and laying claim to a knowledge base which gradually has become more evidence based. The period between the two world wars led to greater questioning of social factors in the aetiology and management of psychiatric disorders. In the UK at least, social psychiatry as a discipline became clearly established and produced impressive studies on life events and their impact on phenomenology, attachment and other social factors. In the last two decades, it would appear that social psychiatry has transmogrified into cultural psychiatry.

Kirmayer, in this chapter, maps out the history of cultural psychiatry as a discipline. In addition, he raises the concerns related to this discipline, especially related to universality of psychopathology and healing practices, development of diverse service needs to black and ethnic minority groups and analysis of psychiatric theory and practice as products of a particular cultural history. Culture has been defined as a civilizing process which, in European history, Kirmayer asserts, had to do with the transformations from migratory groups to agrarian societies to city states and, eventually, nation states. The definition of culture in this context was related to standards of refinement and sophistication. The second definition of culture has to do with collective identity, which is based on historical lineage, language, religion, genetics or ethnicity. Kirmayer suggests that these two definitions have become conflated. The historical development of comparative psychiatry in colonial times and until the 1960s, when research across cultures used dimensions of distress, ignored local cultural practices and interpretation of these experiences. The role of racism in diagnosis and management of individuals with psychiatric illnesses has not entirely gone away. Large-scale migrations from East to West and North to South across the globe have raised questions about ethnocultural diversity. An organized and relative newcomer within the larger discipline of psychiatry, cultural psychiatry is becoming mainstream and beginning to influence health-service delivery and research.

Introduction

Cultural psychiatry stands at the crossroads of disciplines concerned with the impact of culture on behaviour and experience. It emerges from a history of encounters between people of different backgrounds, struggling to understand and respond to human suffering in contexts that confound the alien qualities of psychopathology with the strangeness of the cultural 'other'. The construct of culture offers one way to conceptualize such difference, allowing us to bring together race, ethnicity and ways of life under one broad rubric to examine the impact of social knowledge, institutions and practices on health, illness and healing. Cultural psychiatry differs from the social sciences of medicine, however, in being driven primarily not by theoretical problems but by clinical imperatives. The choice of research questions and methods, no less than the interpretation of findings and the framing of professional practice, is shaped by this clinical agenda, which emphasizes the quest for therapeutic efficacy.

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Over the course of its history, cultural psychiatry has been driven by three major sets of concerns: questions about the universality or relativity of psychopathology and healing practices; the dilemmas of providing services to ethnically diverse populations; and, most recently, the analysis of psychiatric theory and practice as products of a particular cultural history. These concerns correspond to three successive waves of development of the field from colonialist and comparative psychiatry, to the mental health of ethnocultural communities and indigenous peoples in settler societies, and the post-colonial anthropology of psychiatry.

The emergence and development of each of these themes in cultural psychiatry can be tied to major historical events, especially to global patterns of migration and their associated social, political and economic consequences (Castles & Miller, 1998; Papastergiadis, 2000). From the mid 1700s onwards, colonialist expansion of European powers led to observations relevant to psychiatry and to occasional efforts to provide healthcare in distant lands. Large-scale migrations of Europeans to North America, Australia and other regions in the nineteenth and twentieth centuries prompted attention to the impact of ethnicity on mental health and illness. Successive wars made psychological reactions to stress and trauma a salient concern for psychiatry. The Great Depression and the emergence of the welfare state highlighted the impact of social class and poverty as causes of illness. The promulgation of scientific racism forced researchers and clinicians to clarify their thinking about ethnocultural difference. The flight of refugees and displaced peoples following World War II and later conflicts, led to renewed work both on trauma-related disorders and the adaptation of migrants (Murphy, 1955). The UN Universal Declaration of Human Rights in 1948 and emerging anti-colonialist struggles around the world challenged the hegemony of Western versions of history and opened up the consideration of alternative systems of knowledge on both ethical and epistemological grounds.

Most recently, new waves of migration from East to West and South to North have challenged models of culture and ethnicity developed for earlier groups of immigrants from relatively similar European countries (Castles & Miller, 1998). At the same time, increasing recognition of the historical injustices suffered by indigenous peoples has made their cultures a focus of attention both in terms of the damaging effects of forced assimilation and the potential for resilience in indigenous identity, community and healing practices (Cohen, 1999; Kirmayer, Simpson & Cargo, 2003). The growth of the Hispanic, Asian and other non-European populations in the USA, and the corresponding increase in the numbers of mental-health professionals from diverse ethnocultural backgrounds, have pressed for change both from without and within the profession, as reflected in the attention to culture in official psychiatric nosology (Alarcon, 2001; Mezzich *et al.*, 1996). Similar demographic changes are affecting most societies, and will make cultural issues a matter of central concern for psychiatry in the years to come.

The uses of culture

There are three broad but distinct uses of the term culture that are often conflated (Eagleton, 2000; Kuper, 1999) and each has its reflection in the history of cultural psychiatry. Originally, culture meant cultivation: the civilizing process which, in European history, had to do first with the move from migratory groups to agrarian societies (cultivating crops) and then to city-states and larger political entities including nations and empires. Throughout this history, there was a progressive elaboration of codes of conduct and civility and the cultivation of specialized knowledge and power, initially the possession of elite social classes, but gradually accessible to others through formal education (Elias, 1982; Gellner, 1988). Culture in this sense represents a standard of refinement or sophistication, measured against the cosmopolitan life of urban centres, the achievements of those with higher education, and the ‘high culture’ (with a capital ‘C’) of arts and letters. Culture as civilization has influenced thinking about psychopathology from Vico's Renaissance views of culture as a civilizing force (Bergin & Fisch, 1984), through Rousseau's idealization of the noble savage, to Freud's tragic–heroic view of the ego wrestling with conflicts of desire and social constraint in *Civilization and Its Discontents* (Freud, 1962). Although Western European civilization has viewed itself myopically as the singular standard against which others can be judged, there are many other traditions with comparable levels of history and complexity, and some see the contemporary world as a contest of great civilizations with incommensurable values and epistemologies (Huntington, 1996).

A second meaning of culture has to do with collective identity, the setting apart of one group of people from another on the basis of historical lineage, language, religion, gender or ethnicity which may include membership in a community, regional group, nation or other historical people (Banks, 1996). While the notion of culture as cultivation may be presented as a universal system of values that can be attained by anyone allowed the opportunity to become 'civilized' (even if, in practice, essentialized notions of cultural identity subvert this possibility), ethnocultural identity is local and particular, the property of groups who regulate its distribution along lines of historical descent, kinship, citizenship, or other social markers of identity. Ethnicity is differently constructed in each society, and may merge with local notions of 'race', national identity or other invented traditions (Hobsbawm & Ranger, 1983). While ethnicity has been a source of positive identity, self-esteem and group cohesion, it has also fueled discrimination, inter-group conflicts and genocidal violence.

The third notion of culture corresponds to its current use in anthropology as a way of life: the values, customs, beliefs and practices that form a complex system (Kuper, 1999). As such, culture encompasses all of the humanly constructed and transmitted aspects of the material and social world. Culture may reside at many levels of social organization in institutions, knowledge and local practices and includes, but cannot be reduced to, the cultural models internalized by individuals. In the contemporary world, cultural formations may be constituted both by local communities or 'subcultures' and transnational flows of knowledge and practice shared by groups of experts and professionals (Hannerz, 1992, 1996). Psychiatry itself is one such transnational cultural institution with national variants and subcultures.

Comparative psychiatry and the legacy of colonialism

The roots of cultural psychiatry can be traced to the very beginnings of modern psychiatry. Indeed, long before psychiatry was clearly distinguished from other areas of medicine, examples of odd or deviant behaviour among distant peoples stimulated philosophical reflections on the uniqueness of mankind and the impact of the 'civilizing process' on human nature (Jahoda, 1993). These early commentaries drew on travellers' observations of distant peoples who were culturally different, whether coming from a recognizably different civilization or viewed as undeveloped 'barbarians'. This literature reveals an aesthetic fascination with the strangeness of the other that was often both morally and erotically charged (Segalen, 2002). European explorers and colonizers generally viewed their own traditions as the zenith of civilization, while others were seen as backward, primitive and uncivilized (Jahoda, 1999; Gilman, 1985; Lucas & Barrett, 1995; Todorov, 1993).

The taken-for-granted superiority of European civilization demanded that its institutions be established in the colonies, and asylum psychiatry was one of these exports. While attempting to care for suffering individuals, colonial psychiatry also served to justify and maintain the social order of colonial regimes (Bhugra & Littlewood, 2001; Keller, 2001, 2005; McCulloch, 1995; Sadowsky, 1999; Vaughan, 1991). Colonial asylums became important sites for comparative studies of psychopathology. However, their status as colonizers and limited access to the everyday life of people outside hospitals and asylums made it difficult for these practitioners to recognize the social and cultural context of patients' afflictions.

In general, colonizers and alienists did not see large numbers of mentally ill and this prompted speculation about the protective effects of 'primitive' ways of life. The idea that insanity was rare among primitive or uncivilized peoples, as claimed by Jean-Jacques Rousseau, was popular among early writers in psychiatry including Esquirol, Moreau de Tours, Griesinger & Krafft-Ebing (Raimundo Oda, Banzato & Dalgalarrondo, 2005). Sometimes this notion of the 'healthy savage' was framed in terms of the protective effects of living a simple life with few demands in contrast to the increasing expectations for productivity and consumption in the complex, urbanized, industrialized environment of Europe. An increase in nervousness was associated with the over-stimulation of modern civilization, especially for those required to do 'brain work', and hence the upper classes were particularly prone to maladies like neurasthenia or nervous weakness – a diagnosis introduced by the American neurologist George Beard and taken up widely throughout Europe and East Asia (Beard, 1869; Rabinbach, 1990). Over time, the living conditions of the poor in large cities, along with the impact of alcohol and a general erosion of moral and religious values, were invoked to explain the apparent increase in mental disorders in urban settings.

Early studies in comparative psychiatry focused on the exotic in order to examine the universality of major psychiatric disorders. The psychiatric literature of the late 1800s and early 1900s was peppered with reports of 'culture-bound syndromes', e.g. *pibloktoq*, *latah*, *amok*, thought to be uniquely linked to cultural beliefs and practices (Simons & Hughes, 1985). These reports seemed to indicate the malleability of expression of psychopathology, captured in the distinction between *pathoplasticity* and *pathogenesis* (Yap, 1952, 1974). Major psychiatric textbooks usually devoted a chapter to exotic and culture-bound conditions. Unfortunately, early observers paid relatively little attention to the social context of the syndromes they were observing and describing.

For example, *pibloktoq* or 'arctic hysteria', which was described in early accounts by explorers among the polar Inuit, became a stock example of a culture-bound syndrome. Anthropologists and psychiatrists have sought to link pibloktoq to specific features of Inuit child-rearing, social structure, religious practice, environment and nutrition (Brill, 1913; Foulks, 1974; Gussow, 1960; Landy, 1985; Wallace & Ackerman, 1960). Historian Lyle Dick (1995) reviewed all available accounts of pibloktoq and found that the few detailed case descriptions came from Admiral Robert E. Peary's visits to Greenland. There, on a few occasions, Inuit women were observed to become agitated and run out on the ice, stripping off their clothes, prompting others to restrain them until their agitation eventually subsided some hours later. This 'hysterical' behaviour seems entirely inexplicable until Dick provides the missing context: Admiral Peary had sent these women's menfolk out on exploratory missions at a time before solid ice, exposing them to great risk. The women presumably engaged in shamanistic prayer and magic to ensure the men's safety. Peary also thought it important for the well-being of his crew that they have sexual companions and encouraged his men to take Inuit partners with little regard for existing relationships. The women's 'erratic' behaviour, watched with amusement by Peary's men, now seems less evidence of a discrete culture-bound syndrome than a grimly familiar story of vulnerability and exploitation.

In another historical analysis, Marano (1983) showed how the culture-bound syndrome *windigo*, described among the Ojibway as the fear that one is possessed by a spirit that is turning one into a cannibal, probably never occurred as a behavioural syndrome, but was a part of a legend or mythological belief that could be used as an accusation to attack others. This accusation was effective not only in traditional society but served to mobilize the Royal Canadian Mounted Police as well, invoking a new form of social control available as a result of colonization. Once again, a phenomenon better understood in terms of power, conflict and social change was reified as a psychopathological entity located within individuals (Waldram, 2004). Similar historical accounts of behaviours like *amok* or *latah* suggest that adequate description requires attention to the social context of power and the dynamics of protest and resistance (Kua, 1991; Winzeler, 1990, 1995). This tendency to ignore social context also was characteristic of the comparative psychiatry (*Vergleichende Psychiatrie*) advanced by Emil Kraepelin (1856–1926), who visited Southeast Asia and Indonesia to study *amok* and examine the universality of major psychoses (Jilek, 1995). Kraepelin's conclusion was that clinical phenomenology justified a qualified universalism. However, the differences he did find, he explained in terms of a developmental hierarchy:

> based on a comparison between the phenomena of disease which I found there and those with which I was familiar at home, the overall similarity far outweighed the deviant features ... In particular, the relative absence of delusions among the Javanese might be related to the lower stage of intellectual development attained and the rarity of auditory hallucinations might reflect the fact that speech counts for far less than it does with us and that thoughts tend to be governed more by sensory images. (Kraepelin, 1904).

Kraepelin viewed cultural differences as reflections of biological differences in races or peoples and effectively elided the social context of psychiatric illness (Roelcke, 1997). His advocacy of theories of biological degeneration as a cause of mental disorder contributed to the rise of eugenic policies in Germany that culminated in the Nazi genocides.

While not adhering to Kraepelin's biological essentialism, H. B. M. Murphy (1915–1987) at McGill University and Julian Leff at the Institute of Psychiatry in the UK identified themselves as heirs to the tradition of comparative psychiatry and used both clinical observations and epidemiological methods to make systematic cross-cultural comparisons. Although they eschewed the sort of colonialist thinking and social Darwinism that plagued earlier writing, both invoked developmental hierarchies in their explanations of certain cultural differences. Murphy (1982) contrasted 'traditional' and 'modern' societies and Leff (1981) argued for a progressive differentiation of the emotion lexicon in Indo-European languages with contemporary British English as the most differentiated (for a critique, see Beeman, 1985).

Much of the innovative work of Alexander Leighton and Jane Murphy (Leighton, 1981; Murphy & Leighton, 1965) in Africa, Alaska and rural Nova Scotia also falls under the rubric of comparative psychiatry, although they employed dimensional measures of distress and, owing to their anthropological training, were interested in the impact of social and cultural context on mental health and illness. Despite this ethnographic orientation, Jane Murphy's (1976) influential paper arguing for the universal recognition of psychotic symptoms across diverse cultures did not consider the impact of colonial history on attitudes toward psychosis in the African and Alaskan communities she studied (Sadowsky, 1999).

The 'neo-Kraepelinian' revolution of DSM-III in 1980 introduced operationally defined discrete diagnostic categories in place of dimensional or narrative descriptions of psychiatric disorders (Wilson, 1993). With this new nosology and the accompanying technology of highly structured diagnostic interviews, comparative psychiatry followed the rest of the discipline, abandoning in-depth ethnographically informed studies in favour of research organized around discrete diagnostic categories. This line of research has culminated in a series of important cross-national studies of the prevalence, course and outcome of major psychiatric disorders including the International Pilot Study of Schizophrenia (World Health Organization, 1973), the Determinants of Outcome Study (Sartorius *et al.*, 1986), the Cross-National Study of Depression (World Health Organization, 1983), and the International Consortium of Psychiatric Epidemiology (e.g. Andrade *et al.*, 2003). Successive generations of studies have used more refined measures, particularly standardized diagnostic interviews, most recently the Composite International Diagnostic Interview (Robins *et al.*, 1989). However, these instruments continue to have limitations when used across cultures and methodological artifacts have not been eliminated (Hicks, 2002; van Ommeren *et al.*, 2000). As well, most epidemiological studies have made little provision to identify culture-specific symptoms not included in the core definitions of disorders. In this way, the diagnostic categories of psychiatry bury the traces of their origins in European and American cultural history and become self-confirming 'culture-free' commodities ready for export.

Another important line of work in comparative psychiatry has centred on the effectiveness of traditional or indigenous healing practices (Kiev, 1969; Marsella & White, 1982; Rivers, 1924). Drawing from a rich ethnographic literature on healing rituals, Jerome Frank (1961), Raymond Prince (1980) and others argued that psychotherapy shares essential features with traditional healing and that both could be understood in terms of symbolic action at social, psychological and physiological levels. This work has become increasingly important as efforts are made to integrate or coordinate the activity of mental-health practitioners and traditional or indigenous healers in many societies.

Cultural essentialism and racism in psychiatry

A central feature of most colonial enterprises was the use of racist concepts and ideologies to justify the subordination and exploitation of colonized peoples (Fredrickson, 2002). Though they have no clear foundation in biology, notions of race serve to mark off particular groups as intrinsically different and less than other human beings (Lock, 1993). Psychiatry itself has been used to buttress racist perspectives (Littlewood, 1993). The notion that southern or non-Western peoples had underdeveloped frontal lobes and hence were prone to disinhibited behaviours was promoted by several generations of neuropsychiatrists, both to explain cross-national differences and to account for inequalities within colonized nations that actually reflected the legacy of racism, slavery and economic marginalization. For example, influenced by Lucien Lévy-Bruhl's (1923) notion of primitive mentality, Antoine Porot (1918), the head of the École d'Alger, argued that the native Algerian's mind was structurally different from that of the civilized European (Begue, 1996). This biological essentialism was matched by a complete disregard of social, cultural and political context that served colonial interests. This sort of essentialism persisted into the 1950s in the work of J. C. Carothers on the African mind. For Carothers, the African was developmentally child-like owing to underdeveloped frontal lobes that result in an effective leucotomy (Carothers, 1953; McCulloch, 1993, 1995). A whole generation of African psychiatrists was educated with texts containing this tendentious account.

Of course, there were also essentializing accounts of cultural difference presented in psychological terms. In *Prospero and Caliban*, French intellectual Octave Mannoni ((orig. 1948) 1990) described the people of Madagascar as primitive, and uncivilized, with a fundamentally different mentality based on a 'dependency complex' that protected them from the neurotic conflicts that were the burden of Europeans. Although Mannoni later developed a more nuanced account of the psychology of colonization, with Lacan displacing Adler in his psychodynamic theorizing, his earlier portrait remained a provocation to others seeking to understand and escape from the colonization of the psyche that accompanied political domination (Lane, 2002).

The migration of North African workers to France after 1945 stimulated French psychiatrists' interest in cultural difference and gave rise to the field of ethnopsychiatry (Fassin & Rechtman, 2005). Thus, the study of ethnic diversity in colonizing societies was closely linked with the history of colonial comparative psychiatry. At the same time, there was the growing recognition that the colonial context itself was one of exploitation and stress that could account for some of the suffering and symptomatology seen in clinical contexts.

Frantz Fanon (1925–1961) was an important voice in this critique of the colonial origins of psychopathology (Macey, 1996; Razanajao *et al.*, 1996). Fanon denounced the theories of the École d'Alger, which he saw as based on a colonial perspective with racist devaluing of the values, traditions and autonomy of others. In *Peau noire, masques blancs* (1982, original 1952), Fanon powerfully portrayed the self-alienating effects of racism and colonialism. Fanon's account of the psychopathology of colonialism echoed the earlier account by the sociologist W. E. B. Du Bois (1868–1963) in *The Souls of Black Folk* on the 'double consciousness' of African Americans (Du Bois, 1989). Fanon worked in the space between the political and the psychological – insisting on the primacy of politics and power, but showing how it was inscribed in the psychological and how change could come from within and without (Vergès, 1996). Ultimately, however, Fanon was less interested in the dynamics of culture and colonialism than in the struggle for political revolution and fell prey to the same tendency to essentialize cultural difference that plagued writers less aware than he was to the violence of racial stereotypes.

The process of unpacking the impact of racism and colonialism on the psychology of the colonizer and colonized is far from complete, the more so because the forms that oppression takes continue to mutate. This has been one focus of postcolonial theory, which offers a rich array of ideas about identity and alterity in the contemporary world that has as yet had little impact on cultural psychiatry (Bhaba, 1994; Chakrabarty, 2000; Gunew, 2003; Said, 1994).

Ethnocultural diversity: settler societies and indigenous peoples

The large migrations of Europeans to North America, Australia and other countries from the 1700s onwards created settler societies with high levels of ethnocultural diversity. This experience of people from many different national and regional backgrounds living side by side made ethnicity salient (Banks, 1996). Epidemiological studies were conducted from the 1930s onwards on differential rates of psychiatric hospitalization of ethnocultural groups (Westermeyer, 1989). Subsequent waves of migration following World War II and other conflicts made the mental-health needs of immigrants and refugees increasingly important in most psychiatric settings and led to a substantial literature on ethnic differences in illness behaviour.

The response to ethnic diversity has followed different trajectories in different countries owing to the history of colonization and migration but also following local ideologies of citizenship and dominant theories with psychiatry itself (Kirmayer & Minas, 2000; see for example, Baarnhielm *et al.*, 2005; Beneduce & Martelli, 2005; Fassin & Rechtman, 2005; Fernando, 2005). Thus, the US and France share republican values of egalitarianism that imply that all citizens should be treated the same, with no regard to their cultural background (Todorov, 1993). Along with this came the assumption that, over time, ethnic groups would assimilate and acquire the cultural identity and practices of the dominant society. In fact, ethnicity has persisted in most settler societies despite pressure to assimilate. In the US, this ideal has been complicated by the history of slavery and racial discrimination against many groups. The current language of culture refers to 'diversity', defined in terms of ethnoracial blocs (Hollinger, 1995), but this diversity is recognized mainly insofar as it is associated with health disparities (Smedley *et al.*, 2003). In Canada and Australia, the ideology of multiculturalism has encouraged explicit attention to ethnic difference as a positive social value that warrants direct support by the state (Kivisto, 2002). At other moments, and in other societies, ethnicity has been profoundly divisive and, along with biologically essentialized notions of race, served as an incitement to violence and genocide (Fredrickson, 2002; wa Wamwere, 2003).

In Britain, cultural psychiatry has focused more on issues of race than on culture or ethnicity because of the conviction that racism is a crucial determinant of mental health and of the adequacy of psychiatric services (Fernando, 1988; Littlewood & Lipsedge, 1982). African-Caribbean immigrants have been observed to have high rates of schizophrenia. This phenomenon, which affects some other migrant groups in other countries as well, does not appear to be due to diagnostic biases but may result from the stress of marginalization, discrimination and social exclusion (Hutchinson & Haasen, 2004; Kelly, 2005).

Recognition of the importance of culture, ethnicity and race has been prompted by demographic and political changes in settler countries, sometimes crystallized by specific confrontations or violent events that have commanded public attention. In the UK the death of Stephen Lawrence increased public awareness of issues of racism and social exclusion and prompted a government inquiry that led to changes in policy, with attention being directed to counter racism in institutions including health services (Fernando, 2003). In Canada, the Oka Crisis of 1990 (York & Pindera, 1991) led to the reports of the Royal Commission on Aboriginal Peoples and the establishment of the Aboriginal Healing Foundation to provide support for projects to address the legacy of the residential school system (Kirmayer, Simpson & Cargo, 2003). However, much of the response to cultural diversity has been at the grassroots level with minimal governmental support (Fernando, 2005). At the same time, subtler forms of racism and social exclusion continue to go unmarked and unchallenged (Gilroy, 2005; Holt, 2000).

Anthropology of psychiatry

The revolution in philosophy of science provoked by the work of Thomas Kuhn made biomedicine and psychiatry appear not so much universal truths as culturally constructed bodies of knowledge. Postcolonial writing challenged the taken-for-grantedness of Euroamerican values. The antipsychiatry 'movement' of the 1960s (Boyers, 1974) and the labelling theory of mental illness (Rosenhan, 1973; Scheff, 1974) drew attention to the social and political dimensions of psychiatric diagnosis. Historical accounts showed the ways in which psychiatric notions of madness emerged from and helped to maintain core cultural values (Ellenberger, 1970; Foucault, 1965; Porter, 1988; Micale & Porter, 1994). Within mainstream psychiatry itself, the US–UK Diagnostic Project (Cooper *et al.*, 1972) revealed important differences in the practice of British and American psychiatrists, with overdiagnosis of schizophrenia and under-diagnosis of bipolar disorder in the US. Subsequent efforts to improve the reliability of diagnostic practice in the US contributed to the emergence of DSM-III (Wilson, 1993). These and other social changes encouraged a more self-reflective stance and led anthropologists to consider biomedicine and psychiatry as cultural institutions (Good, 1994; Lock & Gordon, 1988; Kleinman, 1988). The anthropology of psychiatry developed a substantial body of literature showing how psychiatric practices draw from and contribute to cultural concepts of the person and experiences of the self (Gaines, 1992; Kleinman, 1995; Young, 1995). The third phase in the history of cultural psychiatry is strongly influenced by this turn toward cultural analysis and critique of the institutions and practices of psychiatry itself.

The seminal figure in this body of work has been Arthur Kleinman (1977, 1980, 1986, 1988, 1995), who, through his incisive writing, vision and leadership, has stimulated a whole generation of scholars. The 'new cross-cultural psychiatry' introduced by Kleinman (1977) argued for a renewed emphasis on ethnographic research. Rather than assuming the universality of psychiatric categories and psychological modes of expressing distress, Kleinman insisted on paying close attention to the social and cultural context of suffering and healing. This approach could be applied equally well across cultures and within the institutional and community settings of Western psychiatry.

Kleinman introduced the notion of the category fallacy, the erroneous assumption that conceptual categories that work well in one cultural context will have the same meaning and utility in another. In cultural psychiatry this is most obvious in questions about the meaning of psychiatric diagnostic categories. A further epistemological complexity arises from what the philosopher Ian Hacking (1999) has called 'the looping effect of human kinds' – that is, the tendency for the ways we categorize the world to become reified and institutionalized as cognitive and social facts.

The importance of these ideas for cultural psychiatry can be seen in the history of the emergence of diagnostic categories like post-traumatic stress disorder (Young, 1995) and dissociative disorders like multiple personality or fugue (Hacking, 1995, 1998). Psychiatric knowledge and practice reflect and reshape folk psychologies (Gaines, 1992; Littlewood, 2002; Nuckolls, 1992). For example, the reception and evolution of psychoanalysis and other forms of psychotherapy in different countries provides a window onto cultural concepts of the person (Cushman, 1995; Ellenberger, 1970; Rose, 1996; Shamdasani, 2003; Zaretsky, 2004). The broad shift away from psychoanalysis and toward biological accounts in the US in the 1980s reflects tensions within the discipline of psychiatry as well as larger political and economic forces (Luhrmann, 2000). Psychopharmacology has played a crucial role in the development of psychiatry, driving diagnostic nosology and clinical practice (Healy, 2002). A growing body of research shows the role of the pharmaceutical industry in controlling the production of clinical 'evidence' and influencing popular conceptions of mental illness, which now extends to marketing new disorders (Lakoff, 2005; Metzl, 2003; Petryna, Lakoff & Kleinman, 2006).

Clinical work is always part of a larger social system. Understanding the impact of this social system on patients' lives and psychiatric practice demands critical and social science perspectives. Of course, the attempt to apply social science perspectives to analysing psychiatric practice raises the problem of self-reflexivity, since social science theory itself is a product of the society it seeks to critique. Indeed, the notion of culture is also a cultural construction that changes with new configurations of society and geopolitical concerns.

The contribution of psychological anthropology

Cultural psychiatry has co-existed with, and derived some of its theoretical models from, the various schools and approaches of psychological anthropology that link individual personality with broader social processes, particularly culturally shaped child-rearing practices (Bock, 1999; Spindler, 1978). Franz Boas (1858–1942), often called the father of American anthropology, argued that culture could affect personality and behaviour by amplifying or suppressing certain traits thus creating conflicts for different individuals. In the 1930s, 'culture and personality' researchers (notably Ruth Benedict and Margaret Mead) attempted to relate social structure, child-rearing and other cultural life-ways to modal national characters and specific patterns of psychopathology within groups (Spindler, 1978; Stocking, 1986). They used mainly ethnographic observations and borrowed psychodynamic theory or learning theory to explain the links between individual and culture.

For Benedict, Mead and later contributors to the field of culture and personality, psychopathology could be understood in part as an exaggeration of cultural traits or as a mismatch between individual personality and overarching cultural norms and values. This tradition enjoyed a period of prominence during and after the Second World War when studies of 'nations at a distance', based on interviews with small numbers of emigrés and analysis of media, were used as a form of military intelligence (e.g. Benedict, 1934).

Benedict (1934) saw culture as personality writ large. Anthropologist Edward Sapir rejected this view, arguing that culture had no reality beyond the actions and representations of individuals, each of whom responds differently to social exigencies. Sapir was a close colleague of psychiatrist Harry Stack Sullivan and looked to psychiatry to provide a way of understanding culture through the vicissitudes of individual biographies (Sapir, 1938; Kirmayer, 2001). This approach led to more theoretically sophisticated accounts of the interplay of culture, social structure and character notably in the work of A. I. Hallowell (1955), but the field of culture and personality waned in the late 1950s owing to the failure to develop more rigorous methodology and a tendency to caricature whole societies with broad strokes (Levine, 2001).

A parallel tradition in psychological anthropology has used clinical psychoanalytic methods and perspectives to study individuals cross-culturally (Devereux, 1961, 1979; Kardiner & Linton, 1939). In these various forms of 'ethnopsychoanalysis,' the emphasis has been on examining the universality of psychodynamics and considering the ways in which these psychological mechanisms might resolve dynamic tensions created by particular social systems. In-depth interviews, prolonged relationships with subjects and attention to 'clinical material' including psychopathological symptoms, dreams, fantasies and 'transference' distortions, all contributed to the effort to characterize the psychic interior cross-culturally. A nuanced attempt to integrate cultural identity and psychoanalytic ideas was developed in the work of the Department of Psychiatry at the Fann Hospital of the University of Dakar in Senegal in the 1960s. Under the direction of Dr Henri Collomb (who remained chief until 1978), a group of clinicians and researchers undertook careful empirical studies on the interface of Senegalese culture and western psychiatry (Bullard, 2005; Collignon, 1978). There is a rich literature based on clinical experiences with psychoanalytic theory and methods that offers insights into the cultural logic of diverse traditions, increasingly conducted by clinicians who can integrate psychodynamic perspectives with their own intimate cultural knowledge (e.g. Crapanzana, 1973; Doi, 1973; Kakar, 1978; Levy, 1978; Obeyesekere, 1981, 1991).

In contrast to the case study approach of ethnopsychoanalysis, the field of cross-cultural psychology has employed quantitative statistical methods to compare personality and psychopathology in different cultural or national groups. Despite its origins in German social psychology (Hogan & Tartaglini, 1994; Jahoda, 1993), cross-cultural psychology has been dominated methodologically by Anglo-American empiricism and conceptually by an individualistic cultural concept of the person (Kim & Berry, 1993; Marsella, DeVos & Hsu, 1985). This cultural concept is taken over from American folk psychology and supports a large body of research that is generally presented as universal truths about the human psyche. The recent movement for indigenous psychologies attempts to reformulate basic models of personality from alternative perspectives, emphasizing, for example, the centrality of relationships with others in the dynamics of the self (Ho *et al.*, 2001).

Another strand in the development of psychological anthropology relevant to cultural psychiatry has its roots in the early ethnographic work of W. H. R. Rivers (1864–1922), who emphasized the rationality and potential efficacy of healing practices in the Melanesian and other societies he studied (Rivers, 1924). As a leading figure in both anthropology and psychiatry, Rivers used a variety of models to understand psychopathology and healing, but was most invested in psychological explanations that could be connected to an evolutionary biology (Young, 1993; 1999). Gregory Bateson (1904–1980) followed the direction of Rivers' work, incorporating psychological notions from Benedict and Mead, but approaching mind with biological metaphors (Bateson, 1972). Bateson challenged the static view of culture in early British social anthropology by developing a 'cybernetic' approach to culture as a dynamical system (Stagoll, 2005; Wardle, 1999). In the 1950s and 1960s, Bateson's ideas about communication, interaction and the 'ecology of mind' had tremendous influence on the emerging field of family therapy.

Psychological anthropology has had a renaissance in recent decades with an increasingly eclectic range of theories brought to bear on understanding personality, identity, and psychopathology (Good, 1992). Most recently, contemporary versions of cognitive, social and developmental psychology, and social neuroscience have provided models for the interplay of culture and psychology (Casey & Edgerton, 2005; Hinton, 1999; Shore, 1996; Shweder, 1991; Stigler, Shweder & Herdt, 1990; Sperber, 1996; Strauss & Quinn, 1997) This work is concerned with understanding culture in terms of discourse, interpersonal interaction, and socially distributed knowledge, and makes links with cognitive science and discursive psychology (Kirmayer, 2006).

Conclusion: a world in flux

As an organized field within the larger discipline, cultural psychiatry has a relatively short institutional history. A section of transcultural psychiatry was established in 1955 at McGill University by Eric Wittkower and Jacob Fried (1959). At the Second International Psychiatric Congress in Zurich in 1957, Wittkower organized a meeting attended by psychiatrists from 20 countries, including many who became major contributors to the field: Tsung-Yi Lin (Taiwan), Thomas A. Lambo (Nigeria), Morris Carstairs (Britain), Carlos Alberto Seguin (Peru) and Pow-Meng Yap (Hong Kong) (Prince, 2000). The American Psychiatric Association established a Committee on Transcultural Psychiatry in 1964, as did the Canadian Psychiatric Association in 1967. H. B. M. Murphy of McGill founded the World Psychiatric Association Section on Transcultural Psychiatry in 1970. By the mid 1970s transcultural psychiatry societies were set up in England, France, Italy and Cuba (Cox, 1986). The major journals in the field, *Transcultural Psychiatry* (formerly *Transcultural Psychiatric Research Review*), *Psychopathologie Africaine*, *Culture Medicine and Psychiatry*, and *Curare*, began in 1956, 1965, 1977 and 1978, respectively.

Over the last 50 years, the discipline has grown from a marginal field, concerned mainly with folklore, exotica and the distant cultural ‘other’, to a dynamic research and clinical enterprise of crucial importance in the light of increasing migration, cultural intermixing and the insights of social neuroscience. Over this same period of time, both the meanings of culture and the dominant theory and modes of practice of psychiatry have changed substantially in ways that have reshaped the field of cultural psychiatry.

Despite this progress, there is a persistent legacy of colonialism in contemporary cultural psychiatry that can be seen in the continuing romance with exoticism, the de-contextualized view of mental-health problems and focus on culture-bound syndromes, efforts to reify and essentialize culture as individual traits, and the tendency to employ developmental hierarchies contrasting traditional and modern societies. The corrective to these biases requires thinking about culture as a dynamic process of creativity and contestation among individuals participating in different forms of life, with issues of power and agency always at stake.

Wittkower adopted the term ‘transcultural’ to imply moving through and beyond cultural barriers (Wittkower & Rin, 1965). Others have preferred to call the field ‘cultural psychiatry’ to indicate that all human experience is culturally constituted and that we can examine cultural meanings in a single society as well as comparatively (Prince, 1997). In the context of globalization, ‘transcultural’ takes on new meaning based on the recognition that cultures are always mixed or creolized, giving rise to new forms (Glissant, 1997; Kraidy, 2005). Many urban settings now present a sort of ‘hyperdiversity’ in which many different groups co-exist and hybrid forms of identity abound. Transcultural psychiatry must explore the significance for mental health and illness of various forms of cultural hybridity at the both social and individual levels (Bibeau, 1997).

Among the central questions for contemporary cultural psychiatry are the nature of the interaction of psychopathological processes and cultural idioms of distress in the genesis and course of disorders; the specific mechanisms of action of sociocultural factors on course of schizophrenia and other disorders; the range of cross-cultural applicability of psychopharmacological, psychotherapeutic and psychosocial interventions – both those derived from biomedicine and those of indigenous origin; and the impact of emerging practice models and healthcare systems that aim to provide culturally sensitive or responsive care across cultures and within culturally diverse settings. To do this, cultural psychiatry must consider how local clinical and research practices reproduce larger gender, class and other social differences of the dominant society.

In addition to these enduring concerns, new issues are emerging. Psychiatry has been enjoined to play a role in conflict resolution and rebuilding communities torn apart by ethnic violence. Cultural psychiatry itself has been co-opted by pharmaceutical companies seeking strategies to open up new markets for their products (Kirmayer, 2006). Clinical trials for new drugs are now taking place in the developing economies of Eastern Europe and South Asia, raising important questions about the role of culture in psychopharmacology. At the same time, the changing configurations of the world system – through migration, ethnic nationalism, ethnogenesis, globalization, telecommunications, and the growing web of the Internet with its communities and identities forged in cyberspace – require us to rethink the nature of culture. These social changes directly impact on health and raise fundamental questions, not only of a scientific nature but also with an ethical or sociomoral dimension that concerns the value of diversity versus integration, of sameness and difference, and the implications for mental health and illness of cultural pluralism and the dramatically enlarged scale of community and malleability of identity made possible by new technologies.

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2

Anthropology and psychiatry: the contemporary convergence

Janis H. Jenkins

EDITORS' INTRODUCTION

Anthropology and psychiatry as disciplines appear to have a considerable amount of common ground. Both are interested in human beings, the societies within which they live and their behaviours. A key starting difference between the two is anthropology's interest in relativism, whereas psychiatry has been interested in universalism. Also, both anthropology and psychiatry have a long history of common interest in phenomenology and the qualitative dimensions of human experience, as well as a broader comparative and epidemiological approach.

Jenkins illustrates the common ground by emphasizing that both disciplines contribute to the philosophical questions of meaning and experience raised by cultural diversity in mental illness and healing. Both disciplines also contribute to the practical problems of identifying and treating distress of patients from diverse ethnic and religious groups. Psychiatry focuses on individual biography and pathology, thereby giving it a unique relevance and transformation. Patient narratives thus become of great interest to clinicians and anthropologists. Development of specializations such as medical or clinical anthropology puts medicine in general and psychiatry in particular under a magnifying glass. Using Jungian psychology as an exemplar could lead to a clearer identification of convergence between the two disciplines. The nexus between anthropology of emotion and the study of psychopathology identified in her own work by Jenkins looks at normality and abnormality, feeling and emotion, variability of course and outcome, among others. She ends the chapter on an optimistic note, highlighting the fact that the convergence between these two disciplines remains a very fertile ground for generating ideas and issues with the potential to stimulate both disciplines.

Introduction

The convergence of anthropology and psychiatry is one of the most productive zones of intellectual activity in the history of ideas, bringing two disciplines to bear on a set of questions fundamental to the definition of human being. The notion of a comparative psychiatry dates back at least as far as Kraepelin. Psychiatrists since Freud have become fascinated with the experiential diversity of ethnographic data, and anthropologists such as Benedict and Devereux, struggling with the slippery boundary between normal and abnormal, have had repeated recourse to the data of psychiatry. Anthropologists such as Levi-Strauss and psychiatrists such as Frank have invoked an analogy between indigenous ritual healing and psychotherapy in their attempts to understand the efficacy of both genres of treatment. Both anthropologists and psychiatrists have struggled with the question of relativity in defining forms of psychopathology, in a debate ranging from the demonstration that there are universal core symptoms of some disorders to the identification of culture-bound syndromes that exist only under certain human conditions. Active collaborations have been undertaken periodically since at least the time of Sullivan and Sapir. Although the expertise of the two disciplines is divergent, both contribute to the philosophical questions of meaning and experience raised by cultural diversity in mental illness and healing. Likewise, both contribute to the practical problems of how best to treat the distress of patients from diverse ethnic and religious groups,

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

and how to conceive psychiatric disorder in successive revisions of the DSM nosology.

My strategy in this chapter does not focus on discriminating the contributions of the two fields, but on outlining a series of topics common to their contemporary mutual interest in the relation between culture and mental illness/healing. In doing so I organize the material in such a way as to call attention to conceptual contrasts that transcend or lie outside the disciplinary distinction between anthropology and psychiatry. How, for example, is it different to examine the cultural factors affecting the use of psychopharmaceuticals and those affecting the use of alcohol and social drugs? What is the consequence of adopting the different perspectives implied by the study of psychiatric treatment and psychiatric services? What is the difference in views of human variability that seek out the existence of culture-bound syndromes and those that recognize cultural variations in psychiatric disorders defined essentially in Western terms? How much in common is there among the perspectives of psychiatric anthropology, (trans) cultural psychiatry, and ethnopsychiatry? Is there a significant difference beyond that of magnitude of trauma in the mental health of immigrants and that of refugees?

Defining the convergence

A variety of statements both synthetic and programmatic have defined the convergence between anthropology and psychiatry since the early essay by Kraepelin on '*Comparative Psychiatry*' in 1904. Particularly useful is the collection of seminal works from 1880 to 1971 edited by Littlewood and Dein (2000), which traces a repertoire of interests ranging across defining the normal and abnormal, the Oedipus complex, family structure, magic and religion, death, suicide, intoxicants, anxiety, symbolism, and culture-bound syndromes. Raimundo *et al.* (2005) examines the historical precursors of cross-cultural psychiatry among nineteenth century alienists, whose work was predicated on the notion that insanity was rare among primitive peoples and increased along with civilization and its increasing levels of cognitive organization, demands for mental production, and occasions for mental excitation. This apparent observation was eventually interpreted in racist neurobiological terms such that the natives' brains were said to be more simple and crude than those of civilized peoples.

Bains (2005) examines the more recent history of transcultural psychiatry, pointing out that its identity as a distinctive discipline dates from after World War II. A powerful voice from this postwar period was Ernest Becker (1962, 2005), whose concern with meaning resonates more than 40 years later. The 1970s and 1980s saw a rapid development and reformulation, in the midst of which a 'new cross-cultural psychiatry' emerged from a synthesis of interpretive approaches from anthropology and an increasingly sophisticated academic psychiatry (Martins, 1969; Wittkower and Wintrob, 1969; Wittkower and Dubrenil, 1970; Galdston, 1971; Kiev, 1972; Kennedy, 1974; Cox, 1977; Padilla and Padilla, 1977; Miller, 1977; Estroff, 1978; Kleinman, 1977, 1980; Murphy, 1983, 1984).

Summarizing the decade of work since Kleinman's (1977) watershed definition of the revitalized interdisciplinary field, Littlewood (1990) contrasted the new cross-cultural psychiatry's anthropological emphasis on psychiatric epistemology and clinical practice to assess the universality of psychopathology with the old cross-cultural psychiatry's relative emphasis on examining the applicability of psychoanalytic concepts to non-Western societies. Writing in the same year Leff (1990) suggested that the shift in focus and the new agenda for investigation was a case of throwing the baby out with the bathwater. Within several years Lewis-Fernandez and Kleinman (1995) hailed cross-cultural psychiatry as a mature discipline addressing the complexities of sociosomatics and clinically relevant cultural processes, while decrying the limited impact of the field with respect to cultural validation of the DSM-IV, persistent misdiagnosis of minority patients, continued presence of racial bias in treatment, and inattention to ethnic issues in medical ethics. This claim to maturity of the field has been reiterated by Lopez and Guarnaccia (2000, 2005) with reference to the study of cultural psychopathology as the study of culture and the definition, experience, distribution, and course of psychological disorders. An important synthesis of the discipline in textbook form has been contributed by Helman (2000).

The mutual relevance of anthropology and psychiatry remains an important concern for scholars and clinicians in the field (Mihanovic *et al.*, 2005; Stix, 1996; Skultans and Cox, 2000). On the one hand, Kleinman (1987, 1988) has highlighted the contribution of anthropology to cross-cultural psychiatry with respect to issues such as translation, the category fallacy in defining psychiatric disorder, and pathoplasticity/pathogenicity, emphasizing anthropology's attention to cultural validity in addition to reliability, and to the relevance of cultural analysis to psychiatry's own taxonomies and methods. On the other hand, Kirmayer (2001) has reprised Edward Sapir's argument that psychiatry's focus on individual biography and pathology gives it a unique relevance for anthropology's concern with cultural transmission, suggesting that recent work focused on illness narratives help to position individuals in a social world. Skultans (1991) examines the uneasy alliance between anthropology and psychiatry historically and with respect to the way differences in orientation between the two disciplines have led to conflicting ideas about the nature of cross-cultural research, particularly anthropological fieldwork.

Theory, method and clinical relevance

Occasional attempts have been made to establish a conceptual and theoretical grounding specific to the convergence of anthropology and psychiatry. One group of scholars has examined the value of Jungian psychology with its emphasis on imagination and phenomenology for both clinical and research work in cultural psychiatry (Abramovitch and Kirmayer, 2003). The key concept of explanatory models, focusing on the patient's understanding of illness episodes, was introduced by Kleinman (1980) and has inspired a substantial body of research, as well as debate about the concept's use in clinical work (Bhui *et al.*, 2002, 2004, Dein, 2002). Foulks (1991) has addressed the underlying concepts of normal, abnormal, and deviant against the conceptual background of social pathology, cultural relativism, evolution and the biological basis of mental disorders, heredity, and the distinction within DSM between Axis I and Axis II spectrum disorders. An evolutionary concept of mental disorder has been elaborated in terms of culture and context by Kirmayer and Young (1999). Paris (1994) argues that evolutionary social science is relevant for transcultural psychiatry insofar as it is consistent with a biopsychosocial model of etiology, and recognizes universals which underlie cultural variations in psychopathology. Jovanovski (1995) suggests that the pathoplasticity of mental disorders across cultural contexts indicates that abnormality is phenotypic rather than genotypic, but argues that neuroses are more associated with culture while psychoses with biology.

Jenkins (1991b) has introduced the notion of political ethos to bridge analysis of the state construction of affect and the phenomenology of those affects in the mental-health sequelae of political violence experienced by refugees. In other work Jenkins (1991a, 1994a,b, 1996) examines the nexus between the anthropology of emotion and the study of psychopathology with respect to distinctions between normal and pathological emotion, feeling and emotion, interpersonal and intrapsychic accounts of distress and disorder, variability of course and outcome, mind–body dualism, and the conceptualization of psychopathology as biologically natural event or sociopolitically produced response. The concept of personality has been addressed by Lewis-Fernandez and Kleinman (1994), who show with examples from Chinese and Puerto Rican societies how socially oriented indigenous interpersonal models of personality and psychopathology can augment the cross-cultural validity of clinical formulations. Byron Good (1994) places meaning squarely at the conceptual center of the convergence between anthropology and psychiatry, with a hermeneutic critique of rationality that flows into a celebration of experience. In the context of a critical examination of how we interpret psychiatric symptoms, Martinez-Hernaez (2000) elaborates the complementarity of psychiatric observation and anthropological understanding.

Equally important as the theoretical and philosophical bridge between disciplines of anthropology and psychiatry is the pragmatic bridge from the conceptual work to its clinical relevance. Alarcon *et al.* (1999) describe five interrelated dimensions that specify the clinical relevance of culture as (1) an interpretive/explanatory tool in understanding psychopathology; (2) a pathogenic/pathoplastic agent; (3) a diagnostic/nosological factor; (4) a therapeutic/protective element; (5) a service/management instrument (see also Emsley *et al.*, 2000). Good and Good (1981) argue cogently for a cultural hermeneutic model for understanding patient experience in clinical practice. Moldavsky (2003) points out that contemporary transcultural psychiatry focuses more on the illness experience than the disease process, while distancing itself from the absolute relativism of antipsychiatry, focusing on clinical issues that aid clinicians in their primary task of alleviating suffering. DiNicola (1985 part I, part II) has offered a synthesis between family therapy and transcultural psychiatry, and Castillo (1997) elaborates a client-centered approach to culture and mental illness. Okpaku (1998) has offered a global compendium of case studies and clinical experience to provide practicing clinicians with a basic foundation of culturally informed psychiatry. Ponce (1998) advocates a value orientations model of culture for use in clinical practice, the rationale and internal logic of which is predicated on the concepts of paradigm and epistemology.

Guarnaccia (2003) has outlined methodological advances that will likely help define research in cross-cultural psychiatry in the early twenty-first century. Hollan (1997) advocates person-centered ethnography as a method ideally compatible with the goals of cross-cultural psychiatry. Experiments have been made with focus-group methods in order to enhance the contextual basis for making culturally sensitive interpretations (Ekblad and Baarnhielm 2002). Rogler (1999) offers a methodological critique of the procedural norms that lead to cultural insensitivity in mental-health research, highlighting the development of content validity based on experts' rational analysis of concepts, linguistic translations that conform rigidly to the literal terms of standardized instruments, and the uncritical transferring of concepts across cultures. The methodological contribution of cognitive neuroscience is discussed by Henningsen and Kirmayer (2000), comparing the two orders of higher level explanation constituted by intentional vs. dynamical systems theory and the subpersonal explanation of cognitive psychology and neurobiology.

From a comparative and anthropological standpoint, Jenkins and Karno (1992) have examined the theoretical status of expressed emotion, one of the most heavily used methodological constructs in studies of major mental disorder. Starting from the WHO cross-cultural studies of schizophrenia, Hopper (1991) critically examines the validity of various aspects of methodological critique registered by anthropologists against such large-scale psychiatric epidemiological studies, concluding that there is a natural alliance between clinicians alerted to cultural factors affecting course and outcome, and ethnographers attuned to cultural beliefs, work patterns, kin-based support, uses of public space, and indigenous understandings of affliction. Uehara *et al.* (2002) suggest that ethnographic understanding in the assessment of Asian-American mental health would benefit particularly from use of semantic network analysis and commonsense-reasoning analysis.

Shared research agendas

The research agenda for this hybrid field continues to be defined and redefined. At the current moment the field has been given a certain degree of coherence and consistency by a collective mobilization to address the strengths and weaknesses of the attempt to integrate cultural factors into the professional psychiatric nosology institutionalized in the DSM-IV. Good (1992) has made a cogent argument mediating between cultural relativists who consider the DSM nosology as culture-bound and ethnocentric, and universalists who understand the nosology to reflect invariant characterstics of psychopathology, pointing out that the psychiatric nosology is a valuable ready-made comparative framework while at the same time being vulnerable to cross-cultural critique by demonstration of variability in psychiatric syndromes. A substantial body of experts collaborated in the effort to incorporate cultural issues into DSM-IV. Eventually included were an introductory cultural statement, cultural considerations for the use of diagnostic categories, a glossary of culture-bound syndromes and idioms of distress, and an outline for a cultural formulation of diagnoses in individual cases (Mezzich et al., 1999). In the aftermath these same experts collaborated in an analysis and critique of what was proposed in comparison to what was excluded (Mezzich *et al.* 1996; Kirmayer, 1997). As of this writing, attention is already being focused on the challenge of further enhancing the role of culture in DSM-V (Alarcon *et al.*, 2002). Meanwhile, the ongoing development and testing of psychiatric categories in the 10th Revision of the International Classification of Diseases has drawn sustained attention of Sartorius (1988, 1991) and colleagues (Sartorius *et al.*, 1993, 1995).

An important tool for furthering the integration of culture into DSM-IV has been its inclusion of an outline for cultural formulation (Lewis-Fernandez and Diaz, 2002). The cultural formulation is perhaps the most concrete expression of the contemporary convergence of anthropology and psychiatry. It is also at the same time a clinical tool in that it is a comprehensive summation of cultural factors in an individual case, and an ethnographic document in which cultural context and themes are elaborated from a person-centered standpoint. It is unclear the extent to which the cultural formulation is currently being used in clinical practice, but it has a strong presence in the research arena as a regular feature in the journal *Culture, Medicine, and Psychiatry*, which for more than a decade has published cultural formulations in the form of brief articles of value to both clinicians and ethnographers. Novins *et al.* (1997) take a step toward using the DSM-IV outline to develop comprehensive cultural formulations for children and adolescents, critically reviewing the use of the outline in the context of preparing cultural formulations of four American Indian 6–13-year olds. Sethi *et al.* (2003) suggest that the cultural formulation can be useful for bridging the gap between understandings of form and content in the understanding of psychiatric signs and symptoms.

The traditional North American conceptualization of ethnopsychiatry focuses on the study of indigenous forms of healing understood as analogous to what in Western terms is broadly defined as psychotherapy (Kiev 1964; Frank and Frank 1991). Renewing and updating this agenda, cultural variants of healing and therapeutic process emphasizing modulations in bodily experience, transformation of self, aesthetics, and religion have been contributed by Csordas (1994, 2002), Desjarlais (1992), Mullings (1984), Laderman (1991), and Roseman (1991). At the same time, the distinction between ethnopsychiatry as traditional, religious, or indigenous healing and Western biomedical psychiatry as a cosmopolitan and scientific clinical enterprise has broken down insofar as professional psychiatries from many countries have been subjected to analysis as ethnopsychiatries (Fabrega 1993; Hughes 1996). This was already evident in Kleinman's (1980) juxtaposition of Taiwanese psychiatry and shamanism in his seminal examination of depression and neurasthenia in Taiwan. It was made emphatic in the collection of papers edited by Gaines (1992) giving equal weight to the cultural construction of both folk and professional psychiatries. Sartorius and Jablensky (1990) have compared diagnostic traditions and the classification of psychiatric disorders in French, Russian, American, British, German, Scandinavian, Spanish and Third World psychiatric traditions.

A variety of approaches, more or less cultural, have been taken to the analysis of professional psychiatry. Al-Sabaie (1989) has examined the situation in Saudi Arabia, and Angermeyer *et al.* (2005) have compared the situation in the Slovak Republic, Russia, and Germany. In the United States, Luhrmann (2000) documents a watershed moment in contemporary psychiatry as cultural meanings and social forces move the entire field from a clinical culture in which psychoanalysis was prominent to one in which biological psychiatry and neuropsychiatry are dominant. Significant works in clinical ethnography in the United States include Angrosino's (1998) study of a home for the mentally retarded, Estroff's (1981, 1982) study of an outpatient psychiatric facility, and Desjarlais' (1997, 1999) work on a shelter for the homeless mentally ill; Biehl (2005) has contributed an examination of an asylum for the socially abandoned mentally ill in Brazil. A volume edited by Meadows and Singh (2001) examines mental health in Australia, though it pays little attention to cultural psychiatry and care for indigenous and migrant groups. Barrett (1996) does a close analysis of how psychiatrists in Australia construct schizophrenia through social interaction and discursive practices.

An early discussion of ethnopsychiatry in Africa by Margetts (1968) emphasizes the importance of investigating topics such as conceptions of normality and abnormality, magic and religion, social hierarchy, life-cycle rituals, symbolism, demonology, secret societies, death and burial customs, politics, suicide and cannibalism. More recently, the state of psychiatry in Africa has been discussed by Ilechukwu (1991), who observes that colonial era notions about the rarity of major mental disorder in Africa have been disproven, leading to changes in the health-care system, with particular mention of the Aro village system which integrates indigenous and western psychiatric care. Swartz (1996, 1998) examines the changing notion of culture in South African psychiatry, from a de-emphasis of difference in order to avoid the use of relativism as a justification for oppression to an interest in diversity with a post-apartheid society, and the potential contribution of this change to developing community-based care, understanding indigenous healing, and nation-building.

In counterpoint to this trend toward analytically indigenizing professional psychiatry are observations about international intercommunication and globalization as processes affecting institutional psychiatry (Belkin and Fricchione 2005). Kirmayer and Minas (2000) observe that globalization has influenced psychiatry through socioeconomic effects on the prevalence and course of mental disorders, changing notions of ethnocultural identity, and the production of psychiatric knowledge. Crises in the global world system in the context of development create a truly global challenge and an urgency in understanding links between culture and mental disorders (Kleinman and Cohen 1997). Fernando (2002, 2003) argues that global psychiatric imperialism and individual racial/cultural insensitivity must be surmounted in order to achieve legitimately universal concepts of mental health. In this domain, theoretical and clinical appear especially clearly as sides of the same coin. For example, thinking about the effects of racism in psychiatry is parallel to viewing psychiatry as an arena in which to analyze and understand racism (Bhugra and Bhui 2002). In a postmodern, postcolonial, and creolizing world, argues Miyaji (2002), attention must be given to clinicians' shifting identities and fluid cultures, as well as to positionality in both local and global power dynamics.

Cultural competence has proliferated as a catchword in parallel with a shift in focus from "treatment" development and efficacy to "service" provision and delivery (Cunningham *et al.*, 2002). Distinctive clinical training has been developed in dozens of residency programs in the United States (Jeffress 1968), such as one for residents treating Hispanic patients and emphasizing the availability of cultural experts in supervision, skills in cultural formulation of psychiatric distress, and culturally distinct family dynamics (Garza-Treviño *et al.*, 1997). Yager *et al.* (1989) describe training programs in transcultural psychiatry for medical students, residents, and fellows at UCLA. Rousseau *et al.* (1995)

show that psychiatry residents' perceptions of transcultural practice vary in relation to their own cultural origin rather than with respect to their degree of exposure to patients from different cultures or their training in cultural psychiatry. International videoconferencing has been introduced to the training of medical students in transcultural psychiatry, in one case linking Sweden, Australia, and the United States (Ekblad *et al.*, 2004). Beyond the training of clinicians, insofar as social and cultural factors can impact treatment modalities and outcomes, managed and rationed healthcare must take this into account to ensure the availability of cost-effective treatment within an integrated system of services to patients of all cultural and economic backgrounds (Moffic and Kinzie, 1996).

An extensive review of empirical work on the perennial topic of cultural variability in psychopathology would require at least as much space as I have devoted to general theoretical, methodological, topical, and clinical considerations. I mention here only the most comprehensive and definitive edited collections as a pointer toward three critical issues: on culture-bound syndromes see the volume by Simons and Hughes (1985); on depression see the volume by Kleinman and Good (1985); and on schizophrenia see the volume by Jenkins and Barrett (2004). The relation of culture to trauma, violence, and memory has been taken up in a series of critical works by Antze and Lambek (1996), Bracken (2002), Breslau (2000), Robben and Suárez-Orozco (2000), Young (1995), Kinzie (2001a,b), and Rousseau (1995). Related to the literature on trauma, the experience of geographical dislocation has become of increasing concern as researchers and clinicians address the mental health of immigrants and refugees (Bhugra, 2000; Boehnlein and Kinzie, 1995; Ingleby, 2005, Hodes 2002; Hollifield *et al.*, 2002; Kinzie, 2001a,b; Azima and Grizenko, 1996; Kirmayer, 2002; Lustig *et al.*, 2004).

The cultural analysis of psychopharmacology both from the standpoint of subjective experience and global political economy is attracting increasing attention (Lakoff, 2005; Petryna, Lakoff and Kleinman, 2006; Jenkins, 2005; Healy, 2002; Metzl, 2003). Significantly more attention should be paid to the consequences of distinguishing studies oriented by the therapeutic discourse of "treatment" (Tseng and Streltzer, 2001; Seeley, 2000) and studies oriented by the economic discourse of "services" (Kirmayer *et al.* 2003) in mental-health care, particularly since the discourse on services has grown increasingly dominant in the arena of research and funding. Finally, although my concern has been with the convergence between anthropology and psychiatry, some acknowledgment must be made of a third discipline that operates in the sphere of mental illness and psychiatric disorder. Psychiatric epidemiology makes an important contribution regardless of the fact that epidemiology shares neither the methodological disposition nor the intellectual temperament that renders the dialogue between anthropology and psychiatry so natural.

These issues do not exhaust the evolving research agenda that continues to take shape in the convergence of anthropology and psychiatry. The underlying comparative approach of this field has led to the recognition of variations in the practice of cultural psychiatry itself across national boundaries (Alarcon and Ruiz, 1995). Freeman (1997) has described the French school of ethnopsychiatric treatment for immigrant families oriented by the psychoanalyst Tobie Nathan. Somewhat different approaches are associated with the British school headed by Roland Littlewood and colleagues, and the North American groups at Montreal including Laurence Kirmayer, Gilles Bibeau, Ellen Corin, and Allan Young. And at Boston including Arthur Kleinman, Byron Good, and Mary-Jo Good. Useful studies could be made comparing these schools' intellectual orientations. Likewise, serious comparison of the treatment strategies adopted in clinics specializing in the treatment of different ethnic groups would be of considerable value.

Concluding considerations

Despite the critical importance of culture to understanding psychopathology, in the United States the National Institute of Mental Health has not emphasized the funding of ethnographic studies of mental health (Manson, 1997). This may be due in part to the difficulty of conducting such studies, and in part to the lack of orientation of anthropologists to NIMH as a research funding source. Additional insight can be gained from Manson's (2003) examination of the epistemological and disciplinary tensions involved in generating the 2001 Surgeon General's report on "Mental health: culture, race, and ethnicity," a document evoked as a touchstone for research priorities in this area.

We must note that there are gaps and silences in the convergence between anthropology and psychiatry. Although the field is implicitly comparative, the greatest part of the literature concentrates on particular cultural settings. Although issues of cross-cultural communication are implicit in virtually all the literature in this field, explicit consideration of ethical issues in fieldwork in psychiatric settings across cultures are rarely raised (Addlakha, 2005; Okasha, Arboleda-Florez, and Sartorius, 2000). Likewise, despite implicit concern with differences in meaning and experience across cultures, the explicit consideration of how these differences intersect with gender differences across cultures is rarely seen, and neither is the role of culture in child psychiatry often addressed (Munir and Beardslee, 2001; Timini, 2002).

In the final analysis, the convergence between anthropology and psychiatry remains en exceedingly fertile ground for generating ideas and issues with the potential to stimulate both parent disciplines. With respect to theory and clinical practice, global political economy and intimate subjective experience, the nature of pathology and the process of therapy, this hybrid field is a critical locus for addressing the question of what it means to be human, whole and healthy or suffering and afflicted.

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Suicide, violence and culture

Michel Tousignant and Arlene Laliberté

EDITORS' INTRODUCTION

Suicide and violence are both culturally determined and influenced. There is considerable evidence that rates of suicide vary dramatically across nations, and cultures deal with these acts in different manners. The relationship between mental illness and suicide also varies. In some cultures, such as China and Sri Lanka, the rates of suicide are very high, but the rates of mental illness among those committing suicide are not. Social factors such as education, employment, high aspirations and poverty, along with stressors such as life events, may play a role. In some societies, the act of suicide remains illegal; therefore it is impossible to get accurate rates of suicide. Violence is related to a number of similar factors and globalization and urbanization may play an important role. Gender differences in suicide and violence vary too.

In this chapter, Tousignant and Laliberté propose that the national and gender differences in suicide and violence are culturally determined. Marital conflicts and relationship problems with in-laws are common causes of domestic violence and dowry deaths are sometimes passed off as suicide or accidental deaths. Embedded within these acts are the gender role and gender-role expectations. Using examples from aboriginal groups for rates of suicide and in Quebec, Tousignant and Laliberté suggest that drug or alcohol problems, along with problems in attachments and problems in relationships and breakdown of relationships, produce inordinate pressure on individuals, which is used as a trigger for seeking a way out. The sociocultural model these authors put forward is important in understanding vulnerability factors, which are more likely to be specific for specific groups. The symbolic violence towards vulnerable individuals, especially in the underclass who are often denied their rights, face prejudice and rejection, and thus get into a downward spiral of self destruction. The lessons for policy makers are many, and empowering vulnerable individuals is an important first step.

Introduction

The analysis of suicide brings new challenges to cross-cultural studies of mental health. Suicide is not, as such, a mental illness, despite the fact that some of its related behaviours are considered symptoms of depression and borderline personality disorder. All the studies based on the psychological autopsy method around the world report a high association between suicide and psychiatric morbidity or comorbidity (Pouliot and DeLeo, 2006). Before generalizing on the extent of the association, we need more conclusive studies, especially from India and China. In countries with a high rate of suicide such as China (Zhang *et al.*, 2002) or Sri Lanka (Marecek, 1998), local psychiatrists are not ready to corroborate that suicide is as highly related to mental illness as is the case in Western countries.

If suicide is related to known factors of mental illness such as poverty, recent life events, alcohol and drug abuse, impulsivity and hopelessness, to name the main ones only, there are central questions raised by the important variations found between countries and, within a single country, between different ethnic groups. For example, many Muslim countries report rates near zero whereas theses rates can rise above 40 per 100 000 in Sri Lanka, the Baltic countries and many former members of the Soviet Union (WHO, 2004). Within Romania, Hungarians have a rate more similar to Hungary than to the

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

rest of the general population according to non-published official records I was shown in 1992. Within Canada, Quebec shows a rate 50% higher than the rest of Canada and the Aboriginals a rate many times higher (Allard *et al*., 2004).

National differences

Hypotheses are needed to explain the wide national differences. Durkheim's theory (1898, 1985) is still a basic reference in the field but is unsatisfactory to account for the numerous data collected during the century after his work. The main limitation of this theory, beyond its lack of operationalization, is the aggregate approach which is now accepted as a good preliminary tool for exploring new ideas but as a less valid one than the study of individual records, especially in the form of the psychological autopsy as proposed by Shneidman (2004). A good cultural explanation should also go beyond archived information and be based on more clinical and ethnological data. Unfortunately, there are few such studies. Mental-health investigators have generally been reluctant to invest in ethnological studies or been insufficiently trained in this area, whereas anthropologists have been rarely involved in epidemiological studies of suicide.

There is certainly no unique model able to explain suicide in general or the cultural variations of suicide across the planet. A good methodological starting point is not to concentrate on national data but to focus attention on these high-risk groups within a nation which account for a large part of the variance of suicide. To paraphrase H. B. M. Murphy (1982), the important question is to identify which groups have higher rates and under which circumstances. Whenever possible, the comparative approach should be completed with a historical study of trends. Many groups with high rates of suicide today were relatively immune one generation ago. Children may take their life, but not their parents; the husbands but not the wives; or relatively more young women in some countries.

The thesis proposed in this chapter is that a subgroup with a high suicide rate within a culture is often a category with a declining or low status, or getting more aware that its rights are thwarted, and unable to build a social identity of outcasts or otherwise. The members of the category committing suicide are also likely to be the object of internal aggression or rejection within the clan or the family and, at the same time, unable to externally express their frustration through legitimate cultural channels or through marginal organizations. This model can throw some light on some of the most spectacular variations noticed in the recent literature. In order to illustrate this model, we will restrict the overview to in-depth analyses of cases where there is information on cultural changes and family dynamics of individual suicides.

Canadian Aboriginals

Many Aboriginal communities of Northern Canada harbour some of the highest suicide rates in the world. Suicide among the Aboriginal people of Canada is higher among the populations of the North, having been put more recently in contact with the shock of *deculturation* as opposed to acculturation. The age-group of 15–25 is generally the most vulnerable. For instance, the youth rate of Aboriginals from British Columbia was five times higher than among the non-Aboriginals during the years 1987–1992 and this trend was similar in many areas of Canada (Royal Commission on Aboriginal Peoples, 1995). In the United-States, the suicide rate among Aboriginals of 19 years old and less in 1997–1998 was 9.1/100 000 compared to a rate of 2.9/100 000 for Caucasian Americans (CDC, 2003). We notice important regional variations however. For instance, in British Columbia, eight of the 29 Aboriginal groups had no suicide or very low rates whereas one third of them had rates over 100/100 000, or approximately seven times the Canadian average (Chandler, 2003; see also Westlake & May, 1986). The explanation proposed by the first group of researchers was that communities with a higher control over their political life and other aspects of daily living tend to have lower suicide rates.

When older members of the Aboriginal tribe of Central Quebec were asked why their generation had very rarely witnessed suicide while the phenomenon had reached an epidemic level among the youth generation, they responded that, in the old times, violence mainly came from outside, from the 'White' society, whereas now violence is a component of family and village life. This appears as a leading thread to understanding suicide in that community and, likely, in other parts of the world (Coloma, 1999).

In one Aboriginal village of Central Quebec with a population of around 2000, there has been more than one suicide per year (Laliberté, 2006). Most people committing suicide were below the age of 35 and one recent series was started by a young girl of only 12 years old. In the year 2003, three teenage girls committed suicide and a fourth one was saved in extremis by her sister while hanging in a closet. A long list of males in their late teens and their twenties has died after being imprisoned or rejected by a girlfriend. Sometimes suicide is made in the presence of other people as when a man rolled under the wheels of a lorry in front of a children's playground. The phenomenon of violence is not restricted to suicide in this environment. There is a case of amok where a driver rushed into a crowd during a ritual celebration, causing many serious injuries. Fights with injuries are common among young men and the situation reached a climax after one homicide when the entire local police force quit and was replaced by an emergency unit.

A study of 30 suicide cases, mostly young adult males, with the psychological autopsy method using a member of the family as informant, provided the following results. Most cases (80%), predominantly males, had a serious problem of alcohol or drug abuse, a fact not far different from young suicides in the rest of Quebec. A majority of these men had also suffered from chronic neglect during their childhood, mainly while both parents used to go on a drinking bout and leave home with the children unattended. Discipline was generally inconsistent with a *laisser-faire* attitude interspersed with outbursts of violence. Suicides were for the most part triggered by two situations. The first was the rejection by the girlfriend or wife. The peculiarity of this community was that the girlfriend was abusing the man in three cases, was pregnant in a few cases, or had been cheating with another man. At least in this sub-group, women appeared to wield a significant emotional leverage over men. Some of the men were living in the girl's parental home and had nowhere to go after being rejected. The other situation related to suicide was to be in police custody or being imprisoned and not visited by family or friends.

These individual observations have to be put in a more socio-historical background in order to understand how the situation has worsened to reach this level. What characterizes these aboriginal communities is first of all a long history of exploitation and discrimination by the 'White' society through invasion of the territory for the purpose of logging or building dams, of treaties signed under ignorance or submission, plus the christening by priests prohibiting the ancestral beliefs and rituals such as the use of drums and sweatlodges. Despite this power imbalance and the introduction of alcohol as a means of payment for furs, suicide was almost unheard of until the forced settlement in villages with Western style houses and home appliances. The goal was well intentioned: children had to be schooled. The dramatic changes in the means of production and income provoked a rupture between the generations. Besides, school brought other values possessed only by the younger generation but with little means by which to translate this learning into market jobs still lacking on the reserves.

Witnessing the rapid decline of their status as providers and of their ancestral culture, some fathers started to exert a desperate form of control over their children, at least in many families where suicide was observed. This took the form of domestic violence and, in some extreme instances, in incest gestures, either with their daughters or with their sons' girlfriends. In one village, the repeated transgressions of a paedophilic priest also acted as a negative model.

Altogether, many important social changes happened at the same time and contributed each in their own way to demoralization and internal aggression within these villages. They are self-evident and easy to document: high level of unemployment and lack of a structured daily life cycle, introduction of hard drugs, presence of multichannels television programs around which daily life is organized, disintegration of communal family life in the form of shared cooked food, and overcrowding with an average of seven residents per house.

What many of these young people who committed suicide have in common is a history of family negligence and violence. At the same time, they belong to a new generation with rising expectations through the schooling process. But social promotion is at the same time hindered by a lack of jobs, most suicide cases being unemployed at the time of their death. Being the object of negligence and rejection during childhood, these youths are later under the influence of rejecting girl-friends or in-laws. Besides, they have no institution or marginal group with a minimal structure to reorient their frustrations and energies. So, when under the pressure of a sudden shock, they cannot contain their rage and they tend to kill themselves within hours only of the triggering event.

Aboriginals of the South Pacific

In the South Pacific Islands, many communities have also experienced a sudden rise of suicide among young men, originating during the period 1975–1980 (Rubinstein, 1983, 1987). The rate for Micronesia during the early 1980s was 48/100 000 and suicides were mainly among the 15 to 29-year-old group. Western Samoa had a rate half that size, but many suicides were apparently hidden by the family due to the subsequent shame because the family was thought to have been incompetent to cope with its internal conflicts (MacPherson & MacPherson, 1987). Cases of suicide were reported from before the modern period as a means to repair damage done to the family and restore its reputation by avoiding a public trial. More recent suicides by young people tend to take the form of revenge on the parents following frustrations by the most educated portion of youth. For a while, young educated men could immigrate more freely to New Zealand, but policy restrictions forced them to stay on the island and to confront a new generation of senior citizens created by the rise in life expectancy. To express their resentment, some of these young took poison in the form of herbicides in the presence of older people.

A similar phenomenon of rising youth suicide took place in the islands of Guam, Ponape, Gilbert and Truk during the same period, recalling an epidemic reported in the schools during the early colonial period (Hezel, 1984). Again, contagions had been reported in the schools of this area during the early colonial period. Hezel (1984) conducted an in-depth analysis of 129 cases in the Truk territory where he estimated that the rate of suicides reached the level of 30/100 000 during a 30-year period. Eleven cases were in children less than 14 years old, suicide at this age being a very rare occurrence in comparison to Western countries. Interviewing kin, Hezel concluded that more than 60% of the cases were provoked by repressed anger. The highest rates were found in the population with a middle level of acculturation and were not closely related with evident signs of psychopathology or alcoholism. A 10-year analysis of a community of 1500 identified 100 persons with a registered suicide attempt and a key informant was of the opinion that half the adult population had in reality attempted to commit suicide.

Many of these suicides are triggered by apparently innocuous incidents such as a reprimand for singing too loud or the refusal by the parents to buy a shirt. The act of dying was not seemingly made with an intention of revenge as in Samoa, though there was a history of chronic conflicts with the family. The attitude was rather one of self-pity epitomized by the emotion called *amwunumwun*, to express abasement.

According to Hezel (1987), the modernization of this region provoked the break of the matrilineal structure organized around the authority of maternal uncles to replace it with the nuclear type of family (see also Hezel, 1987; Rubinstein, 1983, 1987). The wage economy had transferred the authority to the biological father, but these fathers had not learned to behave as fathers but rather as uncles. As the authority structure was cracked, children started to use suicide threats as a means to blackmail and control their parents.

Women in Asia

Men in most countries die two to four times more often from suicide than women. There are two notorious exceptions in Asia: India and China where suicide is more evenly distributed among genders. This should not be considered as an exception to the rule when these two countries amount to one-third of the world population and report more than half the total number of suicides (also see the chapters by Fortune and Howton and by van Heeringen in this volume).

The phenomenon of high female suicide is not new in India and Thakur (1963) quotes Shri Dhebar, a local Congress president in the region of Calcutta, lamenting the situation in a newspaper release of 1955. A survey we made in Bangalore in 1997 with police officers making suicide investigations, nurses in emergency departments and focus groups showed that women had to bear more often than men the responsibility for their own suicide except in the case where they were persecuted by their in-laws (Tousignant, Seshasdri & Raj, 1998). Even when their suffering derived from their husband's bad behaviour, they were expected to suffer the pain and to patiently change their mate's behaviour. In the case of a male chauffeur who committed suicide while dependent on alcohol, his wife was thought to have failed in making him happy. A sociologist, analysing data from Pondicherry where men have a rate double that of women, underlined the general moral strength of women but blamed them nevertheless for divorcing their husbands and pushing them towards death (Aleem, 1994).

The case of dowry death is an important issue which has raised a long debate in the media as well as among experts. This type of suicide is found among young married women below the age of 30, and happens when the bride or her parents are pressured after marriage to continue to pay a dowry exceeding the family financial capacity. According to one forensic enquiry, it accounts for one out of six female suicides (Khan and Ramji, 1984). Statistics from the Indian Parliament (Desjarlais *et al.*, 1995) point out that there were 4000 dowry suicides in India in the years 19880–1990. Because this type of death is usually spectacular, the woman burning herself with kerosene or being so attacked, the popular press is prompt to report on the case. Two field studies quoted by Desjarlais *et al.* (1995) also concluded that around 40% of female suicides were connected with domestic conflicts in the form of harassment, beating and even torture of the wife by the husband or the in-laws. In Pune, a large hospital with a burn ward admits numerous female burn victims daily with a survival rate of 20% (Waters, 1999). There is a female police officer permanently on the ward to take the 'dying declaration' in case of future court litigation by the woman's family. In the population of Durban with Indian ancestry in South Africa, a statistical report included a rate of suicide of 40 per 100 000 among married women between the ages of 15 and 19 (Meer, 1976). A crime reporter from Bangalore mentioned to us the story of four daughters in Agra who had committed suicide because their family was too poor to pay for a dowry. The problem is sufficiently prevalent in this country to have brought the Indian Penal Code to include a law preventing incitement to suicide. Waters (1999) reports three long stories of female suicide or suspected suicide in Pune where a conflict with the in-laws was seen as the source of the suffering. As the tie between the son and his mother is usually very strong, husbands often side with their mother or are shy to oppose their will when she is wrong.

Sometimes, the dejected woman acquires more power after her death than before. For instance, a village woman drowned herself in a local well after receiving a threat from her mother-in-law and her suicide made later marriage arrangements among the in-laws more difficult to arrange (Minturn, 1992).

One pattern of dowry suicide in India fits a scenario where the poverty of the bride's family frustrates the expectations of the in-laws. Another likely scenario is the clash between the bride's assertive personality and the mother-in-law's bad character, as women are increasingly fighting for their rights as in the case of Ashwini in Pune (Waters, 1999). In this example, there was a march of militant women from Ashwini's natal home to her marital home. We are here in the presence of a case of protracted anger following harassment with little outlet to express the bad feelings and hopelessness to redress the wrong. In this regard, Bhugra *et al.* (1999), in a study in West London, found that Asian females who attempted suicide or other acts of self-harm held more liberal views than non-attempters and were probably more frustrated.

China offers a different picture to that of India. There are three times more suicides in rural areas in contrast to urban ones, and female rates are 20% higher than male rates (Phillips, Li & Zhang, 2002; Phillips, Liu & Zhang, 1999). The rate is 30 per 100 000 even in the absence of alcoholism or evident psychopathology in many cases. Altogether, 93% of all suicides in China take place in the countryside. Certainly, the use of pesticides instead of drug prescriptions and the lack of emergency medicine contribute to this high rate. Though the phenomenon is epidemiologically very important, both the national authorities and even the local population were unaware of its extent until recently. An enquiry by a journalist in a village where many older women had committed suicide found that local people were not aware of the extent of the problem. It was not sheer denial of a secret, but the fact that these women had already lost their status and were quickly left to oblivion after their death.

The dynamic of power in the family structure in China is somewhat different from India. Men exert a patriarchal dominance both in external and domestic business and women still have a second-rate status as documented by the surplus of male babies at birth. Traditionally, wives and concubines were encouraged to commit suicide to show their loyalty when their man died. In the modern period, causes leading to suicide seem to be similar to the ones found in India. Conflict between in-laws is the major factor for young married women to commit suicide (Pearson, 1995).

The following case may not be representative but it opens a window on some cultural dimensions of suicide in China (Pearson and Liu, 2002). The material was collected during a series of ethnographic interviews and it happened in a family after the program had started. A conflict quickly arose between Ling and her mother-in-law because her marriage was a love marriage against the family wishes. The tension went up and Ling insulted her mother-in-law seriously using the term 'whore'. The reason for the tension was that not only that Ling was not chosen by the family, but that she came from a village considered 'foreign', cultivating tea instead of rice and wheat. Ling tried her best at first but she soon became rebellious because of the the lack of sympathy. The fact that she had been slapped by her husband after he heard about the insult contributed to isolate Ling even more. To make things worse, Ling coped by converting to Christianity and tried to free herself from the family by having a job outside home. In this case, the suicide was at a great cost to the in-law family, both in terms of its social reputation and the high cost of the funeral to avoid persecution by her biological family. As pointed out by the authors, this case is far from being representative, but it illustrates the power that excluded women can achieve through their death. This suicide is also a case of thwarted anger with no social or personal channel of expression.

Phillips *et al.* (1999) have been considering if recent social changes in China brought about by the economic revolution have had an effect on the high rates of suicide. The answer can only be hypothetical because valid data on suicide from before that period are not available. With regard to the theme of suicide among young women, the economic gap between rich and poor and the awareness of this gap through television may have had a major impact in the rural areas. Also, the weakening of family ties and increasing marital problems related to infidelity are changes with more impact on women. A case study quoted from a report described how Mrs Huan, a 38-year-old woman and her daughter, 17, both killed themselves because the father started to have an affair with another woman in another village and neglected his family. This transgression would have been met with strong community action and sanction in the pre-reform period, whereas nowadays the victims are left with their frustrated feelings. Another young woman of 19 experienced the abuse of her sister-in-law after her own father had died, and decided to find domestic work in the city and she likely became depressed. Finally, another young woman had violent arguments with her husband over her workload in the field before she unexpectedly took a very large dose of insecticides. Some of these suicides may be related to social change, but what seems to come out is the decreasing pressure of social norms in daily life, the lack of reference values in case of conflict, and the population movement towards cities. As men still maintain a higher status, women may be relatively disadvantaged.

One of the first published psychological autopsies in China (Zhang *et al.*, 2004) provided a more systematic analysis of suicide in rural areas. Despite targeting the total population and obtaining a 100% rate of acceptance, only 18 of the 66 cases were female. Family dispute was the major triggering factor as perceived by the close kin. The social analysis revealed that these young women had a more constricted social life and had to heavily rely on the family for support. When the family failed them, there was little way out. A similar conclusion had been reached in a Chinese report quoted by Zhang *et al.* (2004). In an analysis of 260 suicides by young women, nearly half (121) followed a confrontation with the husband or abuse by him; another 13% were related to arranged marriage and 30% were consecutive to quarrels with in-laws, claims about chastity and other related issues. Numerous authors also recalled the Confucian attitude toward death and the possibility of starting a new life to avoid the miseries of this one.

Adult males in Quebec

With a rate of 18 per 100 000, the rate of Quebec is about half more than the rest of Canada. Suicide is predominantly outside of metropolitan Montreal and among the majority French-speaking population. The specificity of Quebec, along with some other Catholic countries with a past of political dominance like Ireland, Poland and Lithuania, is that suicide is relatively more concentrated among men and among men less than 50 years of age rather than among older men as in most Western countries (World Health Organization, Sept. 12, 2006).

A psychological autopsy study covering 72 adult male cases has shown that two-thirds of these men have experienced a long history of abuse and rejection in their family of origin (Zouk *et al.*, 2006). The method used was the Child Experience of Care and Abuse (CECA) interview usually with a brother or sister. In this study, with the exception of suicides related to psychosis, there was a portrait of the suicidal career that stood out. More than two-thirds had a serious problem with drug or alcohol. As a consequence of early life, they had an attachment problem both with their parents and their marital or romantic partners but many were in a marital relationship which lasted over many years. A break or serious threat of a break by the female partner was the triggering factor in nearly half of the cases, and in a third of them the context was the refusal of the woman to support chronic difficulties associated with alcohol, drugs, violence and, as a last straw, financial problems. A significant minority of six was trapped with debts and was seriously threatened with violence. In all these cases, the breaking of the relationship was initiated by the woman and the man had to leave the family or the woman fled with the children. In the majority of cases, there was often less than 48 hours or no more than a week between the triggering event and the suicide. Most of the men with children, even adult children, had a serious conflict with at least one of them or were prevented from having contact with them. Though many men were obviously trying to repair their childhood memories with their own family, the failure of their marriage probably brought back their sense of deep solitude and the pain of rejection. Most partners had tried to be patient with the marital conflicts or had tried to make their companion abstain from alcohol, but had failed.

Most of these men had modest sources of income, being for the most part non-specialized employees and more than half were without work at the time of death. Some had accumulated drug debts, and were unable to pay them and they started to steal or to sell drugs. Altogether, they were both humiliated as providers and as partners, and sometimes as fathers.

The male:female ratio of suicide is not so different in Quebec than in the United States for instance, with similar socio-cultural traits. What attracts attention is that nearly twice as many males during the productive years between 20 and 50 commit suicide in Quebec than in the United States. The comparison would be similar to English Canada after sorting out the suicides from Aboriginal areas. Quebec social scientists suggest two factors for the weak self-image of French Canadians. Women had traditionally more domestic power because males used to be absent from the home in rural areas to work in logging. In the modern era, there is a close mother–child relationship as illustrated by a monograph in the Laurentian area (Grand'Maison & Lefebvre, 1993), and mothers tend to rely on their children for support when in conflict with their partner; little space is left for men. Mothers also take the decision to break the union, partially on the grounds that the man is not a good provider (alcohol debts, absence of wages). Men in this situation prefer to close themselves in and are reluctant or unable to obtain professional help or emotional support from their network.

Conclusions

At the end of this review, we can present suggestions to build a socio-cultural model of suicide. The purpose of this exercise is not to arrive at a universal model of suicide, but to understand some types of suicide specific to certain cultures. The only way to improve this understanding is to accumulate as much information as possible on individual cases of suicide within a specific sub-group and to understand what are the vulnerability factors leading to suicidal behaviour. The model should also apply to a variety of cultural settings including western countries. In the reality of the large metropolis, those who commit suicide are mostly men on the margins of society. There are drug addicts and alcoholic males in a powerless situation trying to gain their lost status by projecting themselves into a universe of fantasies; they are the mentally ill people who are without meaning in a world of values centred on self-determination and competitiveness. We also find them among men in jail or gay youth; in this last group the rate of suicide attempts is extremely high. Whole cultures are also submitted to a similar process as is the case for Inuit and Aboriginal communities. Elsewhere, we find women in poor districts of China and India sharing an underclass status. In all these cases, we find a symbolic violence toward these individuals in the form of denial of their needs and rights, prejudices, rejection, and a process of self-fulfilling prophecy. Exclusion and rejection will provoke in these marginalized groups rage, free-floating aggression and a deep feeling of lack of equity leading to despair. Without support and compassion, or the possibility of channelling this aggression in a collective action by such means as street-gangs, political action, religious-revival movements, which provide a collective identity to replace the fledging ego, isolation and meaninglessness will reinforce the temptation of suicide.

This mode of thinking brings a new challenge to suicide prevention. There is the imperative to heal and not only to treat the illness. There is also the requirement to listen to the suffering, with an attitude going against the social dynamic of exclusion and oppression. In general, suicidal persons are more in need of self-respect than emotional catharsis, not only as individuals but also as part of a collective self. If medication in the form of anti-depressants doubled with psychotherapy can be a useful strategy to cope with despair, this solution is not enough when a significant minority within a culture is alienated from mainstream of society. A real prevention will start with the empowerment of these groups and a call for radical social change. This may not be regarded as the mission of the mental-health professionals, but these have a responsibility to promote a collective form of assistance.

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Psychology and cultural psychiatry

Malcolm MacLachlan and Sieglinde McGee

EDITORS' INTRODUCTION

Psychology as a discipline focuses on the study of human behaviour in different settings; its relationship with psychiatry in general has been one of healthy tension, even though biopsychosocial models of aetiology and management emphasise psychological factors as one of the three prongs along with biological and social factors. Psychology emerged in the Eurocentric tradition, even though mental illnesses and abnormal behaviours had been described for centuries across cultures. The relationship between psychology and cultural psychiatry has been infected by mutual suspicion. The suspicion is due to several reasons, including political imperatives on both sides. Cross-cultural psychology as a discipline aims to provide localized cultural perspective and comparative cultural perspectives, and is a relatively recent development. Psychology focuses on both the individual and their development, and the consequences in response to their actions.

MacLachlan and McGee emphasize that psychology focuses on the smallest unit in society – the individual – and on how the individual's life experiences and characteristics influence health and the experience is seen as central to but not independent of cultural factors. The relationship between medical anthropology, medical sociology and clinical/health psychology is of great interest in trying to make sense of the practice of cultural psychiatry. Describing the development of Problem Portrait Technique, which seeks to convey a likeness of a person's presenting problems through both words and images, is one way of trying to understand a person's inner experience. Some of these questions are fairly similar to questions asked while exploring explanatory models, and this technique gives the clinician a complete outline of causal factors that a more conventional approach to assessment may have overlooked. MacLachlan and McGee argue that the distinction between disease and illness seems a useful one, and indeed one that bridges cultural psychiatry and psychology. Using depression as an exemplar, they raise the question of biology as a mediating factor. The relationship between psychology and cultural psychiatry has to be seen in the context of changing social and cultural nuances, both at macro- and micro-levels.

Introduction

This chapter explores the relationship between psychology and cultural psychiatry. In so doing it focuses particularly on those areas of psychology most salient to cultural psychiatry. We begin with some definitions to try and present some clarity to the plethora of social science and psychology sub-disciplines in this area, as they relate to cultural psychiatry.

Kirmayer and Minas (2000) state that 'cultural psychiatry is concerned with understanding the impact of social and cultural difference on mental illness and its treatment' (p. 438). They identify three lines along which cultural psychiatry has evolved: (1) cross-cultural comparative studies of psychiatric disorders and traditional healing; (2) efforts to respond to the mental health needs of culturally diverse populations that include indigenous peoples, immigrants, and refugees; and (3) the ethnographic study of psychiatry itself as the product of a specific cultural history. These paths reflect broader perspectives in the social sciences, to which we shall return shortly, but now we consider which

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

aspects of psychology are particularly relevant to cultural psychiatry.

Psychology is often defined as the study of human behaviour. However, such a bland definition fails to acknowledge that 'psychology' has been understood to be synonymous with a predominantly Anglo-American perspective on human behaviour; characterised by a rationalist, reductionist and individualist approach to truth seeking. However, this is problematic, for such a psychology is, in itself, a cultural construction. Other psychologies, curiously referred to as 'indigenous', relate different conceptions of how human behaviour ought to be accounted for. Thus we need to acknowledge that there are different – culturally constructed – conceptions of just what psychology is, and how it should study human behaviour (MacLachlan and Mulatu, 2004).

Areas of psychology which might be considered to be of particular relevance to cultural psychiatry include social psychology, clinical psychology and health psychology, with each contributing to a broader understanding of how human behaviour influences health, broadly defined. In our understanding, 'health' here refers to well-being in general, and is not confined to either physical complaints or mental complaints. 'Cross-Cultural' psychology (a perspective within social psychology) must always first be 'cultural' psychology in order for it to be meaningful. Cultural psychology seeks to understand how behaviour is influenced by the social context in which it occurs. It further acknowledges that this context is woven through particular customs, rituals, beliefs, ways of understanding and communicating and so on, so that distinctive patterns of behaviour are *cultivated*. Only by understanding how a culture patterns meaning can we be sure to know that the sort of things we might want to compare between different cultures actually have some similarity. Having established a meaningful similarity in the structure or function of aspects of human behaviour, it may then be enlightening to compare such behaviour in different cultural contexts, that is, across cultures. Thus good cross-cultural psychology should incorporate both the localised cultural perspective, and the comparative cultural perspective (Berry *et al.*, 2002).

Cultural psychiatry and the social health sciences

Already, it may be easy to confuse the distinctive contribution of psychology to the understanding of mental health, not alone in comparison to cultural psychiatry, but also in relation to medical sociology and medical anthropology. Figure 4.1 schematically represents the relationship between these three social health sciences. Psychology focuses on the smallest unit in society, the individual, and how the individual's life experience and characteristics influence health. This experience is seen as central to, but not independent of, structural and cultural factors. Medical sociology provides a wider, societal frame of reference, one that addresses why certain groups are more vulnerable and less well treated than others in a given social system. As a result of medical sociology's interest in the structure and inequalities of a society's health system, this is represented as a 'vertical' oval, which indicates that a particular health culture may be stratified at different levels. Medical anthropology's perspective

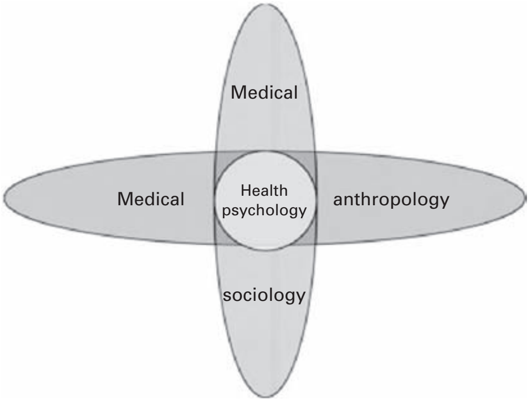

Fig. 4.1. A schematic representation of the relationship between health psychology, medical anthropology and medical sociology.

allows for comparison of the cultural systems that construct differing social and health systems, and therefore this is represented as a 'horizontal' oval, looking across societies. Although some might question the centrality that we – psychologists – have given to psychology (!), we feel that it is justified on the grounds that, whatever one's structural or cultural context, individuals operate according to their own health psychology. In fact, to put it more emphatically – everybody is entitled to their own health psychology! (MacLachlan, 2006).

Kirmayer and Minas's (2000) description of the three paths that cultural psychiatry has followed, noted above, may be seen to have approximate mappings onto the three social health sciences: (1) cross-cultural comparative studies of psychiatric disorders and traditional healing (medical anthropology); (2) efforts to respond to the mental health needs of culturally diverse populations that include indigenous peoples, immigrants, and refugees (clinical/health psychology); and (3) the ethnographic study of psychiatry itself as the product of a specific cultural history (medical sociology). Of course, this mapping is only approximate and in reality many aspects of cultural health are relevant across these three domains.

Culture forms the implicit backdrop to many of the variables studied in psychiatry, psychology, sociology and anthropology. However, the clinician requires an understanding of them in some sort of 'joined-up' fashion. In order to be able to provide any given individual – from whatever cultural background – with the optimal care, we have not only to appreciate this backdrop but also to embrace it in the most conducive manner – from the perspective of the person seeking healthcare.

Figure and ground

As long ago as 1935 Dollard was grappling with the problem of how clinicians ought to incorporate an awareness of culture into their practice. Dollard describes the individual seeking help as a palpable, concrete and real entity. The immediacy of the individual stands out against the abstractness and generalities of his or her culture. Thus Dollard notes that the individual always remains 'figure' while the culture is 'ground'. In other words the individual is seen as the foreground and the cultural context as the background. The difficulty is to appreciate the contribution of each at the same time. One can think of this problem as being similar to that of a reversing figure, where only the foreground or background can be focused on at one time, but both exist together and depend on each other in order to define their own existence. What we really need therefore is a way to see both – foreground and background – at once. Below, we outline how the cultural perspective can be understood, from the perspective of the individual patient/client presenting with a distressing problem. Understanding the cultural braiding of somatic complaints is an important challenge for cultural psychiatry. We now discuss the case of a man presenting with what might be diagnosed as irritable bowel syndrome, and we do this to illustrate use of the Problem Portrait Technique.

The Problem Portrait Technique

According to Chambers' *Twentieth Century Dictionary* a portrait is 'the likeness of a real person'; it is also 'a vivid description in words'. The Problem Portrait Technique (PPT) seeks to convey a likeness of a person's presenting problems through both words and images. First of all, we will consider the use of this technique with words. The PPT is simply one way of trying to understand a person's inner experience.

The problem portrait begins with the person's description of his or her own distress, be it a broken leg, a broken marriage or a broken heart. Perhaps the first obvious question is how and/or why has the problem occurred? What is the cause of the problem? The problem portrait is intended to give an impression of the ecocultural context in which the person is living and in which the problem occurs. This means that we need to know the range of

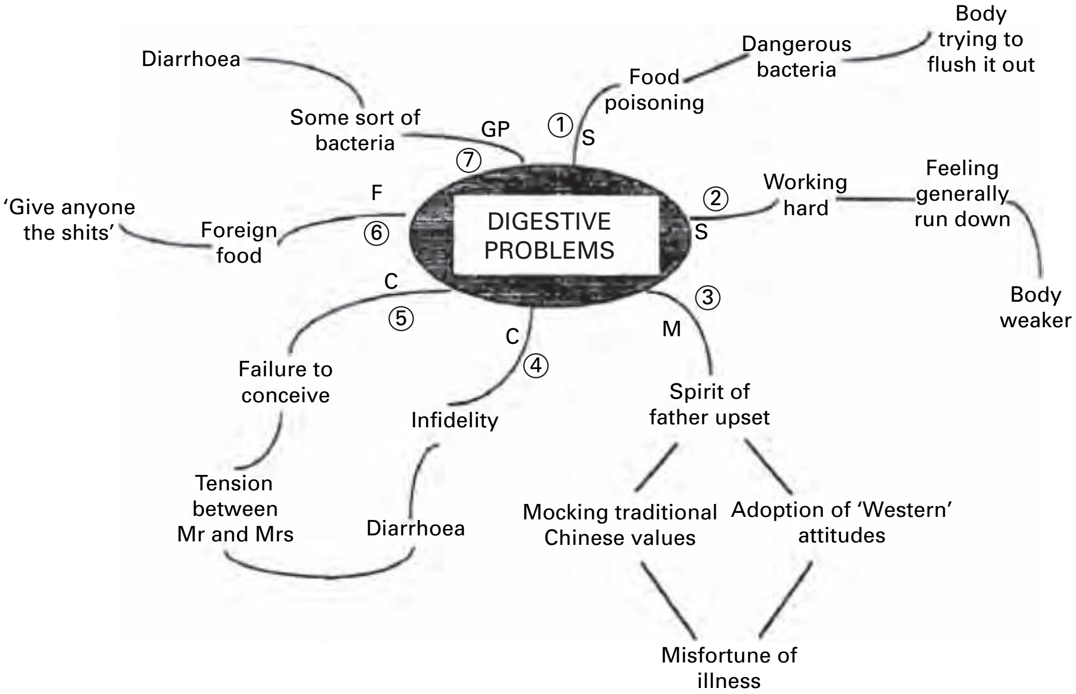

Fig. 4.2. The Problem Portrait Technique illustrating different causes identified by Mr Lim for his 'digestive problems'. S, self; M, mother; C, China; F, friend; GP, most GPs.

causes, which possibly relate to the problem at hand (Fig. 4.2).

Clearly, the list of causes can be long and their excavation requires careful and sensitive interviewing. For some people, explanations for their problems, which arise though consideration of their ecocultural framework, will be easily discussed. In terms of a 'clinician as archaeologist' analogy, their 'social artefacts' are buried just below the surface. Yet for others their social constructions of reality may be much further below the surface, lodged in various strata of uncertainties or unwillingness to speak about things that you and I may not understand and may possibly even ridicule.

To conclude the investigation of possible causes and to appreciate something of the client's expectations of the consultation, he is asked: 'What do you think that most GPs would say about the cause of your problem?' (Note that the client is not being asked to predict what his own GP is going to say – referring to 'most GPs' retains some 'distance'.) This gives us a range of possible alternative causes to work with. The PPT presents the clinician with a complex outline of causal factors that a more conventional approach to assessment would have overlooked. However, those tempted towards a 'simpler' form of assessment – identifying the 'main' or 'real' cause – will simply be operating out of ignorance. If such complexity exists, it is always better to know about it, even if it does not make your job any easier! For each cause given, it is important that the clinician understands its rationale.

Although we now have a sort of 'word map', or picture, of the ecocultural context in which the client is experiencing his problems, we have yet to identify what is 'figure' (foreground) and what is 'ground' (background) from his own perspective. The ease with which he discusses different causal

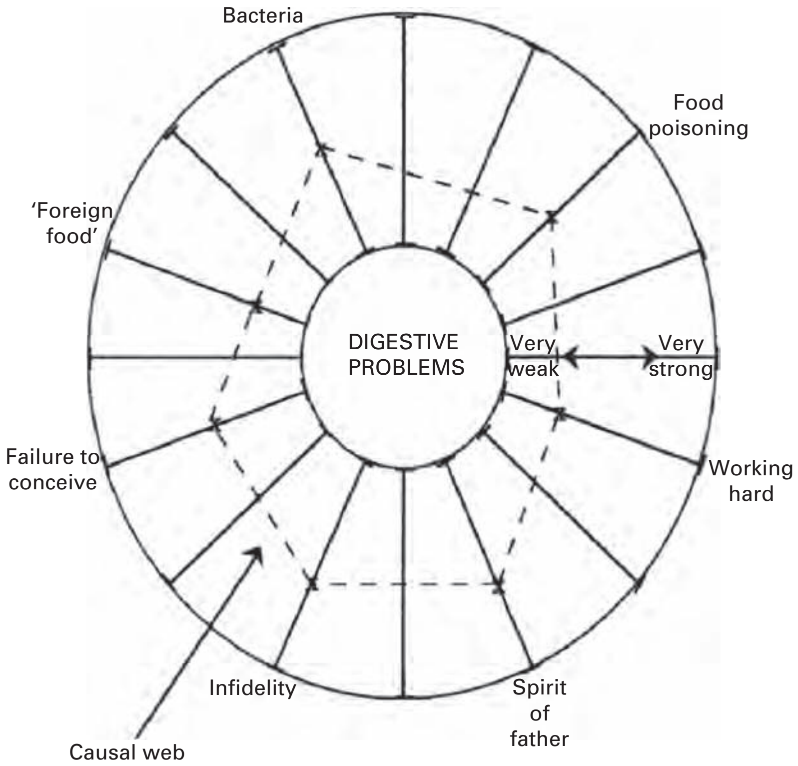

Fig. 4.3. The Problem Portrait Technique for Mr Lim's 'digestive problems' with the strength of different causal factors rated along visual analogue scales.

beliefs may be no indication of this. We can, however, now ask the client to rate the causes that he has mentioned. This could be done in many ways but the recommended way is as follows. A brief description of each cause is written at the end of lines radiating from a circle (Fig. 4.3). Each of these lines is the same length. Each line now becomes a scale of measurement (a visual analogue scale) wherein the strength of belief in each possible cause can be rated.

The further one moves along the radiating arms, away from the centre, the stronger is one's belief in that particular causal factor. The scale may be made clearer by the use of statements 'anchoring' each end of one of the radiating lines.

The client could now rate each of the beliefs described previously. We can also establish some measure of how tolerant of different beliefs he is. If each of the lines radiating from the centre is made the same length (say, 5 cm) then where the 'X' is placed on each line constitutes a relative ranking of the different causal factors. However, most importantly this ranking is not presented in a linear context but in the context of multiple comparisons. There are significant advantages of the attributes of measurement when it comes to statistical analysis. Statistical analysis will not be necessary for the majority of clinicians, however, who simply wish to use the PPT to gain an impression of the range of causal factors and their relative importance.

What we have described here is the 'Rolls Royce' version of the PPT. Sometimes it will be possible to use the technique in its entirety, whereas at other times simplifications and perhaps dilutions of it will be necessary. Constraints of language, translation and time, to mention just a few, may prohibit the power of the technique. However, whether the version used is the 'Rolls Royce' or the 'Mini', the orientation adopted through using the technique should enhance the quality of clinical assessment and therefore the efficacy of the treatment.

Some may feel that, if we study one illness or problem in many different cultures, it is as if we see the problem from many different angles. Thus by taking away the cultural 'noise' we can reveal the true nature of the illness or problem outside its cultural context. This 'sterilising' view sees the cross-cultural perspective affording us with a sort of psychological X-ray, penetrating more deeply to a common bedrock of human processes. Culture in this view is a problem to be overcome, a social construction to be deconstructed and outwitted, something that clouds the essential objective truth. An alternative view developed here is that different cultures create different causes, experiences, expressions and consequences of suffering, be it physical and/or mental. A complaint makes no sense in a cultural vacuum, because its meaning cannot be accurately communicated.

Depression: a classic debate in cultural psychiatry

Depression is dealt elsewhere in this volume (see Chapters, 15, 17 and 19). Our discussion of it here is intended only to highlight the interaction between cultural psychiatric aspects and broader social science – and particularly psychological – issues. According to DSM (Diagnostic and Statistical Manual of the American Psychiatric Association) an episode of Major Depressive Disorder ('depression' from here on) is said to exist when a person experiences either markedly depressed mood or a marked loss of interest in pleasurable activities for most of the day, every day for at least 2 weeks. In addition to this, the person must simultaneously experience at least four or more of the following symptoms: significant weight loss (when not dieting) or weight gain, or a decrease or increase in appetite; under sleeping (insomnia) or oversleeping (hypersomnia); slowing down (psychomotor retardation) or speeding up (psychomotor agitation) of mental and physical activity; fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think or concentrate or indecisiveness; and recurrent thoughts of death or suicide.

Kleinman (1980) has suggested that the way in which people experience distress – such as depression – varies across cultures and at different times within the same culture. He uses the word 'illness' to refer to a person's experience of a disease. Of course, most of the diseases which affect the body are not observed at their source of action. Instead it is the consequences of the disease's actions, the rash, the limp, the lethargy, etc. which is observed. This 'illness behaviour' includes our physical and mental responses to a disease. For the moment it is the psychological component of this response to disease which is of interest to us. A key point in Kleinman's argument is that illness behaviour is the result of an underlying disease process and that this disease process may be expressed in different forms of illness behaviour.

This distinction between disease and illness seems a useful one and indeed one that bridges cultural psychiatry and psychology. It helps us to account for the admittedly vast array of symptoms associated with a diagnosis (of the disease) depression. According to the diagnostic criteria described above, two people may be depressed, but their experience of being depressed may be quite different. For instance, one person may have depressed mood, weight loss, poor appetite, difficulty sleeping and behave in a very slow and withdrawn manner. Another person, with the same diagnosis, may not experience depressed mood at all. Instead, they may show a loss of interest or pleasure in many different activities, gain weight, feel constantly hungry, oversleep and appear very agitated. However, according to the DSM criteria their very different 'illness behaviours' are explained by the presence of the same underlying disease process.

The experience of depression within an individual can vary over time – commonly referred to as the disease course – and, as already noted, it can vary between individuals of the same culture – commonly referred to as a disease syndrome. Kleinman's suggestion that depression can also vary across cultures and across different historical epochs is quite consistent with a biological view of depression. He has also studied a condition known as neurasthenia. This condition, commonly reported in China, is characterized by a lack of energy and physical complaints such as a sore stomach. Kleinman has suggested that while depression and neurasthenia are different illness experiences, they are both products of the same underlying disease processes – depression. In other words neurasthenia is the Chinese version of the 'Western's' depression.

Shweder (1991) suggests that this interpretation 'privileges' a biological understanding of how depression occurs. He points out a range of factors which can theoretically cause depression, including biological ones. Table 4.1 illustrates the different factors in what he calls biomedical, moral, sociopolitical, interpersonal and psychological 'causal ontologies'.

Table 4.1. Different types of causes for depression

Domain	Factors
Biomedical	Organ pathology Physiological impairment Hormone imbalance
Moral	Transgression Sin Karma
Sociopolitical	Oppression Injustice Loss
Interpersonal	Envy Hatred Sorcery
Psychological	Anger Desire Intrapsychic conflict Defence

Based on Shweder (1991).

Kleinman believes that the ultimate cause of depression and neurasthenia is the same. This ultimate cause concerns the experiences of defeat, loss, vexation and oppression by local hierarchies of power. In Kleinman's view such 'sociopolitical' experiences produce a biological disease process. However, the way in which this disease is expressed is influenced by the culture within which one lives. Some forms of suffering – because they can be understood to provide a message, a communication – are more acceptable than others. In North America, for instance, there is a great emphasis on individualism, competitiveness, slogging it out in the market place, achieving, personal growth, realising one's own (amazing!) potential, and so on. There is also a great emphasis on 'letting it out', on the right of the individual to openly express what she or he feels. This allows for the expression of depression as a demonstration of the individual's disillusionment with not 'succeeding'. On the other hand, in China, or so it can be argued, depression is not the 'right' form of suffering. In China, demoralisation and hopelessness may be stigmatised as losing faith in the political ideals of 'the system'. Such a public display of disengagement is not welcome. Instead, a variety of symptoms consistent with fatigue, with being physically run-down, with being exhausted by the pressures of work may be seen as an acceptable reason for failure.

In summary then, Kleinman (1980) suggested that depression and neurasthenia have similar sociopolitical origins, which produce a similar biological disease process, which expresses itself differently in North America and China because the different cultural conditions favour different forms of expression. However, Shweder (1991) suggests that there is no need to say that the Chinese's neurasthenia is somatised depression. We might just as well say that North American depression is emotionalised neurasthenia and that neurasthenia is the underlying disease process, not depression. More important – and more challenging for cultural psychiatry – is, however, Shweder's questioning of the value of talking about a disease processes at all. For him, the concepts of 'illness' and 'disease' do not add any value to our understanding of the relationship between neurasthenia and depression. While these two conditions may have similar origins in socio-political adversity, we are able to distinguish between the two forms of suffering. If there is therefore no need to think in terms of a biological 'middle man', then there is no need for either neurasthenia or depression to be the primary disorder.

Under contention then is the mediating role of biology in a causal chain that recognises an ultimate (social) causal origin that culminates in a proximate personal psychological experience (depression) or proximate personal biological experience (neurasthenia. While the thinking of both Kleinman and Shweder may well have moved on – the dilemma's described above are still central to the interplay between cultural psychiatry and psychology.

This assumed primacy of depression over somatic symptoms has also been explored in Banglagore, India. Mitchell Weiss and colleagues (1995) sought to explore the relationship between depressive, anxious and somatoform experiences, not only from the 'Western' diagnostic perspective of the DSM classification systems, but also from the perspective of individual's own illness experience. Their study used established structured interview schedules to glean both types of information from their interviewees who were all first time presenting psychiatric out-patients attending a clinic in Banglagore. When the same 'symptom' presentation was interpreted by the patient and by the DSM system, generally patients preferred to describe their problems in terms of somatic symptoms while the DSM system described them in terms of depression.

Weiss *et al.* (1995), commenting on their results, write:

> These limitations of the diagnostic system identified here appear to reside more with the professional construction of categories than with the inability of patients and professionals to comprehend each other's concepts of distress and disorder . . . Personal meanings and other aspects of phenomenological and subjective experience should be incorporated into psychiatric evaluation and practice . . . facilitating an empathic clinical alliance and enabling a therapist to work with patients' beliefs over the course of treatment . . .

This seems to chime with our enthusiasm to explore individuals' own health psychology – their personal understanding of the relationship between their thoughts, actions and health, and how their social and cultural context influence these. Thus, whatever the presenting complaint, the belief system of the person who 'owns' the complaint has to be the medium for working through. The context of the presentation – not an abstracted diagnostic system – is what gives the complaint meaning. Without taking the context into account, clinically we can misinterpret the meaning of somatic complaints to be the 'masked' presence of cognitive distortions, low self-esteem, and low mood, and so on. However, we wish to acknowledge that our own views are not in agreement with some others. In a recent review of the literature on somatisation, neurasthenia, and depression in China, Parker, Gladstone and Tsee Chee (2001) concluded that the 'Chinese do tend to deny depression or express it somatically', a conclusion all the more remarkable for their acknowledgement that the literature is fraught with interpretative difficulties due to:

> the heterogeneity of people described as 'the Chinese' and due to factors affecting collection of data, including issues of illness definition, sampling and case finding; differences in help seeking behaviour; idiomatic expression of emotional distress; and the stigma of mental illness (p. 857).

Lee (2001) claims that the Chinese Classification of Mental Disorders (CCMD) instrument has resolved differences between international classification systems and Chinese 'culture-related' disorders. However, in an article curiously entitled 'From diversity to unity: the classification of mental disorder in 21st century China', Lee concludes that 'Personality disorders are not common diagnoses or popular research topics in China because personality disorders are perceived as *moral rather than medical problems*' [emphasis added]. Such a conclusion again seems to resonate with Kleinman and Shweder's debate on depression.

The psychology of transition

Psychologists have a long-standing interest in how people adapt to stressful situations, and the stressful situation of cross-cultural transition has been a focus of much concern. The model outlined in Ward, Bochner and Furnham (2001) distinguishes an affective (how people feel), a behavioural (what people do) and a cognitive (what people think and how they perceive their situation) response to culture change. In this model the affective reaction is thought of as a response to trying to cope with a stressful situation, and individual's personal coping characteristics are stressed as being important in their adjustment. The behavioural component relates to the notion of cultural learning, essentially that people need to have the opportunity of learning culturally relevant knowledge and social skills in order to be able to navigate their way through a socially quite different environment to that into which they were socialised. The behavioural and affective components of the 'culture shock' reaction are seen to be often mutually reinforcing, with positive affective reactions encouraging socially skilled behaviour and negative affective reactions increasing social anxiety. The third component of the 'culture shock' reaction, the cognitive component, is concerned with psychological processes involved in 'looking outward', e.g. stereotyping, prejudice and discrimination towards out groups (those not like me), and those involved in 'looking inward' such as identity formation and transition (see below). This overall affect–behaviour–cognitions, or ABC, model of 'culture shock' continues to be influential.

Ward *et al.* (2001) use the concept of cultural distance to account for different reactions to encountering new cultures, and to different degrees of 'culture shock'. Cultural distance refers to the extent of the 'cultural gap' between participants. For example, there is less of a cultural gap between people from Australia and New Zealand/Aotearoa than between people from Malaysia and Mexico, because in the former there are more customs and beliefs in common, than in the latter. Interestingly, one can actually have more 'cultural commonality' between people from elsewhere than between people from one's own country, e.g. those whose ancestors migrated to Australia or New Zealand/Aotearoa from Britain probably have much more in common with each other than with those who are 'native' to those lands, the Aboriginal people of Australia or the Maori people of New Zealand/Aotearoa. Thus 'culture shock' can apply as much to getting to know your 'neighbours' as it can to migrants getting to know a new country. As much of the research on cultural adaptation has concerned migrants, we now consider this case in more detail.

Acculturation

'Acculturation', a related term to culture shock, refers to the process of transition that is brought about by the meeting of peoples from two different cultures. Such transition may occur in either one, or both, of the cultures. Increasing internationalism and multiculturalism have produced a hive of activity in research and thinking on the effects of people from different cultures coming together. Berry and colleagues (see Berry, 1997, 2003a, and in this volume for a review) have been researching a framework of acculturation that considers to what extent the newcomer modifies his or her cultural identity and characteristics when coming to a new country. The framework is shown in Fig. 4.4. It fits the situation of an immigrant well. Although this acculturation framework expresses the degree of cultural identity as a dichotomised choice, it should be thought of as, in fact, lying along a continuum. The framework (Berry & Kim, 1988; Berry, 1997, 2003a) has been very influential and can provide some valuable insights into cross-cultural experiences. According to the framework a person decides whether or not to keep his or her original cultural identity and characteristics, and also whether or not to acquire the host culture's identity and characteristics (taking the case of an immigrant).

More recently Berry has developed the framework to take account of an important third

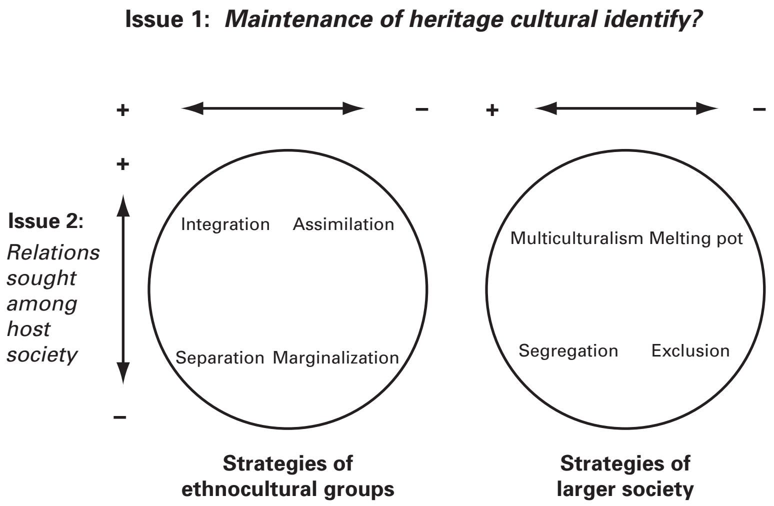

Fig. 4.4. Acculturation strategies among immigrant groups and the receiving society. Adapted from Berry, 1997. (Also see Fig. 13.1.)

dimension – the acculturation attitudes of the – usually much more powerful – receiving society. As illustrated in Fig. 4.4 the same two choices concerning identification with ‘own’ or ‘other’ identity produces four dichotomised options (which again are in reality located along continua). When the dominant receiving society seeks assimilation, this ‘mixing in’ to the receiving society is termed the ‘melting pot’ (or ‘pressure cooker’, in extremes!). When the dominant group seeks separation from immigrants this constitutes their segregation. When the dominant group seeks to marginalise the migrant group, by not wishing them to identify with either their heritage culture or the receiving culture, this is termed ‘exclusion’. Finally, when the receiving society seeks to become a culturally diverse society and recognise the cultural heritage of immigrants while also promoting their own cultural heritage, this is termed ‘multiculturalism’. It is important to note that the two-dimensional model of acculturation developed by Berry and his colleagues has been challenged and continues to be a matter of lively debate (see, for example, Berry & Sam, 2003; Rudmin, 2003).

Health and acculturation

Especially interesting from the point of view of health professionals is that Berry also suggests that the four different types of acculturation have implications for physical, psychological and social aspects of health, through the experience of ‘acculturative stress’. Cultural norms for authority, civility and welfare may break down. Individuals’ sense of uncertainty and confusion may result in identity confusion and associated symptoms of distress. In fact Berry and Kim (1988), reviewing the literature on acculturative stress and mental health, have identified a hierarchy of acculturation strategies: marginalisation is considered the most stressful, followed by separation, which is also associated with high levels of stress. Assimilation leads to intermediate levels of stress, with integration having the lowest levels of stress associated with it (Berry, 1994; Ward *et al.*, 2001). The greatest relevance for this sort of ‘background’ psychological analysis is in the possible interaction of these factors with what might be considered to be psychiatric symptoms. Furthermore, the presence of psychiatric symptoms may push individuals away from preferred modes of acculturation and towards more stressful experiences. The consequences of interactions between acculturative skills and symptomatology however can be quite complex and sometimes counter-intuitive. For instance, Bhugra's (2003) review of the literature on migration and depression – using language as a proxy measure of acculturation – found that 'acculturated individuals' are more likely to be depressed, than those with poorer 'host' language skills. Treating psychiatric symptoms without taking into account the broader acculturation experience may therefore be overlooking factors that are crucial in producing or maintaining these symptoms. Of course, individual therapy will not be able to adequately address the realities of economic segregation, prejudice and so on. In such circumstances cultural psychiatry should seek to engage with advocacy opportunities in order to influence the broader cultural determinants of mental health.

It is important to acknowledge that migration, and the adoption of new lifestyles and diets, as well as many other types of transition, need not necessarily be stressful experiences that interfere with health; in fact, they can be quite positive experiences. It is also important to note that 'acculturation is not everything'. Lazarus (1997) has argued that migrants, for example, experience a range of stressful demands that have more to do with changing contexts than changing cultures. Lazarus and Folkman (1984) see their own 'stress-coping' model accounting for such factors as loss of social support, the need to find new employment, etc., as an equally valid account of migrants' experience. Of course, the stress coping and acculturation accounts interact, the cultural backdrop constructing the meaning of stress-coping difficulties, and perhaps the ways in which these occur and the resources that may be accessible for dealing with them. The general point is, however, that perhaps, at times, migration can be over-culturalised (Ryan, 2005) and that culture therefore may be 'over-cooked' as the primary analytical perspective. It should also be noted that 'cultural identity' may be nested within ethnic, civic and/or national identities (Berry, 2003b).

Practitioner–client communication

Any brief consideration of the relationship between cultural psychiatry and psychology is going to be necessarily selective and restricted, but should at least consider the nature of therapeutic communication, as this is such a culturally saturated medium. Radley's (1994) review of the importance of the healing relationship highlights the neglected area of the influence of faith in healing. We may talk of faith in the practitioner, and faith in the treatment, or the 'placebo effect'. The role of faith in practitioners is no less important than it is in medicines. The actions of a clinician can be seen as having a placebo effect: the doctor's reassurance may make you feel better. Similarly the doctor's involvement in prescribing some treatment may give you greater faith in the treatment. However, without faith in your doctor, treatment or no treatment, your health may continue to be compromised. This presents us with a rather tantalising notion, that of the 'placebo practitioner'.

What exactly would a placebo practitioner be? It would be somebody who looks like and perhaps acts like a competent practitioner but who does not have access to truly therapeutic tools (e.g. effective medicines, techniques or procedures). The theme of placebos and faith is highly relevant to health practices across different cultures. Within one culture the idea of the placebo practitioner is at the root of much professional rivalry. Alternative, or complementary, practitioners are often castigated as presenting themselves as having therapeutic knowledge but in fact being inert. When we consider practitioners from a different culture, the situation becomes even more complex. We may well accept that people from their own culture have some faith in them but we dismiss the efficacy of their methods, e.g. we may not believe that the amalgam of various herbs presented by an Indian traditional healer has any intrinsic value in alleviating an illness, but we may acknowledge that the way in which it is prescribed does have a therapeutic effect.

Frank and Frank (1991) have argued that 'psychotherapy's practitioners are almost as varied as its recipients' (p. 19) and that 'extensive research efforts have produced little conclusive knowledge about the relative efficacy of its different forms' (p. 19). Furthermore, they state 'features common to all types of psychotherapy contribute as much, if not more, to the effectiveness of those therapies than do the characteristics that differentiate them' (p. 20). According to Frank and Frank, people are drawn to psychotherapy because of their persistent failures to cope, resulting from 'maladaptive assumptive systems' (or, how they understand their world), and consequently producing demoralisation – *then people seek therapy*.

The shared characteristics of different forms of psychotherapy may include an emotionally charged, confiding relationship with a helpful person (or group); a healing setting; a rationale, conceptual scheme, or myth that provides a plausible explanation for the patient's symptoms along with a prescribed ritual or procedure for resolving them. The ritual or procedure requires the active participation of both patient and therapist, with this shared belief in the ritual being the means of restoring the patient's health (Frank & Frank, 1991).

These therapeutic elements pervade cultural psychiatry, psychology, traditional forms of healing and perhaps even the more biomedically mediated forms of intervention, such as IVF treatment. Frank and Frank emphasise that myth and ritual have important functions in therapeutic relationships. These include combating the patient's sense of alienation and strengthening the therapeutic relationship; inspiring and strengthening the patient's expectation of help; provide new learning experiences; arousing emotions; enhancing the patient's sense of mastery or self-efficacy; and providing opportunities for practice.

Frank and Frank do not set out to undermine psychotherapy in any way, rather they highlight that it is a culturally constructed system of healing which, in fact, has much in common with other systems of healing, not necessarily in its content, but in its processes it adopts. All healing is comprised of myths and rituals, and it is these elements that often mobilize the 'recipient's' expectations, hopes and commitment. In cultural psychiatry the possibility of distinguishing complaints from their cultural context, and the effects of interventions from cultural expectations, can be daunting and perhaps even counter-productive. Although the scientific method seeks to distinguish the 'active' agents in treatment from more 'common' factors across interventions, or from straight out-and-out placebo effects, the appropriateness of this is increasingly being questioned. Recently Paterson and Dieppe (2005) have in fact argued that it is not meaningful to split complex interventions into the 'characteristic' (particular) and the 'incidental' (more general in the sense of occurring because of the mode of intervention rather than the intrinsic aspect of the treatment). They argue that elements classed as incidental in drug trails may in fact be integral to non-pharmacological treatments. Taking the example of acupuncture and Chinese medicine they note that the simple additive model of the RCTs (randomised control trials) is too simplistic and that therapeutic effects interact on multiple levels. They state that

> treatment factors characteristic of acupuncture include, in addition to needling, the diagnostic process and aspects of talking and listening. Within the treatment sessions these characteristic factors are distinctive *but not dividable from incidental elements*, such as empathy and focused attention (p. 1204) [italics added for emphasis].

They concluded that it is the underlying theory of a therapeutic intervention that should determine which elements are 'active' and which may be considered 'placebo', rather than a simple biomedical common denominator of therapeutics. This perspective has quite profound implications for cultural psychiatry as it is clear that in many healing processes (including non-Western ones) the healing agents, and the beliefs that surround them, may be distinct, but not necessarily divisible.

Returning to Frank and Frank's argument, such a perspective helps to shine a light on our own practices. Hubble, Duncan and Miller (1999), in their review of 'what works in psychotherapy', state

> . . .we found that the effectiveness of therapies resides not in the many variables that ostensibly distinguish one approach from another. Instead, it is principally found in the factors that all therapies share in common (p. xxii).

These factors are the so-called ‘common’ factors. Importantly, however, Hubble *et al.* are at pains to point out – unlike some previous critics – that psychotherapy works!

Hubble *et al.* (1999) stress that different components of the psychotherapeutic process contribute to different extents to positive outcomes: extra therapeutic change (or what happens outside the consulting room), the therapeutic relationship (the common factors), expectancy or placebo effects, and specific techniques (e.g. empty chair, thought record sheets, dream analysis). They also stress that different sorts of psychotherapy work equally well for the vast majority of problems. These arguments are quite challenging for disciplines such as psychology or cultural psychiatry, which, while theoretically being open to relativists’ positions also drive towards the pragmatic need to identify essential therapeutic elements.

Rethinking culture and pathology

Just what culture ‘is’, is becoming increasingly contested, as the notion of ‘culture’ is being used to explain an increasingly diverse array of social phenomenon. MacLachlan (2003) has described a variety of ways in which ‘culture’ can affect people, in terms of both their health and their broader sense of empowerment. A taxonomy, that is intended to be neither comprehensive nor mutually exclusive, is summarised in Table 4.2; and serves to highlight

Table 4.2. A typology of themes relating culture, empowerment and health

Cultural colonialism	Rooted in the nineteenth century when Europeans sought to compare a God-given superior ‘us’ with an inferior ‘them’ and to determine the most advantageous way of managing ‘them’ in order to further European elites.
Cultural sensitivity	Being aware of the minorities among ‘us’ and seeking to make the benefits enjoyed by mainstream society more accessible and modifiable for ‘them’.
Cultural migration	Taking account of how the difficulties of adapting to a new culture influence the opportunities and well being of geographical migrants.
Cultural alternativism	Different approaches to healthcare offer people alternative ways of being understood and of understanding their own experiences.
Cultural empowerment	As many problems are associated with the marginalisation and oppression of minority groups, a process of cultural reawakening offers a form of increasing self and community respect.
Cultural globalisation	Increasing (primarily) North American political, economic and corporate power reduces local uniqueness, and reinforces and creates systems of exploitation and dependency among the poor, throughout the world.
Cultural evolution	As social values change within cultures, adaptation and identity can become problematic with familiar support systems diminishing and cherished goals being replaced by alternatives.

Adapted from MacLachlan (2003).

the scope of cultural influences on health. To conclude, we briefly consider just one of these themes: cultural evolution.

Cultural evolution refers to the situation where values, attitudes and customs change within the same social system, over time. Thus different historical epochs, although being characteristic of the same 'national' culture (e.g. Victorian England compared to contemporary England), actually constitute very different social environments – cultures. Peltzer (1995, 2002), working in the African context, has described people who live primarily traditional lives, those who live primarily modern lives, and those who are caught between the two – transitional people. However, these 'transitional' people can be found throughout the world, including in its most 'advanced' industrial societies. Inglehart and Baker (2000) examined three waves of the World Values Survey (1981–82, 1990–91, and 1995–98), encompassing 65 societies on six continents. Their results provide strong support for both massive cultural change and the persistence of distinctive traditional values with different world views, rather than converging, moving on

> parallel trajectories shaped by their cultural heritages. We doubt that the forces of modernization will produce a homogenized world culture in the foreseeable future (p. 49).

Cultural differences may change, but are unlikely, it seems, to go away.

Use of the term 'cultural evolution' does not necessarily imply biological evolution in the sense of the fittest for the changing environmental niche will prosper at the expense of those less adaptive. Yet adapting to culture change within one's own culture may be every bit as demanding as adapting to cultural change across geographical boundaries, even when the changes within a culture are broadly welcomed (see for instance, Gibson and Swartz's, 2001, account of the difficulties some people in South Africa have faced in making sense of their past experience under Apartheid in the context of their current democratised experience). As regards the problem of suicide, this sort of analysis is not new, but is still not widely accepted. One of the four 'types' of suicide delineated by Durkheim (1897/1952) included, so-called anomic suicide, which was understood as resulting from the state of (the then, i.e. 1900s) 'modern' economies, and the effect they might have on individuals. In particular, dramatic and rapid changes in social structures (such as may accompany sudden increases in a country's wealth) may broadened individual's horizons beyond what they can cope with, especially when such changes are accompanied by diminishing forms of traditional support structures.

This cultural evolution argument, along with aspects of cultural globalisation and several other cultural themes noted in Table 4.2 have been incorporated into discussions of why Ireland has experienced such a rapid rise in suicide over the past ten years, why it has such a high male:female suicide ratio (compared to other European countries), and its strong correlation with increased Gross National Product (Smyth, MacLachlan & Clare, 2003). There is a particularly strong relationship between male suicides (with most of these being accounted for by young men, particularly more recently) and increased economic growth, as indexed by GNP, with an associated correlation of $r = 0.82$. Thus changes in the Irish economy, which have surely been a hallmark of the 'Celtic Tiger'; seem to be in some ways associated with changes in the rate of suicide, particularly among young men.

The challenge for cultural psychiatry is to recognise, as Berman (1997, p. 6) states that:

> culture is the nutrient medium within which the organism is cultivated. Suicidality grows, as well, when that culture is pathological . . . Suicidal behaviour can be designed to protect, to rescue the self from otherwise certain annihilation.

The interface between cultural psychiatry and psychology is in the domain of the individual's interaction with broader social identities, values and customs. To articulate this interaction requires not just recognition of the interplay between psychology and cultural psychiatry but also that with medical sociology and medical anthropology. Culture is not however simply a cloak which a person dons and which then determines their behaviour. Individuals are active agents who sift through their culture, not passive receptacles of it. Cultural psychiatry and psychology have to developed ways of working with people which recognizes this complexity, engages with individuals' right to their own health psychology and embraces the broader social and cultural context in which they live.

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Spirituality and cultural psychiatry

Kate M. Loewenthal

EDITORS' INTRODUCTION

Spirituality and religion are core aspects of people's identity in several cultures. This identity allows them to seek help from folk or social sectors and, eventually, from professional sectors. Both spirituality and religion play an important role in shaping an individual's beliefs and behaviours, which may or may not be culturally sanctioned. Clinicians often avoid exploring the patient's spiritual and religious beliefs because of the fear of upsetting them or not being certain as to how to handle them. There are key issues between spirituality and psychiatry, which include those of boundary, those of defining normality or deviance and uncertainty about the role of the other side.

In this chapter, Loewenthal raises four issues that reflect the relationship between psychiatry and spirituality. The first of these is differentiation between religiosity and spirituality. The role of spirituality within psychiatry, differentiation of spiritual and cultural factors and the universalism of these factors are the other issues which Loewenthal addresses in her chapter. There is no doubt that contents of delusions can be influenced by religious factors, but equally managing distress using rituals sanctioned by religions is important in assessment and management. The question of gender and age needs to be addressed further. Anecdotal evidence indicates that females and older people are more religious in their outlook. Religious and spiritual factors also influence help-seeking behaviours. In exclusive religious groups, religious and spiritual resources within the group may be perceived as and followed as providing effective relief from psychological distress. It is obvious that religious and spiritual factors will influence referral and may also reduce stigma. Similarly, these beliefs may increase adherence to therapy by modifying expectations from therapeutic interventions. Religious matching of therapists with those of the patients may need to be considered, although it may not always be practical. The possibility that spiritual beliefs may have negative effects cannot be excluded entirely. Unhelpful bias in diagnoses may create further problems of which clinicians should be aware.

Introduction

Belo had been sent away from his Indonesian village for aggressive and threatening behaviour. Doctors could not help. He saw himself as on a mission to seek the purpose of life from a guru in a different area. When he returned, he said he had been ordered by Allah (Tuhan) to teach the village the right ways of Islam. Although his manner was intense, his speech was calm and clear. He claimed he could see through people, knowing what they thought. He had a special stone which sparkled when held near a person who understood the purpose of life. He claimed that his deceased uncle (Om) was directing his movements, also that he could see through objects and into the future, and that he was a prophet. He threatened and beat up 'bad' children, destroyed banana plants and the villagers were worried about future disasters. Among the villagers, there was much debate about what to do about Belo – should he be expelled again, or sent to hospital – but this could be too expensive – or what? It was agreed that a hen should be sacrificed to appease a red-haired Jin who had met Belo in the forest. Belo's actions were being controlled by this Jin, not by Tuhan, or by Om, as Belo claimed. In spite of this difference of opinion, Belo agreed to the hen sacrifice. Belo was also given herbal treatment. Over the years, Belo suffered intermittent attacks of craziness, and was sometimes locked up. The villagers accepted that many people go

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

through periods of craziness, for example, children when distressed, or young people in love, and that there was always hope that Belo would settle down (Broch, 2001).

Jonah has become a much more religiously observant Jew over the years. As in other orthodox Jewish homes, his family kitchen has different utensils for cooking and serving milk and meat foods. However, unlike other kosher kitchens, the cupboards are stockpiled with stale loaves of bread, opened but disused bottles of tomato ketchup, packets of salt, and other foods that are neither meaty nor milky – most people will use these neutral, non-milk non-meat foods with both milk and meat meals, but Jonah becomes frightened after, say, a bottle of ketchup or a loaf of bread has been used at a meal. The children may have touched it with meaty hands, he alleges, so we may not be permitted to use it with milky food. Jonah's rabbi has been consulted frequently, and has tried to convince Jonah, very tactfully, that he is going to unnecessary lengths. Jonah's wife and children feel they are being driven crazy, but Jonah insisted that his actions and beliefs are religiously appropriate and he does not need help. Finally, he was persuaded to seek professional advice. (Greenberg. 1987; Greenberg & Witztum, 2001).

Ellen, a Pentecostalist Christian, was born in the West Indies and lives in London, working as a psychiatric nursing auxiliary. She is a religious enthusiast: patients and colleagues tolerate her attempts to convert them, and to persuade them that Jesus will help them more than the doctors can. One day, she starts rolling on the floor, babbling incoherently. The psychiatrist who witnessed this wondered if she was practicing glossolalia – speaking in tongues – encouraged in Pentecostalism. He invited an opinion from her fellow church members. They said that this was not genuine speaking in tongues: she was ill and needed medication. (Littlewood & Lipsedge, 1997).

These examples throw up several important themes in considering spirituality in the context of cultural psychiatry.

- Spirituality is an essential premise, and a core aspect of self-concept and of coping.
- Spiritual and religious forces are seen to play a key role in shaping beliefs and behaviours – including unacceptable ones.
- Spiritual and religious beliefs are an intrinsic feature of the cultural group, therefore difficult to distinguish from cultural factors.
- However, the sufferer and his or her social circle may have different views on precisely which spiritual and religious factors are important, for example, whether Belo's actions were being controlled by a Jin, Tuhan (Allah), or Om, or whether Jonah had gone too far with his religious scruples.
- Spiritual and religious beliefs influence the kinds of help believed to be effective and acceptable.

These lead to questions, and this chapter will discuss some of these.

Aims

In this chapter we will first consider several aspects of the relations between cultural psychiatry, and spiritual and religious issues. In particular, we ask:

- do spirituality and religiosity need to be distinguished?
- what role does spirituality play in cultural psychiatry?
- can we distinguish spiritual from cultural factors?
- can we generalise from Western, Christian studies on spirituality in relation to mental health?

Then we examine, in the context of cultural psychiatry how spiritual and religious factors affect:

- the prevalence of psychiatric illnesses,
- help-seeking and compliance,
- diagnosis, and decisions about clinical management and therapy.

Psychiatry and spirituality, some issues

Psychiatry and the related mental-health professions have had a long and sometimes difficult relationship with spiritual and religious issues, and cultural factors are often deeply embedded in these difficulties.

Here are four particular issues.

Do spirituality and religiosity need to be distinguished?

Religiosity is in itself difficult to define, given the many social, cognitive, experiential and other factors involved. Am I religious because I identify myself as an orthodox Jew? Because I believe in G-d? Because I am aware of G-d's presence? G-d's unity? G-d's support? Most authors would accept that religion involves affiliation and identification with a religious group, cognitive factors – beliefs, and emotional and experiential factors (Brown, 1987; Paloutzian, 1996; Loewenthal, 2000). In the last decade, there has been growing emphasis on spirituality, as something different or separable from religion (Zinnbauer *et al.*, 1997; Speck, 1998). Wulff (1997) suggested that spirituality is possibly a contemporary alternative to religion in today's pluralistic society. King & Dein (1998) argued that using spirituality as a variable in psychiatric research encompasses a broader range of both people and experiences than does the religious variable: spirituality is 'a person's experience of, or a belief in, a power apart from their own existence' and that power is revered and sacred. Spirituality might be what all religious–cultural traditions have in common, and, contemporary commentators say, is an aspect of human experience open to those who do not identify with a specific religious tradition. Helminiak (1996) argued that the study of spirituality can be undertaken scientifically, and is 'different from the psychology of religion as generally conceived'. Zinnbauer *et al.* found a number of features that distinguished adults who defined themselves as religious, from adults who defined themselves as spiritual but not religious. Those who said they were spiritual but not religious were more likely to engage in New Age religious beliefs and practices, but were less likely to be engaged with the beliefs and practices of traditional religions. However, it is noteworthy that in the Zinnbauer *et al.* study, all those who defined themselves as religious also regarded themselves as spiritual.

This indicates support for the view that spirituality is possible outside the context of organised or traditional religion, but is also a common feature of different religious traditions. When the term 'religious' is used in this chapter, this has the implication that spirituality is an essential feature. There are, additionally, practices and beliefs specific to a given cultural–religious group.

What role has spirituality played in psychiatry?

Spirituality has been problematic for psychiatry for two reasons.

First, the 'demon problem'.

J has violent abdominal pains and insists that these are caused by bad spirits unleashed by a former friend, whose boyfriend has left her and taken up with J.

The person who believes that s/he is being persecuted by malign spiritual forces presents dilemmas for the clinician. How helpful is it to think of this as delusory? Would s/he be better off without a spiritual belief system, or is the belief system simply affecting the shaping of symptoms? Should spiritually based remedies be deployed? Is the person in fact suffering from psychiatric illness?

Belief in possession by malign spiritual forces has been a long-standing problem in psychiatry. Kroll & Bachrach (1982) and Lipsedge (1996) reviewed medieval documentation to conclude that, in the past, demons were not invariably regarded as the only possible causes of psychiatric illness: stress, fever and malnutrition were more likely to be seen as causal factors. Nevertheless, belief in malign spiritual forces as possible causes of psychiatric illness is probably culturally and historically universal, even though stress and other factors are also seen as important, by lay people as well by those professions empowered to help the psychologically disturbed (e.g. Pfeifer, 1994; Srinivasan & Thara, 2001; Loewenthal, 2006).

There are two factors: the conviction that illness may be caused by malign spiritual forces, and the possibility that the positive symptoms of schizophrenia, delusions and hallucinations, may be common among non-disordered people – that make for difficulties in diagnosis and treatment.

The 'demon' problem is only one way in which spiritual issues obtrude in psychiatry.

The second major set of difficulties is the debate over whether religion is consoling or harmful. The consolations of religion have been recognised by the provision of chaplaincies in psychiatric hospitals. Towards the end of the eighteenth century there were attempts to treat the insane more humanely, and spiritual issues were important. But attitudes were as mixed as they were strong. In the 1790s, Tuke, a Quaker merchant, founded the York retreat, where prayer and religious devotion were seen as central to the healing process. In Britain, the Lunacy Act of 1890 ordered a church in every asylum, which the inmates had to attend twice a day. In France, by contrast, Pinel – who abolished chains for the insane in the Bicetre – insisted that the mentally ill should not be exposed to religious practices, as it was felt that these might encourage delusions and hallucinations.

These contrasting attitudes and practices appear elsewhere. Thus Freud (1927, 1928, 1930, 1939), spearheaded a movement which viewed religion as possibly crippling for psychological health. A few weeks ago, at a meeting involving users of mental-health services, one user complained that, although she and her fellow Christians on their psychiatric ward found prayer and bible study very helpful (and indeed as we shall see there is considerable scientific support for this), they were not permitted to organise ward prayer meetings or bible-study sessions. The Christian patients believed that the ward staff feared that this would ‘make some patients worse’.

There is some mutual mistrust, with religious authority figures suggesting that the ‘psych’ professions – psychiatrists, psychoanalysts, psychotherapists, clinical psychologists – are not to be trusted. For example: ‘Psychoanalysis has effected no cures. Freud and his cohorts are charlatans and vampires that prey upon society’ (Miller, 1984).

Neeleman & Persaud (1995), treading a cautious path, suggest that religious and spiritual issues are indeed outside the clinician’s area of competence, and could therefore best left alone in negotiating treatments. Recent years have seen less reticence. For example, there have been strongly advocated moves for reconciliation between spirituality and psychotherapy, that spirituality should be taken into account in psychiatric and therapeutic practice (e.g. Bhugra, 1996; King-Spooner & Newnes, 2001, Foskett, 2004; Pargament & Tarakeshwar, 2005; Crossley & Salter, 2005).

Can we distinguish spiritual and cultural factors affecting mental illness?

The question was highlighted for me when a psychiatrist commented that he thought that studying religion and mental health was the same thing as studying culture and mental health. King & Dein (1998) suggest that psychiatrists regard spirituality as ‘cultural noise to be respected but not addressed directly’.

Works on cultural psychiatry normally offer much material involving spiritual issues, with spiritual and religious factors subsumed under the heading of culture. Belo’s story from the beginning of this chapter is one example.

To the observing ethnographer, or the visiting psychiatrist, religious and spiritual beliefs and practices may be seen as part and parcel of the culture. For the Western-trained psychiatrist, religious factors may seem distinct from culture only when they appear in a patient from the same cultural group. But we can see from the examples that began this chapter that discussions about clinical management among the patient’s own group often seem to involve strategies that are specifically spiritual and religious. This could be important, particularly because we need to understand the importance for users of the spiritual sanctioning and origins of their behaviour – as with Belo and Jonah – and also the importance of the religious endorsement of clinical interventions. For example, Belo, Jonah and Ellen all felt their behaviour was spiritually inspired. Also, it was important for Belo to accept that the hen sacrifice would be spiritually valid, for Jonah to accept that his rabbi approved his psychiatric treatment, and for Ellen to know that her fellow church members thought she should have medicine. These behaviours and decisions were embedded in particular cultural context, but it is the spiritual dimensions that have special significance for understanding, and for clinical management.

Can conclusions about spirituality and religion in relation to mental health, based on research in Western Christian groups, be applied to other cultural-religious groups?

There are two suggestions in particular that need airing.

One is that religion has generally benign effects on health and mental health (e.g. Koenig, McCullough & Larson, 2001). This is a broad conclusion: some effects are null, and some are negative. Some aspects and styles of religion and spirituality may be unhelpful. Outstanding examples have emerged from Pargament and his collaborators (e.g. Pargament, 1997) on styles of religious coping that have positive and negative outcomes on well-being: for example, belief that G-d is supportive is helpful, belief that G-d is angry is reliably associated with poor outcomes. Studies of religion and mental health have problems with research methods. Most studies have involved a cross-sectional design; most researchers have studied the relations between measures of spirituality/religion and health/mental health at one point in time. This makes it difficult to draw conclusions about what is causing what. Prospective studies would enable firmer conclusions, but there are (as yet) few of these. The biggest problem, in the context of our present concerns, is the narrow range of religious traditions (mainly Christian) and cultures (North American and other Western cultures). There have been only a small number of studies of Hindus, Jews, Muslims and other groups.

So the first suggestion that needs examining in the transcultural context is that spirituality may be beneficial for mental health. The rich ethnographic material available suggests that findings from current research cannot always be generalised into other cultural contexts.

The second suggestion is that not only psychiatric but also spiritual support can be offered by a professional with appropriate training. This is an issue in culture-sensitive service provision that is likely to become a topic for debate in the future. Can, say a Christian minister, with training in and understanding of the beliefs and customs of other faith traditions, provide a form of spiritual support that is acceptable and helpful to members of other religious traditions, for example, Muslims, Jews, Hindus, even Christians of other denominational affiliations. This is a contentious issue: members of some religious groups may be happy to receive some professional (i.e. psychiatric, clinical–psychological) mental health support from professionals outside their religious group, even though they might have reservations about whether they are being fully understood (e.g. Cinnirella & Loewenthal, 1999). However, they might feel that spiritual support needs to come from an qualified religious leader in their own tradition. Some chaplains may find that they can offer support to members of other faiths, and this may be gratefully accepted, but this probably does not imply that this service is going to serve all needs across the board, obviating the need for religiously specific support.

Having reviewed these preliminary issues – whether spirituality and religion need to be distinguished, the varied role played in psychiatry by spiritual issues, the difficulty of distinguishing spiritual and cultural factors, and generalisability of research on Western Christians to other groups – we now turn to examine the ways in which spirituality might affect prevalence, help-seeking, compliance, diagnosis and decisions about clinical management.

Prevalence

Cultural and spiritual/religious factors may affect prevalence and referral rates for different conditions.

Depression

Overall, there is a reliable association between higher religiosity and lower levels of depression (e.g. Koenig, 1998; Koenig *et al.*, 2001; Loewenthal, in press). There are some aspects of religiosity that are exceptions to this general tendency, but a number of features of religion have now been identified that are likely to play a causal role in ameliorating or preventing depression. These include:

- religiously based coping beliefs (Maton, 1989; Pargament, 1997; Loewenthal, MacLeod, Goldblatt *et al.*, 2000; Koenig *et al.*, 2001) particularly the belief that G-d is benign and supportive
- social support – warm and confiding relationships, esteem, practical help, and companionship are all encouraged among religious groups (Shams & Jackson, 1993; Loewenthal, 2000).
- reduced stress – at least some stressors of the type that could cause depression (e.g. Loewenthal, Goldblatt, Gorton *et al.*, 1997a).
- positive mood states, many of which are religiously encouraged, play a role in reducing depressive mood and illness. These include purpose in life, joy, optimism, and forgiveness (Seligman, 2002; Joseph *et al.*, 2006).

The main aspects of religion which may foster depression are firstly, beliefs that G-d is punishing, vengeful, or simply indifferent (Pargament, 1997), and secondly, situations in which religious forces encourage persecution, warfare and other horrific circumstances. However, it remains unclear whether these things are more likely to be encouraged in the name of religion than they are in the name of some non-religious ideology, such as socialist justice, liberty, equality and fraternity, or a Great Leap Forward.

Another factor affecting depression prevalence is a combination of gender and religiously supported attitudes to alcohol use. Depression is widely concluded to be more prevalent among women than among men (Paykel, 1991; Cochrane, 1993). Referral rates also show a similar pattern. However, there are some groups among which depression may be as prevalent among men as among women: (orthodox) Jews (Levav, Kohn *et al.*, 1993; 1997; Loewenthal *et al.*, 1995) the Amish, diabetics (C. Bradley, personal communication 1999), actively religious Christians (Kendler, Gardner & Prescott, 1997). What these groups have in common is low or no use of alcohol. The alcohol-depression hypothesis suggests that societies in which men are as likely to be depressed as women are ones in which (particularly men's) depression is not masked by alcohol use and abuse (Loewenthal *et al.*, 2003a,b).

The overall effect in most studies is a reduced likelihood of depressed mood and illness among the religiously active.

Anxiety

This has been less heavily investigated in relation to spirituality than has depression. There seem to be two important and conflicting effects.

Firstly, spirituality and religious commitment are usually associated with feelings of obligation to perform religious duties. Earlier commentators, notably Freud (1907) commented that this relieved guilt, but it has become more apparent that spiritual satisfaction is an important factor. This might involve scrupulosity with regard to diet, religiously prescribed cleanliness, or caring for others, for example. A number of studies have indicated that religiosity is associated with higher levels of subclinical anxiety and obsessionality (Lewis, 1998; Loewenthal *et al.*, 1997b). Clinical levels of anxiety and obsessive-compulsive disorder are not more likely among the religiously active, though cultural–religious context can affect the shaping of symptoms (Greenberg & Witztum, 2001).

The second important effect works in the opposite direction. Heightened spirituality, religious faith, awareness that (once one has done what is humanly possible) all is in the hands of heaven – these beliefs and states of awareness are associated with lower anxiety. This effect can be obscured by the tendency for individuals under stress to increase their levels of religious and spiritual activity – notably prayer and meditation. In cross-sectional studies this can give a muddled picture. But with sufficient attention to research design, measurement and interpretation, there is now reasonable confidence that these effects dominate the relations between anxiety and religious/spiritual factors (Koenig *et al.*, 2001).

Psychosis

Schizophrenia is sometimes said to be roughly similar in its prevalence across different cultural groups – a lifetime prevalence of approximately one in 200. It is admitted that diagnostic criteria can vary, and there is still vigorous debate about the nature and classification of psychosis (Bentall & Beck, 2004). Variations in prevalence may be a result of variations in the occurrence and classification of culture-specific symptoms and syndromes. An important example is the misdiagnosis of fervent prayer and other religious coping behaviour as psychotic symptomatology. Bipolar (manic-depressive) disorder may be influenced by spiritual factors, notably meditation (Wilson, 1997). Yorston (2001) has suggested that meditation may precipitate manic episodes, possibly the result of neuropsychological factors. It is possible that the affected individuals are predisposed to the disorder (perhaps as a result of genetic factors), and the spiritual practices which are followed by manic episodes may have been attempts to cope with depressive episodes.

One important conclusion is that prevalence estimates may rest on diagnoses based on 'symptoms' which are in fact attempts to cope, stimulated by stress, often using spiritual and religious devices, which may be quite effective. This can make it difficult to disentangle the conflicting effects of culture, religion and spirituality on prevalence, but the existence of conflicting effects does not imply inconclusiveness. A further noteworthy point is that there are many culture-specific symptoms and syndromes, with religiously flavoured symptoms; again the causal roles of spiritual and religious factors are complex.

Help-seeking and compliance

Prevalence is not necessarily reflected in referral rates. Of the many aspects of religion and spirituality that might affect help-seeking and referral, we can identify two broad groups of factors: firstly, religious and spiritual factors affecting views about treatments and ways of coping, and secondly religious and spiritual factors affecting social-psychological dynamics.

Views about treatments and ways of coping: religious coping, religiously influenced beliefs about the efficacy and acceptability of different treatments and coping methods

Particularly in exclusive religious groups, religious and spiritual resources within the group may be seen as offering effective relief from mental health difficulties (Koenig, 1998; Greenberg & Witzrum, 2001; Loewenthal, 2005; G. Leavey, K. Loewenthal & M. King, unpublished data), and the practices and beliefs of mental-health professionals are unacceptable religiously, spiritually harmful, and ineffective.

> We treat such problems in the community. We give the person with difficulties a boost, talking about belief, and trust in G-d, saying we must not despair . . . everything is from Heaven (Orthodox Rabbi, quoted in Greenberg & Witztum, 2001).

Some early work suggested that clients were generally more religiously active than mental-health professionals, even though more recent work (e.g. Roskes, Dixon & Lehman, 1998) suggests that this may no longer be the case. The outrageously anti-religious statements of Freud and others may have helped to foster a view that it is spiritually dangerous to seek psychological help. There may be more specific concerns: that psychologists and psychiatrists might encourage or condone sexual or other behaviours that are not religiously acceptable – homosexuality, for example, or speaking disrespectfully about parents (Loewenthal, 2005). Some professionals may misunderstand or fail to consider their patient's spiritual and religious concerns.

There is of course growing evidence of the effectiveness of much religious coping: prayer, trust, belief in a benevolent, fair G-d, perception of purpose – all these have been empirically shown as effective (e.g. Pargament, 1997; Maltby, Lewis & Day, 1999; Loewenthal *et al.*, 2000), and they are perceived as effective (Loewenthal *et al.*, 2001).

There is also growing consensus that the majority of users and potential users of mental-health services are generally pragmatic in their use of different kinds of help for psychological problems; use is determined by availability and cost-effectiveness, and preferably confidentiality. Clients will shop around until they find something accessible that works. These factors can help to explain the relative popularity of prayer, religious and spiritual healing (Campion & Bhugra, 1998; Sembhi & Dein, 1998; Loewenthal & Cinnirella, 1999).

These beliefs – the effectiveness and accessibility of spiritually based help and coping methods, and religious barriers to seeking professional help, combine to give the result that substantial numbers of patients – up to 70% or more in some studies – will have used one or more spiritually based treatment before seeking professional help.

It is unknown for what proportion of people who use spiritually based support or help, that help is sufficiently effective, or there is 'spontaneous' remission, so that further help is not sought. Some professionals may be concerned the religious and spiritual barriers to seeking professional help may result in further deterioration. This is an important concern, but there is no substantial evidence in place as yet.

Religious and spiritual factors affecting social–psychological dynamics: trust for clinicians, stigma and the own-group dilemma

There are social–psychological effects that rest on religious and spiritual factors, and which affect help-seeking and referral. Foremost among these is *stigma* – the fear that one is or will be discredited by significant others. Stigmatisation is likely to be associated with mental illness, and strong in close-knit religious groups (e.g. Muslim, Black Christian, Orthodox-Jewish). For example:

- 'Our people do not want everyone to know they have a problem.'
- 'I would think that many people would prefer something more confidential than an open meeting.'
- 'What kind of people would use this (service)? Must be people who can't cope.'

While members of many religious groups say that they would feel best understood by a professional who shares their own religious background, they also have fears that this might lead to their condition becoming known:

- 'I would think twice before going to a counsellor from my community. I would not want everyone to know.'

(Examples from Cinnirella & Loewenthal, 1999; Loewenthal & Brooke-Rogers, 2004).

Stigmatisation almost certainly occurs more strongly in tightly knit religious groups and collectivist social milieux, than it does in complex, urbanized, individualistic societies. So insofar as religious and spiritual factors play a role in the formation and maintenance of close-knit, collectivist groups, stigmatization is a likely by-product. This is hypothetical, and empirical work on this topic is lacking.

Adherence

Adherence may be difficult to assess in psychiatry and psychotherapy, but can be reflected in taking prescribed medication, keeping appointments, or developing an acceptable working relationship, and these are all related to trust and confidence in the professional. Trust and confidence are likely to be higher for a professional who is seen to understand and respect clients' explanatory models (Bhui & Bhugra, 2002), including spirituality, and who may be able to address any spiritual concerns (Fabrega *et al.*, 2000; Pargament & Tarakeshwar, 2005).

However, some caution is needed. Pargament *et al.* (1997) list some of the potential dangers of spiritually sensitive therapy, for example, overestimating the importance of spirituality.

Individuals may feel that using a professional from their own cultural–religious group will involve a feeling that their spiritual concerns are best understood, but as mentioned, there are raised concerns about stigma and confidentiality involved in consulting an own-group professional. Even if these are resolved by finding a professional from another geographical area, where there is less likelihood of the consultation becoming known, problems can remain. As Loewenthal (2005) points out, the client may have magical expectations of the therapist, over-idealise them, and expect him or her to give advice which is not appropriate in the therapeutic situation. Dein (2002), Loewenthal & Brooke-Rogers (2004), Fernando (2005) and others have discussed some of the difficulties in implementing culturally and spiritually-sensitive mental health care. Apart from the financial difficulties experienced by those providing such services, which almost always spring from the voluntary sector, there is almost no research funding and effort invested in discovering whether the extent that cultural–religious matching of providers and clients really:

- results in more effective services,
- results in matching explanatory models (or maps), or
- whether the latter is important for adherence, and improved outcomes.

Diagnosis and clinical management

Diagnostic and treatment decisions can be based on patients' religious behaviours and feelings. There are also at least two diagnostic areas in which there may be biases based on information about religious behaviour and affiliation: psychosis, and obsessive-compulsive disorder.

Many religions endorse and encourage spiritual experiences and behaviours which might be construed as psychotic symptoms: the hearing of voices, visions, and religious practices such as glossolalia, ecstatic states, trances, dancing, and other behaviours involving dissociative phenomena.

There is a growing amount of work to suggest that:

- visions, voices and experiences that may often be interpreted as spiritual are genuine from the experiential and phenomenological perspective;
- among psychotic patients, these experiences are significantly more unpleasant, uncontrollable and persistent than among others (Peters *et al.*, 1999; Davies, Griffiths & Vice, 2001);
- a range of visions, voices and other hallucinatory experiences are extremely common among those not suffering from psychiatric problems. They are seldom reported for fear of being taken as signs of madness (e.g. Hinton, Hufford & Kirmayer, 2005).

Nevertheless, these behaviours may be taken as symptoms of psychosis. This may be one cause of the so-called Afro-Caribbean schizophrenia 'problem': higher referral and possibly prevalence of schizophrenia among Afro-Caribbeans in western countries. Ineichen (1991), and Thomas *et al.* (1993) and Loewenthal & Cinnirella (2003) reported that schizophrenia is more commonly diagnosed among Afro-Caribbeans in the UK than it is among other ethnic groups, and that this overdiagnosis occurs for Afro-Caribbeans in Europe and the USA, but not in Africa or the Caribbean. Littlewood & Lipsedge (1981a,b) found that a form of Sz with a relatively good prognosis was more common among Afro-Caribbeans than among other groups, and this was characterised by 'religiously flavoured symptoms'. One explanation, based on Bhugra (2002) is that when individuals (from ethnic–religious minority groups) are under stress, they may adopt religious coping strategies, which decline when – for whatever reason – there is remission. Thus religious behaviours are not so much a symptom of distress but a form of coping. This is speculative, but there is much in the clinical literature to confirm that the past tendency to misdiagnose religious coping behaviour as symptomatic of psychopathology may still persist (Loewenthal, 1999).

If one knows that a religious tradition requires cleanliness before prayer, or purification from sin, for example, by confession, it is tempting to conclude that obsessive-compulsive disorder (OCD) may be fostered by these religious demands, by the over-zealous wish for spiritual purity. Nevertheless, it has been concluded that – while religiosity may be associated with non-clinical scrupulosity, and can influence which obsessional symptoms are developed in OCD, it does not actually cause OCD. But as with psychosis, there may a persistent diagnostic bias. Gartner *et al.* (1990) Yossifova & Loewenthal (1999), and Lewis (2001) all found that both clinicians, clinical trainees and lay people were more likely to diagnose OCD when a patient was described as religiously active.

Nevertheless, we cannot conclude that patient religiosity, spirituality and cultural background have a uniformly negative effect on clinical decision-making, although this is a persistent fear among potential patients. There is no striking evidence of diagnostic biases regarding clinical conditions other than schizophrenia and OCD. In one recent study, Janes (2005) found that clinical outcomes were rated (by clinicians) as just as good for psychotic patients with religious symptoms, as for psychotic patients with other symptoms. Many clinicians are aware of the possibilities for the diagnostic biases associated with patients' religious behaviour, and make efforts to overcome these biases (Littlewood & Lipsedge, 1997).

Conclusions

This chapter has looked at cultural–spiritual–religious factors and their impact in cultural psychiatry. In providing services, and in making clinical decisions, it is important to bear in mind that specific spiritual beliefs and practices are not uniform within any culture.

Three kinds of effects of spirituality on mental health seem to be important. Firstly, that while there are some damaging effects of spiritual beliefs and practices, these may be outweighed by the beneficial effects. Work on how and whether these beneficial effects may be harnessed to bring clinical benefits is only in very preliminary stages. Secondly, there may be unhelpful diagnostic biases and clinical decisions based on patients' religiosity and spirituality, particularly perhaps when religious practices are culturally unfamiliar. It needs to be explored whether these exist for disorders other than schizophrenia and OCD, and whether they are pervasive and persistent. Thirdly, religious coping behaviour is felt to be spiritually and psychologically beneficial. However, when individuals are under stress, there may be an increase in religious coping, and this can lead to an impression that the religious behaviour is a sign of illness. This effect needs to be explored carefully in longitudinal studies, and is a possibility that clinicians need to bear in mind.

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6

Culture, ethnicity and biological psychiatry

Chia-Hui Chen, Shi-Kai Liu and Keh-Ming Lin

EDITORS' INTRODUCTION

The differences between universalist and relativist positions related to pharmacological interventions are of great interest to researchers and clinicians alike. The variations in social forces and cultural traditions and attributed similarities are proofs of the universality of the biological processes underlying psychiatric problems. Regional and ethnic variations almost always exist and associated biological and social factors must be considered in managing patients. Chen and colleagues, in this chapter, highlight the interface between biological psychiatry and neurosciences on the one hand and culture and ethnicity on the other. They raise three issues on the subject – those of generalisability, variations in groups and individuals and finally the theoretical implications embedded in cross cultural research is commonly observed and well documented. Beside genetic predispositions, it also stands to reason that influences of culture on biological processes could also lead to disease susceptibility. Biological markers responsible for disease and response to medication have not been studied in all cultural and ethnic groups. Biology is not culture free, and the complex interaction between culture and biology includes genetic vulnerability and resilience related to environmental factors. People with different ethnic and ancestral backgrounds have different genetic profiles, which may indicate differential risks for specific disorders.

Physical and social milieus within which people live are shaped by cultural factors, thus the interaction of biology and culture shapes responses and outcomes in various psychiatric disorders.

The significance of biology in cultural psychiatry

Starting with the founding fathers of our field, including Kraepelin and Freud, psychiatric thinkers over this past century have struggled with issues related to 'universality', or cross-cultural applicability, of theories and approaches related to psychopathological conditions. Such interests led to Kraepelin's grand tour of the East in 1904, where, to his great relief, he found cases confirming his conceptualization of dementia praecox, but at the same time noticed variations in symptom presentations and courses (Murphy 1982; Jilek 1995). This marked the birth of a discipline variably called 'comparative psychiatry', 'ethnopsychiatry' or 'cultural psychiatry', along with a rich and ever-growing literature, documenting both similarities and variations in psychiatric phenomena across cultural and ethnic groups.

Traditionally, scholars have tended to regard such variations as consequences of social forces and cultural traditions, and attribute similarities as proof of the universality of the biological processes underlying psychiatric problems (Lin *et al.*, 1993). However, with the remarkable recent progress in biological psychiatry, psychopharmacology and neuroscience, it is now clear that such a demarcation may be largely artificial and overly simplistic. Variation is the rule rather than the exception in the biological world. Recent advances have made it clear that, in practically all biological characteristics examined, regional and ethnic variations almost always exist, typically superimposed on individual variations. Although mechanisms responsible for such variations are still awaiting further clarification, genetics clearly play an important role. In addition, cultural and other environmental factors interact with genetic and other biological determinants to shape psychopathological manifestations

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and psychopharmacological responses. With the field rapidly progressing, it is particularly important that we do not neglect such interactions and interplays for a number of reasons, which will be briefly elaborated below.

Firstly, knowledge on the interface between biological psychiatry and neuroscience on the one hand, and culture and ethnicity on the other, is essential for rendering state-of-the-art quality psychiatric care available for the majority of the human populations. Most of the development of psychiatric diagnosis and treatment has thus far emerged from Western countries, based on studies conducted on subjects of Caucasian origin. However, in reality, they represent only a small fraction of the world's populations. According to the United Nations, over 83% of the world population lives outside Europe and Northern America ((UN) 2005). Even in these 'Western' countries, the populations have become increasingly heterogeneous. It is problematic to assume that findings derived from any particular population group would automatically be applicable for others. 'Generalizability' is at issue, but the significance of which often has been ignored or minimized. In order for biological advances to optimally benefit 'non-Western' populations residing not only outside of the 'Western' countries, but increasingly those living in large number in all metropolitan areas in these countries, it is crucial that ethnic and cultural factors be taken seriously.

Secondly, as mechanisms responsible for cultural and ethnic differences often are similar or identical to those determining individual variation, studies in the former serve an important heuristic function for advancing our field's understanding for the latter. This is essential for the application of scientific progress at the clinical level for individual patients seeking care, whose personal, ancestral, developmental and lifestyle backgrounds importantly determine the 'natural' course of their illnesses as well as their responses to interventions. Advances on these fronts are essential for realizing the goals of 'individualized medicine'.

Finally, cross-cultural research is also important for its theoretical implications. To the extent that results of studies conducted across a number of different ethnic/cultural groups point in similar directions, the findings might be regarded as universal or possessing a greater degree of validity, which should have a greater chance of enhancing our understanding of the underpinning for the disease processes, or for the effectiveness and utility of the intervention methods. Results that diverge across cultural/ethnic groups, on the other hand, would require rethinking regarding the validity of the original theories or hypotheses, and further exploration into mechanisms that might be responsible for such discrepancies. Thus, cross-cultural biological research represents a very powerful (but often neglected) tool for psychiatric research. Its results can also be very helpful in the development of future research directions and guiding clinical practice.

In this chapter, current research on the relationship between cultural psychiatry and biological psychiatry, including knowledge of ethnic and cultural difference and similarities of disease susceptibility, interpretation of neurobiological correlates and responses to psychopharmacotherapy will be reviewed.

Culture and disease susceptibility

Cross-cultural/cross-ethnic variations in the prevalence and pathogenesis of medical diseases are commonly observed and well documented. They include not only relatively rare genetic disorders, but also malignancies as well as many 'common disorders'. For example, sickle cell anemia is more prevalent in sub-Saharan black Africans and African-Americans. Tay–Sach disease is relatively more common (although still rare) in Ashkenazi Jews as compared to Sephardic Jews and non-Jews (Charrow, 2004). There are also reports of cross-cultural differences in the prevalence of common disorders such as cardiovascular diseases, diabetes mellitus, thyroid autoimmunity, obesity, osteoarthritis, various kinds of malignancies, and infectious diseases (Polednak, 1989).

Above and beyond the issue of cross-ethnic variations in the prevalence of diseases, culture and ethnicity also significantly influence symptom manifestations, clinical course, outcome and treatment responses. For example, mortality after heart failure is lower in Japanese population than in Caucasian patients (Sasayama, 2004). In African-Americans, the prevalence of hypertension is disproportionately high, leading to higher rates of stroke, renal disease, heart failure and other end organ manifestations (Blaustein and Grim, 1991).

Seemingly paradoxically, much less information has been available on cultural/ethnic variations in the epidemiology and phenomenology of psychiatric disorders, perhaps due to a prevailing belief in the universal nature of the biological processes underpinning psychiatric diseases. However, in recent years, prominent scholars in the field have started to question such an assumption, pointing out the presence of biases in psychiatric research, both at the researcher and the institutional levels, in over-emphasizing cross-cultural similarities (Lawson, 1986). For example, Kleinman convincingly argued that this was exactly what happened with regard to most, if not all, of the cross-cultural and cross-national studies on schizophrenia and depression sponsored in the last three decades by the World Health Organization (Kleinman, 1988). At different levels, including study designs, subject selection and the interpretation of the results, these studies showed strong biases towards finding the universality of psychiatric disorders, as expected. Together, they serve as good examples on how powerful cultural influences (in this case, professional culture) are influencing psychiatric research itself.

This notwithstanding, emerging data suggest that culture and ethnicity represent powerful forces in determining risks for psychiatric morbidity. For example, substantive reports demonstrated increased rates of schizophrenia and mania in African-Caribbean populations in England (King *et al.*, 2005). African-Caribbean patients with schizophrenia show more affective symptoms, and a more relapsing course with greater social disruption but fewer chronic negative symptoms, than White patients (Harrison *et al.*, 1988; King *et al.*, 1994; Bhugra *et al.*, 1997; Sharpley *et al.*, 2001). In studies where the susceptibility of schizophrenia seems to be similar across cultures, questions regarding the prevalence of subtypes that may have divergent neurobiological correlates remain to be scrutinized (Marcolin, 1991). Besides schizophrenia, reports also showed cultural variations in the risks of mood disorders. For example, a recent study reported that Jewish males had significantly higher rates of major depression than Catholics, Protestants, and non-Jews (Levav *et al.*, 1997). In a study examining ethnic characteristics of mental disorders in US, researchers found that Blacks were significantly less likely than Whites to have major depressive episode, major depression, dysthymia, obsessive-compulsive disorder, drug and alcohol abuse or dependence, antisocial personality and anorexia nervosa, but they were significantly more likely than Whites to have phobia and somatization (Zhang and Snowden, 1999). Lifetime prevalence rates of schizophrenia, obsessive-compulsive disorder, panic and drug abuse or dependence were significantly lower among Hispanics than among Whites. Asians also had significantly lower rates than Whites of schizophreniform, manic episode, bipolar disorder, panic, somatization, drug and alcohol abuse or dependence and antisocial personality (Zhang and Snowden, 1999). Similarly, the present research of suicide behaviour showed a variety of suicide rates across different regions of the world (Marusic, 2005).

Except for the ‘rare’ genetic diseases mentioned above, genetic factors that might contribute towards these observed ethnic variations remain unclear. However, along with the prominent progress in the search for the ‘susceptibility genes’ for major psychiatric disorders, it has become clear that most, if not all, of the prevalence of the genetic polymorphisms with demonstrated links to these disorders vary significantly across ethnic groups. For example, the catecholamine-O-methyltransferase (COMT) allele has been reported to account for

4% of the risk of schizophrenia (White *et al.*, 1976; Bassett and Chow, 1999; Egan *et al.*, 2001), and 5-HT transporter gene-linked polymorphic region (5-HTTLPR) polymorphism is associated with the development of a number of conditions, including depression, suicidality, impulsivity and alcoholism (Lesch *et al.*, 1996; Arango *et al.*, 2003). The distribution of both genotypes vary substantially. For example, the s allele of the 5-HTTLPR ranges from 25% in African Americans to 75% in East Asians (Patkar *et al.*, 2002; Smits *et al.*, 2004)). However, the relationship between the variations in these 'susceptibility genes' and the reported differences in the prevalence of corresponding psychiatric disorders remain to be further clarified.

Besides genetic predispositions, it also stands to reason that influences of culture on biological processes could also lead to disease susceptibility. Recent advances in neuroscience have made it clear that the brain is extremely plastic throughout an individual's entire life, and environmental (not only physical, but to an even greater extent, social) forces constantly shape and reshape the function and structure of the brain (Huttenlocher, 1979; O'Leary *et al.*, 1981; Hoffman and Dobscha, 1989). This plasticity is even more evident and extensive during infancy, early childhood and even adolescence. Animal studies as well as limited research on humans have demonstrated that learning produces lasting changes in neuronal architecture and alterations in gene expression (Hoffman and Dobscha, 1989). Despite the remarkable harmonizing effect of 'globalization', different contemporary cultural systems continue to exert powerful effects in differentially shaping the social, as well as physical, environment of human beings (Bhugra *et al.*, 1997). Variations in methods of childrearing and education, as well as cultural influence on childhood experiences through other mechanisms, can thus play an important role in the neurodevelopment and maturation, and influence the whole nervous systems.

As important as these cross-ethnic findings are, caution needs to be exercised in their interpretation, since much remains to be further developed in terms of cross-cultural research on the incidence and prevalence of psychiatric disorders. Cross-cultural clinical and epideminological studies continue to be plagued by case definition, reporting biases and other nosological problems. Variables such as education, gender, age, language of the patient and socioeconomic backgrounds can all influence diagnosis, case identification and symptom reporting in different cultures. Because of these limitations, findings and discussions regarding cultural/ethnic differences in the prevalence of psychiatric morbidities must be regarded as tentative at this point, requiring further clarification with ingenious research designs and approaches.

Ethnicity, culture and biological markers

As we make significant advances towards a better understanding of the pathophysiology of major psychiatric disorders, it is important to keep in mind that, in other branches of medicine where 'biological markers' have long been available, substantial variations in the distribution and clinical relevance of these markers exist across cultural/ethnic groups. Thus, contrary to prevailing assumptions, the role and meaning of biological traits and states in relation to the etiology, pathophysiology and clinical course of diseases are not necessarily identical or even similar across populations. Examples range from HLA typing to biological correlates of common disorders including hypertension and diabetes, and biomarkers associated with various types of malignancies (Polednak, 1989). Paralleling this, recent genomic studies have shown that 'candidate genes' identified in a particular ethnic group often do not work in the same way when examined in other ethnic populations. Such 'population stratification' effects are so prevailing and so likely misleading in genomic studies that various methods have been developed in the last decade to deal with the problems (Hutchison *et al.*, 2004).

Although relative to other branches of medicine, the search for biomarkers in psychiatry still is in its infancy, emerging data have shown that ethnic/cultural factors represent similarly important issues to be considered. In the following, relevant literature will be reviewed and summarized.

Schizophrenia

Etiology of schizophrenia may be heterogeneous and caused by interplay of various genetic and environmental factors (Crow, 1980; Tsuang *et al.*, 1990; Garver, 1997). As other diseases of complex etiology often show marked cross-cultural varieties, it is reasonable to assume that the same situation exists in schizophrenia. Further, such complexity would be reflected in proposed biological markers for such a condition. Possible biologic markers for schizophrenia that have been reported include dopamine and monoamine oxidase (MAO) activity, creatinine phosphokinase activity, serotonin concentrations, frequency of human leukocyte antigen (HLA) type, and catecholamine metabolism (DeLisi *et al.*, 1980; Luchins *et al.*, 1980; Jackman *et al.*, 1983; Bridge *et al.*, 1984). A neural diathesis-stress model of schizophrenia also proposes that stress augments the effect of the HPA axis on dopamine synthesis and receptors (Walker and Diforio, 1997). However, to date, there are only sporadic reports describing cultural/ethnic differences of biological measures in schizophrenic patients. Most studies regarding the biological markers of schizophrenia did not include cross-cultural comparisons (regrettably, they often did not even describe subjects' ethnic/cultural backgrounds) (Lawson, 1986). The findings include the following: (1) platelet serotonin concentrations were found to be increased in African-American schizophrenic patients compared to African-American control subjects, with no differences found between Caucasian patients and Caucasian control subjects, nor between African-American and Caucasian patients with affective disorders (Jackman *et al.*, 1983) ; (2) ethnic contrasts in platelet and lymphocyte monoamine oxidase activity have been also reported. A significant correlation was found between low MAO activity and persistence of schizophrenia symptomatology among Caucasians but not among African-Americans (DeLisi *et al.*, 1980; Bridge *et al.*, 1984); (3) an increase in HLA-A2 antigen frequency had been seen among African-American schizophrenia patients as compared to their Caucasian subjects (Luchins *et al.*, 1980); and (4) Asian schizophrenia patients had significant higher catechol-O-methyltranferase activity than their Caucasian counterpart (Rivera-Calimlim and Reilly, 1984).

On the other hand, in other studies where the role of ethnicity was examined, there appeared to be no substantive differences in regard to the role of some of the proposed biomarkers of schizophrenia. For example, both Asian and Caucasian patients with higher plasma homovallilic acid (HVA) concentrations had better response to haloperidol treatment. Together, these findings point to the complexity of the relationship between biomarkers and disease states, and demonstrate the importance of considering ethnic/cultural factors in such investigations (Chang *et al.*, 1990).

Depression

The search for biological markers for depression has been intense for the past several decades, resulting in voluminous reports indicating alterations in the function of neurotransmitter systems, especially the serotonin, norepinephrine and cholinergic systems, as well as disturbances in the hypothalamic–pituitary–adrenal (HPA) axis (Rubin *et al.*, 1987; Richelson, 1991). Seen in such a context, relatively little attention has been paid to the application of these findings *vis-à-vis* ethnicity and culture. The extant literature in this regard is largely focused on two of the most commonly studied biologic markers of depression: the dexamethasone suppression test (DST) and sleep EEG abnormalities, especially shortened rapid eye movement (REM) sleep latency (Rush *et al.*, 1982).

Dexamethasone suppression test is one of the most studied biological markers of depression (Carroll *et al.*, 1981). Although the value of this test in clinical use is not as robust as initially hoped for, the development of DST represented a major breakthrough in the history of biological psychiatry, leading to generations of ever more sophisticated studies on the HPA axis and the pathophysiology of depression. Abnormal DST response rate has been generally reported to be approximately 50% in patients with major depression (Rush *et al.*, 1982). However, according to Escobar, 'Anglo' subjects had more than twice the rate of DST nonsuppression compared with African-American and Hispanic patients, all of whom were diagnosed as having major depression (Staner *et al.*, 1994). However, no control subjects were included in this study. Therefore, the specificity and diagnostic confidence for each cultural group could not be calculated. A World Health Organization (WHO) study of 541 subjects with major depression and 220 control subjects was conducted in 13 sites (Escobar *et al.*, 1984). They found nonsuppression rates of 71% in Copenhagen (presumably mostly Caucasian subjects) and 15% in Moscow (ethnicity unknown). The rates in Japan sites (Nagasaki and Sapporo) were relatively low at 21% and 23% non-suppression rates, respectively, followed by an African site (25%) and the Californian site (42%; ethnicity unknown). On the other hand, studies in Taiwan showed some different results. An inpatient DST study conducted showed high non-suppression rates ranging from 59% to 67% (Coppen *et al.*, 1984). However, another study examined in the outpatient revealed an extremely low non-suppression test rate of 7% (Hwu *et al.*, 1987; Lu *et al.*, 1988). One of us and his colleagues had examined the HPA axis function of depressed patients and normal controls in four ethnic groups. The results show, overall, depressed patients tended to have higher HPA axis activity than normal controls. Groups of African-American subjects tended to have higher baseline urinary cortisol level but lower free cortisol levels than other ethnic groups. The Chinese and White patients with prominent fatique showed lower postdexamethasone cortisol level than the other ethnic groups (K. M. Lin, R. E. Poland, unpublished data. 2001).

It is well established that alterations in sleep patterns are commonly presented in depressive disorders. Total sleep time, sleep efficiency and rapid eye movement (REM) latency are all reduced during depression (Hwu *et al.*, 1985). In contrast, the proportion of REM sleep in total sleep time is increased in depression (Thase *et al.*, 1996). Among these, shortened REM sleep latency is a widely studied biologic abnormality associated with major depression. Data showed that there may be ethnic difference in the architecture of sleep. One study by the WHO reported on sleep EEG abnormalities at eight different sites in Europe, North America and Asia (Kupfer, 1995). In this study, the REM latency was shorter in depressed patients from Tokyo and Mexico City than in depressed patients from other sites. These sites presumably represented persons of varied ethnicity. A more recent study focusing on the African-American race in depression showed that African-American patients with depression had less total sleep, less slow-wave sleep, more stage 2 sleep, and lower REM density than White patients who had similar clinical symptom profiles (Mendlewicz and Kerkhofs, 1991). There were two studies about the EEG changes in depressed patients and healthy controls from four ethnic groups (Giles *et al.*, 1998). In that study, African-American subjects showed more stage 1 and stage 2 sleep but less stage 4 sleep. The Hispanic subjects had higher REM density than Asian and White patients. Among depressed patients, the African-American and Asian subjects had less total REM sleep and shorter REM duration during the first three REM episodes but longer REM duration during the fourth REM episode, compared to the white and Hispanic subjects. These findings suggest that there are significant cross-ethnic differences in sleep patterns in depressed patients, especially in the REM measures and depth of sleep. However, etiological interpretations of these findings are still needed.

Substance abuse

Many biological markers have been used to detect or evaluate substance-use disorders or substance-induced disorders. Some examples include abnormal

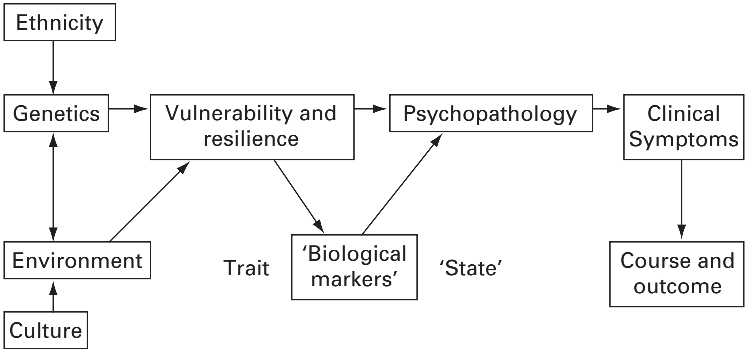

Fig. 6.1. A schematic model for studying culture–biology interactions.

liver function tests, increased RBC mean corpuscular volume, evidence in blood and urine, clinical signs of intoxication or withdrawal. One study of alcoholism showed that carbohydrate-deficient transferring was higher in African-American alcoholic patients than Caucasian alcoholic patients who consumed comparable amounts of alcohol (Poland *et al.*, 1999; Rao *et al.*, 1999). There has also been much research on cultural differences in ethanol metabolism. Differences in the hepatic isoenzymes involved in alcohol metabolism between Caucasians and Asians have been linked to cross-cultural variations in the response to alcohol and in the frequency of the 'flushing response' (Behrens *et al.*, 1988).

Conclusions

The relationship between culture and biology in psychiatry is complex (as shown in Fig. 6.1). Disease vulnerability is decided by various factors, including genetic and environmental influences. People with different ethnic/ancestral backgrounds possess divergent genetic profiles, leading to differential risks for specific disorders. At the same time, people live in milieus (both physical and social) that are shaped by cultural forces. Thus, it should not come as a surprise that ethnicity and culture often exert major influences on the onset, prevalence, pathology, 'natural course' and treatment outcome of various medical and behavioural problems, and that biological markers proposed to be associated with these conditions should be interpretation in the context of culture and ethnicity. Biology is not 'culture-free', findings derived from the field of biological psychiatry need to be understood in the context of culture and ethnicity to avoid misleading and mis-interpretation.

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7

Ethnic inequalities and cultural capability framework in mental healthcare

Kamaldeep Bhui and Dinesh Bhugra

EDITORS' INTRODUCTION

There is considerable evidence in literature, as has been shown consistently in this volume, that rates of some types of mental illness are higher in black and ethnic minority groups when compared with others. This has been attributed to a number of reasons, of which misdiagnosis keeps being referred to. The explanations for ethnic inequalities are multi-layered, and include social inequalities. A large number of factors influence help seeking as well as clinical assessments and outcomes of therapeutic consultations. There is no doubt that values of majority cultures dramatically influence these processes. Explanatory models held by patients and carers will dictate which pathways to professional care they follow. Help seeking is also determined by the personal, folk and social resources an individual has.

Bhui and Bhugra explore the major causes of ethnic variations in the patterns of health-service usage, which are many, and include cultural variations in explanations of distress, knowledge about the local care systems, geographical and emotional accessibility of services. The culture of healthcare delivery can also influence attitudes towards patients, their carers and their problems. There is no doubt that these processes are mediated through social and cultural factors, including lifestyle. They suggest that a cultural-capability framework which assesses cultural identity, explanatory models, individual and organizational dynamics with a clear emphasis on reflexivity in the assessment may enable the clinician to engage cultural minorities in decision-making and engagement in therapeutic alliances. Inequalities in mental healthcare are particularly stark in some clinical settings, such as forensic care or primary care. Some ethnic groups are over-represented in each of these settings. Community and organizational factors also play a role in help seeking, as well as dissatisfaction with such approaches. Inequalities in healthcare emerge from consequences of the actions of individual practitioners and organizational cultures working together. Cultural capability includes sensitivity, awareness, empathy, knowledge and adjustment to consultation and treatment according to cultural factors if services are to be used effectively by patients.

Introduction

Over two decades of British psychiatric research demonstrate ethnic inequalities in service use, experiences and benefit from services (Department of Health, 2003). A similar picture is described in USA studies; this confirms ethnic disparities in access to services and interventions, as well as variations in clinical outcomes (Snowden, 2003; US Department of Health and Human Services, 2001; van Ryn & Fu, 2003). A number of mechanisms are proposed to explain the higher incidence of schizophrenia among some black and ethnic-minority patients and the higher rates of using inpatient care and compulsory detention. These processes are mediated, not uniquely through biological or genetic predispositions alone, but through social and cultural mediators such as lifestyle, social networks, expectations and attitudes to mental-health services, coping styles and socio-cultural vulnerabilities (Sharpley, *et al.*, 2001). It is known that the culture influences help-seeking behaviour and characteristic expressions of distress (Bhui, Bhugra, and Goldberg, 2002; Gater *et al.*, 1991). It is also possible that the cultures

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of healthcare organisations and professional practice can reduce access to desired interventions among some ethnic groups; for example, coronary artery bypass grafts and angioplasty are less frequently performed for south Asians needing ravascularisation for ischaemic heart disease (Feder *et al.*, 2002). At the same time, health professionals may impose undesirable interventions on some ethnic groups; for example, compulsory detentions among black Caribbean people (Bhui *et al.*, 2003). The major causes of ethnic variations in the patterns of mental-health service use are many. Although much of the data upon which this paper is based arises from the UK context, the potential explanations are of importance in other countries including the North American continent, where the data for black people in the UK are mirrored in the reported service-used data for African Americans (US Dept of Health and Human Services, 2001).

Although much attention is given to ethnic minorities and their contact with mental-health services, migration alongside ethnicity must also be considered as a risk factor for mental health care. Ethnic variations of health status are often explained away as being secondary to social inequalities. Social inequalities are invariably evident following migration and resettlement. In particular, migrants who flee persecution have not usually prepared for their residence in a new country, may leave their own country impulsively, and, necessarily, seek employment to secure monies, accommodation and food. Entering the employment market and social integration involves overcoming obstacles such as language differences, prejudice, and different work cultures. For professionals migrating to the UK to seek work, along with migration rules there are distinct national certification and regulation requirements, so their former qualifications, income levels and status may be eroded following the migration experience. Social inequalities appear to be transmitted through cultures and society; consecutive generations continue to face similar obstacles as those faced by new immigrants, but their expectations and skills in negotiating these obstacles are different. Berry (1997) has outlined how bi-culturally proficient migrants are more able to access resources, whilst sustaining their identification with their culture of origin. Thus an integrated cultural identity reflects, and perhaps encourages, more successful adaptation. However, the relationship between migration and wealth is complex. Although migration controls are usually in place to restrict immigration, so as to limit the perceived drain on scarce resources, recent data compiled by the Home Office in the UK show that migration is actually profitable for host nations (Dobson *et al.*, 2001). Studies in Germany, the United States and the UK show that foreign-born people contribute more to the state in taxation than they consume in benefits and social security. Nonetheless, some groups fare badly. Caribbean-origin black people have very high rates of unemployment, whilst Bangladeshi and Pakistani people have the lowest incomes in the UK. Unemployment and other deprivation indicators are known to be related to, and are possibly aetiological risk factors for, mental-health problems (Fryers, Melzer and Jenkins, 2003). Although social inequalities explain a great deal of ethnic inequalities in health, they do not fully explain these. Other factors, such as discrimination, have independent effects (Nazroo, 2003). Cultures of adversity and impoverishment shape opportunities for health gains through health promotion, and choice over service use. National policies attending to migrant well-being can inadvertently be detrimental if they encourage cultural identities that are not adaptive, for example, through an emphasis on assimilation: giving up one's culture of origin and adopting host cultural values (Berry, 1997). In this context, this chapter describes ethnic inequalities of access to mental-health services in the UK, and then focuses specifically on methods to improve the cultural capability of mental-health services and clinical practice.

Psychiatric and forensic services in the UK

There are higher rates of non-affective psychosis among Black Caribbean people, with the highest rates in the second generation, so dismissing biological and genetic pre-disposition among black people as a plausible explanation (Harrison *et al.*, 1988; Hutchinson *et al.*, 1997; Sharpley *et al.*, 2001). Few studies have examined first-incidence data among other groups, although some studies indicate that South Asians in the UK are less likely to use inpatient care but have a similar incidence of schizophrenia (Gupta, 1991; King *et al.*, 1994). A consistent finding is that African-Caribbean people have higher rates of psychiatric admissions, both compulsory and voluntary, and over-representation in psychiatric forensic services (Bhui, Christie and Bhugra, 1995; Coid *et al.*, 2000). This contrasts with similar rates of psychosis (broadly defined) across population samples of ethnic minorities (Nazroo, 1997). Over-engagement in forensic psychiatric and general psychiatric services, when preliminary data suggest similar rates of population level psychoses, require explanations that reflect different risk factors for African-Caribbean people, and/or different pathways and influences on help seeking and treatment options across ethnic groups. Similar account needs to be given for lower representation in inpatient care, despite apparently similar risk of incident schizophrenia among South Asians in the UK.

Such effects may be articulated by less social support leading to more crises contacts (Cole *et al.*, 1995) and delayed contact with services. It is possible that early care experiences, and failures of such care, can become established patterns of interaction with all carers, including service providers. So given the higher rates of single parents and 'within-family unofficial fostering' among Caribbean people, less secure attachment (Arai and Harding, 2002) with parental figures may be replicated in more avoidant or distant relationships with services (Mallett *et al.*, 2002; Adshead, 1998).

Professional perceptions of greater risk among black people may in part be fuelled by black people not wishing to engage voluntarily. A consequence is that more coercive and compulsory legal powers are used (van Ryn and Fu, 2003). This tendency not to reach an alliance may feed professionals' perceptions of dangerousness and criminality (Lewis, Croft-Jeffreys and David, 1990), by public mistrust of mental-health services (Mclean, Campbell and Cornish, 2003; Sainsbury Centre for Mental Health, 2003), and by patients' dissatisfaction with services (Parkman *et al.*, 1997). An additional controversy is to what extent diagnostic uncertainty can be attributed to ethnic variations in affective and non-affective symptom prevalence (Kirov and Murray, 1999; Hickling *et al.*, 1999). These studies suggest more 'manic' or 'excited' presentations among Caribbean origin people, perhaps with greater religious flavour (Littlewood and Lipsedge, 1998). If black people are presenting in crisis more often than other cultural groups, and there are ethnic variations in the symptoms being presented, then clinical assessments among black people are more often conducted in crisis, a situation that is not conducive to weighing complex decisions. Consequently, crises will generate more conservative and risk-adverse approaches to clinical management.

Actual differences in levels of past violence, aggression or offending behaviour may also explain the tendency of professionals to be less tolerant of voluntary treatment or voluntary disengagement among black people (Wessely, 1998). So, if the risk factors among minorities militate against voluntary treatment, then this may explain the excess compulsory admission rate and over-representation in specialist and forensic care. Yet, recent data on mental-health act admissions showed that Caribbeans were no more likely to have violent presentation or substance misuse problems when admitted to prison or to secure psychiatric facilities (Bhui *et al.*, 1998; Lelliott, Audini and Duffett, 2001). A similar picture emerges when looking at data on forensic populations. A national cross-sectional study of over 3000 prisoners found that fewer Black and South Asian male prisoners reported childhood traumas and conduct disorder (Coid *et al.*, 2002b). Fewer black people received previous psychiatric treatment compared to whites. Different rates of offending and lower rates of psychiatric morbidity may explain the relative excess of sentenced black prisoners in comparison with white sentenced prisoners (Coid *et al.*, 2002a). In a study of men remanded to Brixton Prison, in comparison with White men, the courts were less likely to seek a psychiatric report among black people (Black African, Caribbean, and Black British combined: 20%–28%; white 41%). Black people were more likely to be identified as needing a psychiatric report at the time of reception into prison (Black African and Black Caribbean: 50%–59%), whilst Black British people, specifically, were more likely to be identified as having a mental-health problem in the courts, at reception to the prison, or later during the remand whilst on the prison wings (Bhui *et al.*, 1998). This tendency to not be identified to have a mental-health problem until in the prison, or at least after court appearance, was confirmed by Coid *et al.*, 2002b. So, black sub-groups may have distinct experiences that are patterned according to their identity (Black British vs. African Caribbean self-rated identity), and if there appear to be few risk factors for aggression, other than specific offences, what can account for the over-representation in forensic and secure services?

Are black people less likely to comply with conditions of bail, or to come back for outpatient appointments? Black people are more dissatisfied with consecutive contacts with inpatient admission environments (Parkman *et al.*, 1997), and so may fear voluntary engagement with agencies of which they are suspicious and in which they have little confidence (Sainsbury Centre for Mental Health 2003; McLean *et al.*, 2003). This may explain more absconding from inpatient care (Falkowski *et al.*, 1990) and less likelihood of voluntary engagement in community programmes of mental-health care. An alternative explanation is that there are ethnic variations in perceptions of what constitutes mental illness. For example, Pote and Orrell (2002) report that African Caribbean people were less likely to view 'thought disorder' as pathological; Bangladeshis were less likely to conclude that hallucinations and suspiciousness were mental-health problems. Therefore, some of the objections of specific ethnic groups may be explained by divergent professional–patient conceptualisations of what constitutes a mental-health problem. Bhui found ethnic variations in explanatory models for common mental disorders, and ethnic variations in general practitioners' assessments of common mental disorders (Bhui *et al.*, 2002) thus leading to uncertainty in clinical encounter. Faced with uncertainty about the patterns of symptoms presented by culturally different groups, clinicians may also be influenced by the social circumstances of patients. Lower patient incomes, more severe disorders and less experienced physicians, are all reported to be more commonly found by ethnic minorities presenting to services and explain less psychosocial talk in the consultation (Cooper-Patrick, *et al.*, 1999).

Primary care

A systematic review of the evidence on ethnic variations in access to specialist psychiatric care concluded that African-Caribbean groups are more likely to be referred to specialist care by GPs, and least likely to be recognised to have a mental disorder in primary care (Bhui *et al.*, 2003). South Asians are more likely to visit their general practitioners, are considered to present somatic manifestations of mental distress more commonly than other groups, are less likely to have a recognised mental disorder than White groups, and even if this is recognised, they are the least likely to be referred to specialist care by GPs (Bhui *et al.*, 2003). van Ryn and Fu (2003) using data from the USA, describe a valuable schema for understanding cognitive distortion in the assessment of perceived clinical needs and risks among ethnic groups. They argue that such errors of judgement are influenced by provider beliefs about help seeking and providers' interpretation of symptoms; these influence diagnostic practice, decision-making and the recommended choice of interventions.

Help-seeking behaviour itself can shape the response of providers, and the provider behaviour can, in turn, shape the presentation of symptoms. For example, it is known that the earlier a physical symptom is presented in the primary-care consultation, the more likely it is that the general practitioner assigns a physical diagnosis (Tylee *et al.*, 1995). A study of primary-care presenters in South London demonstrated that, for similar levels of common mental disorder (anxiety and depression combined), general practitioners more often assigned a mental illness label to White English people than to Punjabi Asians, who, despite having similar levels of somatic symptoms, were more often assigned a somatic-illness label in accordance with the general stereotype (Bhui *et al.*, 2001). Thus, general practitioners' expectations, congruent with their gatekeeper role, and their reliance on physical idioms of distress, lead them to underestimate the severity of common mental disorders among South Asians (Kirmayer, 2001; Bhui *et al.*, 2003).

Encountering physicians of a different race/ethnic group has been shown to be associated with distrust and a lack of satisfaction among African Americans in the USA (Corbie-Smith, Thomas and St George, 2002; Doescher *et al.*, 2000). In contrast, a British study of primary-care presenters found that GPs of South Asian background were not better at recognising mental disorders among South Asians (Odell *et al.*, 1997, Jacob *et al.*, 1998). Indeed, South Asian GPs were poorer at recognising mental disorders among South Asian patients than were GPs of other cultural backgrounds (Odell *et al.*, 1997). Similarly, from a pool of South Asian GPs, Punjabi and non-Punjabi GPs were equally able to recognise common mental disorder among Punjabi or non-Punjabi patients, but South Asian GPs were less effective in recognising common mental disorders among English women (Bhui *et al.*, 2001). Thus gender–culture consultation dynamics are equally important to assess.

Despite international research showing that there are a finite number of emotions that are recognised in all societies and cultures (surprise, disgust, fear, anger, contempt, happiness and sadness (Shiori *et al.*, 1999), it is known that the accurate recognition of these emotional states varies with culture of the observer (Elfenbein and Ambady, 2002, 2003; Shiori *et al.*, 1999), and becomes more precise the greater the exposure to the cultures in which emotions are being assessed. It may be that, when assessing emotional states across cultures and socio-economic groups, the emotional content is not fully appreciated, and that such fine-grain omissions account for some of the dissatisfaction of ethnic minorities.

Community and organisational factors

Consultation outcomes do not rely only on patient characteristics, but also on clinician characteristics, and organisational factors. The knowledge, skills and resources of the care provider interact with those of the patient, leading to a complex negotiation of meanings and actions during and after a consultation. These negotiations are constrained by the values each participant brings to the consultation, and the expected role each participant assumes. The care provider has the additional context of their organisation culture, and its policies, ethos and flexibility (or lack of it). Yet, all patients do not become patients until they elect to consult health professionals. Before this they may consult the community's social and folk sector of healthcare provision, in which family, friends and folk healers are active agents (Kleinman, 1980; Grewal and Lloyd, 2002). Different cultural groups have different explanatory models that dictate distinct recommended pathways to secure care and recovery. Help-seeking from healthcare services may therefore be triggered at quite different stages of the access chain by people from distinct cultures. Furthermore, communities and individuals from distinct ethnic groups have coping strategies and resiliency promoting behaviours/beliefs that may also mediate quite distinct pathways into care and recovery (Sproston and Bhui, 2002).

Some organisations can foster and display beneficial levels of cultural awareness and competency to manage the health and social care needs of ethnic minorities, whereas others simply function in a colour and culture blind approach and offer a fixed package of interventions and delivery systems, irrespective of culture (Cross *et al.*, 1999). Cross *et al.*, (1999) asserts that there are six stages in the progression from cultural destructiveness, through incapacity, blindness, pre-competence, competence, and then proficiency. Might such findings reflect discrimination? Discrimination can be defined on the basis of individual prejudicial intentions of health care providers, or by organisational policies and procedures, which compound distress, do not address existing healthcare needs and perhaps even add to healthcare needs through neglect. Not all inequalities of access are necessarily discriminatory, or undesirable. For example, the lower recognition of mental disorders among South Asian patients by general practitioners may, in fact, be the outcome of a shared decision by GP and patient not to proceed with referral to specialist care. Such a decision is not necessarily thought about in an explicit manner, but emerges through the negotiated and contested meanings and values and expectancies that arise in a consultation. For example, the different assessments among South Asians in primary care may reflect cultural idioms of distress that do not trigger the same concern in a GP as might more classic complaints of depression and suicidal thinking presented among White British patients. GPs generally act to exclude serious mental illness, and do not always consider anxiety and depression to be serious as confirmed by studies showing that GP assessments of depression have high specificity but low sensitivity (Bhui, Bhugra and Goldberg, 2000; Chew-Graham *et al.*, 2002; Jacob *et al.*, 1998). Such processes, even if they involve a shared decision between GP and patient, may deprive some patients of appropriate and timely interventions, although this may be explained away as patients exercising choice in accord with their culturally determined belief systems (Sproston and Bhui, 2002). The dilemma is whether to impose a medical, psychiatric, or sociological intervention, each with attendant risks and benefits. Or, go along with culturally unique explanations and prescriptions of treatment, for example, to alter diet to improve mood, risking chronicity, suicide attempts, loss of job and relationship difficulties.

An alternative cause of poorer outcome for minorities may be that the interventions, service delivery systems and access issues are irrelevant because an accepted intervention is ineffective in a specific ethnic group. This could be considered as an issue in the use of talking treatments for some ethnic groups who do not see this as a relevant part of recovery, wanting more immediate instrumental action to assist with housing, benefits, employment and prejudice (Fenton & Karlsen, 2002). Or, an intervention may not be as effective or carry with it adverse consequences that diminish its value as an intervention when applied to other cultural or ethnic groups. For example, differing profiles of drug metabolism and drug efficacy in different cultural groups means that Asian people need lower doses of anti-psychotic, and that African-Americans can benefit from smaller doses of antidepressant (Bhugra & Bhui, 2001; Lin, Anderson & Poland, 1995). A lack of knowledge about these issues can lead to a poorer experience of service contact for some ethnic groups, and some may not be willing to tolerate future bad experiences leading to disengagement. This will not foster confidence among patients who feel that their complaints are unheard. Complaints about medication being sedative, or causing side effects may have a pharmacological basis, but may also reflect differing attitudes to medication as a way of controlling emotions. For example, among Sikh and Islamic scriptures the use of intoxicants to control suffering, as opposed to devotion to God to overcome and tolerate suffering, is condemned (Bhui, 1999). Under the influence of such teachings, and spiritual practices, medication and physicians are subordinate to supernatural influences, and so medication is avoided. Therefore, evidence-based interventions may not lead to equal benefit or be equally acceptable as an intervention.

Inequalities in outcome can not always be considered organisational failures to deliver effective services. However, if ethnic minorities do not feel that mental-health services are there to serve their best interests, how can they subject themselves to this system of care of which they are suspicious? Professionals may justify this as an inevitable part of the care of the mentally ill. Nonetheless, it does leave the impression among the public that liberty is threatened, choice is removed and inappropriate or ineffective treatments might be forced upon them.

Inequalities are consequences of the actions of individual practitioners and organisational cultures acting together. Social exclusion is mirrored in the economy of healthcare manifesting as alienation, non-participation and an absence of public corporate ownership which erodes any effort to provide services by consent. The service-user movement largely ensures accountability and participation, rather than any promise of improved clinical outcomes (Crawford *et al.*, 2002). Such approaches, if fully inclusive of ethnic minorities, may actually improve the inequalities of access, not due to changes in individual action by care providers, but by differing thresholds for patients to subject themselves to voluntary treatment mediated by more trust and ownership in the system of care. Such action will also ensure that the values and organisational practices that oppress are open to persistent transformation leading to more attractive and acceptable practices. Such a shift in values of organisations may also lead to a shift in professional values. The whole movement in cultural psychiatry, once a marginalised speciality, has now raised fundamental questions about the constitution of mental healthcare. Thus, it holds lessons for mental-health care generally, and any service solution will reap benefits for all patients, and not only those from the minority groups.

Cultural capability, policies and practice

Every single patient has culture as does every single mental-health professional. Thus an understanding of cultural values and factors is the basic first step in understanding what the patient is going through. Clinicians may over- or under-diagnose illness behaviours if they are not aware of what is seen as normal and what is seen as deviant in that particular culture. Without knowing the norms of the patient's culture, the clinician is not always likely to assess cognition and affect. Thus, sharing ethnicity and cultural background may help somewhat but it cannot be taken for granted that this would help. Understanding the experiences, the ethnographic accounts and the impact of the patient's cultural peers can help. Knowing the patient's culture's sources of power whether these are political, economic mythological is useful. An awareness of patient's socio-cultural milieu (within which the individual lives and functions) is essential in understanding the idioms of distress, pathways into care and psychopathology, and may also help in increasing treatment adherence. Understanding the patient's cultural framework of reference enables the clinician to empathise with the distress. The tendency is to project different social images or personality types when using different languages (these could equally be language of clinical transaction). We recognise that for the patients to speak another language (secondary language) may have uncertain consequences for the clinical encounter. Bilingual patients may choose to withhold information if they are interviewed only in their secondary language. They may not be able to express affect easily but may express facts easily. Cultural framework of reference thus has to incorporate the individual's functioning within which language is a firm part of the identity. The choice of language combined with 'medical' or technical language will bring problems of its own.

Certain aspects of the mental-state examination cannot be translated, e.g. ambivalence, social withdrawal. A critical first step in the clinical encounter is for the mental-health professional to identify and recognise the cultural dimension by becoming aware of his or her own cultural encumbrances. Patients may well have strong feelings about their culture and about the culture of the mental-health professional they are facing. These feelings can be positive as well as negative.

Cultural relativism relates to the differences in beliefs, feelings, behaviours, tradition, social practices and technological arrangements that are found among diverse people of the world (Fabrega, 1989). Using biopsychosocial approaches means that the clinician must be aware of relativist values. Fabrega's argument is that both psychiatric illness and culture meaningfully implicates humans as holistic and symbolic creatures. By arguing for the importance of specific social and cultural factors in the content, experience, expression or distribution of a psychiatric or other illness, a relativist is committed to a qualitative, descriptive and ethnographic approach in understanding the patient's experiences. Understanding social factors such as inequalities in employment or housing and cultural factors such as role of family, child-rearing practices, religions and dietary taboos will enable the mental-health professional to speak in a language the patient feels comfortable with. Simply ticking boxes to say that mental-health professionals are culturally capable will not do.

In order to address inequalities of access to services and experiences of services, there have been calls for cultural sensitivity, awareness and more recently for cultural competency of all professionals. 'Cultural competency' is often reduced to knowledge about specific cultural groups, and tends to be applied concretely as if competence were a static entity that once acquired can be taken for granted. More recently, the term 'cultural capability' has been adopted. This includes elements of ability in more general term, referring to possession of skills, knowledge, and powers, or something being possible. Capability also refers to the possession of an aptitude, especially one that derives from person's character. It includes (i) awareness, (ii) competency around particular tasks, skills, knowledge, and attitudes to practice and (iii) the ability to progress learning in new situations. Thus it mandates reflective practice, continuing professional development, the acquisition of transferable skills and self-efficacy in learning. It is relevant not only to cultural working practices, but to all mental-health care, and indeed all professional care (Table 7.1; Sainsbury Centre for Mental Health, 2003), but specific modifications and programme enhancement are necessary for a comprehensive culturally capable workforce to be developed. Through such a programme, the detailed competencies can be set within a framework of culturally capable practice that will adapt to new populations to make possible a truly multi-culturally effective service.

Table 7.1. Capability framework

- Performance: what people need to possess and what they need to achieve
- Ethical: integrating knowledge, values, and social awareness into professional practice
- Reflective practice
- Implement evidence based interventions
- Lifelong learning
- Negotiate above principles with new cultural frame of reference, ethical values and absence of evidence base

These issues have been under continuing consideration for over two decades. In the UK, the Department of Health recently launched *Inside/Outside*, a framework for the eradication of ethnic inequalities of mental-health care that goes far beyond service provision. This document emphasises not only cultural capability by developing the workforce, but also encourages measures to improve public mental health and community resilience by recommending significant investments in community development workers to promote well-being, community inclusion and improved communication as well as routes to influence service development. There is also a framework for research, which promises more ethical research studies with more equitable funding of projects. The impact of this policy document is yet to be assessed; however, one of the unique aspects of this policy is that it was put out to a national consultation that specifically targeted Caribbean-origin black people, South Asians, and Chinese people including service users and carers. A policy document titled *Delivering Race Equality*, following *Inside/Outside*, placed more emphasis on organisational strategies, and the use of the Race Relations Amendment Act as a lever to ensure compliance. These policies considered in isolation demonstrate different facets of a necessary process to eradicate ethnic inequalities, and provide more appropriate care.

The American Psychiatric Association sets out how to undertake a cultural formulation to enhance existing practices when assessing mental status of patients (Griffith, 2002). This emphasises enquiry about cultural identity and explanatory models. This should take place alongside an assessment of the impact on the therapeutic relationship of culture of the professional and/or patient. Cultural factors related to the socio-cultural environment (discrimination, unemployment, asylum laws) should also be considered as factors that impact on mental health. Finally, there should be an overall statement outlining any culturally relevant aspects of diagnosis and treatment. Professionals should take particular care to ensure that the rationale for the treatment is understood, and does not break any cultural taboos, or undermine any cherished cultural beliefs, as this may lead to potential non-compliance. Most importantly, any further investigations that are necessary should be stated explicitly, including the gathering of more information and assessment with voluntary or specialist providers. Tseng (2003) sets out different perspectives of cultural capability: sensitivity, awareness, empathy, knowledge, adjusting the relationship between a patient and the mental-health professional and treatment modifications. These descriptions are essentially clinical practice-based solutions. Bhui & Bhugra (1998) extended individual practice-based solution to ones involving the community, voluntary organisations, and independent providers, including experiential, behavioural, cognitive behavioural, motivational systems of learning that take account of subjective experiences of distress. Bhui, Christie & Bhugra (1995) outlined how opportunities to address discrimination experiences within services had to be enshrined in equal-opportunities policies, alongside flexibility in the interventions and service components that were available, in accordance with the most effective model of culturally capable services as defined by Moffic & Kinzie (1996). They argue for innovation in service structures and styles of delivery to optimally manage distress in the cultural group of interest. The emphasis on removing the organisational constraints to culturally capable practice are now more evident; there is a greater focus on values and attitudes, and reviewing changes in the characteristics of organisations (Bhui, 2002; Siegel *et al.*, 2003). These approaches mandate the inclusion of organisational performance standards for training, education, employment practices and policies, values and attitudes, language differences, accessibility, appropriateness, attractiveness of services and continual feedback from communities. These are now being enshrined in performance indicators for organisations, to ensure all aspects of an organisation's activities are cognisant of the need to place cultural capability at the centre of discussions about clinical effectiveness and governance. The recommendations are derived largely from clinicians and organisations that have grappled with the challenge of providing culturally appropriate services. As such, they are a natural development in a chain of proposed solutions that have been implemented, evaluated and modified to promote culturally capable mental-health care. In the UK individual 'cultural competence' training was announced to be necessary for all practitioners; but the same ambition to make organisations culturally capable has not been realised, albeit, the Race Relations Amendment Act in the UK requires all public bodies to ensure they are acting in a non-discriminatory manner.

Conclusions

It is clear that a range of possible explanations for these inequalities may be proposed. These include the influence of culture on the illness behaviour, the effects of cultural identity and explanatory models in the consultation process, and the lack of cultural capability of services and professional practices. Institutionalised and individual factors must be addressed to eradicate undesirable inequalities.

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PART II

Culture and mental health

Culture and psychopathology: general view

Wen-Shing Tseng

EDITORS' INTRODUCTION

Cultures have a major role to play in the upbringing of an individual and these are not knowingly imbibed. An individual, even before birth, is influenced by cultural factors, e.g. the colours expected in the nursery or of the clothes; the role of wearing female-gender clothes by male children. The patterns of child-rearing also influence the ways in which culture is absorbed. From playmates, peers, school, university and other organizations, individuals continue to imbibe culture, its expectations of the individual and its norms. The relationship between culture and psychopathology is multi-layered and multi-faceted. Cultures sanction idioms of distress, define normality and deviance, create illnesses and dictate pathways into care.

Tseng, in his chapter, provides an overview of the relationship between culture and psychopathology. Bringing together social factors which cause social disorganization and distress, Tseng argues that certain social conditions 'aetiologically' may cause mental disorders. They only facilitate or make certain groups of people more vulnerable to psychopathology. Thus, they may increase a person's susceptibility or vulnerability, but not as aetiology. He further illustrates that culture can have pathogenic (i.e. culture is a direct causative factor in forming psychopathology) or pathoselective (i.e. culture makes most people select culturally influenced selection patterns which result in the manifestation of some psychopathologies). It may be pathoplastic (modelling of manifestations of psychopathology), pathoelaborating (behaviour patterns get exaggerated to the extreme), pathofacilitative (some conditions are more common in some cultures) or pathoreactive (influence people's reactions to distress). Tseng suggests that culture has a broader, more direct effect on minor as opposed to major psychiatric disorders on all these levels. Personality disorders vary according to cultures and their types. Cultural input is so significant, Tseng argues, that culture-related specific syndromes are often unevenly distributed, concentrated in certain cultural regions that offer the cultural conditions for forming them. Thus, clinicians working across cultures need to be clear that psychopathology is multi-faceted and involves many factors affecting the patient.

Study of culture and psychopathology: historical review

Pioneer exploration

Awareness of the possible impact of ethnicity on psychopathology started as early as the middle of the eighteenth century. Following the early immigration of British people to the New World, America, many other European immigrants, mostly Irish and German peasants, flocked into the United States. Many superintendents of mental hospitals (British in ethnic background) noticed the existence of ethnic or racial differences in mental illness. Based on their clinical impression, they tended to regard the Irish and German immigrants as 'inferior' Americans, in contrast to the earlier British immigrants. They even speculated that Irish and German people, in contrast to British people, were more susceptible to mental disorders and more resistant to treatment (Wittkower & Prince, 1974).

Towards the end of the nineteenth century, European people colonized many areas in Africa, Central America, and Southeast Asia. They began to build and staff 'lunatic' asylums. Early colonial European physicians lacked anthropological

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

knowledge and sophistication. In addition, they often held condescending attitudes toward the natives. They described unusual symptom patterns among the indigenous people. For example, *pibloktoq* (Arctic hysteria) among the polar Eskimo people, *amok* (indiscriminate mass homicide attacks) and *latah* (startle-induced dissociative reaction) among Malay people, and *koro* (genital-retraction anxiety disorder) among Indonesians and Southern Chinese. These 'peculiar' or 'exotic' syndromes (described from a Euro-American point of view), outside of the formal (Western) psychiatric classification system, were later clustered together by cultural psychiatrists and labelled culture-bound syndromes (see Bhugra *et al.*, Chapter 11 in this volume). The discovery of unique psychopathologies among different ethnic groups certainly stimulated Western psychiatrists' interest in, and awareness of, the cultural contribution to mental disorders.

In the 1890s, the German psychiatrist Emil Kraepelin, based on his clinical experience with German patients, developed a classification system of mental disorders. He was concerned with the cross-ethnic applicability of his psychiatric classification system. He travelled to Southeast Asia and other areas of the world to see whether or not his classification system could be applied to other ethnic groups. He was relieved to find that his classification system in general was useful across cultures. However, he also discovered some differences in clinical symptoms of mental disorders in different societies. For example, depression patients in Indonesia, in contrast to German patients, rarely presented delusions of guilt. Based on his study, the concept of comparative psychiatry was developed, that is, comparing psychopathology across cultures (Jilek, 1995).

Various attempts at studies in the early stages

A pioneer in the field of culture and mental health, American anthropologist and sociologist Marvin K. Opler (1959) carried out a formal cross-ethnic comparison of the symptomatology of schizophrenia in Italian-American and Irish-American patients. Examining hospitalized schizophrenic patients of different ethnic backgrounds in New York City, he reported that seven variables (homosexual tendency, preoccupation with sin and guilt, behaviour disorders, attitude toward authority, fixity in the delusional system, somatic complaints, and chronic alcoholism), among a total of ten variables, showed significant differences between the Italian-American and Irish-American patients. He reported that there were more Italian patients than Irish patients manifesting overt homosexual tendencies during psychotic conditions, behaviour problems and attitudes of rejecting authority. In contrast, more Irish patients than Italian patients were preoccupied with sin and guilt ideation, manifested chronic alcoholism and had fixed delusional thoughts. Opler's study opened the door to the study of schizophrenic symptomatology cross-ethnically. However, it was later criticized by scholars that the findings revealed basic ethnic personality differences of patients rather than differences in the schizophrenic disorders themselves.

Another early-stage cross-cultural investigation was attempted by pioneer H. B. M. Murphy and his colleagues (1963), from McGill University, Montreal, Canada. Utilizing an international network they had established around the world, they distributed a questionnaire containing a list of 26 symptoms or signs of schizophrenia to psychiatrists in different cultures and regions. The psychiatrists were asked to rate the frequency of symptoms they observed in their clinical practices. Based on the analysis of the data provided by the respondents, the distribution of schizophrenic symptoms appears to vary according to social and cultural factors, as well as to observational and conceptual factors of the psychiatrists. The investigators were aware of the limitations of such surveys of their subjective clinical impressions. However, it was one of the early attempts to examine the possible impact of social and cultural factors on severe mental disorders. A by-product of the survey was the interesting finding, based on reports by some Asian psychiatrists, that there was a relatively high percentage of the simple and catatonic subtypes and a low percentage of the paranoid subtype of schizophrenia in their clinical settings. This stimulated the question as to whether or not the delusional systems that are the most familiar feature of chronic schizophrenia in Euro-American hospitals are an essential part of the disease process. Why there are different distributions of subtypes of schizophrenia among patients of different cultural background is another challenging question.

Systematic explorations at later stages

More than a decade later, a systematic study on a larger scale was launched by the World Health Organization, the International Pilot Study of Schizophrenia (IPSS), involving nine study centres around the world (WHO, 1973), namely: Aarhus (Denmark), Agra (India), Cali (Colombia), Ibadan (Nigeria), London (UK), Moscow (USSR), Taipei (Taiwan, China), Washington (USA), and Prague (Czechoslovakia). It was the first formal comparative study involving multiple culture sites around the world, using standardized methods to collect information and compare the clinical picture of schizophrenia from different societies of divergent ethnic/culture backgrounds.

The results revealed first that the average percentage scores of symptoms were very similar across all the centres. All had high scores on: lack of insight, predelusional signs, flatness of affect, auditory hallucinations (except the Washington centre), and experiences of control. This indicated that the schizophrenic patients from diverse cultural settings shared a basically similar symptomatology. It was also revealed that, among all the patients studied from all the centres, there were differences in subtypes of schizophrenia. Among all the schizophrenic patients studied (811 cases in total for all centres together), the largest diagnostic group (323 patients) was paranoid schizophrenia in all individual centres except Agra in India, Cali in Colombia, and Moscow in the USSR. The diagnosis of hebephrenic schizophrenia was assigned to 86 patients in all, with 20 cases in Cali and Taipei in Taiwan, China. Of 54 total cases of catatonic schizophrenia, 45 were found in Agra, Cali and Ibadan in Nigeria (WHO, 1973). This showed that the distribution of the catatonic subtype was rather uneven among the nine study centres, found mainly in three centres in developing societies. This finding supported the previous clinical impression of cultural psychiatrists that subtypes of schizophrenia vary among different ethnic–racial groups.

In the late 1950s, in order to examine the possible effects of social class on the occurrence of mental disorders, including severe disorders such as schizophrenia, Hollingshead and Redlich (1958) carried out an epidemiological investigation in the Great New Haven area in the United States. The subjects were grouped into five social classes, according to the ecological areas of residence, occupation, and education. The results revealed that the patients diagnosed as psychotic (mainly with schizophrenia) were found more in the lower social classes. This stimulated scholars to pursue a social theory of psychopathology.

Social theory of psychopathology

Several hypotheses have been proposed from a social psychiatric perspective in the past to explain some epidemiological findings – that is, why psychopathologies (major psychiatric disorders) are more prevalent in certain societies or social classes than in others. The social disorganization hypothesis was proposed by Faris and Dunham (1939), who observed that the majority of psychiatric patients admitted to a mental hospital near Chicago, in the United States, came mainly from inner-city areas. Based on this observation, they speculated that extreme social disorganization, characterized by poverty, communication breakdown, high mobility and transiency, racial conflict, social isolation or other unfavourable social conditions that were often observed in urban settings may contribute to high rates of psychopathology, particularly schizophrenia.

The social-disorganization hypothesis was questioned by many scholars, who pointed out that it was not undesirable social conditions that contributed to major mental disorders, but that severe mental patients, who have difficulty surviving in ordinary communities, tended to drift into poor, disorganized community settings (Meyerson, 1941, Clausen & Kohn, 1959).

Instead of taking the view that mental patients drift into undesirable social settings, Robert Hare (1956) speculated that certain kinds of patients, associated with the nature of the psychopathology from which they were suffering, were attracted to so-called ‘undesirable’ social environments. His social-attraction hypothesis was based on an epidemiological study he carried out in Bristol, in the United Kingdom. He pointed out that the inner city of Bristol contained both rich and poor people. Hare found that there were areas where schizophrenic patients congregated. This phenomenon led him to hypothesize that social disorganization in some inner-city areas can attract schizophrenic individuals who find social contact aversive.

As opposed to social disintegration, social cohesion was considered a significant protective factor for patients suffering from the mental disturbance of depression. Chance (1964) conducted a cross-cultural survey to assess the degree of social cohesion observed in various societies, with correlations to the frequency of depression. He reported that there was a significant correlation between social cohesion and depression, namely, severe feelings of worthlessness and guilt tended to occur among members of highly cohesive groups.

One issue that needs to be clarified is that, even though certain social conditions may contribute to a higher prevalence of mental disorders, this does not necessarily mean that certain social conditions ‘aetiologically’ cause mental disorders; they only facilitate or make certain groups of people more vulnerable to psychopathology. In other words, they may increase a person’s susceptibility or vulnerability, but not as aetiology.

Different ways culture contributes to psychopathology

The issue is not whether social and cultural factors influence psychopathology, but in what ways they do. It has been elaborated that, from a conceptual point of view, there are six different ways that culture can contribute to psychopathology (Tseng, 2001, pp. 178–183). They are the following.

Pathogenic effects

Pathogenic effects refer to situations in which culture is a direct causative factor in forming or ‘generating’ psychopathology. Cultural ideas and beliefs contribute to stress, which, in turn, produces psychopathology. Stress can be created by culturally formed anxiety, culturally demanded performance, culturally prescribed restricted roles with special duties. Therefore, culture is considered to be a causative factor, because culturally shared specific beliefs or ideas contribute directly to the formation of a particular stress, which, in turn, induces a certain mode of psychopathology. The psychopathology that occurs tends to be a culturally related, specific syndrome; for instance, the folk belief that death will result if the penis shrinks into the abdomen, inducing the *koro* panic; or the popular anxiety over the ‘harmful’ leaking of semen, leading to the development of the semen-loss anxiety disorder, or dhat syndrome.

Pathoselective effects

Pathoselective effects refer to the tendency of some people in a society, when encountering stress, to select certain culturally influenced reaction patterns that result in the manifestation of certain psychopathologies. For example, in Japan, cultural influences lead a family encountering serious stress or a hopeless situation to choose, from among many alternative solutions, to commit suicide together, forming the unique psychopathology of ‘family suicide’ observed in Japanese society (Ohara, 1963). A Malaysian man humiliated in public, following cultural custom, is expected to take a weapon and kill people indiscriminately to show his manhood, an occurrence called an *amok* attack. Without their knowing it, culture has a powerful influence on the choices people make in reaction to stressful situations and shapes the nature of the psychopathology that occurs as a result of those choices. Of course, this only applies to minor psychiatric disorders, particularly of culture-related specific syndromes, not to major psychiatric disorders.

Pathoplastic effects

Pathoplastic effects refer to the ways in which culture contributes to the modeling or ‘plastering’ of the manifestations of psychopathology. Culture shapes symptom manifestations at the level of the content presented. The content of delusions, auditory hallucinations, obsessions, or phobias is subject to the environmental context in which the pathology is manifested. For instance, an individual’s grandiose delusions may be characterized by the belief that he is a Russian emperor, Jesus Christ, Buddha, the president of the United States, or the prime minister of the United Kingdom, depending on which figure is more popular or important in his society. If a person develops a delusional disorder with ideas of persecution, based on his social background, the subject who follows him, tries to poison him, or otherwise persecutes him, may be either a member of the CIA, the KGB, a communist, a political enemy, a deceased person’s malicious spirit, an evil spirit, or an agent from outer space.

Depending on the intensity of the plastic effect and the degree of modification of symptomatology, culture will affect the psychopathology in such a way that the disorders could be recognized as ‘atypical’, ‘subtypes’, or ‘variations’ of disorders officially recognized in the current Western classification system.

Pathoelaborating effects

While certain behaviour reactions (either normal or pathological) may be universal, they may become exaggerated to the extreme in some cultures through cultural reinforcement (Simon, 1996). This is well illustrated by the unique mental phenomenon of *latah*, which is mainly observed in Malaysia. The phenomenon is characterized by the sudden onset of a transient dissociative attack induced by startling. The person is often provoked on social occasions and acts like a clown, providing social entertainment. Thus, culture supports the *latah* attack, and elaborates the function of this unique mental condition. Another example relates to suicidal behaviour. The decision to end one’s life as a way of dealing with a difficult situation can be influenced by society and culture. Japan is well known for *hara-kiri*, or *seppuku*, the formal manner of suicide performed by a warrior, or *samurai*, as an honourable way of ending his life (rather than surrendering to the enemy and being humiliated). As a means of punishment, or to atone for wrongfulness, there are many other ways for ordinary people to end their lives that are described in daily language: *oyako-shinju* (parent–child double suicide), *ikka-shinjiu* (family suicide), *jio-shi* (double suicide by a couple due to an obstructed affair), or *kan-shi* (when a subordinate commits suicide to transmit loyal advice to an authority figure).

Pathofacilitative effects

Pathofacilitative effects imply that, although cultural factors do not change the manifestation of the psychopathology too much – that is, the clinical picture can still be recognized and categorized without difficulty in the existing classification system – cultural factors do contribute significantly to the frequent occurrence of certain mental disorders in a society. In other words, the disorder potentially exists and is recognized globally, yet, due to cultural factors, it becomes prevalent in certain cultures at particular times. Thus, ‘facilitating’ effects make it easier for certain psychopathologies to develop and increase their frequency. For instance, the excessive concern with body weight and the perception of slimness as beauty may facilitate the occurrence of excessive dieting and even a pathological eating disorder; a liberal attitude towards weapons control may result in more weapon-related violence or homicidal behaviour (Westermeyer, 1973); cultural permission to consume alcohol freely may increase the prevalence of drinking problems.

Pathoreactive effects

Pathoreactive effects indicate that, although cultural factors do not directly affect the manifestation or frequency of mental disorders, they influence people's beliefs and understanding of the disorders and mould their 'reactions' towards them. Culture influences how people perceive pathologies and label disorders, and how they react to them emotionally, and then guides them in expressing their suffering. Consequently, the clinical picture of the mental disorder is coloured by the cultural reaction – at a secondary level – to the extent that the total process of the illness varies.

An example of pathoreactive effects is *susto*. *Susto* is a Spanish word that literally means 'fright'. The term is widely used by people in Latin America to refer to the condition of loss of soul (Rubel, 1964; Rubel *et al.*, 1985). Susto is based on the folk belief that every individual possesses a soul, but, through certain experiences, such as being frightened or startled, a person's soul may depart from the body. As a result, the soul-lost person will manifest certain morbid mental conditions and illness behaviour. It should be pointed out that, although the cause is uniformly considered to be spiritual–psychological reasons relating mostly to a frightening experience or misfortune, from a clinical point of view, the manifested syndrome is quite heterogeneous, without a commonly shared syndrome (Gillin, 1948). It is culture-related only in the sense that the morbid condition is 'interpreted' after the fact according to folk concepts of 'aetiology', and certain ways of regaining the lost soul, such as rituals, are offered. Therefore, the role of culture is interpretation of and reaction to the illness.

Post-traumatic stress disorder associated with war is another example of pathoreactive effects. How the society perceives the disorder and reacts to the emotional sequel – with a sympathetic attitude, many social welfare benefits, or none – will influence how many people will claim to have such a disorder and how they will describe the severity of their suffering.

Cultural influences on different groups of psychopathology

It is clear that culture contributes to psychopathology in different ways. It is important to recognize the different ways in which cultural impact may be observed, depending on the different groups of disorders or the nature of psychopathology. Generally speaking, psychopathology that is predominantly determined by biological factors is less influenced by cultural factors and any such influence is secondary or peripheral. In contrast, psychopathology that is predominantly determined by psychological factors is attributed more to cultural factors. This basic distinction is necessary in discussing different levels of cultural impact on various types of psychopathologies.

From a cultural perspective, it is useful to consider the existence of a spectrum of psychopathology. At one end is severe pathology (customarily referred to as a major psychiatric disorder), predominantly determined by biological causal factors, only indirectly related to culture, and characterized by disability. At the other end, the pathology is less severe, without gross reality distortion (thus, it is labelled minor psychiatric disorder). It is predominantly determined by psychological causal factors, is characterized by suffering from distress, and tends to be closely related to culture. This is a hypothetical conceptual spectrum, placing different groups of psychopathologies between two extreme poles. From a cultural point of view, it helps to clarify the different roles culture plays in different groups of psychopathology (Tseng, 2001, pp. 184–190). Therefore, an attempt will be made to discuss how culture, in different ways, affects the psychopathology of different groups. It will start from the organic mental disorder, which is primarily caused by biological factors, to culture-related specific psychiatric syndromes, which are essentially induced by cultural factors (see Fig. 8.1).

Organic mental disorders

By definition, organic mental disorders are caused by organic aetiological factors. Thus, culture does not have a 'direct' causal effect on these disorders. Also, the manifestation of the disorder will be almost similar, disregarding the ethnic or cultural background of the patient. In other words, there is no room for

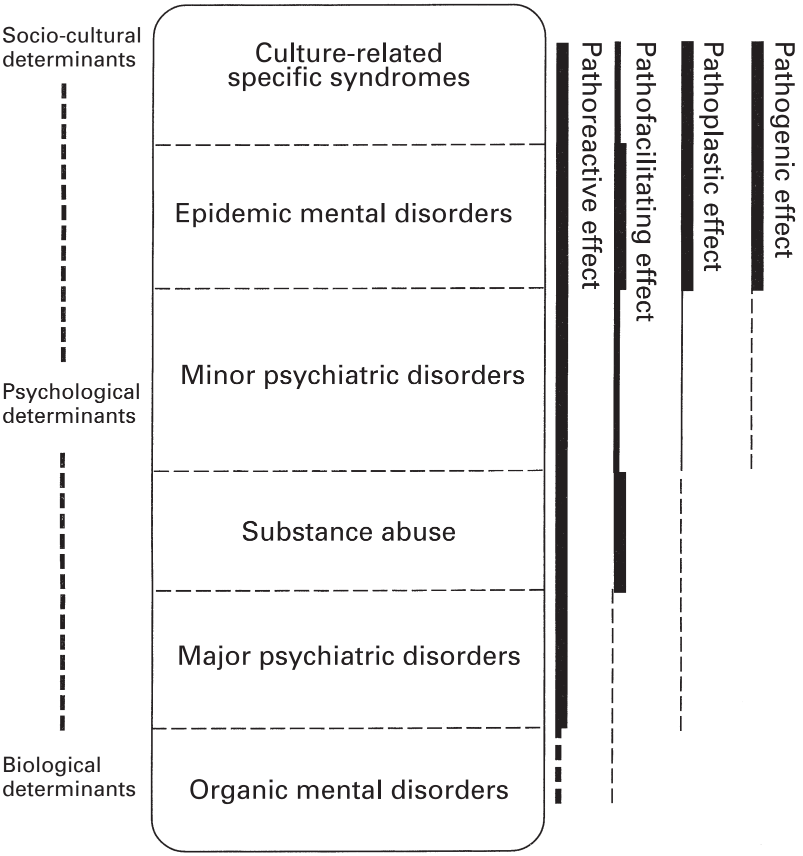

Fig. 8.1. Spectrum of psychopathology: different natures of determinants and their cultural impact. [From: Tseng, W. S. *Handbook of Cultural Psychiatry* (p. 190). (Academic Press, 2001)]

pathogeneric or pathoplastic effects for organic mental disorders. However, cultural factors – such as a unique lifestyle collectively shared by a group of people – may 'indirectly' contribute to the occurrence, or influence the prevalence, of certain organic mental disorders, illustrating pathofacilitating effects.

A good example is the degenerative disease of the nervous system called *kuru* among the Fore tribe people of New Guinea. About 1% of the population, mainly women, die annually from this fatal disease. The Fore people themselves believe that *kuru* is caused by sorcery. Yet a recent study has shown that *kuru* is a disease caused by a virus that attacks the central nervous system after a long incubation period (Harter,1974). The Fore people have a custom of eating human brains, which contain a virus that causes the disease. It is interesting to note, as pointed out by Keesing (1976), that it was the custom for Fore women to ritually eat the bodies and brains of their dead relatives. Consequently, the disease was transmitted through the females. This illustrates clearly that, while culture does not cause this organic disease of the central nervous system, the culture-rooted habit of eating human brains contributes significantly, though secondarily, to the transmission of the organic mental disorder.

Another example is sexual behaviour related to organic mental disorders, such as neurosyphilis, gonoencephalitis, or AIDS-related neuropsychopathy. While culture is not an aetiological factor in these organic mental disorders, a society's attitude toward sexual behaviour, particularly outside of marriage, and its tolerance of promiscuity, will certainly affect the sexual behaviour of its members. This, in turn, will influence the prevalence of sexually transmitted diseases and resulting mental complications.

Through pathoplastic effect, culture may influence the content of organic mental symptoms to some extent, such as through confabulation. However, its impact is minimal and peripheral, not important enough to change the manifestation of the psychopathology of the disorders.

Major psychiatric disorders: schizophrenia

Scholars and clinicians have made tremendous efforts to understand the nature of schizophrenia, one of the most commonly observed major psychiatric disorders, from biological, psychological and social and cultural perspectives, in terms of its manifestation and frequency of occurrence.

In the late 1970s, stimulated by the success of the IPSS international study of the clinical picture of schizophrenia, involving multicultural centres, as described above, the World Health Organization launched another multisociety investigation, the WHO Collaborative Study on the Determinants of Outcomes of Severe Mental Disorders (DOS) (Jablensky *et al.*, 1991). This time, 12 study centres were selected: Aarhus (Denmark), Agra and Chandigarh (India), Cali (Columbia), Dublin (Ireland), Honolulu and Rochester (USA), Ibadan (Nigeria), Moscow (USSR), Nagasaki (Japan), Nottingham (UK), and Prague (Czechoslovakia). The goal of the study, which was mainly concerned with schizophrenia, was twofold: to investigate the incidence and prognosis of the disorders. Methodologically, to determine incidence, all individuals from a defined catchment area making first contact with a psychiatric or other service agency due to symptoms of a possible schizophrenic illness were identified, assessed and examined for incidence rate.

The results revealed that (Jablensky *et al.*, 1991, pp. 45–52), if a stricter research definition of schizophrenia was used, the incidence rates did not differ among the centres with a range of 0.7 to 1.4 per 10 000 population aged 15 to 54. This finding of incidence rates was compatible with the findings of other epidemiological studies carried out in the past in several different countries – although each investigation used its own methods. The limited range of difference of prevalence among different cultural backgrounds support the notion that schizophrenia tends to occur predominantly due to biological–hereditary factors. It means that there is no room for pathogenetic effects for the major psychiatric disorder of schizophrenia. As described previously, there is a pathoplastic effect on the manifestation of the symptomatology, including the subtype of the disorder of schizophrenia.

There is some information that hints at possible pathoreactive effects on schizophrenia. As the second phase of WHO's International Pilot Study of Schizophrenia (IPSS), a 2-year follow-up study was carried out to examine the outcomes of the schizophrenic patients in the different sites investigated (Sartorius *et al.*, 1977). Surprisingly, the results revealed that the level of social development has a certain relation to the short-term prognosis of schizophrenia, that is, cases in developing societies, in contrast to more developed societies, have more favourable outcomes. It has been speculated that family, social and cultural factors may have pathoreactive effects on functional psychoses, such as schizophrenia, resulting in different prognoses. An accommodating community, a supportive family and a relatively simple lifestyle may favour recovery from the psychotic condition (Sartorius *et al.*, 1978).

Affective disorder: depression

The cultural aspects of depression have created keen interest among cultural psychiatrists since the 1960s. This interest coincided with the availability of antidepressants for treatment, but was motivated by the discovery that, in spite of a sharply increasing clinical trend of diagnosing depression in Euro-American societies, there was a low prevalence of it in non-Western societies.

In order to explain the possible reason for the low prevalence of depression diagnosed in non-Western societies, some clinicians used the concept of 'masked depression' developed in the past. The concept takes the view that when certain individuals react to loss or frustration, instead of manifesting the emotional reaction of depression, they show other clinical pictures, such as somatization or behaviour problems. This view is founded on the basic assumption that when a person encounters the psychological trauma of loss or frustration, he or she responds primarily with the mood disorder of 'depression'. If, for some reason, the person is not able to respond with depression, and the trauma is manifested by another mental condition, it is considered to be masked depression. This clinical assumption is misleading in cross-cultural applications. It assumes that human beings are allowed to react emotionally only in a defined way, ignoring that there are rich variations in the emotional and behavioral reactions of human beings in different cultural environments through pathoplastic effects. It is biased in identifying one reaction as primary and others as 'masked'.

From a cultural perspective, it is more useful to understand the problem-presentation styles (or patterns) manifested by patients. The information and problems presented by patients to physicians are subject to various factors, including patient–therapist relations, culturally moulded patterns of making complaints, and the clinical settings in which the interactions take place. This also applies to depression. Complaining about depression vs. somatic symptoms deserves careful evaluation and consideration. Simon and colleagues (1999) used data from the World Health Organization study of psychological problems in general healthcare to examine the relation between somatic symptoms and depression. They found that, among patients studied at 15 primary-care centres in 14 countries on five continents, about 10% who presented somatic symptoms to the primary caretaker met the criteria for major depression. Further, they revealed that a somatic presentation was more common at centres where patients lacked an ongoing relationship with a primary-care physician than at centres where most patients had a personal physician. This indirectly supports the view that the nature of complaints made by patients is closely related to patient–doctor relations.

Cultural variations are recognized even among clinically recognized conditions of depression. In the late 1970s, German cultural psychiatrist Wolfgang Pfeiffer (1968) reviewed literature on depression in non-European cultures. He pointed out that the 'core' symptoms of depression (i.e. change of mood, disruption of physiological functions, such as sleep and appetite, and hypochondriacal symptoms) in these cultures were the same as in Europe. However, other symptoms, such as feelings of guilt and suicidal tendencies, showed variations of frequency and intensity among cultures. This view was later supported by other investigators (Binitie, 1975; Sartorius, 1975).

For instance, based on clinical observation of depressive illness in Afghanistan, Waziri (1973) reported that the majority of depressed patients expressed 'death wishes' instead of suicidal intentions or thoughts. In Afghanistan, people with Muslim backgrounds believe suicide is a sin. It is a cause of serious guilt to destroy the life that is given by God. Waziri said that the depressed patients who were asked how they viewed life answered that they 'wished they were dead' or that they had 'prayed to God to take their life away'. Actually, the suicide rate among the general population was very low, namely 0.25 per 100 000 population (Gobar, 1970), which was significantly lower than the average rate reported in many other cultures, namely, about 10 per 100 000 population. This illustrates that, even though a suicidal tendency is associated with depression, cultural attitudes either sanctioning or forbidding self-destruction can modify the expression of suicidal ideas through pathoplastic effect.

The presence or absence of self-deprecation, self-blame in the form of feeling ashamed or guilty is another aspect that has gained attention and been debated from cross-cultural perspectives.

According to Prince (1968), in Africa, mental-emotional self-castigation is rare or absent in the early stages of depressed patients. Earlier, Murphy, Wittkower and Chance (1967) had proposed that the higher incidence of guilt feelings in Western cultures was perhaps due to the influence of the Christian religion. However, after examining depressed Christian and Muslim patients in Cairo, El-Islam (1969) reported that the presence or absence of guilt feelings was often associated with the level of education or literacy and the degree of depression rather than religious background. He concluded that guilt and Christianity are not necessarily closely linked.

Beginning in 1972 (Sartorius *et al.*, 1983), WHO systematically investigated the possibility of cultural variations of depressive symptomatology, using standardized methods. Five study centres in four countries were involved: Basel (Switzerland), Montreal (Canada), Nagasaki (Japan), Teheran (Iran), and Tokyo (Japan). The WHO Schedule for Standardized Assessment of Depressive Disorders (SADD) was used for clinical assessment by trained clinicians in each study centre. Specified diagnostic criteria of the International Statistical Classification of Diseases and Related Health Problems, 9th Version (ICD-9), were included in the study of depressive patients. A total of 573 patients from the five centres were examined. Results revealed similar patterns of depressive disorders in all settings. Patients in all the sites were found to have high frequencies of sadness, joylessness, anxiety, tension, lack of energy, loss of interest, concentration difficulties and feelings of inadequacy, but there were also considerable variations in the frequencies with which certain symptoms appeared across the study centres. For example, guilt feelings were present in 68% of the Swiss patients, but in only 32% of the Iranian patients; somatic symptoms were present in 57% of the Iranian patients, but in only 27% of the Canadian patients. Suicidal ideas were present in 70% of the Canadian patients, but in only 40% of the Japanese patients. There were different levels of severity of depression in the different study centres: patients in Nagasaki, Montreal and Basel were more anergic and retarded than patients in Tokyo and Teheran. It is not clear whether the differences in frequency of certain symptoms were due to the levels of severity of depression or to ethnocultural variations.

It is important for clinicians to be aware that the clearly defined and sharply distinguished depressive state is not necessarily a rule. Rather, it is often mixed with anxiety and a somatic state. This is true for patients from Western countries (such as America) and, even more so, from societies with different cultures. Depressive disorders include various clinical conditions on a spectrum that ranges from primarily biologically determined depressive ‘disorders’ (exemplified by endogenous, periodically occurring depression) to predominantly psychologically related depressive ‘reactions’. The human mind does not respond to an internal or external situation purely according to a defined ‘disorder’. This is particularly true when a person is reacting to psychological distress. The response is often a combination of anxiety, depression, anger, a feeling of frustration and many concomitant physiological symptoms. This is very important for cross-cultural applications. Diagnostically mixed types of disorders can be more the rule than the exception. Sometimes, when a classification system that originated in one culture is applied to another, an ‘atypical’ type is a more typical occurrence, while a ‘typical’ type is more atypical.

With an increase in clinical knowledge, psychiatrists now take the view that depression, particularly of a severe or endogenous type, is closely related to biological factors. However, as pointed out by Marsella and colleagues (1985), even if some types of depression are shown to have primary biological causes, cultural factors could still modify the behavioral expression of the biological factors (pathoplastic effects) and interpret the abnormal experiences and responding to the social reactions to that behaviour differently (pathoreactive effects).

Perhaps, from a cultural psychiatric point of view, one of the most useful areas of study is that of the psychological causes of depression from a cross-cultural perspective, because it offers a rich resource of examples of how human beings experience psychological trauma or distress and react to loss or frustration in various ways. Of course, it would need to focus on the study of 'reactive' rather than 'endogenous' depression. Dynamic psychiatrists view depression as a reaction to loss, deprivation, frustration, injury to self-esteem, conflict over the aggressive drive, or as a threat to a personality structure marked by narcissism or dependency. In addition to these clinical theories, the psychological causes for depression can also include social–cultural determinants.

Analytically orientated clinicians speculate that childhood separation produces a vulnerability to depression that can be triggered by separation in adult life. A parent's death during one's childhood can precipitate later depression, and separation, divorce or the prolonged absence of parents may cause the same delayed result. It is not always the loss itself that plants the seed of later depression. The circumstances of the original loss and the provision or lack of alternative relationships or supportive figures also influence the emotional impact of the initial trauma. From a socio-cultural viewpoint, family structure (such as the nuclear or extended family), child-rearing practices (e.g. child-rearing with or without care), and the presence or absence of parental substitutes (e.g. grandparents or other relatives who live nearby) all must be considered causes or deterrents to later depression.

Furthermore, how a community views death and ritualizes mourning may also affect the occurrence of depression. For instance, in Samoa, death is seen as a natural event in life. Behaviour patterns in the Samoan family and community provide effective support when someone dies (Ablon, 1971). Indian people living in Fiji still hold the traditional view that, when a woman's husband passes away, she is no longer allowed to participate in any social activities, or to have any social contact with men other than her father-in-law and brothers-in-law. Remarriage is unthinkable, even if she is still young. She is expected to devote herself to the care of her children and to observe her widowhood for the rest of her life. Consequently, many widows suffer from depression. This phenomenon is not observed among the indigenous Fijian women living on the same island, who have no such views of or practices for widows.

A social, occupational or economically deprived status can also help weave the fabric of depression. In fact, the minority status of an ethnic group may outweigh ethnic characteristics as a contributing cause of depressive illness. Fernando (1975) compared Jewish and Protestant depressive patients in the East End of London. He studied familial and social factors and found that increasing paternal inadequacy and weakening ethnic links and religious faith were related to depressive ills among Jews, but not among Protestants. He suggested that mental stress arose from the marginal position of Jews in British society, rather than from specific traits or customs within Jewish culture.

Substance abuse and dependency

Mental disorders associated with substance abuse and/or dependency are basically biophysiological in nature; however, there is room for psychological input. Culture has pathoselective and pathofacilitative effects on the prevalence of abuse. For instance, it is well illustrated that, if a society takes a firm attitude toward drinking, such as most Muslim societies, alcohol consumption is very low and problems with alcohol are relatively rare. In contrast, if a society takes a relatively liberal attitude toward drinking, such as most Euro-American societies and Korea and Japan in Asia, alcohol consumption is very high and the prevalence of alcohol-related problems tends to be higher. Indulgence in alcohol and other substance intoxication as a way of dealing with stress becomes culturally available or a favoured choice.

It is generally observed that, when there is rapid socio-cultural change, particularly associated with cultural uprooting, substance abuse tends to increase sharply, particularly among youngsters. There are numerous examples to illustrate that, among many culturally deprived minority groups, the problems of substance abuse and dependency among young people are often very prevalent and serious.

Suicidal behaviour

Because suicidal action is well-defined behaviour, with official data often available, it is relatively more suitable for cross-cultural comparison than other kinds of psychopathology. Nevertheless, there are some problems inherent in the cross-cultural study of suicide. Strictly speaking, suicide is not a homogeneous clinical phenomenon. Suicidal behaviour may occur as a complication of severe psychiatric disorders, a secondary reaction towards stigmatized mental disorders that are chronic or untreatable. It is often associated with substance abuse or dependence. Many other suicide behaviours occur as daily life reactions to emotional turmoil or frustration, and very much reflect the distress that exists in a society or cultural system. However, the different natures of suicide behaviour are generally not distinguished in statistical data of suicide, but are lumped together, which influences the interpretation of the information from a sociocultural perspective. In addition, in some countries such as India and Pakistan, suicide is an illegal act; therefore getting accurate figures can be a problem.

Based on official data available from the World Health Statistics Annuals, supplemented by resources from individual investigators (mostly data from underdeveloped and developing countries), the total suicide rates – (per 100 000 population) of different countries (or societies) in different world regions for the period between 1950 and 1995 is compiled (Tseng 2001, Table 22.1). As a result, several findings can be obtained.

Firstly, there is a rather wide range of rates among the different countries. They can be arbitrarily subdivided into five groups: ‘very high’, ‘high’, ‘moderate’, ‘low’, and ‘very low’. The ‘very high’ group has total suicide rates above 25 per 100 000 population. Hungary, Sri Lanka, Micronesia, Finland and Austria belong to this group. The ‘high’ group has total suicide rates between 15 and 25 per 100 000 population. South Korea, Japan, Switzerland, Denmark and Germany belong to this group. Many countries, including the United States, France, the UK, Belgium and Canada, belong to the ‘moderate’ group, which has total suicide rates between 10 and 15 per 100 000 population. The ‘low’ group, with total suicide rates between 5 and 10 per 100 000 population, includes New Zealand, Norway, the Netherlands, and Italy. Several countries, such as Mexico, Egypt, Malaysia and the Philippines, with total suicide rates below 5 per 100 000 population, belong to the ‘very low’ group. It is noticed that there is a difference of almost 30 to 40 times between the very-high-rate countries, such as Hungary (37 to 38) and Finland (24 to 25) and the very-low-rate countries, such as Mexico (0.7 to 2.1), the Philippines (0.6 to 1.5), Malaysia (0.5 to 1.5) or Egypt (0.2 to 0.5). This range of difference in rates is very wide in contrast to other psychiatric disorders, such as schizophrenia, which have a difference of merely several times. Many of the very-low-rate countries are Muslim or Catholic societies that have prohibitive religious attitudes toward self-killing.

Another valuable finding is that the suicide rates for socially or economically stable countries are generally stable, even over several decades. This is true for many countries or societies. Yet, if there is dramatic sociocultural change or political turmoil, there are relatively obvious vicissitudes of suicide rates.

Examining the World Health Organization mortality database for the period 1955 to 1989, La Vecchia and his colleagues (1994) pointed out that, with respect to trends over time, the figures for suicide rates were relatively favourable in less developed areas of the world, including Latin America and several countries in Asia. (In the WHO database, there was no data available from most of the African countries to make comment possible about that region.) In contrast, there was an upwards trend, particularly among elderly men, in Canada, the United States, Australia and New Zealand. In other words, culture has a significant pathofacilitating effect on suicidal behaviour.

Minor psychiatric disorders

Culture has a broader, more direct effect on minor, as opposed to major, psychiatric disorders on all the levels of pathogenetic, selective, plastic, elaborating, facilitating and reactive effects.

Among minor psychiatric disorders, conversion and dissociation disorders are good examples of the rich effects of culture. The prevalence of conversion or dissociation varies greatly among different societies (due to pathofacilitating effects). It is also clear that, in some societies, in contrast to other forms of psychopathology, it is preferable to deal with stress (pathoselective effects) by repressing or dissociating the painful emotion. Although some theories have been proposed to explain why certain cultural traits or certain child-rearing patterns favour the occurrence of conversion or dissociation (pathogenetic effects), there is not yet any solid data to support such speculation. However, it is obvious that different societies have different reactions to the phenomena of conversion or dissociation (pathoreactive effects), which, in turn, may facilitate the occurrence of the psychopathologies.

Neurasthenia is another minor psychiatric disorder that deserves cultural discussion. The term neurasthenia was originally invented by an American neuropsychiatrist, George M. Bear, in 1869, to describe a clinical syndrome with core symptoms of mental fatigue, associated with poor memory, poor concentration, irritability, headaches, tinnitus, insomnia and other vague somatic complaints. This diagnostic category was not included initially in Diagnostic and Statistic Manual of Mental Disorders, First Version (DSM-I) of the American Psychiatric Association, but was included in its second version (DSM-II) in 1968. Subsequently, when the radical revision was made for its third version (DSM-III) in 1980, the term was removed from its classification system. However, the term has been widely used in other societies in Europe, including Russia, and Asia. In China, associated with the introduction of modern psychiatry into China in the late nineteenth century, the term neurasthenia, a translation of the Chinese term s*henjing-suairuo* (nerve-weakened disorder), became a commonly accepted medical term. The concept of *shenjing-suairuo* is compatible with the traditional Chinese medical concept of *shen-kui* (kidney-deficiency disorder), and is easily understood and accepted by the lay person, as well. When an extensive epidemiological study of psychiatric disorders was carried out in China in 1986, neurasthenia comprised 58.7% of the total neurotic disorders identified at the time of the survey.

It is interesting to note that American cultural psychiatrist Arthur Kleinman (1982) carried out a clinical study of patients diagnosed by Chinese clinicians as having neurasthenia, and claimed that 87% of the patients he examined could be 'rediagnosed' as having a depressive disorder. However, many prominent Chinese psychiatrists insisted that neurasthenia was a recognized psychiatric disorder distinct from depressive disorders (Yan, 1989; Young, 1989; Zhang, 1989). This made it clear that we need to carefully examine and diagnose patients across cultures by using clinicians' own classification systems. We also need to determine the cultural implications and clinical functions of making diagnoses for patients in their own societies.

Personality disorders

Different cultures emphasize different personality traits as ideal. Therefore, defining or labelling deviations from 'normal personality' is clearly a culture-relative exercise, whose boundaries are reflective of the specific values, ideas, worldview, resources and social structure of the society (Foulks, 1996). For instance, dependent personality disorder is defined as 'having difficulty making everyday decisions without an excessive amount of advice and reassurance from others', and 'needing others to assume responsibility for most major areas of his or her life'. This definition needs careful consideration, depending on whether the person concerned is living in an individual or a collective society. In a collective society, considering, consulting with, or depending on others is a cultural expectation that does not necessarily imply that the person is suffering from dependency. The concept of antisocial personality disorder is defined by the failure to conform to 'social norms', having problems maintaining culturally desirable interpersonal social relations (such as reckless disregard for the safety of others, deceitfulness, or aggressiveness), and a lack of socially expected guilt feelings for wrongful behaviour. Clearly, socio-cultural judgement is needed, in particular, to define those personality disorders.

Generally speaking, the frequency of various personality disorders is difficult to examine through epidemiological studies for cross-cultural comparison, because, methodologically, the surveys are one-time studies and do not examine a person's life thoroughly or objectively enough to make it possible to diagnose a 'personality disorder'. Nevertheless, among all of the recognized personality disorders, antisocial personality disorder, due to its nature, is considered by scholars and clinicians as the easiest to identify and study, with epidemiological data relatively available for cross-societal comparison.

The Epidemiological Catchment Area (ECA) study carried out in the United States examined data for antisocial personality disorder among the three ethnic groups surveyed, namely, Caucasian-American, African-American, and Hispanic-American. The lifetime prevalence rates were found to be 2%, 2.3% and 3.4%, respectively. Robins, Tipp and Pryzbeck (1991) therefore claimed that, in the United States, there were no racial differences in the prevalence of antisocial personality disorder. At the same time, the racial distribution of the United States' prison population reflected racial disparity. Kosson, Smith and Newman (1990) reported that African-Americans, who comprise less than 13% of the general population, represented 45% of the prisoners in the United States. These results suggest that an overpathologizing bias toward African-Americans resulted in more subjects sentenced to prison under the diagnosis of antisocial personality disorder (Lopez, 1989). Alarcón and Foulks (1995) pointed out that as many as half of America's inner-city youth may be misdiagnosed with this disorder. They argued that the criteria are inappropriate for settings in which value systems and behavioural rules encourage learning to be violent as a protective strategy for survival.

Lynn (2002) intensively examined all available literature on psychopathy and related antisocial behaviour among various racial or ethnic groups: Black (African-American or African), Eastern Asian, Hispanic, (Native) North American, and White (Caucasian American or European). The data reviewed came in multiple forms. For the adults, Lynn used the data from the psychopathic deviate scale of the Minnesota Multiphasic Personality Inventory (MMPI), moral values assessed by Defining Issues Test (DIT), honouring financial obligations (by college students for paying back tuition loans), aggressive behaviour (including homicide, robbery, assault, rape, spouse battering) as reported officially in crime rates, as well as long-term monogamous relationships and extramarital sex. For children, he examined the data relating to conduct disorder as reflected on the Child Behaviour Checklist (CBCL), school suspensions and exclusions, attention deficit hyperactivity disorder. Based on all the information he gathered, he pointed out that there are racial and ethnic differences in psychopathic personality conceptualized as a continuously distributed trait, such that 'high values of the trait are present in Blacks and Native Americans, intermediate values in Hispanics, lower values in Whites and the lowest values in East Asians'. He indicated that all the data he collected were derived from various societies in different geographical regions. It would be difficult to construct an environmental explanation for the presence of this pattern in so many locations. Lynn speculated that racial genetics may contribute to the difference. However, Zuckerman (2003) criticized that the differences between African-American, Native-American, and Hispanic, and European-American groups (in American society) in terms of antisocial behaviour are more functions of social class, historical circumstance and their positions in Western society than of racial genetics.

There is a limited amount of reasonably comparable epidemiological data about personality disorders cross-socially. Unless a similar methodology and criteria are used, there is no point in making cross-cultural comparisons. To date, there have been few cross-cultural comparisons of personality disorders using data obtained with the same epidemiological survey methods. The questionnaire used in the National Institute of Mental Health Epidemiological Catchment Area (NIMH-ECA) study in the United States was translated into Chinese and applied in an epidemiological study in Taiwan (Hwu *et al.*, 1989). The results found the prevalence of antisocial personality disorder (APD) to be 0.14% in Taiwan, which was remarkably less than the 3% that was found in the United States (Compton *et al.*, 1991). However, the results may be criticized on methodological grounds, including the design of the instrument and how it is surveyed. In order to determine antisocial behaviour, there are items in the instrument, such as: 'to earn money illegally, such as to sell stolen objects, illegal drugs', 'physically abuse spouse or sexual partner', 'having extramarital affairs more than three times', 'having sex with more than ten persons within a year' or 'to be paid to have sex with others'. Those items refer to dyssocial behaviours that are relatively unlikely to occur in a society that, generally speaking, is more or less tightly restricted by culture. The response to these items will accordingly be reduced, which will influence the total score needed for diagnosing APD (as done in America).

From a cultural perspective, Cooke (1997) hypothesized that individualistic societies, in contrast to collective societies, are more likely to produce glibness and superficiality, grandiosity, promiscuity, and multiple marital relationships, together with a lack of responsibility within relationships than are collectivist societies. This suggests that antisocial behaviour is subject to pathofacilitating effects, that is, certain cultural environments make it easier to develop such a disorder.

Epidemic mental disorders

It needs to be pointed out that, when psychiatric disorders occur in an epidemic or collective manner, such as mass hysteria, epidemic panic disorder, it becomes clearer that social and cultural factors play a significant role in the occurrence of these rather unique mental pathologies. Pathogenic, selective, plastic and facilitating effects are all significantly involved in the psychologically contagious collective mental disorders.

For instance, careful study of the *koro* epidemics that have occurred in Southern China, Thailand and India, has indicated that certain common factors contributed to the eruptions of the collective mental epidemics: the commonly shared folk belief (that shrinking of the penis could potentially result in death); the existence of community anxiety, either due to interethnic conflict, social disaster, or war, which serves as the grounds for the occurrence of the community-based, massive anxiety attack; the transmission of anxiety, fear, and panic among people, which promotes the contagious occurrence of the epidemic disorder.

Culture-related specific psychiatric syndromes

Culture-related specific psychiatric syndromes, also known as culture-bound syndromes, are mental conditions whose occurrence or manifestation is closely related to cultural factors and, thus, warrant understanding and management primarily from a cultural perspective. Since the presentation of a culture-related syndrome is usually unique, with special clinical manifestations, it is called a culture-related specific psychiatric syndrome. From a phenomenological point of view, such a condition is not easily categorized according to existing psychiatric classifications, which are based on clinical experiences of commonly observed psychiatric disorders in Western societies, without adequate orientation toward less frequently encountered psychiatric conditions and diverse cultures worldwide (Tseng, 2001, pp. 211–263). These are discussed further in this volume by Bhugra *et al.*, Chapter 11.

By definition, the development of culture-related specific syndromes is heavily influenced by cultural factors. In most cases, the pathogenic, selective, plastic, elaborating, facilitating and reactive effects of culture all work together to some extent to contribute to the occurrence of such specific syndromes. Among them, pathogenic effects are characteristically at work in some disorders. That is, cultural beliefs or attitudes have direct and aetiological effects on the development of the psychopathology. This is particularly true in the case of *koro* syndrome (anxiety or panic attack resulting from the folk belief that excessive shrinking of the penis into the abdomen will cause death), *daht* syndrome (anxiety based on the common belief that excessive semen loss will result in illness), frigophobia (a fixated, morbid fear of catching cold based on the folk belief that excessive cold will result in serious effects on health), *voodoo* death (intense fear that often results in sudden death, based on the belief that breaking taboos or curses will cause fatal outcomes).

Cultural input is so significant that culture-related specific syndromes are often unevenly distributed, concentrated in certain cultural regions that offer the cultural conditions for forming them. This illustrates pathoselective and facilitating effects in their extreme. In the past, it was believed by some scholars that culture-related specific syndromes were ‘bound’ to particular ethnic groups or cultural units. Thus, they were called ‘culture-bound syndromes’. Recently, this view has changed. Based on cross-cultural literature and findings, scholars have come to realize that such syndromes may be closely related to certain cultural features, but are not necessarily ‘bound’ to any particular ethnic group or ‘cultural entity’. The syndromes may occur across the boundaries of ethnicity, society, or cultural units, as long as they have common cultural ‘traits’, ‘elements’, or ‘themes’ that contribute directly to the formation of such pathologies; see Sumathipala *et al.* (2004). An example is the *koro* syndrome. Scholars considered it a disorder observed particularly among the Chinese, because the term *suoyang* (shrinking of the male organ) was described in ancient Chinese traditional medical books with the implication that such phenomena is a sign of a terminal state near to death. However, *koro* epidemics have also been reported not only in Southern China, but in Thailand and India, which are not ethnically related to China, but share the same basic concern that excessive sexual activity is harmful to the health of men.

Summary and clinical implications

In summary, culture affects psychopathology in different ways. Culture may cause the psychopathology (psychogenic effect); contribute to the selection of psychopathology (pathoselective effect); shape and modify the clinical manifestation of the psychopathology (pathoplastic effect); promote the occurrence of certain pathologies (psychofacilitating effect); elaborate on the nature of psychopathology (psychoelaborating effect); and influence the way society reacts to the occurrence of psychopathology (psychoreactive effect). Further, there are different kinds and levels of cultural impact on various groups of psychopathology – including organic mental disorders, functional psychoses, substance abuse and dependency, minor psychiatric disorders, epidemic mental disorders, to culture-related specific syndromes. It is fair to say that, overall, culture has a moderate, but not unlimited, impact on psychopathology (Draguns, 1980), depending on the cultural group involved and the nature of the cultural influence.

It is important for clinicians to be aware that the process of clinical assessment and the evaluation of psychopathology is a dynamic process involving many factors coming from the patient, the clinician and both sides interactionally. The process includes how the patient perceives stress, responds to it, and communicates and complains to a clinician. It is subject to the patient’s personality, the nature of the stress, the severity of the pathology and socio-cultural factors, including how to seek help and present problems. At the same time, beyond the clinician’s personality, professional orientation and clinical experience, the clinician’s cultural background, including value system and concept of normality and pathology, will directly and indirectly influence his or her clinical work, including assessment, judgement and diagnosing the psychopathology. A culturally competent clinician needs to have culturally orientated attitudes, and the knowledge and experience to understand, assess and evaluate the psychopathologies of patients from diverse cultural backgrounds.

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Developmental aspects of cultural psychiatry

Joseph Westermeyer

Ambrose Uchtenhagen, M.D., Ph.D., Professor of Social Psychiatry at the University of Zurich, Zurich, Switzerland, provided the original impetus to this historical analysis.

EDITORS' INTRODUCTION

The development of psychiatry as a discipline has moved from the observational to the social and, in the last few decades, to an increased emphasis on genetic and gene–environmental interactions in the causation of psychiatric disorders. The emphasis in cultural psychiatry varied between Western Europe and the USA. In Europe, often the social anthropologies followed the colonial masters in observing the natives and their rituals in their natural habitat. These led to misconceptions about diagnosis and a management of psychiatric cases but, more importantly, it meant that the traditional way of dealing with mentally ill individuals and mental illness were criticised, looked down upon and in some cases even destroyed. The traditions, however, survived perhaps of oral tradition of history and information being passed on across generations.

Westermeyer in this chapter sets out the global context within which cultural psychiatry has emerged and started to make its presence felt. He argues that cultural psychiatry has many features in common with social psychiatry in that both relate to social institutions such as family, community and psychiatric institutions. There are distinctions between the two types of psychiatry as well in that their focus is somewhat different. Illustrating the historical context by using migration as an example and the notions of racial and ethnic superiority/inferiority became more apparent. Current status of cultural psychiatry follows on from two different traditions – European and American. Westermeyer notes that differences between social psychiatry and cultural psychiatry persist in spite of attempts to use terms such as sociocultural psychiatry. The use of different social units across the two specialties and the relative importance of nation state provide clear pointers in different directions in which the two specialties lead. In the last few decades or so, cultural psychiatrists have become involved in providing services and directing service planning for migrant or minority ethnocultural groups. Cultural consultation and acting as cultural brokers have been important steps forward in making psychiatric services accessible. Westermeyer makes a strong case for psychiatry to move into international psychiatry away from national psychiatries.

Introduction

Cultural psychiatry includes numerous subfields, some more theoretical in nature and others quite practical in orientation. Literally scores of subfields can be described, from early tomes on culture and psychoanalysis (such as Freud's *Totem and Taboo* (Freud, 1918) to latter-day research on the genome and ethnopsychopharmacology (Lin *et al.*, 1993). These subfields vary almost as much as the field of psychiatry itself. However, for purposes of presenting a coherent historical development of the field, four principal areas will be described here. Other iterations of the field should become apparent to the reader.

Perhaps the first modern efforts in cultural psychiatry were directed at describing psychopathology across cultures, noting the similarities and differences in psychiatric disorder among various cultures. Emil Kraeplin began such studies over a century ago, first observing differences among psychiatric patients in Europe and later travelling to several

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

countries outside of Europe for the same purpose (Boroffka, 1990). Later investigators, such as Tsung Y Lin (Lin, 1989) and Alexander Leighton (Leighton, 1981), expanded this stratagem in the mid-1990s with their epidemiological studies of various disorders within and across populations. These descriptive and epidemiological approaches to the understanding of psychiatric disorder vis-à-vis culture continue to the present time, girded by use of psychiatric rating scales, scheduled psychiatric interviews, and even newer methods, such a genomic and neuroimaging studies (Cheng *et al.*, 1993; Tseng *et al.*, 1990).

It was not long after these early descriptive and prevalence studies that investigators began to consider what factors in cultures might augur for or against psychiatric disorder. These investigations concerned the beliefs, attitudes, behaviour, customs, values, practices, and traditions of patients as these cultural factors might affect psychiatric disorder. Around 1930, Odegaard first demonstrated the link between large-distance cross-cultural emigration and mental disorder, citing cultural factors in the increased rates of several disorders among immigrants (Odegaard, 1932). Later researchers studied culture itself as potential pathogen; examples included political extrusion of subgroups as refugees (Ahearn & Athey, 1991)and the influence of rigid cultural roles on psychopathology (Al-Issa, 1982). Studies of culture as resource have emphasized social networks (Speck & Attneave, 1974) and culturally prescribed strategies for adaptation and coping (Knafl & Gilliss, 2002).

Following World War II, increased travel resulted in psychiatrists from one culture rendering care to patients from other cultures. International travellers included refugees, foreign students, tourists, foreign ‘guest workers’ and others. In addition, internal migration and urbanization resulted in ethnic minorities and remote rural dwellers relocating to urban areas. The clinical imperatives stemming from this novel situation greatly stimulated practical aspects of cross-cultural psychiatry. These issues included the role of the translator in psychiatric evaluation (Westermeyer, 1990), the psychiatrist’s cultural norms and their potential influence on diagnosis (Adebimpe, 1981), clinical presentations or syndromes influenced by culture (Abbey & Garfinkel, 1991), reliability of cross-cultural diagnoses (Westermeyer & Sines, 1979), and applicability of psychometrics across languages and cultures. Since many patients in cross-cultural contexts were fleeing war and/or political oppression, assessment and care of trauma-related disorders become a prominent feature in studies and in clinics (Basoglu, 1992, Kinzie & Tran, 1980).

Over the last few decades, ethnopsychiatry studies have addressed psychiatric practice within a particular cultural framework. These studies have examined practitioners, systems of care, diversity and possible inequalities of care and care outside of the professional mainstream (e.g. over-the-counter medications, indigenous or folk healing, ethnic differences in access to care and patient satisfaction) (Collins *et al.*, 1984; Delgado, 1995; Szapocnik *et al.*, 1984). On the micro-level, the role of ritual and ceremony in treatment and healing has been assessed (Johnson *et al.*, 1995). One psychiatrist with public-health training has addressed cultural perspectives of a people towards their own mental-health improvement (Thompson, 1996).

Cultural psychiatry and social psychiatry possess many features in common (Gruenberg, 1983). For example, social psychiatry addresses psychiatry as it is related to social institutions, such as the family, community, licensing bodies, economics, education, politics, law and public health (Kessler *et al.*, 1995). It may also encompass the study of psychiatric institutions, such as clinics, hospitals, research institutes, academic centres and professional guilds. Social psychiatry includes the study of patients in groups, including special groups of patients (e.g. students, military units, factory workers) (Portela, 1971), special social circumstances affecting patients (e.g. disasters, racism) (Blendon *et al.*, 1995), and special social therapies (e.g. family, group, milieu, industrial, recreational) (Mollica *et al.*, 2002). In general, social psychiatry and cultural psychiatry differ in the mono-cultural emphasis of the former and the bi- or multi-cultural emphasis of the latter. Contrasts in the development of these two psychiatric fields over time provide a perspective regarding their foundations, functions, and perhaps their future.

Historical origins of social and cultural psychiatry

Social and cultural psychiatry may seem virtually indistinguishable at first glance, since both fields concern groups of people *vis-à-vis* psychiatric disorder and its treatment. However, they have been separate fields with relatively little overlap and interaction. This paradox becomes comprehensible in view of their differing historical origins and developments.

Origins of social psychiatry can be discerned in the early efforts of Pare, Rush and others in providing humanistic care for psychiatric patients, during the late 1700s and early 1800s (Farr, 1994). These efforts arose in Western Europe and North America in a particular socio-philosophical setting, a period of social revolution. Individual rights and the dignity of the individual, in the vanguard of social thinking, were extended to the care of those with psychiatric disorder, including alcoholism. At this early stage a cultural psychiatry cannot yet be discerned.

Later in the 1800s, research by the first social scientists presaged work by social psychiatrists in the early 1900s. An example was the study of suicide by the sociologist Durkheim in France. Social concerns with child raising, work, social equity and influences of society in ameliorating or exacerbating psychiatric disorder began in this era. During this period, Freud, Roheim and other psychiatrists also began considering the effects of cultural influences on psychiatric disorder (Freud, 1918, Roheim, 1926). To a considerable extent, they mimicked the work of the social psychiatrists. These early cultural psychiatrists were Europeans, some of whom later emigrated to the United States. It is likely that they would have identified themselves as psychoanalysts interested in culture, rather than as cultural psychiatrists.

Those psychiatrists beginning work in cultural psychiatry were largely analysts, as exemplified by Freud and Roheim working in the 1910s and 1920s. Their work was largely qualitative, deductive and inferential. Perhaps stimulated by their work, the psychiatric epidemiologists Odegaard, Malzburg, and T. Y. Lin began studying the prevalence of various psychiatric disorders in association with culture during the 1930s (Lin *et al.*, 1978; Malzberg, 1964; Malzerg, 1940; Odegaard, 1932). Unlike the earlier generation of cultural psychiatrists, this later generation employed methods that were inductive and quantitative. Moreover, their studies were replicable and could be statistically analyzed. During this period, cultural psychiatry studies were undergoing a change from philosophical treatises to scientific enterprises. It is likely that these group of investigators would have considered themselves psychiatric epidemiologists, rather than cultural psychiatrists – a professional identity that had not appeared prior to mid-century.

By mid-century yet another generation of cultural psychiatrists had appeared. This group had training in both psychiatry and one of the culture-related sciences (e.g. anthropology). A foremost example was the North American Alexander Leighton, whose first work was in the Japanese relocation/concentration camps established by the American government during World War II (Leighton, 1981). His students and colleagues, including Dorothea Leighton (Leighton & Leighton, 1941) and J.A. Lambo (Lambo, 1955), played seminal roles in the establishment of cultural psychiatry as an international field within psychiatry. Later they used the terms ‘culture and psychiatry’ and ‘cultural psychiatry’. In their careers the field of cultural psychiatry was launched and could be clearly identified.

During the 1970s the numbers of psychiatrists writing on cultural psychiatry topics increased geometrically. Perhaps influenced by the Leightons and their colleagues, many of these investigators were North Americans, albeit from many ethnic groups and including many immigrants (Abad & Boyce, 1979; Favazza & Oman, 1978; Gaviria & Wintrob, 1979; Griffith & Ruiz, 1977; Haldipur, 1980; Jilek, 1976; Kimura *et al.*, 1975; Lin *et al.*, 1979; Marcos *et al.*, 1973; Prince, 1976; Spiegel, 1976; Tsuang, 1976; Westermeyer, 1972; Winkelmayer *et al.*, 1978; Wintrob, 1973; Yamamoto & Satele, 1979). Australian psychiatrists, although fewer in numbers, also contributed much new understanding to the field around the same time (Edwards, 1972; Krupinski *et al.*, 1973). Psychiatrists in the United Kingdom began work in the field, examining fundamental issues regarding diagnostic nomenclature and the relationship between language, cultural meaning and the expression of psychiatric symptoms (Leff, 1974; Morice, 1977) as well as addressing cross-cultural care (Cox, 1976). African psychiatrists, influenced by Lambo and by their UK mentors, also began to publish work in cultural psychiatry (Ifabumuyi & Rwegellera, 1979). A few studies began to appear on the European mainland (Sartorius et al., 1978; Steinbrunner & Scharfetter, 1976). Clearly, by 1980 an international cultural psychiatry was well established. Two journals, one from Canada (*Transcultural Psychiatric Research Reviews*) and one from the United States (*Culture, Medicine, and Psychiatry*), symbolized the coming-of-age for the field.

Early social psychiatry developments and their effects on cultural psychiatry

Child psychiatry

An early clinical endeavour in social psychiatry was the development of child-study/child-care centres in the 1920s, based on the notion that early care might prevent subsequent psychiatric disorder. Only several decades later did cultural psychiatrists undertake studies of children from a cultural perspective. Many of these studies focused on refugee children and adolescents (Ahearn & Athey, 1991; Carlin, 1979; Harding & Looney, 1977; Kinzie *et al.*, 1986; Sack *et al.*, 1996; Savin *et al.*, 1996; Williams & Westermeyer, 1984), thus paralleling the studies being undertaken among refugee adults. Additional work included cross-cultural differences in the clinical assessment of children and their families (Tseng *et al.*, 1982), culture and the abuse of children (Berry-Caban & Brue, 1999; Lujan *et al.*, 1989), and possible cross-generational effects of war and genocide (Leon *et al.*, 1981; Major, 1996; Sack *et al.*, 1995).

Refugees and other traumatized populations

During the immediate post-World War II era, European psychiatrists firmly established social psychiatry as a major subfield while American psychiatrists continued to focus on psychoanalysis (Romano, 1994). Those European psychiatrists who started this field were suckled on the social disorganization and chaos of World War II. They learned first-hand from their childhood, adolescence and early adulthood the power of social organizations to assault, injure, and destroy the human community with its fragile veneer of civilization. They also learned the value and power of social institutions to protect, organize and give meaning to human existence. The brightest and ablest of them turned these war-wrought lessons to the care of the new European casualties – those whose lives, families and communities were being undermined by the social changes and the alcohol–drug epidemics in post-World War II Europe (Sartorius, 1989; Sartorius *et al.*, 1978, 1980).

Social psychiatry in Europe evolved within a context of crisis, beginning first in a social milieu of want and reconstruction, but reaching full fruition in a milieu of relative wealth. This broad-based effort was truly revolutionary. It involved entirely new concepts in psychiatric assessment and modes of psychiatric treatment and rehabilitation that were fundamentally different from the psychological focus that predated them. One of these survivor–innovators was Vladimir Houdolin, one among several eastern European psychiatrists who identified early on the growing problem of alcoholism and developed several innovations later imported to the United States (detoxification facilities, employee-assistance programmes, residential programmes). Another survivor, Ambrose Uchtenhagen, along with other western European psychiatrists, identified the epidemic of drug abuse among the 'lost youth' of modern Europe and established a score of creative treatment approaches (e.g. therapeutic commune, industrial rehabilitation, heroin maintenance, methadone maintenance in rural communities). Norman Sartorius, cited above, led World Health Organization efforts in developing an international psychiatry founded on rational planning and scientific understanding.

Building on earlier work, but adding their own innovations, they developed new psychiatric theories and institutions to meet these new epidemics. New therapeutic institutions included day programmes, half-way houses, recovery farms, factory-sited and commune-sited recovery groups, neighbourhood-sited clinics, use of the family and the community to support the recovering person, and examination of the family and the society as aetiologic agent or precipitating force in the development of psychiatric and substance disorders – modalities widely used (and studied) by cultural psychiatrists.

As evidence that a new field of psychiatry had appeared, the International Journal of Social Psychiatry appeared in Europe. Several chairs of Social Psychiatry were appointed in Europe. National societies for the advancement of social psychiatry also began in countries of Europe, subsequently leading to the International Society of Social Psychiatry. The field attracted behavioural scientists from such fields as Sociology, Epidemiology and Political Science. Similar developments did not occur in the United States during the period from 1970 to 2000 when this broad-based professional movement was most active.

Early lessons

The American experience with immigration

In the mid-1800s, during a period of heavy immigration, American psychiatrists observed that immigrants had a much higher-than-expected prevalence of disabling mental conditions (Malzberg, 1940). This led to efforts to identify which nationalities or ethnic groups were most apt to be institutionalized at public expense following immigration. Originally focused on immigrants themselves, further investigations revealed that several countries of western and central Europe (England in particular, but also Germany and other countries) were sending criminals, debtors, unemployed persons and institutional inmates to the United States at public expense. As an outgrowth of these studies, immigration procedures to screen immigrants disabled by mental disorder were established. International agreements were negotiated, so that disabled persons might be returned to their communities-of-origin at the expense of shipping companies and the countries-of-emigration. These early treaties did much to solve the social–financial crisis presented by disabled immigrants to the United States. The entire experience was also a telling lesson regarding the potential dangers of unregulated immigration.

Unfortunately, the events did little to contribute to the understanding and care of psychiatric patients. On the contrary, theories evolved on both sides of the Atlantic purporting to 'prove' the inherent superiority – or inferiority – of specific national or ethnic groups. The political corollaries of these populist theories were writ large in the subsequent European Holocaust of the 1940s (Freyberg, 1980; Nadler & Ben-Slushan, 1989).

A tenuous beginning

During the early 1900s, Freud established the study of psychopathology and culture as a legitimate field (Freud, 1918). Freud accomplished this through his literary writings on past and current cultures. In doing so, he often misquoted original references in his development of a particular topic, laying greater emphasis on the theory than on the facts supporting it. His playing loose with the cultural data undermined his standing with serious students of culture. Nonetheless, his writings found favour among social and behavioural scientists in the United States during the 1920s and 1930s (Mead, 1947). By the 1960s, his cultural psychiatry work and the works of his disciples were no longer so widely popular.

As noted above, a few psychiatrists from Europe and Asia were conducting solid, reliable studies during the first half of the twentieth century. The Eastern European Kraeplin first traveled from Poland, where he was trained, to work in Switzerland. Later he travelled from Europe to Malaysia, studying hundreds of psychiatric cases along the way. He observed that mental illness in very diverse cultures contained great similitude (Boroffka, 1990). Around 1930, the Norwegian psychiatrist Odegaard conducted a milestone epidemiological study of emigrant Norwegians to Minnesota, comparing them to Norwegians who remained at home and native-born Norwegian Americans (Odegaard, 1932). Influenced by Odegaard's work, Tsung Y. Lin conducted the first field-based epidemiology of psychiatric disorder among Han Chinese and aboriginal peoples of Taiwan during World War II (Lin *et al.*, 1978). These and similar works provided a solid foundation for the work of cultural psychiatrists in the latter half of the twentieth century.

In the United States, Alexander Leighton – trained as psychiatrist, psychoanalyst and anthropologist – initially studied Japanese-American people in relocation/concentration camps. His early observations in this context, his later studies, and his devotion to training cultural psychiatrists played a critical role in the establishment and acceptance of cultural psychiatry. Among his many students was Lambo of Nigeria, who led the development of psychiatry in Africa. Lambo was later division chief of psychiatry at the World Health Organization in Geneva and subsequently deputy chief of WHO.

Confluence of need and expertise

Following World War II, cultural psychiatry studies began pouring out of nations with significant immigrant populations. These included especially Australia (Krupinski, 1967), Canada (Tyhurst, 1977) and the United Kingdom (Cox, 1976; Leff, 1974; Littlewood, 1980). In Norway, a country that received thousands of displaced persons following World War II, Eitinger (himself a refugee from Nazi prison camps) led this effort (Eitinger, 1959; Eitinger, 1960). H. B. M. Murphy and his European colleagues – working in Switzerland, France and other European countries under the auspices of the United Nations – were early contributors to the care and resettlement of refugees (Murphy, 1955).

The principles of European social psychiatry current at the time demanded that all persons have access to psychiatric services, regardless of wealth or ethnicity. This strategy required that clinicians learn to work efficiently and effectively with scores, if not hundreds of ethnic peoples whose life ways fell outside of the societal mainstream. In order to treat psychiatric disorders among minorities and refugees (not previously done in any concerted fashion), clinicians had to acquire additional knowledge, skill, attitudes, and experience.

Later waves of refugees from the anti-Communist uprisings in 1950s eastern Europe produced additional important studies in Canada (Mezey, 1960). The flood of Southeast Asian refugees throughout the world likewise contributed new concepts, understanding, and methods to cultural psychiatry (Beiser & Fleming, 1986; Hauff & Vaglum, 1994; Kinzie *et al.*, 1982; Mollica *et al.*, 1985; Westermeyer, 1989a). The diaspora from African nations has also brought hard-wrought lessons to cultural psychiatry (Jaranson *et al.*, 2004).

Cross-cultural treatment

In the 1960s and 1970s a new and growing generation of cultural psychiatrists became interested in treatment – a departure from earlier psychiatrists interested in epidemiology, diagnostic categories, and clinical assessment. Scores of psychiatrists joined in this effort. Among the most influential American psychiatrists was John Spiegel, living in Boston and training therapists to work with blue-collar Irish. His early work established the clinical relevance of cultural transference and counter transference for cross-cultural psychiatric assessment and care (Spiegel, 1976).

Current status of cultural psychiatry

Cultural psychiatry has progressed as a distinct field in Europe during recent decades. Persons displaced from their home countries across the face of Europe stimulated early studies. Later, immigrants from former colonies stimulated the development of new skills as well as theory (Cox, 1976; Leff, 1974). The flow of refugees and torture victims from Indochina, South Asia, the Middle East, Africa, and Latin America has encouraged novel approaches to clinical services (deJong, 1996). Seminal studies on cultural psychiatry topics have appeared in European journals. Conferences on topics relevant to cultural psychiatry have taken place at an increasing rate over the last decade. The European Community has stimulated cross-national studies through the establishment of a clearinghouse for alcohol–drug data. Such European psychiatric journals as *Acta Psychiatrica Scandinavica, British Journal of Psychiatry, Psychopathology, Alcoholism, and Addictions* have published studies on cultural psychiatry for decades.

Evidence for a cultural psychiatry subfield exists in several domains within North America. Several journals on cultural psychiatry and related fields have appeared (and some have disappeared): i.e. *Ethos, Medical Anthropology, Medicine Psychiatry Culture, Psychological Anthropology* and *Transcultural Psychiatric Research Reviews*. Several psychiatrists from Canada and the USA – all with experience living in other societies and/or among American ethnic groups – established the Society for the Study of Psychiatry and Culture (SSPC) in the 1970s. The SSPC has an annual meeting and newsletter. From the 1950s to the current time, several clinical and research training programs in cultural psychiatry (largely, but not exclusively funded by the federal government) have appeared and disappeared. Currently, about 200 North American psychiatrists identify themselves as cultural psychiatrists, with a like number of anthropologists, epidemiologists, sociologists and social psychologists working in the field of cultural psychiatry.

Social and cultural psychiatry: an analysis of similarities and differences

Despite their common focus on groups of people in relation to psychiatry, cultural and social psychiatry differ greatly from one another. As elaborated above, they possess quite different origins, both in terms of original purposes and founding leaders. Since their establishment, their directions and primary concerns have diverged greatly. Despite some geographic overlap in their genesis and evolution over the last century, social psychiatry and cultural psychiatry have remained largely separate entities. In view of these numerous conceptual, methodological, and historical differences, the failure of the integrative term ‘sociocultural psychiatry’ to gain wide acceptance can be understood – although the term ‘socio-cultural’ recurs infrequently in published articles (Coombs & Globetti, 1986, Dozier, 1966; Tseng *et al.*, 1988; Westermeyer, 1992).

Other non-historical factors suggest additional explanations for the lack of mutuality between the two fields. One of these factors is the different social unit emphasized by each subfield. Social psychiatry has focused on social institutions and groups of patients. In contrast, cultural psychiatry has focused on the psychology of the patient and the clinician as culturally derived or influenced, e.g. cultural transference and counter transference (Spiegel, 1976); assessment and care of patients from cultural backgrounds notably different from those of their clinicians (Cox, 1976).

Another difference is the relative importance of the nation-state. From the standpoint of social psychiatry, the nation is the ‘universe’ of interest. Viewed from cultural psychiatry, any one nation is simply a single case study among many case studies. Given this difference in orientation, cultural psychiatrists are apt to perceive social psychiatrists as ethnocentric. On the contrary, social psychiatrists may view cultural psychiatrists as overly relativistic.

These historical and ahistorical factors explain the paradox of little mutual overlap between two supra-individual fields. Of perhaps more importance, this analysis (if valid) suggests that we can expect little spontaneous integration between the two fields. Despite their differences, social and cultural psychiatry have benefited each other in numerous ways. In the opening sections, we have considered ways in which social psychiatry has fostered cultural psychiatry. In the next section, we will review contributions of cultural psychiatry to social psychiatry.

Contributions of cultural psychiatry to social psychiatry

Cultural psychiatry has made its greatest contribution to social psychiatry in those settings in which a large number of culturally or ethnically diverse patients seek psychiatric services. These benefits have occurred in several areas of clinical endeavour.

One contribution has been the development of methods to assess psychopathology across cultures and languages. This contribution has been relevant for those social psychiatric programmes and clinics serving foreign students, immigrants, refugees, and guest workers. These methods, useful both clinically and for research purposes, have included the following:

- translation of rating scales and psychometric instruments from one language/culture to another language/culture;
- selection, training, and collaboration with psychiatric interpreters;
- pathoplasticity (and lack thereof) in various psychiatric disorders ;
- rates of psychopathology among different migrating groups;
- syndromes common to or over determined in certain cultures;
- use of the anthropological literature or a cultural consultant in assessing a patient's worldview, cognition and behaviour.

Cultural psychiatry has also contributed to the cross-cultural treatment of psychiatric patients from cultures not familiar to the clinician. These contributions have consisted of the following:

- the role of social and cultural transference and counter transference in facilitating and/or impeding the clinician–patient relationship;
- common features of psychotherapy apt to be beneficial across cultural and ethnic boundaries;
- ethnic similarities and differences in pharmacodynamics and pharmacokinetics of psychotropic agents.

Perhaps the greatest contribution to social psychiatry planning has been increased understanding of the relationship between migration and psychopathology. Such studies have been conducted over six decades in both clinical and population surveys, on both internal (within country) and foreign migrants. Migration has resulted in increased rate of virtually all psychiatric disorder, including many parapsychiatric problems, such as divorce and juvenile delinquency. Over determination of certain symptoms and syndromes among migrants has been well shown, e.g. depressive symptoms, paranoid symptoms, Folie à Deux/Famille/Milieu syndromes, and psychosomatic symptoms. Back-migration into labour-exporting populations (e.g. Ireland, Bavaria, Mexico, Caribbean) has been associated with concentration of psychopathology into those groups who contribute guest workers or migratory workers to other countries and regions. Onset of psychopathology in relation to duration since relocation has also been studied with depression occurring early, alcoholism and drug abuse later and schizophrenia independent of time-since-migration.

Cultural psychiatry has provided information on 'worst-case scenarios' to social psychiatry. By comparing rates of psychiatric disorder among diverse societies, cultural psychiatrists have determined that rates of schizophrenia or bipolar disorder have not been apt to exceed a percentage or two of the general population, unless one lives in a society that exports workers to other areas (e.g. Martha's Vineyard, an island in the USA; Bavaria; the Caribbean; Mexico; Bavaria) (Westermeyer, 1989b). Depressive disorders and anxiety disorders are not apt to differ greatly, although social phobia may be over determined among ethnic minorities who are economically disadvantaged relative to those living around them (Regier *et al.*, 1984). On the other hand, alcoholism and drug abuse may increase to levels that can seriously undermine an entire people. For example, lifetime prevalence of alcoholism among some American Indian (adults only) has reached 20% to 25% (Boehnlein *et al.*, 1993). Life prevalence of opium addiction among entire communities of certain Asian poppy farmers (including children and adults) has ranged from 8% to 12% (Westermeyer, 1992). These data are consistent with a life risk among males of around 40% to 60% and among females of around 20% to 25%. Such data can guide social psychiatrists in planning for preventive and clinical services.

Latter-day contributions of social psychiatry to cultural psychiatry

Occasionally since 1960 and especially since the mid-1970s, cultural psychiatrists have been charged with providing services to large numbers of patients from foreign or minority ethnic/cultural groups. Such circumstances have occurred during the development of psychiatric services for minority peoples (particularly in North American) and for refugee peoples (in North America and Europe primarily, and more recently in other regions). Cultural psychiatrists in governmental and university settings have employed social psychiatric service approaches. These have consisted of the following:

- cultural consultation to local professionals, clinics, hospitals and programmes not familiar with assessment and treatment of foreign or minority patients;
- training of indigenous foreign or minority persons to serve as interpreters and/or co-therapists for foreign or minority patients;
- if a critical mass of patients exists, development of special outpatient clinics, day programmes, or inpatient units providing care to foreign/minority patients;
- development of specialized programmes for a foreign/minority group (e.g. torture victims, PTSD victims among refugees, group therapy for surviving solo parents, delayed or missed grief groups, ‘acculturation therapy’ for those failing to acculturate due to chronic psychiatric conditions).

Although providing useful clinical services, these activities have not contributed appreciably to the theory or methods of cultural psychiatry. However, these clinical services have contributed to the available clinical epidemiology data as well as an enriched compendium of case reports.

Opportunities for collaboration between social and cultural psychiatry

Social and cultural psychiatry have contributed to one another on a practical, operational or instrumental level. However, each has failed to make substantive contributions to the other. It appears that substantive integration between the two subfields on a conceptual level is a difficult, perhaps even an unnatural undertaking. If this is true, it is likely that special efforts will be required to overcome historical and other factors. Nonetheless, several opportunities currently exist for a substantive and mutual collaboration between the two fields. These opportunities include the following.

An international psychiatry

The separate existence of an entire national psychiatric classification system in one country (the DSM system in the United States) and a number of national psychiatric categories in ICD-10 demonstrates that psychiatry is still in the era of ‘national psychiatries’. For decades, the fields of international surgery, medicine, and pediatrics have clearly existed. Until we can have one international diagnostic schema, we will remain a less-than-equal partner within medicine.

Agreement between the two systems is greater than in the past, and cultural–national differences have been acknowledged in both DSM and ICD as never before. Over the next decade or two, cultural psychiatrists (working with social psychiatrists, biological psychiatrists and others) could contribute to a better understanding of those epidemiological–diagnostic–therapeutic similarities in psychiatric disorder across cultures, as well as recognition of differences. Moving beyond recognition of these cultural–national differences to an understanding of these differences would serve psychiatry generally.

Controlled studies by the European Community (EC)

Collaboration among EC nations has great potential for assessing psychiatric policy and programmes. As European countries utilize similar and diverse interventions, the consequences of their decisions can be assessed and compared. The United States and Canada may be able to collaborate with the EC – a culture area with numerous similarities to North America. Such studies require comparable sampling and data collection – tasks for which the sampling and data collection methods employed in WHO studies are eminently suited. Although difficult, it might even be feasible to conduct crossover studies among countries. For example, countries 1 to 5 might apply intervention X, while countries 6 to 10 might use intervention Y. After assessing the effects of these interventions, the countries might then switch interventions, with countries 1 to 5 using intervention Y and countries 6 to 10 using intervention X. Although such complex international efforts seem beyond achievement, in fact such international collaboration has already occurred in the study of nosocomial infection on 1 417 intensive care units among 14 European countries (Vincent *et al.*, 1995). If such international collaboration is feasible for a health problem with relatively limited mortality, morbidity and cost, collaboration should also be feasible for extremely common problems with much greater mortality, morbidity and cost (e.g. alcoholism, drug abuse, depression, schizophrenia).

Statecraft regarding behavioural disorders

Statecraft in relation to substance use disorders, pathological gambling, eating disorders and other behavioural disorders remains at a rudimentary level in most, if not all countries (Westermeyer, 1999). On the contrary, statecraft (i.e. the art and science of conducting state affairs) is fairly sophisticated in areas related to road-building, international commerce and control of communicable disease. In the absence of an international statecraft *vis-à-vis* these disorders, each society must learn largely through its own mistakes. In the alcoholism field, principles of statecraft have been evolving for centuries (Paredes, 1975) continuing down to the present time. One of the earliest efforts was the containment of the Gin Epidemic in England during the 1600s and 1700s. Effective interventions have included legislation over alcohol production, importation, sale, and use (e.g. hours of sale, locations of off/on sale, age limitations, drinking under certain conditions such as driving and working), as well as legislation requiring establishment and funding of prevention, early intervention, and treatment-rehabilitation (e.g. detoxification centres, corporate regulations, insurance coverage). Several countries have decreased alcohol-related problems (especially in middle-aged men) after two decades of trial-and-error, learning hard-won lessons that could be replicated in other countries. Even in countries having notable success in reducing alcohol problems overall, such problems among young males have either not improved or have become worse, indicating the need for further international co-operation with age/gender-focussed anti-alcoholism efforts.

Statecraft in the drug-abuse field began with the efforts of several Oriental nations trying to contain tobacco and opium dependence in the 1600s (Westermeyer & Canino, 1997). Despite its long history, drug-use/abuse statecraft is still in the early stages of development in most of the world, as evidenced by dramatic shifts in drug-control policies and treatment approaches. Reubank has demonstrated the absence of a relationship between drug use (whether cannabis or 'hard drugs') and drug policies among 12 countries of northern, western, southern and central Europe (Reubank, 1995). His findings suggest that informal social controls and socio-cultural attitudes are more important in determining drug abuse prevalence that is official government policy. The need for international co-operation in this area grows ever more critical as many countries open their national boundaries and possess greater disposable income (Gerevic & Bacskai, 1995).

Epilogue

It has been an honour to know and work with Ambrose Uchtenhagen. Our collaborations through the World Health Organization have brought us to the wharves of Penang, the back alleys of Bangkok, the Northern Plains of the United States, the remote lake country of Canada and the mountains of Switzerland. There have been other, more important journeys as well. Ambrose Uchtenhagen has taught me, through his example, to be ever a respecter of persons, an open yet critical student of other peoples' ideas and lifeways, and a hospitable guest to the unexpected experience. In our work together, I have learned to be more patient than nature endowed me, to come more slowly to closure on any topic lest important data be ignored, and to listen carefully lest valuable ideas be lost.

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Explanatory models in psychiatry

Mitchell G. Weiss and Daryl Somma

EDITORS' INTRODUCTION

Similar experiences of illness or distress are seen as being caused by different elements across different cultures. Feeling gutted and sinking heart are idioms of distress which are remarkably different across cultures, but their implications at an individual level are very similar. Furthermore, the causation of the distress will be seen as remarkably different. It is evident that, in traditional cultures, the locus of control may be seen as external which may be coloured by cultural expectations, whereas in others the locus of control may be internal. Within each culture, however, individuals may carry their own explanations which may or may not be strongly influenced by individual's culture. From a clinical perspective, it is crucial that clinicians are aware of explanatory models that patients bring to the therapeutic encounter so that engagement can begin.

Weiss and Somma examine the concepts of the explanatory model framework, its appeal to health professionals and social scientists as well as its limitations. The illness explanatory framework deals with notions about an episode of illness and its treatment by all who are engaged in the clinical process and understanding these models means that patients' views on their conditions are being acknowledged. Weiss and Somma emphasize that the model must be distinguished from other ways the term is used which may refer to the nature of health and other problems in general. They explain three formulations of illness explanatory models and describe conceptual underpinning of the illness explanatory framework. In the beginning of the illness explanatory model framework provided a means of bring cultural differences between patients and clinician (especially when they came from different ethnic and cultural backgrounds) in multicultural settings. However, Weiss and Somma illustrate that this approach should also be seen as managing concerns about an imbalance over-emphasizing biology in the biopsychosocial model. They are also aware of possible critique of the model. This critique includes the perceived fixed and static nature of the model and that clinical interests do not take into account the influence of social context. Perhaps the most significant criterion is based on the question of whether too much emphasis on the model in explanatory model exists. Models are important for developing theory and for research. The approach remains a useful one for bridging the interests and experiences of clinicians and their patients.

Introduction

Over the past three decades the illness explanatory model framework has stimulated research in clinically applied medical anthropology, guided clinical training, sparked controversy in the health social sciences and guided developments in the field of cultural psychiatry. This formulation of explanatory models was conceived both to advance perspectivism in clinical medical practice and public health, and to show how ethnomedical study of sickness and medicine should contribute to cultural anthropology and social analysis. The appeal of the explanatory model framework for clinical training is based on the premise that it is important to examine relationships and consequences of interactions between patients' ideas about their health problems and those of clinicians and professionals who are responsible for their care. Although the clinical interests and applications of illness explanatory models extend to all aspects of medicine, it was mainly experience and interest in psychiatry and

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culture, and their effects on medical practice through consultation liaison, that spurred initial interest and development of the illness explanatory model framework. In bridging the interests of psychiatry, medicine and medical anthropology its influence has been unrivalled.

This chapter examines the concept and underpinnings of the explanatory model framework, its appeal to health professionals and social scientists and its limitations. Because it was defined in very simple terms and applied to so many clinical and social science questions, the idea of illness explanatory models means different things to different people, and various ambiguities and misinterpretations have resulted. Consequently, some psychiatrists, other health professionals and social scientists have been wary of its influence and the possibility of overselling its significance, and we examine the nature of their critiques. The chapter concludes with a discussion of the current role of explanatory models in cultural psychiatry, approaches to studying explanatory models and their influence on the development of cultural epidemiology.

What are illness explanatory models?

The illness explanatory model framework as it is now commonly understood developed in the late 1970s, and it is associated most closely with the influence of Arthur Kleinman and networks in cultural psychiatry, medicine and medical anthropology. Among various accounts in the literature, one that is frequently cited defines the illness explanatory model as 'notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process', (Kleinman, 1980, p. 105). Interest in explanatory models was equally concerned with everyone involved in clinical encounters. At the outset, inasmuch as explanatory models were expected to provide a framework to guide ethnomedical study of societies and health systems, attending to 'the conceptions of sickness held by patients, communities, practitioners, and researchers' was essential (Kleinman, 1977a). As a clinical interest, explanatory models were particularly notable because they acknowledged the significance of patients' points of view as complementary to health professionals' assessments. In that sense, they referred not so much to formal structural or predictive models, but rather to the way people think and speak, as a way of explaining illness (Helman, 2004).

This formulation must be distinguished from other ways the term explanatory model is used, which may refer to the nature of health (and other) problems in general, rather than anchored to specific illness episodes and experiences. Social scientists and empirical researchers in many fields commonly apply the term explanatory model to statistical models, analysis of epidemiological patterns and theoretical propositions about a wide range of phenomena. If we distinguish studies of Kleinman's illness explanatory models from these generic non-illness explanatory model studies, one finds the latter are far more frequent in the medical literature (e.g. 'Crowding and violence on psychiatric wards: explanatory models'; 'A test of two explanatory models of women's responses to battering'; 'Explanatory model to describe school district prevalence rates for mental retardation and learning disabilities'). When we examined 677 Medline references with the term *explanatory model* or *explanatory models* in their title or abstracts in March 2006, we found 181 of these citations were for articles concerned with illness explanatory models, and 62 were concerned with mental-health problems (Table 10.1).

The illness explanatory models of patients, family, doctors and others concerned with health problems and the clinical process did not refer to a professionally elaborated explanatory theory or to research findings derived from empirical study of explanatory variables and outcome measures, even though they might be influenced by them. Instead, these explanatory models were representations of illness, described with reference to a set of cognitive explanations; symptomatic, emotional and social experiences; and to prototypic personal history and associations that collectively characterized the

Table 10.1. Medline illness explanatory model studies and their focus on psychiatric problems over successive 5-year periods

Period	All illness EMs	Mental-health problem EMs	
	N	*N*	Percentage
1976–1980	1		0
1981–1985	14	1	7.1
1986–1990	25	7	28.0
1991–1995	30	12	40.0
1996–2000	50	19	38.0
2001–2005	61	23	37.7
Total	181	62	34.3

illness at a particular point of inquiry. Clinical writing described explanatory models variously as ideas, notions, or beliefs about 'the nature, name, cause, expected course, and desired treatment for an episode' of illness (Kleinman, 1986, p. 84). These notions were responsive to fundamental questions concerning the why, what, and how of illness: 'Why me? Why now? What's wrong? How long will it last? How serious?' (Kleinman, 1988b, p. 156).

Three formulations of illness explanatory model

Efforts to make social-science concepts accessible in a clinically applied medical anthropology, as well as a process of ongoing rethinking of the role of explanatory models in health social science research beyond their clinical interests, have also led to ambiguities. Consequently, the significance and even the nature of explanatory models are understood differently by various authors. One may discern three relatively distinct formulations, each with some interest in both representational and predictive features of explanatory models. In its narrowest sense, the illness explanatory model is concerned primarily or exclusively with an account of the reasons for illness, that is, causal attributions or perceived causes. In that sense, it is less concerned with experience, behaviour or social factors as contexts, unless they are identified as causes. This conceptually scaled-down version of explanatory models may simplify the clinical ethnographic enterprise to a degree that seems simplistic from an anthropological perspective. On the other hand, for clinicians with little interest in engaging in social science research, or even in any kind of research, working with a clear operational definition enhances the appeal of this formulation.

Another view of explanatory models is more comprehensive and aims to be truer to the ethnographic interests that initially motivated interest in a task in clinical ethnography. This broad formulation eschews the idea of an explanatory model concerned solely with perceived causes; they may be an important part, but they are not the whole of an illness explanatory model. Referring to important contributions of Byron Good (1977) to the early development of the concept, Kleinman wrote:

> 'Patient and family EMs often do not possess single referents but represent semantic networks that loosely link a variety of concepts and experiences' (Kleinman, 1980, pp. 106–107, see also p. 108, fig. 4).

The role of a semantic network analysis, rooted in ideas of causal webs and the influence of social networks, was complementary to the interests in cognitive accounts of perceived causes. In the early phase of its development, illness explanatory models were expected to link the clinical process to ethnographic interests, a means of constructing new models for medical anthropology (Kleinman, 1978b), and advancing the interests of ethnomedicine (Fabrega, 1975).

Inasmuch as features of the clinical applications and the nature of the inquiry somewhat resembled the process of exploratory psychotherapy, psychiatrists were especially interested and influential in developing the approach. The explanatory model framework, however, differed markedly from standard psychiatric practice on several counts. In response to the tension between accepting a fixed nosological standard and acknowledging the influence of culture and context, standard psychiatric paradigms were no longer merely authoritative tools for clinical assessment. They also became the objects of study and a process of rethinking that was concerned with the validity and utility of interpretive models of psychoanalysis, phenomenological diagnostic assessment and the biology of mental disease.

The third formulation of the illness explanatory model was concerned with the intricacies and expectations from modelling the interaction of explanatory models of patients and others involved in the clinical process, especially their doctors or other healers. Although this model of the interacting patient and healer models was largely representational, it was also presented with a promise for empirical study that would test its validity based on whether it could predict the course of the clinical process. In that sense, it was comparable to the generic interests of other non-illness explanatory models. In his seminal exposition of the illness explanatory model framework, Kleinman proposed analysing clinical encounters with reference to the explanatory models of patients (EM_p), their family (EM_f), and their doctors (EM_d), each of which might be multiple ($\mathrm{EM}_{p.1,p.2\ldots}$, etc.) (Kleinman, 1980, p. 112, fig. 5). He advocated empirical studies to test hypotheses concerned with how these models interact, especially the premise that congruent models would result in better clinical outcomes, and that incongruent models require negotiation.

Conceptual underpinnings

The priority of the illness explanatory model framework, with its appreciation of the relevance of patients' and healers' points of view and various ways that cultural contexts influence both, was related to important parallel and prior developments. These included Leon Eisenberg's (1977) distinguishing fundamental features of disease and illness that highlighted limitations of exclusively biological and technical approaches to medical practice. The work of George Engel (1977) focused on advancing the biopsychosocial model of psychiatry and medicine, arguing that each perspective alone was inadequate, and together they were complementary. Although Eisenberg and Engel were each responding to identified problems in American medicine, their contributions were also applicable to a dilemma that resulted from a daunting rift between biological reductionist and cultural relativist approaches. Kleinman had identified these as an inescapable feature of anthropological and cross-cultural health studies (Kleinman, 1977a).

Kleinman also regarded the illness explanatory framework as one among a group of contributions to an 'ethnomedical programme'. Like Eisenberg's formulation of disease and illness, the semantic illness network model of Good (1977) was closely related to the interests, substance and tasks of the illness explanatory model framework. Other relevant work included Fabrega's enduring interest in ethnomedicine and ethnomedical models (Fabrega, 1990). These were complementary and shared interests, but each with a distinctly different focus and appeal: explanatory models for bringing anthropology to medicine, and ethnomedicine for bringing medicine to anthropology.

Another important influence was given less attention in the literature on explanatory models than may have been warranted. The ideas and contributions of the so-called emic–etic paradigm have now become so well accepted as a tool for social research that it is difficult to appreciate how controversial they were several decades ago. Kenneth Pike developed this framework acknowledging the insider's and the outsider's perspective for social analysis from experience studying previously unknown languages without a bilingual guide (Pike, 1967; Headland, Pike and Harris, 1990). Drawing on basic linguistic concepts, he developed a paradigm for cultural study and social analysis. From the concept of phoneme and phonemic analysis, referring to the basic unit of meaning within a language, valid with reference to a particular language, came the notion of emic. A phonetic analysis of language, on the other hand, examines basic units of sound with reference to phonological universals, as conceptualized by linguists independent of any particular language. In the disease/illness and explanatory model paradigms of Eisenberg and Kleinman, this perspectivist view was brought into health and medical studies, clinical practice and training. Although the focus on culture at large and on individual patients or individuals may differ, the task of eliciting explanatory models shares a common interest in elaborating an emic account of health problems.

Developing the explanatory model framework

The decade from the late 1970s was an important period in the development and promotion of the illness explanatory model framework. Much of the subsequent literature on the topic has referred to Kleinman's (1980) book, *Patients and Healers in the Context of Culture*, and its paradigmatic questions have guided considerable clinical training and research on the topic (p. 104n). The intellectual landscape, however, had already been diligently paved with a series of publications in key journals of their respective fields that indicated practical approaches for clinical medical anthropology in psychiatry (Kleinman, 1978a) and internal medicine. Theoretical contributions arguing for needed models in medical anthropology (Kleinman, 1978b) and for development of the 'new cross-cultural psychiatry' (Kleinman, 1977b) also referred to explanatory models, but sparingly. The term figured far more prominently in the articles on clinically applied medical anthropology. The relative prominence in usage of the term reflected a balance between the enthusiasm for the utility of explanatory models in clinical settings (Blumhagen, 1981), and modesty for claims of their anticipated contribution to ethnographic field research:

> The explanatory models approach, however inadequate it may be for the ethnographer or novelist, brings meaning, person, family, feeling into the process of clinical judgement, and this opening to the humanness of suffering, in my experience, is often all that is needed to reaffirm for the physician the critical importance of psychological and social issues in a particular case and thereby make him less tolerant of delivering simply a technical 'fix'. (Kleinman, 1981, p. 375)

The journal *Culture, Medicine, and Psychiatry* (*CMP*) was first published in 1977, and this journal provided a forum that established the illness explanatory model framework in cross-cultural psychiatry, social medicine, and medical anthropology. Figure 10.1 presents an analysis of Medline citations for articles concerned with illness explanatory models from a textword search and manual review to exclude articles on non-illness explanatory models. Clinical and social medicine interests in the topic are reflected by a steady increase in Medline citations over the years. In the early 1980s, articles from *CMP* constituted a major fraction, but now there are few. A full text search of the term in all *CMP* journal articles, however, through 2005 shows that attention to explanatory models as a term and concept firmly embedded in the literature remains relatively constant.

Relevance for clinical practice and training

Since the late 1970s, assertions of the value of explanatory models in clinical practice were based on two considerations. They provided a means of bridging cultural differences between patients and clinicians with different backgrounds in multicultural practice settings, and they also provided a means of bridging conceptual differences and promoting empathy and a therapeutic alliance, even when patients and clinicians came from similar cultural backgrounds. This was the argument that initially motivated development of an approach and efforts to promote clinically applied medical anthropology for general medical care (Kleinman, Eisenberg and Good, 1978).

Explanatory models were particularly important for both general psychiatry, where the same considerations for a clinical medical anthropology applied (Kleinman, 1978a), and for cultural psychiatry, which had additional compelling interests in questions of cultural validity, and which had become

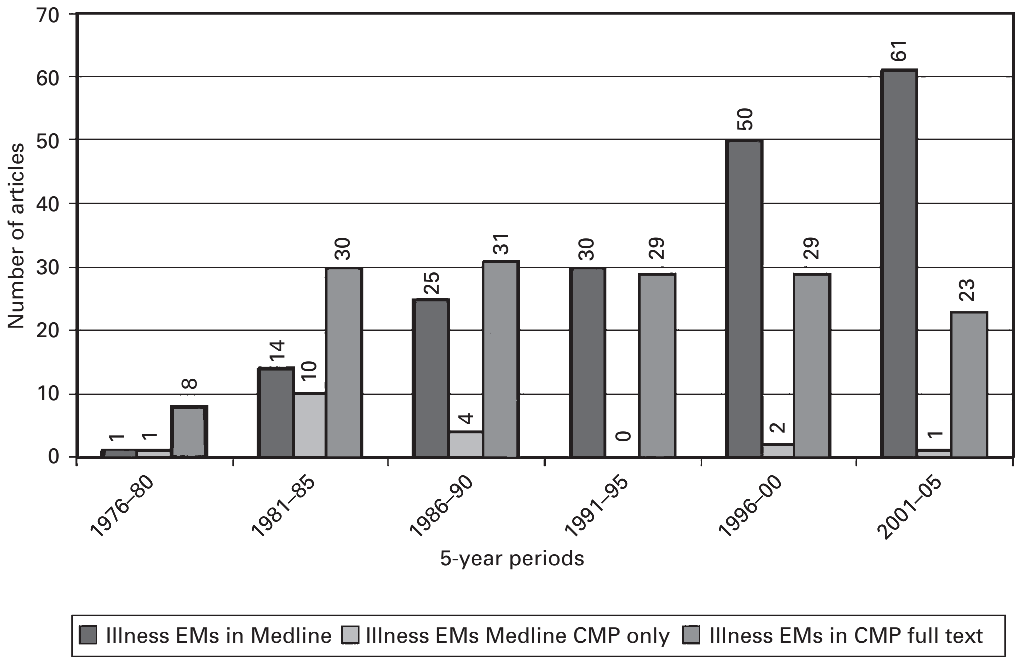

Fig. 10.1. Medline articles on illness explanatory models and use of the term in the text of CMP articles.

sensitive to the potential for the misleading influence of category fallacies. Littlewood (1990) explained that a category fallacy resulted from mistaking professional Western explanatory models of mental illness for universal concepts of psychopathology. He also argued that an anthropologically informed approach to clinical practice served the interests of ethnic minorities; furthermore, attention to explanatory models elevated somewhat crass consideration of insight, which was typically reduced to the question of whether a patient agreed or disagreed with the doctor's views.

Advocacy for clinical attention to explanatory models also reflected concerns about an imbalance overemphasizing biology in the biopsychosocial model. Careful attention to patients' explanatory models, Kleinman had argued, may be regarded as a hallmark of empathy and ethical practice, and clinicians' failure to consider explanatory models of patients and their families could be taken as a mark of disrespect and arrogance (Kleinman, 1988a, p. 122). Such considerations suggested the need to ensure that supervision and training curricula recognize awareness and skill in working with explanatory models as a core clinical task, representing an important contribution of cultural psychiatry to clinical practice (Alarcón *et al.*, 1999).

Recently, an editorial of Bhui and Bhugra (2002) renewed that call. Despite evidence that shared concepts of illness are associated with more satisfied patients (Callan and Littlewood, 1998), clinicians still lack the clinically relevant social science skills to assess and work with illness explanatory models – skills that 'should be of prime importance in clinical psychiatric practice'. At the same time, interests in cultural competence in American medical education, which emphasize the value of working with explanatory models, suggest that such efforts to promote cultural sensitivity should be regarded as a mainstream, rather than marginal, feature of clinical training (Betancourt, 2004). A detailed curriculum with guidelines and examples has been developed for primary care by Carrillo and colleagues (1999). Exploring explanatory models, clarifying their context, and negotiating their implications with patients comprise the content of their module 3: Understanding the meaning of the illness.

The relevance of explanatory model for clinical assessment in psychiatry has been explicitly acknowledged in the outline of the cultural formulation in DSM-IV, Appendix I, and in the American Psychiatric Association's proposed research agenda for DSM-V (Mezzich *et al.*, 1999; GAP, 2002; Alarcón, 2002). The cultural formulation was a product of the advisory group on culture and diagnosis, intended to provide a framework of clinical training that would enhance cultural sensitivity. It has been used for training in cultural psychiatry, and it has also been used as a guideline for case reports published in the psychiatric literature (Lewis-Fernandez, 1996). The outline for the cultural formulation as a guideline for assessment requires elaboration of cultural explanations of the presenting illness. Although the interest of these cultural explanations is broad, the term explanatory model is used in the narrow sense, referring to the patient's 'perceived causes or explanatory models' among the broader features of the cultural explanation.

This section of the DSM-IV refers to another feature of cultural assessment with important historical implications, that of culture-bound syndromes. These also refer to a local configuration of illness, but they are associated with a conceptualization of an illness entity. The illness explanatory model, on the other hand, is concerned mainly with individual explanations of illness episodes, which may conform to a greater or lesser extent with various patterned illness entities – either professional disorders or local culture-bound syndromes – and the particular ways that both of these are related to an individual's experience and interpretation of illness.

Critical assessment

Countering the enthusiasm arising from the potential of explanatory models for bringing the influence of social science into medicine, there were also reservations. From the outset and thereafter, several critiques of the explanatory model framework have questioned its relevance. Although accounts of explanatory models repeatedly emphasize their fluidity, contradictions and shifting content, more akin to 'cognitive maps' (Kleinman, 1988a, p. 122), some authors find the framework too fixed and rigid. Williams and Healy (2001) characterize explanatory models as 'reified and implicitly static', suggesting an alternative formulation of 'exploratory map' to account for patients' definitions of their problems. A second critique is based on concerns that the clinical interests of explanatory models do not adequately account for the influence of social context. A third critique was based on the question of whether too much emphasis on the 'model' in explanatory model, which initially had been very appealing, was still a good idea.

A Marxist critique of medicine and the explanatory model framework developed in the late 1970s, first by Frankenberg (see Thomas, 1978). He argued that interests in the social determinants of health problems and failure to incorporate them adequately in the agenda of explanatory model studies rendered the enterprise inconsequential. Taussig, Frankenberg and Young argued that clinical paradigms were inherently inferior to political economic and social models of health and illness. Alan Young presented this argument in two papers, one in a provocative editorial published in *CMP* (Young, 1981) with eight rejoinders, and the second in an article on the anthropologies of illness and sickness in the *Annual Review of Anthropology* for 1982 (Young, 1982). He asserted that because Kleinman's interest in medical beliefs and practices is essentially clinical, it is inadequate to deal with more essential social priorities. He argued that analysis of the social relations of sickness identified two critical problems with the explanatory model approach: it confuses the class basis of power relationships with a feature of interpersonal relationships, and it fails to define sickness as 'a process for socializing disease and illness.'

Young advocated an alternative to illness explanatory models for studying 'socialized knowledge' of sickness, assessing prototypes and chain complexes. Stern and Kirmayer (2004) demonstrated that all three types of these illness representations – namely, explanatory models, prototypes, and chain complexes – could be assessed and reliably coded.

The problem of models

The appeal and the pitfalls of models for health systems and research were identified already in the first article of the first issue of *CMP*. Eisenberg (1977) pointed out that models were important and useful because they helped to construct reality and to lend meaning to a chaotic world. They are rightly regarded as particularly important for research because they determine the kind of questions we ask, the kind of data we gather, and the ways we analyse and interpret them. He cautioned, however, that 'models are indispensable but hazardous because they can be mistaken for reality itself rather than as but one way of organizing that reality' (p. 18).

Models were also identified with the important academic task of theory building. The use of the term explanatory model in the anthropological literature, before Kleinman introduced the illness explanatory model, referred to a formal theoretical description of a social phenomenon of interest for anthropological study. In that sense the term 'explanatory model' referred to an account that could successfully explain something. Nutini (1965), for example, reflecting on the task of model building wrote, 'Mechanical models constructed out of ideal behaviour, and statistical models based on actual behaviour are the best; they are the "most explanatory" models that we can build.' The various frameworks from and for medical anthropological research were all conceived as ethnomedical models, including products of Fabrega's work suggesting a multi-level schema for ethnomedicine, Eisenberg's disease-illness model, Good's semantic network model, and the explanatory model framework itself. Kleinman made that point in an editorial titled, 'Culture, and illness: a question of models' (Kleinman, 1977).

Before two decades had passed, however, their appeal as a guide to anthropological study had dwindled. It had not yet become clear how efforts to model the explanatory models might be turned into the kind of empirical research envisioned at the outset and then postponed. Kleinman himself appears to have accepted essential features of the Marxist critique of the clinical orientation and interests of explanatory models. Nearly two decades later, with academic interest by then focused more squarely on ethnography, he explained that he no longer respected the 'formalism, specificity, and authorial certainty' of any kind of models, including explanatory models. 'Clinically, the explanatory model approach may continue to be useful, but ethnography has fortunately moved well beyond this early formulation' (Kleinman, 1995, p. 9).

Research on explanatory models

The early promise of the explanatory model framework as a guide to ethnographic studies in medical anthropology and ethnomedicine may remain unfulfilled, but interest in the topic for clinical and cross-cultural research, especially in cultural psychiatry, is strong and growing. The value of acknowledging, comparing and accommodating different notions of illness in a globalizing world and in multicultural societies is difficult to disvalue or ignore. From a Medline search through the year 2005, which identified 181 articles concerned with illness explanatory models, 62 were concerned with psychiatry or mental health. Among single-disease studies, 10 focused exclusively on depression and 7 on schizophrenia; the remainder studied other conditions or a mix of disorders. About half of these articles report empirical data from clinic-based studies (30, 50.8%), and a smaller portion report community studies (12, 19.7%).

A review of this literature identifies several sets of interests, including applied clinical interests, fundamental questions in the field of cultural psychiatry and approaches to studying explanatory models. Brendel (2003) examined theoretical aspects of explanatory models, considering recent relevant work in the fields of ethics and philosophy of science. Other research suggests that consideration of clinician and patient explanatory models contributes to a more sophisticated explanation of insight for patients with schizophrenia (McGorry and McConville, 1999).

Among the clinically orientated publications, authors have been especially prolific on the topic of the cultural formulation. The journal *CMP* has a special section devoted to these case studies, and they are also published elsewhere, as much a feature of cultural psychiatry as case reports are in the general medical literature. Several studies indicate the utility of explanatory models in providing culturally sensitive care to immigrant patients (Daley, 2005; Bennegadi, 1996). Bhui and colleagues (2002) questioned whether the nature of patients' perceived causes of common mental disorders affected the likelihood of Punjabi and ethnic English patients in Britain receiving a diagnosis in primary care. Other clinical interests consider how to use information about illness explanatory models effectively in the course of psychotherapy. Anxiety attributed to a violent death in a previous life became the focus of therapy for a Druze patient in a case reported by Daie and colleagues (1992).

A focus of research that closely follows from historical interests in the field considers not only patients' explanatory models, but also those of clinicians and health workers. The negotiation of professional and patient ideas about problems like eating disorders, which are often contested conditions, becomes especially important (Swartz, 1987). Addressing different priorities, a study in South India noted that mental-health case workers had ideas about psychotic problems that diverged markedly from professional concepts (Joel *et al.*, 2003). Sensitizing clinicians to the likely differences in concepts of mental-health problems between them and their patients has been recommended as a way to enhance the sensitivity of case finding among ethnic Chinese (Chan and Parker, 2004) and in Africa (Aidoo and Harpham, 2001). Based on experience in Goa and Harare, Patel (1995) suggests that emic research instruments are needed not only for culturally valid case identification (Rodrigues *et al.*, 2003), but also for epidemiological studies. Research on depression in Bangalore, India, also considered the cultural validity of depression, anxiety and somatoform disorders by examining the relationship between emic concepts and professional diagnoses (Weiss *et al.*, 1995).

Practical questions of behaviour concerned with the influence of explanatory models on patterns of help seeking have remained matters of interest for planning community mental-health services. Research has examined the influence of such ideas about illness on help seeking in child psychiatry clinics in Hong Kong (Ho and Luk, 1997), for panic disorders in Lesotho (Hollifield *et al.*, 1990), and among various ethnic groups in Britain (Sheikh and Furnham, 2000). Several studies also indicate the value of examining the effects of illness explanatory models on adherence to treatment for various psychiatric and medical conditions (Weiss *et al.*, 1992; Wong *et al.*, 1999).

Explanatory-model studies have been applied to elaborate the cultural context and meaning of various mental disorders, including schizophrenia (Larsen, 2004; Niehaus *et al.*, 2004), depression among elderly Koreans (Pang, 1998), other psychiatric conditions, and acquisition of a non-specific identity as a psychiatric patient (Sayre, 2000). With reference to cultural and historical context, studies have also considered how current experience and meaning of psychiatric disorders in India relates to classical humoral concepts and medical traditions of Ayurveda (Weiss *et al.*, 1986). Lee's (1995) research on anorexia suggests that efforts to associate that condition with Western explanatory models may result in a category fallacy. He argues that the disorder is fundamentally determined by cultural influences and may lack a core psychopathology.

Research has also used the framework of explanatory models for various cross-cultural comparisons. These include ideas about mental distress (Eisenbruch, 1990), schizophrenia in four cultural groups (McCabe and Priebe, 2004), and ideas about substance misuse among German and Turkish youth in Germany (Penka *et al.*, 2003). Focused studies on determinants of undesirable outcomes have considered the role of explanatory models in a study of use of traditional healers for obsessive-compulsive disorder and Tourette's syndrome in Bali (Lemelson, 2004). Ethnographic data from interviews with participants of an internet community with a 'pro-anorexia' anti-treatment agenda consider their underlying explanatory models, showing how they diverge from the views of health professionals and others who regard anorexia nervosa as a dangerous disorder (Fox, Ward and O'Rourke, 2005).

Studying explanatory models and directions for research

Despite inconsistencies in the way that it is understood, the diverse interests of explanatory model research briefly reviewed above suggest that illness explanatory models are likely to remain an important interest of cultural psychiatry. These studies have developed in various ways, and with reference to broad, narrow and intermediate formulations of the concept of illness explanatory model. They have also used various research methods. Some studies elicit explanatory models with open-ended questions in the style of a clinical interview. Some investigators refer to the eight questions Kleinman suggested in *Patients and Healers* (1980, p. 106n) as a guide, or include some modification (Aidoo and Harpham, 2001). More open-ended assessment may also rely on motivating illness narratives from which qualitative analysis extracts explanatory models. The illness narrative technique is especially useful for elaborating detail and context (Kleinman, 1988a), but may present problems for working with variables suitable for specific comparisons and testing hypotheses. In practice, to specify the explanatory models or other conceptualizations derived from the narrative, an approach to coding is required (Stern and Kirmayer, 2004).

Efforts to construct a brief, semi-structured interview to elicit illness explanatory models efficiently led to the development of the Short Explanatory Model Interview (SEMI) by Lloyd and colleagues (1998). Constructed in the style of a psychiatric epidemiological assessment, it inquired about the essential features of the illness explanatory model of patients in primary care, consistent with the accounts of Kleinman, interests of illness narratives and a formulation embodied in earlier explanatory-model interviews (Weiss 1997, 2001). The SEMI was field tested with a sample of three ethnic groups in London and in Harare. In both studies, patients with suspected common mental disorders were asked about their presenting problems, and in the London sample patients were also asked to comment on two vignettes depicting symptoms of depression and somatization. Subsequent research has also used the SEMI to study explanatory models of psychosis among mental-health workers (Joel *et al.*, 2003) and patients representing four ethnic groups (McCabe and Priebe, 2004).

Earlier explanatory model interviews, known collectively as Explanatory Model Interview Catalogue (EMIC interviews) (Weiss 1997, 2001), were initially developed in Mumbai and Bangalore with separate versions for study of patients with leprosy (Weiss *et al.*, 1992) and psychiatric disorders in outpatient clinics (Weiss *et al.*, 1995). Conceived as an approach for systematically studying a broad formulation of explanatory models for different health problems in different settings (clinics and communities), there is no single definitive EMIC interview, but rather a family of instruments, each constructed with reference to a common framework, and an adaptation constructed to accommodate questions motivating a particular research study. The term EMIC was initially conceived both to designate the local, i.e. *emic*, perspective and as an acronym for explanatory-model interview catalogue. These interviews remain interested in the local *emic* account of illness. The distribution of categories, informed by complementary qualitative data, constitutes a cultural epidemiology of representations of illness that collectively may be regarded as an emic account or an explanatory model suitable for empirical study.

Each EMIC interview is associated with a particular study and locally adapted. Their structure typically includes sections concerned with illness-related experience, meaning, and behaviour, formulated in open-ended and category-specific probing questions that inquire about patterns of distress, perceived causes, and help-seeking and risk-related behaviour. The coding is designed to facilitate comparisons, and analysis of the relationship between features of illness explanatory models and outcomes of practical clinical interest or public-health significance. The data sets typically include category codes and illness narratives linked to questions of the interview, so that the structure may facilitate integrated analysis of quantitative and qualitative components of a data set, aided by use of appropriate software.

Conclusions

The concept of illness explanatory models developed by Arthur Kleinman arose during a fertile period in the development of clinically applied medical anthropology, and it remains a useful approach for bridging the interests and experience of clinicians and their patients. Although broadly conceived, especially at the outset, as a framework for advancing cultural psychiatry, enhancing cultural sensitivity and psychosocial interests of clinical practice, and contributing to the development of ethnomedical studies, it has become less appealing as a framework for ethnography because the clinical orientation of explanatory models did not fulfil initial promise as a guide for social analysis. Subsequent advances in medical anthropology have not been particularly concerned with backward compatibility in that regard. Nevertheless, the concept of explanatory models has been firmly established in the lexicon of culture, health and illness studies and remains highly valued for eliciting a perspectivist account of illness. Attention to explanatory models remains as much a priority as ever, because working with them enhances empathy, respect and a therapeutic alliance.

Although attention to explanatory models remains well justified for inclusion in psychiatric and medical curricula, questions about the significance and implications of findings from explanatory model studies remain. How well do explanatory models predict behaviour? What particular features of explanatory models are most important in that regard? How do explanatory models relate to other sociocultural features of health and health problems, such as stigma and gender? In addition to enduring clinical interests, these are the questions that should motivate further study of explanatory models.

Concern about promoting technological fixes and an exclusively biological approach to essential features of health policy and clinical practice that are essentially social and cultural remains salient. Health social-science research, especially cultural epidemiology, and culturally sensitive clinical practice and training continue to benefit from a formulation of illness explanatory models that suits their use, and more so when their study is complemented by attention to political, economic and social forces that influence health and illness.

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Culture-bound syndromes: a re-evaluation

Dinesh Bhugra, Athula Sumathipala and Sisira Siribaddana

EDITORS' INTRODUCTION

For over a century, cultures in traditional societies were seen as providing exotic and esoteric clinical conditions, which were not 'seen' in other cultures. The history of clinical anthropology followed two different routes in Western Europe and North America. By and large in the colonial times the anthropologists studied the ruled populations, whereas in North America the focus was on native and aboriginal groups. As a result, the clinicians who went to work in the colonies decided that certain conditions occurred only as a result of civilizations and that the colonialized people could possible not suffer from these. On the other hand, conditions were seen 'exclusively' in certain ethnic groups and were a result of under development of the brain and the behaviour was uncivilized. Amok, seen in the Malay archipelago, was criminalized by the British. Consequently, a previously acceptable social behaviour was criminal behaviour and all those who suffered from it were sent to prison. There is clear evidence that a similar response is seen in other cultures but not seen as criminal.

Using amok among other so-called culture-bound syndromes, Bhugra and colleagues set the scene on the development of the concept of culture-bound syndromes. They argue that all psychiatric syndromes are affected by culture and are within this boundedness. Running amok in the Far East is no different from individuals taking guns and shooting randomly and indiscriminately at school children. Latah has similar hyperstartle response in other cultures. Dhat or semen-loss anxiety as seen in culture-bound manner in the Indian subcontinent has been historically reported in so-called developed countries. Using historical accounts, the authors argue that, in North America, cornflakes and crackers were invented and marketed as a treatment for masturbation in the 19th century. These anxieties are related to prevalent social and economic factors and should be seen as studies in that particular context. They suggest that the term 'culture-bound syndromes' as it stands should be abandoned.

Introduction

The role of culture in affecting the idioms of distress and how these are expressed where help is sought and who provides the help and how resources are allocated is well known and described. The development of cultural psychiatry historically is discussed elsewhere in this volume (see Chapter 41). However, the historical aspects were also very strongly influenced by the research interests and movement of anthropologists from the West (Europe and, to a lesser extent, America) to the rest of the world. The British anthropologists followed the path of the imperial and colonial conquerors. This influenced the coming of age of not only anthropology but also psychiatry, of which social psychiatry gradually gave way to cultural psychiatry. As a consequence of imperialism and colonialism, indigenous methods of medicine were suppressed in large parts of the world. In addition, 'new' clinical diagnoses and categories were created and imposed on the ruled population. Thus, distress which may have been expressed in social idioms became medicalised and new syndromes were created.

The so-called culture-bound syndromes (CBS) have been described under a broad rubric which

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highlights the exotic nature of the symptoms. Whereas Littlewood and Lipsedge (1985) refer to these as episodic and dramatic reactions specific to a particular community and as locally defined discrete patterns of behaviour, Hughes (1996) sees these as unique and distinctive but in those who are seen as 'the others' (i.e. those individuals who form a group which is outside the main group, immaterial of how it is defined). Murphy (1977) and Haldipur (1980) indicate that the inclusion of these syndromes in cultural psychiatry is a reflection of their Euro-centric heritage where these syndromes have been institutionalised in the classificatory systems. As Hughes (1996) points out, phenomenologists must go beyond the semantic difficulties of using what is called 'label-grip', i.e. the paralysis of analytic acumen created by (perceived) powerful labels of culture-bound syndrome. Historical analysis of such symptoms therefore becomes of great interest so that one begins to understand and identify when these symptoms became pathologised and medicalised. The generic differences between the culture-bound syndromes and non-culture-bound syndromes have to be explored.

In this chapter we aim to evaluate the status of culture-bound syndrome in modern-day clinical practice by studying the historical development of three well-known culture-bound syndromes in detail. These are *dhat* (semen-loss anxiety), *amok* and *latah*. Although we aim to touch upon other culture-bound syndromes, our contention remains that time has come to abandon these concepts and we propose to discuss our reasons for this in the concluding part of this chapter.

Definitions

Culture-bound syndromes were defined as rare, exotic with unpredictable and chaotic behaviours at their core with those experiencing these seen as uncivilised (Bhugra and Jacob 1977). These authors further suggest that these behaviours were placed in the context of Western diagnostic systems without any cultural links between environmental stressors and social environment and consequently symptoms often tolerated and accepted in the social–cultural context became medicalised. In some conditions legal proscriptions were the first step before medicalisation.

Hughes and Wintrob (1995) argue for a contextual (and by implication socio-cultural) frame of reference for understanding clinical significance of these conditions. Yap (1962) suggested that the variety of terms used to describe these conditions be replaced by a typical culture-bound psychogenic pychoses, which he subsequently shortened to culture-bound syndromes (Yap, 1969). For over a century, culture-bound syndromes were seen as occurring in the exotic East, but recently Western culture-bound syndromes such as bulimia, shoplifting and Type A behaviour patterns have been ascribed by Littlewood (1996) and Hughes (1996). Hughes (1996) indicates that Type A personality trait is linked with patient's perceptions of chronically struggling against time and resulting frustrations contributing to failure to achieve goals, leading to aggressiveness and impatience in interpersonal relationships, perhaps as a result of thwarted ambition. However, this type of behaviour pattern may be a result of egocentric or individualistic societies. As Hofstede (1980, 1984) highlights, cultures can be broadly divided into individualistic (egocentric) or collectivist (sociocentric), within which individuals too can be egocentric (idiocentric) or sociocentric (allocentric). The individualist cultures focus on I-ness, where kinship links are weaker and the individual may or may not focus on immediate (nuclear) family. Studies have demonstrated that, with increasing Gross National Product (GNP), rates of divorce and crime go up. In collectivist cultures, kinship forms the basis of identity and relationships with group solidarity and sharing of material and non material resources. Individuals in certain settings may behave in a collective fashion even if they are in individualistic societies, but the important fact remains that more often than not they will behave like the society they were brought up in (Bhugra, 2005).

Society and illness

The importance of this distinction into sociocentric and egocentric (or collectivist and individualistic) societies and individuals is embedded in differential rates of common mental disorders in these populations and crime figures as well (Maercker, 2001). This also indicates that societies with different economic, social and political structures will have differential rates of crime, disorder and pathways into care.

As noted above, and often equated with ethnic psychoses (Devereux, 1956) and hysterical psychoses (Yap, 1969), culture-bound syndromes are unclassifiable and exotic according to Arieti and Meth (1959). This range of names and characteristics indicate that the nosology of these syndromes has been problematic from their very genesis. The usage of the suffix 'bound' to illustrate the boundedness of these symptoms to individual cultures is both its problem and the perceived solution. It is fairly clear that underlying pathology of most of these syndromes is not confined to one culture, and by stating that these are culture-bound to indicate their boundaries defined by cultures leads to a possible confusion across cultures. Mezzich *et al.* (1996) suggest that an anthropological framework in reaching diagnoses therefore became important.

Hughes (1985) notes that labels of atypical psychoses and exotic syndromes imply deviance from a standard diagnostic base, and this abnormality (in the eyes of one group) and normality (in the eyes of culture within which it generates) indicates the underlying conflict. Exotic becomes foreign, exciting, deviant and different, thereby confirming the diagnosis in 'the other'. The patient who is already 'the other' in relationship to the clinician and the diagnostician thus has another layer of otherness conferred upon them, making it difficult to place the diagnosis in the true cultural context. It is useful to reiterate that diagnosis of psychiatric condition is not only Euro-centric but also androcentric and anthropocentric.

Both the major diagnostic classificatory systems of ICD-10 (WHO, 1992) and DSM-IV (APA, 1994) have been amended to incorporate culture as a factor in the diagnosis and these diagnostic formulations are explicitly committed to taking a theoretically neutral position regarding aetiological factors and an explicitly descriptive approach regarding symptoms and will confound reliability of diagnosis (Hughes, 1985).

Varieties of culture-bound syndromes

A large number of culture-bound syndromes have been identified and interested readers are referred to Simons and Hughes (1985).

In this chapter, three main syndromes are discussed to illustrate, firstly, that most of the symptoms also appear in other cultures and are not confined to a single culture. Secondly, we report that the prevalence of similar symptoms varies according to economic factors and perhaps social evolution.

Dhat or semen-loss anxiety syndrome: derived from the Sanskrit word *dhatu* (metal) and referring to constituent parts of the body, *dhat* is colloquially expressed as a synonym for semen. Wig (1960) described the *dhat* syndrome as consisting of vague somatic symptoms of fatigue, weakness, anxiety, loss of appetite, guilt and symptoms of sexual dysfunction attributable to loss of semen following nocturnal emissions or masturbation or loss through urine.

Indian historical texts describe the symptoms of semen-loss anxiety. In Ayurvedic texts dating from between 5000 BC and the seventh century, the process of semen production was described as '. . . food converts to blood which converts to flesh which converts to marrow and the marrow is ultimately converted to semen. It is said that it takes 40 days for 40 drops of food to be converted to one drop of blood and 40 drops of blood to one drop of flesh and so on' (Bhugra and Buchanan 1989). Thus historical information influences the individual psyche and knowledge, and semen starts to take on a precious importance. These ideas then compound the degree of weakness experienced by the individual and the physical symptoms of anxiety and depression then give rise to physical symptoms which present as somatic symptoms. These notions of semen loss and resulting weakness associated with anxiety and depression is seen across the Indian subcontinent. This perceived weakness is so dominating that the vaids and hakims advertise their fares and clinic timings on walls, landscapings, cable TV and newspapers.

In an intriguing study from Chandigash in North India, Malhotra and Wig (1975) studied 175 individuals aged 30–50 in the community and, using a case vignette, explored the public perceptions of semen loss, its aetiology and potential management. The variety of reasons and management strategies given were associated with social class of the respondents. One-third of respondents did not favour any interventions at all, whereas social-class IV respondents were more likely than any other group to see nocturnal emission as abnormal and least likely to see psychological persuasion as a mode of treatment. Diet and marriage were seen as potential management strategies, along with avoiding bad company, masturbation and access to exotic literature. The authors called the *dhat* syndrome a sex neurosis of the Orient and concluded that susceptible individuals react to the belief system of semen loss. This seeking of medical interventions and doctors or quacks providing intervention thus confirms the underlying or resulting physical complaints.

A majority of the rest of the studies from the Indian subcontinent relate to clinical populations. In these studies, the syndrome is often described and diagnosed as a separate entity and many authors do not give the associated psychiatric diagnosis. Thus sometimes the syndrome is seen and recognised as a culture-bound syndrome. Our contention is that this approach reflects a historical anomaly and looking at some of the detailed data it would appear that:

(a) the syndrome is accompanied by easily and clinically recognisable common mental disorders; and
(b) its descriptions abound in other cultures (European and Western) as well.

Chadda and Ahuja (1990) studied 52 patients who had volunteered passage of dhat in the urine as their presenting complaint in the clinic and 80% were said to have accompanying hypochondriacal symptoms, although these clinical descriptions do not make clear whether the diagnosis of hypochondriasis was made by patients or clinicians or what specific criteria were used to define such hypochondriasis. Interestingly, they report that seven patients (who did not have hypochondriasis) had ‘pure’ *dhat* syndrome. Our contention is that it is possible that this preoccupation with *dhat* itself is a hypochondriacal preoccupation. Bhatia and Malik (1991) in another study from the same centre in North India reported that of 144 consecutive patients attending a sexual dysfunction clinic, 93 presented with passing *dhat*. On assessing these 93 cases using Hamilton rating scales and ICD-9 diagnostic categories, a significant number had one or more somatic symptoms of which physical weakness was the commonest. One-third reported sexual problems and half scored above 7 on Hamilton scale for depression. Nearly one-third received no psychiatric diagnosis. These authors report ‘pure’ *dhat* syndrome in a much larger proportion in 60 (41.7%) patients yet these included patients (Table 11.1).

Using a case control design study, Chadha (1995) compared those presenting with *dhat* with controls who had neurotic disorders. He defined *dhat* in the urine as *dhat* syndrome although not all sufferers from the *dhat* syndrome acknowledge this. Nearly half were reported to have depressive disorder, 18% had anxiety disorder and 32% had somatoform disorders – the figures for controls were 54%, 30% and 16%, respectively, which reflect the source of data collection for the controls. However, the validity of diagnosis and associated psychiatric diagnosis can be questioned. Similar findings of depression in 52% and 16% having anxiety disorders had been previously reported in 1985 by Singh from another part of North India.

De Silva and Dissanayake (1989) from Sri Lanka observed that, in their cohort of 38 cases recruited from a sexual dysfunction clinic, various

Table 11.1. Findings of studies conducted in clinical settings

							Mode of loss (one or more)					
Study	Setting	No.	Inclusion criteria	Presenting symptom	Attributes to semen loss	Duration of semen loss	in sleep	with urine	masturbation	sex heter.	sex homo.	other
Behere & Natraj (1984)	Psychiatric out-patient clinic at Psychiatry Dept. Institute of Med. Sci. India	50	Consecutive referrals. Main complaint of *dhat* discharge	Associated symptoms: impotence, marital probs. premature ejaculation, weakness, others??	No, this was the presenting symptom itself	Less than 3 months to more than 1 year.	? yes unclear	? yes unclear	? unclear as given it a cause	? unclear		
Singh, 1985	Psychiatric out-patient clinic, Ptia. India	50	Consecutive patients of male potency disorder and complaint of *dhat* ($N = 30$)	Primary complaint of loss of semen but accompanied by mental and physical symptoms	Unclear. No reference attribution.	Not reported	no? NR?	yes	no? NR?	no? NR?	no? NR?	No NR?
De Silva & Dissanayeke (1989) Descriptive Study	Referrals to a University psychiatric clinic in Sri Lanka	38	Clear – See the next column. They belonged to four different clinical presentations	Four different groups: (1) Excessive loss of semen (2) Specific sexual dysfunction (3) Anxiety about present or future sexual function (4) Multiple phys/psych. symptoms	The presenting complaint. Yes Yes Yes	6 months – 20 years	Yes*	Yes	Yes*	Yes	Yes*	Yes
Chadda & Ahuja (1990) Descriptive Study	University psychiatric clinic in India/Delhi	52	Passage of *dhat* in urine was presenting feature but has elicited somatic symptoms		Yes (all)	1–12 months			Yes*	Yes*	Yes	Yes

* indicated seen in majority/common NR-not reported.

explanations of semen loss were offered. These included excessive loss of semen or associated sexual or physical dysfunction and the accompanying belief that loss of semen was harmful. A majority of individuals reported continuing loss of semen and the duration varied from 6 months to 20 years. More than 50% were found to have somatic symptoms. More than half (53%) received diagnosis of anxiety, 40% of hypochondriasis and 5% stress reaction. The sample size is small but it indicates the presence of psychological and somatic symptoms to be significant.

Deveraja and Sasaki (1991) also collected data from the same clinic in Sri Lanka and, from 35 patients attributing their symptoms to loss of semen, 50% had somatic symptoms and 35% sexual deficiencies. They attempted to replicate the findings in Japan but were not able to do so. They also conducted a survey of beliefs of undergraduates in Sri Lanka and Japan. Using an 18-item questionnaire, they found that Sri Lankan students were more likely to believe in semen loss.

In China

In China, texts suggest that women have the ability to steal vital fluid from men and this loss of semen can lead to disease (Bottero, 1991). Weakness in the Chinese people connotes loss of vital energy (*qu*) and excessive loss of semen through sexual intercourse or masturbation creates anxiety because semen is said to contain *jing* (the essence of *qu*) which, when lost, produces weakness (Kleinman, 1988). Yap (1965) posits that a healthy exchange of *yin* and *yang* in sexual intercourse maintains a balance. Following masturbation, nocturnal emission or homosexual intercourse, *yang* may be lost but without corresponding gain of *yin*, and the resulting imbalance therefore leads to disease. This has been associated with epidemics of *Koro* (another so-called culture-bound syndrome where the individual holds the belief that the penis is shrinking into the body and disappearing) (Yap 1965, Rin, 1966, Tseng *et al.* 1988).

The Taoist techniques in ancient China held that seminal essence was located in the lower part of the male abdomen, and the purpose is to increase the amount of life-giving seminal essence (*ching*) by sexual stimulus while at the same time avoiding possible loss (Bullough 1976). It was essential that the woman reach orgasm in intercourse so that the man would receive her *yin* essence; the more *yin* essence he himself received without giving out his precious male substance, the greater his strength will grow and this could be achieved through coitus reservatus – keeping the penis in the vagina but avoiding orgasm. Another technique was to practise *huan ching pu nao* (making the *ching* return to nourish the brain), suggesting that this method and positive thinking would lead to seminal essence to ascend and rejuvenate parts of the body. Masturbation for men was seen as leading to a loss of vital essence. Manipulation of genitals without orgasm was encouraged, but involuntary emissions were viewed with concern; caused by fox spirits, these led to weakness in men.

Views on semen loss in the West

From the times of Hippocrates and Aristotle, semen has been considered extremely important for the healthy functioning of the individual. Although Greeks in ancient times saw masturbation as a natural substitute for men lacking opportunity for sexual intercourse, they also believed that the semen supplied the form and the female supplied the matter fit for shaping. Galen, following the example of Aristotle, stated:

> Certain people have an abundant warm sperm which incessantly arouses the need of excretion: however, after its expulsion, people who are in this state experience a languor at the stomach orifice, exhaustion, weakness, and dryness of the whole body. They become thin, their eyes grow shallow ... (Hawkins, 1963) (See Galen, 1963 reprint)

– a description not too dissimilar from that of the modern *dhat* syndrome (Table 11.2).

Table 11.2. Time line of the historical perspective and development of beliefs related to 'semen loss'

Person	Period	Comments
Agnivasa	?1500BC?	Charaka Samhita – *An Indian Treatise on Medicine*
Susruta	?	Susruta Samhita – *An Indian Treatise on Surgery* (the traditional Ayurvedic knowledge of the above two named teachers was systematised and edited in these two texts between 600BC and AD1000 – *samhita* means 'collection'). Semen is the most concentrated, perfect and powerful bodily substance. Its preservation guarantees health and longevity.
Hippocrates	?460–377BC	*Diseases II*: Semen supplies the form to the human body
Aristotle	384–322BC	'Sperms are the excretion of our food, or to put it more clearly, as the most perfect component of our food'
Celsus	AD50	'It results in death due to consumption'
Galen	AD130–201	Involuntary loss was termed as 'gonorrhoea' – it robs the body of its vital breath; 'losing sperm amounts to losing the vital spirits'; exhaustion, weakness, dryness of the whole body, thinness, eyes growing hollow, are the resulting symptoms
Giovanni Sirubaldi	1642	Added gout as caused by semen loss (in *Geneanthropeia*, Europe's first textbook on sexuality)
Jean-Etienne Dominique Esquirol	1772–1840	'One of the most common cases of melancholia and dementia and also commonly suicide'
Andrew Tissot	1728–1797	'Losing one ounce of sperm is more debilitating than losing forty ounces of blood' in *Treatise on the Diseases Produced by Onanism*. His basic tenet was that debility, disease and death are the outcome of semen loss
Henry Maudsley	1835–1918	Semen loss, especially if it occurs through masturbation, results in serious mental illness
George Beard	1839–1883	'One of the commonest explanations of neurasthenia is wastage of sexual energy, often in the form of nocturnal emissions (involuntary emissions)'
Sigmund Freud	1856–1939	'Neurasthenia in males is acquired at puberty and becomes manifest in the patient's twenties. Its source is masturbation, the frequency of which runs completely parallel is that of male neurasthenia'. Freud opposes Steckel's view that semen loss has no pernicious effect on brain functioning
The Lancet (articles and editorials by George Dangerfield and W. H. Ranking)	1840–1843	'On physical disability, mental impairment and moral degeneration caused by seminal loss' 'The symptoms, pathology, causes and treatment of spermatorrhoea'

Predating the Christian era, Jewish writers also acknowledged that deposit of semen anywhere else other than in the vagina was unacceptable. The male then had to become ritually pure after such emission and a short period of continence was normally required.

Masturbation was regarded as a crime deserving the death penalty according to one Talmudic writer. A fear of loss of semen was well known, but why this loss of semen was so feared is not entirely clear (Bullough, 1976). Bullough hypothesises that a loss may imply the failure of the male's duty to procreate and replenish the earth. It is, of course, possible that unexpected or inappropriate loss of semen may lead to reduction of the tribe, thereby making it vulnerable to other factors.

In Western European cultures masturbation was often prohibited on religious grounds. Even nocturnal emissions were seen as a sin and it required three nights of an hour-long standing vigil, provided the sinner had been given an adequate diet of beer and meat. If he had been on a rigid diet, the sinner was required to sing 28 or 30 psalms or to undertake extra work. Apparently, it was assumed that a person who has been fasting would have less control over his bodily processes, hence involuntary nocturnal emissions in these individuals were less serious.

The attitudes to non-heterosexual behaviour and loss of semen varied in the Middle Ages (see Bullough, 1976 for a further discussion). However, for our purposes, Tissot's writings in the eighteenth century provide an interesting overview (Tissot, 1764, reprinted 1974). He believed that, even with an adequate diet, the body could waste away through diarrhoea, blood loss and seminal emission. Semen caused the beard to grow and muscles to thicken, hence involuntary loss weakened the male. Frequent intercourse was dangerous in itself but the most dangerous loss of semen occurred when the individual lost it through unnatural means – the most debilitating through masturbation. Such waste of semen could lead to cloudiness of ideas and madness, decay of bodily powers, acute pains in the head, pimples on the face, eventual weakness of the power of generation (as indicated by impotence, premature ejaculation, gonorrhoea, priapism and tumours of the bladder) and disordering of the intestines. This is again not dissimilar to the symptoms and concerns of the patients who present with *dhat*. Tissot gave scientific credibility to the Western hostility to sex. The similarities between the then prevalent hostility to sex in the West and current hostility to sex in the Orient are uncanny. From being a sex-positive society, Hindu culture has become obsessed with procreation and the main purpose of sex is procreation rather than pleasure. The emerging middle classes of the eighteenth century in the West embraced Tissot's ideas with great enthusiasm, and sexual purity became a way of distinguishing themselves from the sexual promiscuity of the noble and the lower classes. Tissot (1764, reprinted 1974) led the Western world into an age of masturbatory or shall we say *dhat* insanity.

Though Tissot's work did not reach the USA until 1832, his influence was apparent in the writings of Benjamin Rush – father of American psychiatry. Rush believed that all diseases could be caused by debility of the nervous system and propounded that careless indulgence in sex would lead to seminal weakness, impotence, dysuria, tabes dorsalis, pulmonary consumption, dyspepsia, dimness of sight, vertigo, epilepsy, hypochondriasis, loss of memory, myalagia, fatuity and death (Rush, 1812).

Graham advocated graham flour (unbolted wheat) and graham cracker as a cure for debility, skin and lung disease, headaches, nervousness and weakness of the brain – much of which resulted from sexual excess. Graham (1834) blamed orgasm on the abuse or misuse of sexual organs. Over-indulgence in sex caused languor, lassitude, muscular relaxation, general debility and heaviness, depression of spirits, loss of appetite, indigestion, faintness and a sinking feeling in the pit of the stomach, increased susceptibility of skin and lungs, feebleness of circulation, chilliness, headache, melancholy, hypochondria, hysterics, feebleness of senses, impaired vision, loss of memory, epilepsy, insanity, apoplexy, etc. Like the Hindu perceptions, Graham believed that the loss of an ounce of semen was equivalent to the loss of several ounces of blood, with the result that every time a man ejaculated he lowered his life force and exposed his system to diseases. These attitudes are not dissimilar to attitudes held by patients presenting with *dhat* syndrome.

In France, Lallemand (1839) also was concerned with involuntary loss of male semen, which would lead to insanity. Acton, an English physician, also encouraged men to engage in sex infrequently so that they would not lose their energy through prolonged sexual activity. He maintained that the worst kind of seminal emission was masturbation (Acton, 1871).

Kellogg (of the breakfast cereal fame) (1882) believed that the nervous shock accompanying the exercise of the sexual organs was the most profound to which the nervous system was subject, and produced a long list of symptoms including physical and psychological – ‘the dangers were terrible to behold, senile genital excitement produced intense congestion and led to cultural irritation, priapism, piles and prolapsus of rectum, atrophy of the testes, varicocoele, nocturnal emissions and general exhaustion’. His cereals were developed as a panacea for treating masturbation. Every loss of semen was regarded as equivalent to the loss of four ounces of blood and, although the body could eventually replace the loss, it took time for it to recuperate (Hunter, 1900).

In the 1840s, articles on the involuntary discharge of seminal fluid dominated *The Lancet*. Dangerfield (1843) suggested that, as a result of involuntary discharge,

> the patient complains of weakness, restlessness and listlessness, his manners are shy and nervous with a remarkable timidity and indisposition to answer questions, his complexion is generally pale, slightly emaciated, gradually loses memory, has dull pain, and feeling of weakness especially in the lower extremities, along with fatigue. On further investigations, the physician will find that he has been afflicted for some time with seminal emissions during sleep accompanied by libidinous dreams.

In a comprehensive review, Darby (2001) suggests that male circumcision was advocated as a cure for spermatorrhoea (as well as masturbation) and this was the testing ground on which regular medical practitioners sought to establish their credentials and to demarcate themselves from quacks (!). He argues that William Acton in Britain and George Beaney in Australia were representatives of the battle for professional turf and the medical right to manage all the functions of the body. Unfortunately for the regular doctors, until circumcision became an option, the treatments they offered differed little from those of their rivals. Walker (1985, 1987, 1994) points out that nineteenth-century medical orthodoxy held that any seminal loss weakened the system. In Australia they followed the line of the colonialists, who in turn were pushing for various treatments for semen loss. Darby (2001) cautions that it is not possible to draw a hard and fast line between regular doctors and quacks – the former exhibited plenty of evidence of ignorant faddism and eccentricity, while the latter frequently offered more humane and less damaging treatments. Beaney graduated from Edinburgh and settled in Melbourne in 1857; he published extensively on the damaging effects of spermatorrhoea, suggesting that semen was more precious than blood and that treatments for spermatorrhoea were effective if victims avoided the quacks. Spermatorrhoea was defined as an abnormal emission of the seminal fluid, and that of all the diseases to which man is liable, there are few others which induce so much mental anxiety as this; it embitters all the victim’s (sic) social relations and subjects him to the harrowing reflection that he is the object of the taunts and jeers of those about him (Beaney, 1870).

Masturbation was both a specific form of spermatorrhoea and its cause, which then ruined the nervous equilibrium of their sexual system. The consequences of masturbation and spermatorrhoea included inflammation of the urethra, bladder irritation, disturbed sleep, erotic dreams, confusion of mind, vertigo, wakefulness, depression, tuberculosis, epilepsy and impotence. Darby (2001) suggests that Beaney’s views are religious tub-thumping and not scientific. However, it is possible that Beaney is merely reflecting the prevalent view of spermatorrhoea and the semen-loss anxiety. In making his views more culturally specific to Australian manhood, Beaney makes the point that the relatively free and easy life of the Antipodes, the more relaxed social structure and the more intimate mingling of the sexes lead to increasing sexual precocity among children, thus magnifying the threat to Australian manhood. The treatments recommended included sitz baths, alcohol and chemical compounds like potassium bromide and phosphorus and application of electricity to the nervous system. Gradually, circumcision came to be seen as a treatment for these sexual urges. Thus it would appear that, in the nineteenth-century colonies too, the anxieties related to semen loss persisted. Whether the clinicians were reflecting their own anxieties or those of their patients remains a moot point. What is clear is that semen-loss anxiety is neither a new condition nor confined to the Orient.

The scientific backing to morality and making sexual activity prohibitive continued unabated in the nineteenth and early twentieth centuries. The impact of these on the 'patients' is uncertain but there is little doubt that a lot of the writings of Graham, Kellogg and others were directed at the general population. Therefore, there must have been a need for such advice because most of these monographs went into several editions and were translated into several languages. The similarities between their writings and the present-day descriptions of *dhat* are very similar.

We have presented historical data from among the studies from the West (Australia is included in the West in this context), and our contention is that with industrialisation and colonisation, the anxiety about semen loss in the West diminished and the same is likely to happen in South Asia as well. If we understand *dhat* as a culture-bound syndrome, the historical evidence indicates that it was prevalent in Europe, the USA and Australia in the nineteenth century. It may have disappeared in response to prevalent social and economic factors, whereas it is still prevalent in South Asia. We think that the universality of symptoms of anxiety (in this case secondary to fear or actual loss of semen) has to be acknowledged.

Although there are discrepancies in the data from modern-day India and only descriptions exist in the eighteenth and nineteenth century, it proves that *dhat* syndrome is not culture-bound and it is not an exotic neurosis of the Orient. Furthermore, it is our contention that the *dhat* syndrome as described in the literature from the Indian subcontinent is not always a homogeneous entity; and although syndromes by definition are heterogeneous, the symptoms described are more likely to be psychological or psychosomatic, even though their attribution to *dhat* may be culture influenced. Our contention is that collectivist societies allow anxiety to be expressed in a way that is secretive, and semen loss in the context of procreation becomes significant.

We welcome the amendments to DSM–IV in that it offers an outline for cultural formulation where multi-axial diagnostic assessments are supplemented by providing a systematic review of the individual's cultural background and the role of the cultural context in the expression and evaluation of symptoms and dysfunction along with the effect that cultural differences may have on the relationship between the individual and the clinician. Cultural identity of the individual and cultural explanations of the individual's distress as well as factors related to psychological environment, levels of functioning and the relationship between the individual and clinician, are important. If all these factors are taken into account and used seriously in diagnoses, then the scope for culture-bound syndromes becomes even more limited, even though DSM–IV retains the category of culture-bound syndromes.

We acknowledge Tseng's (2001) assertion that cultures do influence psychopathology through pathogenetic, pathoselective, pathoplastic, pathoelaborating, pathofacilitating and pathoreactive effects, but we believe that the interaction between the individual and the culture is extremely complex. Even if culture is being pathofacilitatory or pathoreactive, the individual pathology can be, and will be, influenced by other factors, such as personality traits, peer and family support available to the individual, alternative explanations of the experience, etc. The society and culture will no doubt dictate pathways into help seeking and care and resources – economic, political and human-allocated. Tseng

(2001) proposes that these syndromes be subgrouped according to the six impacts of cultures, but we maintain that the time has come to abandon this category altogether and focus instead on multiaxial systems which include cultural factors in aetiology and management. *Dhat* provides an illustration that, when looked at carefully, these conditions transcend cultural boundaries and any variations should be seen in the cultural/individual context.

We believe that attribution patterns on explanatory models regarding semen-loss anxiety need to be studied in different cultures in order to confirm what we have hypothesised. We accept that loss of semen is a shared belief reported from certain societies. It may be that this is reported because the clinicians and the researchers are aware of it and therefore are willing to ask questions regarding such an attribution.

Latah

Latah is often used as a classical example of culture-bound syndromes (Bhugra and Jacob 1997). This is a dissociative state provoked usually by a short, loud noise or a prod in the ribs which is associated with altered consciousness, coprolalia, echolalia, echopraxia and, in extremely severe cases, 'command automation'. Yap (1952) described the condition as occurring in middle-aged women of the Malay or other indigenous races of South East Asia. The clinical features include sudden onset after an acute fidget, episodic echolalia, echopraxia and coprolalia and induced by sudden touching in poor vulnerable individuals, and the culture sees this as a state rather than a disease (Friedman, 1982). In a study, 50 cases of *latah* were diagnosed in 12 000 Malaysians. Of the 50 cases, 7 had clinical diagnosis of schizophrenia, neurosis or adjustment reaction; another 14 had mixed diagnoses and were all women. The cases had sexual conflict as an associated factor (Chiu *et al.*, 1972). Simons (1985) described three types of *latah* – immediate response, attention captive and the role *latah*. The role *latah* is influenced by social factors and the individuals thus affected are female and may have marginal social status. Although Yap (1952) saw coprolalia as a publicly sanctioned expression of sexual undertones, as did Murphy (1976).

Winzeler (1995) in an ethnographic study of *latah* summarised *latah* paradox thus: (the paradox) is the proposition that while *latah* can only be understood in highly specific culture terms unique to the Javanese (or to the Javanese and other Malay peoples), it occurs also among various distant peoples as well (p. 3). Writing about *latah* and *amok* has been in conjunction with other favourite colonialist topics, which created and perpetuated images of Malays as mentally deficient, thereby justifying and indeed encouraging the European domination (Alatas, 1977: 48). Winzeler (1995) concurs with this observation but is generous in his interpretation that these Orientalist observers did not mean to do so. Included in the accounts are the general observations about the Malayan character, which might indicate inferiority and a possible improvement under European rule. In the context of *latah* this observation becomes further complicated because the focus of study is sexual woman. The perceived nervous, sensitive and volatile nature of the colonised was not confined only to the Malay but also to other ruled populations who had to be saved from themselves. Although initially written about by Western psychiatrists and observers, Malay psychiatrists such as Yap contributed to these observations.

The earliest record of *latah* is said to be in 1849 (Winzeler, 1995). Exotic startle patterns were also reported from Maine and Siberia in the last quarter of the nineteenth century and similar patterns emerged from descriptions in Norway, Iceland and Madagascar (Winzeler 1995, p 33). Yap (1952: 515) too noted that the French, Italian, Dutch and English observers had used the term *latah* in non-Malaysian instances.

Thai, Indonesian, Philippine, French Canadian, Lapp and African descriptions of conditions similar to *latah* have been offered. In Indonesia sometimes a term *gigiren* is used (Winzeler 1995, p 40) which is roughly similar to *mali mali* used in the Philippines and *bahtschi* in Thailand. In cases of *bahtschi* the people affected were women, factory workers and migrants to urban areas. ‘Jumping’ was described among the French Canadians in rural Maine where responses were provoked by startle or commands given in a quick lowered voice and the affected individuals will then imitate voices and actions (Beard, 1886). Even then Winzeler (1995, p 41) points out that these actions were seen as exotic and therefore to be explained away by reference to arctic or tropical climates, non-Caucasian racial constitutions and outlandish customs and beliefs. Nearly a century later, Chapel (1970) and Kunkle (1967) found and reported on such cases. Among the Lapps similar behaviour was found (Collinder, 1949: p. 152). Although women were seen to be affected more commonly, the African-Arabian type of *latah* and the French Canadian variety affects men more commonly. Automatic obedience is less likely in the Arab-African variety, as is coprolalia. These differences may reflect the type of society and cultural norms and values, which may influence the symptom content.

Winzeler (1995), in his ethnographic study from the centre of the coastal plain in Malaysia, suggests that the term *latah* has been used in different ways. It can be used as talking nonsense, or a particular pattern of behaviour or a tendency to such behaviour. Two forms of *latah* were observed – these were startlers or followers. He found that although children may play at *latah*, the condition is largely limited to adults (Winzeler, 1995: p. 62). More common among women (attributed to women having less soul or blood than men) and the poor, *latah* has become a stylised, more or less common, pattern of behaviour.

Winzeler (1995: p. 75) emphasises that, although *latah* has been analysed both as a startle reaction (Simons 1980, 1983) and as a fear reaction by Yap (1952), these are closely related. Startle has been associated with both magical transformations and magical power. The relationships between *latah*, shamans and midwives and trance states are well known. Is it then possible that the trance states are common to other conditions and other states? There is no doubt that, whatever form *latah* takes, it has symbolic meaning and by providing an opportunity for tomfoolery and aggressive teasing along with sexual humour, it allows an expression which is otherwise inhibited. *Latah* allows an inversion of dominant cultural standards of polite and proper behaviour (Winzeler 1995: p. 99). Winzeler (1995: p. 129) argues forcefully that *latah*, whether true or imitative, must be seen as a form of trance and understood in that light.

Susto refers to fright or some loss and represents a disorder among Latinos in the US, Central and South America and Mexico, and the main worry is related to fear. It is seen as an event which by its fearful nature leads the soul to leave the body, and results in unhappiness, sickness and social withdrawal. Such feelings may persist for years after the initial fright. The core symptoms of poor or increased appetite, too little or excess sleep, feeling low, poor motivation, low self-worth, somatic symptoms of aches and pains may be seen. At one level these can all be associated with depression.

Rubel *et al.* (1984) studied three communities in Central America. *Susto* patients were identified using a number of clear criteria, along with levels of social stress and levels of psychiatric impairments along with levels of organic disease. Patients with *susto* had significantly higher levels of psychiatric pathology, and an average of 5.15 diseases per patient was diagnosed. The prevalence of mental disorders was different across the three communities studied. Digestive disorders were more common among the patients of *susto* when compared with controls. On objective laboratory tests, levels of haemoglobin indicated that patients were more likely to be anaemic compared with controls. Rubel *et al.* (1984: p. 112) point out that they did not believe in supranatural or magical causation, but utilised an open system model emphasising interactions among the social, emotional and biological dimensions of individuals. These authors found that *susto* was associated with the person’s perceptions of their inadequacy in the performance of their social roles. The aggregation of symptoms indicated an organic causation. It can be argued that the ‘stress’ of the fright may push the individual towards a depression-like condition.

Amok describes a syndrome with an element of dissociation where an individual commits furious

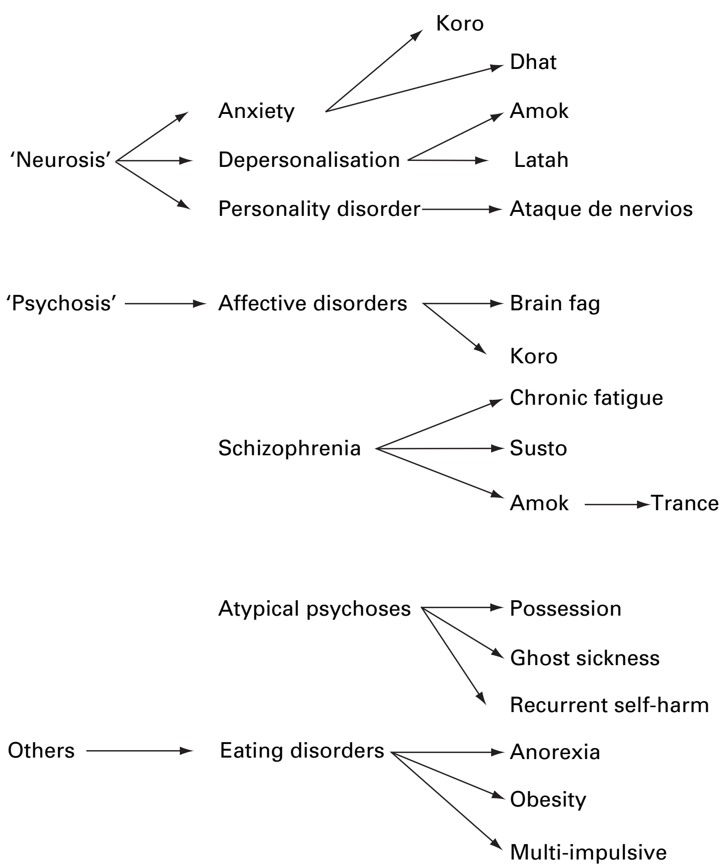

Fig. 11.1. Interaction between psychiatric disorders and culture-bound syndromes. (Modified from Bhugra and Jacob, 1997.)

or violent assault of homicidal intensity often associated with indigenous population of the Malaysian archipelago (Carr and Tan, 1976). The predominant and most dramatic aspect of the syndrome is mass assault which would warrant placing it in the impulse control category (Bhugra and Jacob, 1997). Of the ten cases of true *amok* reported by Carr and Tan (1976), seven had delusions and/or hallucinations at the time of admission. Alcohol (Westermeyer 1982) and cerebral malaria (van Loon, 1927) were reported as causes. Folk explanations include *amok* as war preparation and response to strict hierarchical society. *Amok* is often seen as a culture-bound syndrome, but similar attacks as exemplified by the Columbine School massacre are no different than attacks of *amok* but are never seen or discussed as such. *Koro* is often reported from China and countries of Southeast Asia (probably originating from the Japanese word signifying tortoise) and usually the male sufferer has a primary feeling that his penis is shrinking into the body with a fear of impending death. This is often accompanied by feelings of intense panic and attempts to stop penile retraction by tying weights to it and accompanied by depersonalisation. Folk explanations include worry and guilt about sex (Yap, 1965) and changes in socio-economic status. Perceptions of size are also changed. It has been reported from other parts of the world, including an epidemic in Nigeria. Figure 11.1 describes the relationship between psychiatric and culture-bound disorders.

Western culture-bound syndromes: eating disorders, shoplifting, parasuicide, agoraphobia and flashing have been described as Western culture-bound syndromes (Littlewood and Lispedge, 1985, Rittenbaugh 1982, Winzeler, 1995). Increasingly with changes in socio-economic conditions and power structures there, these too are beginning to appear in other societies.

Conclusions

The changes in the exclusivity of culture-bound syndromes to certain geographical areas indicate the impact of globalisation, urbanisation and industrialisation. There are significant problems in the use of terms such as culture-bound syndromes because all psychiatric conditions are culture-bound and the time has come to abandon the concept of culture-bound syndrome. Such usage also indicates its colonial heritage. Syndrome by definition is inclusive and often vague and in an interesting turn of phrase culture-bound syndrome is paradoxical and quixotic.

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12

Psychiatric epidemiology and its contributions to cultural psychiatry

Robert Kohn and Kamaldeep Bhui

EDITORS' INTRODUCTION

The relationship between cultural psychiatry and psychiatric epidemiology is of constructive tension. Although in certain fields of cultural psychiatry epidemiology studies are problematic because of small numbers, the basic premise of epidemiology can be employed provided the interpretation of the findings is clearly contextualized. The measurement of psychopathology across cultures using the same set of tools is fraught with major difficulties. The category fallacy under these circumstances raises critical questions. It is also of interest that often these assessment tools move from Euro-US centric settings to the rest of the world, rather than the other way around.

Kohn and Bhui examine the contribution of psychiatric epidemiology to cultural psychiatry, and some controversial questions. They argue that psychiatric epidemiology has evolved since the study by Jarvis in 1855 in which higher rates of mental illness were found among the Irish immigrants in the pauper classes in Massachusetts, USA. Since then, psychiatric epidemiology has undergone at least three generations of evolution, followed most recently by the fourth stage from which cultural epidemiology has emerged as the a new branch of epidemiology, taking in perspectives from medical anthropology, epidemiology and public health. The implications of these changes are tremendous, both for clinicians and researchers.

Introduction

The methodological advances of psychiatric epidemiology revealed the limitations of earlier psychiatric research. These critiques had implications for the use of diagnostic instruments, and for the methodological advances needed to study cultures and compare mental-health problems in diverse cultural groups. Psychiatric epidemiologists have undertaken cross-national comparisons, but have not always paid attention to the critiques of cultural psychiatry and anthropology. From a public health point of view, these advances have highlighted the significant burden of mental illness in many societies in the world, and the need for greater emphasis on providing mental health care. Availablity of care may vary from indigenous practices within the lay and folk sectors of healing, to the use of statutory services.

Several questions arise in the role of psychiatric epidemiology in cultural psychiatry.

- Have these methodological advances preserved the meaning of culture (the emic) in the research of heterogeneous populations?
- Is it valid and appropriate that research instruments used for case ascertainment and establishment of disability in one culture and society, be translated and adapted for use across differing groups of people; or should instruments always be constructed ground-up for every single cultural group?
- Perhaps, a more challenging question is whether DSM-IV or ICD-10 can be applied universally.

If the answer to some or all of those questions were in the negative, research findings from conventional psychiatric epidemiology might legitimately be challenged. Clues from epidemiological studies about etiology and treatment would then be open to suspicion. Indeed, some have argued that comparative epidemiology and psychiatric research does not have a place in researching culturally diverse

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

populations. Although such statements are often interpreted to imply that the study of culture should be restricted to anthropologists or sociologists using qualitative methods; alternatively, research of cultural groups has also been proposed to only be possible if people from the culture of interest undertake the research either as service users or sufferers of mental-health problems, or even as professional researchers. The latter proposition requires a substantial commitment to build capacity for research among diverse groups, by recruiting researchers from diverse cultural backgrounds.

Psychiatric epidemiology: a brief history

Epidemiology is the study of the distribution of diseases, disorders or conditions in populations, and the factors that contribute to that distribution. The goals of psychiatric epidemiology are to describe the occurrence of mental or behavioral disorders; determine the risk factors associated with their onset, course and outcome; provide data for programme planning and evaluation in the domains of prevention, care and rehabilitation; and assist in the determination of clinical syndromes.

One of the first major attempts to examine the true prevalence of mental disorders in the community was conducted by Jarvis in 1855 in Massachusetts, USA. His study included both treated and untreated cases in the community. Jarvis found that the Irish immigrants to the state were at increased risk for psychopathology, a result due to individuals in the pauper class having 64 times higher of a risk of ‘insanity’. Since this seminal study, psychiatric epidemiology has undergone at least three discernible generations of methodological advancement (Dohrenwend and Dohrenwend, 1982). Each generation has improved its methods of data collection and the classification of disorders and the criteria used for measurement of disorders.

The first generation

From the turn of the last century to World War II, studies consisted of interviews with informants and agency records in order to ascertain persons with mental disorders in the community (Dohrenwend and Dohrenwend, 1974). The two main problems with studies of that period were, incomplete case ascertainment and lack of reliability or validity in clinical diagnoses, as the latter were taken at face value. This period highlights the problems associated with making determinations of prevalence or risk factors from treated cases; persons in treatment are not a random sample of all people with mental disorders (Cohen & Cohen, 1984; Kohn *et al.*, 1997). In addition, due to the uncertainty about the validity of clinical diagnoses, as opposed to more precisely measured diagnosis obtained from diagnostic interview schedules, the potential for biased and inaccurate prevalence estimates and risk factor profiles becomes self evident.

The second generation

Following World War II, studies used an expanded definition of psychiatric disorders with the introduction of the Diagnostic and Statistical Manual (American Psychiatric Association, 1952). In this group of studies, community residents were directly interviewed usually by a single psychiatrist or by a team headed by a mental-health professional. Except for a few North American studies such as the Stirling County (Leighton *et al.*, 1963a), in Canada, and the Midtown Manhattan Study, in the USA (Srole *et al.*, 1962), these interviews typically did not employ standardized data collection procedures (Lin, 1953). Studies in developing countries were frequently conducted by researchers from other societies, for example, Leighton *et al.* (1963b), a North American psychiatrist, investigated the Yoruba in Nigeria. This practice may introduce bias, and may actually retain ethnocentric and culturally invalid methods.

Case identification in the second generation studies were made by psychiatrists following evaluation of protocols collected by interviewers. The second generation of psychiatric epidemiology also used screening scales comprised of symptom items. These scales, such as the General Health

Questionnaire (Goldberg *et al.*, 1976), attempted to screen and distinguish cases from non-cases using empirically determined cutoff scores (Shrout *et al.*, 1986). This second generation resulted in a number of advances in psychiatric epidemiology including: the use of survey methods and probability samples of community respondents; the development of reliable impairment scales used in psychiatric research today; the recognition that there was no single cause of mental illness; and the focus on social and cultural influences on mental health (Dohrenwend and Dohrenwend, 1982). This second generation, however, had a number of limitations. Impairment scales assumed a unitary dimension to mental illness and did not examine specific diagnostic categories limiting the usefulness for cultural psychiatry research. This generation of studies emphasized the role that stress had on psychiatric disorder, and with few exceptions, they ignored other causes such as genetics, infections, early childhood experience, and biological factors that may vary across cultures, and indeed applied similar threshold for case ascertainment across cultural, national and ethnic groups. These studies also overlooked the difficulties of classifying race, culture and ethnic group, and did not address the problems of recruitment of hard to reach groups into research.

The third generation

This era of research evolved the explicit diagnostic criteria and produced structured clinical interview schedules, both of which contributed to improved diagnostic reliability, of syndromes as defined by conventional psychiatric field studies mainly among Euro-American populations. Among the earliest instruments used was the Present State Examination (PSE; Wing *et al.*, 1977) which was geared to generated diagnoses consistent with the International Classification of Disease (ICD) criteria (World Health Organization, 1978). In addition, there were instruments such as the Schedule for Affective Disorders and Schizophrenia (SADS; Endicott and Spitzer, 1978) which generated diagnoses according to Research Diagnostic Criteria (RDC; Spitzer *et al.*, 1978); and the Diagnostic Interview Schedule (DIS; Robins et al. 1981) that generated Diagnostic and Statistical Manual III (DSM-III) diagnoses (American Psychiatric Association, 1980). More recently, new third-generation instruments have been developed, such as the Standardized Psychiatric Examination (SPE; Romanoski and Chahal, 1981), the Revised Clinical Interview Schedule (CIS-R; Lewis and Pelosi, 1990), and the Schedules for Clinical Assessment in Neuropsychiatry (SCAN; Wing *et al.*, 1990), which use ICD criteria, largely based on the PSE. These instruments also enabled a symptom based analysis of metal distress, and could therefore explore symptom clusters within any one diagnostic group. The Composite International Diagnostic Interview (CIDI; Robins *et al.*, 1988) generates diagnoses according to both ICD-10 (World Health Organization, 1992) and DSM-IV (American Psychiatric Association, 1994) criteria.

There remain two major issues facing this third generation of psychiatric epidemiological studies: the cross-cultural validity of the diagnostic criteria used and the cross-cultural reliability of interview schedules, which are administered by lay-interviewers. The difficulties around recruitment to studies, and engagement of socially excluded groups in the research process became more openly acknowledged as researchers engaged with the observations of anthropologists, sociologists and cultural psychiatrists. However, cultural factors aside, each of the advances did help to better test the association between sociodemographic variables and specific mental disorders, with greater validity and precision. Have these three stages of development in psychiatric epidemiology translated into a better understanding of cultural psychiatry issues?

The alliance between culture and psychiatric epidemiology

There are good reasons to conclude that psychiatric epidemiology has provided insights into the understanding of mental illness within and across cultural groups. Psychiatric prevalence surveys have been conducted already in nearly all regions of the world, including in some developing countries (Andrade *et al.*, 2003; Kohn *et al.*, 2004). These studies have provided results, which are compelling as universally valid findings.

First, no society is immune from mental illnesses; these are common and are among the most disabling medical conditions in both the developed and developing world (WHO, 2001). These studies have shown that gender differences across specific psychiatric disorders are nearly universal, such as the 2:1 female to male ratio found for major depression, with rare exceptions (Egeland & Hostetter, 1983; Levav *et al.*, 1997). Schizophrenia has been shown to consistently be more prevalent among individuals in the lower social classes (Goldberg & Morrison, 1963; Dohrenwend *et al.*, 1992; Kohn *et al.*, 1998). The elderly, contrary to earlier beliefs, are now thought to have lower rates of mental illness than younger cohorts, except for dementia (Blazer *et al.*, 1987). Traumatic events that occur to both individuals and groups, and man-made or natural catastrophes, have been shown to have short-term as well as long-lasting effects on mental health (Levav, 1998; North *et al.*, 1999; Mollica *et al.*, 2001). In addition, new insights have been gained with regard to immigration and mental health; for example, non-traumatized immigrants may have better mental-health outcomes than the second generation in open societies (Vega *et al.*, 1998), and the country one immigrates to may result in differential psychological distress (Flaherty *et al.*, 1988a).

Cross-national comparisons and cultural psychiatry

Cross-national comparisons have been used in psychiatric epidemiology to provide insights into cultural differences in the risk and outcome of specific psychiatric disorders. The determinants of schizophrenia study from the World Health Organization (Jablensky *et al.*, 1992) raised substantive issues relevant to cultural psychiatry, namely, that schizophrenia is a universal disease, that the rates vary little across countries, and the possibility that individuals with schizophrenia in developing countries may have better outcomes. However, at variance with this popular textbook view is the finding that if the raw data with confidence intervals are inspected the incidence rates are consistent for narrowly defined schizophrenia, but not for broadly defined schizophrenia. Indeed, even for narrowly defined schizophrenia the investigation probably did not have the power to detect smaller differences. Furthermore, the prognosis of schizophrenia is thought to be better in developing countries, and this does require explanation (see Chapter 7, and reference Kirkbride *et al.*, 2006).

A large number of studies using the DIS (Weissman *et al.*, 1997) and the CIDI (Bijl *et al.*, 2003) worldwide have made cross-national comparisons and have shown communalities across countries. The similarities across studies may be more meaningful than their differences, since the latter can be attributed to methodological variability between studies. Psychiatric epidemiology is now attempting to address these methodological shortcomings; for example, the World Mental Health, 2000 multi-country epidemiological effort is designed to reduce the issue of problems related to methodological variability (Kessler, 1999; World Mental Health Survey Consortium, 2004).

Do these cross-national comparisons contribute to cultural psychiatry? Indeed, one might question whether cultural psychiatry as a body of research and practice claims to own cross-national comparisons, or do these simply fall into international psychiatry as a form of universalism, minimizing cultural issues. Tseng (2001) proposes that ‘In a strict sense, psychiatric epidemiology does not relate closely to cultural psychiatry, even when cross-ethnic, racial, societal, or national comparative epidemiological studies are carried out, unless the epidemiological investigations are conducted in conjunction with an examination of core cultural variables, namely the beliefs, values, and attitudes of subjects, their families, or others in the

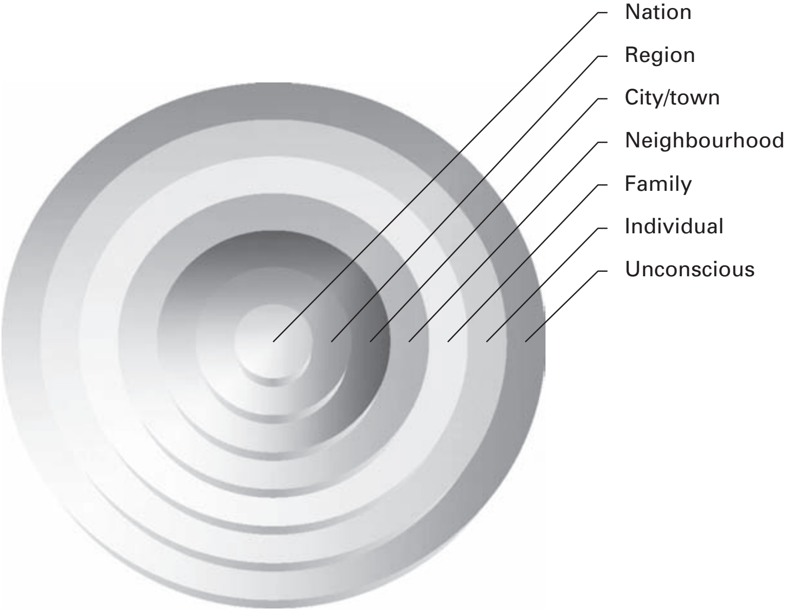

Fig. 12.1. Where is culture located and how is to be measured?

community surveyed.' One might argue that culture is found at several levels (Fig. 12.1).

Where does culture exist: in society, in a local region, in a town, among sub-groups such as families or congregations, or does it exist within the mind of one person? Where should research on culture be focused? Tseng's proposition suggests that cultural psychiatry research should focus on families, and take account of the emic perspective, adhering to the traditional social–anthropological endeavours proposed by Kleinman (1977). However, we propose that other bodies of evidence and research can contribute to cultural psychiatry, especially if they are interrogated in order to complement more emic studies, and by ensuring that methods do reflect more scientific measures of, for example, race, ethnic group, etc.

For example, the finding that children of African-Caribbean immigrants are at increased risk for schizophrenia (Sharpley *et al.*, 2001), or of some ethnic groups, but not others, that immigrated to the Netherlands (Selten *et al.*, 2001), constitute a *bona-fide* cultural psychiatric-related finding that generate intriguing hypotheses for investigation. Indeed, most biological or physiological hypotheses have been unfruitful, and so environmental factors are favoured and cultural factors beyond social conditions appear to play a significant role. However, the attitudes, beliefs and values of the subjects were not explicitly investigated. Also, the study of variables such as religious affiliation, gender, socioeconomic status, immigration, trauma, war, race or ethnic origin within a country or across countries constitutes a valid contribution to cultural psychiatry. Variations of risk factors or rates across these groups require explanation, and further in-depth research.

Cross-cultural applicability of psychiatric epidemiological instruments

Experience shows that adapting an instrument for cross-cultural use is often more cost effective and facilitates cross-cultural comparisons than developing new instruments to measure similar constructs.

The complexity of translating an instrument varies depending on how much the construct being measured differs between the two cultures. Procedures for translating instruments across cultural groups have been well outlined (Sartorius and Kuyken, 1994; Bhui *et al.*, 2003). Admittedly, the often used back-translation technique is not beyond criticisms. Bilingual translators may be able to achieve equal back-translations yet fail to achieve optimal interpretations of the meaning of the item. Also, after an instrument is translated, it is still necessary to evaluate the adapted version in the target population. Aside from translation issues, several questions regarding validity and reliability need to be answered before such an instrument can be applied (Flaherty *et al.*, 1988b). Content equivalence: are the items that make up the concept in the original culture relevant to the host culture? Semantic equivalence: do the translated items have the same meaning in the target culture? Technical equivalence: do the methods of data collection yield different results in the target culture? Criterion equivalence: how do the results of the adapted version of the instrument compare to independent criteria measuring the same construct? Conceptual equivalence: are the same variables being measured? However, most psychiatric epidemiological studies do not adapt these approaches in full, often adhering to an ethnocentric approach, one in which the researcher mistakenly assumes that the concepts completely overlap in the two cultures.

Frequently, as noted above, instruments are used with individuals that differ from the population in which the instruments were originally developed and normed, a methodological danger that has a substantive impact. This results in the risks of making skewed interpretations of results if the populations differ on some latent variable. Examples of such methodological shortcomings are readily available in the psychiatric epidemiology literature; rarely are these standards met beyond good-faith efforts at accurate translations and small reliability studies in the now widely used large-scale psychiatric epidemiological surveys across countries (Wittchen, 1994). For example, are the extremely low rates of psychopathology in China (Wang *et al.*, 1992) and Taiwan (Hwu *et al.*, 1989) based on studies using the DIS, reality or artifact? Advances have been made; researchers in dementia have been partially successful in developing culturally fair instruments (Hendrie *et al.*, 1995). Ongoing epidemiological research on schizophrenia and other mental disorders in Ethiopia appear to demonstrate that culturally valid studies in distinct cultural settings are possible (Alem *et al.*, 1999). There are limits, however, to the incorporation of local cultural constructs into an instrument in use, least it loses the capacity to measure the intended original construct and still be able to serve in cross-cultural studies (Canino *et al.*, 1997).

What are reasonable methodological expectations for valid research taking into account cost constraints? To conduct validity and reliability studies for each instrument and on every cultural group, although ideal, is economically not feasible, and may raise insurmountable obstacles for any meaningful epidemiological research.

Early on in the third generation of psychiatric epidemiological research data were collected using mental-health professionals (Levav *et al.*, 1993). The norm now is the use of lay interviewers employing a fully structured diagnostic instrument, in part due to the high costs of psychiatrically trained personnel. In addition, the current size of the large-scale prevalence studies resulted in lay interviewers becoming a financial and logistical necessity. What has been lost with these instruments and interviewers is the ability to carefully probe and interpret behaviour in a clinically and culturally meaningful manner, as responses to fully structured interview schedules are to be accepted at face-value regardless of the presenting behaviour, for example, someone who is actively hallucinating but denies it in the initial probing would be recorded as not having a psychotic symptom. Reliability studies examining inter-rater reliability against semi-structured instruments administered by mental-health professionals have shown good agreement for many (Ustun *et al.*, 1997), but not all disorders, in particular schizophrenia and somatization disorder, and frequently panic disorder, generalized anxiety disorder, and dysthymia (Wittchen, 1994). Psychiatric epidemiology unfortunately has had to compromise the ability to obtain data that are richer in their ability to derive cultural interpretation and meaning for the economics and constraints of the research environment.

Application of universal diagnostic systems

Perhaps the most important contribution to come out of psychiatric epidemiology, and yet the most controversial, is the application of a universal diagnostic system and criteria such as the ICD and DSM. If one takes the position that psychiatric nosological systems cannot be applied cross-culturally as they are imposed constructs devoid of a meaningful cultural context (Mezzich *et al.*, 1992), then most of psychiatric epidemiology has made little to no contribution to cultural psychiatry. Alternatively, it may be argued that cultural-bound syndromes, as represented in diagnostic manuals as cogent and absolute entities, do not exist, and may even be classifiable elsewhere within the current nosological system (Lopez-Ibor, 2003). Fabrega (1994) has placed psychiatric diagnostic systems in their proper perspective alluding to the tension created by its use internationally:

> Although in theory applicable to all people regardless of populational/genetic, national, or cultural background, it is used by clinicians of highly specific cultural origin, and in settings characterized by distinctive cultural traditions about sickness, healing, non-sickness or health, and social behavior.

Psychiatric epidemiology does offer the possibility to examine whether symptom criteria differ across different populations, and if symptom criteria can be applied similarly across groups. Only once we have a better understanding of the genetic basis of mental illness, can this controversy be resolved regarding whether the phenotypic presentation of mental illness is indeed highly variable across cultures. Until the genetic basis of mental illness becomes reality, culturally based studies in psychiatric epidemiology are faced with what Kleinman (1977, 1988) terms a category fallacy in diagnosis. However, this straw man is easy to attack, and destroy if diagnostics are misunderstood to simply be an operationalized and value-free enterprise. Rather, diagnosis should be a process, in which the emic is understood alongside the etic, and in which the clinician explores relevance, cultural appropriateness of behaviours and beliefs, and reflects on the transference and counter-transference including attention to race and ethnic factors, differences, similarities in the consulting room. ICD and DSM are not intended for use as representations of hard scientific facts, but the best we have in an evolving nosology of benefit to the majority of patients, and worth considering in clinical practice which may actually diverge from the ostensibly valid and universal systems in order to truly reflect the distress experiences as felt and lived by people, service users, and patients. The Cultural Formulation as described in DSM IV does set out a humanistic process and not a technology. Genetic epidemiological and dimensional classifications of psychopathology are likely to enable more complex and less static categorical classifications; these will be more difficult for clinicians to use, and for patients to understand, but they will retain greater potential for authentic representations of psychopathology, and may be more able to embrace cultural dimensions/factors as variables that should be considered for their central importance in resilience, recovery and illness behaviour.

Cultural epidemiology: a brief introduction

There are several foci that must be addressed within psychiatric epidemiology. Firstly, studies using methodological advances that combine cultural variables and qualitative data into epidemiological surveys need to be more common place (de Jong & van Ommeren, 2002). This type of epidemiological research Weiss (2001) has termed cultural epidemiology, when studies apply locally valid categories of

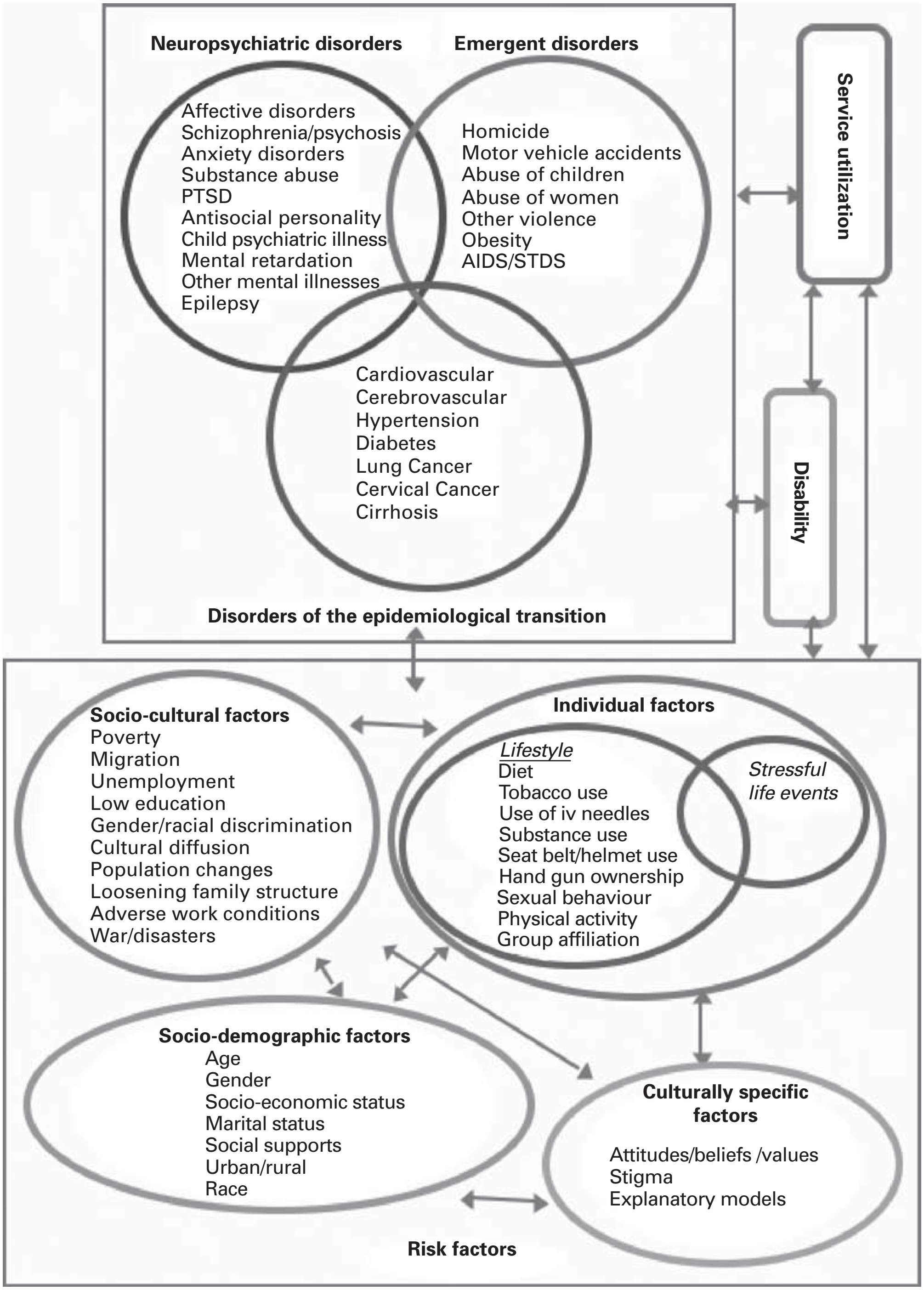

Fig. 12.2. Disorders and conditions of concern for psychiatric epidemiology.

experience, meaning and behaviour into them. Secondly, psychiatric epidemiological studies that test cultural psychiatric hypotheses need to be further fostered in developing countries and special populations in developed countries using local investigators. Thirdly, psychiatric epidemiology should incorporate assessments of risk factors that are primarily cultural: attitudes and behaviours that are culturally based in the research design; this may provide opportunities to test epidemiological theories albeit instruments and analytic techniques will need re-examination; for example, adjusting for ethnic group can not be undertaken uncritically; stratifying by ethnic group will lead to smaller sample sizes but must be recommended in the first instance, and ethnic/cultural groups should reflect the requirements of hypotheses and not just the convenient ethnic/cultural group classifications used in census and politically motivated data sources. Fourthly, psychiatric epidemiology focused on cultural psychiatry should also address public health issues that allow for service planning, and addressing local and global population needs.

To make psychiatric epidemiology more relevant to the cultural context of changes that are currently occurring in societies and the increased focus on behavioural and life-style issues, psychiatric epidemiology must include, in addition to the traditional neuropsychiatric disorders, an increased emphasis on emergent disorders and disorders of the epidemiological transition, that examine individual risk factors, socio-demographic, socio-cultural factors, and culturally specific factors across the lifespan, for a range of conditions (Fig. 12.2).

Conclusions

To sum up, psychiatric epidemiology across its three generations has made important contributions to cultural psychiatry, including the demonstration that there are universalities in the presentation of psychopathology. It has also shown that diagnostic criteria and instruments can be applied across different populations and cultures. These accomplishments have not been without controversy, leaving open the argument that psychiatric epidemiological studies all to frequently ignore the cultural context of the populations being studied thus adding little to the study of cultural psychiatry. However legitimate this debate is, psychiatric epidemiology remains an integral component of cultural psychiatry research. At a minimum, it provides the latter both tools and methodologies thus further contributing to secure the scientific evidence required to be a credible evidence-based field of study. Cultural epidemiology is now gathering momentum, but is likely to be challenging, given it requires greater stringency as far as research methods go, a stringency that will be perceived as a nuisance by the culturally blind and naïve clinician and researcher.

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Acculturation and identity

John W. Berry

EDITORS' INTRODUCTION

Cultures have never been static. Their fluid nature means that individuals in any culture are equally likely to be influenced by effects of other cultures and factors with which they may have direct or indirect contact. Some of the cultural characteristics and inherent traits in individuals are more prone to changes than others. The impact of one culture on another depends upon a number of factors, such as the degree of the contact, duration of this contact and purpose of such contact. If one culture invades another for political and economic reasons, the outcome is likely to be different than if the contact is through media at a distance. Linked within this process is the process of urbanization, which brings another set of changes within one culture.

Berry, in this chapter, defines acculturation as a process of cultural and psychological change in cultural groups, families and individuals following intercultural contact. Cultural identity refers to the ways in which individuals establish and maintain connections with, and a sense of belonging to, various groups.

The processes and outcomes of these processes are highly variable, with large group and individual differences. This chapter focuses on describing some of these processes, the strategies people use to deal with them, and the adaptations that result. Three questions are raised: how *do individuals and groups seek to acculturate?;* how *well do they succeed?; and are there any relationships between how they go about acculturation and their psychological and sociocultural success? In reviewing studies addressing these questions, Berry notes that evidence indicates that the most commonly chosen strategy is integration (defined as preferring to maintain one's cultural heritage while seeking to participate in the life of the larger society), rather than assimilation, separation or marginalization. In most cases, this integration strategy is also the most adaptive, both psychologically and socioculturally. Its implications are important for public policy.*

Acculturation: cultural and individual

Acculturation is the process of cultural and psychological change that takes place as a result of contact between cultural groups and their individual members (Redfield, Linton & Herskovits, 1936). Such contact and change occurs during colonization, military invasion, migration and sojourning (such as tourism, international study and overseas posting); it continues after initial contact in culturally-plural societies, where ethnocultural communities maintain features of their heritage cultures. Adaptation to living in culture-contact settings takes place over time; occasionally it is stressful, but often it results in some form of mutual accommodation. Acculturation and adaptation are now reasonably well understood, permitting the development of policies and programmes to promote successful outcomes for all parties.

The initial research interest in acculturation grew out of a concern for the effects of European domination of colonial and indigenous peoples. Later, it focused on how immigrants (both voluntary and involuntary) changed following their entry and settlement into receiving societies. More recently, much of the work has been involved with how ethnocultural groups and individuals relate to each

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other, and change, as a result of their attempts to live together in culturally plural societies. Nowadays, all three foci are important, as globalization results in ever-larger trading and political relations: indigenous national populations experience neo-colonization, new waves of immigrants, sojourners, and refugees flow from these economic and political changes, and large ethnocultural populations become established in most countries.

Graves (1967), introduced the concept of psychological acculturation, which refers to changes in an individual who is a participant in a culture contact situation, being influenced both directly by the external (usually dominant) culture, and by the changing culture (usually non-dominant) of which the individual is a member. There are two reasons for keeping the cultural and psychological levels distinct. The first is that, in cross-cultural psychology, we view individual human behaviour as interacting with the cultural context within which it occurs; hence separate conceptions and measurements are required at the two levels (Berry *et al.*, 2002). The second is that not every individual enters into, and participates in, or changes in the same way; there are vast individual differences in psychological acculturation, even among individuals who live in the same acculturative arena (Sam & Berry, 2006).

A framework that outlines and links cultural and psychological acculturation, and identifies the two (or more) groups in contact (Berry, 2003) provided a map of those phenomena which I believe need to be conceptualized and measured during acculturation research. At the cultural level we need to understand key features of the two original cultural groups prior to their major contact, the nature of their contact relationships, and the resulting dynamic cultural changes in both groups and in the emergent ethnocultural groups, during the process of acculturation. The gathering of this information requires extensive ethnographic, community-level work. These changes can be minor or substantial, and range from being easily accomplished through to being a source of major cultural disruption. At the individual level, we need to consider the psychological changes that individuals in all groups undergo, and their eventual adaptation to their new situations. Identifying these changes requires sampling a population and studying individuals who are variably involved in the process of acculturation. These changes can be a set of rather easily accomplished behavioural shifts (e.g. in ways of speaking, dressing, eating, and in one's cultural identity) or they can be more problematic, producing acculturative stress as manifested by uncertainty, anxiety, and depression (Berry, 1976). Adaptations can be primarily internal or psychological (e.g. sense of well-being, or self-esteem) or sociocultural (Ward, 1996), linking the individual to others in the new society as manifested for example in competence in the activities of daily intercultural living.

Cultural identity

During acculturation, individuals have to deal with the question: 'Who am I?' Although this question has many dimensions (such as age, gender, social class, religion), we are concerned here with the cultural dimension of the question. Considerable research (e.g. Berry, 1999, Liebkind, 2006; Phinney, 1990) has revealed evidence for a complex pattern of thoughts, feelings and social relationships that make up a person's cultural identity.

As for acculturation, the issue of one's cultural identity comes to the fore during intercultural contact: individuals engage two systems of cultural norms, beliefs and practices, and attempt to sort out who they are in relation to these two ways of living. Cultural identity involves, at its core, a sense of attachment or commitment to a cultural group, and is thus a cultural as well as a psychological phenomenon. In this sense it requires the existence of a cultural group, which can be actual and viable at present, remembered from one's past, or imagined in one's future. And, as for acculturation, cultural identity involves the possibility of change, both over time, and from situation to situation. This malleability renders it difficult to pin down as a relatively stable feature of an individual's psychological make-up.

Intercultural strategies

Not all groups and individuals undergo acculturation in the same way; there are large variations in how people seek to engage the process. These variations have been termed acculturation strategies (Berry, 1980, 2003). A parallel concept of identity strategies (Camilleri & Malewska-Peyre, 1997) has been proposed to specify the variations in the ways that individuals may identify themselves during intercultural contact and the ensuing process of acculturation. Which strategies are used depends on a variety of antecedent factors (both cultural and psychological); and there are variable consequences (again both cultural and psychological) of these different strategies. These strategies consist of a number (usually related) components, including attitudes and behaviours. Preferences about how to live interculturally, and the actual behaviours that are exhibited in day-to-day intercultural encounters reveal marked variations from group to group and from person to person. These variations in ways of acculturating are sometimes referred to as the 'how?' question in acculturation research (Berry *et al.*, 2006).

Acculturation strategies

The centrality of the concept of acculturation strategies can be illustrated by reference to each of the components included in the framework mentioned earlier (Berry, 2003). At the cultural level, the two groups in contact (whether dominant or non-dominant) usually have some notion about what they are attempting to do (e.g. colonial policies, or motivations for migration), or what is being done to them, during the contact. Similarly, the kinds of changes that are likely to occur will be influenced by their strategies. At the individual level, both the behaviour changes and acculturative stress phenomena are now known to be a function, at least to some extent, of what people try to do during their acculturation; and the longer term outcomes (both psychological and sociocultural adaptations) often correspond to the strategic goals set by the groups of which they are members.

Four acculturation strategies have been derived from two basic issues facing all acculturating peoples. These issues are based on the distinction between orientations towards one's own group, and those towards other groups (Berry, 1980). This distinction is rendered as (1) a relative preference for maintaining one's heritage culture and identity and (2) a relative preference for having contact with and participating in the larger society along with other ethnocultural groups. It has now been well demonstrated that these two dimensions are empirically, as well as conceptually, independent from each other (Ryder, Alden & Paulhus, 2000). This two dimensional formulation is presented in Fig. 13.1.

These two issues can be responded to on attitudinal dimensions, represented by bipolar arrows. For purposes of presentation, generally positive or negative orientations to these issues intersect to define four acculturation strategies. These strategies carry different names, depending on which ethnocultural group (the dominant or non-dominant) is being considered. From the point of view of non-dominant groups (on the left of Fig. 13.1), when individuals do not wish to maintain their cultural identity and seek daily interaction with other cultures, the Assimilation strategy is defined. In contrast, when individuals place a value on holding on to their original culture, and at the same time whish to avoid interaction with others, then the Separation alternative is defined. When there is an interest in both maintaining one's original culture, while in daily interactions with other groups, Integration is the option. In this case, there is some degree of cultural integrity maintained, while at the same time seeking, as a member of an ethnocultural group, to participate as an integral part of the larger social network. Finally, when there is little possibility or interest in cultural maintenance (often for reasons of enforced cultural loss), and little interest in having relations with others (often for reasons of exclusion or discrimination) then Marginalization is defined.

This presentation was based on the assumption that non-dominant groups and their individual

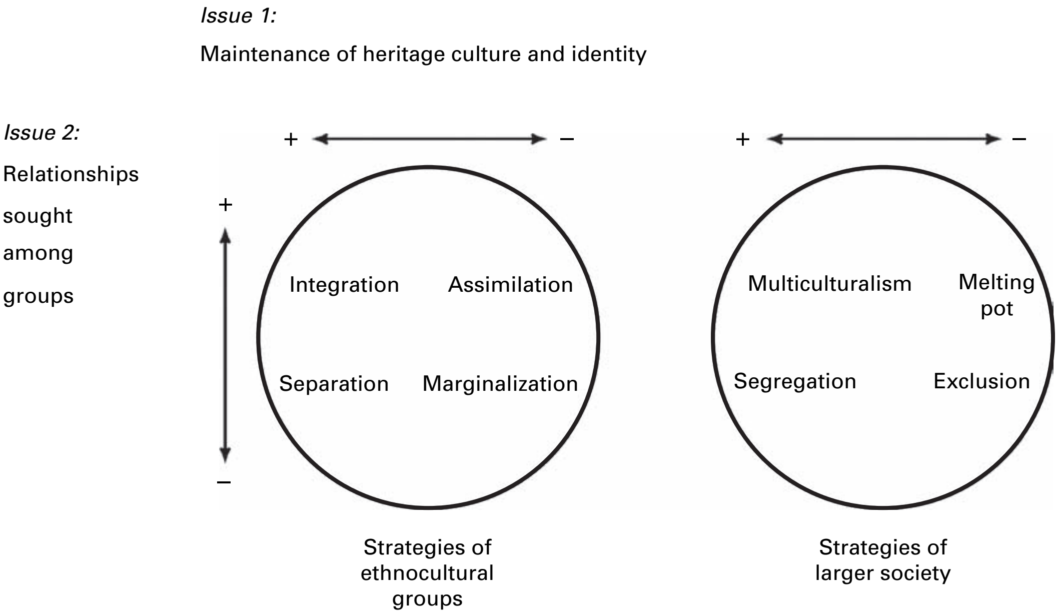

Fig. 13.1. Acculturation strategies in ethnocultural groups and in the larger society. (Also see Fig. 4.4.)

members have the freedom to choose how they want to acculturate. This, of course, is not always the case. When the dominant group enforces certain forms of acculturation, or constrains the choices of non-dominant groups or individuals, then other terms need to be used (see below).

Integration can only be 'freely' chosen and successfully pursued by non-dominant groups when the dominant society is open and inclusive in its orientation towards cultural diversity. Thus a mutual accommodation is required for Integration to be attained, involving the acceptance by both groups of the right of all groups to live as culturally different peoples. This strategy requires non-dominant groups to adopt the basic values of the larger society, while at the same time the dominant group must be prepared to adapt national institutions (e.g. education, health, labour) to better meet the needs of all groups now living together in the plural society.

These two basic issues were initially approached from the point of view of the non-dominant ethnocultural groups. However, the original anthropological definition clearly established that both groups in contact would change and become acculturated. Hence, a third dimension was added: that of the powerful role played by the dominant group in influencing the way in which mutual acculturation would take place (Berry, 1974). The addition of this third dimension produces the right side of Fig. 13.1. Assimilation when sought by the dominant group is termed the 'Melting Pot'. When Separation is forced by the dominant group it is 'Segregation'. Marginalization, when imposed by the dominant group it is 'Exclusion'. Finally, Integration, when diversity is a widely accepted feature of the society as a whole, including by all the various ethnocultural groups, it is called 'Multiculturalism'.

With the use of this framework, comparisons can be made between individuals and their groups, and between non-dominant peoples and the larger society within which they are acculturating. The ideologies and policies of the dominant group constitute an important element of intercultural research (see Berry *et al.*, 1977; Bourhis *et al.*, 1997), while the preferences of non-dominant peoples (their acculturation strategies) are a core feature in acculturation research, (Berry *et al.*, 1989). Inconsistencies and conflicts between these various acculturation preferences are commonly sources of difficulty for acculturating individuals. Generally, when acculturation experiences cause problems for acculturating individuals, we observe the phenomenon of acculturative stress, with variations in levels of adaptation. These phenomena are sometimes referred to as the 'how well?' question in acculturation research.

Identity strategies

A parallel approach to understanding variations in how individuals engage their intercultural worlds uses the concept of identity strategies. This approach has been developed by Camilleri and colleagues (Camilleri, 1991; Camilleri & Malewska-Peyre, 1997). These *stratégies identitaires* have clear similarities to the various acculturation strategies discussed above.

Just as the notion of acculturation strategies is based on two underlying dimensions (own cultural maintenance, and involvement with other cultures), there is now a consensus that how one thinks of oneself (i.e., one's cultural identity) is also constructed along two dimensions (Phinney, 1990). The first is identification with one's heritage or ethnocultural group, and the second is identification with the larger or dominant society. These two aspects of cultural identity have been referred to in various ways: ethnic identity and civic identity (Kalin & Berry, 1995); ethnic identity and national identity (Berry *et al.*, 2006) and heritage identity and national identity. Moreover (as for the acculturation dimensions) these dimensions are independent of each other (in the sense that they are not negatively correlated, or that more of one does not imply less of the other).

These two identity dimensions have both theoretical and empirical similarities with the four acculturation strategies: when both identities are asserted, this resembles the Integration strategy; when one feels neither, then there is a sense of Marginalization; and when one is strongly emphasized over the other, then the cultural identities resemble either the Assimilation or Separation strategies. Evidence for this link is found in numerous empirical studies where acculturation strategies and cultural identities have both been assessed. For example, these two strategies have been examined together by Georgas and Papastylianou (1998) among samples of ethnic Greeks remigrating to Greece. They found that those with a 'Greek' identity were high on the Assimilation strategy, those with a 'mixed' (e.g. Greek–Albanian) were highest on Integration, and those with an 'Indigenous' (e.g. 'Albanian') identity were highest on Separation. These findings are consistent with expectations about how acculturation and identity strategies should relate to each other. Similarly, Laroche *et al.* (1996) found the expected correspondence between measures of cultural identity and acculturation strategies in studies with French–Canadians. In a large international study of immigrant youth (Berry *et al.*, 2006), this consistent pattern was also found: those who preferred Integration had strong ethnic and national identities; those who preferred either Assimilation or Separation had a strong identity with one, but weak identity with the other group; and those who preferred Marginalisation, had weak identities with both groups.

In their work on identity strategies (e.g. Camilleri & Malewska-Peyre, 1997) a distinction is drawn between a 'value identity' (what an individual would like to be ideally; cf. acculturation attitudes) and their 'real identity' (what an individual is like at the present time; cf. acculturation behaviours). These two aspects of identity can be very similar or very different (cf. the discrepancy between acculturation attitudes and behaviours). In the case of discrepancy, individuals will usually strive to reduce the difference between the two. During intercultural encounters, non-dominant individuals (e.g. Muslim migrants in France, where most of Camilleri's work has been done) may begin to perceive a greater difference between their real self (as rooted in their own culture), and a new ideal self that is communicated, perhaps imposed, by the dominant French society. For Camilleri and Malewska-Peyre (1997), such discrepancies are particularly large among immigrant adolescents, who often share the values of their peers in the dominant society, in opposition to those of their parents' heritage culture group. This frequently leads to conflict that needs to be resolved using various strategies to preserve an individual's 'coherence of identity'.

One of these identity strategies is to maintain 'simple tolerance', avoiding identity conflict by clinging to one's heritage cultural values, and ignoring or rejecting challenges to these from the dominant culture; this identity strategy resembles the acculturation strategy of Separation. A second identity strategy is that of 'pragmatism' in the face of pressure to adapt to the dominant culture. In this case, young immigrants maintain 'traditionalist' identity and behaviour in their relationships with their parents (and their heritage cultural community), and a 'modernist' orientation with their peers; this may also be seen as a 'chameleon identity'. When such a combination is possible, it resembles one form of the Integration acculturation strategy. Another strategy that resembles Integration is that of 'conflict avoidance by complex coherence'. In this case, individuals use a 'strategy of maximization of advantages' in which the most advantageous aspects of each culture are selected and interwoven into one's identity. Of course, when one's heritage culture no longer contributes to one's sense of self, then exclusive identification with the dominant society may take place, resembling the Assimilation acculturation strategy. Alternatively, when both the heritage and dominant cultures are not part of one's identity (which is the case frequently of young immigrants in Europe), the situation of Marginalization is present.

Acculturative stress

Three ways to conceptualize outcomes of acculturation have been proposed by Berry (1992; see Fig. 13.2). In the first conception (behavioural shifts) we observe those changes in an individual's behavioural repertoire that take place rather easily, and are usually non-problematic. This process encompasses three sub-processes: culture shedding; culture learning; and culture conflict. The first two involve the selective, accidental or deliberate loss of behaviours, and their replacement by behaviours that allow the individual a better 'fit' in with the larger society. Most often, this process has been termed 'adjustment' (Ward, 1996), since virtually all the adaptive changes take place in the non-dominant acculturating individual, with few changes occurring among members of the larger society. These adjustments are typically made with minimal

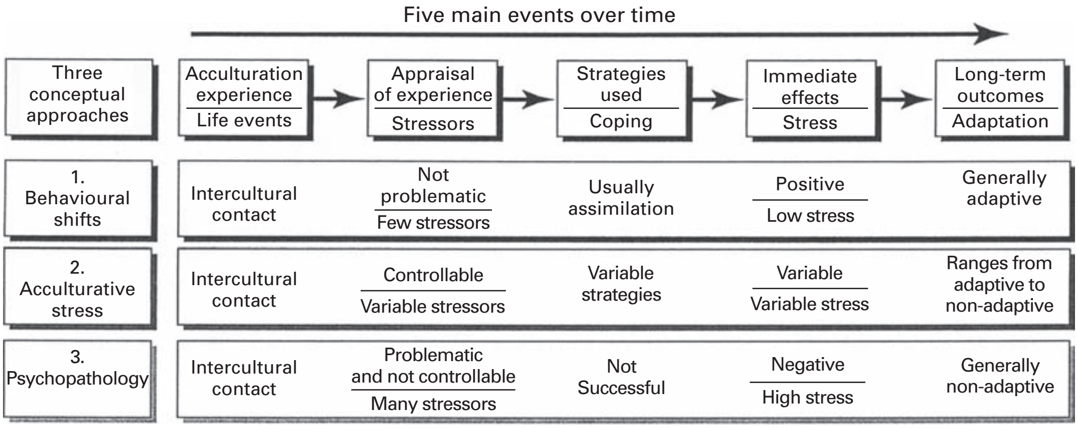

Fig. 13.2. The process of acculturation and adaptation, with three conceptual approaches.

difficulty, in keeping with the appraisal of the acculturation experiences as non-problematic. However, some degree of conflict may occur, which is usually resolved by the acculturating person yielding to the behavioural norms of the dominant group. In this latter case, Assimilation is the most likely outcome.

When greater levels of conflict are experienced, and the experiences are judged to be problematic but controllable and surmountable, then the second approach (acculturative stress) is the appropriate conceptualization (Berry, 1970; Berry, Kim, Minde & Mok, 1987). In this case, individuals experience change events in their lives that challenge their cultural understandings about how to live. These change events reside in their acculturation experiences, hence the term 'acculturative' stress. In these situations, they come to understand that they are facing problems resulting from intercultural contact that cannot be dealt with easily or quickly by simply adjusting or assimilating to them. Drawing on the broader stress and adaptation paradigms (e.g. Lazarus & Folkman, 1984), this approach advocates the study of the process of how individuals deal with acculturative problems on first encountering them, and over time. In this sense, acculturative stress is a stress reaction in response to life events that are rooted in the experience of acculturation.

A third approach (psychopathology) has had long use in clinical psychology and psychiatry. In this view, acculturation is usually seen as problematic; individuals usually require assistance to deal with virtually insurmountable stressors in their lives. However, contemporary evidence (e.g., Beiser, 2000; Berry & Kim, 1988; Berry *et al.*, 2006) shows that most people deal with stressors and re-establish their lives rather well, with health, psychological and social outcomes that approximate those of individuals in the larger society.

Instead of using the term culture shock (see Ward, Bochner & Funham, 2001*)* to encompass these three approaches, we prefer to use the term acculturative stress for two reasons. Firstly, the notion of shock carries only negative connotations, while stress can vary from positive (eustress) to negative (dis-stress) in valence. Since acculturation has both positive (e.g. new opportunities) and negative (e.g. discrimination) aspects, the stress conceptualization better matches the range of affect experienced during acculturation. Moreover, shock has no cultural or psychological theory, or research context associated with it, while stress (as noted above) has a place in a well-developed theoretical matrix (i.e. stress-coping-adaptation). Secondly, the phenomena of interest have their life in the intersection of two cultures; they are intercultural, rather than cultural in their origin. The term culture implies that only one culture is involved, while the term acculturative draws our attention to the fact that two cultures are interacting, and producing the problematic phenomena. Hence, for both reasons, I prefer the notion of acculturative stress to that of culture shock.

Relating these three approaches to acculturation strategies, some consistent empirical findings allow the following generalizations (Berry, 1997; Berry & Sam, 1997). For behavioural shifts, fewest behavioural changes result from the Separation strategy, while most result from the Assimilation strategy; Integration involves the selective adoption of new behaviours from the larger society, and retention of valued features of one's heritage culture; and Marginalization is often associated with major heritage culture loss, and the appearance of a number of dysfunctional and deviant behaviors (such as delinquency, and substance and familial abuse). For acculturative stress, there is a clear picture that the pursuit of Integration is least stressful (at least where it is accommodated by the larger society), while Marginalization is the most stressful; in between are the Assimilation and Separation strategies, sometimes one, sometimes the other being the less stressful. This pattern of findings holds for various indicators of mental health (Berry & Kim, 1988; Schmitz, 1992), and for self-esteem (Phinney *et al.*, 1992).

Individuals engage in the appraisal of these experiences and behavioural changes. When they are appraised as challenging, some basic coping mechanisms are activated. Lazarus and Folkman (1984) have identified two major coping functions: problem-focused coping (attempting to change or solve the problem) and emotion-focused coping (attempting to regulate the emotions associated with the problem). More recently, Endler and Parker (1990) have identified a third: avoidance-orientated coping. It is not yet clear how the first two coping strategies relate to acculturation strategies since both forms of coping are likely to be involved in Assimilation and Integration. However, the third (avoidance) closely resembles the Separation and possibly the Marginalization strategies.

Adaptation: psychological and sociocultural

As a result of attempts to cope with these acculturation changes, some long-term adaptations may be achieved. As mentioned earlier, adaptation refers to the relatively stable changes that take place in an individual or group in response to external demands. This was referred to earlier as the 'how well?' question. Moreover, adaptation may or may not improve the 'fit' between individuals and their environments. It is thus not a term that necessarily implies that individuals or groups change to become more like their environments (i.e. adjustment by way of Assimilation), but may involve resistance and attempts to change their environments, or to move away from them altogether (i.e. by Separation). In this usage, adaptation is an outcome that may or may not be positive in valence (i.e. meaning only well-adapted). This bi-polar sense of the concept of adaptation is used in the framework in Fig. 13.2, where long-term adaptation to acculturation is highly variable ranging from well to poorly adapted, varying from a situation where individuals can manage their new lives very well, to one where they are unable to carry on in the new society.

Adaptation is also multifaceted. The initial distinction between psychological and sociocultural adaptation was proposed and validated by Ward (1996). Psychological adaptation largely involves one's psychological and physical well-being, while socio-cultural adaptation refers to how well an acculturating individual is able to mange daily life in the new cultural context. While conceptually distinct, they are empirically related to some extent (correlations between the two measures are in the + 0.4 to + 0.5 range). However, they are also empirically distinct in the sense that they usually have different time courses and different experiential predictors. Psychological problems often increase soon after contact, followed by a general (but variable) decrease over time; sociocultural adaptation, however, typically has a linear improvement with time. Analyses of the factors affecting adaptation reveal a generally consistent pattern. Good psychological adaptation is predicted by personality variables, life-change events, and social support while good sociocultural adaptation is predicted by cultural knowledge, degree of contact, and positive intergroup attitudes.

Research relating adaptation to acculturation strategies allows for some further generalizations (Berry, 1997; Ward, 1996). For all three forms of adaptation, those who pursue and accomplish Integration appear to be better adapted, while those who are Marginalized are least well adapted. And again, the Assimilation and Separation strategies are associated with intermediate adaptation outcomes. While there are occasional variations on this pattern, it is remarkably consistent, and parallels the generalization regarding acculturative stress.

The most comprehensive evidence for the relationship between how people acculturate and how well they adapt comes from the study of immigrant youth mentioned above (Berry *et al.*, 2006). Individuals who carry out their intercultural lives in an 'integrative' way of acculturating (i.e. those who preferred Integration, had positive identities with and had social contacts with peers from both groups, and were able to speak both languages) had positive psychological and sociocultural adaptation. In sharp contrast, poor adaptation was the outcome for those youth who were 'diffuse' in their way of acculturating (with a pattern made up of unclear acculturation attitudes and weak identities with both groups). In second place, with respect to how well they were adapting, were youth with an 'ethnic' orientation to acculturation (a preference for

Separation, a strong ethnic but a weak national identity, and close ties with peers from their own group but weak ties with members in the national society). And third, somewhat surprisingly, were adolescents with a 'national' orientation to acculturation (a preference for Assimilation, a strong national but a weak ethnic identity, and close ties with peers from the national society, but weak ones with peers from their own ethnic group). This pattern of relationships between how and how well people manage their acculturation has clear implications for their wellbeing, and some further implications for how professionals in clinical practice and the schools, and for policy makers in various levels of government.

Implications

For policy makers, it is now evident that policies that promote Assimilation do not lead to well-adapted individuals who are in the process of acculturation. This long-standing preference of many countries to try to absorb immigrants and members of ethnocultural groups into some homogeneous single national culture has no research support. Even worse is any public policy that leads to their Marginalization, combining the exclusion of immigrants or refugees from participation in the larger society, and the denial of their own cultural rights. Segregation as a policy also lacks research support, although there is some evidence (Berry *et al.*, 2006) that when sought by acculturating individuals and groups (i.e. Separation), moderately good psychological adaptation results. The large body of evidence in support of Integration (and of Multiculturalism as a public policy) provides ample evidence for pursuing this way of organizing intercultural living in culturally plural societies.

At the individual level, including clinical practice in counseling, psychology, psychiatry, and social work, the same evidence supports the encouragement of individuals to maintain or regain their links with both cultures. Of course, the vast individual differences in acculturation and identity strategies outlined in this chapter makes it essential to first discover *how* each individual is trying to live. Tools are available to make this determination (Arends-Toth & Van de Vijver, 2006), and should be employed to find out both how they are currently, and how they would prefer to, live interculturally. On this basis, and with the knowledge that an integrative way is usually preferable, efforts can be made to guide acculturating individuals towards more positive adaptations.

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Cultural consonance

William W. Dressler

EDITORS' INTRODUCTION

The definitions of culture make it in some ways easy to understand but at the same time the inherent ambiguity in the definition makes it difficult to be used readily as a variable in research. Quite often language is confused with the ethnic group, ethnic groups are conflicted with racial identity and cultures get replaced with nation states in research studies and data analysis. The definitions of culture must include some dimensions which are easy to measure and their impact on mental illness easily gauged. Historically in epidemiological studies one group of individuals is compared with another group of individuals in a way that both groups are seen as homogenous and individual differences are ignored. Cultures influence physical illnesses as much as they do mental illnesses although the mediating factors may be different. The role of individual and the cultural characteristics have to be part of the assessment.

In this chapter, Dressler provides a theory of cultural consonance which links collective representations that make up the culture of a group with the practices of individuals who enact these representations. He argues that efforts to define more precisely the role of culture in processes of both physical and mental illnesses coincided with the development of the concept of psychosocial distress. Dressler suggests that the study of collective meanings and the relationship of culture to the individual are fundamental in culture theory. His concept of cultural consonance begins with the assumption that culture is both learned and shared and that the locus of culture is within individual beings and in the aggregate social groups made of human beings. Within the group, knowledge is distributed unevenly for several reasons. Cultural knowledge is both schematic and modular. The cultural model of a domain includes the elements of that domain and the intricate and complex relationship between these elements. Dressler points out that in cultural consensus analysis agreement among a set of informants is evaluated by collecting their responses first to a set of questions that sample knowledge of a domain. Each individual can then be observed putting their knowledge of the cultural model to use. Thus not only sharing can be evaluated, consensus can be quantified and intracultural diversity can be examined in two ways. In analysis, culturally best responses can be analysed. This approach can be used both for physical and mental illness. The individuals live in cultures and, especially if they have moved from cultures they were born in, the model allows these values to be ascertained.

Introduction

The importance of culture in the risk of a variety of disorders, including (but not limited to) cardiovascular disease and mental-health problems, is virtually unquestioned. A considerable amount of research effort has been expended on these general classes of health problems, since early studies documented cross-cultural differences in their distribution and set the stage for subsequent investigations. For example, with respect to cardiovascular disease, in the 1920s Donnison (1929) had already documented cross-cultural differences in mean blood pressure, while Kraepelin, working even earlier, suggested that the cultural milieu altered the risk of psychiatric disorder (Jilek, 1995).

What has bedevilled research ever since is how to conceptualize 'culture' in such a way that is useful

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in the research process. By that I mean a concept of culture that leads to the unambiguous measurement of some relevant dimension of culture, so that the influence of culture on health can actually be gauged relative to other potential risk factors. This is no small task, given that it requires that we start with very basic questions about what culture is, and then be able to follow a path with some fidelity from the theoretical to the empirical. It is, furthermore, no small task given that many excellent minds have bent their energies to its resolution, while workers in the field still lament the lack of a solution (Jenkins and Barrett, 2004).

There are, however, reasons for optimism, primarily because in the past twenty years there have been theoretical and methodological breakthroughs regarding our understanding of some very basic features of culture. These breakthroughs have come principally from the subfield of cognitive anthropology (D'Andrade, 1995). These insights can be adapted to the task of understanding the cultural dimensions of the risk of disease and, in turn, the special demands placed on culture theory by the study of health and disease can be productive with respect to the elaboration of that theory (Dressler, 1995, 2001).

In this chapter, the development of a theory of cultural consonance is described. This theory links the collective representations that make up the culture of a group with the practices of individuals who enact those representations. The individual differences in the implementation of these shared representations link culture as an aggregate, social phenomenon to risk at the level of the individual.

Orientations in the study of culture and health outcomes

A thorough review of the study of culture and health would be beyond the scope of this chapter; however, a brief discussion of how researchers have approached the topic will be useful for clarifying some of the important questions to be addressed. Also, the focus will be on blood pressure as a measure of cardiovascular health, and on mild or moderate psychological distress (as assessed by symptom checklists) as a measure of mental health. This is an appropriate emphasis since these are among the most often encountered outcome measures in cross-cultural research.

The initiation of systematic studies of cultural processes and health can be usefully dated to the Stirling County project of Leighton and associates with respect to psychological distress, and the studies of migration, modernization, and blood pressure carried out by various investigators. Leighton formulated a 'social disorganization' hypothesis. He argued that communities could be ordered along a continuum from the most integrated to the most disorganized or disintegrated. Indicators of the degree of disintegration included level of poverty and family stability, but above all else a disorganized community was characterized by a 'confusion of its cultural values' (Leighton and Leighton, 1967). Social change or modernization led to social disorganization, and the associated confusion of cultural values was related to psychological distress. Social disorganization (a term that he used interchangeably with social disintegration) was a characteristic not of individuals, but of communities. Communities could be assigned a position on the continuum of social disintegration by an ethnographer working over time in the community. Then, epidemiologic survey methods could be used to compare and contrast rates of psychological distress in these communities.

Studies of migration, modernization and blood pressure employed similar methods. In studies of migration, groups moving from traditional societies to urban centers in the same or other societies have been followed, showing that mean blood pressure increases in the urban centre. Similarly, communities arrayed along a continuum of modernization have been compared, showing that persons in the more modernized communities have higher mean blood pressures. These outcomes have been attributed in part to the conflict in values and beliefs between tradition and modernity, or between a home and host community, and the subsequent stresses of those conflicts (Dressler, 1999).

These kinds of studies established a baseline in research on culture and health. But the difficulty of unambiguously attributing these large-scale differences between communities to the influence of cultural factors is immediately apparent. Given the research design, it is just as likely that other kinds of differences such as diet or the separation of an individual from traditional sources of social support could account for these results. Just what role culture *per se* plays in the process is unclear.

Efforts to define more precisely the role of culture in these processes coincided with the elaboration of theories of psychosocial stress in the social sciences (Lazarus, 1966). Such theories were useful in providing categories of variables that might be important in the process. These included factors that increased the risk of distress, called 'stressors', that could be chronic or acute, as well as factors that helped individuals to withstand the effects of these stressors, called 'resistance resources'. These resources could be social, as in social-support systems, or psychological, as in specific patterns of individual coping with stressors. The elaboration of this general model has made it extremely influential in explaining individual differences in blood pressure and psychological distress.

Cross-cultural researchers used the general stress model as a source of inspiration in examining cultural factors associated with community-level differences in health outcomes. For example, an inevitable result of development efforts was a stressful incongruence between new status aspirations derived from exposure to the Euroamerican middle class and expressed through a medium of material lifestyles, and the economic means to achieve those aspirations (Dressler, 1982, 1991a). As local communities develop, individuals become increasingly familiar with the middle-class lifestyle of the developed world, including, as it does, considerable material comfort in the form of housing and consumer goods, as well as an elaboration of leisure activities. It is important to recognize, too, that what represents the concrete instantiation of a valued lifestyle in one community may differ from its representation in another community. (For example, in the African American community in the rural, southern United States, achieving a leadership position in the church is regarded as a part of a successful lifestyle, along with material goods.) The achievement of such a lifestyle is, typically, problematic in developing societies, given the slow pace of economic growth and job formation. The result is a stressful incongruence between status aspirations and economic resources, the outcome being higher blood pressure and psychological distress (Dressler, 1982, 1991a).

But contemporary stress theory suggests that stressors can be moderated by a number of factors, not least of which is the availability of both instrumental and emotional support from persons in one's social network. Where this social support is high, persons are protected from the deleterious effects of stressors, and where support is low, stress effects are enhanced (Cassel, 1976). In cross-cultural research it was found that status incongruence was buffered by social support, although, again, it should be noted that the exact composition and meaning of a social support network may differ from one community to another (Dressler, 1982, 1991a,b).

These studies illustrate the application of theories of the stress process in cross-cultural research. From the standpoint of theory and method, the important point here is how one gets from a broad view of cultural influences to specific operational indicators of stressors and supports. This requires linking the intensive descriptive methods of ethnography to more extensive, quantitative methods for hypothesis testing. A traditional approach using ethnographic methods involves participation in, and observation of, daily life, along with the interviewing of key informants, to arrive at an understanding of the culture. These methods are used to understand what, in the definitions of the persons in the local community, constitute important status aspirations, avenues for economic mobility, and social relationships within which individuals could anticipate support. Then, variables are operationalized in epidemiologic survey work to be consistent with that ethnographic understanding, and the distribution of blood pressure and psychological distress are examined relative to variation in those culturally defined stressors and supports.

Essentially, this same overall theoretical orientation and research design have been used by McGarvey to study blood pressure in Western and American Samoa (Chin-Hong and McGarvey, 1996; McGarvey and Schendel, 1986); by Bindon to study blood pressure in American Samoa (Bindon *et al.*, 1997); by Janes to study blood pressure and symptom reports among Samoan migrants to northern California (Janes, 1990); by Dressler to study blood pressure and depressive symptoms in an African American community in the rural Southern US (Dressler, 1991a, 1991b); and, more recently, by McDade (2001) to study immune function among Samoan adolescents. Two points stand out when these studies are compared. Firstly, in each context, basic theoretical constructs (e.g. status incongruence, social support) are operationalized with different measures, because the aim is to understand as precisely as possible what represents, for example, social status or social support in each setting, and then to measure those constructs as sensitively as possible in terms of those local representations. Second, the local ethnographic context can also alter the patterns of associations among the variables. For example, Bindon *et al.* (1997) found the association of status incongruence and blood pressure to be concentrated within certain household types. They argued that issues of status were differentially salient or meaningful for different kinds of families, thus changing the effects of status incongruence within different types of families.

This specific set of studies can be used to elucidate a nascent culture theory in the study of health. Clearly, the collective meaning of events and circumstances at the local level is central. While stress theory has long been guided by the assumption that personal or idiosyncratic meaning is an important part of the process, the studies reviewed above have aimed at understanding what is collectively meaningful with respect to status or social support, and then measuring factors in those terms (although it is worth noting that in his original formulations of the stress model, Lazarus (1966) placed heavy emphasis on collective meaning). Similarly, when introducing additional factors (e.g. family structure) into the process, the emphasis has been on the collective meaning of that factor and why, given that meaning, it might alter the relationships among the variables. An understanding of these collective meanings has been arrived at through conventional ethnographic field methods.

A second major feature of these studies is the explicit effort to link collective meaning to individual behaviour. The study of health outcomes demands this. It is the study of how experience gets written on the body and mind in terms of measurable physiological and psychological outcomes, and to do so it must trace culture to the individual.

These two issues – the study of collective meanings and the relationship of culture to the individual – are fundamental in culture theory. In fact, these form a part of a basic conundrum in culture theory that has continued to the present from its articulation in the nineteenth century (Boudon, 1988; de Munck, 2000; Keesing, 1974; Shore, 1991). That is, how can we sensibly retain a theory of culture as collective meaning and at the same time reconcile that with locating culture and behaviour in individuals? The danger here is reducing culture to the beliefs and values of individuals in order to connect the cultural to the individual. To some, such a social–psychological reduction may seem unproblematic, yet it seems to be inadequate to capture the complexity of cultural phenomena, for, as Keesing notes: ‘Social meanings transcend, by some mysterious alchemy of minds meeting, the individuation of private experience (1974: 84).’ At the same time, without linking the cultural to known psychophysiologic mechanisms mediating long-term problems of individual adaptation such as high blood pressure, the process by which culture shapes biological response will remain unspecified.

The studies reviewed above point the way to such a model, but await a more explicit development of theory and method, which is discussed below.

Background to a theory of cultural consonance

A theory of cultural consonance begins with the assumption that culture is both learned and shared, and that the locus of culture is both within individual human beings and in the aggregate social groups made up of human beings. This seeming contradiction is resolved when the concept of sharing is elaborated to mean, in part, 'distributed' (Sperber 1985). Following Goodenough (1996), culture is defined as the learned, shared knowledge that one must possess to function adequately in a social group. It is important not to confuse the meaning of the term knowledge with closely related concepts like belief. Here, knowledge is used in Searle's (1995) sense of the understandings that constitute human institutions. For example, to 'know' something about marriage in American society is to know that social expectations are such that one man will marry one woman; they will live independently of their families; they will pool economic resources; they will raise common children; they will anticipate sexual exclusivity; and, they will enter the union with the expectation of a lifelong commitment. To 'believe' something about marriage in American society is to adopt an evaluative stance relative to all or parts of that definition of marriage. But the definition, and the knowledge of that definition, constitute (or create, or construct) that social institution.

It is assumed that this knowledge is distributed within the social group, but the actual way in which that knowledge is distributed is an empirical issue. That is, this knowledge could be widely shared; it could be weakly shared and highly contested; it could be concentrated within one or more social subgroups; or, it might be widely shared but with specific points of contention. This distribution of knowledge means, at the least, that individuals command differing degrees of cultural knowledge; at the same time, even if any given individual does not him- or herself have very elaborate knowledge of a particular cultural domain, there is a sense of the collective, that 'we' think or do certain kinds of things (D'Andrade, 1984; Keesing, 1974; Searle, 1995). It is this distributive quality of culture that makes it an aggregate property of a social group while, at the same time, locating it squarely within the cognitive structures of individuals (Atran, Medin, and Ross, 2005; Rodspeth, 1998).

The form that cultural knowledge takes is described well by current culture theory in cognitive anthropology (D'Andrade 1995; Strauss and Quinn, 1997; Romney and Moore, 1998; Shore, 1996). Cultural knowledge exists in varying degrees of schematicity or modularity, so that the term 'cultural model' can be used as a shorthand way of denoting this knowledge that is skeletal, in outline form, and shared (D'Andrade, 1992). The cultural model of a domain includes the elements of that domain and the relationships among those elements. It describes widely assumed and understood processes within the domain, and how that domain links with others. The modular form of cultural knowledge makes it highly generalizable. For example, in the oft-cited example of a model for going to eat in a restaurant, understanding how this process works generally applies to French, German, Latin American and Chinese restaurants in the United States (D'Andrade, 1995). The cultural schema can be tailored and applied to many specific instances.

Cultural models will vary considerably in abstraction and their link to other models. For example, a model of small-scale commercial transactions (i.e. how to buy something) can be incorporated into many more comprehensive models (e.g. going on holiday).

Again, however, to be a truly cultural model, this modular knowledge must be shared. It is a shared understanding of what are, in many cases, arbitrary models of the world that gives those models causal potential (Tylor 1871; Berger and Luckman 1967). Assessing sharing has been a major problem in culture theory and research. With the advent of the cultural consensus model, however, a systematic way for evaluating the degree of sharing, or consensus, in a cultural domain became available (Romney, Weller and Batchelder, 1986). In cultural consensus analysis, agreement among a set of informants (and in many applications a small set, e.g. around 30, is sufficient) is evaluated by first collecting their responses to a set of questions that sample knowledge of a domain. Then, a kind of statistical thought experiment is conducted in which an aggregate model of the 'culturally best' responses is proposed, and the degree to which each informant's responses match that aggregate model is evaluated. If, overall, there is a relatively high degree of correspondence between each informant's set of responses and the hypothesized culturally-best model, then it can be said that there is consensus regarding that knowledge, and it is further reasonable to infer that each individual is using the same or a very similar model. Note that the responses to the questions by each informant, and the aggregate responses, are generated by each informant's knowledge of the cultural model, but these are not the model *per se*. The cultural model remains a hypothetical construct of which we have evidence, but which we do not observe directly. We can observe each individual putting their knowledge of the cultural model to use.

Cultural consensus and cultural consonance

There are several important theoretical and methodological advances provided by the cultural-consensus model. Firstly, sharing can be unambiguously evaluated. Secondly, consensus can be quantified, and low consensus versus high consensus cultural domains (and everything in between) can be identified. Thirdly, intracultural diversity can be examined in two ways. On the one hand, the degree to which some individuals match the aggregate model better than others in their own knowledge can be quantified in terms of the cultural competence coefficient (which is literally the correlation of the individual's profile of responses and the hypothesized aggregate model). The higher this coefficient, the more effectively an individual's responses replicate the responses of the group as a whole. These cultural competence coefficients can then be compared by social category, to determine what the mean level of competence is of individuals in different social categories. On the other hand, there may be more than one consensus model for a domain, and these can be identified using cultural consensus analysis. Fourthly, the culturally best set of responses is estimated in the analysis; these represent the most likely answers to those questions offered by any generally culturally competent member of that society, and, given the level of cultural consensus, it is possible to define the confidence in the reliability and generalizability of the responses (these properties are discussed by Handwerker, 2002).

In summary, a theory of cultural models and the cultural-consensus model provide a means for resolving the apparent paradox of culture as a term the referent of which is both an aggregate and the individual. Cultural models are located in the heads of informants, to be sure, but cultural models have certain aggregate properties in that such models (not mental models in general, but *cultural* models specifically) are distributed across minds. The size and shape of the cultural model can only be extracted from responses of a sample of individuals, and the resulting model (or, more precisely, culturally appropriate responses to questions generated by that model) is not some simple averaging of individual thoughts and ideas, but rather takes into account the fact that some individuals are more competent in that model than others. The culturally-best set of responses estimated from cultural consensus analysis gives higher weight to informants who are more culturally competent.

This approach enables us to describe what is prototypical and appropriate in a given cultural domain, as that is understood within a social group. One critique that has been traditionally leveled against cognitive approaches in culture theory is that they deal with how things are thought to be and not with actual practice or behaviour. Bourdieu (1990) in particular has argued that the study of cognitive orientations as constructive of understanding must be linked both to the position of an individual in the social structure and to the ways in which culturally constructed knowledge is realized in practice (see Crossley 2001). The link of cultural model and behaviour is likely to be imperfect for two reasons. Firstly, in many domains, the cultural model will provide only general guidelines for behaviour that must be sorted out in the context of specific influences and constraints within a given context. (It is worth noting, too, that a theory of cultural models leaves ample room for individual agency, within certain limits.) Secondly, some individuals, while they know the model, will be unable to act on it. In many instances this inability to act on a model will be a function not of the individual's motivation, but of limits placed on the individual action, principally as a function of social and economic constraints (Dressler, Santos and Balieiro 1996). What this means is that for some people, under some circumstances, there will be a gap between their knowledge of what is culturally prototypical, and what they themselves are doing. The link of individual practice to shared cultural models is a measurable phenomenon. I have proposed the term 'cultural consonance' for this link, defined specifically as the degree to which individuals, in their own beliefs and behaviours, approximate the shared expectations encoded in cultural models.

A number of authors anticipated the theoretical construct of cultural consonance. For example, Cassel, Patrick and Jenkins (1960) argued that, among migrants to a novel cultural setting, there may be a mismatch between the values and expectations of the migrant and the values and expectations of the host society (see also Bhugra, 2004). French, Rogers and Cobb (1974) proposed a concept of 'person–environment fit' to describe the consistency between an individual's attitudes and the values of a particular social setting.

The construct of cultural consonance can be regarded as distinct in two senses. Firstly, as argued thus far, a theory of cultural consonance is embedded in a cognitive theory of culture, and is thus more explicit in describing the larger environment of shared meaning in which individuals act. Secondly, there is a clear set of research procedures associated with the theory of cultural consonance for determining the degree of sharing within a particular cultural domain, and then in turn connecting shared meaning to individual belief and behaviour. There is thus a direct, measured link from collective representation to individual practice.

That there are social costs to the violation of social expectations is well-known. The question, however, is: what are the psychological and biological costs of low cultural consonance?

Cultural consonance and health outcomes

Cultural consonance and its associations with health outcomes have been examined in three major studies, two conducted in urban Brazil and one in the African American community of a small city in the Southeastern United States (Dressler, 2005; Dressler and Bindon, 2000). The Brazilian studies examined a variety of outcomes, including blood pressure, depressive symptoms, body composition, and food intake; the US study focused exclusively on blood pressure. Cultural consonance is an extremely flexible concept in the sense that a person's consonance could be measured within virtually any cultural domain. The initial studies of cultural consonance focused on the cultural domains of lifestyle and social support because these had proven significant in earlier studies of sociocultural stress that laid the groundwork for the concept of cultural consonance. Lifestyle refers to the accumulation of material goods and the adoption of related (especially leisure time) practices. As Veblen (1899) pointed out in the nineteenth century, lifestyle is a way of projecting into mundane social interaction a claim to a particular social status. Although Veblen is usually associated with the notion of 'conspicuous consumption' with respect to lifestyles, he also argued that the majority of people aspire to what he called 'a common standard of decency'; that is, individuals seek not to exceed local standards of lifestyle, but rather to attain what is collectively regarded as a 'good life', often more a kind of modest domestic comfort than a high level of consumption. In examining cultural models of lifestyle in Brazil and in the African–American community, this is precisely what we found (although the specific content of models differs between societies).

Social support refers to the help and assistance that individuals can anticipate and receive in times of felt need. There are several facets to social support, and one that has received relatively little attention is the cultural model of social support. In our work, we have found that there are shared models of appropriate sources of social support in relation to specific kinds of problems. These tend to be quite variable across societies. For example, in Brazil, the cultural model of social support is somewhat like a series of concentric circles around the individual, with family and friends forming the inner circles, and less intimate relationships forming the outer circle. At the same time, there are distinct kinds of problems for which certain kinds of supporters can be approached, even if they are regarded as more intimate. In the African American community, there is a separation between kin and nonkin supporters, with one or the other set of supporters being preferred within different social contexts (Dressler and Bindon 2000; Dressler *et al.*, 2005).

In both studies we confirmed, using cultural consensus analysis, that there were broadly shared cultural models of lifestyle and social support. Then, in survey research, we asked individuals specifically about their own lifestyles and patterns of social support. Cultural consonance is measured by how closely an individual's reported behaviour corresponds to the culturally prototypical patterns described by the cultural models. In Brazil, we found higher cultural consonance in both dimensions to be associated with lower blood pressure, fewer reported symptoms of depression, higher caloric intake, and lower body fat and body mass index (Dressler, Balieiro and Santos 1997, 1998, 2002; Dressler *et al.*, 2004). In the African American community, we found an interaction between cultural consonance in lifestyle and cultural consonance in social support, such that for all respondents higher cultural consonance in lifestyle was associated with lower blood pressure, but the association was stronger for individuals who also had high cultural consonance in social support (Dressler and Bindon, 2000).

More recent work in Brazil has enabled us to extend the cultural consonance model in two ways. Firstly, using more precise methods of data collection and analysis from cognitive anthropology (Ross, 2004), we have confirmed the outlines of the cultural models of lifestyle and social support from previous studies. Secondly, we have expanded the cultural domains examined, by including national identity, family life, and food. These cultural domains were selected for study both on the basis of their theoretical interest and on the basis of ethnographic observation. For example, with respect to the cultural domain of family life, there is ample theoretical justification for its inclusion in any study of health outcomes, and, the family is a cultural domain that is the focus of much interest and discussion in everyday discourse in Brazil. Food is also a focus of much interest in Brazil (DaMatta, 1985). From a theoretical standpoint, it is useful to separate the cultural meaning of food from nutrient intake, and examining food as a cultural domain enabled us to do that (Oths, Carolo and Santos, 2003). Finally, there has been considerable historical interest in national identity in the social sciences (Leite, 2002; Gorer, 1948), and cultural domain analyses and the measurement of cultural consonance afforded a novel approach to its examination.

In analyses thus far (and we are still very much in the thick of analyzing these data) we have already accomplished several goals. In research published thus far, the following results have been obtained. Firstly, using more precise methods, we have confirmed the cultural models of lifestyle and social support. Secondly, we have replicated, after a period of ten years, the association of cultural consonance in both domains and arterial blood pressure. Thirdly, we have observed that there are shared cultural models in the domains of national identity, family life, and food, and we have developed measures of cultural consonance in each domain. Fourthly, we have observed associations between cultural consonance in these domains with blood pressure and various measures of psychological distress (including depressive symptoms, perceived stress, and locus of control). And fifthly, cross-sectionally, cultural consonance is associated with blood pressure and psychological distress controlling for other, relevant variables, such as (depending on the particular outcome variable used) nutrient intake, the body mass index, socioeconomic status, and other measures of stress and coping (Dressler, 2005; Dressler *et al.*, 2005; Dressler *et al.*, 2005). Completed analyses as yet unpublished show the association of cultural consonance with body composition, and that cultural consonance is prospectively associated with psychological distress at a 2-year follow-up.

Issues in the study of cultural consonance

This theory of cultural consonance, and its associated measurement model, deals with a number of difficult issues. Perhaps most importantly, it takes seriously the two sides of culture: as an environment of shared meaning that refers to an aggregate, and as a set of understandings that individuals learn within that environment of shared meaning. It then takes the additional step of examining how individuals are differentially able to put those understandings into practice in their own behaviour. Ultimately, results thus far suggest that there are psychological and physiological costs to low cultural consonance.

What mediates the effects of cultural consonance? At one level, cultural consonance must shape an individual's sense of how the world works, in the sense discussed by Aaron Antonovsky (1981) many years ago. Antonovsky argued that a person who maintained good health in its broadest sense would have a world view that he described as a 'sense of coherence', defined as:

> . . . a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected (Antonovsky 1979: 123).

The individual with a higher level of cultural consonance (although not necessarily the highest level, see Dressler, 2005) shares an understanding with her peers of how the world is supposed to work, and her world, in fact, conforms to that expectation. On the other hand, the individual with a lower level of cultural consonance is faced with a world in which things simply do not work out in accordance with expectation.

The gap between expectation and experience is especially acute in the cultural domains we have studied because cultural competence in the domains is so widely and uniformly distributed. That is, 'everyone' (within the limits of individual competences) knows the models, but not everyone is able to enact those models in their lives. It is this sense of 'incoherence' that is likely to be stressful and contribute to the risk of disease.

There are many interesting questions yet to be pursued in the study of cultural consonance and health outcomes. For example, we have found that cultural consonance in the domains of lifestyle and social support have quite specific associations with blood pressure; with the exception of a small effect of cultural consonance in family life, cultural consonance in no other domain is associated with blood pressure. With psychological distress, on the other hand, higher cultural consonance in every domain is associated with lower psychological distress. Exploring the basis for these varying patterns of association will be of considerable utility to better understand this process.

Another interesting avenue of investigation will be the effects of cultural consonance where there is clear intracultural diversity in cultural models. This refers to the existence of two or more cultural models of a single cultural domain in a single social group. For example, Chavez *et al.* (2001) found alternate, and only partially compatible, cultural models of reproductive cancers among women in southern California. Cultural competence in one of these models tended to be associated with ethnicity, although there was considerable overlap in competence among ethnic groups as well. These researchers then examined the influence of cultural consonance with different cultural models on health behaviours, finding that cultural consonance with only one of three alternative cultural models of reproductive cancers was associated with positive health behaviors. This research, although not dealing with direct associations with health outcomes, provides an example for the investigation of the health effects of cultural consonance in the context of intracultural diversity.

In the final analysis, the theory of cultural consonance and the results from the empirical analysis of this theory suggest that, in health, culture matters. Individuals live out their lives in a space of meaning constructed out of shared cultural models. Where their personal beliefs and behaviours situate them in this space can have profound implications for their well-being.

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PART III

Culture and mental disorders

Neurosis

Santosh K. Chaturvedi and Geetha Desai

EDITORS' INTRODUCTION

Although there have been concerns about the use of the term neurosis, which has been eliminated in DSM IV, the term has been retained in ICD-10 and used widely, although pejoratively at times. The prevalence of neurosis varies across cultures and the cultural pressures determine how these symptoms persist. The classical example of this is the use and diagnosis of the term neurasthenia. Used extensively in the Far East, China and other nations, the symptoms are not too dissimilar to depression or chronic fatigue and the diagnosis carries a social cachet.

In this chapter, Chaturvedi and Desai provide an overview of the concept of neurosis. They point out that neurosis is considered a maladaptive pattern of behaviour following a stressful situation which leads to an avoidance of responsibility and the stressful situation itself. They argue that there must be an evidence of stress, the reaction to the stress must be maladaptive and there should be an evidence of anxiety proneness. The anxiety provoking situations in the past should have resulted in excessive nervousness, depression or somatic symptoms. They point out that not only is the diagnosis influenced by culture but the importance given to symptoms and the meaning assigned by the clinician will depend upon culture. These symptoms may reflect a failure to cope but may also be a cry for help, requiring support and understanding from the friends, families and professionals.

Introduction

The term 'neurosis' has been ascribed various meanings and definitions. There has been an effort to abandon this term; however, it is still used by physicians and many psychiatrists in their clinical practice. In ICD-10 all neurotic disorders have been clubbed under the rubric 'neurotic, stress related and somatoform disorders'. In DSM IV the term has been eliminated.

Neurosis is considered a maladaptive pattern of behaviour (or reaction), following a stressful situation, which tends to avoid responsibility (instead of facing up to the stress) and the stressful situation itself. Three factors, which have to be taken into consideration while making a diagnosis of a neurotic disorder, are as follows.

1. There should be an evidence of stress (or stressful situation) of recent origin which should have some temporal relationship with the development of symptoms. Many times a presumed or perceived stress rather than an actual stress may be present.
2. The reaction to the above stress (actual or presumed) should appear to be maladaptive, i.e. instead of coping and facing the stress, there is a tendency to avoid the stress and its consequences.
3. There should be an evidence of anxiety proneness. The anxiety provoking situations in the past should have resulted in excessive nervousness, depression or somatic symptoms.

Incidentally, in most cases routinely diagnosed as a neurotic disorder, the above factors are not taken into consideration or there is a lack of clear cut evidence for the stress, anxiety proneness, or tendency to avoid stress or responsibilities. Interestingly, stress and coping have a close association with cultural factors.

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

Cultural aspects of mental disorders including neurosis have been studied extensively. The phenomenological experience and expression of that experience differs across cultures and these affect the diagnosis and labelling of disorders. Not only the diagnoses differ across cultures, but the importance given to symptoms and the meaning assigned by the psychiatrist depending on their cultural background also differ. The diagnosis of neurosis is influenced to a considerable degree by the subject's perception of illness. The cultural factors may influence the symptom presentation; help seeking and the explanations for the illnesses. Epidemiological studies of neurotic disorders have proved to be challenging mainly due to differences in the concepts of neurosis. The various manifestations of neurotic disorders in different cultural settings contribute to this difficulty. Various neurotic disorders have been discussed below in terms of epidemiology, symptoms and treatment with some reference to the role of cultural factors.

Neurotic depression

Neurotic depression is one of the commonest psychiatric diagnoses in patients attending psychiatric clinics, psychiatric outpatient departments or mental health facilities. Though it is commonly encountered, its concept, nosological status, etiology, course and management are poorly understood. Patients with somatic symptoms, anxiety, depression, dysphoria or any other unclear psychopathology are labelled as having neurotic depression. This category is also used for cases that develop depression secondary to or as a reaction to any emotional precipitating factor (reactive depression or depressive reaction).

In the West, a new approach to the understanding of depressive disorders has emerged over the last four decades or so, and the studies have focused more on dysthymic disorders, atypical depression, characterological depression, minor depression, etc. But for many clinicians, it is a habit to diagnose these cases as neurotic depression. Various factors have been taken into consideration while making a diagnosis of neurotic depression. As mentioned above, there should be evidence of stress (presumed or perceived) of recent origin, which should have some temporal relationship with the development of symptoms. The reaction to the above stress should appear to be maladaptive and there should be some evidence of anxiety proneness. The anxiety provoking situations in the past should have resulted in excessive nervousness, depression or somatic symptoms.

Epidemiology

Patients with neurotic depression usually remain in outpatient treatment. They may form nearly 25%–30% of all psychiatric patients in a general hospital psychiatric set-up, and nearly 10%–15% of the psychiatric hospital population. In general population, neurotic depression was reported to be nearly 10–20/1000 population. It is more common in women and the commonest age groups are between 20 and 35 years.

Clinical features

The commonest signs and symptoms are feelings of sadness, weeping spells, lack of interest in surroundings and activities of daily life. Sadness is non-pervasive and becomes less on removing the person from the stressful situation. The symptoms are generally worse in the evening. Depressive cognitions may occur at the same time as the feelings of sadness. The patient usually tends to blame others or the environment, and does not hold himself responsible for his symptoms. The feelings of anxiety, tension and nervousness, along with autonomic symptoms are invariably present. The feelings of guilt, self-depreciation and self-blame may be absent. The reactivity of mood is preserved. Somatic symptoms or bodily complaints are present in many of the cases. The common bodily complaints are headache, body ache, and pain in the back, feelings of weakness, fatigue and palpitations. Lack of appetite is mild and there may be periods of overeating. The lack of appetite usually does not lead to loss of weight. Sleep is disturbed in many cases, the commonest disturbance being either difficulty in falling asleep or intermittent awakenings. Alternatively, hypersomnia may be present. Suicide itself is generally not a feature of neurotic depression but suicidal gestures or attempts may occur frequently. Depressive personality traits may be evident in some cases.

The core features of depression have attracted a great deal of attention in the cross-cultural studies. The most salient feature of depression is a distinction between psyche and soma or the mind–body dualism. This distinction is evident in the formulation of depressive disorders which revolve around particular affects and associated somatic symptoms. The latter are relatively easy to ascertain across cultures. The difficulty lies in determining the presence of depressed mood as defined by the West, because of assumptions about emotion and its phenomenology. In many cultures there are essentially no terms to describe depression and internal emotional states. The absence of such terms does not in itself preclude the existence of related affect, or even analogous categories of illness. Certain cultures discourage display of extreme sadness and sorrow. In many cultures, an illness, with features of depression is called by other local names (nervous problem) in order to shift the emphasis to the physical nature of the illness (which is acceptable), from the emotional one (which may not be acceptable).

Shenjing shuairuo, known as neurasthenia in the West, is a condition highly prevalent among the Chinese. It is characterized by feelings of physical and mental exhaustion, difficulty concentrating, memory loss, fatigue and dizziness. A number of associated physical complaints similar to those seen in depression include difficulty in sleeping, appetite disturbance, sexual dysfunction, headaches and irritability. There is an ongoing debate regarding whether or not this is a Chinese label for depressive disorders. *Shenjing shuairuo* is associated with lesser stigma than the term depression. In Central and South America, many people attribute illness to an acute fright (*susto, espanto*, *pasmo*). Similar ideas are found in Asia and Africa. An intense fright leads to a sudden flight of the soul from the body. This 'soul loss' is the underlying cause of the illness. Despite its explicit links to fright, *susto* may be associated more closely with depression than with anxiety disorders.

Anxiety neurosis

The experience of fear in response to threat of injury that accompanies fight-or-flight response is a universal phenomenon. Even though anxiety is a universal phenomenon, the context in which it is experienced, the interpretations of its meaning, and the responses to it, are strongly influenced by cultural beliefs or practices. Earlier studies examined cultural differences on self report measures of anxiety symptoms, and established significant differences in prevalence. In epidemiological studies significant differences in rates of anxiety disorders have been noted among ethno-cultural groups. Mexican Americans have higher rates of simple phobias. A cross-national study involving surveys in the United States, Canada, Puerto Rico, Germany, Taiwan, Korea and New Zealand found comparable rates. Although many anxiety disorders show comparable prevalence among major ethno-cultural groups in the general population, substantial differences in rates are found in clinical epidemiologic studies, probably due to differential patterns of help seeking.

Cross-cultural studies have found substantial differences in the symptomatology of anxiety. These include differences in the prominence and type of specific fears as well as associated somatic, dissociative and affective symptoms and syndromes. A variety of culture-related forms of anxiety disorders also have been identified including *koro* in south and east Asia, semen-loss anxiety syndrome (*dhat, jiryan* in India, *sukra praneha* in Srilanka, *shen-k'uei* in China), *taijinkyofusho* in Japan, as well as various 'nervous fatigue' syndromes, including ordinary *shinkeishitsu* in Japan, *brain fag* in Nigeria and *neurasthenia* in China. Cultural influences are apparent in the content and focus of anxiety disorders.

The current classificatory systems like DSM-IV and ICD-10, categorize anxiety disorders into generalized anxiety disorder, phobic anxiety disorder and panic disorder.

Generalized anxiety disorders (GAD)

Epidemiology

Prevalence rate of GAD ranges from 2.5 to 6.4 per cent. The 1-year prevalence rate for men is around 2% and 4.3% for women.

Aetiology

GAD results when a predisposed or vulnerable individual is exposed to stress. Family studies have shown that 15% to 20% of family members of patients with GAD have the same disorder with a much higher prevalence among monozygotic twins, suggesting that genetic predisposition is of considerable importance. Early adverse experiences have been considered important in the development of anxiety disorders. Conditioning theories propose that GAD arise due to an inherited predisposition to excessive lability of the autonomic nervous system, and when the initial fear responses become generalized by conditioning to previous neutral stimuli. Cognitive behavioural theories propose that GADs are due to incorrect and inaccurate response to perceived dangers. The inaccuracy is developed because of the selective attention to negative details in the environment, distortions in information processing and a negative evaluation of one's own ability to cope.

Clinical features

The main symptoms of GAD are: worry and apprehension, free floating anxiety, motor tension like restlessness, inability to relax, headache, aching of the back and shoulders and stiffness of the muscles; autonomic hyperactivity, experienced as sweating, palpitation, dry mouth, epigastric discomfort and giddiness. However, the intensity and frequency of these symptoms is less as compared to that of other anxiety disorders as panic disorder, social phobia and simple phobia. These patients often complain of difficulty in concentrating, poor memory and heightened sensitivity to noise. The appearance of these patients is characteristic, and includes a strained face, horizontal folds in the forehead, restless and fidgety with pale skin and sweating. Sleep disturbance may present as a difficulty in falling sleep and intermittent awakening. Other less prominent symptoms of GAD are tiredness, depressive symptoms, obsessional symptoms and depersonalization.

Differential diagnosis

GAD needs to be differentiated from some common psychiatric and physical disorders. In depressive disorders, anxiety is often a symptom of depression and depressive symptoms can also occur in an anxiety disorder. It is therefore useful to make the diagnosis on the basis of the severity of two kinds of symptoms and by the order in which they appear. Thus, whichever type of symptom appears first and is more severe is considered the primary condition. Schizophrenics sometimes complain of only anxiety, especially in initial part of the assessment interview. In order to avoid misdiagnosis, patient may be asked what is his explanation about the origin or cause of his anxiety symptoms. Alcohol or drug use can mask the underlying GAD. It is helpful to determine whether the GAD is primary or secondary. If the patient reports more anxiety symptoms in the morning, it would suggest the possibility of alcohol dependence. Some people consume alcohol or drugs in order to reduce their anxiety.

Panic disorder (PD)

Epidemiology

The lifetime prevalence of panic attacks is 10%. The life time prevalence of panic disorders is 1.5 to 3.5%.

Morbidity and impairment of quality of life in PD is comparable to that of depression.

Aetiology

The biochemical hypotheses suggest that there is possibility of abnormality in alpha-2 receptor functioning and also a dysfunction in benzodiazepine and 5-HT receptor functioning. According to hyperventilation hypothesis, patients with anxiety neurosis increase their breathing as well as their level of sympathetic arousal and since they engage in neither flight nor fight they may breathe off more CO_2 than they produce. Hyperventilation produces symptoms resembling those of panic attacks. Psychological explanation starts with observations on individual differences in response to one of the provoking agents – hyperventilation. Over-breathing may lead to physical symptoms which in turn give rise to worries that increase the level of anxiety further. This gives rise to a vicious circle leading to a panic attack. This psychological hypothesis confirms that cognitions are abnormal in people who experience panic attacks and those cognitions amplify the anxiety response.

Clinical features

The first panic attack is often totally spontaneous. The major symptoms are extreme fear and a sense of impending doom. Physical signs include palpitation, tachycardia, dyspnoea, and sweating. The attack is brief, and usually lasts for 10 to 30 minutes, rarely longer. Some patients may experience depersonalization and syncopal attacks during these episodes. In between attacks patients may have anticipatory anxiety about having another attack. Hyperventilation may produce respiratory alkalosis and other symptoms. Co-morbidity is very common in PD; around 30% to 90% of patients with PD have comorbid anxiety disorders, and around 50% have major depression. A study of patients referred to the psychiatric outpatient clinic in Qatar found that panic disorders typically involved fear of after death than of dying *per se*. Cultural beliefs may make unusual symptoms salient and clinicians unfamiliar with the local idioms of distress may be misled, at times to the extent of considering such patients psychotic. This is particularly likely when cultural differences make dissociative symptoms more prevalent.

The Nigerian culture-related syndrome of *ode-ori* is characterized by prominent somatic symptoms including culture-specific symptoms such as feelings of heat in the head, or sensations of parasites crawling in the head. Sensations of worm crawling in the head are common non-specific somatic symptoms in equatorial Africa that may be prominent symptoms of panic disorders or generalized anxiety disorder as well as other psychiatric disorder. *Ode-ori* may also be associated with paranoid fears of malevolent attack by witchcraft. Such fears are common in societies where witchcraft is practised or is a part of local belief.

Differential diagnosis

The presence of thyroid, parathyroid, adrenal and substance-related disorders can cause symptoms of panic attacks. Symptoms like chest pain, especially in predisposed patients with cardiac risk factors, may warrant further cardiac tests. Situational-bound panic attacks may indicate conditions like phobia, OCD and depressive disorder.

Phobic anxiety disorders

This group of disorders is characterized by anxiety and phobic symptoms which occur only in particular circumstances, avoidance of the situations which provoke anxiety and also the experience of anticipatory anxiety. Common phobias are simple phobia, social phobia and agoraphobia.

Simple phobia

Epidemiology

Life time prevalence of simple phobia is 4% in men and 13% in women.

Aetiology

Simple phobias are common in childhood, and by early adolescence most of the childhood fears subside but only a few persist into adult life. Genetic predisposition may contribute. According to psychoanalytic theory, phobic object or situation may have a direct associative connection with the primary source of the conflict, and this is symbolized by additional defense mechanism, like avoidance, by which the person can escape suffering serious anxiety.

Clinical features

There are phobias confined to highly specific situations such as certain animals, heights, thunder, darkness, flying, closed spaces, dentistry, sight of blood and fear of exposure to specific diseases, and many others. Diagnosis is made when a person exposed to the above mentioned situations, experiences psycho-physiological manifestations of anxiety and subsequently avoids such fear-provoking situations.

Differential diagnosis

Phobic disorders need to be differentiated from other disorders that have fear as a symptom. Hypochondriasis is characterized by fear of having a disease, contrary to the reassurance given by the doctors. Specific disease phobia is the fear of contracting the disease, and hence avoiding situations which may produce the disease. Obsessive-compulsive disorder patients may avoid knives because they have an obsessive fear of killing someone, whereas patients with a specific phobia involving knives may avoid the same for fear of cutting themselves.

Social phobia

Epidemiology

Social phobias are almost equally prevalent in men and women. The one year prevalence of social phobia has been estimated as 7% for men and 9% for women.

Aetiology

Genetic factors are suggested based on the observation that social phobias are more common among the relatives of the social phobics than the general population. Phobias could also illustrate the interaction between genetic constitutional diathesis and environmental stressors. Cognitive factors in the causation of social phobia arise from an undue concern that other people will be critical or the fear of scrutiny.

Clinical features

In social phobia inappropriate anxiety is experienced in situations in which the person is observed and could be criticized. They tend to avoid such situations. The situations include restaurants, canteens, dinner parties, seminars, board meetings, etc. Japanese form of social phobia, *taijinkyofusho*, provides an example of the interaction of cultural beliefs and practices with anxiety. The core symptom is the fear that one will offend or make others uncomfortable through inappropriate social behaviour and self-presentation including staring, blushing, emitting an offensive odour or having a physical blemish or misshapen features. This fits with Japanese preoccupation with the proper public presentation of self in society. A study of Japanese-American students and community sample of adults in Hawaii found that symptoms of *taijinkyofusho* were substantially correlated with those of social phobia. Although there were no differences between Asian and western students in mean levels of *taijinkyofusho* symptoms, higher levels of *taijinkyofusho* symptoms (but not other social phobia symptoms) were found among less acculturated individuals, lending some support to the notion that the distinctive feature of *taijinkyofusho* are associates with Japanese culture. There is also a difference in the value psychiatrists in Japan and United States assign to feelings of victimization, the Japanese viewing them as more or less normal while their western counterparts, when confronted with Japanese cases, tend to view such feeling as persecutory or delusional. This leads Western psychiatrists to diagnose Japanese cases of *taijinkyofusho* as paranoia and paranoid schizophrenia. Furthermore, while the *taijinkyofusho* sufferer feels victimized by his symptoms, the feeling of victimization is primarily expressed in terms of embarrassment or unpleasantness the symptoms are thought to arouse in others.

Differential diagnosis

Patients with social phobia experience anxiety only when confronted with the phobic stimulus unlike in panic disorder. An agoraphobic patient is often comforted by the presence of another person in an anxiety provoking situation, whereas a patient with social phobia may become more anxious in the presence of other people. Differentiation from anxious avoidant personality disorder may be difficult and the assessment needs to be supplemented with detailed case personal history and extensive interviews. Avoidance may be a symptom of depression, but it would be accompanied by other characteristic depressive symptoms. Subjects with schizoid personality disorder have a lack of interest in interaction rather than the fear of socializing like in social phobia.

Agoraphobia

Epidemiology

One-year prevalence of agoraphobia without panic disorder varies between 1.7 and 3.8 per cent and the lifetime prevalence is about 6 to 10 per cent.

Aetiology

Cognitive theories explain the genesis of agoraphobia to be due to the misinterpretation of minor physical or somatic symptoms. However, these theories could not explain the fear, when minor physical symptoms predate the disorder or were a consequence of it. Biological theories suggest that initial unexpected anxiety attacks result from environmental stimuli acting on a biologically predisposed individual. Freud viewed agoraphobia as arising from a symbolic substitution of a suppressed wish and this view persists in modern day psychoanalysis too.

Clinical features

Agoraphobic patients avoid situations where help is not easily available. The term agoraphobia includes fears not only of open spaces but also situations like crowded stores, closed spaces, busy streets and wherever there is a difficulty of immediate or easy escape to a safe place. It is one of the most incapacitating of phobic disorders. Two groups of symptoms are described in agoraphobics, panic attacks and anxious cognitions about fainting and going crazy. Severely affected individuals become completely house-bound, especially women, making them house-bound house-wives! Most patients are less anxious when accompanied by a trusted person or a family member. Depressive symptoms, depersonalization and obsessional thoughts may also be present.

Differential diagnosis

Differential diagnosis includes all the medical disorders which cause symptoms of anxiety or depression. Psychiatric differential diagnosis includes major depressive disorder, social phobia, generalized anxiety disorder, panic disorder, paranoid personality disorder, avoidant personality disorder and dependent personality disorder.

Obsessive-compulsive disorder

Obsessive-compulsive disorder is a debilitating syndrome characterized by obsessions and compulsions. Obsessions are recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate and cause marked anxiety and distress. Compulsions are repetitive behaviours or mental acts that the person feels forced to perform in response to an obsession.

Epidemiology

The prevalence of OCD is about 1.9–2.5%. A study conducted in diverse cultures reported consistent rates of OCD in various countries except Taiwan.

Clinical features

The common obsessions are about contamination, doubt, bodily symptoms, need for symmetry, aggressiveness, religion, blasphemy and sex. Common compulsions are checking, washing, counting, needing to ask or confess symmetry, and precision and hoarding. Cultural factors can influence the form and content of obsessions and compulsions. Certain thought contents occur more frequently than others and raise the question whether this variation in frequency reflects the cultural characteristics of the patients studied or are an inherent feature of the disorder.

Obsessional fears concern inability to control one's own harmful impulses. These are attributed to the devil that is thought to force them, on individuals whose faith is not strong enough to counter the evil. In studies of OCD patients seen in psychiatric clinics of Saudi Arabia and Egypt, the most common themes of obsessions and compulsions were religious. Muslim upbringing emphasizes on religious ritual. The symptomatology of OCD then involves repetition and internal struggle with forbidden thoughts as these engender the greatest anxiety for the individual. In the context of orthodox Muslim religion moderate repetition of thoughts and actions appears normal at least to the afflicted person. This probably contributes to a relatively low rate of presence of insight.

Preponderance of obsessions concerning dirt and contamination were seen commonly in Indians. Obsessions with aggressive content were infrequent. The Hindu code of ethics provides for a great variety of purification rituals. Dirt implies different meanings in different cultures. Dirt means germ/dust for Western patients, but implies fecal contamination for Indian patients.

Dissociative or conversion disorder

Conversion and dissociative disorders were previously considered as subtypes of hysteria. The common theme shared by the hysterical disorders was a partial or complete loss of function of body parts or loss of normal integration between memories of the past, awareness of identity and immediate sensations, and control over bodily movements. Hysterical neurosis is believed to be gradually becoming infrequent in the West though it is a common diagnosis in the developing countries. The decline in hysteria in the West has been accompanied by a compensatory rise in the incidence of anxiety and depression. Conversion may be a means of expressing forbidden feelings or ideas, as a kind of communication when direct verbal communication is blocked.

Some culture-bound syndromes like *latah* and *amok* represent means of expressing anger and rage when it is not culturally permissible. These are regarded as variants of hysteria. There is a tendency to avoid the use of the term hysteria in view of its many and varied meanings. In DSM-IV, this group of disorder characterizes symptoms or deficits involving voluntary motor or sensory functions. Dissociative amnesia, fugue and identity disorder are classed together in a separate category of dissociative disorders. In ICD-10 these conditions are classified as dissociative disorders.

Conversion disorder

Epidemiology

Lifetime prevalence of having conversion symptoms is reported to be around 33%; however, conversion disorders are much less prevalent, and in many Western and developed countries, conversion disorders have disappeared. Some studies from general hospital psychiatry units report that 5% to 16% of psychiatric consultations are diagnosed as conversion disorders. The female to male ratio varies from 2:1 to 5:1.

Aetiology

Biological theories suggest a non-dominant hemispheric dysfunction in patients with conversion disorder. Psychosocial theories include psychoanalytic theory of intra-psychic conflicts converting to physical symptoms. Socio-cultural theory suggests conversion as a form of communication of an emotionally charged feeling repressed by personal or cultural restraints.

Clinical features

Clinical features are mainly motor symptoms like abnormal gait, manifesting as staggering, ataxia with gross jerks and inability to stand without support (astasia-abasia). Pseudoseizures, hysterical blindness and sensory symptoms like anaesthesia, hyperesthesia and paraesthesia are common conversion symptoms. Psychogenic vomiting, urinary retention, pseudocyesis (pseudo-pregnancy), globus hystericus (feeling of lump in the throat), and some visual disturbances are described under conversion disorder.

Dissociative disorders

A normal person has a unitary sense of self and this unifying experience of self consists of an integration of a person's thoughts, feeling and actions into a unique personality. The key dysfunction in the dissociative disorder is the loss of the unitary state of consciousness.

Aetiology

Hypnotizability, suggestibility and dissociation seem to be inter-related. A high degree of hypnotizability is noted among dissociative disorder patients. Another postulation is that dissociation could be due to the deficiency or reduction of mental energy that is responsible for the unitary sense of self by binding various psychological functions together. If there is a psychological trauma, the binding power of the personal self is impaired and certain psychological functions escape from its control. Psychoanalysts have proposed a conflict model in which a strong ego protects itself from psychological pain through the operation of a defensive mechanism of repression, which manifests phenomenologically as dissociation.

Clinical presentations

Dissociative amnesia

The main feature is loss of memory of important recent, usually traumatic events. Invariably the onset is sudden, and very often the events are physically or emotionally traumatic, like accidents or unexpected bereavements. Amnesia may be localized and rarely complete or generalized. Personal identity usually remains unchanged and an apparent unconcern about the memory loss is observed frequently. Dissociative amnesia is generally short-lasting and self-limited.

Dissociative fugue

Dissociative fugue has all the features of dissociative amnesia, along with an apparently purposeful journey away from home or place of work during which self-care is maintained. After establishing a new residence, occupation and identity, the person has no memory of the past and is not aware that the memories are missing. Fugue often remits spontaneously and recurs rarely. The memories of events during the fugue state may be recalled under hypnosis. Those patients with conflict may require prolonged psychotherapeutic interventions.

Dissociative identity disorder

This is also known as multiple personality disorder and has been reported predominantly in the West and is rare in the developing countries. The important characteristic feature of multiple personality disorder is the presence of two or more distinct personalities within a single individual with only one of them being manifest at a time. The cause of this disorder is largely unknown; however, traumatic events in childhood either of physical or sexual abuse is commonly reported. The change from one personality to another is often sudden and dramatic. Each personality is complete, with its own memories, characteristic personal preferences and behavioral patterns. The personalities may be of either sex and may be disparate and extremely opposite. Nothing unusual is found in the mental status of these patients except for amnesia for the events occurred during the previous personality. Often prolonged interviews and multiple contact with the patient may lead the clinician to arrive at a diagnosis of multiple personality disorder.

Trance and possession disorder
The central feature of dissociative trance disorder is the temporary alteration in the state of consciousness or loss of customary sense of personal identity without replacement by an alternate identity. An associated narrowing of the awareness of surroundings and also some stereotyped behaviours maybe present. Episodes occur in discrete attacks and there is amnesia for the trance state. In possession attacks, an episodic alteration in the state of consciousness is characterized by the replacement of customary sense of personal identity by a new identity. These could be stereotyped and culturally determined behaviours or movements that are experienced as being controlled by the possessing agent. Trance and possession states can occur in various religious and cultural contexts. It becomes a disorder only when it occurs involuntarily or is unwanted and also when it intrudes into ordinary activities by occurring outside religious or other culturally accepted situations. Possession states and trance is common in the Indian subcontinent.

Other dissociative phenomenons of interest are *latah* and *amok*. *Latah* is well described among Malaysians. It is characterized by hypersensitivity to fright or startle, often with echopraxia, echolalia, command obedience, and dissociative or trance like behaviour. *Amok* is characterized by homicidal frenzy, preceded by brooding and followed by amnesia.

Somatoform disorder

Somatoform disorders are characterized by physical complaints for which no obvious, serious and demonstrable organic findings can be discerned. There is some evidence or presumption that psychological factors, stresses or conflicts seem to be initiating, exacerbating and maintaining the somatic symptoms.

Somatization disorder

Epidemiology

Lifetime prevalence of somatization disorder in the general population is estimated to be 0.1 or 0.2 per cent. Female to male ratio is 5 to 1. Higher rates of somatic symptoms in Hispanic psychiatric patients with depression and also for Hispanic community respondents regardless of psychological status have been identified.

Diagnosis

According to DSM-IV, for the diagnosis of somatization disorder, there should be four pain symptoms, two gastrointestinal symptoms, one sexual and one pseudo-neurological symptom, beginning before 30 years of age. On the other hand, ICD-10 criteria require at least two years of multiple and variable physical symptoms with no adequate physical explanation, persistent refusal to accept advice and some degree of impairment of functioning.

Aetiology

Somatization as social communication includes the use of bodily symptoms to manipulate or control relationships. Psychoanalytic theories suggest that hysteria represents a substitution of somatic symptoms for repressed instinctual impulses. Neuropsychological tests demonstrate equal bifrontal impairment of the cerebral hemispheres and nondominant hemispheric dysfunctions in patients with somatization disorder. Other aetiological factors include heightened awareness of bodily sensations, misinterpretations of normal sensations as evidence of illness, excessive anxious preoccupation with illness and early loss or separation from parents. Familial and genetic factors are also implicated in the etiopathogenesis of somatization disorder.

Clinical picture

The main clinical features are multiple, recurrent, and frequently changing physical symptoms, which have usually been present for several years. Most patients have long and complicated history of consulting several doctors. Symptoms include the gastrointestinal sensations, multiple skin symptoms, sexual complaints and menstrual irregularities. The presentation of bodily symptoms in most cultures, regardless of source, constitutes an idiom of distress. In many cultures, the presentation of personal or social distress in the form of somatic complaints is the norm. In the past, somatization was believed to be a phenomenon in non-western countries, now it is established that it is a world wide phenomenon, though it appears common in developing countries. In an effort to explain such cultural differences, models that incorporate mind/body schemas prevalent in various cultures have been studied. In the West, the mental and medical health is seen as arising out of mind and body respectively. In non-western countries the body is understood as a whole rather than a dualistic model seen in the West.

The types of symptoms presented in different cultural settings are diverse. In Latin America, certain somatoform disorders are described. *Ataque de nervios* is commonly reported in Puerto Rican and Caribbean subjects. It commonly follows stressful events and manifests as somatization and dissociative symptoms, with dramatic behavioral correlates. *Ataques* are common in women, particularly those who are older, unmarried and with low levels of education. The common somatic manifestations of *ataque de nervios* are headache, trembling, palpitations, stomach disturbances, a sensation of heat rising to the head, numbness of extremities and at times pseudo-seizures, fainting or unusual spells. Hot and cold syndromes are the cultural dimensions reported by Puerto Ricans that may affect their health use patterns is the 'hot–cold' theory of disease and therapies.

Hwa byung is a Korean folk illness label commonly used by patients suffering from a multitude of somatic and psychological symptoms, including constricted, oppressed, or pushing-up sensations in the chest, palpitations, heat sensations, flushing, headache, epigastric mass, dysphoria, anxiety, irritability and difficulty in concentration. It is said to be a common condition that afflicts less-educated, middle-aged married women in times of stress.

Somatic neurosis is a chronic neurotic syndrome among Muslim women in India who report multiple somatic symptoms. This somatic neurosis is different from anxiety neurosis and depressive neurosis. Socio-cultural factors may be contributing to these differences.

Hypochondriasis

Epidemiology

Six-month prevalence rate of 4% to 6% among general medical patients population have been reported. There are no significant differences in social status, education, and marital status. The age of onset is most commonly between 20 and 30 years of age.

Aetiology

Major aetiological theories suggest a role of amplification and augmentation of normal bodily sensations; psycho-dynamically as a derivative of aggressive or oral drives; as a defence against guilt or low self-esteem; as a socially learned illness behaviour eliciting interpersonal rewards; and as a psychiatric syndrome characterized by functional somatic symptoms, fear of disease, bodily preoccupation and the persistent pursuit of medical care.

Clinical features

There are mainly physical complaints without any demonstrable underlying organic pathology, which are described with minute specific details. The symptoms reflect no recognizable disease pattern. There is also a persistent refusal to accept the advice and reassurance of several different doctors that there is no physical illness or abnormality underlying the symptom. In hypochondriacal disorder, the patient tends to ask for investigations to determine or confirm the nature of the underlying disease.

The culture-related syndrome *koro* involves an intense acute fear that the penis is shrinking into the body and when involution is complete, the sufferer will die. *Koro* affects individuals who are vulnerable due to pre-existing anxiety, sexual, reproductive and relationship concerns, recent stressful life events, and, perhaps, suggestibility. This is a cultural variant of hypochondriacal disorder.

Somatoform pain disorder

The essential feature of this disorder is the presence of pain that is not fully accounted for by a general medical, neurological or specific psychiatric disorder. Somatoform pain disorders are quite common not only in psychiatric clinics, but also in other medical and surgical specialties, where it goes undetected. Pain disorder is diagnosed twice as frequently in women as in men and the peak age of onset are in the fourth and fifth decades.

Psychodynamic theorists suggest that the aches and pains may be a symbolic expression of an intrapsychic conflict. Biological theorists implicate the role of serotonin and endorphins in the central nervous system's modulation of pain. Another popular theory called gate-control theory describes that the different nerve impulses from peripheral nociceptors are modulated by stimulation of other sensory afferent fibres.

Clinical features

The patients with pain disorder constitute a heterogeneous group with various sites and nature of pain symptoms, like low back pain, headache, facial pain and chronic pelvic pain. The pain is of sufficient severity to cause distress or impairment of functioning. Psychological factors are considered to have an important role in the onset, severity, exacerbation or maintenance of the pain. Pain patients are also found to have substance abuse disorders as they tend to use alcohol, analgesics or other substances in an attempt to reduce the pain. Major depressive disorder is one of the commonest comorbid psychiatric disorders in patients with pain disorder.

Neurasthenia

Neurasthenia, also known as chronic fatigue syndrome (CFS), is a condition of uncertain cause commonly ascribed to the effect of stresses of modern life on the human nervous system. Many physicians have observed that the symptoms of chronic fatigue are not readily explained by organic disease or psychiatric conditions. Consequently, it became regarded as a 'medically unexplained' condition. In ICD-10 the syndrome is included under 'other neurotic disorders'. Neurasthenia is the commonest neurotic disorder in China (see above). In a survey conduced in China neurasthenia was nearly twice as commonly diagnosed than depressive neurosis. This term is readily accepted by the medical practitioners there and has lesser stigma attached to it.

Aetiology

Clinical observation of patients with CFS have led to the investigation of a number of hypotheses about the underlying pathophysiological mechanisms. It could be caused by chronic infections such as Brucellosis or Epstein–Barr virus infection. Other hypotheses include immune dysfunction, sleep abnormalities and cardiovascular or respiratory abnormalities. Neuroendocrine abnormalities like adrenal dysfunction, abnormal serotonergic function and cerebral perfusion abnormalities are reported in CFS.

Clinical features

Primary complaints in neurasthenia are tiredness and fatigue. This fatigue lasts for months to years, and typically begins soon after a viral fever or exposure. In addition to fatigue, the syndrome is characterized by myalgias and cognitive changes such as forgetfulness and poor concentrations.

Patients may complain of sexual weakness also, which needs to be addressed in the light of cultural background, and needs to differentiate from *dhat* syndromes in men or women. In young males in the Indian subcontinent, *dhat* syndrome manifests as bodily, mental or sexual weakness attributed to loss of semen, by masturbation, sexual activity or loss of 'semen' in the urine. In women, tiredness, fatigue and exhaustion is attributed to passage of normal vaginal discharge, this is considered as loss of vital elements, akin to semen in men.

In Japan, other types of neurasthenia are recognized namely – neurasthenia, neurasthenic reaction or reactive neurasthenia and pseudo-neurasthenia. In China, neurasthenia or *shenjingshuairou* meaning weakness of nerves are reported by intellectual individuals with probable sociopolitical factors underlying the cause. In Taiwan neurasthenia is regarded as a clinical entity and called as *shinkeishitsu*, which is characterized by obsessive and introverted personality traits and sociophobic symptoms.

The role of cultural factors in the development, presentation, and management of neurotic disorders needs to be appreciated. The explanatory models employ the cultural formulation to get an understanding of the disorder. The neurotic symptoms reflect a cry for help, an indication of the failing coping methods and need for support and understanding from their family, friends and professionals. These need to be understood and addressed under the unique cultural framework of the individual.

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Schizophrenia and related psychoses

Assen Jablensky

EDITORS' INTRODUCTION

Schizophrenia has a special place in the field of psychiatry in general and cultural psychiatry in particular. This was the first psychiatric condition which was studied across cultures under the aegis of the World Health Organisation (WHO). The two studies – the International Pilot Study of Schizophrenia and Determinants of Outcome of Severe Mental Disorders – set the benchmark for comparing illnesses across cultures. While welcomed by the epidemiologists that similar epidemiological methods can be employed across cultures, the critique by anthropologists and social scientists claimed that these studies looked at commonalities and ignored the differences. There is also some evidence that the outcome of schizophrenia appears to be better in low-income countries, although these findings have been challenged.

Jablensky, as one of the original scientists involved in the WHO studies, provides an overview of schizophrenia research across cultures. He gives a brief introduction to the epidemiology but focuses on phenotypic comparability of schizophrenia across populations. This is an important point if one is to deal with the question of misdiagnosis, which is sometimes seen as conflating the rates of schizophrenia. He emphasises that schizophrenic disorders in non-Western populations can be reliably distinguished from the acute transient psychoses and other disorders such as affective disorders, although he acknowledges that there may be some symptomatic overlap between affective disorders and schizophrenia. Jablensky cautions that a good deal of the variation may be attributed to methodological difficulties, including study design, sample size, diagnostic patterns and methods of data analysis. The real variation noted in these rates is possibly related to the multifactorial nature of the illness. Comparing rates in isolated populations may indicate genetic factors at play. High rates of schizophrenia among migrant groups raise a number of issues. Better outcome in low-income countries has been attributed to gender, acute onset, being married, close access to social networks and the length of remission appeared to be unrelated to antipsychotic treatment. Jablensky notes that the factors underlying better outcome of schizophrenia in low-income countries are likely to be a result of interaction between genetic variation and specific aspects of environment. It is possible that changes in traditional societies due to urbanization and industrialization may also affect the outcome in future.

Introduction

Interest in the manifestations and frequency of mental disorders in non-Western cultures, primarily the psychoses, dates back to the colonial era. In the nineteenth century, British, Dutch and French colonial administrations imported into their overseas dependencies the 'enlightened' asylum model of care for the mentally ill and built mental hospitals for custodial care of patients with intractable chronic illness and 'dangerous' psychotics. In 1903, Kraepelin travelled to Java and, after several weeks spent at the Buitenzorg (now Bogor) hospital, came to the conclusion that the basic forms of dementia praecox and manic-depressive insanity in the Javanese were generically the same as those in Europe, though 'racial characteristics, religion and customs' might modify their clinical manifestations. Although Kraepelin saw in this primarily a confirmation of his nosological system, he

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

anticipated ‘rich rewards’ for the potential of comparative research to ‘throw light on the causes of mental disorder’ and proposed ‘comparative psychiatry’ as the systematic study of mental disorders and personality traits across different cultures (Kraepelin, 1904).

However, during decades to follow, the sources on the epidemiology of schizophrenia and other psychotic disorders in non-European cultures remained restricted to mental-hospital statistics or rudimentary field surveys undertaken by psychiatrists or colonial public health administrators. Typically, the conclusion was that ‘true’ schizophrenia and depression were rare among indigenous peoples, but that chronic psychotics were well tolerated in the community. The ideological framework in which such early observations were embedded varied between benign paternalism and overt racism. In a monograph, published by the World Health Organization, Carothers (1953) claimed that the paucity of structured delusional contents and the lack of systematization of delusions in ‘the African’ could be explained by a congenital underdevelopment of the frontal lobes of the brain. Similar assumptions led other authors to conclude that depression was rare in sub-Saharan Africa or in Asia because of the lack of Judaeo-Christian cultural values which made the experience of guilt possible.

The sketchy and often distorted picture of the epidemiology of psychoses in the developing countries started to change in the post-colonial era when locally born psychiatrists, educated in the West, entered practice and teaching in their countries. Though trained in the colonial metropolis, they were keen to understand the nature of mental disorders in their own cultures and to introduce culturally appropriate alternatives to the colonial mental hospital, such as the ‘psychiatric village’ (German, 1972). In a series of studies on schizophrenia among the Yoruba in Nigeria, Lambo (1965) pointed to the limitations of the Western diagnostic concepts when applied to African cultures. In Asia, Yap (1974) charted systematically the so-called ‘culture-bound syndromes’ and highlighted their differentiation from schizophrenia. The first epidemiological surveys which generated incidence and prevalence data on psychoses, including schizophrenia, were carried out by Rin and Lin (1962) in Taiwan; Raman and Murphy (1972) in Mauritius; and Leighton *et al.* (1963) in Nigeria. In addition to indigenous investigators, European and North American psychiatrists and anthropologists laid the foundations of cross-cultural psychiatry in which psychosis research featured prominently. Since the late 1950s, a number of epidemiological surveys were carried out in India and China. Although the methods and diagnostic criteria used were rarely described, these surveys provided data of considerable historical interest on general trends and patterns, reviewed by Murphy (1982).

The comparative study of schizophrenia and other psychoses across different populations and cultures gained in scope and momentum with the research programme of the World Health Organization initiated in the 1960s. Two multicentre studies, the International Pilot Study of Schizophrenia (WHO, 1973, 1979; Leff *et al.*, 1992) and Determinants of Outcome of Severe Mental Disorders (Sartorius *et al.*, 1986; Jablensky *et al.*, 1992; Jablensky *et al.*, 2000) generated a wealth of cross-sectional and follow-up data on over 2000 cases of schizophrenia and related disorders in 16 geographically defined areas in 12 countries in Africa, the Americas, Asia and Europe. These studies utilized for the first time standardized diagnostic criteria and assessment methods in community and hospital-based data collection by teams of local psychiatrists and other mental-health workers who not only had been trained to use such research tools but participated in their development. Although the areas covered by the WHO studies were not exhaustive of all the variation that may exist in the incidence of schizophrenia and related conditions, this research provided a unique database enabling direct comparisons of the population rates, psychopathology and outcomes of the major psychoses across various cultures.

Schizophrenia: phenotypic comparability across populations

Despite the availability of ICD-10 and DSM-IV criteria that should facilitate its reliable diagnostic identification, schizophrenia essentially represents a broad clinical syndrome with some internal cohesion and a characteristic evolution over time. The existence of a specific brain disease (or diseases) underlying the syndrome is still a hypothesis, notwithstanding the variety of neurobiological and cognitive features or tentative susceptibility genes, associated with the disorders. Thus, the question whether cases diagnosed as schizophrenia in different cultures are phenotypically homologous is of critical importance, considering that the biological basis of the disorder still eludes us and no objective diagnostic test is available. To claim that schizophrenia is universal implies that its features can be reliably identified in different populations, i.e. the constellation of symptoms is coherent and replicable; consistent associations with age and gender are present; and course, outcome and response to treatment show a common pattern. Provided that the population size is sufficient for a low-incidence disorder to be detectable, no human group has yet been found to be free of schizophrenia. Although no single symptom is pathognomonic, the overall clinical presentation of schizophrenia is remarkably similar across cultures. Acutely ill patients in different cultural settings describe the same characteristic symptoms, such as hallucinatory voices commenting in third person on their thoughts and actions, thoughts being taken away or broadcast, or their surroundings being imbued with special meaning. Negative symptoms, such as psychomotor poverty, social withdrawal and amotivation, commonly occur irrespective of the cultural setting. The conclusion that patients diagnosed with schizophrenia in different cultures suffer from the same disorder is further supported by the similar age- and sex-specific distribution of the onset of symptoms, which peak in early adulthood and, in females, have a second, lower peak after age 35. Considering the variety of social norms and beliefs about illness across cultures, the similar ways in which the core symptoms of schizophrenia are experienced and described by people in various cultures is striking, suggesting that the pathophysiological basis of the disorder may be similar in different populations.

Notwithstanding such similarities, variations seem to exist that may affect its recognition and treatment. Lambo (1965) described a characteristic symptom-complex in Nigeria consisting of anxiety, depression, vague hypochondriacal symptoms, bizarre magico-mystical ideas, episodic twilight or confusional states, atypical depersonalization, emotional liability and retrospective falsification of memory based on hallucinations or delusions. Certain variants of the syndrome, such as an acute onset form and a catatonic subtype appear to be more common in traditional rural communities. In the WHO 10-country study (Jablensky *et al.*, 1992) acute onset characterized 40.3% and catatonic schizophrenia 10.3% of all the cases in developing countries, compared to 10.9% and 1.2% in the developed countries. A common clinical problem in developing countries is the differentiation of schizophrenia from psychoses due to infectious or parasitic diseases. In particular, African trypanosomiasis often results in a symptomatic psychosis which has a slow, insidious onset and may mimic schizophrenia. Since a variety of infectious, parasitic and nutritional diseases are endemic in the developing world, it has been suggested that a high proportion of the cases of schizophrenia in those populations may in fact be symptomatic psychoses accompanying physical diseases. However, among some 500 individuals with psychotic illnesses, screened in India and Nigeria for the WHO 10-country study, only 11.7% were excluded on grounds of having a physical disease that might explain their psychotic symptoms. Thus, problems of differential diagnosis may arise in respect of organic brain disorders, but it is unlikely that the majority of schizophrenic illnesses in the Third World can be attributed to underlying organic aetiology.

All this being said, schizophrenic disorders in non-western populations can be reliably distinguished from the acute transient psychoses, the so-called culture-bound syndromes, and probably the affective disorders, although the boundary with the latter has not been sufficiently explored and some symptomatic overlap may exist. Family morbidity data are still scarce but where such information is available, it suggests that genetic factors contribute to the transmission of schizophrenia in the same way as in the developed countries.

Prevalence

Table 16.1 presents an overview of prevalence studies conducted in different populations at different times, selected on broad criteria of sample representativeness and of diagnostic assessment likely to be compatible with present-day criteria. The studies

Table 16.1. Selected prevalence studies of schizophrenia

Author	Country	Population	Method	Prevalence per 1000
Studies in developed countries				
Brugger (1931)	Germany	Area in Thuringia ($n = 37\ 561$)	Census	2.4
Strömgren (1938); Bøjholm & Strömgren (1989)	Denmark	Island population ($n = 50\ 000$)	Repeat census	3.9 (3.3)
Lemkau *et al.* (1943)	USA	Household sample	Census	2.9
Essen-Möller *et al.* (1956); Hagnell (1966)	Sweden	Community in southern Sweden	Repeat census	6.7 (4.5)
Crocetti *et al.* (1971)	Croatia	Household sample	Census	5.9
Rotstein (1977)	Russia	Population sample ($n = 35\ 590$)	Census	3.8
Robins & Regier (1991)	USA	Aggregated data across 5 ECA sites	DIS interviews	7.0
Jeffreys *et al.* (1997)	UK	London health district ($n = 112\ 127$)	Census, sample interviewed ($n = 172$)	5.1
Jablensky *et al.* (2000)	Australia	4 urban areas ($n = 1\ 084\ 978$)	Census, sample interviewed ($n = 980$)	5.9
Studies in developing countries				
Rin & Lin (1962); Lin *et al.* (1989)	Taiwan	Population sample	Repeat census	2.1 (1.4)
Dube & Kumar (1972)	India	4 areas in Agra ($n = 29\ 468$)	Census	2.6
Padmavathi *et al.* (1987)	India	Urban ($n = 101\ 229$)	Census	2.5
Salan (1992)	Indonesia	Area in Jakarta ($n = 100\ 107$)	Key informants, sample interviewed	1.4
Waldo (1999)	Kosrae (Micronesia)	Island population ($n = 5500$)	Key informants, sample interviewed	6.8
Kebede & Alem (1999)	Ethiopia	District south of Addis Ababa ($n = 227\ 135$)	Key informants, sample interviewed	7.1
Zhang *et al.* (1998); Phillips *et al.* (2004)	China (mainland)	Population sample ($n = 19\ 223$)	Census	5.3

differ widely in many respects of methodology but have in common a high intensity of case finding. The term 'census' refers to surveys aiming at ascertaining every member of an entire community or a population sample. Several were repeat surveys, in which the original sample was traced and re-examined after an interval of 10 or more years (the findings on follow-up are quoted in brackets). Studies reporting hospital morbidity only are not included.

These studies have produced point prevalence estimates in the range of 1.4 to 7.1 per 1000 population at risk. However, in most instances these are raw (non-standardized) figures, which may not be directly comparable due to demographic confounders such as age structure of the population, mortality and migration, and thus may not reflect the true variation across different populations. Thus, the question whether major differences exist in the prevalence of schizophrenia in different populations and cultures has no simple answer. The majority of studies have found similar prevalence rates, though a small number of populations (referred to below) clearly deviate from the central tendency. However, the magnitude of such deviations in schizophrenia is modest when compared to other multifactorial diseases, such as diabetes, ischaemic heart disease or multiple sclerosis, in which 30-fold (or greater) differences in prevalence across populations are not uncommon.

Incidence

Incidence rates provide a better estimate of the 'force of morbidity' (the probability of disease occurrence at a given point in time). The estimation of incidence depends on how reliably the point of onset can be identified. Since it is not possible at present to determine with any accuracy the beginnings of the putative cerebral dysfunction underlying schizophrenia, the onset of the disorder is usually defined as the point in time when its symptoms reach the threshold of recognition. The first hospitalization is not a good index, since the interval between the 'true' onset of overt symptoms and the point at which diagnosis is made and treatment initiated (the 'duration of untreated psychosis', or DUP) is likely to vary across different settings and cultures. A better approximation is provided by the time of the first contact with any psychiatric or general medical service at which an incipient or ongoing psychotic illness is recognized as such for the first time.

Table 16.2 presents findings from 13 incidence studies of schizophrenia. Studies that have used a 'broad' definition of schizophrenia (ICD-8 or ICD-9) suggest that rates based on first admissions or first contacts vary about threefold, between 0.17 and 0.54 per 1000 population per year. Studies using more restrictive criteria, such as the Research Diagnostic Criteria (Spitzer *et al*., 1978), DSM-III or its successors, or ICD-10, report incidence rates that are two to three times lower than those based on 'broad' criteria.

Comparative incidence data: the WHO ten-country study

Up to date, the only study which has generated directly comparable incidence data for different populations is the WHO ten-country investigation (Sartorius *et al*., 1986; Jablensky *et al*., 1992). Incidence rates were estimated from first-in-lifetime contacts with any 'helping agency' (including traditional healers in the developing countries), monitored prospectively over a 2-year period of case finding. Potential cases and key informants were interviewed by clinicians using standardized instruments, and the timing of onset was ascertained for the majority of patients. For 86% of the 1022 patients the first manifestation of diagnostic symptoms of schizophrenia was within a year of the first contact and, therefore, the first-contact rate was accepted as a reasonable proxy for the onset of psychosis. Two definitions of 'caseness' were used: a 'broad' clinical classification comprising ICD-9 schizophrenia and paranoid psychoses and a restrictive definition, including 'nuclear' schizophrenia with Schneiderian first-rank symptoms (Wing *et al*., 1974). The rates for the 12 study areas are shown in Table 16.3.

The differences between the rates for 'broad' schizophrenia (0.16–0.42 per 1000) across the

Table 16.2. Selected incidence studies of schizophrenia

Author	Country	Population	Method	Rate per 1000
Europe and North America				
Ødegaard (1946)	Norway	Total population	First admissions, 1926–1935 ($n = 14\,231$)	0.24
Häfner & Reimann (1970)	Germany	City of Mannheim ($n = 330\,000$)	Case register	0.54
Liebermann (1974)	Russia	Moscow district ($n = 248\,000$)	Follow-back of prevalent cases	0.20 (male); 0.19 (female)
Helgason (1964)	Iceland	Total population	First admissions, 1966–1967 ($n = 2388$)	0.27
Castle *et al.* (1991)	UK	London (Camberwell)	Case register	0.25 (ICD); 0.17 (RDC); 0.08 (DSM-III)
Nicole *et al.* (1992)	Canada	Area in Quebec ($n = 338\,300$)	First admissions	0.31 (ICD); 0.09 (DSM-III)
McNaught *et al.* (1997)	UK	London health district ($n = 112\,127$)	Two censuses 5 years apart	0.21 (DSM-IIIR)
Brewin *et al.* (1997)	UK	Nottingham	Two cohorts of first contacts (1978–80 and 1992–94)	0.14 (0.09) (ICD-10)
Haukka *et al.* (2001)	Finland	Finnish birth cohorts 1950–1969	National hospital discharges register	0.62 (male) 0.49 (female)
Scully *et al.* (2002)	Ireland	Two rural counties ($n = 104\,089$)	First contacts 1995–2000	0.14 (male) (DSM-IV) 0.05 (female)
Asia, the Caribbean and South America				
Raman & Murphy (1972)	Mauritius	Total population ($n = 257\,000$)	First admissions	0.24 (Africans); 0.14 (Indian Hindus); 0.09 (Indian Moslems)
Lin *et al.* (1989)	Taiwan	3 communities ($n = 39\,024$)	Household survey	0.17
Rajkumar *et al.* (1993)	India	Area in Chennai ($n = 43\,097$)	Household survey	0.41
Hickling & Rodgers-Johnson (1995)	Jamaica	Total population ($n = 2.46$ mln)	First contacts	0.24 (broad); 0.21 (restrictive)
Mahy *et al.* (1999)	Barbados	Total population ($n = 262\,000$)	First contacts	0.32 (broad); 0.28 (restrictive)
Selten *et al.* (2005)	Surinam	Total population ($n = 481\,000$)	First contacts	0.18

Table 16.3. WHO ten-country study: annual incidence rates per 1000 population at risk, age 15–54

		Broad definition[a]			Restrictive definition[b]		
Country	Area	Male	Female	Both sexes	Male	Female	Both sexes
Colombia	Cali	0.14	0.06	0.10	0.09	0.04	0.07
Czech Republic	Prague	0.06	0.12	0.09	0.04	0.08	0.06
Denmark	Aarhus	0.18	0.13	0.18	0.09	0.05	0.07
India	Chandigarh (rural)	0.37	0.48	0.42	0.13	0.09	0.11
India	Chandigarh (urban)	0.34	0.35	0.35	0.08	0.11	0.09
Ireland	Dublin	0.23	0.21	0.22	0.10	0.08	0.09
Japan	Nagasaki	0.23	0.18	0.21	0.11	0.09	0.10
Nigeria	Ibadan	0.11	0.11	0.11	0.09	0.10	0.10
Russia	Moscow	0.25	0.31	0.28	0.03	0.03	0.02
UK	Nottingham	0.28	0.15	0.24	0.17	0.12	0.14
USA	Honolulu, HA	0.18	0.14	0.15	0.10	0.08	0.09
USA	Rochester, WA	0.15	0.14	0.15	0.09	0.08	0.09

[a] ICD-9

[b] Diagnosis of 'nuclear' schizophrenia (S +) assigned by the computer algorithm CATEGO (Wing *et al.*, 1974) on the basis of symptoms subsequently incorporated into the ICD-10 diagnostic criteria for schizophrenia.

study areas were statistically significant ($P < 0.001$, two-tailed test); however, those for 'nuclear' schizophrenia were not. Since 'nuclear' schizophrenia represented a subset of the cases of 'broad' schizophrenia, greater scatter and wider confidence intervals could be expected for the 'nuclear' rates. However, this was not the case, suggesting that 'nuclear' schizophrenia is more homogeneous and occurs at a similar frequency in different populations. Subsequently, replications of the design of the WHO ten-country study using the same instruments and procedures have been carried out with very similar results by investigators in India (Rajkumar *et al.*, 1993), the Caribbean (Hickling & Rodgers-Johnson, 1995; Mahy *et al.*, 1999), and the UK (McNaught *et al.*, 1997; Brewin *et al.*, 1997).

Variation in the incidence and prevalence of schizophrenia across populations: how much similarity and how much difference?

Two systematic reviews of the literature (Goldner *et al.*, 2002; McGrath *et al.*, 2004) highlight the existence of considerable variation in schizophrenia rates across geographical regions. A good deal of this variation may be attributed to methodological differences between the studies, including study design and coverage of case finding (hospital-based, field surveys, case registers, birth cohorts), sample size, diagnostic practices, and methods of data analysis. For example, birth cohort studies and case registers tend to produce higher rates than surveys and hospital admission studies (Bresnahan *et al.*, 2000). However, notwithstanding such bias and limitations, real variation is undoubtedly present (as in any human disease) and the interesting research questions concern its extent and sources as clues to a better understanding of aetiology.

Since schizophrenia is a low incidence disorder (though its chronicity and associated burden of disability place it high on the public health agenda), variation would be much more visible to the naked eye in the comparison of rates obtained from relatively small geographical areas and communities. In a study of an ethnically and socioeconomically homogeneous rural region in Ireland with a total population 29 542 (Youssef *et al.*, 1991; Scully *et al.*, 2004) the overall prevalence of 3.9 per 1000 was well within the ‘modal’ range, but analysis by small district electoral divisions revealed significant variation in rates, ranging from 0.0 to 29.4 per 1000. Similar variation has been reported in the Roscommon study, a genetic epidemiological investigation in another region of Ireland (Kendler *et al.*, 1996). Such local variation stands in stark contrast to the more uniform rates usually found in studies of large urban areas or at national level and is attributable to a number of factors, including spatial clustering of cases due to genetic vulnerability within extended pedigrees; differential mobility and mortality; and differential exposure to risk factors influencing intrauterine growth and early neurodevelopment. Such (and other, still to be discovered) effects may give rise to ‘outlier’ pockets of high or low incidence and prevalence which tend to cancel each other in larger population agglomerations. Their systematic study, though involving considerable methodological difficulties, has been unduly neglected in favour of the ‘macro’ epidemiology of psychoses.

Populations and groups with unusually high and low rates: genetic isolates

Isolate populations are characterized by their origins in a small number of ancestors, a degree of inbreeding and a restricted admixture of immigrants, due to geographical or cultural seclusion over multiple generations, sometimes ranging over thousands of years. Such populations may vary considerably in size, but are likely to be less heterogeneous with regard to genetic make-up and environmental exposures, than the panmictic (outbred) populations constituting the world’s majority, in which theoretically all individuals are potentially mating partners. The so-called young isolates comprise up to 20–30 generations, and typically have arisen following drastic population-size reductions (bottlenecks) due to wars, famine, religious persecution or other cataclysms. Subsequent population expansion results in a more uniform genetic background, including wider intervals of linkage disequilibrium, a more uniform environment and lifestyle, and significantly higher or lower prevalence of certain diseases, including psychiatric disorders. If coupled with availability of genealogical memory or records, such isolates present unique opportunities for genetic linkage and association studies of mendelian (monogenic) diseases, and, hopefully, complex traits, including schizophrenia, bipolar disorder and other psychiatric syndromes (Varilo & Peltonen, 2004).

A number of isolated populations in different parts of the world, including Finland, Iceland and northern Sweden; the Pima Indians; the Bedouins; the inhabitants of the Central Valley of Costa Rica, several areas in Quebec, as well as religious communities, such as the Old Order Amish, the Hutterites and the Mennonites, have been studied by epidemiologists and geneticists with a view to identifying large pedigrees, informative for a range of complex diseases ranging from asthma and diabetes to schizophrenia and bipolar disorder. Not all of these studies have produced incidence and prevalence rates for such populations, but several selected examples where this has been accomplished highlight the extent of variation in the frequency of psychoses that exists in such unusual groups.

High rates of psychoses (two to three times the national or regional rate) have been reported for population isolates in northern Sweden (Böök *et al.*, 1978) and several areas in Finland (Hovatta *et al.*, 1997). Though the whole population of Finland shares some features of an old isolate (approximately 2000 years), the northern and eastern regions of Finland have been settled relatively recently (in the sixteenth/seventeenth century) and one particular sub-region with a current population of 18 000 was founded by 40 families at the end of the seventeenth century, i.e. 12 generations back (Arajärvi *et al.*, 2004). Genetic–epidemiological studies in this isolate estimate the lifetime risk of schizophrenia at 2.2%, compared to 1.2% for the whole of Finland (Hovatta *et al.*, 1997). A recent case-register based study of a birth cohort (14 817 individuals) from this region established a lifetime prevalence of 1.5% for schizophrenia spectrum psychotic disorders (Arajärvi *et al.*, 2005).

Daghestan in the Northern Caucasus (Russian Federation) is a region that has been inhabited over 3000 years by some 26 small ethnic groups constituting together at least five genetically distinct populations, varying considerably in their morbidity patterns. Possibly the highest lifetime-risk estimate for schizophrenia (4.95%) has been reported from one such highland subisolate (3000 members) (Bulayeva *et al.*, 2005). The population of the region consists of 26 ethnic subisolates in which the lifetime risk of schizophrenia was found to vary from 1.46% to 4.95%, which is possibly the highest risk estimate ever reported for an isolate population.

The population of the Palau islands (Micronesia), currently 20 470 people, has been geographically and ethnically isolated from other Pacific populations for nearly 2000 years. A genetic epidemiological study of treated cases estimated the lifetime risk of schizophrenia at 2.77% in males and 1.99% in females, i.e. high in excess of the 'modal' risk of about 1% reported for large outbred populations. All of the 160 Palau cases were concentrated in 59 families, each traceable to a single common founder, with 11 of them having 5 to 11 affected members each (Myles-Worsley *et al.*, 1999).

At the other extreme, the lowest known prevalence rate of schizophrenia in any population (and a very low rate of bipolar disorder) has been found among the Hutterites in South Dakota, a Protestant sect of European descent whose members live since the 1870s in closely knit, endogamous rural communities in Manitoba (Canada) and South Dakota US). According to well-preserved pedigree records, all of the present 35 000 Hutterites are descendants of fewer than 90 ancestors who lived in the eighteenth and early nineteenth century. Reduced genetic heterogeneity and communal lifestyle with minimum variation in environmental exposures make this population an ideal laboratory for a variety of disease studies (Ober *et al.*, 2001; Newman *et al.*, 2004), including psychiatric disorders. An early epidemiological study, in which the entire population of several Hutterite communities was screened, resulted in a schizophrenia lifetime prevalence of 1.1 per 1000 (Eaton & Weil, 1955). Subsequent reanalysis of the data using DSM-IIIR criteria (Torrey, 1995), and a repeat survey (Nimgaonkar *et al.*, 2000) replicated the original finding. Both genetic (low frequency of psychosis-predisposing alleles) and lifestyle factors (protective community support) have been proposed as an explanation for the unusually low rate of psychosis. Negative selection for individuals with schizoid traits who fail to adjust to the communal lifestyle and eventually migrate without leaving progeny has also been suggested, but not definitively proven.

Low rates have also been reported for certain Pacific island populations. Two surveys in Taiwan (Rin & Lin, 1962; Lin *et al.*, 1989), separated by 15 years during which major social changes took place, found that the prevalence of schizophrenia decreased from 2.1 to 1.4 per 1000. In both surveys, the aboriginal Taiwanese had significantly lower rates than the mainland Chinese who had migrated to the island after World War II.

High rates of psychosis in immigrants and ethnic minorities

Since the publication of the first report on an increased prevalence of psychoses among African-Caribbean immigrants to the UK (Hemsi, 1967), an increasing number of studies have shown very high incidence rates of schizophrenia (about 0.6 per 1000) in the African-Caribbean population in the UK (Bhugra *et al.*, 1997; Harrison *et al.*, 1997). The excess morbidity is not restricted to recent immigrants and is, in fact, higher in the British-born second generation of migrants. Similar findings of nearly fourfold excess over the general population rate have been reported for the Dutch Antillean and Surinamese immigrants (Selten *et al.*, 1997), and more recently, Moroccans and other non-Western immigrants in The Netherlands (Veling *et al.*, 2006). Research to date has not identified unequivocally any specific cause explaining this phenomenon. Little evidence has been presented to support earlier suggestions that these psychotic illnesses might be explained as substance-induced episodes or acute transient psychoses. Neither the cross-sectional symptom picture, nor the course and outcome of these disorders present any atypical features that would set them apart from ICD-10 or DSM-IIIR/DSM-IV schizophrenia (Harrison *et al.*, 1999; Hutchinson *et al.*, 1999), although a report highlighting poor diagnostic agreement ($\kappa = 0.45$) between a Jamaican psychiatrist and British psychiatrists assessing the same cases (Hickling *et al.*, 1999) should not be ignored. Notably, incidence studies in the Caribbean (Hickling & Rodgers-Johnson, 1995; Bhugra *et al.*, 1999; Selten *et al.*, 2005) do not indicate any excess schizophrenia morbidity in the countries of origin from which migrants are recruited. Explanations in terms of biological risk factors, such as increased incidence of obstetric complications or maternal influenza, have been put to the test but found no support (Hutchinson *et al.*, 1997; Selten *et al.*, 1998).

The effects of migration on the incidence of psychosis have been studied extensively since the 1930s (Ødegaard, 1932) but the recently reported data on morbidity in second-generation migrants do not fit easily into previously described patterns. A potentially important finding is the increased incidence of schizophrenia among the siblings of second-generation African-Caribbean index cases, as compared to the incidence of schizophrenia in the siblings of white index cases with schizophrenia (Hutchinson *et al.*,1996). Such increases in the morbid risk within sibships (in the absence of a similar increase in the risk among parents) suggest a lowered threshold for the expression of the disorder in carriers of susceptibility alleles that might be induced by environmental stress. Hypotheses involving psychosocial risk factors, such as lack of a supportive community structure, acculturation stress, demoralization resulting from racial discrimination, and blocked opportunity for upward social mobility have been proposed (Bhugra *et al.*, 1999) but not yet definitively tested. Although psychosocial stress is most likely to affect the majority of immigrants at risk, a plausible pathogenetic mechanism involving specific gene–environment interactions and linking such stress to the incidence of psychosis remains to be demonstrated.

Course and outcome

Systematic investigations into the course and outcome of schizophrenia were initiated by Kraepelin (1919) who believed that the natural history of the disorder could provide a provisional validation of the disease concept until final verification could be achieved by establishing the brain pathology and aetiology. Arguably, the greatest extent of variation in schizophrenia across populations and cultures is manifest in the course and outcome of the disorder. Early reports, based on small clinical samples, pointed to a less disabling course and a high rate of recovery from schizophrenic psychoses in developing countries such as Mauritius (Raman & Murphy, 1972) and Sri Lanka (Waxler, 1979) in cases that, according to 'Western' prognostic criteria should have poor outcome. Selection bias could not be ruled out in such studies based on hospital admissions; standard assessment procedures and explicit diagnostic criteria were not used; and clinical improvement could have been confounded with the social adjustment many patients achieve in a comparatively undemanding environment. Thus, room was left for doubts about the validity of findings of a better prognosis of schizophrenia in non-Western environments.

Many of these methodological issues were addressed in the WHO multi-centre studies by employing standardized assessment and more refined measures of course and outcome than in previous research. In the International Pilot Study of Schizophrenia, IPSS (WHO 1973; 1979), the 2– and 5–year follow-up assessments of patients indicated significantly higher proportions of patients in India, Colombia, and Nigeria having better outcomes on all dimensions than patients in the developed countries. For example, the initial psychotic episode had remitted during the 5-year follow-up in as many as 42% of the patients in India and 33% of the patients in Nigeria, whereas the majority of patients in the developed countries had experienced persisting psychotic symptoms and disablement. In either setting, patients with good and poor outcome could not be clearly distinguished on the

Table 16.4. Two-year course and outcome in the WHO ten-country study: developed and developing countries

Course and outcome measures	% patients in developing countries	% patients in developed countries
Remitting, complete remissions	62.7	36.8
Continuous or episodic, no complete remission	35.7	60.9
Psychotic $<5\%$ of follow-up	18.4	18.7
Psychotic $>75\%$ of follow-up	15.1	20.2
No complete remission during follow-up	24.1	57.2
Complete remission for $>75\%$ of follow-up	38.3	22.3
On antipsychotic medication $>75\%$ of follow-up	15.9	60.8
No antipsychotic medication during follow-up	5.9	2.5
Hospitalised for $>75\%$ of follow-up	0.3	2.3
Never hospitalised	55.5	8.1
Impaired social functioning throughout follow-up	15.7	41.6
Unimpaired social functioning $>75\%$ of follow-up	42.9	31.6

basis of their initial symptoms, though they all met the ICD-9 criteria for a diagnosis of schizophrenia.

Nevertheless, the IPSS was not free of bias, since patients were recruited from hospitals. Bed availability and admission policies could have led to over-inclusion of chronic cases in the developed countries and of recent-onset, acute cases in the developing countries. Such confounding factors were largely eliminated in the subsequent WHO ten-country study (Jablensky *et al.*, 1992), in which uniformly assessed first-episode cases were assessed upon their first contact with community or hospital services. The 2-year follow-up (and longer-term follow-up in several of the centres) provided ample confirmation of the finding that the outcome of schizophrenia was generally better in developing than in developed countries (Table 16.4).

Analysis of the data led to the conclusion that the better overall pattern of course and less disabling outcome in the study areas in developing countries was primarily due to a significantly greater percentage of patients remaining in a stable remission of symptoms over longer periods after recovery from an acute psychotic episode, rather than to milder or shorter psychotic episodes. This pattern was significantly predicted by setting (developing country), acute onset, being married or cohabiting with a partner, and having access to a supportive network (close friends). Being female was generally associated with a more favourable outcome. The length of remissions was unrelated to antipsychotic treatment, which generally was administered for much shorter periods of time to patients in the developing countries. Independently of the WHO studies, a high proportion of better outcomes of schizophrenia in developing countries has been reported by numerous investigators (Kulhara & Chandiramani, 1988; Ohaeri, 1993; Thara, 2004).

The factors underlying the better outcome of schizophrenia in developing countries remain insufficiently understood but, in a very general sense, are likely to involve interactions between genetic variation and specific aspects of the environment. Differences in the course and outcome of a disease across and within populations may be related to varying frequencies of predisposing or protective alleles coding for proteins involved in neurodevelopment, neurotransmitter and receptor regulation, or intracerebral signalling between brain subsystems. While such genetic differences undoubtedly exist, nothing specific can at present be said as to their role in the course and outcome of schizophrenia. On the other hand, a strong effect of the psychosocial environment is entirely plausible, considering the contrasts between developing and developed countries with regard to social support systems, kinship networks and beliefs about mental disease (Warner, 1983). It is, therefore, unlikely that the differences in the course and outcome of schizophrenia across populations and cultures could be explained by the operation of a single factor.

The observed differences may result from the additive or interactive effects of several factors, including (a) genetic and pathophysiological differences between acute and insidiously arising schizophrenic syndromes which may have differential propensities towards recovery and stabilization; (b) lower incidence in traditional societies of the type of chronic stress to which people with schizophrenia are particularly vulnerable; (c) higher probability in traditional societies of an individual–environment fit that minimizes social isolation and withdrawal and prevents the development of secondary disabilities.

As regards (b), the WHO ten-country study found that the index of expressed emotion (EE), a short-range predictor of psychotic relapse, was as effective in Indian families (Wig *et al.* 1987) as in European and North American families, but that high-EE families were significantly rarer in India than in Denmark or the UK. This established a potentially important and specific cultural difference. If this finding could be replicated in other settings in developing countries, the relative rarity of at least one type of pathogenic stress in the daily environment of schizophrenic individuals would be demonstrated.

However, it is unlikely that EE is the only type of stress to which schizophrenic individuals respond with psychotic exacerbation. Murphy (1982) proposed four criteria for schizophrenia-evoking stress: (i) a situation demanding action or decision; (ii) complexity or ambiguity of the information supplied to deal with the task; (iii) unless resolved, the situation demanding action or decision persists; (iv) the person has no 'escape route' available. Each one of the components of the putative model may occur at different frequencies in traditional and industrialized societies, a proposition that should be testable epidemiologically or experimentally.

As regards (c), the most important differences between traditional cultures and the industrial Western societies concern the sick role and beliefs and practices related to mental illness. Thus, the suggestive power of magical–mystic explanations of mental illness and of traditional healing practices may not cure schizophrenia but is likely to lower the barriers to spontaneous recovery and reintegration in the community. Generally, the findings of a better outcome for schizophrenia in traditional societies are compelling and set a research agenda that may lead to discoveries with fundamental implications for the management and treatment of schizophrenia in both developing and developed countries.

Acute and transient psychotic disorders

Acute psychoses, different from schizophrenia or manic-depressive illness, were first described in French psychiatry as *bouffées délirantes* (Magnan & Legrain, 1895), and as *cycloid psychoses* (Kleist, 1921; Leonhard, 1995) in German psychiatry. The clinical picture overlaps with the *psychogenic psychoses* described by Danish psychiatrists (Wimmer, 1916; Strömgren, 1986) and the *schizophreniform psychoses* described by Langfeldt (1939) in Norway. These disorders represent a modest fraction of psychiatric morbidity in Western countries but are considered common in many parts of the developing world. Their correct and timely recognition is important because of their benign prognosis which is quite different from the outcome of schizophrenia or major mood disorders. ICD-10 includes a separate rubric (F23) with five subdivisions and diagnostic guidelines which aim at differentiating such acute psychoses from schizophrenia. Since little is known about their pathophysiology and genetics, this group of disorders provides a rewarding field of inquiry for clinical and epidemiological research.

Common features of these states include rapid onset ('out of the blue'), few prodromal signs, dramatic and variable symptom presentation, short duration and equally rapid recovery with few residual signs. Often, but by no means always, they arise in response to psychosocial or physiological stress, but there is no characteristic family history, and the premorbid personality is inconspicuous. Recurrence of such episodes is the rule and the relapse rate is lower than in schizophrenia or affective disorder.

The French concept of *bouffées délirantes* is probably the earliest description of an acute, transient psychosis. The term refers to an acute, brief non-organic psychosis which typically presents with a sudden onset of fully formed, thematically variable delusions and hallucinations against a background of mild clouding of consciousness and fluctuating affect, and typically results in spontaneous recovery with some probability of relapse. Mental trauma is either absent or plays a minor role in the causation of *bouffées délirantes*, whose aetiology was primarily attributed to a vulnerable mental constitution.

The description of the cycloid psychoses includes sudden onset, pervasive delusional mood, variable delusions, hallucinations in any modality, labile affect, and psychomotor disturbances (excitement or inhibition). Stressful life events may precipitate a psychotic episode but the content of the psychotic experiences does not reflect the traumatic event. Leonhard emphasised the polarity of the dominant disturbance in cycloid psychoses and distinguished three subtypes: (i) 'anxiety-happiness psychosis' (extreme shifts of affect between intense fear and ecstatic elation); (ii) 'motility psychosis' (impulsive hypermotility and psychomotor inhibition); (iii) 'confusion psychosis' (incoherent pressure of speech and mutism). The duration varies from days to a few weeks but recovery is always complete, though there is a risk of further episodes in which much the same symptoms tend to recur.

The concept of psychogenic psychosis, introduced by Sommer (1894) and later elaborated by Jaspers (1963) and Scandinavian psychiatrists, defined a psychotic reaction, originating in traumatic experiences, which is psychologically understandable in terms of several criteria: (i) its content reflects the nature and significance of the psychic trauma; (ii) there is a temporal relationship between the trauma and the onset; (iii) removal of the traumatizing factor results in recovery; (iv) the overall prognosis is good. However, the extent to which transient psychotic illnesses actually meet the criteria laid down by Jaspers and Wimmer is uncertain as few studies have attempted to explore its validity.

Conclusions: prospects for epidemiology in the search for the causes of psychoses

Important insights into the nature and causes of psychotic disorders, primarily schizophrenia, have been gained from population-based studies, although essential questions still remain unanswered. With regard to schizophrenia, the clinical syndrome appears to be robust and identifiable reliably in diverse populations and cultures, suggesting that a common pathophysiology and, possibly, common genetic predisposition are likely to underlie its manifestations. At the level or large population aggregates, no major differences in incidence and morbid risk have to date been detected, though small geographical-area variation exist and appear to be related to a mix of risk factors whose effects may be attenuated in large, heterogeneous populations.

The study of 'atypical' populations, such as genetic isolates or minority groups, may be capable of detecting unusual variations in the incidence of schizophrenia and other psychoses that could provide novel clues to the aetiology and pathogenesis of these disorders. Notwithstanding the difficulties in the genetic dissection of complex disorders, emerging powerful methods of genomic analysis will eventually identify polymorphisms and haplotypes associated with schizophrenia risk. The majority are likely to be in genes of small effect, although one cannot rule out the possibility that genes of moderate or major effect will also be found, especially in isolate populations or at the level of neurocognitive and neurophysiological abnormalities underlying the disorder. Establishing their population frequency and associations with a variety of phenotypes, including personality traits, will be a major task for comparative epidemiology.

At present, no single, or major, environmental risk factor influencing the incidence of schizophrenia or other psychoses has been conclusively demonstrated. Further studies using large samples are required to evaluate potential risk factors, antecedents and predictors, for which the present evidence is inconclusive. The relationship between genotype and phenotype in schizophrenia is likely to be mediated by complex causal pathways involving gene–gene and gene–environment interactions, 'programmable' neural substrate, and stochastic events. Three models of the joint effects of genotype and environment have been proposed (Kendler & Eaves, 1986): (a) the effects of predisposing genes and environmental factors are additive and increase the risk of disease in a linear fashion; (b) genes control the sensitivity of the brain to environmental insults; and (c) genes influence the likelihood of an individual's exposure to environmental pathogens, e.g. by fostering certain personality traits.

A complementary research strategy proceeds from evidence that the ICD-10 or DSM-IV clinical diagnoses of schizophrenia and other non-affective psychoses may not represent relevant phenotypes for genetic research (Jablensky, 2006). This leads to an exploration of alternative, intermediate phenotypes (or 'endophenotypes'), such as neurocognitive abnormalities or temperament and character traits associated with schizophrenia that may be expressed in both affected individuals and their asymptomatic biological relatives. A prerequisite for the application of this approach is the establishment of population prevalences for such endophenotypes in epidemiological samples.

Current epidemiological research is increasingly making use of existing large databases, such as cumulative case registers or birth cohorts to test hypotheses about risk factors in case-control designs. Methods of genetic epidemiology are increasingly being integrated within population-based studies. These trends predict a bright future for epidemiology in the unravelling of gene–environment interactions that are likely to be the key to the understanding of the aetiology of psychoses. In this context, research into psychotic disorders in non-Western populations can provide valuable information on the genetic heterogeneity, the impact of the environment, and the course and outcome of psychotic disorders. Both traditional communities and societies undergoing transition in their social organization can contribute critically to the better understanding of the relationships between culture and mental disorder and the variety of human experience in coping with mental illness.

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17

Affective disorders

Paul Bebbington and Claudia Cooper

EDITORS' INTRODUCTION

Depression in particular, and affective disorders in general, are prime examplars of cultural influences on feelings and emotions. Many languages do not have words which can be applied to depression, even though feelings of sadness, unhappiness and associated biological factors have been reported from a large number of cultures and societies. The development of cultural psychiatry in the context of political and social settings indicates that constructs of illnesses or the development of research questions are linked with a number of factors which are changing regularly, from the concept of the happy native who did not suffer from depression in the 1950s to the recent multicentre studies which found that depression exists across cultures even though its prevalence and its recognition varies.

Bebbington and Cooper in their chapter provide a brief historical context in the development of cultural psychiatry. Cultures are internalized by individuals and the social response to distress is thus influenced accordingly. They propose that feeling bad (like other feelings and emotions) is related to a feedback loop with processes of social evaluation and self-comparison. These cognitions of lowered self regard and fear of future circumstances are culturally influenced and socially mediated. The use of language and somatic metaphors indicates not only cultural differences but also social class and education. Biomedical explanations may exist in different settings and interpretations of feelings of dysphoria are influenced by a number of factors. Using illustrations from different cultural settings, Bebbington and Cooper argue that cultural influences on the frequency of affective disorders are going to be influenced by processes of globalization as cultures are not impervious to external change. The role of fundamentalism and nationalism embedded within back-to-basics will in addition impact upon the changes in cultures which are also going to be influenced by urbanization, changes in family structures and breakdown of social structures. Prevalence of major depressive disorders using standardized assessments in population surveys varies 16-fold. The use of Western diagnostic instruments by themselves cannot explain such massive variation. Bebbington and Cooper suggest that culturally mediated differences in the meaning of dysphoria, acculturation and social factors need to be explored further.

Introduction

Transcultural psychiatry follows a long time-line, reaching back to Kraepelin's early studies in Java (Kraepelin, 1904; trans. 1974). The basic tenets of the discipline have shifted and evolved, particularly over the last 50 years. During this period, major and subtle contributions have been made, among others, by Alexander Leighton, Arthur Kleinman and Lawrence Kirmayer. Part of the value of their work, certainly for the current writers, is that none espouses a strong form of cultural relativism. Sadly, most psychiatrists have generally adopted a universalist position, anthropologists a relativist one, and rigid positions do not enable dialogue. One ironic consequence was the strange and unholy alliance between colonial-era psychiatrists and cultural anthropologists. They cohered in arguing that the Western construct of depression was rare in non-Western cultures. However, in the first case, the argument was based on inattention and a racist allegation about the capacity of their patients to

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

experience depression, whereas cultural anthropologists claimed that in non-western cultures, distress was categorized in different albeit equally valid ways. Another of the ironies of the older approach to transcultural studies was that cultures were seen as hermetic, as categorically distinct in the same way that some psychiatrists regard psychiatric categories. This ignores the reality that cultures are almost always porous to influence from outside, a process that has been quickened by globalization (Bhugra & Mastrogianni, 2004; Kirmayer, 2006).

Leighton's innovative combination of psychiatric epidemiology and ethnography led to his classic work in Nova Scotia and Nigeria (Leighton, 1959; Leighton *et al*., 1963a,b). He concluded that there was great variability within cultures, and between individuals, wherever they were, but that there was a common core of striving in all (Barkow, 2006). Readily acknowledging his debt to Leighton (Kirmayer, 2006), Kleinman argued that we should beware the presumption that psychiatric categorizations will have the same meaning when transferred to another culture. His view is that psychiatric constructs of depression are not universal, that there are different ways of understanding the body and self, and that this may lead to fundamental differences in psychopathology (Kleinman, 1977, 2004).

Before Kleinman's thesis, transcultural psychiatry strongly reflected the assumption that there was a central biological pathogenesis of mental disorders, on which culture exerted a merely pathoplastic effect (Yap, 1974). To what extent might culture influence biology? This is a more complicated question in the mental than in the physical sphere. In the latter, the physical functioning of the individual can be affected by culturally influenced choices, for example diet. This might happen in the mental sphere as well, but in addition, the expression of mental events is shaped by culture to an important degree irrespective of biology. As Kirmayer (2006) elegantly phrases it, psychological mechanisms must include discursive processes that are fundamentally social. Under these circumstances, the embodiment of distress may be biological only in the trivial sense that we are all biological. How a built-in cultural preparedness is embodied in the human brain may be of interest (Adolphs, 2002; Blakemore *et al*., 2004), but may yet have little influence on cultural diversity beyond allowing it to develop. Alternatively, as Kirmayer has suggested, cultures that emphasise a focus on bodily symptoms in dysphoria may affect the body in ways that aggravates the symptoms themselves (Kirmayer and Young, 1998; Kirmayer *et al*., 2004). Indeed, the situation is more complicated still. As Kirmayer (2006) puts it, 'cultural identity and illness explanations are works in progress, marked by tentativeness, multiplicity, and contradiction . . .'. Thus he found illness narratives would actually evolve over the course of a 1–2-hour interview.

The consideration of the impact of cultural context offers an additional dimension for the appreciation of psychiatric disorders in general. However, the worry remains that this transcultural dimension is now something acknowledged by the mainstream but not part of it. Thus, if most psychiatric epidemiologists stop to think about it, they are likely to agree that it is central to our understanding of psychiatry, but they will then bracket it in such a way that it does not inform their routine conceptualizations of scientific problems in psychiatry.

This chapter addresses the problem of dysphoria, and its relation to the psychiatric construct of depressive disorder. The transcultural psychiatry of depressive disorder can be seen as pivotal both to transcultural psychiatry and to our more general understanding of psychiatric disorder. Culture must limit the sources, form and expression of individuals' distress, and their explanatory models, coping styles and help-seeking behaviour. It will also modulate the social response to the expression of distress (Kirmayer, 2001). We will attempt to analyse dysphoria in its most basic terms in order to see the points at which it is shaped into a cultural phenomenon.

The ways of feeling bad

There are a number of important questions about establishing the incidence and prevalence of depression in different cultures. The first is whether the very experience of depression can be recognized in non-western cultures. It would be carrying the principle of cultural relativism to ridiculous extremes to suggest that dysphoria is restricted to the inhabitants of Western cultures. Human beings clearly do not feel the same at all times, and to varying degrees they sometimes feel bad. We have developed layers of conceiving and describing this such that it has become difficult to analyse bad feelings in (even relatively) value-free terms. Feeling bad certainly covers awareness of pain, of lowered mood and of reduced functioning. These are related to each other empirically. They are also related in a feedback loop with processes of social evaluation and self-comparison. Thus part of feeling bad involves cognitive processes such as lowered self-regard and fear of future circumstances. Bad feelings are therefore inevitably socially mediated.

Ways of talking about feeling bad

Talking about feeling bad is part of normal human discourse. As such, it requires an appropriate lexicon and a socially approved way of using it. The weight given to the different forms of feeling bad described above depends on social values. Some societies, particularly the current developed economies of the Western world, clearly place particular value on the social comparison aspects of feeling bad, in other words, the social validation of the individual. Such societies may be seen as emphasising and elaborating that part of the lexicon of feeling bad relating to dysphoric mood and cognitive processing. Other cultures may play these aspects down in a way that brings expressions of pain to the fore. Thus approved ways of expressing distress and the words for expressing it shape each other in a reciprocal and progressive manner. The consequence is that dysphoria may be described in terms that do not represent identical categories in different languages. This is particularly likely to be the case in languages where the common root lies very far back in time. This is an empirical issue to be decided by research.

A number of authorities have claimed that non-western cultures sometimes lack words representing even the symptoms of depression (Leighton *et al.*, 1963b; Marsella, 1977). Thus the emotional lexicon is of considerable intrinsic interest. Most words for expressing distress in Western languages derive from corporeal metaphors. Depression and anxiety derive from roots expressing physical pressure or constriction (Leff, 1981). Some of the difficulty for Western psychiatrists in interpreting the self-reports of people from other cultures may be an inability to grasp metaphorical language in another tongue. Bhugra and Mastrogianni (2004) list a number of phrases from a variety of languages that can quite easily be seen as somatic metaphors for mental experiences.

Leff (1973) examined the differentiation of emotional states in different cultures using data from the International Pilot Study of Schizophrenia (WHO, 1974). This study involved translating the Present State Examination into seven languages, of which two were not Indo-European. It was found that the words depression, anxiety and tension were especially hard to translate into Chinese and Yoruba, and in the latter had to be expressed in terms purely of the somatic accompaniments of the emotion. Nevertheless, once this was done, the research team felt that a degree of validity was attained. Leff also found that the correlation between depression, irritability and anxiety varied between the different centres, being particularly high in non-western countries. As he pointed out, this might arise because the symptoms were genuinely more associated, because the patients differentiate between them less well, because the psychiatrists failed to distinguish them, or a combination of these possibilities. However, something similar was seen in American black participants in the US/UK project (Cooper *et al.*, 1972). They spoke English as a first language, so it is clear that, even when a lexicon is available for describing an emotional state, it does not guarantee that everyone will use the words in the same way.

Leff (1974) also found that there were differences between psychiatrists in recognizing the distinction between affects in different groups of patients. Western psychiatrists distinguished irritability, anxiety and depression in all the patients interviewed, while those from developing countries only did so when rating the patients from the West. It is therefore possible that this difference arose because western psychiatrists were imposing a distinction that did not exist in the patients who came from developing countries. Western psychiatrists may also be more ready to differentiate emotional states than their own patients (Leff, 1977).

The availability of a rich emotional language does not guarantee the expression of emotion in psychological terms. Even within Western cultures, there has been a class difference, with working-class people being more likely to manifest distress in somatic terms. Moreover, in the West the use of somatic symptoms to express distress has been declining more rapidly than any change in language. This has been linked to individualism in the West, in contrast to the group values of traditional societies (Leff, 1981). Such refinement of emotional expression may have been driven equally by psychiatrists and novelists. Leff (1978) demonstrated that psychiatrists indeed make emotional distinctions that their patients do not.

Leff (1981) thus argued that the expression of emotions and, by implication, of neurotic experience is fluid, and that the activity of psychiatrists actually creates the subject matter of classifications that they think they merely apply to what is there.

Leff's synthesis actually comprises two statements, firstly, that Western cultures distinguish more between nuances of the psychological expression of dysphoria than do non-Western cultures, and secondly, that psychologism is related to an adherence to individual rather than group values. However, there are certainly cultural counterexamples that work against the second statement. The Pintupi aborigines of Australia have a language rich in emotional terms, including different words for *the fear that makes you stand up* and *the fear that makes you turn around*, and this in a culture that clearly places more value on the group than on the individual (Morice, 1978). In practice, the situation is, as ever, likely to be complicated. There is probably variation between individuals within any given culture along the idiocentric/allocenric dimension and this may interact with the cultural attributes (Bhugra, 2005).

It is clear that some cultures use conceptualizations of the form of dysphoria that differ from the syndromes employed by Western scientists. However, this, while of intrinsic interest, is not relevant to the cross-cultural identification of those syndromes. The fact that some cultures organize their concepts of dysphoria in a different way does not mean that Western syndromes cannot be applied within those cultures. All this requires is that most of the symptoms that constitute the syndromes can be recognized.

Ways of explaining bad feelings

In many cases, bad feelings can easily be attributed to bad circumstances, particularly given that it is part of the human capacity for theory of mind to be able to do this. Sometimes, however, theory of mind fails to satisfy the human requirement for satisfactory explanation, and an explanation from some other domain than the social is sought. The two main alternative candidates are religion and bio-medicine.

Religious explanations in terms of the actions of a superior being tend to require appeasement and acceptance, and it may be more satisfying to bring in additional or alternative ascriptions in terms of the malign behaviour of other humans through concepts of witchcraft. It may also imply rectification through positive action.

Biomedical modes of explanation exist in many, perhaps most, cultures. The most powerful of these is Western medicine, partly because of the economic power of the West, and partly because biomedicine is bolted on to scientific empiricism and its progress is relatively easy to demonstrate. Other major biomedical systems comprise Ayurvedic and

Chinese medicine. Biomedical explanations invoke ideas of bodily balance (*qi*, the humours, homeostasis, the immune system, genetic expression) and the influence of noxious environments. Treatments are sought in the restoration of balance and the removal of noxious influences. Although notions of balance, whatever the medical system involved, may be seen in dimensional terms, diseases themselves are primarily categorical constructs. This is true in Chinese and Ayurvedic medical traditions as in Western medicine. The category may be defined in terms of a single symptom, or in terms of a syndrome. Concentrating on single symptoms is an easy way to establish a category (as, for example, in *koro* and *windigo*), but empirically the symptoms are likely, willy-nilly, to be located within a syndrome of related symptoms (Leff, 1981). This has implications for cross-cultural interpretations of dysphoria.

Biomedicine and feeling bad

Biomedicine is a set of procedures that are located in socio-cultural space. In the West, that space includes the assumptions that lie behind experimental science. However, in all cultures it also includes the prescriptions of illness behaviour: the complex interaction between modes of discourse surrounding distress and the way physicians, representing the cultural construct of medicine, respond and deal with it.

This aspect of human behaviour had major impetus from the work of Parsons (1951) on the sick role and of Mechanic (1962) on illness behaviour. In order to become the focus of a medical approach, people have to behave as if they are sick. This involves translating feeling bad into words describing these feelings that may form the basis of a sickness dialogue. There are socially prescribed ways of doing this that permit access to the sick role. This role involves a varying degree of relief from social obligations, and also makes the sufferer a focus of obligation for others. The role is, however, only ‘partially legitimated’ as the sufferer acquires the obligation to seek health. This may be carried out at an informal level, for instance with relatives: thus the sick person may rest, as an approved way of facilitating recovery. However, the obligation to seek health may also be formalized, involving consultation with approved persons (doctors, largely, and registered doctors at that) who validate the status of sickness, and offer advice that sufferers decline at peril of losing approval for that status. Recovery is then both expected and monitored. If recovery does not occur, even for good medical reasons, sufferers enter a chronic sickness role of diminished standing. Deviation from the illness behaviour required in the sick role may elicit considerable sanctions. We do not approve hypochondriasis or hysteria because they seem to involve attempts to enter the sick role without paying the dues of health-seeking. Likewise, over-stoical behaviour, although often attracting admiration, is the bane of preventative health programmes.

Approved claims on the sick role are based on the categories of illness acknowledged in a given culture. In this respect, Western cultures have an interesting attitude towards the possibility of psychiatric disorder. It is reckoned to lie within the general biomedical domain, but also to be an allowable alternative to physical conditions and to the expression of physical distress. In other cultures, this separation is often not made, and approved expressions of distress are limited to the physical alone. People expressing apparently psychological distress in physical terms are regarded in a Western medical context as being *somatizers*, with the implication that their illness behaviour is substandard in some way. Thus people who make hysterical or hypochondriacal presentations of their unease are either tutored in, or dragooned towards, more psychological accounts. Medical opinions therefore partake of general societal attitudes towards disorder.

This analysis of the way the behaviour of distressed and dysphoric people is shaped by the cultural environment emphasizes the way the latter influences the choice of emphasis upon different aspects of the experience, the way things that happen in that environment are given meaning linking them to the dysphoria, and the way key representatives of the cultures responds to the sick person.

Kleinman in China

In this regard, there is still great value in revisiting the pioneering work on neurasthenia by Arthur Kleinman in China (Kleinman, 1986). These led him to regard somatization as a form of illness behaviour shaped by the local culture in a way that was reflected in the experience of depression (Kleinman 1986). This was very much a socio-political interpretation of cross-cultural psychiatry, involving consideration of the way in which individual identity and socio-political realities mutually influence each other. His researches carried out in 1980 and 1983 in Hunan province in mainland China, also cast light on the sorts of factors that may serve to maintain the use of indigenous categorizations.

The concept of neurasthenia was originally a Western one that emerged in Europe and America in the nineteenth century. It was then introduced early in the last century into China via Germany and Japan. Once there, it took vigorous root, probably because it cohered with long-enduring Chinese ideas that disease was caused by weakness of the vital essence. Following the virtual abandonment of neurasthenia in the West, it has effectively become an indigenous Chinese category. However, after the communist takeover in China, the official view was that neurasthenia was the result of an imbalance between environmental demands and an individual's capacity to cope, and therefore particularly common in capitalist societies. In consequence, the high prevalence of neurasthenia in China had become an embarrassment by the end of the 1950s. The Great Leap Forward of 1959 provided for *the rapid combined treatment* of neurasthenia (by labour, psychotherapy, drugs and political argument). Although results were reputed to be good, over the succeeding years the condition tacitly became acceptable again. Nowadays in China, neurasthenia remains a very common diagnosis in primary care, general medicine and psychiatry, while depression is rarely diagnosed. The syndromes of neurasthenia and of depression clearly overlap, although the emphasis in the former is upon the somatic symptoms. The key question is whether the Chinese diagnose the former where Western psychiatrists could and would diagnose the latter.

Kleinman's research was partly designed to answer this question. He studied 100 cases with a diagnosis of neurasthenia. He used the SADS (Schedule for Affective Disorders and Schizophrenia; Spitzer & Endicott, 1978) to generate DSM-III classes and found that 93 met the criteria for depression and 87 for major depressive disorder. Sixty-nine also met criteria for anxiety disorders. Despite this, the presenting symptoms were predominantly somatic, and virtually all the patients had consulted general physicians before visiting the psychiatric department. Although nearly all the patients were dysphoric, this could only be established by direct questioning. The patients were ready to acknowledge psychosocial precipitants, but regarded the condition itself as being organically mediated and actively rejected the label depression. Although many showed a good response to antidepressants, this did not change their views of their condition.

Many patients with neurasthenia experienced social circumstances that in the West would lead to a direct expression of distress and dysphoria. These related both to circumstances within the family and to the wider world of post-revolution China. China was, in the 1980s, a relatively poor country struggling to make its way through a political system that exerted close and direct control over people's lives, particularly in the workplace. As a result, many patients had good reason for a sense of powerlessness in situations that seemed desolate and unending. Moreover, the Cultural Revolution had often been accompanied by the direct and deliberate spoiling of people's social identities, a process that often seemed to have been internalized. Their predicament is readily understandable, despite the cultural divide. Why then is the expression of this distress so different in emphasis? It is not that the

Chinese do not share the psychological experiences that might be endorsed by a Westerner in a similar position, but they emphasise the somatic symptoms. Moreover, although prepared to admit the social occasions of their condition, they believe these activate an essentially physical disorder.

Kleinman speculated about the reasons for this pattern of expressing distress. In part, it was rooted in family and social conditions that had long existed in China: psychiatric disorders were viewed as criticism of the family, and were therefore associated with considerable stigma. However, in communist China the expression of depressed affect was also a political act, implying criticism of the regime. Neurasthenic symptoms were not so regarded, and were thus a sanctioned pattern, available to those in distress, and responded to reasonably positively by relatives, workmates and physicians. For many of Kleinman's patients, neurasthenic behaviour offered the only allowable avenue to a degree of control over their circumstances. Neurasthenia seemed to have a function in modern Chinese society of containing the threat of dissidence by affording it the marginal legitimation of illness behaviour.

Kleinman argues that it is not so much somatization in China that requires explanation but the psychological modes of expressing distress of some people in Western societies. He agrees with Leff that such modes are clearly egocentric. However, he makes the very interesting suggestion that egocentricity itself has a stabilizing function whereby personal distress is detached from the structure and organization of society as a whole. The question then becomes one of how individual societies arrive at their own particular way of dealing with the threat represented by dysphoria.

Finally, we return to the relationship between the syndromes of neurasthenia in China and depression in the West. In our view, it is an empirical question whether the syndromes of neurasthenia and depression can be seen as partly or wholly equivalent and, if not, which classificatory scheme is most useful. The very over-inclusiveness that gives it its cultural value in China might make neurasthenia less useful scientifically than Western concepts of depression.

Kleinman distinguishes between illness, essentially the behavioural exposition of discomfort and the social status deriving from it, and *disease*, the underlying process leading to the discomfort. We share Kleinman's view that illness is culturally constructed, albeit biologically constrained. However, the scientific processes of case definition and case recognition, although related to the patient's ways of deploying symptoms, are certainly not completely reducible to them. If they were, Kleinman would not have been able to translate neurasthenic patterns of illness behaviour into American classificatory systems.

However, the situation is further complicated, as disease categories set up primarily for scientific purposes then became part of the discourse between patient and physician, between patient and society. This has clearly happened with neurasthenia in China. Kleinman's studies suggest that, although indigenous categories of metal illness have an intrinsic interest, this is more in the cultural than in the psychiatric sphere – in other words, the existence of indigenous categories does not reflect on the applicability of classifications originated in the West. We are thus not convinced that he has sufficiently distinguished between the cultural uses and functions of illness and the scientific uses and functions of classification and case definition.

The WHO Collaborative Study on Standardized Assessment of Depressive Disorder (WHO, 1983) illuminated this issue. The study involved the assessment of 583 patients in five urban centres in four countries (Basle, Montreal, Tehran, Nagasaki and Tokyo). Only Tehran could be regarded as being in a developing country, so some of the opportunity represented by the initiative was lost. The first aim of the study was to collect comparable information on groups of depressive patients in the different centres in order to record the extent of cultural differences in the expression of depression. The Schedule for the Standardized Assessment of Depressive Disorder (SADD) was developed specifically for this project, together with a glossary. It had a set of core items representing a consensus of the symptoms that indicate the essential features of depression. There was facility for open-ended questions about less typical symptoms. In fact, very few culture-specific symptoms were elicited, although this might have been due to the restricted range of locations. All in all, the patients from different centres were strikingly similar. They all exhibited a core of depressive symptoms – sadness, joylessness, anxiety, tension, lack of energy, loss of interest, impaired concentration and ideas of insufficiency, inadequacy and worthlessness. This similarity between centres was confirmed by principal component analysis.

Feelings of guilt and self-reproach have been seen as strongly related to the Judaeo-Christian tradition – such feelings were commonest in Basle and Montreal, least so in Tehran. Associated with this may be the relative rarity of suicidal ideation in Tehran. In contrast, somatic symptoms were commonest in Tehran and least so in Basle and Montreal. However, all these differences were matters of degree and in any case not large. In general, the psychiatrists felt that SADD was an effective way of eliciting the characteristics of depression in all the centres.

The transcultural perspective certainly illuminates the essentially Western psychiatric conceptualizations of depression. However, the virtue of regarding diseases as heuristic categories affording a framework for clinical investigation is twofold: the validity of other conceptualizations is readily acknowledged, but, by the same token, their existence does not invalidate the use of the disease categories themselves.

Cultural influences on the frequency of affective disorder

Culture must, to some degree, be internalized by individuals whose knowledge, beliefs and attitudes are shaped in the process, otherwise the culture would not exist. Nevertheless, aspects of culture remain external and constrain the actions of individuals who might not otherwise be constrained (thus, laws govern behaviour in a way individuals may resent even while complying). Cultural variables will therefore act both at the ecological level and at the level of methodological individualism (Diez-Roux, 1998). Thus, in addition to the issues of identification brought about by cultural differences, living within a given culture may influence the frequency of depressive disorder. It may do so inherently by constraining opportunity and influencing the likelihood of particular sorts of stress.

The myth of a simpler and better world persists in the expectations of some researchers about the prevalence of depressive disorder in non-Western cultures. However, it is now couched in more precise terms, such as the benefits of life in the extended family, and the undemandingness of agrarian economies. Others are more pessimistic: for them it is the fearfulness of life at the mercy of an unpredictable and often vicious physical and social environment that colours their investigations. Thus, contrary predictions can be made about the frequency of dysphoria in different cultural contexts. Comparisons between different settings are therefore exploratory, and indeed the prevalence of depression may be used to say something about the dysfunctionality of a changing culture.

There has been considerable emphasis recently, and probably with good reason, on the adverse effects of rapid socio-cultural change. Thus the cultural context may itself be in a process of alteration that unsettles at the level both of ideas and of the physical environment. The effects of such cultural and physical change are in practice difficult to untangle. Attempts have been made to measure cultural change at the level of individual attitudes and behaviour, and these have been related to levels of affective disorder in immigrants to a different culture, and in cultures themselves undergoing rapid change (Mavreas and Bebbington, 1990; Bebbington *et al.*, 1993).

Some of this change falls under the rubric of globalization. This term implies the importation and exportation of cultures and thus an attenuation of cultural boundaries. It is seen as being bound to impact on transcultural differences in levels of depression (Bhugra and Mastrogianni, 2004). Although there are countervailing forces reducing the impact of globalization, such as fundamentalism and nationalism (Bibeau, 1997), these are by their nature rearguard actions. There is no doubt of the accelerating changes or of the rapid flow of ideas and practices (Harvey 1989).[1]

Bhugra & Mastrogianni (2004) note that perhaps the key aspect of globalization is urbanization. In developing countries this is now extremely rapid, producing ever expanding megalopolises,[2] whose streets are paved with hardship, disillusion and an ever-present threat of catastrophe. Kleinman (1991) has noted the great increase in behavioural and social disturbance associated with such urbanization. In the poorest countries, urbanization occurs in the context of very high rates of unemployment and severe deprivation of the basic necessities of life. Bhugra & Mastrogianni (2004) also point out that the untrammelled and increasing power of multinational companies operating in developing countries adds to these hardships and threatens to create a sense of impotence.

International comparisons of the prevalence of affective disorder

If we accept the results of Kleinman's studies, we may conclude that Western concepts of psychiatric disorder can usefully be applied into non-Western societies, permitting comparisons that have some plausibility. This has been assisted by attempts to standardize classifications, the definitions of categories of disorder, and the methods of case finding. Before this, comparisons were always open to the charge of being tendentious. This probably accounts for the increase in recorded rates of depression in non-western cultures that followed national independence, a tendency noted early on by Prince (1977). The problem, of course, is that there are as many cultures as societies and all that can be learned from comparing a Western and a non-Western society is that different rates might be explicable in terms of the obvious cultural differences.

Clearly the crucial design for cross-national comparison has to be the community psychiatric survey. The WHO collaborative study of mental illness in primary care attenders (Üstün and Sartorius, 1995) provides comparative rates of depression in 15 countries. Prevalences varied from 2.6% (Nagasaki) to 29.5% (Santiago). However it is impossible to make sense of these variations in terms of the likely population prevalence of the disorder. They are much more likely to represent variations in pathways to care, in the structure of health systems and in attitudes towards the role of physicians. We are thus thrown back on the necessity of unselected community samples.

When Bebbington (1993) reviewed population surveys of affective disorders in different locations, there was little consistency in the methods of case finding and comparisons were of dubious merit. The obtained differences in prevalence were as likely to reflect the differences in methods of case identification as a true variation in the frequency of depression. On the surface, things would seem to have improved considerably since then. Certainly a considerable number of investigations have used ostensibly uniform case-finding techniques in the hope of being able to provide rate comparisons with more precision. These studies can be grouped according to the diagnostic instrument used. In particular, the Diagnostic Interview Schedule (DIS) (Robins *et al.*, 1979) and the Composite International Diagnostic Interview (CIDI – Robins *et al.*, 1988) have been used extensively in large surveys. Attempts have also been made to base estimates on figures adjusted for the known vagaries of the commonly used instruments. Wittchen and Jacobi (2005) have reported an ambitious attempt to

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[1] Among the cultural commodities exported by globalization are of course Western ideas of medicine and of psychiatry. It should be noted that both biological and transcultural psychiatry are cultural products, indeed both are products of a Western scientific culture.

[2] The Chinese city of Chongqing now has a population over half that of the United Kingdom.

produce a Europe-wide estimate of the prevalence of psychiatric disorder. They calculated that the overall 12-month prevalence of major depression was 8.3%.

In the remaining part of this chapter, we will focus on the prevalence of major depressive epidemiological surveys of psychiatric morbidity using the DIS, the Clinical Interview Schedule – Revised (CIS-R; Lewis *et al.*, 1992), and the CIDI (Tables 17.1–17.3). Major depressive disorder has the advantage of being a category defined by a fairly high threshold, and we choose it in the hope that this will increase the consistency of recognition. It is also a disorder sufficiently severe clearly to merit therapeutic intervention.

As might be expected, most surveys are located in developed economies. The early Epidemiologic Catchment Area (ECA) studies carried out in five sites in the US (Robins & Regier, 1991) give quite low prevalences for major depression, both for lifetime and 12 month prevalence. The figures from the more recent National Health and Nutrition Examination Survey III are higher, but include only subjects aged 15 to 40 years. The values from other developed states include several from Europe and are around twice as high as the US figure. The values from East Asia are variable but very low (Table 17.1).

There have been relatively few studies permitting international comparisons using the CIS-R (Lewis *et al.*, 1992). They are listed in Table 17.2. The large British National Surveys of Psychiatric Morbidity carried out in 1993 and 2000 (Singleton *et al.*, 2001) used this instrument, which is delivered by lay interviewers and performs reasonably against semi-standardised instruments in the hands of psychiatrists (Brugha *et al.*, 1999). The two British surveys give levels of major depressive episode of around 2½%. Similar results were obtained by Weich *et al.* (2004) in various British minority ethnic groups. The Goan community survey of women gave results perhaps on the low side, while a survey from Santiago de Chile suggests an increased rate.

Population surveys using CIDI have become a large global business in themselves. The purposes are perhaps more to do with comparison of how

Table 17.1. Prevalence of major depressive disorder using the Diagnostic Interview Schedule

			Prevalence		
Study	Area	*N*	Lifetime	1 year	1 month
Robins & Regier (1991)	ECA Studies USA	19 182	4.9%	2.7%	
Riolo *et al.* (2005)	USA – White		10.4%		
	USA – African-American	8 449	7.5%		
	USA – Mexican-American		8.0%		
Canino *et al.* (1987)	Puerto Rico	1 513	4.3%	3.0%	
Bland *et al.* (1988)	Edmonton, Canada	3 258	9.6%	5.2%	
Oakley Browne *et al.* (1989)	Christchurch, NZ	1 498	11.6%	5.8%	
Lepine *et al.* (1989)	Paris, France	1 746	16.4%	4.5%	
Wittchen *et al.* (1992)	West Germany	481	9.2%	5.0%	
Faravelli *et al.*(1990)	Florence, Italy	1 000	12.4%		
Rihmer *et al.* (2001)	Five areas in Hungary	2 953	15.0%		
Karam (1992)	Beirut, Lebanon	526	19.0%		
Karam *et al.*(1998)	Four areas in Lebanon	658	16.3–41.9%		
Hwu *et al.* (1989)	Taipei and rural regions, Taiwan	11 004	1.5%	0.8%	
Lee *et al.* (1990)	Seoul and rural regions, Korea	5 100	2.9%	2.3%	
Chen *et al.*(1993)	Shatin, Hong Kong	7 229	3.7%		
Hollifield *et al.* (1990)	Village in Lesotho	456			12.4%

Table 17.2. Prevalence of depressive episode (studies using CIS-R/ ICD-10 criteria)

Study	Area	*N*	Prevalence
Singleton *et al.* (2001)	British National 1993	10 108	2.3%
Singleton *et al.* (2001)	British National 2000	8 580	2.6%
Patel *et al.* (2006)	Women in Goa, India	2 494	2.0%
Weich (2004) (EMPIRIC)	Irish	733	1.8%
	Black Caribbean	694	2.2%
	Bangladeshi	650	2.1%
	Indian	643	1.7%
	Pakistani	724	2.4%
	White	837	2.4%
Araya *et al.* (2001)	Santiago, Chile	3 870	5.5%

nations deal with their mentally ill citizens than with comparison of frequency. The World Mental Health Survey Initiative (www.hcp.med.harvard.edu/wmh/) coordinates 28 surveys with sample sizes ranging from 1300 to 36 000. In addition to the replication of the US National Comorbidity Survey, ten are located in European countries, three in the Middle East, six in South and East Asia, five in Latin America, and two in sub-Saharan Africa. The initiative is built around the use of the CIDI, and publications are now emerging from it. Some of the results appear in Table 17.3, along with earlier surveys based on CIDI. These studies have a slightly spurious uniformity of method – the precise form and the method of administering CIDI differs between surveys in a way that may contribute to differences in prevalence. The WMHSI does have the advantage that the surveys are committed to using a single version of CIDI.

Epidemiologists have, in any case, expressed worries about CIDI, arising initially from the discrepancy between the results from the ECA surveys and the original National Comorbidity Survey (Kessler *et al.*, 1994). The high prevalences of major depressive disorder in the original NCS let to a degree of worry about what was actually being identified. Narrow and his colleagues (2002) attached a clinical significance criterion to the data and the overall one year prevalence of major depressive disorder fell from 10.1% to 6.4%. This suggests that the DIS has higher recognition thresholds than the CIDI, as indeed does the CIS-R and the SCAN (Brugha *et al.*, 1999, 2001). It was possible to apply clinical severity ratings *ab initio* to the replication of the National Comorbidity Survey (Kessler *et al.*, 2005a), and this resulted in only a quarter of the recognized cases being given a severe rating. The conclusion must be that, when comparing the values in Tables 17.1 and 17.2 with those in Table 17.3, allowance must be made for grade inflation.

It is probably best to focus on the 12-month prevalence values, as the figures for lifetime prevalence may be affected by differential influences on recall. The value for the replication of the NCS in the US is 6.7%. European values range from 3.0% to 9.1%, although the overall value for the very large ESEMeD sample is around 4%. A high rate might perhaps be expected in the Ukraine as it moves towards a market economy, but the high rate in Finland is surprising. The rates from South America vary a little, but are generally consistent with European rates, as are the values from the Australian National Survey.

Once more, however, the rates from East Asia, in particular those from the Beijing/Shanghai survey, are low, just as they were in the DIS surveys. Moreover, despite the low overall 12-month prevalence, only one-sixth of major depressive disorder in China were rated as severe (Shen *et al.*, 2006), and only a fifth in Japan (Kawakami *et al.*, 2005). This

Table 17.3. Prevalence of major depressive disorders using the CIDI

Study	Geographical area	*N*	Diagnostic criteria	Prevalence			
				Lifetime	12 mth	6 mth	1 mth
Kessler *et al.* (1994)	USA National	8098	DSM-IIIR	17.7%	10.3%		
Kessler *et al.* (2005a, b)	USA National	9282	DSM-IV^2	16/6%	6.7%		
Breslau *et al.* (2006)	USA: Hispanic	527	DSM-IV	13.5%			
	USA: Non-Hispanic blacks	717		10.8%			
	USA: Non-Hispanic whites	4180		17.9%			
Hicks (2002)	Chinese-American women	181	DSM-IV	21%			
Takeuchi *et al.* (1998)	Los Angeles Chinese-Americans	1747	DSM-IV	6.9%	3.4%		
Beals *et al.* (2005)	American Indian ribes	3041	DSM-IIIR	5.5%	3.5%		
Henderson *et al.* (2000)	Australian National	10 600	ICD-10		5.1%		
Lindeman *et al.* (2000)	Finnish National	5993			9.1%		
Lepine *et al.* (2005)	French National	2894	DSM-IV^2	21.4%	6.0%		
Haro *et al.* (2006)	Spanish National	5473	DSM-IV^2	10.5%	3.9%		
De Girolano *et al.* (2006)	Italian National	4712	DSM-IV^2	10.1%	3.0%		1.4%
Bromet *et al.* (2005)	Ukrainian National	4725	DSM-IV^2	14.6%	8.4%		4.8%
ESEMeD (MHEDEA) (2006)	Six European countries[1]	21425	DSM-IV^2	12.8%	3.9%		
Karam *et al.* (2006)	Lebanon	2857	DSM-IV^2		4.9%		
Zilber *et al.* (2001)	Immigrants from former Soviet Union living in Israel for >5 years	140	DSM-IV		2.7%		1.9%
Shen *et al.* (2006)	Beijing/Shanghai	5201	DSM-IV^2		2.0%		
Fones *et al.* (1998)	Singapore (Chinese, Malaysian and Indian ethnicities)	2947	ICD-10				5.5%
Kawakami *et al.* (2005)	Four Japanese Communities	1664	DSM-IV^2		2.9%		
Thavichahart (2001)	Bangkok, Thailand	2948	DSM-IV	19.9%			
Caraveo-Anduaga *et al.* (1999)	Mexico City	1932	ICD-10 (RDC)	7.9%	4.5%		
Medina-Mora *et al.* (2005)	Urban Mexico	5826	DSM-IV		3.7%		
Vicente *et al.* (2004, 2006)	Four regions in Chile	2978	DSM-IIIR	9.2%	5.7%	4.7%	3.4%
Vorcaro *et al.* (2001)	Bambui, Brazil	1041	ICD-10	15.6%	10.0%		8.2%
			DSM-III-R	12.8%	9.1%		7.5%
Gureje *et al.* (2006)	Yoruba speaking areas of Nigeria	4984	DSM-IV^2	2.3%	1.0%		

[1] Belgium, France, Italy, Germany, the Netherlands, Spain
[2] WMH – CODI

requires further consideration, which Parker *et al.* (2001) have provided. They were left with the conclusion that when faced by structured interviews, Chinese participants were still unlikely to vouchsafe positive endorsements of cognitive and dysphoric depressive symptoms, and that they still focused on the somatic features of their distress. It is possible that a semi-structured interview would be more effective, in the same way as Kleinman's interviews managed to elicit much more of the non-somatic symptoms. Chan and Parker (2004) suggest that sensitive cross-examination seems more likely to elicit depressive symptomatology in a cultural context that tends to restrain its expression.

The studies from the Lebanon are of particular interest for three reasons: they include some very high rates indeed; they are not consistently high; and they were carried out at different times. They thus allow an estimate of the effects of the extreme stress of war. Karam *et al.* (1998) reported a high lifetime prevalence for major depression of 27.8% in four Lebanese communities in war time, with a 12-month prevalence in two Beirut neighbourhoods following intense conflict of 41%. However, this fell to 14.4% in the four years following cessation of conflict. By the time of the CIDI survey, a period of rebuilding in the Lebanon (Karam *et al.*, 2006), the 12-month prevalence was in line with European values, although the proportion of severe disorders was 43%. We can only imagine what it is at the time of writing.

The recent report by Gureje and colleagues (2006) is the only CIDI survey carried out in Africa. It is of particularly interest because the prevalence are extremely low. There have been a few studies from Africa using other methods of case identification dating back to the Ugandan survey by Orley and Wing (1979), and including investigations of township women in Harare (Abas and Broadhead, 1997), in a South African township (Smit *et al.*, 2006) and a more recent study in rural Uganda (Bolton *et al.*, 2004). After due allowance for the methods used, these cohere in suggesting very high rates of depression. The quoted period prevalence were 17% (Harare); 33% (South African township); and 21% (Uganda). The discrepancy with the Nigerian study is hard to explain, particularly as life can be extremely difficult in sub-Saharan Africa, especially in townships.

The role of cultural attributes in explaining international differences in rates of affective disorder

Our inspection of international population surveys certainly indicates appreciable variability in rates of major affective disorder. Some of this is likely to be explicable in terms of transcultural aspects of the issues we described earlier: culturally mediated differences in the meaning of dysphoria, and the way it is discussed and handled. It still seems likely that the low rates of disorder in East Asian samples, in particular those drawn from the ethnic Chinese samples, are best explained in Kleinmanian terms. Further evidence for this comes from acculturation studies. Thus, Australian Chinese immigrants are able to recognize and ascribe depressive symptoms, and the likelihood of their receiving a diagnosis of major depression is increased by their degree of acculturation (Parker *et al.*, 2005). Increasing acculturation in East Asian immigrants to the US was associated with increased attention to affective components of the self (and less to the somatic aspects) (Chen *et al.*, 2003). However, levels of somatic symptoms associated with dysphoria are not affected by levels of acculturation in Chinese-Americans (Mak and Zane, 2004). Thus it is possible that the major influence of exposure to Western ideas about dysphoria and its expression is upon its affective and cognitive components.

There are of course other impacts from exposure to a new culture than at the level of ideas. In a study of Korean immigrants to the US, those abandoning their Korean identity were more likely to be depressed (Oh *et al.*, 2002), although learning the language and making social contacts within the new culture reduced depression. In a large study of Chinese-Americans bilingualism was however not a protective factor (Hwang *et al.*, 2000). The impact of immigration on depression is not clear-cut, and almost certainly depends in a complex manner on the several and various aspects of the specific migration (Bhugra, 2003). This is reflected in, for example, the clear differences in rates of depression between the various Hispanic groups in the US (Oquendo *et al.*, 2004).

This brings us to an important point. Many of the stresses faced by immigrants are little to do with clashes of cultural belief, but relate rather to treatment that would be perceived as bad irrespective of culture: difficulties in housing, employment, and permission to maintain their refugee status. Likewise, the large variations in rates of affective disturbance over a short period of time in the Lebanon cannot have been related to aspects of Lebanese culture. The specific explanation lies in the impact of war on civilian mental health, an impact so extreme that it is unlikely to be moderated much by cultural variation. The anecdotal accounts of extreme psychiatric morbidity in the long aftermath of the Rwandan genocide tell a similar story. These responses reflect universals of the human condition.

It is probable that ideas that emerge from a transcultural psychiatric perspective are best tested in terms of specific hypotheses using measures designed to test them in specific populations. These can relate attributes of the culture to the attitudes and behaviours of individual members, and are likely to be particularly productive in the modern context of rapid cultural change (e.g. Ghubash *et al.*, 1994). Isaiah Berlin's classic essay 'The Hedgehog and the Fox' starts from the aphorism that the fox knows many things, the hedgehog but one. Progress in transcultural psychiatry is likely to depend on the presence of many scholarly foxes. It is a hugely complex area in which hedgehogs are not likely to get very far.

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Substance misuse

Shamil Wanigaratne, Susan Salas and John Strang

EDITORS' INTRODUCTION

Addictions of different types have been around for a long time in the history of mankind. The use of mind altering substances is well known and well described in scriptures across many faiths. Human beings use these substances to make themselves feel happier, 'drown their sorrows' and for a variety of reasons. The use of alcohol and other substances of addiction varies dramatically across cultures and is dictated by cultural norms and societal expectations as well as availability. The global prevalence of associated disorders and patterns of use and abuse indicates the nature of influence that cultures have.

In this chapter, Wanigaratne et al. *highlight that an understanding of the continuum of the use and abuse of substances is fundamental to developing interventions which will be culturally acceptable. They argue that co-morbidity in psychiatric disorders with substance misuse is worth examining from a cultural perspective. Within migrant groups, patterns of use of specific substances such as* khat *may mirror those from the country of origin. The legal and illegal nature of certain substances adds another dimension to management as well diagnosis. Using* khat *as an example, the authors point out the relationship between socialisation and* khat *use in different nations. The possibility of medicalising some of the problems must be kept in mind. The use of interventions also has to be cultural sensitive and culturally appropriate.*

Ah, my Belove'd, fill the Cup that clears
To-DAY of past Regrets and future Fears:
To-morrow! – Why, To-morrow I may be
Myself with Yesterday's Sev'n thousand Years.
Omar Khayya'm (1048–1122) (FitzGerald, 1859)

Introduction

The use of mind altering or intoxicating substances has been part of human lifestyle from the beginning of time. As food and eating are often defining features of a culture, so are the intoxicants. Just as eating is essential for survival but can give rise to disorders culturebound or otherwise, intoxicants too similarly become problematic in many societies, although the type of intoxicant and society's tolerance vary. Unfortunately, ethnicity and culture is lacking in many of the current dominant conceptualisations and formulations. By considering the contribution of culture, we cannot only further our understanding of the nature and aetiology of substance use disorders and the pattern of presentation of these disorders, but can also inform the design of effective interventions both to treat and prevent these problems (Oyefoso, 1994). This chapter examines the continuum of substance use, misuse and dependence and how culture interacts with perceptions, attitudes and formulations when substance use is seen as problematic. It also summarises what is known about global prevalence data for different substances of use/misuse, and the different responses to tackle what is seen as a growing worldwide substance misuse problem. We also explore what is considered to be a 'problem' and the extent to which culture influences what is seen as pathological. The example of *khat* will be presented in relation to what happens to a substance when it moves outside its original cultural context.

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The smoking of the waterpipe will also be considered in relation to the increasing concerns about the associated health effects. Beyond definitions, this chapter also looks at how cultural perspectives/formulations could be used to help interventions at an individual, societal and global level.

World Health Organisation global prevalence picture

There are a number of recent studies that attempt to estimate prevalence of substance misuse problems globally. The results from the international consortium of psychiatric epidemiology (Vega *et al.*, 2002) is one such example. It is clear from a country by country perspective, or a global perspective, that there are some main substances of use and misuse, but others are influenced by culture. It is estimated that globally 1000 million people smoke tobacco, 76 million people are suffering from alcohol use disorder and 15 million people are suffering from drug use disorder (United Nations Office on Drugs and Crime, 2005; West, 2006; WHO: www.who.int). The health burden of tobacco smoking is enormous (WHO: www.who.int), and the health and social cost of alcohol misuse is also enormous (Room *et al.*, 2003). Yet from an economic perspective, the legal substance industry is also a major source of revenue for most governments globally. It is not difficult to argue that the revenue factor dampens the enthusiasm of any government to intervene to reduce the consumption of these substances. On the other hand, a great deal of effort and resources in Western industrialised nations and international bodies (who are in turn influenced by them) go into combating illegal drugs such as cannabis, cocaine, heroin and amphetamines. International conventions and agreements that are driven by Western industrialised countries, especially when they decide on legality or illegality of substances, can therefore be accused of ignoring cultural perspectives of substance use, making some cultural practices that had gone on for centuries illegal overnight (Charles and Britto, 2001). It can be argued that cultural psychiatry could play a major role in enhancing our understanding of the cultural and social practices involved, which in turn may influence and result in changing some internationally held views and local legislation. An excursion into this area must also look at substances such as *khat* and betel nut, whose use is specific to certain cultures or regions in the world. Examining the use and misuse of these substances enables us to see the factors upon which our current concepts of substance misuse and dependence are developed. The current situation with these substances, particularly *khat*, gives us insight into the process of how legality or illegality of some substances is determined. Instead of attempting to deconstruct our current conceptualisations and definitions, examining the very live debate about the status of *khat* more than illustrates how our existing concepts were formed.

From a psychiatric point of view, the picture of co-morbidity or the co-occurrence of mental-health problems with substance misuse problems becomes greatly important as it is a significantly challenging clinical area. The interaction between substance use and mental-health problems and various causal models is also worth examining from a cultural perspective. For example, the use of cannabis in early teens and its suggested link with the development of psychosis (McGhee *et al.*, 2000; Patton *et al.*, 2002; Clough *et al.*, 2005) is worth examining, as cannabis use is very much part of a number of cultures. Substance use and misuse among immigrant communities is a major consideration within this context. In Western countries there are often myths about substance misuse among immigrant communities. Taking the United Kingdom as an example, there is a perception among the public and many professionals that substance misuse among ethnic minorities is greater than in the indigenous population; however there is no evidence to support this belief, and indeed there is evidence to support the opposite (McCambridge and Strang, 2005). Nevertheless, there is evidence to show that substance use among immigrants is greater than compared with those living in their countries of origin

(Wanigaratne, Unnithan and Strang, 2001). There is also evidence for ethnic differences for consumption of different substances in countries such as the United Kingdom (Best *et al.*, 2001). This is undoubtedly mediated by culture.

The continuum of substance use, misuse/dependence

The issue of substance use vs. problematic use is fundamental to an examination of this area from a cultural perspective. It can be argued that this is the most crucial issue in the field of addictions. The philosophical question of what is normal, and what is abnormal, is at the heart of psychiatry and abnormal psychology and is decided by the society and cultures. In most instances, the line to define normal is drawn on a pragmatic basis on an assumption of common and societal values, which are strongly influenced by dominant religious or political forces. At present, Eurocentric or Northern Hemispheric values may be most influential. The reader is referred to anthropological explorations of alcohol use by Douglas (1987) and the work of Heath (1976, 1978) for a more in-depth exploration of this issue. For the purpose of this chapter, it is important to delineate the basic concepts and issues. In our modern thinking, legality of a substance appears to be one of the key factors influencing where the line is drawn between the 'normal' and 'problematic'. Society is a key factor in determining whether a substance is harmful. The degree of 'control' an individual has over his substance use is key in the conceptualisations of 'addiction', which has become synonymous with what is seen as problematic substance use. Biological changes within the individual's brain or 'neuroadaptation' as a result of substance use is another factor. Problematic substance use, which is essentially the concern of psychiatry, psychology and other mental-health professions, is seen as falling into two categories. These are 'dependence' (implying both physical and psychological dependence) and 'abuse or harmful use'. There is remarkable agreement between the two dominant international diagnostic classification systems, the DSM IV of the USA and the WHO ICD 10, when it comes to substance 'dependence' (Table 18.1). The concordance between the definitions of both diagnostic systems is probably due to the fact that they are both based on the seminal work of Griffith Edwards in the UK (Edwards and Gross, 1976) in trying to establish a working definition of alcohol dependence. The validity of the dependence syndrome described in DSM IV and ICD 10 for different substances and in different cultures has been investigated by the WHO in 12 different countries (Nelson *et al.*, 1999). The findings largely support the content validity of the two systems for alcohol, opioids and cannabis, but not for other substances.

The two systems differ somewhat when it comes to defining abuse or harmful use (Table 18.2). DSM IV uses the term 'abuse', and ICD 10 uses the term 'harmful use'. The DSM IV definition places heavy emphasis on the social consequences of substance use, thus making it possible for the diagnosis to be culture-specific, while the ICD 10 definition excludes socially negative consequences, emphasising physical and mental consequences and thus enabling diagnosis to be made across different cultures (Finch and Welch, 2003).

However, emphasising the power of norms (culture) in terms of motivating restraining addictive behaviours in his excessive appetite theory of addictions (Orford, 2001) strongly criticises DSM and ICD systems:

> . . . at the very core of addiction, according to this view, is not so much attachment *per se* but rather conflict about attachment. The restraints, controls and disincentives that create conflict out of attachment are personally, socially and culturally relative. No definition of addiction or dependence, however arbitrary, will serve all people, in all places, at all times. From this perspective, systems such as DSM and ICD which claim universality may in fact be standing in the way of scientific progress by leading us to believe that such absolutes might exist. (Orford, 2001, p. 29)

The merits and consequences of ignoring the cultural context when defining substance misuse problems will be further explored in this chapter.

Table 18.1. ICD-10 and DSM-IV classifications of the dependence syndrome

ICD-10	DSM-IV
Evidence of tolerance such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses	Tolerances as defined by either of the following: * Need for markedly increased amounts of the substance to achieve intoxication or desired effect * Markedly diminished effect with continued use of the same amount of substance
A physiological withdrawal state when substance use has ceased or been reduced as evidenced by:	Withdrawal as manifested by either of the following:
* The characteristic withdrawal syndrome for the substance, *or*	* The characteristic withdrawal syndrome for the substance
* Use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms	* The same (or closely related) substance is taken to relieve or avoid the withdrawal symptoms
A strong desire or sense of compulsion to take the substance	No equivalent criterion
No equivalent criterion	There is a persistent desire or unsuccessful efforts to cut down or control substance use
Difficulties in controlling substance-taking behaviour in terms of its onset, termination or levels of use	The substance is often taken in larger amounts or over a longer period than was intended
Progressive neglect of alternative pleasures or interests because of psychoactive substance use	Important social, occupational or recreational activities are given up or reduced because of substance use
Increased amount of time necessary to obtain or take the substance or recover from its effects	A great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects
Persisting with substance use despite clear evidence of overtly harmful consequences. Efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm	The substance use is continued despite knowledge of having a persistent or recurrent physical and psychological problem likely to have been caused or exacerbated by the substance

Table 18.2. ICD-10 and DSM-IV criteria for harmful use and substance abuse

ICD-10 criteria for harmful use	DSM-IV criteria for substance abuse
A pattern of psychoactive substance abuse that is causing damage to health, either physical or mental. The diagnosis requires that actual damage should have been caused to the mental or physical state of the user. Socially negative consequences, or the disapproval of others are not in themselves evidence of harmful use	● Recurrent substance use resulting in a failure to fulfil major role obligations at work, school or home ● Recurrent substance abuse in situations in which it is physically hazardous ● Recurrent substance-related legal problems ● Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

Cultural context and substance use

The DSM IV definition of substance abuse takes into consideration negative social consequences of substance use and includes legal problems resulting from substance use in its criteria. An individual being arrested for being in possession or using an illegal substance would meet one of the criteria laid down in the diagnostic system. The question of legality of a substance and its relationship with concepts of substance misuse is paramount in looking at this field and dominant diagnostic systems from a cultural perspective. As stated earlier, use of different mind-altering substances has been part of many cultures for hundreds if not thousands of years. References to opium in Sumerian ideograms in about 4000 BC and Assyrian medical tablets of 700 BC and Cannabis in China and the East several thousand years BC can be cited as examples (Berridge and Edwards, 1987). The use of opium, cannabis and cocaine for medical and recreational purposes in nineteenth-century England and the changes in attitude, social context and legal status from common use to 'dangerous drugs' is charted in the classic text *Opium and the People* (Berridge and Edwards, 1987). Outside the Western world, exploring 'substance use in India', Charles and Britto (2001) outline the implications of international covenants and agreements and state that 'countries such as India had to criminalise traditions that were centuries old and accept the homogeneous definition of drug addiction and its management. The decision to adhere to demands, made under the pressure of the World Bank and the IMF, is reported to have transformed the drug scene in many parts of India, which had a tradition of controlled use of cannabis and opium products for well over a thousand years (Charles and Britto, 2001, pp 467). India is a country that can boast of being a melting pot of many cultures. Most of the world religions are practised by citizens of India and many of its cultures encourage the use of mind altering substances for medical, religious and social use. The traditional systems of medicine in India (e.g. Ayurveda, Siddha, Unani and Tibbi), as well as home remedies, tribal medicine and folk medical practices, use cannabis and opium as components of treatment (Chopra and Chopra, 1990; Britto and Charles, 2000). Even when legislation in countries allows for medicinal use of banned substances (e.g. Narcotic Drugs and Psychotropic Substance Act, 1985), these actions can backfire: thus in India implementation in terms of providing a licensing and distribution structure has been unsatisfactory, forcing individuals to act outside the law. In Sri Lanka, a systematic method of distributing opium to traditional practitioners was devised but in the year 2000 the 'international donor community' forced it to stop this. There are also many examples in India where cannabis is associated with social and religious ceremonies particularly among the Hindus (e.g. Shivaratri and Holi) and aid practices such as meditation by yogis and sadhus (Fisher, 1975; Charles and Britto, 2001). Similarly, there are many examples from traditional Indian social and cultural practices where cannabis, opium and other mind-altering substances are used (e.g. during marriage ceremonies) (Chopra and Chopra, 1990; Masihi and Desai, 1998).

The above section briefly outlines the implication of one aspect of a diagnostic system, namely legality and its ramifications from a cultural perspective. It must be emphasised that legality or legal problems are not the only issues that need to be taken into consideration when assessing and intervening with substance misusers from a cultural perspective.

The culture of poverty and substance misuse

The link between poverty and substance misuse has been established in many countries. Recent studies in Sri Lanka have shown how poverty itself gives rise to a culture that promotes and maintains substance use, particularly drinking (Baklien & Samarasinghe, 2003). The 'culture of poverty' or 'poor culture' makes drinking an integral part of it and traps the individual by giving him/her an identity within it and by subtle and direct means preventing the individual from escaping poverty. It is as if poverty not only makes the channels into substance misuse easier to slide down, but also makes the channels of exit more difficult to negotiate. Customs and traditions promote the use of alcohol and at the same time, ensuring that the individual gets deeper into financial difficulties, thus making it impossible to overcome poverty. The individual finds that acceptance of current circumstances is more adaptive than trying to overcome them (Baklien & Samarasinghe, 2003). In such cultures alcohol use and related behaviours such as domestic violence become accepted public norms. Mental-health problems and associated manifestations such as 'learnt helplessness' become intertwined in this tapestry. Interventions to reduce alcohol consumption have to go hand in hand with poverty alleviation work taking into consideration the subtleties and mechanisms of their interdependence.

What happens when a substance moves from one cultural context to another? The case of *khat*

Khat is also known as *qat*, *chat* and *miraa*. The botanical name for *khat* is *Catha edulis*. It is an evergreen plant which grows in high altitudes in the Eastern African and Arabian Peninsula. The chewing of *khat* is a pastime that was recommended by mystics and commenced around the tenth century (Kandela, 2000). *Khat* is structurally similar to amphetamine. It has two major psychoactive ingredients, Cathinone and Cathine (which have similarities to the amphetamines). Cathinone is chemically unstable, and is only present in the first couple of days after harvesting of the plant. The leaves of the *khat* plant are chewed by the user. *Khat* must be chewed a short time after picking for maximum effect. Sometimes, *khat* is also drunk in tea with honey.

Several million people are frequent users of *khat* (Kalix & Breaden, 1985). *Khat* is often linked to the Islamic faith because many users are Muslim. A prevalence study conducted in Ethiopia found that 80% of users were Muslim, who reported using *khat* in order to gain a good level of concentration for prayer (Alem *et al.*, 1999). However, Islam prohibits the consumption of alcohol or of any substance that veils the mind. The use of intoxicants and alcohol are prohibited in various verses in the Q'uran:

> 'O you who believe! Intoxicants and gambling are abominations of Shatans handiwork. So strictly avoid all that in order that you may be successful' (Al-Ma'idah 5:90)

There is a whole social process that occurs in relation to *khat* use. People go to the market to buy fresh *khat* around midday. It is usually sold in bundles wrapped in banana leaves. The quality varies according to price. After buying *khat* in the market, people go and have a steam bath or eat a hot curry (Kennedy, 1987). This makes them thirsty, so they drink water or soft drinks. This enhances the effect of chewing *khat*. *Khat* is usually chewed in company after around 3 pm. In Yemen, men group together at a '*khat* party'. Wealthy homes have a room set aside for this purpose, known as *mafraj* (Weir, 1985). Whilst chewing *khat*, the men also smoke the water pipe/*shisa*/*narghile*. During the *khat* session, men talk about business and personal affairs. The *khat* is stored in the men's cheeks in a ball. It is never swallowed.

The principal effects of *khat* are increased alertness, increased ability to concentrate, confidence, friendliness, contentment and flow of ideas. Many use *khat* to study (Kennedy, 1987). Khat is also used for medicinal purposes. In women, it is used to relieve headaches and to assist women in childbirth (Stevenson *et al.*, 1996). It is also used as an aphrodisiac (Kirkorian, 1984).

Health implications of smoking *khat*

There is some debate about whether *khat* can cause dependence (Cox & Rampes, 2003). Some state that there is no evidence of physical dependence (Ghodse, 2002) and most users report no physical withdrawal symptoms with cessation of *khat* (Cox & Rampes, 2003). There are a number of negative health consequences which have been reported with the use of *khat*. Oral consumption of *khat* in the Arabian Peninsula has been associated with oesophageal cancer (Gunaid, 1995). The first case of *khat* induced psychosis was reported over 40 years ago (Carothers, 1965), although very few cases of psychosis due to *khat* use have been reported, despite its heavy use in East Africa and Arab countries (Pantellis *et al.*, 1989). In an annual report for the Eastern Mediterranean region, the World Health Organisation expressed concern about the continued use of *khat*, especially in Yemen (WHO, 2000).

In addition to the physical and psychological side effects of chewing *khat*, its impact on the family has also been reported. There are socio- and economic implications as the family income is diverted to fund the habit (Kalix, 1984). Men who chew *khat* can also spend many hours outside the home, leaving their wives to care for the children.

The impact of migration on *khat* use

Reports of *khat* use in the UK began to circulate in newspapers from the mid-1980s (Hogg & Rogers, 1985; Pantellis, 1989). Cathinone became controlled under the Misuse of Drugs Act (1971). In its unrefined form, *khat* is not a prohibited substance in the UK, but it has been prohibited in the USA and in some European countries, such as France. Cultivation and trade in *khat* was banned in Saudi Arabia over 50 years ago (Zaghoul *et al.*, 2003). Kuwait, Morocco and Egypt have a preventative ban on *khat*. Yemen has tried on many occasions to dissuade people from chewing *khat*.

Somalian users were studied in Italy (Nencini *et al.*, 1989). They found that, whilst *khat* was easily available, it cost more than cocaine and alcohol. The general pattern of use they found was that users met at the weekends to chew *khat* in order to participate in community social life and not for the effects of the drug alone. Somalians' use of *khat* in the UK has also been studied (Griffiths *et al.*, 1997). In this study, 207 Somalians were interviewed; 76% had increased their use since coming to the UK. Some reported moderate depression and a minority reported severe depression. Adverse effects of chewing *khat* were sleeplessness, anxiety and depression. Another study of Somalians in the UK (Nabuzoka & Badhadhe, 2000) found that chewing *khat* had a social dimension, occupied a significant proportion of users' time and was associated with other drug use. Most users reported negative health effects, but said that they used *khat* to cope with feelings of dislocation from their country of origin and as a form of recreation.

More recently, there has been an emerging pattern of *khat*-induced psychosis in London (Cox and Rampes, 2003) and in Australia (Stefan & Mathew, 2005). *Khat*-induced psychosis is often associated with increased consumption (Cox & Rampes, 2003). Increased consumption is associated with the onset of psychoses. It is thought that 25% of cases improve with the cessation of use of *khat*. The remainder respond swiftly to anti-psychotic medication (Stefan & Mathew, 2005).

Should we be concerned about *khat*?

Should we be medicalising *khat* or should we view it as a harmless indigenous substance with strongly associated cultural and social roots? It would be relatively easy to medicalise and prohibit *khat* use. However, this would then deny users the opportunity to exercise their own right to decide whether to chew it or not. In contrast, alcohol is tolerated in many societies, at least to some extent, despite the evidence of major problems for some who drink. Could a similar approach be taken with *khat*? Anthropologists hold a very different view of alcohol in comparison to their medical colleagues (Douglas, 1987). They have contributed to the study of alcohol by considering the social aspect of its usage. Perhaps they have a role to play in the case of *khat* outside its normal context. Medicalising *khat* reduces the importance of, and role of the social aspects. *Khat* parties may have a positive effect on users' psychological well-being by connecting them to members of their community. However, it would seem that use of *khat* does, at times, result in psychosis. Further studies need to be conducted from an anthropological and social perspective, in order to enhance our understanding of the use of *khat* outside its original cultural context.

Smoking the waterpipe

The waterpipe is also known as the *shisha*, 'hubble bubble pipe', 'hookah', *arghile*, *narghile*. It has been smoked for around 400 years (Knishkowy & Amitai, 2005). There are differing opinions about where the practice first started. Some believe it started in India, others believe it started in Turkey (Onder *et al.*, 2002).

The waterpipe consists of a glass vase/bottle with a metal body and a hose pipe with a mouthpiece. The glass vase/bottle part of the waterpipe is partially filled with water. The small bowl at the top of the pipe is then heated using charcoal and the tobacco, called *maasel*, is placed in a small bowl in the top of the pipe. The smoke travels through the water before it is inhaled by the user via a hose pipe. The maasel comes in many flavours, such as cherry, mint, strawberry and apple. The smell of the smoke can be very pleasant. Smoking the waterpipe is a social activity and people usually pass the hose part of the pipe to each other. To refuse to share a pipe is seen as insulting. The smoking session lasts from 30 to 45 minutes. It should be noted that sometimes users mix tobacco with cannabis (Knishkowy & Amitai, 2005).

Prevalence data on smoking the waterpipe are scarce and probably inaccurate as they do not capture those who smoke at home. Use of the waterpipe is increasing in all Arab societies (Maziak *et al.*, 2004). With globalization and the increase in migration, we are likely to see an increase in its use elsewhere (Knishkowy & Amitai, 2005). The extent of waterpipe smoking in the West by migrants is unknown.

Given that the waterpipe is smoked in many Arab societies, it is worth considering the Islamic perspective on smoking the waterpipe. In Islam, actions which are permissible are known by the Arabic word *halal*. Actions which are forbidden are known by the Arabic word *haram*. In our experience of working with Islamic scholars, most view smoking the waterpipe as neither *halal* nor *haram*. It is viewed as *makrooh*. *Makrooh* is an Arabic word which means disliked or not recommended.

Little is known about the health effects of smoking the waterpipe, as many smokers are also cigarette smokers. Reported health risks associated with smoking the waterpipe include the transmission of tuberculosis, hepatitis and herpes. Some cafés use disposable mouth pieces in order to reduce this risk. There is concern that waterpipe smoking can lead to dependence. People who begin smoking it recreationally in cafés can progress to smoking it on their own (Maziak *et al.*, 2006). Waterpipe smoking is associated with some of the health problems seen with cigarette smoking (WHO, 2005). It has been reported that, during one session of waterpipe smoking, the user inhales as much smoke as if they are smoking 100 cigarettes (WHO, 2005). However, given the sharing nature of smoking the waterpipe and the lack of scientific studies, this is questionable and has yet to be proven. The WHO (2005) takes a firm stance on the use of the waterpipe and recommends that it is regulated in the same way as cigarettes, that the public and health professionals are educated in relation to the health risks, that their use is banned in public places where cigarette smoking is banned and that the health risks associated with its usage are advertised.

Interventions for substance misuse problems

We have illustrated above how culture plays a part in substance use and misuse and how this aspect is often ignored in definitions and conceptualisations in the field. It is also a fact that, in every community and in every country, there are individuals whose substance use becomes problematic to themselves and/or to others. This would be the case whether one operates within the dominant diagnostic systems (DSM IV & ICD 10) or not, although what may be considered a 'case' may differ. Whether or not an intervention is required will be influenced by the extent to which the substance is deemed, at that time in that particular society, to be problematic, as well as on the basis of other considerations such as co-occurring mental-health problems. Treatment in general would involve a medical intervention such as detoxification or substitute medication and a range of psychosocial interventions. These interventions are described in numerous texts (e.g. Institute of

Medicine, 1990; Seivewright, 2000; Ghodse, 2002; Edwards *et al.*, 2003) and will not be explored here. Instead, some examples from the limited literature of non-Western traditional interventions in the treatment of alcohol- and drug-misuse problems will be outlined. Reviews of traditional interventions in this area are rare. Jilek (1994), in a scholarly review, outlines a number of non-Western treatment approaches in a number of countries and societies including, Asia (Buddhist, Hmong shamanic rituals based on Islamic traditions, Taoist traditions, Hindu and Arab Islamic traditions), North America (Eskimo Spirit Movement, American Indian ceremonials, Indian Shaker Church), Central and South America (Mexican, Ecuadorian and Peruvian folk healing) and Southern Africa (Afro-Christian cults). Whilst there are significant variations in the philosophies, rituals, interventions and rehabilitation approaches in these non-Western treatments, some common themes and patterns also emerge (Jilek, 1994). The interventions or programmes are generally group based, although individual counselling may also take place. The programmes are invariably abstinence based and may be aimed at a single substance such as opiates and alcohol or poly-substance use. Whilst these interventions are grounded in a particular country, culture or community, hence widely different, there are strong themes or factors that emerge as critical. The following factors can be distilled from a variety of programmes:

- strong belief or religious component
- aversive component/experience
- cathartic abreaction
- herbal medication component (reversing withdrawal effects and reducing craving, e.g. Spencer *et al.*, 1980; Yang and Kwok, 1986; Shanmugasundaram *et al.*, 1986)
- use of sedatives and prolonged periods of sleep
- physiotherapies (e.g. steam baths, massage, hydrotherapies)
- traditional treatments such as acupuncture
- symbolic rituals (e.g. old self in a coffin, burning opium pipes, etc.)
- repetitive rituals (Naikan therapy Japan)
- transcendental meditation and yogic practices (relaxation)
- rituals that involve altered states of consciousness
- ceremonial/community aspect
- active involvement of family and community.

In traditional treatments, in spite of considerable variety in procedure, most of them follow the general principle of initial internal purgation and external cleansing from chemical and spiritual pollution combined with sedative alleviation of withdrawal symptoms, followed by spiritual didactic counselling (Jilek, 1994). The main features held in common in these traditional approaches are the ritual use of culturally valid symbolism, words and acts and may have an overt and covert commonality with Western therapeutic community approaches. It can be argued that these approaches may have directly and indirectly influenced each other, hence the commonality. There are also examples where a Western Therapeutic Community model has been adapted and modified incorporating local religious and cultural traditions. The Mithuru Mithuro movement in Sri Lanka is such an example, where the Therapeutic Community model has been adapted to incorporate Buddhist practices and Sri Lankan traditions in the rehabilitation of drug- and alcohol-dependent individuals.

Evaluating these programmes from a Western positivist methodology that would meet the criteria for evidence of effectiveness is problematic for a number of reasons, which are outlined in the next section. Nevertheless, some of these programmes have been evaluated and these reports paint a very positive picture. Most programmes report a very low drop-out rate (80%–90%) and six-month abstinence rates of up to 70%. A programme in Egypt integrating Islamic spiritual approach found that the compliance rate was higher than other non-religious programmes and was more cost effective (Baasher and Abu El Azayem, 1980). In Thailand the outcomes of traditional treatment centres have been found to be comparable with government treatment centres (Poshyachinda, 1980; Westermeyer, 1980). In Malaysia a study looking at outcomes of traditional treatment methods taking non-traceable patients as failures found 1-year abstinence rates ranging from 8% to 35% (Spencer *et al.*, 1980). In Japan, Naikan therapy showed outcomes of 53% abstinent in 6 months, 49 % in 1 year (Takemoto *et al.*, 1979). In Malawi a study showed an average 2.8 years of abstinence after joining a healing church (Peltzer, 1987). On the other hand, folk treatment in Central and South America, where abstinence was the expressed goal, only reduced consumption and improved personal and family function was achieved (Singer and Borrero, 1984).

Research perspective

One of the nine biggest questions facing the field of addictions today is 'why are some individuals, strata in society, ethnic groups and cultures more susceptible to addictions than others?' (West, 2006). We put forward five guiding principles to be borne in mind in such work:

- (i) It is valuable to incorporate the diverse perspectives of different disciplines – medical anthropology, sociology, psychiatry, and psychology – when researching culture in isolation within different paradigms.
- (ii) There is a need for good epidemiological data that also looks at history, traditions and cultural contexts of substance use.
- (iii) Assessments and study of mental health and substance use must be undertaken with an awareness of specific influence of culture, and how culture could mediate (i.e. beliefs).
- (iv) Avoid importing potentially inappropriate treatments developed in other contexts and for other communities, and do not seek to impose preconceptions of the effectiveness of traditional treatment programmes and approaches.
- (v) Consider the potential worth of separate culturally sensitive integration of efforts to integrate traditional approaches to Western countries that have large immigrant and ethnically diverse populations.

To illustrate the challenges facing research in this area, the scientific evaluation of traditional treatment programmes can be taken as an example. Jilek (1994) outlines six possible constraints to the process: (1) the sacred or arcane character of the ceremonies; (2) the healer's practices and prescriptions are often considered private or clan property; (3) the healer's reluctance to divulge information because of negative experience of enquiring authorities interested in illicit drug use; (4) the interfering effects of experimental research with the conduct of traditional ceremonies; (5) the difficulty of evaluating the merits of a single therapeutic method when several are often combined (this is a problem in evaluating most substance-misuse treatments); and (6) the practical difficulties in conducting outcome studies by case follow up, due to the lack of reliable records. These difficulties can only be overcome if different methodologies used by different disciplines are combined in evaluation work. Such an approach would enable the same rigour to be applied to evaluation of traditional programme that is acceptable to Western evidence databases.

Conclusions

Substance use is as old as humanity itself. At present, there is a body of evidence that points to a trend in the increase of mind-altering substances which may be due to a number of factors such as globalisation, increased travel, stresses in modern living as well as increase in leisure time. 'Culture' very much plays a part in determining which mind-altering substance is used and the patterns of substance use in many societies. In every society there is a cost involved in the use of mind-altering substances. This cost could be in the form of health burden to the individual and ultimately to the society; economic burden; disruption to family life and fabric of society; increase in crime.

It can be argued that, in any society, despite the overall cost or burden to that society, compared to the overall number of people who might be using mind-altering substances it is a relatively small proportion of individuals whose substance use becomes problematic. For some of these individuals, there may be a predisposition to problems with substances or other mental-health problems. But this must be considered against our background understanding of the considerable elasticity of the levels of problems with alcohol and tobacco – which vary greatly between societies and communities and over time, and for which factors such as price and availability are major influences on the extent of use and on associated harm. Some of these individuals may develop mental-health problems as a result of their substance use and some individuals may develop a dependence to mind altering substance. Psychiatry and psychology are disciplines that are called upon to explain and define problems in this area and intervene to help individuals. Cultural considerations have not always been evident in the work of psychiatrists, abnormal psychologists and researchers in this area. In Western countries where there are immigrant groups from different cultures, it is difficult to conceive how effective prevention and treatment for substance misuse problems for these individuals can be found without exploration of the cultural context. Incorporating relevant traditional practices into Western treatment programmes could only enhance the effectiveness of these treatments for individuals from different cultural backgrounds. Globally, where there is great pressure to tackle the rising substance misuse problems and governments seek Western style interventions to deal with it, perhaps an approach where both Western and traditional treatment options are made available to individuals and where appropriate combining these methods should be attempted. Scientific evaluation of these efforts should also go hand in hand if we are to overcome what is seen as a global pandemic.

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19

Culture and mental disorders: suicidal behaviour

Sarah A. Fortune and Keith Hawton

EDITORS' INTRODUCTION

Suicidal behaviour is one of the common behaviours that is influenced by cultural attitudes to death and self-harm. Rates of suicide vary dramatically across cultures. Even within migrant populations rates of self-harm vary. Thus biological factors alone cannot explain this huge variation. In societies and cultures where suicidal behaviour still remains an illegal act, it is impossible to collect accurate information on epidemiological and aetiological factors. Religion itself and attitudes to suicide within each religion also play a significant role in discouraging self-harm.

In this chapter by Fortune and Hawton the focus is beyond Europe and the West. With clear definitions and epidemiological exploration of the existing data, the authors discuss the differential rates of suicide across cultures and deliberate self-harm among different ethnic groups. Amongst other varying patterns of possible causation and explanations for their act, the ethnic minority groups tend to express less regret compared with their White counterparts. Elevated rates of suicide have been reported in migrants, especially in women originating from the Indian subcontinent. A striking observation is that they also used more violent and dramatic methods to commit suicide, such as burning and hanging. The rates of suicide and deliberate self-harm are lower in men of South Asian and Caribbean ancestry. Interestingly, findings are beginning to emerge that the newly expanding economies of Kazakhstan and Ukraine are beginning to report an increase in rates. Rapid industrialization and urbanization may change the social networks and systems and perhaps also increase substance abuse. The interesting paradox highlighted by the authors is that the traditionally low reported rates of suicide in Black males in the USA increased between 1980 and 1995. Differences between White and Black youth narrowed during this period. Differences are related to gender and age. The rates among indigenous populations are also noted to be elevated. Fortune and Hawton argue that ethnic density theory may not be entirely applicable to these groups. The global shift in methods of suicide also means that preventative strategies will have to be modified accordingly.

Epidemiology

Terminology and definitions

Many people consider self-harm or suicide at some point in their lives. Some will engage in an act of deliberate self-harm (DSH); this includes those who intend to die, but the act does not result in death (attempted suicide), those who self-harm by other means, and those who die by their own hand (suicide). These phenomena can be considered as successive parts of a continuum of suicidality from none to severe. Although a continuum exists, there are two main points of discontinuity. First, of those who have suicidal ideas, only a small proportion engage in some form of deliberate self-harm. The boundary between thoughts and an actual act of self-harm is therefore an important behavioural threshold. Second, some people engage in DSH once, and never repeat, while others engage in DSH several times during their lifetime.

In this chapter *suicide ideation* is defined as thoughts about an act of DSH or suicide, including wishing to kill oneself, making plans of when, where

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and how to carry out the act, and thoughts about the impact of one's death on others (Shaffer & Pfeffer, 2001). *Deliberate self-harm (DSH)* is defined as any form of intentional self-poisoning or self-injury (such as cutting, taking an overdose, hanging, self-strangulation and running into traffic), regardless of motivation or the degree of intention to die.

In the United Kingdom, as in many other countries, suicides are classified using the International Classification of Diseases (World Health Organisation, 1996). The coroner determines whether or not an unexpected death is suicide. The apparent suicide rate may partly reflect the way in which verdicts are designated by coroners, especially in relation to the number of deaths designated as suicides, due to underdetermined cause ('open' verdicts) and accidental deaths. For example, a recent rise in youth suicide in Ireland is, in part, explained by a reduction in the number of 'open' or 'accidental' verdicts and a corresponding increase in 'suicide' as a verdict (Cantor *et al.*, 1997; Connolly, 2003), although this has been accompanied by a real rise in the number of suicides.

One key concept in the field of culture and mental health is that of acculturation. Acculturation is discussed in an earlier chapter of this book. Briefly, acculturation relates to changes in cultural attitudes, values and behaviours that result from contact between two distinct cultures. Race and ancestry reflect genetic and population boundaries (Bamshad, 2005), whereas ethnicity is part of an individuals self-concept. Ethnic identity and how individuals relate to their own group and to wider society, is part of acculturation. Acculturative stress refers to a situation where the acculturation process causes significant problems for the individual. This has been associated with poor mental health including anxiety, depression and psychosomatic symptoms (Berry *et al.*, 2002), and also suicidality (Lau *et al.*, 2002).

Suicide and DSH around the world

Rates of non-fatal suicidal behaviours and suicide vary internationally, although the available data are of inconsistent quality, making robust comparisons problematic (Schmidtke *et al.*, 1999; Vijayakumar *et al.*, 2005b). Culture appears to mediate the effects of international socio-political and economic trends on suicide (McKenzie *et al.*, 2003a; Vijayakumar *et al.*, 2005a). In general terms, Central and South American countries have the lowest rates of suicide, and European nations have the highest suicide rates (Lester & Yang, 2005). China, India and Sri Lanka have relatively high suicide rates, as do central Asian countries in economic transition such as Kazakhstan and the Ukraine (Vijayakumar *et al.*, 2005b).

Deliberate self-harm among ethnic minority groups in the United Kingdom

Ethnicity is not currently recorded on death certificates in England and Wales. Place of birth is available and is sometimes used as a proxy for ethnicity. However, up to half of the ethnic minority population is born in the United Kingdom (UK). In addition, coroners appear less likely to return a verdict of suicide for ethnic minority groups (Neeleman *et al.*, 1997). Because there is a lack of centralised data on DSH and suicide in different ethnic groups in the UK, we will consider a number of specific studies on ethnic minority groups in the UK to try and establish an aggregate picture.

A study of Asian ($n = 196$) and White ($n = 975$) patients admitted to a poisons unit in Birmingham following self-poisoning showed that Asian-born women had an annual rate of self-poisoning of 376 per 100 000 compared with 299 per 100 000 for UK-born women. This trend was reversed for Asian-born males (102 per 100 000) compared with UK-born males (190 per 100 000) (Merrill & Owens, 1986). Young Asian women were more likely than White women to report that marital problems, conflict over traditional customs, or racial prejudice at least partly contributed to their acts of self-poisoning, and were less likely to have a history of psychiatric disorder or treatment. A later study by the same authors showed no significant difference in the rates of self-poisoning between Asian and English women, but lower rates among Asian and West Indian males (Merrill & Owens, 1988).

In a detailed study of 434 patients presenting to services following DSH in Ealing in London, rates of DSH were two and a half times higher among young Asian women than in White women, and seven times higher than in Asian men. The rates among Black women were similar to those of White women. Black men had much lower rates of DSH presentations than White men. Self-poisoning was the most common method across all ethnic groups (Bhugra *et al.*, 1999b).

In a comparative study, 27 Asian women presenting to services in London following DSH were compared with a matched group of Asian women attending GP surgeries and White women presenting to medical services. Compared with the GP control group, Asian women who engaged in DSH were more likely to have had a previous history of DSH and psychiatric disorder. Compared with White women who had engaged in DSH, Asian women were more likely to report that they had wanted to die and regretted this had not been the outcome. They were also less likely to have used alcohol in the episode of DSH and less likely to abuse alcohol in general. Overdose was the main method of DSH for both groups; however, Asian women had taken fewer tablets. The rates of psychiatric disorder were high in both groups (Bhugra *et al.*, 1999a).

There have been only a few studies of DSH among ethnic minority children and adolescents in the UK, mostly focused on London. In a small, retrospective study of adolescents presenting to a child guidance clinic in Coventry, disciplinary crises were the most common precipitants for DSH by both White and Asian adolescents. However, the nature of conflict in Asian families pertained to disagreements over Western style of dress and failure to observe religious traditions (Handy *et al.*, 1991). In a study of 76 adolescents admitted to hospital in London following DSH, inception rates for South Asian and White patients were very similar and overdose was the most common method in both groups (Bhugra *et al.*, 2003). Similar to the study conducted with adults mentioned above, none of the Asian patients expressed regret about the episode of DSH. A more recent study showed lower rates of DSH among Asian youth (Bhugra *et al.*, 2004). In another, study referral rates to psychiatric services following DSH for Black adolescents were comparable to the proportion of Black youth in the community and Black and White adolescents shared similar profiles with regard to prevalence and type of psychiatric disorder (Goddard *et al.*, 1996).

In a large community-based study in schools, Hawton *et al.* (2002) found that DSH was less common among Asian (6.7%) and Black (6.7%) girls compared with White girls (11.6%). Rates of DSH were similar among Asian (2.7%) and White males (3.3%).

There is a lack of centralised data on DSH in ethnic minority groups in the UK. To date the studies suggest that the rates of DSH are higher in Asian women compared with White women, and lower among Asian and Black men. The patterns appear similar in children and adolescents.

Suicide among ethnic groups in the UK

Soni Raleigh *et al.* (1990) examined suicides in England and Wales between 1970 and 1978 and calculated proportional mortality ratios (i.e. the ratio of suicide deaths to other causes of death). These authors argued that suicide among young Indian women, particularly those aged 15–24 years, was much more frequent than expected, although strangely the male age-specific rates were used as the standard. Indian women were more likely to use hanging and burning as methods, compared with White women for whom the most common method was poisoning. In a subsequent study, Soni-Raleigh and Balarajan (1992a) extended the period of investigation to 1983 and included 239 suicides among immigrants from the Indian subcontinent. Elevated rates of suicide were found among Indian women, but also in East African women, particularly in the 15–24 year age group. Low rates were found in Indian men of all ages.

A broader study of suicide across 17 immigrant groups in England and Wales between 1979 and 1983 indicated that men born abroad had higher rates of suicide than generally found in England and Wales at that time. However, a significant correlation was found between the rates of suicide of men from these groups and the rates in their country of origin, which suggested that immigration alone did not account for their elevated rates of suicide (Soni Raleigh & Balarajan, 1992b).

A more recent study confirmed the findings of earlier studies that young Indian women are at higher risk of suicide than other women. The age-specific rates of suicide for 20–44 year-old Indian women in London were 23.2 per 100 000 compared with 9.5 per 100 000 for White women and 0.5 per 100 000 for Afro-Caribbean women. Young Afro-Caribbean men had a suicide rate of 26.5 per 100 000, which was very similar to that of White men (27.0 per 100 000). Lower rates were observed among men of African origin (15.0 per 100 000) and Indian origin (18.1 per 100 000) (Neeleman *et al.*, 1997).

More recently, data from the National Confidential Inquiry into Suicides of People in Psychiatric Care has indicated that, between 1 April 1996–31 March 2000, people of ethnic minority groups who were in contact with mental-health services at the time of their death, or had been within the 12 months prior to their death, accounted for 6% of all patient suicides, or approximately 70 per year (Hunt *et al.*, 2003). Patients from ethnic minorities more often used violent methods of death. Female patients from South Asia were more likely than their White counterparts to use burning (self-immolation) as a method of suicide. Ethnic minority patients were more likely to be unemployed. Black Caribbean patients were particularly likely to be isolated, unemployed, have a diagnosis of schizophrenia, to be misusing substances and to have a history of violence. In contrast, South Asian patients were more likely to suffer from affective disorders and less likely to abuse substances. A history of previous self-harm was present in about half of all patients, with very similar figures across ethnic groups. Compliance with medication and side effects were more problematic for ethnic minority patients, although they were no more likely to be lost to follow-up by services (Hunt *et al.*, 2003).

Irish-born migrants also have higher rates of DSH (Burke, 1976) and suicide (Neeleman *et al.*, 1997). Although White and English speaking, Irish migrants have shared the experiences of racism and discrimination, which challenge integration with wider society and an individual's sense of identity (Aspinall, 2002). Irish men and women are also over-represented in psychiatric hospital admissions (Bracken *et al.*, 1998), with high rates of comorbid alcohol abuse (Leavey, 1999), factors which are associated with an elevated risk of suicidal behaviours. Increasing prosperity in Ireland is associated with changing patterns of migration and may alter suicide rates of those living away from Ireland.

Young Indian women are at higher risk of suicide compared with other women in the UK. Lower suicide rates are observed in men of Indian and African origin. The previously observed protective effect in Afro-Caribbean men is disappearing among younger men in this ethnic group. Several studies suggest that members of ethnic minority groups are more likely to use violent methods of death.

We now turn to considering suicidal behaviours in other countries, specifically continental Europe and Russia, the USA and Asian countries. We then examine this phenomenon in specific at-risk groups, particularly indigenous peoples.

Eastern Europe and Russia

The fall of communist regimes in Eastern Europe in 1989 and the break-up of the former USSR in 1991 were significant socio-political and economic events, which had a major impact on the lives of 400 million people in this region. The quality of data available to researchers about mortality in Russia has been relatively poor since the 1920s, in part due to the communist interpretation of suicide as a failure of communism and a revolutionary act (Pridemore & Spivak, 2003). However, authors generally agree that, for at least four decades, Russia has had one of highest suicide rates in the world. During the 1990s, high mortality and morbidity rates were associated with increases in alcohol consumption, unemployment and depression (for review, see Pridemore & Spivak, 2003). Ten of the fifteen former Soviet nations experienced a rise in suicide rates after 1991, with particular increases in Estonia, Latvia and Lithuania (Lester, 1998). A study of Russians in Estonia found significant increases in their suicide rate following Estonian independence, which the authors argued reflected the significant new demands on the Russian minority to cope with the loss of their privileged position, to learn the Estonian language and to adapt to the significant socio-political changes of the period (Varnik *et al*., 2005).

There is scant data on rates of suicide ideation and DSH in Eastern European nations. One study of 4706 Slovenian high school students found that, compared with 19 250 Dutch high school students, Slovenian adolescents aged 15–19 years were six times more likely to report suicidal ideation in the past month (28.9% vs. 5.9%), and four times more likely to report a suicide attempt in the past year (5.3% vs. 1.5%). Slovenian students reported much higher rates of adverse family circumstances, but lower rates of exposure to suicide within the family, the latter finding possibly reflecting the taboo of suicide in Slovenian society (Tomori *et al*., 2001).

United States of America

In the USA, suicide rates in 2002 were highest among White males (20.0 per 100 000) followed by American Indian and Alaskan Natives (16.4 per 100 000), Black or African American males (9.8 per 100 000), and lowest among Hispanic or Latino men (8.3 per 100 000) (US Department of Health and Human Services *et al*., 2004). The rates among indigenous people in the USA are considered in more detail below.

Historically, the rate of suicide among Blacks in the USA has been considerably lower than Whites (Bingham *et al*., 1994). However, from 1980–1995 there was a dramatic increase in suicide deaths among Black youth. Suicides by White adolescents also increased during this time and the gap between the two ethnic groups closed (Joe & Kaplan, 2001). The largest increase for Black youth occurred in the South and Midwest regions (Centers for Disease Control and Prevention, 1998). The pattern of suicide deaths differs between Black males and White males in two main ways. First, the ratio of male to female suicides among the Black community is much higher, and second, rates of suicide in Black men increase in early adulthood, level off in middle age and decline in late adulthood. In contrast, rates in White men increase across the lifespan, particularly in late adulthood (Joe & Kaplan, 2001).

The factors leading to suicide among the Black community are not clearly understood, in part due to the low base rate of suicide in this group. A study conducted by Castle *et al*. (2004) using National Mortality data was unable to identify any factors which conferred greater risk for Blacks compared with Whites.

There is a different pattern of suicide among women in the USA. In 2002 suicide rates for White women were 4.7 per 100 000, 4.1 per 100 000 among American Indian and Native Alaskan women, 1.8 per 100 000 for Hispanic or Latino women, and lowest among Black women at 1.6 per 100 000 (US Department of Health and Human Services *et al*., 2004). Several authors (for example, Nisbet, 1996) have hypothesised that, although rates of depression and suicide ideation are comparable among Black and White women, the former experience considerable protection against suicide through social support networks, and, for some, single motherhood (Fernquist, 2004).

Hispanic youth are the fastest growing group in the US population so that by 2020 they will represent the largest ethnic minority group (Centers for Disease Control and Prevention, 2004). Suicide in Hispanic females is most prevalent among those aged 45–54 years, followed by those aged 15–19 years (Centers for Disease Control and Prevention, 2004). As in the general population, firearms (45%) and suffocation (34%) were the most frequently used methods among Hispanic males between 1997 and 2001. However, females used firearms (29%), suffocation (29%) and poisoning (27%) at similar rates (Centers for Disease Control and Prevention, 2004).

There are inconsistent findings regarding rates of suicide ideation and DSH among Blacks in the USA. However, in a review, Joe and Kaplan (2001) conclude that, across all age groups, rates of DSH are higher among women than men, and that more African-American adolescents engage in DSH than do White youth. Also African-American males are more likely to require medical attention following DSH. However, Oquendo *et al.* (2004) found that Blacks (2.69% lifetime attempts) were less likely to make a suicide attempts, than Whites (3.26%) and all Hispanic groups (3.7%), except Cubans.

In a national sample of high-school students grades 9–12 in 2003, 21% of all females reported seriously considering suicide in the previous 12 months, with the highest rates among Hispanic or Latino females (23.4%), compared with Black or African-American girls (14.7%) and White girls (21.2%). The pattern for suicide attempts was similar, with 11.5% of all females reporting at least one attempt in the previous 12 months, including 15% of Hispanic/Latino females, 10% of Whites and 9% of African-Americans. The rates of suicide ideation reported by males were lower (12.8%), with fewer differences apparent across ethnic groups: Hispanic (12.9%) and Black males (10.3%). African-American males had the highest rates of suicide attempt (7.7%), followed by Hispanic (6.1%) and White males (3.7%) (US Department of Health and Human Services *et al.*, 2004).

A study of 258 high school students in the USA found that, compared with White students, Black students reported more reasons for living and lower levels of suicide ideation. The two groups reported similar levels of depression and exposure to suicide, and for both groups there was a strong relationship between severity of depression and suicide ideation (Gutierrez *et al.*, 2005). In line with these findings, several studies have indicated that Hispanic youth, particularly females, experience higher rates of suicide ideation, DSH and hopelessness compared with their White and Black peers (for review, see Canino & Roberts, 2001). An overview of psychosocial perspectives on suicidal behaviour among young people in the USA is provided by Hendin (1995).

In the USA suicide rates are highest among Whites. The historically low rates among Blacks have been altered by a significant increase in the number of deaths among young Black men and the gap between White and Black suicide rates is closing. There are inconsistent findings on the rates of non-fatal suicidal phenomena among ethnic minority groups in the USA. However, the apparently high rates of DSH in female Hispanics are of concern, given the rapid growth of the Hispanic population.

Asian countries: India, Japan, Taiwan, Hong Kong and China

The prevalence of suicide in developing countries is difficult to establish. It is thought that approximately 100 000 people kill themselves each year in India, but it has also been suggested that the true figures may be three times higher (Joseph *et al.*, 2003). Statistics based on police records indicate that the rate of suicide in India is only slightly higher among males than females (e.g. Steen & Mayer, 2004), in contrast with the larger gender ratios found in most other countries. One of the possible explanation for this may be that, in several countries, the act of suicide remains illegal.

In a verbal autopsy study conducted by Joseph *et al.* (2003) in the Kaniyaambadi region of Southern India of deaths between 1994 and 1999, the mean suicide rate was 95.2 per 100 000, which is an extremely high figure. The female to male ratio was 0.84:1, with a greater number of female compared with male deaths among those aged 15–24 years. Women were more likely to burn or drown themselves. In contrast with previous psychological autopsy studies, which have identified mood disorders as the most common form of psychiatric disorder present at the time of death, a population-based case-control study of 100 suicides in Chennai indicated that affective disorders and alcoholism occurred with similar frequency (Vijayakumar & Rajkumar, 1999).

Suicide among female adolescents appears to be a particular problem in India. In Vellore, southern India, a verbal autopsy study of deaths between 1992 and 2001 of individuals aged 10–19 years showed that between half and three-quarters of deaths in young women were due to suicide (148 per 100 000), compared with one-quarter of deaths among young men (58 per 100 000) (Aaron *et al.*, 2004). In a study of 222 suicides in individuals aged 10–18 years in New Delhi there were more female (55.4%) than male deaths by suicide. Hanging was used more frequently by girls as the method for suicide (57%) than boys (49.5%), whereas poisoning was more commonly used by boys (49.5%) compared with girls (37.4%) (Lalwani *et al.*, 2004). These findings are the reverse of those in adolescents who have died by suicide in other countries.

In several Asian countries the rates of suicide are relatively high in older adults, despite the traditional respect for older people in Asian cultures (Chiu *et al.*, 2003). For example, in Japan which has had a traditionally had a high rate of suicide, the suicide rate in 2002 was 23.8 per 100 000, with suicides in older people accounting for 24% of all deaths. Rates of suicide in Japanese men are highest among those aged 55–59 years (71 per 100 000 in 2002) and among those over 85 years. Female suicide rates are highest among elderly women (85–89 years, 33 per 100 000) (Shiho *et al.*, 2005). Suicide in the elderly in Japan has been associated with physical illness and the failure to detect and treat depression (Shiho *et al.*, 2005). Depression among the elderly in parts of Asia is frequently manifested by somatisation rather than obvious depressive symptoms, so detection of depression by GPs has been a focus of a number of intervention initiatives (Chiu *et al.*, 2003). Among middle-aged Japanese men, various factors including economic pressures and *inseki-jisatu*, or responsibility-driven suicides to demonstrate remorse for an untoward event (Takei, 2004), are also thought to contribute to suicides.

A similar pattern is observed among elderly people dying by suicide in Hong Kong. In a recent study the female to male ratio was 1.7:1, in contrast with many western countries, with a ratio of 1 in younger age groups (Yip *et al.*, 2003). Depression and physical ill-health were identified as risk factors in a large community study (Yip *et al.*, 2003). In Hong Kong a recent dramatic increase in suicide by charcoal burning in an airtight space, especially by people aged 25–54 years, has been linked to individuals being overwhelmed by debts who learnt of this lethal method through newspaper coverage (Chan *et al.*, 2005). At the same time, suicide is now the leading cause of death among females aged 15–24 years in Hong Kong. A recent study of Hong Kong adolescents showed that traditional values such as obedience and respect for elders were protective against suicidality for girls but not for boys. Endorsement of self-direction was correlated with reduced suicide risk for boys, but not for girls (Lam *et al.*, 2004).

In a community study of 1000 elderly people in Taiwan, 16.7% reported having had suicidal thoughts in the previous week. Suicide ideation was associated with depression, lower levels of education and lack of community participation (Yen *et al.*, 2005). A small case-control psychological autopsy study in Taiwan showed that lower levels of acculturation and social assimilation were associated with increased rates of suicide among native Taiwanese (Lee *et al.*, 2002).

More males than females die by suicide in all countries for which data are published, with the exception of China (Cantor & Neulinger, 2000). Perhaps half of all female suicides in the world occur in China (Murray & Lopez, 1996). Both young and elderly women are at higher risk, and rural women at greater risk than urban women (Pearson & Liu, 2002). Several studies have been conducted to establish the validity of Western data collection methods, including psychological autopsy, in China (Zhang *et al.*, 2002). Women in China have relatively low status and suicide has been associated with negative life events rather than mental-health disorders (Phillips *et al.*, 2003). Highly toxic organophosphate pesticides are widely available, and are the most common method of suicide among women. Their deaths often appear to be impulsive, occurring in the context of family conflict (Pearson *et al.*, 2002).

The true prevalence of suicide in developing countries is hard to establish. However, it appears that there are high rates of suicide in India, particularly among young women. Methods of suicide differ among young people in India and are the reverse of those who have died by suicide in other countries. In several Asian countries the rates of suicide are relatively high in older adults, despite the traditional respect for older people in Asian cultures. These deaths are associated with depression and physical ill-health. China has more female than male suicides. Given the populous nature of this country half of all female suicides occur in China.

Aboriginal/indigenous populations

A number of countries report an over-representation of indigenous or aboriginal populations in suicide deaths, for example First Nations people in the USA, Metis and Inuit in Canada (Kirmayer *et al.*, 1996), Australian Aborigines (Tatz, 2001) and New Zealand Māori (Ministry of Health, 2005).

In the USA, among young males aged 15–24 years, American Indian and Alaskan Native peoples had the highest rates of suicide (27.9 per 100 000), followed by Whites (17.7 per 100 000), with Black youth having the lowest rate (11.3 per 100 000) (US Department of Health and Human Services *et al.*, 2004). Among American-Indian and Alaskan Native populations, suicide is associated with youth. Older members of these communities are much less likely to die by suicide compared with the general population (Le Master *et al.*, 2004). The Navajo tribe have much lower rates of suicide than other ethnic minority groups, which may be associated with traditional life-affirming beliefs and protection from acculturative pressures due to their large and isolated tribal area (Middlebrook *et al.*, 2001). In a study of 1638 Northern Plains American-Indians aged 15–57 years, non-fatal suicidal behaviours were more frequent among females, as with many other ethnic groups, and among younger compared with older respondents. Suicide attempts were associated with depression, post traumatic stress disorder, substance abuse and violence (Le Master *et al.*, 2004).

In Australia there has been increasing concern about the rate of suicide among Australian Aboriginal people (Elliott-Farrelly, 2004), particularly among young men and those in custody (Tatz, 2001). In 1998 there were 109 deaths among Aboriginal people, 94 male and 81 aged 15–39 years with a male to female ratio of 6.7:1. Hanging was the most common method of suicide, among both males and females (Steenkamp & Harrison, 2000). There are significant regional differences in suicide rates with highest rates in Northern Territory and Queensland (Parker & Ben-Tovim, 2002). It has been argued that mainstream risk factors provide an incomplete understanding of Aboriginal suicide and that issues such as marginalisation, lack of purpose, disintegration of social support networks, persistent grief, illiteracy and alcohol abuse contribute to suicides in this community (Tatz, 2001).

New Zealand has a high suicide rate among young people by international standards (Ministry of Health, 2005). Until the mid-1980s, suicide rates among Māori (indigenous peoples) were lower than non-Māori. However, there was a sharp rise in suicides among young Māori men from this time, reflecting a significant increase in overall rates of youth suicide. There were also changes in the collection of census data (Skegg *et al.*, 1995), which may have increased the number of people identifying as Māori. Currently, more Māori than non-Māori die by suicide, this pattern evident being among both males (Māori: 19.7 per 100 000 vs. non-Māori: 15.6 per 100 000) and females (5.9 per 100 000 vs. 4.8 per 100 000) (Ministry of Health, 2005).

In New Zealand the annual hospitalisation rate following DSH is reported as 128.2 per 100 000 (Ministry of Health, 2005), although this is likely an underestimate as it does not include presentations to GPs, or patients treated in emergency departments and discharged. The rates of hospitalisation for DSH in 2002 for Māori females were lower than for non-Māori (132.1 per 100 000 vs. 176.7 per 100 000), but higher among Māori males compared with non-Māori males (100.6 per 100 000 vs. 82.7 per 100 000) (Ministry of Health, 2005). Māori men aged 25–29 years had the highest rates of DSH (310.6 per 100 000), with the highest rates of DSH among Māori women occurring in those aged 20–24 years (321.7 per 100 000).

In comparison with some studies, which have suggested a protective value of living in areas with high ethnic density (Neeleman *et al.*, 2001), a detailed study of 127 patients aged 12–85 years presenting to a hospital emergency department in an area with a higher than average Māori population found that Māori were over-represented, accounting for 40% of all presentations and 30% of the community. Age-standardised rates of presentation were 131 per 100 000 for Māori females compared with 107 per 100 000 for non-Māori females, with an even greater difference evident between Māori males (120 per 100 000) and non-Māori males (36 per 100 000). Māori patients were less likely to self-poison but tended more often to use violent methods of DSH (Hatcher *et al.*, 2005).

A recent national health study of 9,699 New Zealand adolescents provides greater understanding of the issues facing Māori adolescents. This study showed that Māori youth were significantly more likely to report significant symptoms of depression (16.2%) than European/Pakeha students (11.7%, OR 1.3, 95% CI 1.11–1.52), had higher rates of suicide ideation in the past year (26.0% vs. 22.6%, OR 1.18, 95% CI 1.03–1.36) and were twice as likely to report a suicide attempt in the last year (11.5% vs. 5.7%, OR 1.75, 95% CI 1.42–2.15) (Adolescent Health Research Group, 2005).

A number of countries report higher rates of suicidal phenomena among indigenous peoples including in Canada, USA, Australia and New Zealand. Young indigenous people appear particularly vulnerable to engaging in suicidal behaviours. Some studies show increased rates of depression and a tendency towards more violent methods.

Refugees and asylum seekers

Refugees and asylum seekers face particular migration difficulties. Their migration is often forced by adverse circumstances, which themselves are associated with poor mental health. In addition, the experiences of unemployment, social isolation, fears for the safety of family and friends and the significant stress of applying for asylum and refugee status influence adjustment. High rates of depression, anxiety and post-traumatic stress disorder have been found in this population (e.g. Keller *et al.*, 2003; Sultan & O'Sullivan, 2001), conditions that are associated with elevated rates of suicidal behaviour. The role of detention in the exacerbation of these mental-health problems concerns many professionals (Procter, 2005). Some asylum seekers may perceive suicide as preferable to forced repatriation, with the period immediately following the rejection of refugee applications being a time of particularly high risk.

There are considerable mental health difficulties in refugee populations (for review, see Fazel *et al.*, 2005). In a study of 297 Afghan women in two refugee camps in Pakistan, more than one third were found to be suffering from a mental disorder, mostly depression, and of these women 91% reported suicide ideation in the past month (Hafeez, 2003). Trauma and poor psychological functioning may be both acute and chronic difficulties for many refugees. In a study of 240 refugees in Norway, severe and enduring mental-health problems were common, with poorer outcomes associated with unemployment, ongoing separation from family members and severe life-threatening trauma prior to exile (Lie, 2002). In contrast, Silove *et al.* (2005) showed that Vietnamese refugees who settled in Australia generally did well over time, with only a small proportion showing enduring mental-health problems after ten years and had fewer mental-health problems than Australians. From the data reviewed above, it is apparent that more investigations are required.

Overview of aetiological factors

Models of migration, mental illness and suicide

Aetiological factors have been addressed earlier, but will be reconsidered in more detail in the following section. It is now generally agreed that there is a relationship between migration and mental-health problems. The explanatory models for this include high morbidity in the home countries of migrants that they bring with them, biopsychosocial vulnerability among migrants, acculturative stress, misdiagnosis (particularly the use of Western nosology for non-Western groups) and racial discrimination (Bhugra & Arya, 2005). There appears to be a protective effect for people from ethnic minorities who live in communities with high numbers of people from those minorities (Neeleman *et al.*, 2001). Bhugra and Arya (2005) also hypothesise that migration from a sociocentric society to a egocentric society leads to the greatest levels of distress and psychiatric morbidity.

The research conducted on risk factors associated with suicidal behaviour have largely been conducted in developed countries. A recent review of risk factors in developing countries indicates that while some risk factors such as gender, living in rural communities, alcohol abuse, stressful life events and a history of DSH appear to be generalisable to developing countries, other factors do not. For example, being single, divorced or widowed is associated with elevated risk in Western countries but is less clearly associated with risk in studies conducted in China and India. Also, sociocultural factors appear as least as important as mental illness in developing countries (Vijayakumar *et al.*, 2005a).

Psychiatric morbidity among ethnic minority groups in the UK

Schizophrenia is associated with elevated risk of suicide (Harriss & Barraclough, 1997) and the rates of schizophrenia in migrant groups in the UK are 1.9–14.6 times higher than in Whites (Bhugra, 2004). However, in a large multi-centre follow-up study of suicide and attempted suicide among African-Caribbeans with psychosis, there was no significant difference in the number of suicides between White British and Caribbean patients (McKenzie *et al.*, 2003b).

Depression is a risk factor for both DSH and suicide. The rates of depression and anxiety in South Asians were previously thought to be the same, or lower than, those in the general UK population. However, in a community survey of 10 000 adults women of Asian and Oriental background were twice as likely to suffer from depression as their White counterparts (Meltzer *et al.*, 1995). In another study UK-based members of Indian families reported higher rates of suicidal ideation compared with their siblings living in India (7% vs. 1.7%) (Creed *et al.*, 1999). The protective effect of living in extended families appears to be dependent on generational status, rather than on acculturation. Sonuga-Barke and Mistry (2000) found in Asian families that grandmothers and children had better mental health in extended families compared with nuclear families, but mothers had higher rates of depression and anxiety in extended families and these families tended to engage in more traditional cultural customs and social activities.

The aetiology of depression in migrants is complex, involving biopsychosocial factors which interact with life events during different phases of the migration process, and may be affected by factors such as culture shock, cultural identity and local ethnic density (Bhugra, 2003). Premorbid vulnerability may make some migrants more likely to develop depression after migration, or depression may contribute to reasons why others migrate.

The role of religion

The importance of religious beliefs in relation to suicidal behaviour has been debated for some time. On one hand, it appears that countries with strong religious or spiritual elements to their culture appear to be associated with lower suicide rates (Vijayakumar *et al.*, 2005a). On the other hand, some religions condemn suicide to a lesser degree. For example, in a population-based study of 390 individuals of South Asian decent in West London, suicidal ideas were more common among Muslims (18.4%) and Hindus (12%) than among Sikhs (4.9%) (Creed *et al.*, 1999). There is some debate as to whether religion plays a role in whether or not an individual develops suicidal thoughts or behaviours, or alternatively it influences their willingness to admit to them.

Burning is a highly lethal method of suicide. It is particularly associated with Indian culture, both in India (Batra, 2003) and among Indian immigrants to other countries such as England (Soni Raleigh & Balarajan, 1992a). Burning is more frequently used by women than men. Sati is an act with historical cultural and religious importance in India, and not usually associated with mental illness (Bhugra, 2005).

The importance of intent and method across cultures

The cultural meaning of suicide and method of death varies to some extent across cultures. The importance of establishing the intent or motives underlying episode of DSH has attracted much recent debate. Acts of deliberate self-harm may have a variety of motives or intentions. However, it also appears that across cultures there are some universal experiences that are associated with DSH. In a large study of 1646 DSH patients in 13 European countries the intentions or motives for the act of DSH were investigated by providing patients with a list of possible intentions and asking them to score the relevance of each to their act of DSH. Examples of possible intentions included finding ones thoughts unbearable, wanting to get away from an unbearable situation, wanting to die and wanting to get help. The pattern of intentions were extremely consistent across countries, gender and age (Hjelmeland *et al.*, 2002). The majority of the acts involved self-poisoning with analgesics or psychotropic drugs. Nevertheless, the consistent patterns of intentions were striking.

As discussed above, there is significant variation between cultures in the methods most commonly used for suicide. The preferred methods of suicide in any given country have an impact on suicide rates, given that some methods are potentially more lethal than others. In addition, deaths involving a certain method may increase or decrease depending on the availability of that method (Grossman & Kruesi, 2000; Hawton, 2005). For example, in the USA firearms are the most common method of suicide among both Blacks and Whites (Stack & Wasserman, 2005), but account for a relatively small number of deaths in the UK, New Zealand and Australia. A decrease in the use of firearms and self-poisoning among young people in the USA was accompanied by an increase in deaths by suffocation, mostly hanging. Suffocation is now the most common method of death in those aged 10–14 years, surpassing firearms (Centre for Disease Control, 2004). The substitution of method relies on both the acceptability and availability of alternative methods; the increasing rates of hanging suggests that this has become an increasingly acceptable method of suicide (Centre for Disease Control, 2004). It is also extremely accessible as well as having a high rate of lethality. The reason for the spread in acceptability of hanging as a method of suicide is not known. Media portrayal and reporting of suicide may be one factor.

The use of pesticides in agrarian communities such as in China and Sri Lanka means that a similar method (self-poisoning) is associated with much higher mortality in these countries with countries where analgesics are the most frequently used substance for self-poisoning (Eddleston *et al.*, 2005). Also, individuals in developed countries have a second level of protection due to the greater density and proximity of adequate medical services compared with people living in developing countries.

Help seeking and health-service utilisation

Studies of health-services utilisation have identified complex interactions between cultural beliefs and help seeking. In addition, cultural meanings of illness and treatment and explanatory models of illness are culture bound, in a way that may not fit with the health services that are available. For example, several studies have identified that somatisation can be a pathway into health services for migrants experiencing depression (Bhugra, 2003). Burr (2002) conducted a qualitative study of mental-health care workers providing services to South Asian women, and found that, although the detrimental impact of social inequity on these women was apparent, many workers explained depression or suicide among Asian women as being pathologically related to their culture.

Acculturative stress in migrating groups and subsequent generations

Acculturative stress is a dynamic construct and appears to alter over time and across generations. The findings of studies in this area are mixed. Some have found differences in acculturative stress between first- and second-generation immigrants (e.g. Sands & Berry, 1993), while other studies indicate that later generations may experience greater degrees of acculturative stress, and hence increased suicide risk (Hjern & Allebeck, 2002; McKenzie *et al.*, 2003b), than their immigrant parents. A study of three generations of Canadian immigrants found that young adults who identified closely with their heritage culture had higher rates of suicidal ideation (Kennedy *et al.*, 2005). Some parents experience the acculturation of their offspring as a rejection of their personal values, which can be a source of considerable family distress and conflict (Roer-Strier, 1991). In an interesting study of 285 Asian-American children and adolescents attending an outpatient psychiatric service high levels of family conflict were associated with increased suicidality among those who were less acculturated compared with their more acculturated peers (Lau *et al.*, 2002).

Conclusions

The findings we have reviewed in this chapter suggest that there is significant variation in rates of suicide, DSH and suicidal ideation around the world. Developing countries such as China and India appear to have relatively high rates of suicide, particularly among women. Given the populous nature of these nations, they contribute very heavily to the global burden of suicide. To date, most epidemiological research has been conducted in developed countries. The generalizability of risk factors identified through this process to developing countries and the role of culture requires further exploration.

Despite the fact that culture influences the manifestation of mental illness, the acceptability of suicide and the preferred methods of suicide, it appears that globally there are increasing rates of suicidal behaviour among the very young, and the very old. In addition, a number of developed countries such as the UK, Japan and USA experience relatively high suicide rates among middle-aged men.

The globalization of information has already resulted in rapid transmission of previously unknown and very lethal methods of suicide, for example the spread of the use of charcoal burning from Hong Kong to Taiwan and the rapid rise in the popularity of this method. Hanging also appears to be increasingly used by young people, both male and female, as a method of suicide in countries including the UK, USA, Australia and New Zealand. The mechanisms underlying the apparent increased acceptability, cultural meaning and preference for this method requires further research, including the possible role of the media in influencing this trend.

As noted above, the ratio of female to male suicides in China and India differ from the pattern in other countries, with relatively high rates in women. Although it is not yet certain how Chinese women fare if they move away from their home country, young Indian women appear to carry with them their risk of suicide. For example, the rates of DSH and suicide appear to be elevated in Asian women (but not men) living in the UK.

Indigenous peoples in many countries experience high rates of social marginalization, unemployment and substance abuse and are often over-represented in prison and welfare populations. Young people, particularly young men in indigenous populations such as Australian aborigines, New Zealand Māori and American First Nations peoples, have high rates of both DSH and suicide.

The relationship between migration, mental health and suicide is important. Also intergenerational changes and the possibly protective influence of ethnic density need to be investigated further as there are mixed findings. In addition, some of those experiencing forced migration appear to experience chronic exacerbation of mental distress and suicidality as a result of government policies in some countries relating to the management of refugees and asylum seekers.

National suicide prevention strategies are now in place in many developed countries around the world. They share common elements such as intervention at a public-health level and a focus on high-risk groups and high-risk individuals (Beautrais, 2005). The establishment of suicide prevention strategies in developing countries is also important (Vijayakumar *et al.*, 2005c). The findings presented in this chapter suggest that addressing suicide prevention in ethnic minority groups in national suicide prevention strategies involves a range of complex factors, including, for example, the awareness of commonly used methods for suicide in an ethnic group's country of origin, cultural attitudes towards suicide and help-seeking, and willingness to use locally accepted sources of help or methods of preventing distress. Therefore, suicide prevention strategies need to be strengthened by inclusion of elements that account for the differences experienced by ethnic minority groups. For example, the detection and efficacious treatment of psychiatric disorder is an important element of suicide prevention. Members of ethnic minority groups may carry the burden of increased risk for mental illness and suicide, but many studies have found that they tend to present late to mental-health services, are less satisfied with the services, or do not experience a good fit between mainstream mental-health services and their cultural models of health and well-being. The development of culturally responsive mental-health services is therefore an important challenge for the future.

As highlighted in this chapter the data available on the rates of DSH and suicide in many countries are poor. This makes understanding of the phenomena more challenging and presents problems for the evaluation of suicide prevention initiatives. In addition, the countries in which poor data are kept regarding suicidal behaviour are often struggling to provide basic healthcare services to their people and suicide is one of a number of serious health issues they face.

Directions for future research include establishing a clearer understanding of the magnitude of DSH and suicide in different ethnic and cultural groups in the community including improved understanding of the meaning of suicide for women compared with men in different cultural contexts. It appears that global shifts in methods of suicide are occurring; however, the role of culture is not clearly understood.

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20

Personality disorders and culture

Matthieu Crews, Paul Moran and Dinesh Bhugra

EDITORS' INTRODUCTION

The concept of the self varies across cultures. The notion of the self is at the core of an individual's personality. There had always been an assumption that child development was fairly similar across cultures until Margaret Mead highlighted the problem. Only in the last few decades has the relativism in child-rearing and differing personalities become clearer and of interest to clinicians and researchers. The way one thinks of the world and deals with others around one is dictated to a large degree by culture and society. The notion of being sociocentric in an individualistic society will raise a few eyebrows and, similarly, being egocentric in a collectivist society will bring about a large degree of opprobrium.

Crews and his colleagues in this chapter bring together anthropological views and some cross-cultural epidemiological data in order to argue that the cross-cultural concept of personality does vary and there is some indication that some types of personality disorders are more common in some cultures than in others. There are, in addition, still problems in the diagnosis of personality disorders where two major classificatory systems hold somewhat different positions. The distinction between trait and disorder is an important one, but often gets ignored. Historically, temperament (trait) has been identified for several millennia. Shared norms of behaviour are essential to the survival of any society. The social definitions (which are culturally sanctioned) of acceptable or unacceptable behaviour lead to ostracization or criminalization of the individual. The problems in managing these individuals in clinical settings are many. A paucity of longitudinal data on these disorders and their outcome indicates that the predictive validity of such diagnosis is problematic. Crews and colleagues indicate that the help-seeking is influenced by cultural norms. The diagnosis of personality disorders is not consistent. Yet the politicians attempt to influence this process by dictating what is treatable and what is not. Recent debate in the UK about the 'development' of so-called 'dangerous severe personality disorders' has highlighted this. This confirms the fact that psychiatric diagnoses are diagnoses within a cultural context, especially in the field of personality disorder.

Introduction

Although there is now a large body of research supporting the validity of psychiatric diagnoses, the nosological status of certain categories of psychiatric disease remains in dispute. Among the most controversial psychiatric diagnoses are the personality disorders. The current UK government has identified that these disorders are a key public-health concern and has recently announced proposals to introduce radical new legislative powers to control people with personality disorders (Hansard, 1999). However, within the medical profession, there is some ambivalence about whether personality disorders constitute medical conditions at all.

Tyrer *et al.* (1991) point out that, for many years, the term personality disorder has been imbued with negative qualities of degeneracy (Koch, 1891), untreatability (Maudsley, 1868) and conflict (Henderson, 1939), and a quarter of a century after their observation there appears to be little change. They illustrate eloquently some of the problems associated with the concept of personality and personality disorder. Using Schneider's (1923) definition, which

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sees personality disorder defined as abnormal personalities who suffer through their abnormality and through whose abnormalities society suffers, they note that this would mean that Himmler and Goering had normal personalities between 1933 and 1939; and Sakharov and Mandela were personality disordered, as they have caused suffering to themselves and to others. As they argue that definitions of personality disorder often intertwine persistent behaviour, attitudes, subjective distress and impact on relationships, a balanced weight should be given to all of these. They caution that, although personality disorder may have the characteristics of enduring traits, this should not be seen as permanent.

Definitions

There are two current operational definitions of personality disorder. The International Classification of Mental and Behavioural Disorders (ICD-10) (WHO, 1992) defines a personality disorder as: 'a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption'. The DSM-IV (APA, 1994) definition is very similar: 'an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture'. ICD-10 recognises eight categories, whilst DSM-IV recognises ten and these are all listed in Table 20.1. The DSM-IV system also groups the personality disorders into three clusters: Cluster A, characterised by odd or eccentric behaviours; Cluster B, characterised by dramatic or flamboyant behaviours, and Cluster C, characterised by anxiety or fear.

Table 20.1. The current classification of personality disorders

DSM-IV	ICD-10
Cluster A	
Paranoid	Paranoid
Schizoid	Schizoid
Schizotypal	–
Cluster B	
Antisocial	Dissocial
–	Emotionally unstable:
–	(a) impulsive type
Borderline	(b) borderline type
Histrionic	Histrionic
Narcissistic	–
Cluster C	
Avoidant	Anxious
Dependent	Dependent
Obsessive-Compulsive	Anankastic

Source: NB Blanks indicate that there is no equivalent of the disorder in that particular classification scheme.

A brief history of the term 'personality disorders'

Formal personality characterisation can be traced back to early Greek society (Tyrer, Casey and Ferguson, 1991). Aristotle and his student, Theophrastus, developed a literary style known as 'character writing', whereby the essential features of certain common personality types were distilled into pithy verbal portraits. Examples included 'the slanderer' with his 'malevolent disposition of the soul' and the 'flatterer' who degraded himself with 'self-profiting intercourse'. In the fourth century BC, Hippocrates described a classification of temperament (which was later modified by Galen), based on the four bodily humours: choleric (irascible), melancholic (sad), sanguine (optimistic) and phlegmatic (apathetic). Later, over the centuries, in addition to body fluids, a person's shape, size and even the contour variations in their skull were used to make predictions about the nature of their underlying personality.

The first clinical separation of abnormal personality from mental illness has been attributed to Philippe Pinel, who described a series of patients who had committed impulsive aggressive acts whilst they were in possession of clear intact reasoning

(Pinel, 1801). He referred to these cases as *'mania sans delire'* ('insanity without delusion'). The description of behavioural disturbance in the absence of mental illness was later pursued by an American, Benjamin Rush, who believed that there existed certain individuals who suffered from a defect of 'the moral faculties of the mind' (Rush, 1812). In a similar vein, in Britain, Pritchard used the term 'moral insanity' to describe a wide range of diverse emotional conditions which could lead to behaviour deserving social condemnation (Pritchard, 1835). The modern classification of personality disorder came about largely from the clinical observations of Kurt Schneider, who described ten types of pathological personality, which closely resemble the subtypes in the current classification schemes (Schneider, 1958).

Cross-cultural perspectives on personality

Anthropologists have long been aware of cross-cultural differences in the concept of 'person'. Schweder and Bourne (1984) highlight other people's conceptions of the person and ideas about the self. There is no doubt that the concepts of the self vary across cultures (see Morris, 1994). From a psychiatric perspective, however, an alternative concept of the person described by Shweder and Bourne (1984) is that of the phenomenon which looks at the apparently alien concept, belief or value. They suggest that the concept of the *context-dependent* person (italics added) is one expression of a broader sociocentric organic view of the relationship of the individual to society, which in turn is an aspect of the holistic world view adopted by many cultures. The notion of the privacy of the self and how that is developed is an important one, especially if this varies around the sociocentric or egocentric concepts of the individual and the society.

Morris (1994) argues that the cultural conceptions of the person and the human being as a generic social agent and as a psychological self are important. The Western conceptions of the self, according to Morris (1994), are individualistic with a relatively inflated concern with the self, which in extreme gives rise to anxiety and a sense of narcissism, but it is also materialistic and rationalistic, thereby reflecting the thought of Western culture. The self structure in the West is therefore individuated, detached, separate and self-sufficient, and Morris proposes that the concept of the Western self is to be placed in the context of cultural hegemony of capitalism and of bourgeois mode of thought. We do not propose to dwell on this argument, but raise the possibility that with changes in mode of production in traditional societies it is likely that concepts of the person would shift.

Geertz (1975), for example asserts that:

> the Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe . . . is however incorrigible it may seem to us, a rather peculiar idea within the context of the world's cultures.

A characteristic feature of 'Western thinking', noted by many ethnographers, is the tendency to abstract the notion of the 'individual' from the social role. In earlier human communities, a more sociocentric conception of the person has been noted. Within these cultures, the notion of the person is inextricably linked to the performance of social roles. To members of such cultures, the Western concept of the autonomous individual who is free to make choices is alien or even bizarre.

In a seminal paper entitled 'Does the concept of the person vary cross-culturally?', Shweder and Bourne compared the personality descriptions given by 17 American adults, living in Chicago, with those provided by 70 Oriya residents of Bhubaneswar, in the state of Orissa, India (Shweder & Bourne, 1984). In their free descriptions of personality, Oriyas were more concrete than Americans. They described their intimates by reference to behavioural instances and qualified their descriptions by reference to contexts. These differences were shown to be independent of the effects of education, socioeconomic status and language and the authors concluded that the difference was a cultural phenomenon – so-called 'creations of the collective imagination'.

The work of Edward Sapir, Margaret Mead and Ruth Benedict has highlighted the existence of important differences in the 'personalities' of cultures (for example, Benedict's classic account of four Plains Indian cultures). It has also been recognised that shared norms of behaviour are essential to the survival of any society (Aberle *et al.*, 1960). However, within any culture, it is acknowledged that some individuals will inevitably fail to conform and will deviate from social norms:

> These abnormals are those who are not supported by the institutions of their civilisation. They are the exceptions who have not easily taken the traditional forms of their culture. (Benedict (1934))

For Benedict, normality was not an absolute quality of personality, but was 'relative to the dominant configuration of one's society'.

The work of the World Health Organization Alcohol, Drug Abuse and Mental Health Administration programme has demonstrated that, in theory, it is possible to assess personality disorder in different nations, languages and cultures using a semi-structured interview (Loranger *et al.*, 1994). Loranger *et al.* (1994) reported on the use of International Personality Disorder Examination (IPDE) on 716 patients from 14 centres in 11 countries. The IPDE was modified from Personality Disorder Examination and uses nearly 150 criteria over the previous five years to reach a diagnosis of personality disorder. Even within the sample, using ICD-10 criteria, 2.4% were diagnosed as having paranoid personality disorder and with DSM III-R the prevalence was 5.9%. Antisocial personality was diagnosed in 3.2% with ICD-10, but in 6.4% using DSM III-R. The prevalence of any personality disorder was 39.5% using ICD-10 criteria and 51.1% using DSM III-R. They do not give findings from each centre, but the two-fold variation within two different classificatory systems presents a significant problem. In their conclusions, the authors argue that these distinctions are of such a degree because in DSM-III R antisocial personality disorder includes unlawful behaviours and criminal acts, whereas ICD-10 focuses more on generic concepts such as lack of empathy. These authors also point out that two most frequently diagnosed types in the sample as a whole are disorders that were not included in ICD-9 and DSM-II. These are borderline disorder and avoidant or anxious types. This shift indicates the impact culture and society can have on development and recognition of new diagnoses.

The only personality disorder to have been systematically studied in community surveys of psychiatric morbidity has been antisocial personality disorder. Such surveys reveal important cross-cultural differences in the prevalence of this disorder. Rates vary from 0.14% in Taiwan to 3.7% in Canada (de Girolamo & Reich, 1993). Currently, it remains unclear as to whether such differences reflect differences in the 'true' prevalence of the disorder, or differences in the respective 'personalities' of Taiwan and Canada (i.e. reflective of differences in the willingness of Taiwanese and Canadian people to report antisocial behaviour). From the perspectives of anthropology and epidemiology, there is clearly a need for cross-cultural validation of the other personality disorder categories.

Are personality disorders really diseases?

A major contribution of medical anthropology has been the distinction between 'disease' and 'illness'. Eisenberg (1977), defines illnesses as 'experiences of discontinuities in states of being and perceived role performances'. Diseases, on the other hand, are 'abnormalities in the function and/or structure of body organs and systems'. Psychiatrists have long disagreed in their concept of disease and consequently the boundaries of psychiatry are inevitably somewhat arbitrary (Kendell, 1975). It has been argued that the absence of consistent physical markers in those regarded as mentally ill means that there is no justification for labelling these people as having a disease – the term 'psychiatric disease' is merely a metaphor for alarming or socially undesirable behaviour (Szasz, 1972). Personality disorders exemplify this problem par excellence as, since the time of Schneider, the definition has stressed socially deviant behaviour. This is particularly unsatisfactory when the society from which normative behaviour is derived, may itself be 'abnormal', for example, Nazi Germany.

The highest rates of personality disorders are found among prisoners. The ONS survey of psychiatric morbidity among prisoners in England and Wales found that the prevalence rate of personality disorders was almost 80% in the remand population, with antisocial personality disorder having the highest prevalence rate (Singleton *et al.*, 1998). Defining a large proportion of the population (for example, prisoners) as sick on the basis of social deviance creates major logistical problems for mental-health teams, who are then left to deal with the considerable responsibility of caring and treating these 'sick' individuals. Indeed, over twenty years ago, Schwartz & Schwartz (1976) warned of the damaging effects of forcing psychiatrists 'into a role which is completely out of character with the traditional healing role of physician and has more in common with that of gaoler.'

In addition to concerns relating to the 'disease status' of the personality disorders are problems surrounding the reliability, validity and utility of the diagnosis. Studies of the reliability of the clinical assessment of personality disorder have shown that the agreement between clinicians' diagnoses of personality disorder is often no better than chance (Mellsop *et al.*, 1982), although the use of a standardised instrument does improve the situation. There is a paucity of longitudinal data on these disorders and therefore, the predictive validity of the diagnosis remains uncertain. Perhaps the most alarming indictment of the diagnosis is evidence suggesting that it is a label applied to patients whom health professionals dislike. In a study in which 240 psychiatrists were asked to read case vignettes, patients with an identical history, but given a previous diagnosis of personality disorder in the vignette, were rated as more difficult, annoying, attention-seeking, and less deserving of care compared to control subjects (Lewis & Appleby, 1988).

Morice (1979) argued that there was a general agreement among psychiatrists over some subtypes of personality disorders, but not in differentiating between trait and disorder. Obviously, a high degree of agreement will be seen on the basis of behaviours and lifestyles. He points out that, in the context of transcultural perspective, it is even more difficult to differentiate between trait and disorder. Reporting on rates of personality disorder, he noted a ten-fold variation across studies. His ethnocentric interpretation of these findings focuses on emphasis placed on behaviour across different cultural and socioeconomic groups. He illustrates this by giving an example of aborigines using 'sorry cuts' on themselves following bereavement and aggression to others may be interpreted as culturally legitimate behaviour. The high rates of personality disorder are seen as a response by perhaps misinterpreting hostility and aggression. Using a Pintripi–English dictionary, Morice points out that there are many words that denote anger, which can be general state, state of legitimate anger and state of unsanctioned aggressive behaviour.

It is important to note that the definition of personality disorders includes 'social disruption' and it is therefore entirely possible for an individual who has no subjective distress, but who causes societal disturbance, to be labelled as unhealthy or 'diseased' (see the examples cited by Tyrer *et al.* (1991) above). The potentially damaging effects of being given a psychiatric label are well documented and may include a negative impact on self-esteem, marginalisation and discrimination within society. Such phenomena almost certainly occur in 'personality-disordered' patients, although remain unexplored from an anthropological perspective.

Gender and personality disorder

The medical establishment has often been criticised for its patriarchal nature. Psychiatry has not escaped such criticism. It has been argued that a 'male view' of disease continues to dominate psychiatric thinking. Indeed, Marcie Kaplan suggests that:

> masculine-biased assumptions about what behaviours are healthy and what behaviours are crazy are codified in diagnostic criteria; these criteria then influence diagnosis and treatment rates and patterns. (Kaplan, 1983)

With respect to the personality disorders, women significantly outnumber men in the diagnoses of dependent, histrionic, and borderline personality disorders (Russell, 1995). This finding has led to the suggestion that these disorders represent no more than exaggerated sex role stereotypes. For example, the DSM-IV criteria for histrionic personality disorder emphasise 'excessive emotionality', whilst the criteria for dependent personality disorder emphasise 'submissive behaviour' and needing 'others to assume responsibility for most major areas of his/her life'. From a research perspective, there is evidence to suggest that in a clinical setting, although application of the criteria may not be sex-biased, the application of the diagnosis may indeed be (Ford & Widiger, 1989). Similarly, there is evidence showing that although the phenomenology, risk factors, and long term outcome of borderline and antisocial personality disorders are very similar, borderline personality disorder is more frequently diagnosed among women, whilst antisocial personality disorder occurs more frequently in men. A contemporary epidemiological view is that the difference in prevalence of these conditions reflects biological shaping of a common base of impulsive personality traits (Paris, 1997). However, some anthropologists have suggested that these disorders might be 'spurious' medical labels with cultural histories, representing values strongly congruent with familiar cultural stereotypes: the 'independent' male and the 'dependent' female (Nuckolls, 1992).

The health-seeking behaviour of personality-disordered patients

It has been suggested that the word 'illness' stands for 'what the patient feels when he goes to the doctor', and 'disease' for 'what he has on the way home from the doctor's office' (Helman, 1998). With the exception of users of psychotherapy services, in Western society, it is unusual for someone to visit a doctor complaining of personality difficulties. The label of 'personality disorder' is more usually 'earned' as a result of displaying certain 'dysfunctional personality traits' to the doctor, such as a repeated need for 'excessive reassurance', or 'demanding' and 'manipulative' behaviour. (Arguably the diagnosis may have as much to do with the personality of the clinician as it does with that of the patient!) Unlike other mental and physical disorders, the diagnosis will rarely be shared with the patient, as there is no specific 'treatment'. However, the doctor may record the diagnosis in the case notes and will certainly make a mental note of the difficult encounter. Indeed, there is substantial evidence to show that the diagnosis is frequently made in psychiatric settings, where prevalence rates of personality disorder may be as high as 30%–40% (de Girolamo & Reich, 1993). General practitioners are frequently able to identify their 'heartsink' patients, although the extent to which this term overlaps with personality disorder remains unexplored. Personality disorder is also a common diagnosis among so-called 'revolving-door patients' (Saarento *et al.*, 1997). Such patients are defined by their frequent use of health services. However, in this context, the diagnosis seems to add little to the treatment plan, as the patient's difficult behaviour, i.e. frequent use of services, is merely reformulated as a symptom of their underlying psychopathology, i.e. a personality disorder. Perhaps a more informed approach is to attempt to disentangle the patient's specific needs (e.g. psychological symptoms, such as feelings of hopelessness) rather than merely arriving at the rather unhelpful diagnosis of personality disorder – a diagnosis which may only serve to engender therapeutic nihilism.

Smith (1990) in a small-scale study gave a 40 item Narcissistic Personality Inventory to 14 Asian, 58 Caucasian and 16 Hispanic-American women attending college. The Asian group comprised Chinese, Japanese, Filipino and Vietnamese women, thereby illustrating cultural heterogeneity, whereas

Hispanic women were primarily of Mexican descent. Mean narcissism scores for Asian women were dramatically lower than those for Caucasian women, especially on authority, exhibitionism, superiority and vanity. The cultural norms, which expect these women to be submissive, may be playing a role here. Bearing in mind that numbers are small and attending college, it is difficult to generalize these findings. However, these findings indicate that there may well be cultural differences in personality traits. Lasch (1979) had noted an increase in trend of narcissism in the USA in the 1970s.

Borderline personality disorder (BPD) is characterised by impulsive behaviour, repetitive parasuicide, affective instability and unstable intimate relationships. Paris (1996a) argues that BPD is sensitive to sociocultural context and is probably less frequent in traditional societies. Patients in traditional societies are said to have more classical neurotic symptoms and less behavioural ones (Murphy, 1982) which could be explained by family structure and kinship patterns which may not encourage expression of emotion. Thus conversion systems may be more prevalent in traditional societies. Antisocial personality disorder (ASPD) is seen rarely in East Asian societies (Hwu *et al.*, 1989) and Japan (Sato and Takeichi, 1993). Paris (1996b) argues that the societies which have lower rates of ASPD are more cohesive socially, which makes the development of antisocial pathology less likely. It is possible that the notion of shame and bringing dishonour especially to the family are strong deterrents. Antisocial pathology shares a common dimension of impulsivity with BDP, but related to concept of the self the impulsive behaviour will differ against the individual self or social self. ASPD is reported more commonly in males and BPD in females, and therefore it is likely that the two conditions are somehow variants of the same personality type and their different behaviour manifestations reflect the effects of gender (Paris, 1994) but may also be linked with gender roles and gender role expectations. Paris (1996a) also emphasises that the prevalence of the most characteristic symptom of BPD – repetitive parasuicide – shows a sensitivity to cultural context. Furthermore, there is the suggestion that BPD is becoming more common in North America (Millon, 1993). The risk factors for BPD include trauma, emotional neglect, family dysfunction and parental separation or loss (Paris, 1994). Millon (1993) hypothesises that borderline pathology emerges under conditions of rapid social change and in the presence of breakdown of community norms and values. This will fit in with a potential increase of the condition in egocentric or individualistic societies and is less likely to occur in sociocentric or collective societies. Paris (1996a,b) suggest that children growing up in dysfunctional families in traditional societies have more opportunities (or likelihood) to buffer the effects of negative experiences, thus the extended or joint family may absorb some of the trauma. Those children who make attachments outside the nuclear family are less likely to develop responses to pathology in their parents (Kaufman *et al.*, 1979). Thus extended family members in collectivist societies may provide role models and support. It is also likely that collectivist societies reward those behaviours which are associated with group cohesion and discourage behaviours which are associated with individualism.

In her comments on the observations of Paris (1996a), Miller (1996) focuses on the heterogeneity of individuals within cultures. She indicates that comparable disorders may exist in other cultures. All cultures contain some individuals who perceive themselves to be unable to meet what is expected of them, and how the resultant distress is expressed differs across cultures, as does the response to it. Miller illustrates this by indicating that feeling good and the pursuit of happiness as a constitutional right is common in the US, whereas despair may have different meanings.

A need to re-define personality variation in the social context?

The political–economic approach (Ackerknecht, 1943) within medical anthropology attempts to recontextualise disease in a broader social setting. In Western countries over the past 50 years, there has been a progressive 'medicalisation' of social problems and everyday life:

> One of the characteristic mental traits of our culture is the labelling of phenomena with psychiatric diagnoses. (Ackerknecht, 1943)

Doctors have found themselves increasingly concerned with the 'diagnosis' and treatment of socially unacceptable behaviour. The DSM-4 diagnostic category of 'antisocial personality disorder' may be seen to be one extreme example of the process of medicalisation. The term is closely related to the older antiquated concept of sociopathy and central to its definition is a 'disregard and violation of the rights of others' – typically manifested as law-breaking behaviour.

It should be emphasised that the medical profession has not merely been a passive participant in the process of medicalisation. Indeed, psychiatrists have often exacerbated the process by invoking 'biopsychosocial' explanations for many of society's problems. As Frankenberg (1980) notes, such explanations may serve a convenient function in advanced capitalist societies where 'making conflicts social is too threatening'.

Currently in the UK and, in part, fuelled by these explanations, there is an expectation that psychiatrists should be able to prevent serious violence. A recent series of highly publicised crimes committed by people with personality disorders has heightened anxiety about violent crime. This has prompted the UK government to respond with a proposal for new legislation, which would include the 'indeterminate reviewable detention' and compulsory treatment of people who have a 'dangerous severe personality disorder' (Hansard, 1999). The government's proposals have provoked angry debate within the medical profession, although broad professional consensus about the utility of the diagnosis antisocial personality disorder is lacking.

Antisocial personality disorder is heavily over-represented among low social classes (Kessler *et al.*, 1994) and individuals with the disorder invariably report histories of childhood abuse and neglect – phenomena which have been shown to be strongly associated with poverty. Quite apart from the fact that violence is as much a comment on the society in which we live, and not a medical disorder, it would seem that if enacted, the proposed legislation could result in the further marginalisation of an already disadvantaged section of our society. If there was ever a need to 'make disease social', it is in the arena of antisocial personality disorder.

Conclusions

From an anthropological perspective, it has been shown that there are substantial problems with the diagnosis of personality disorder. The term does not adequately meet the criteria for a 'disease' and may be misapplied with potentially dangerous consequences. In addition, little data exists to demonstrate that these disorders occur outside of Western cultures. Further research is needed. From an anthropological perspective, there appears to be a particular need to explore the illness narratives of people who have been given the diagnosis. If certain universal themes were to emerge from these narratives, this might then lend some support for the current Western psychiatric classification of these disorders. Finally, it must be emphasised that deviancy is a relative social construct and not an absolute fixed entity. From a political economic perspective, a plea has been made to re-define personality variation within its proper social context.

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Culture and obsessive-compulsive disorder

Padmal de Silva and Dinesh Bhugra

EDITORS' INTRODUCTION

Obsessive-compulsive disorder is one of those disorders in which the contents of the obsessional ruminations and compulsive rituals are very strongly influenced by culture, even though epidemiological data are not as strong as in many other psychiatric disorders. The management of the ritual and ruminations, especially if they are influenced by culture, has to be culturally modified too. One must bear in mind that the genetic aspects of aetiology and management using pharmacotherapy create problems of their own. The role of culture in encouraging purity in the context of food preparation is well described in anthropological and sociological literature.

In this chapter, de Silva and Bhugra highlight the impact of religion and superstition on the aetiology of obsessive compulsive disorders. They argue that, within each culture, there are concerns which are common, which also allow the contents of ruminations to be affected. In addition, the contents also reflect religious ideas and themes. In some religious settings, hyperscrupulosity is noted, which is also heightened in patients with obsessive-compulsive disorder. Themes of dirt, purity, contamination and aggression can be culturally sanctioned. The cognitions vary across cultures, therefore it makes sense that cognitions related to rituals and compulsions will also vary. Personal responsibility as a key component has been shown in some cultures. Similarly, superstition and perfectionism and responsibility have been linked together. It is possible that culturally sanctioned rituals may be seen as aberrant and abnormal if the individual is being assessed outside the context of their culture. Their normal distress thus becomes abnormal and clinicians have a duty to ascertain whether these contents are part of the cultural make-up or are demonstrating real hardship and impairment of functioning. Assessing religious beliefs and cultural practices is an important first step in assessing patients with obsessive-compulsive disorder.

Introduction

Obsessive-compulsive disorder (OCD) is a major anxiety disorder, and is well described in the literature (see de Silva & Rachman, 2004, for a brief account). It is characterized by unwanted, intrusive cognitions (thoughts, images, impulses) which are recurrent and persistent, and by compulsive behaviour that the person carries out – usually unwillingly – out of a strongly felt inner urge. These compulsive behaviours are mostly overt motor action (e.g. repetitive hand washing, checking things, touching and arranging objects); but they can also be internal or covert (e.g. counting backwards from ten to one, silently saying a prayer a fixed number of times, conjuring up a visual image of a particular description). For a clinical diagnosis of OCD to be made, the person must experience either obsessions or compulsions. However, in most cases the person has both, usually interlinked: the obsession generates discomfort and/or anxiety, which can be dissipated, albeit temporarily, by the successful completion of the compulsive behaviour. The obsession and/or the compulsion must cause distress and/or interfere with the person's life and activities for the diagnosis to be warranted (American Psychiatric Association, 1994). These stipulations are important, as many people have unwanted intrusive cognitions, and/or

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minor compulsive behaviours, which are neither distressing nor handicapping.

Some historical precursors

Some early writings contain accounts of behaviours and cognitions which today many would consider as constituting OCD (de Silva & Rachman, 2004). The early Buddhist text *Dhammapadatthakathā* describes a monk, Sammuñjani, who engaged in sweeping the monastery with a broom repeatedly. This took up most of his time and the activity took priority over everything else (see Burlingame, 1979).

The Japanese Zen master Hakuin (1685–1768) is reported to have suffered from serious obsessional thoughts and doubts as a young man. An even more influential religious figure in the West, Martin Luther (1483–1543), was tormented by severe intrusive cognitions, which took the form of doubts and blasphemous thoughts. One of his recurrent thoughts was whether he had confessed his sins fully and properly. He also had doubting thoughts that he might have carried out various sinful acts.

John Bunyan (1628–1688), the author of *Pilgrim's Progress*, also suffered distressing obsessional thoughts of a blasphemous and malicious nature. One of his major fears was that, instead of words of praise for God, he might utter blasphemous words. He struggled hard to get rid of satanic ideas and thoughts renouncing God and Jesus, but achieved only occasional success in this endeavour. An illuminating passage in his autobiographical book, *Grace Abounding to the Chief of Sinners* published in 1666 (see Bunyan, 1998), describes one of his unwanted intrusive thoughts vividly:

> But it was neither my dislike of the thought, nor yet any desire and endeavour to resist it, that at the least did shake or abate the continuation of force and strength thereof; for it did always in almost whatever I thought, intermix itself with, in such sort that I could neither eat my food, stoop for a pin, chop a stick, or cast mine eye to look on this or that, but still the temptation would come, *Sell Christ for this, or Sell Christ for that; Sell him, Sell him*.

The English writer and lexicographer Samuel Johnson (1709–1784) had numerous worrying thoughts and evidently compulsive behaviours. These are noted in his biography written by his friend and companion Boswell. One such behaviour was to go out or in at a door or passage by a certain fixed number of steps from a certain point. If this went wrong, he would go back and start again. Boswell referred to this as 'another particularity' that Johnson had (Boswell, 1791, 1980).

The Danish philosopher Søren Kierkegaard (1813–1855) and Norwegian playwright Henrik Ibsen (1828–1906) have also been described to have had behaviour suggesting obsessions and compulsions. The former is said to have kept 50 cups and saucers in his cabinet, each set in a different pattern. The latter evidently compulsively destroyed and rewrote his works, striving for a perfect end product. He also is said to have taken an hour or more to get dressed in the morning. Toates & Coschug-Toates (2002) have given more detailed accounts of these.

Culture and OCD

It should be clear from the above that obsessions and compulsions, and thus OCD, are not confined to one culture or one period of time. OCD is found in different parts of the world, and in different cultures. Clinical accounts of the disorder are available in the scientific literature and even in fiction from most Western cultures, as well as from many other parts of the world including India, Pakistan, Sri Lanka, Nepal, Hong Kong, Taiwan, Egypt, Singapore, Saudi Arabia and Turkey. The similarities of the OCD symptoms found in reports from these diverse cultures are remarkable. The basic characteristics of the disorder transcend cultures and eras.

However, OCD is not entirely free from cultural influences (de Silva & Rachman, 2004; Steketee, Quay & White, 1991). There are several ways in which cultural factors play a significant part in this disorder.

Before discussing these, however, it is useful to look at the prevalence of OCD in cultures and the question of whether these prevalence rates of OCD vary across cultures.

Prevalence of OCD in different cultures

The much cited Cross National Collaborative Study (Weissman *et al.*, 1994) investigated the life-time prevalence of the disorder across several countries. Life-time prevalence of OCD was approximately 2.3 per cent in the United States, Canada, Puerto Rico, Germany and New Zealand. The figure for Korea was slightly lower at 1.9, and for Taiwan less than one-third at 0.7. Data are also available from other, unrelated, studies. Figures comparable to those of the United States and Canada were found in Iceland by Stefansson (1993). On the other hand, investigations of ethnicity and OCD have yielded lower rates in African, Afro-Caribbean, and Asian groups in Britain (Meltzer, Gill & Petticrew, 1995), and in Australian aborigines (Jones & Horne, 1973). A low frequency of the disorder has also been reported for sub-Saharan Africa (German, 1972).

It is difficult to draw definite conclusions from these studies, as different screening methods have been used. The use of diagnostic criteria to ascertain prevalent rates has also varied. While the work of Cross-National Collaborative Study has made valuable strides in standardizing data collection methods and thus ensuring comparability across the countries studied, the overall picture does not warrant a firm answer to the question as to whether there are significant differences among nations and cultures in the prevalence of OCD.

Common concerns within culture

People of a particular culture, or a particular era, have common concerns. These shared concerns tend to be reflected in the obsessions and compulsions found in that population. For example, obsessions and compulsions related to possible contamination by asbestos was a relatively common problem among OCD patients in the United Kingdom three decades ago. More common in recent years have been obsessions, and associated compulsions, with the theme of HIV/AIDS.

The influence of religion

An aspect of human life which might be expected to have a bearing on a person's psychological well-being and mental health is religion. Key issues in this area have been well discussed in Bhugra (1996). As religion represents, and determines, some of one's major beliefs and concerns, it is not surprising that clinical OCD reflects this. Many authors, including Rachman (2003), have emphasized this point. The content of the obsessions can reflect religious ideas or themes. Studies have also shown that OCD patients with clearly religious obsessions (cf. Martin Luther's and those of John Bunyan's as noted above) tend to be significantly more religious than those who do not experience such obsessions.

A symptom commonly found in OCD patients is a heightened degree of scrupulosity (see de Silva & Rachman, 2004). Hyperscrupulosity has been noted in some religious persons in the Christian tradition, and priests have had to deal with 'parishioners who prayed excessively and who came to confessions far beyond what was justified by reality' (Worthington *et al.*, 2005, p. 184). The doubts and worries of Bunyan and Luther reflect this, as do the obsessional cognitions of some patients presenting at clinics today.

Several empirical studies investigating OCD in particular cultural settings have shown a link between the presentation of clinical OCD and religion. Studies in India have shown a preponderance of OCD with themes of dirt and contamination, and low frequency of obsessions with aggressive content, among Hindu patients. This is seen as reflecting the preoccupation with matters of purity and cleanliness, and the presence of a variety of purification rituals, in that culture (Akhtar, 1978; Akhtar *et al.*, 1978; Khanna & Channabavasanna, 1988). Chaturvedi (1993) has provided a discussion of the ways in which the Hindu culture can affect the presentation of OCD. For example, the 'ritualistic avoidances during menstruation in themselves may generate conflicts and precipitate obsessional behaviour or give content to an already existing obsessional illness' (p. 185). A report by Sharma (1968) has shown that the themes of obsessions in Nepal, a predominantly Hindu country, are often related to religious practices. In a study carried out in Egypt, it was found that both obsessions and compulsions showed the influence of the Muslim culture (Okasha *et al.*, 1994). Compared to British samples, the Egyptian sample had obsessions mostly linked to religious matters, and to cleanliness and contamination. Muslims are required to pray five times a day, preceded on each occasion by a ritualistic ablution. Strict fundamentalist Muslims may be required to perform complex ritualistic cleansing if they should touch a woman. How the concerns with cleanliness, and the ritualistic ways of achieving it, are reflected in the OCD symptoms of patients in this context is understandable. Maghoub & Abdel-Hafeiz (1991) found that, in the Muslim culture of Saudi Arabia, the themes of obsessions were more often related to religious practices than were evident in British OCD patients. A study from Israel (Greenberg & Witzum, 1994) looking at OCD symptoms in a sample of 34 patients found symptoms linked to religious practices in 13 of 19 ultra-orthodox Jewish patients, and in only one out of 15 non-ultra orthodox Jewish patients.

In addition to influencing the content of obsessions and compulsions, there seems to be another way in which religion can influence OCD. Rachman (1997) has argued that normal intrusive cognitions, which most people experience, turn into clinical obsessions as a result of the significance the person attaches to his thoughts. Those with a strict religious background tend to attach a high degree of significance to some of their unwanted intrusions, in a way that most people do not. Blasphemous or sexual thoughts, for example, may cause a great deal of distress, and the thoughts are perpetuated through this mechanism in those brought up in a strict religious background. Rachman (2003) has given several examples of this process. It seems that getting a 'bad' thought is perceived as sinful or immoral by these individuals; a thought about a 'bad' act (e.g. harming someone, unacceptable sexual behaviour) may be seen as sinful as the behaviour itself. This 'thought–action fusion' invests a great deal of significance to the thought which then becomes a persistent and recurrent obsession.

Sica, Novara and Sanavio (2002a) investigated OCD symptoms and cognitions in three groups in Italy. These were: 54 Catholic nuns and friars, 47 lay Catholic persons who regularly attended church, and 64 students not particularly involved with religion. After controlling for anxiety and depression, the two religious groups scored higher than the students on measures of obsessionality, perfectionism, inflated responsibility, over-importance of thoughts and control of thoughts. Moreover, measures of control of thoughts and over-importance of thoughts were associated with OCD symptoms only in the religious subjects.

Comparisons of OCD cognitions across cultures

One recent study has examined the links between OCD cognitions and symptoms across different cultural groups. Kyrios *et al.* (2001) compared large, non-clinical, samples of Australian and Italian college students on several dimensions of OCD symptoms and cognitions. They focused on three dimensions of inflated responsibility (safety of others; blame and responsibility for faults and negative outcomes; need to control, hinder or compensate for negative outcomes), three dimensions of perfectionism (socially prescribed; self-orientated; other-orientated), and five symptom domains of OCD (impaired mental control; contamination; checking; urges/worries; overall obsessionality). The results suggested a greater association in the Australian sample between some specific cognitive domains (blame and personal responsibility for faults and negative outcomes, and self-oriented perfectionism) with the symptom domain scores. Their conclusion was that the Anglo-Celtic culture, represented by the Australian sample, might be more concerned about issues of personal control than the Italian culture.

A detailed review of this area has been given by Sica *et al.* (2002b). While stressing the need for further research, they conclude from their review of the available literature that a high involvement in religion seems to play a particular role in OCD psychopathology. They also emphasize that the influence of this factor on the aetiology is an open question which requires further examination.

Superstitions

Another phenomenon that is relevant in this context is superstition. Different cultures have distinctive superstitious beliefs and practices arising from them (Jahoda, 1969). There are not many empirical investigations of links between OCD and superstitions. In a pioneering study, Leonard *et al.* (1990) conducted semi-structured interviews about superstitions with 38 children with OCD, and with 22 matched controls. The parents also had semi-structured interviews about their child's developmental rituals (e.g. doing things in exactly the same way, games with elaborate rules). No differences were found between the two groups in the frequency of superstitions. However, the OCD patients were identified by their parents as having significantly more ritualized behaviours in childhood. In a questionnaire study, Frost *et al.* (1993) found that measures of superstition were correlated with overall compulsiveness, compulsive checking, perfectionism and responsibility. They were not, however, correlated with compulsive cleaning/washing. The correlations between superstition and the cognitive measures (perfectionism and responsibility) were larger than those between superstition and overt OCD symptoms. This suggests that superstitions might be associated more closely with obsessional thoughts than with compulsive behaviours. As the content of superstitious beliefs and related behaviours vary across cultures, it may be inferred that this is one way, albeit a minor one, by which cultural differences in OCD are determined.

In sum, there are several ways in which cultural factors play a role in OCD. These may be summarized as follows.

- Content of obsessions/compulsions may reflect common concerns within a culture.
- Obsessions/compulsions may be linked to religious beliefs and/or practices.
- Those with strict religious beliefs may be more prone to developing clinical obsessions, as a result of attaching high significance to unwanted intrusive thoughts.
- Superstitions prevalent in a culture may be reflected in the OCD symptoms in members of that culture.

Implications for clinical practice

Considering these links, clinicians have to be aware of several implications for clinical practice. Some of these are noted below.

It is possible that the culturally accepted and sanctioned rituals that a person performs may be seen as aberrant if the person lives among people of a very different culture. The person may become distressed, and be referred for help, simply as a result of being perceived as abnormal by others. Clinicians need to ascertain carefully whether the apparent symptoms are merely part of one's cultural make-up, and/or whether they cause real impairment of functioning or genuine distress.

In the overall assessment of a patient referred for help, the clinician needs to make a careful assessment of the patient's religious/cultural beliefs and practices. Indeed, it is clear from the literature that in all cases of psychiatric disorder these factors have potential relevance (e.g. Koenig & Larson, 2001), and assessing these will enable the clinician to get a full understanding of the presenting symptoms, including an understanding of the significance the patient attaches to them. It will also guide the clinician in negotiating realistic treatment goals with the patient.

In terms of actual therapy, there is a small but important literature about the role of cultural factors. It has been shown that the religious coping that a person learns from his/her culture often has relevance in the clinical picture, and that clinicians need to pay attention to this (e.g. Pargement, 1997). Several authors have also argued that clinicians should have sensitivity to cultural issues. For example, Witztum & Buchbinder (2001) have written about culture-sensitive therapy with religious Jews, while Juthani (2001) has highlighted cultural-religious parameters that are relevant in the treatment of Hindu patients.

Specifically in relation to OCD, Rachman (2003, 2006) has argued, and provided evidence, for the use of carefully planned cognitive tactics to enable the patient to understand the link between his obsessions and religious concerns in cases where the obsessional problems are related to, or caused by, religious ideas. Cognitive treatment of religious obsessions, Rachman says, is also helped by elucidating the exacerbating effects of low mood. Advice of a religious authority or counsellor can also be helpful; such a person will provide clarification and comfort, while supporting the psychological therapy. A case example given by Rachman (2003) is worth citing here. The patient was a 43-year-old practising Catholic. As a child he had been given a bible that contained a disturbing picture of the devil. Soon after that he began to have intrusive thoughts and images about the devil. He tried to neutralize these by praying, and by repeating the sentence 'I love God and God alone'. During the treatment he was helped to make the connection between his religious obsessions and his other obsessions, which were about harming. This led to a reinterpretation of his 'blasphemy' as one manifestation of a psychological disorder, i. e. OCD. He made good progress and reported decreasing frequency of the religious obsessions. The distress and interference caused by them also declined significantly. With further therapy he showed a shift in his beliefs about religious obsessions, and felt that God would not want him to suffer. To quote; 'We reviewed the adaptive implications of changing the meaning of his religious obsessions, and then spent the remainder of the sessions introducing the idea of . . . thought–action fusion. He felt that this played a role in his reluctance to challenge his harm obsessions, and agreed to begin to challenge the negative meaning placed upon ambiguous events or incidences' (Rachman, 2003, p. 72).

Another implication for therapy relates to the greater significance attributed to personal control and responsibility in some cultures than in others. If the preliminary findings on this, noted above from Italian and Australian samples (Kyrios *et al.*, 2001), are replicated in subsequent research, it would be plausible to argue that cognitive reappraisals encouraged in the psychological therapy of OCD could profitably take into account these cultural factors. Cognitions, which will be changed using CBT, will be culturally influenced. Therefore, the clinicians must explore normative religious rituals and cultural explanations for this prior to commencing any intervention.

There is also the general issue of whether, in a given culture, there is a preference for psychological therapy over pharmacological treatment, or vice versa. While a therapist treating OCD will wish to use the best treatment for each patient's presentation, the latter's ability and willingness to accept and comply with the treatment will, to some degree at least, be influenced by his culture's attitude to the therapy.

Finally, there is the question of using, in the treatment of OCD, therapeutic strategies that may be derived from cultural traditions. Rachman (2006) has discussed the religious tactics that are used for dealing with certain type of OCD problems. In the Judaeo-Christian tradition, these include: prayers, pardons, offerings, disclosure, confessions, repentance and so on. Religious persons suffering from OCD often report that they resort to some of these in order to combat their obsessions. Such strategies may well be considered for incorporation into clinical treatment approaches, with the proviso that their efficacy is properly evaluated. The general points on religious coping made by Pargement (1997) and others have similar implications.

A further specific example is the relevance of Buddhist strategies in this area, which has been discussed by de Silva (1985, 2001). The discourse Vitakkasaṇthāna Sutta of the *Majjhima Nikāya* deals with the control of unwanted, intrusive cognitions which particularly hinder one's meditative efforts. When unwanted, unwholesome cognitions occur during meditation, one is advised to use one of five strategies in order to eliminate them. The techniques are further elaborated and explained in the commentary *Papañcasūdanī*. A summary of these is given below.

1. *Switch to an opposite or incompatible thought*. The first is to reflect on an object which is associated with thoughts which are the opposite of the unwanted thought. This means that if the unwanted cognition is associated with lust, one should think of something promoting lustlessness; if it is associated with hatred, one should think of something promoting loving kindness; and if it is something associated with delusion or confusion, one should think of something promoting clarity. This exercise of switching to a thought that is incompatible with the unwanted one, 'like carpenter getting rid of a coarse peg with a fine one', is said to help eliminate the unwanted intrusion.
2. *Ponder on the disadvantages*: *'Scrutinize the peril'*. If, however, the unwanted thought still keeps rising, one is advised to ponder on the perils and disadvantages of the thought. This would help one to immediately rid one's self of the thought in question, 'like the case of a young man or woman, who is eager to look nice and clean, would be revolted and disgusted if he/she finds the carcass of a snake, dog or human being round his neck and would immediately cast it aside'.
3. *Ignore and distract*. If that too fails, the technique of ignoring the unwanted thought is recommended. One is to strive not to pay attention, 'like a man who closes his eyes or looks in another direction in order to avoid seeing a visual object that he does not wish to see'. It is suggested that various distracting activities may be used in order not to pay attention, or dwell on, the unwanted cognition. These include: recalling of a doctrinal passage one has learned, concentrating on actual concrete objects, or indeed some unrelated physical activity, like darning a worn out part of one's robe.
4. *Reflect on the removal of the sources of the thought*. If the unwanted cognition still persists, then a further strategy is recommended; this is to reflect on the removal or stopping of the sources of the target thought. This is explained with the analogy of a man walking briskly who ask himself 'Why am I walking briskly?' and then slows down his pace as he sees no reason to walk briskly; then reflects on his walking and stops and stands; then reflects on his standing and sits down; and finally reflects on sitting, and then lies down.
5. *Control with forceful effort*. If the above strategy, too, fails then a fifth method is advocated, which is to forcefully restrain and dominate the mind, 'with clenched teeth and tongue pressed hard against palate'. This use of effort is linked to 'a strong man holding, restraining and dominating a weaker man'. One is to use the 'effort of one part of the mind to control another'.

The recommendation is, very clearly, to use these five strategies in a hierarchical way. Each of the five is to be resorted to if the preceding one fails. This is compared to the progressive use of five weapons in a battle. The bow is to be used first, if the bow breaks, use the spear and then the sword, etc.

Interestingly, many of these are very similar to strategies used in present-day cognitive-behaviour therapy (e.g. thought-switching, thought-stopping, covert sensitization). These similarities have been discussed in detail elsewhere (de Silva, 1985, 2001).

Early Buddhist texts offer a further technique which has relevance to the treatment of obsessions. In present-day therapy, satiation/habituation training is commonly used. The patient is advised to expose himself/herself to the unwanted thought repeatedly and/or for prolonged periods (de Silva & Rachman, 2004). This is similar to aspects of the mindfulness meditation advocated in the Satipatthāna Sutta of the *Majjhima Nikāya*. In developing mindfulness or awareness of one's thoughts, which is part of the overall mindfulness training, one is advised to be alert to all cognitions that arise, including unwanted ones. If and when an unwanted thought arises, one is to face it directly and continuously, rather than try to get rid of it. The thought then loses its salience and the chances of its persistence and/or recurrence diminish (see de Silva, 1985).

These Buddhist techniques can be incorporated into the treatment of obsessions in OCD patients – indeed, as noted above, the modern parallels of some of them are already widely in use. The use of these with Buddhist patients, with the explicit acknowledgement that they are part of the Buddhist tradition, may well enhance therapeutic compliance, as they will not be seen as alien. It is, however, important that their efficacy is evaluated in the clinical context.

As alluded to earlier, the relationship between pharmacotherapy and psychotherapy is complex. Furthermore, as described by Liu in this volume, the role of psychopharmacology across different ethnic groups and cultures must include knowledge of differing pharmacodynamics and pharmacokinetics. These changes in metabolism of drugs are influenced by genetic and ethnic factors as well as factors to do with lifestyle, such as smoking and dietary factors. Although anti-depressant medication has been used, there appears to be some evidence that one anti-depressant medication is significantly more effective than another for the treatment of OCD (Pigott, 1996, Murphy & Pigott, 1990. For example, tricyclic anti-depressants and monoamine oxidase inhibitors have been ineffective for patients with OCD (see Pigott and Seay, 1997), but cloripramine, fluvoxamine, fluoxetive, sertraline and paroxetine have all demonstrated efficacy in patients with OCD. Most studies indicate that 60%–80% of patients with OCD receiving adequate response will respond to serotonin response inhibitors (STIs such as sertraline, clomipramine, fluoxetine, fluvoxamine and paroxetine). Pigott and Seay (1997) observe that determining the most effective medication for an individual with OCD continues to represent a very lengthy process. Another complicating factor in managing OCD is its co-morbidity with depression, which is equally culturally influenced. The chances of medication failing are linked with co-morbid conditions such as personality disorder, social phobia and with presence of soft neurological signs. Co-morbid depression and presence of bizarre or fixed obsessional beliefs are not associated with poor outcome (Pigott and Seay, 1997). Treatment of OCD that combines behaviour therapy with anti-depressant medication is used often, though the outcome is not always better (McLeod, 1997).

Conclusions

This chapter considered the links between culture and OCD. Particular attention was paid to religion, which is a major aspect of culture. The ways in which culture can influence clinical OCD was discussed. Finally, the implications for clinical practice, in dealing with patients presenting with OCD, were explored. The clinicians as part of their assessment must explore what is normal according to the patient's culture and then and then only make plans for interventions. The involvement of religious leaders as sources of information and possible co-therapist must be remembered. Using illustrative techniques from different religions increases the acceptability of the services and therapeutic techniques.

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22

Culture and eating disorders

Mervat Nasser

EDITORS' INTRODUCTION

Although eating disorders have been described historically, they have often been seen as Western 'culture-bound' syndromes. There are, however, occasional case reports beginning to emerge from different cultures across the globe. The prevalence studies of eating disorders in low income countries have initially demonstrated lower than expected rates and if disordered eating patterns exist these do not reach diagnostic categories of illness levels. Furthermore, as eating disorders are generally more reported among females, the gender roles and gender-role expectations would vary across cultures. In cultures where the female is seen as a vessel for procreation, the identity of the female would be different from cultures where females have equal rights to males.

In this chapter Nasser emphasizes the nature of the eating disorder syndrome and its merging with prevalent and culturally acceptable eating behaviours which call for an interpretation grounded in the culture. The cultivation of the body ideal and promotion of thinness values in certain subcultural groups and the impact of fashion, media and diet industry put the female under a tremendous amount of pressure. The increased prevalence in the female, in the urban settings with increased social mobility and changes within family structures, also plays a role. She argues that the culture boundedness/specificity of eating pathology stood first on the assumption that societal mandates regarding thinness were rooted in Western cultural values and conflict. However, in the last decade or so, studies from different parts of the world have indicated that eating disorders are beginning to emerge in these societies. Nasser points out that cases of eating disorders identified among ethnic minorities in the US and the UK could possibly have been the result of acculturation and culture change. The role of Westernization needs to be considered but the issue by itself does not offer the whole explanation. She argues instead in favour of eating disorders being a marker of cultures in the process of transition and their recent increase a result of consumerism, shift from collectivist to individualist patterns, changing gender roles and increased alienation of the individual. The displacement of the locus of power to the body has been noted historically at times of cultural transition and, through this framework, intervention and prevention strategies can be developed.

Eating disorders and the sociocultural risks

Eating disorders are unique among psychiatric disorders in the degree to which social and cultural factors influence their epidemiology and development. Both anorexia and bulimia nervosa were subsumed under this term that was basically introduced to acknowledge the full spectrum of eating pathology (DSMIV and ICD10) (APA, 1993; International Classification, 1992). This was, in fact, based on epidemiological research carried out in the 1980s that showed significant morbid concerns over weight issues to be prevalent in general populations. In community studies nearly 2% to 5% of girls and women were found to have a partial or subclinical form of an eating pathology (Johnson-Sabine *et al.*, 1988; King, 1989; Dancyger and Garfinkel, 1995). The findings were clearly consistent with the 'spectrum hypothesis' of eating disorders and ran parallel to reported steady increase in the rate of their occurrence (Lucas *et al.*, 1991), with some studies showing an increase

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

from 80% to 150% over a period of two decades (Jones *et al.*, 1980).

The nature of the eating-disorder syndrome, and the fact that it clearly merges with the prevalent and the culturally acceptable behaviour of dieting, called for an interpretation that that is grounded in the culture we live in. The phenomenon was therefore, understandably, linked to the cultivation of a certain type of body ideal and the promotion of thinness values through media, fashion and diet industry. This was supported by the increased risk of those who belong to certain sub-cultural groups where the demand for thinness is endemic, such as dancers, models and athletes (Garner and Garfinkel, 1980, Szmukler *et al.*, 1983, King and Mezey, 1987, Weight and Noakes, 1987).

Eating disorders were also shown to have marked sex bias, affecting ten times more women than men. This was seen by feminist theorists as an illusory answer to the dilemma that many women in the Western world face. From this perspective, the thinness ideal came to represent a metaphorical synthesis between old notions of attractiveness and fashionability and the new modern values of autonomy, achievement and self control (Orbach, 1986).

Another epidemiological finding that emerged in the 1990s was the apparent increase in the prevalence of disorders of eating in proportion to the level of urbanisation in any given society (Rathner and Messner, 1993; Hoek *et al.*, 1995). This was explained on the basis of social mobility and changes within family structures with a tendency towards nuclearisation. Also, as cities urbanise, eating patterns, food preferences and meal times seem to change with the inevitable rise in the rates of obesity and a subsequent increase in weight consciousness and disordered patterns of eating (for further discussion refer to Nasser and Katzman (1999).

So, within this framework cultural, subcultural and intracultural risks in the pathogenesis of eating disorders were easily discernable (Table 22.1). The apparent absence of these disorders in non-Western cultures and societies added yet another cross cultural support and made some regard the phenomenon of eating disorders as exclusive to Western culture.

Table 22.1. Eating disorders and the sociocultural risks

- Value system risks: cultivation of thinness ideal by prevailing culture
- Gender risks: women ten times more at risk than men/ gender ambivalence/gender inequality
- Vocational risk: prevalent in sub-groups where thinness is licence to success (dancers, models and athletes)
- Urban risk: social mobility, changes in family structure, eating patterns and food preferences

Eating disorder, culture-bound, culture-specific or ethnic disorder

Prince (1983) argued that eating pathology fulfils all the criteria required for the syndrome to be regarded as ‘culture bound’. Culture-bound syndromes are considered local reactions within the generalist context of psychiatric diagnosis, where ‘culture’ is only of importance in shaping the final presentation of the disorder, i.e. *pathoplastic*. Russell (1985) speculated on the likelihood that neurotic illness could possibly be expressed nowadays as anorexia nervosa or bulimic disorder and called for exploring the mechanisms underlying these transformations and the role played by cultural forces in their metamorphosis.

On the other hand, the culture-specific or the ‘meaning-centred’ approach is based on the relativity of both normality and abnormality which, according to Kleinman (1977), can only be understood within the social and cultural context. In this context differences within societies are emphasised, particularly those variable ways of perceiving and conceptualising the world. This approach examines the mind through shared cultural categories and focuses on the relationship between public and private symbolism and how the individual makes sense of his/her own personal situation (Littlewood, 1984).

The Kleinmanian approach is not concerned with whether culture-bound syndromes are similar to mainstream psychiatric categories or not; instead it tends to see these syndromes in terms of specific cultural preoccupations and the meaning they impart. The approach is an interpretative one that searches for explanatory models for the disorders in question within cultures. Attributing an explanatory or causative force to cultures implies that cultures are *pathogenic*, meaning that cultures could generate psychopathology (see Tseng in this volume).

The culture-boundedness/specificity of eating pathology stood first on the assumption that societal mandates regarding thinness were rooted in western cultural values and conflicts, and was, as previously mentioned, based on epidemiologic *evidence*, i.e. the absence of sufficient published data to confirm their occurrence in non-Western cultures and societies. This was assumed to reflect perceived differences in aesthetic standards between West and non-West. In contrast to the Western ideal of thinness, non-Western societies were seen to favour plumpness and associate with it positive attributes of wealth, fertility and femininity. The fact that the majority of these societies also belong to third-world economies, made them appear protected from developing a disorder commonly associated with wealth and affluence. Also, the role of women in non-Western societies continued to be seen within a restricted framework of the stereotyped and the traditional and therefore considered immune from the challenges of modernity that women in the West face (Nasser, 1997).

In recent years the term 'ethnicity' has increasingly been in use, in an attempt to overcome some of the difficulties that surround the definition of culture. Ethnicity, which is often confused with race or nationality, refers to a socially constructed phenomenon that implies shared and distinctive traditions that are maintained between generations and lead to a sense of a group identity. The notion of ethnic disorder that was introduced by Devereux's (1955) was thought to embrace a broad array of cultural forces that are shared by a large number of societies, rather than a particular geographic locale. Gordon (1988, 2000) employed this model of an ethnic disorder in the eating disorders case to show how symptoms of these syndromes reflect exaggeration of normal attitudes and behaviours that are pervasive in a particular group or culture.

The argument for the ethnic nature of eating disorders is a plausible one, and yet it is like the meaning-centred approach to culture boundedness in being fundamentally based on the absence of these disorders in other groups or cultures (Nasser, 1997).

The emergence of eating disorders in other cultures and societies

Not withstanding the debate about the definition of role of culture in the eating disorder psychopathology, there is now an increasing body of evidence that challenges the notion of the Western boundedness/specificity of those syndromes. In the 1990s, a surge of publications from different countries in the world suggests that eating disorders are increasingly becoming a global phenomenon. Recent research from the Middle East, the Far East, South America and Africa, all indicate that eating disorders are now emerging in these societies with similar or even higher rates to those reported in the West.

These studies were mainly community surveys, modelled on those carried out in the West, in the majority of which the Eating Attitude Test Questionnaire (EAT) was the main instrument. The EAT, is a self-report questionnaire that was originally devised to elicit abnormalities in eating attitudes and measure a broad range of symptoms characteristic of anorexia nervosa. Doubts were raised about the validity of the EAT in different cultural settings and its susceptibility to cultural misinterpretation (King & Bhugra, 1989). Despite those concerns, the EAT was nonetheless helpful in facilitating research and allowing preliminary comparisons across cultures (Nasser, 1995) (Fig. 22.1).

These EAT studies went hand in hand with studies of ethnic minorities in USA and UK. An increase in the prevalence of eating disorders among black, Native Americans and Hispanic communities in

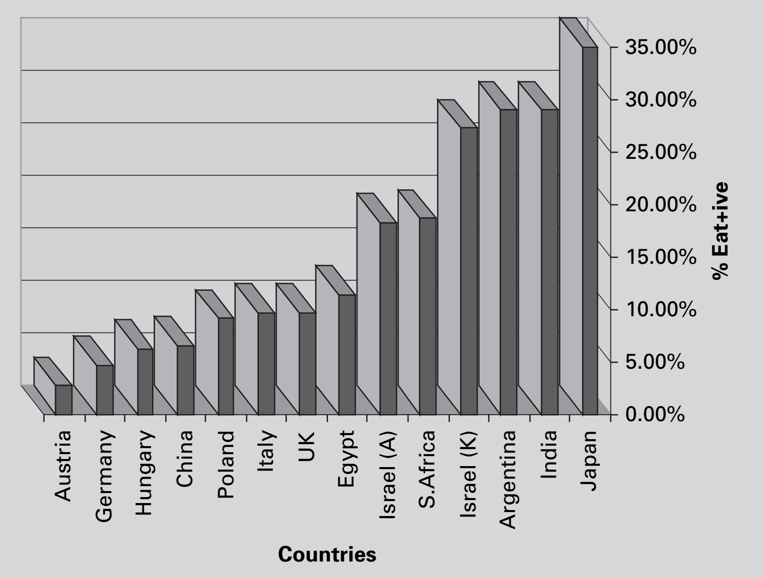

Fig. 22.1. Percentage of dieting/abnormal eating attitudes worldwide.

the USA were reported. Similar results were also obtained among the Asian and the African-Caribbean immigrant populations in the UK.

One of the other major findings was the emergence of eating psychopathology in Eastern Europe following the politico-economic changes. Eating disorders that were largely unreported in Eastern Europe before the collapse of the communist regimes began to appear in eastern European literature. High rates of abnormal eating attitudes were reported in Hungary, Poland and the Czech Republic (for a detailed review of this published research refer to Nasser, 1997).

Table 22.2 covers the countries that have reported eating disorders from the 1990s up until recently, however this list is by no means exhaustive. It shows that countries that reported eating disorders prior to 1990 were mostly European or North American countries, whereas those reporting after 1990 include Hong Kong and mainland China, South Korea, Singapore, South Africa, Nigeria, Mexico, Argentina and India. These reports, however, were entirely based on case histories and not substantiated by epidemiological studies (Gordon, 2001).

Eating disorders – the shift from 'Western' to Western-ised'

The cases of eating disorders identified among ethnic minorities in the United States and the United Kingdom were nonetheless regarded as orphan cases that could have resulted from a process of acculturation that is the identification of a small group with the values of larger group. A similar process of acculturation also can occur through 'culture change' subsequent to the identification of a peripheral culture with a more central and dominant one (Hannerz, 1995). Hence, attempts to explain the emergence of eating disorders in other non-Western societies were initially based on decoding this culture change by examining the relation between exposure to Western cultural norms and values and increased vulnerability to eating disorders (Nasser and Katzman, 1999). This meant that the phenomenon continued to be seen within the remit of one setting, i.e. the 'West'– if it is not exclusively 'Western', it had to be 'Westernised'.

The concept of Westernisation was nonetheless often restricted to the process of identification with

Table 22.2. Countries reporting eating disorders

*Argentina
+Australia
Belgium
*Brazil
Canada
Chile
*China
Czech Republic
+Denmark
Egypt
France
Germany
*Hong Kong
Hungary
*India
*+Iran
+Israel
Italy
Japan

*Mexico
The Netherlands
+New Zealand
Nigeria
Norway
Poland
*Portugal
*Singapore
*South Africa (Blacks)
+South Africa (Whites)
*South Korea
Former Soviet Union
+Sweden
+Switzerland
*Turkey
*United Arab Emirates
+United Kingdom
+United States

+Formal epidemiological studies carried out.
*First reports since 1990.
Reproduced with permission from Richard Gordon, (2001).

Western values in relation to weight and shape preferences for women. This is commonly attributed to the power of the global media in homogenising public perceptions in this respect (Nasser, 2000). And yet, the argument for the cross-cultural identification with the Western value system through 'unified media' systems is rather simplistic, as it fails to address the following questions.

1. Given that Western Europe and northern America constitute what is commonly known as the West, why should the rates of eating morbidity be higher in the American society than in central Europe (Neumarker *et al.*, 1992)?
2. Even within Europe itself, why there should there be any differences between east and west Europe, given their shared European heritage (except for a very brief historical period of 50 years or so)? And, how true is the claim that eating disorders began to appear in eastern Europe only after the decline of communism (Rathner *et al.*, 1995)?
3. What possibly could be the reasons behind the reported 800% increase of eating morbidity in the Kibbutz in the past 25 years (Kaffman and Sadeh 1989)?
4. Why should there be any differences at all in the rates of eating disorders between the 'north' and the 'south' of Italy – or any culture within a culture for that matter (Ruggiero *et al.*, 2000)?
5. What is the explanation for differences in the rates of anorexia nervosa between urban and rural Japan and indeed the reasons behind their reported 100% increase in only a 5-year period (Ohezeki *et al.*, 1990, Suematsu *et al.*, 1995)?
6. What significance could be attached to the apparent rise of eating disorders among black South Africans girls after the fall of the Apartheid regime (Le Grange *et al.*, 1998)?
7. Why is anorexic self-starvation in Hong Kong not associated with a fear of fatness, while in the West such fear is considered pathognomonic (Lee, 1995)?

Well, the sceptic might just say that these idiosyncrasies prove the unreliability of the research methodology adopted in these studies, but it would equally be simplistic to dismiss them as mere artefacts.

Eating disorders as marker of cultures in transition

The socio-cultural models of the late twentieth century remained overly focused on weight and media control in an effort to capture how existing social structures could exercise a quantitative and qualitative influence on individual psyches.

In order to begin to understand the reasons that may lie behind such variabilities, one needs to have a deeper understanding of the type of culture we live in, which appears to be multiple fragments within a globally 'homogeneous/homogenised entity'.

The world is not only globalising by reasons of mass media or information technologies, most societies are undergoing a rapid state of urbanisation and many are now subscribing to one economic market strategy. The standardisation of an aesthetic ideal and the marketing of this ideal could indeed be sufficient explanation for this global phenomenon. However, following markets there has also been a worldwide rise in consumerism with increased access to fast/fat and trendy American food. This global change in diet is now likely to increase the rates of obesity in the majority of societies, with the inevitable outcome of increased weight concerns and eating psychopathology.

It has also been argued that the transition in some countries from state-controlled economy to markets has undermined the collective social structure and resulted in the disappearance of some of the social networks that provided women with protection in their education, employment and child-care rights. This is seen to be behind the greater ambivalence felt by women of former socialist regimes about their position in society now. Feminist writers in the West considered the confusion of gender roles to be a fundamental ethos in women's vulnerability to eating disorders.

With an increase in economic freedom in various countries has come a departure from State-supported privileges. While potentially providing freer opportunity for all, there has in fact been greater differentials of wealth and poverty between countries and within the same country. A market economy is based on the principle of cost-effectiveness, which heightens competition as well as standardisation as increases in productivity are sought. A deregulated economy is built on the primacy of individual choice which can produce increased social inequalities as well as social isolation, and is likely associated with increased commercialisation and material aspirations (Catina and Joja, 2001; Nasser and Katzman, 2003).

Several clinicians and researchers from Eastern Europe have suggested that the increase in commercialism and changing gender roles, coupled with the depletion of state-offered benefits (such as education, employment, and health care), may result in the comodificaiton of the human body and modifications to its form to fit with global standardisations of beauty, marketability and adaptability (Rathner, 2001). This, in turn, may make women more susceptible to eating problems as they may be forced to not only adapt their bodies to a new form but form their identities to a new role.

One final area to consider is the role of online cultures and the alienation of the individual. Is it possible that the deregulated media deregulates the relationship between the individual and society? Several authors have attempted to explore this concept such as Morley and Robins (1995), demonstrating that changes in computer culture have reflected a change in how we relate to our own nation as a geographic entity. As one types and taps into a shared global environment, they may in fact be travelling beyond their familiar nexus to ideas and fashions never considered by their homes or home country.

There is no doubt that there are inherent advantages in the potentially unlimited choices but to negotiate these choices the individual needs to learn how to reformulate an identity amidst an influx of visual information and images. Identities in the new media order will need to be similar and different at the same time! Individual personalised cultures will inevitably arise within the context of the uniform and the universal. This means the act of transmitting image/information will change from broadcasting to narrow casting with special programming aimed at specific target and differentiated audiences. How does one fit in and where? How does one connect to others and in what way?

Historically, the displacement of the locus of power to the body was noted to occur during periods of cultural transition particularly at times when 'identity definition or redefinition' is called for. Under these conditions, morbid forms of bodily control are seen as symptomatic of the 'transition in culture' and not the 'culture' *per se* (Nasser and DiNicola, 2001).

Katzman (1997), and Katzman and Lee (1997), have argued that eating disorders may be precipitated by problems with transition, dislocation and oppression that produce solutions in manipulations of weight, diet and food. Confusion in racial identity was speculated to be behind the immigrants' increased susceptibility to developing eating disorders in both USA and UK. The powerful wish of the immigrants to be accepted and their need to fit into the host/White society necessitated a high level of acculturation, where women in particular believed that integration was only possible through the adoption of the prevailing aesthetic and social standards.

Within this framework, it could be argued that countries undergoing major and rapid cultural changes as well as immigrants and minority groups on the fringe of a main stream cultures, are more at risk for developing 'disordered forms of bodily regulation', be it eating disorders or otherwise. The issue at stake here is the threat to cultural identity and the need for self-definition, which is commonly done nowadays through the vocabulary of the body. Bodily practices like body building, piercing, tattooing and scarring may not be all that different from psychological phenomena such as eating disorders and self-mutilation, where the body in its cultural context becomes a tool to communicate about culture itself, its norms, taboos, ideals and boundaries.

Implications for prevention and intervention

As one examines the movement of eating disorders from individual neurosis to cultural marker of distress, it becomes increasingly important to identify ways of operationalising treatment and prevention strategies. By organising our research and clinical questions around ways of assisting women in self-determination, control and connection rather than simply documenting media and weight insults, we may be able to progress beyond the limitations of our current strategies and provide alternatives for women struggling with eating disorders as a 'answer' to complex personal, social and personal problems. Nasser and Katzman (1999) suggested that the prevention of eating problems will be enhanced by the provision of new social supports and the careful work of providing new ways of belonging at the work and school level. They also recommended a shift in emphasis towards competencies rather than pathology in prevention and treatment strategies.

The link between power and knowledge production has been explored in a number of preventative strategies. For example, in the participatory model empowering knowledge is constructed through dialogue, self-inquiry and reflection based on life experiences (Piran, 1995, 1996). However, the question remains as to how to generate dialogue and engage individuals who share the same predicament worldwide? Perhaps the answer lies in taking advantages of the existing information technology. Electronic connections may provide a new way of achieving female connectedness, one in which women may be able to help other women whom they would not have been able to access in the past. Linked by computer technology, women may be able to overcome their social and political isolation and gain new insights into formulae for success and survival.

Computer technology can maximise the efficacy of the participatory preventative model in a global sense. The role of the facilitator could be taken over by specifically designed computer programmes. Other models of prevention can be employed, again through producing computer programmes or other types of mass media geared towards the enhancement of self-esteem, teaching coping skills and promoting positive cognitions related to negotiations of power and control and to the significance of the individual in relation to the environment.

Similar techniques are currently being used in the management of eating disorders focusing on psycho-education and self help cognitive strategies. An internet-based cognitive-behavioural self-help guide for the treatment of bulimia (http://www2saluted.org/demo/) was developed within a European Multi-Centre Study, the SALUT project, 2005. The efficacy of the programme is under investigation but the pilot results are encouraging.

These interactive web-based multi-media programmes are likely to make specialist therapies available to many more people who traditionally would have been unable to access such help Recognition of these new mechanisms is likely to stimulate research devoted to a transnational perspective for the prevention and management of eating disorders.

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Child and adolescent psychiatric disorders

Nisha Dogra, Panos Vostanis and Niranjan Karnik

EDITORS' INTRODUCTION

One of the key components of culture is the child-rearing patterns, and within each setting the child absorbs cultural values without actually being aware of this. The roles allocated to and expected of children and adolescents indicate cultural expectations and norms. The definitions of illness in childhood are also affected by cultural mores. The bringing up of children, parenting and attachment patterns are all influenced by cultures. In collectivist cultures kinship will be responsible for bringing the children up in times of disaster and within such settings multiple parental roles will exist. This raises interesting questions about development of the individual as well as their concepts of the self.

Dogra and colleagues in this chapter place childhood and adolescent disorders in the context of the cultures. Comparative and cultural analysis reveals a variety of childhoods. Using a multi-dimensional aspect of culture and a social constructionist view, these authors emphasize that, as children and adolescents do not often present themselves to services, the context of the family becomes crucial and the expectations of the families and cultures placed on them will change in response to various external factors. The prevalence of psychiatric disorders in different cultures and in different ethnic groups varies according to a number of factors. Cultural and ethnic factors are also associated with differential access to healthcare services in a similar way as seen in adults. Referral bias, low cultural competence, cultural differences in expression and tolerance of symptoms and help seeking behaviours all play a role. The prevalence of different illnesses in different groups reflects influences of family and relationship with parents. Effects of cultural and socioeconomic stressors on the young may be mediated through other factors. Dogra et al. *emphasize that consideration of culture and the social world is important in understanding individuals who present with psychiatric symptoms, and more so in the case of children and young people it is necessary to consider how these are perceived within the context they present. The families should be seen as unique within the wider culture which influences child-rearing patterns.*

Introduction

Before focussing on the pathology of the major psychiatric disorders of childhood, there is a need to consider the role of children in different cultures. The way that children are perceived within any society is, to some degree, culture dependent. As far as social science is concerned, one aspect of the study of society is the study of childhood and its construction by society, of the place and condition of children in society and, by extension, the study of age itself – questions of development and maturation over time, of how experience at different ages is defined, and of how society responds to differences in age. The meaning of age and the treatment of different ages are found to vary between societies, between social groups and over time. Such meanings and practices may be argued to have only a limited connection with biological factors and much to do with society and the role of different age groups within it. However, childhood can also be conceptualized as a social construction; it is neither a natural nor universal feature of human groups that appears as a specific structural and cultural

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component in many societies. Childhood is a variable of social analysis. Comparative and cultural analysis reveals a variety of childhoods, rather than a single or universal phenomenon. Children's social relationships and cultures require study in their own right independent of the perspective and concern of adults (Walker, 2005).

Children are, and must be, seen as active in construction and determination of their own lives, the lives of those around them and of the societies in which they live. An examination of the experience of childhood around the world today shows how greatly varied it is, and how it has changed throughout history. Contemporary children in some countries are working from the age of 8 and are independent from the age of 14, whereas in other countries they do not leave home or begin work until they are 21. The conventional developmental norms show how adults representing a society or culture construct childhood and, therefore, how to measure children's progress and to detect mental-health problems. They are, however, set down as absolutes and are based on notions of adults' fears and lack of confidence in children and perhaps rooted in adults' own childhood (Walker, 2005).

Theoretical perspectives

These contexts are important when considering all psychiatric disorders but particularly those that do not have a predominantly organic basis. Falicov (1995) identified four theoretical perspectives to try and harmonize systemic theory with the idea of culture. These were:

- Ethnic-focused: this stresses that families differ but assumes that diversity is primarily due to ethnicity. It focuses on the commonality of thoughts, behaviour, feelings, customs and rituals that are perceived as belonging to a particular ethnic group.
- Universalist: this is that families are more alike than they are different. Hence, universalist rules are thought to apply to all families.
- Particularist: this believes that all families are more different than they are alike. No generalizations are possible, each family is unique.
- Multi-dimensional: this goes beyond a one-dimensional definition of culture and ethnicity, and aims at a more comprehensive and complex definition of culture that embraces other potential variables.

For the purpose of this chapter, the perception of culture as a multi-dimensional entity with a social constructionist bias is central. Age is only one aspect of the way that culture influences the role of children. It is also mindful to be aware that there are big differences in the way that female children are perceived compared to male children and this can have fundamental influences on how the needs and wishes of children are interpreted. Within the Human Rights legislation, there is a move to view all children as having fundamental rights. It is implied that these rights stretch beyond cultural boundaries. However, in establishing them they do not acknowledge the gender differences that exist.

Timimi (2005) claimed that some non-Western cultures do not have any cultural ambivalence towards childhood and that children are welcomed into stable, nurturing extended-family structures where duty and responsibility override individualism as the dominant value system. He then described this as being a family-centred culture and argues that they produce happier, easier to control children. Such polarized views of culture, that is the Western as being all bad and the others as positive and good for children, are probably unhelpful. For example, Timimi (2005) fails to discuss the issue of gender (Kumar *et al.*, 2005). In addition, not all non-Western cultures are sociocentric or kinship based.

There is the issue that children do not often present themselves to child and adolescent mental-health services, and the context of the family is even more crucial than when considering adults. Families and the expectations that different cultures place on them change, as do the roles of children within them. There is now more diversity than ever in what constitutes a family.

Patterns and prevalence of child psychiatric morbidity across different cultural and ethnic groups

During the last two decades, there has been a substantial amount of child psychiatry epidemiological research, with recent indication of a gradual rise in psychiatric disorders in young life, accounting for changes in diagnostic criteria and research methods (Collishaw *et al.*, 2004). However, there has been relatively limited evidence on the nature and severity of mental-health problems and disorders in non-Western child populations, and in non-White ethnic groups within Western societies. The interpretation of the existing literature and some comparative studies indicate a number of emerging methodological and sociocultural factors that impact on the findings. Some of these factors also apply to adult studies, while other issues (measures and informants used) are specific to children and adolescents.

Many studies used standardized instruments (predominantly, the US-developed Child Behaviour Checklist; Achenbach, 1991; and, more recently, the UK-developed Strengths and Difficulties Questionnaire; Goodman, 2001) to establish broad rates of morbidity from varying sources of information (usually parents, sometimes teachers and, in some studies, adolescents, as neither self-report form is available for the less cognitively able pre-adolescent children) (e.g. Heyerdahl *et al.*, 2004; Kashala *et al.*, 2005). Despite the cross-cultural validation of these instruments, the differences between such designs has resulted in varying prevalence rates of mental-health problems, and usually an overestimate of disorders. These methodological difficulties are more pronounced in pre-school children (Luk *et al.*, 1991; Prior *et al.*, 1999). Studies with two-stage designs, i.e. using first-stage screening and second-stage interviewing methods, have addressed such difficulties, particularly those that have recently used the same or adapted diagnostic instruments. Overall, such studies tend to come up with a prevalence of around 20%–25% from child mental-health problems and between 9% and 12% of child psychiatric disorders in the general population (e.g. United Arab Emirates – Eapen *et al.*, 1998; UK – Meltzer *et al.*, 2000; Brazil – Fleitlich-Bilyk & Goodman, 2004). As within Western societies, these rates increase with social deprivation (e.g. Brazil – Flietlich & Goodman, 2001; Russia – Goodman *et al.*, 2005b), which possibly accounts for the raised prevalence in inner-city compared to rural children within the same country (e.g. Goodman *et al.*, 2005a), although one should not discount the importance of more subtle underlying mechanisms of social networks, family relationships and constructs of mental health across rapidly changing urban communities in developing countries.

There has been surprisingly limited evidence on the prevalence of disorders within different ethnic groups in western populations. There are a number of inter-related factors involved, which all possibly play a part in the presentation of child mental-health problems, such as adjustment to a different society and socioeconomic deprivation (Costello *et al.*, 1997; Stansfeld *et al.*, 2004), experience of racism and discrimination (Caughy *et al.*, 2004), impact of past trauma and immigration (Stevens *et al.*, 2003), cultural influences on symptom presentation (Fishman & Fishman, 1999), perceptions of mental health and mental illness (McKelvey *et al.*, 1999), different threshold of reporting problem behaviours (Loo & Rapport, 1998), changing family structures and gender expectations, sense of identity and self-esteem within a marginalized societal group, and family and parenting attitudes (e.g. towards discipline – Chang *et al.*, 1995).

Future research needs to focus on specific questions related to these variables, and try to establish their impact on overall child psychiatric morbidity, as well as specific conditions. Although not all types of child psychiatric disorders could be covered within this chapter, the major types of disorders are briefly discussed below in relation to cultural issues.

Schizophrenia

There are limited data on the prevalence of schizophrenia in the general young population as studies have used broad categories of psychosis, without standardized assessments (Hollis, 2000). Males appear to be over-represented in clinical studies of childhood-onset schizophrenia but in studies of predominantly adolescent schizophrenia, there tends to be an equal gender ratio. King *et al.* (1994) compared the annual incidences of psychosis in people from different ethnic groups aged between 16 and 54 years. Raised incidences of schizophrenia were not specific to African Caribbean, with members of all ethnic minority groups more likely to develop a psychosis. Their explanation was that personal and social pressures of belonging to any ethnic minority group in Britain were important determinants in the excess of psychotic disorders found. However, for some ethnic groups numbers were very small indeed.

Furnham and Chan (2004) found that Chinese youth, compared to the British, did not use more superstitious beliefs to explain the behaviour of people with schizophrenia. However, the Chinese held more negative attitudes and beliefs about schizophrenia. McCabe and Priebe (2004) compared explanatory models among people with schizophrenia from four cultural backgrounds. Whites cited biological causes more frequently than the three non-White groups, who cited supernatural and social causes more frequently. This kind of work has not yet been undertaken with youth of ethnic minorities. Pote and Orrell (2002) also found ethnicity to be an important factor in influencing perceptions of schizophrenia.

Del Bello *et al.* (2001) found that African-American young males were more commonly diagnosed with schizophrenic spectrum disorder than were African-American women, Caucasian women or men. There were significantly more African-Americans diagnosed with conduct disorder than Caucasians who were more often diagnosed with alcohol use disorders and major depression. They concluded that structured interviews would determine whether the disparity in clinical diagnosis is secondary to actual gender and racial differences in the rates of illnesses in hospitalized adolescents, or due to other factors that may contribute to diagnostic practices. Results from such a study with adults indicated some significant race differences in diagnosis even when a semi-structured instrument and DSM criteria were used; Whites were more likely than African-Americans to receive a diagnosis of bipolar disorder and less likely to be diagnosed with schizophrenia (Neighbors *et al.*, 2003). Bui and Takeuchi (1992) found African-Americans over-represented in existing public mental-health facilities, with Asian-Americans and Hispanics being under-represented. There were also differences in the lengths and type of treatment for the different groups.

Psychotic symptoms in children and adolescents are diagnostically non-specific, occurring in a wide range of functional psychiatric and organic brain disorders (e.g. affective disorders, autistic spectrum disorder, substance-use-related psychosis and temporal-lobe epilepsy). Catatonic states are more likely in the developing world. Lopez *et al.* (2004) found that, for Mexican-Americans, family warmth was a significant protective factor, whereas for Anglo-Americans, family criticism was a significant risk factor. This suggests that the role of families may be relevant across all cultures but that the specifics may be family and culture dependent.

Cultural and ethnic differences may also be associated with differential access to services. For example, Cuffe *et al.* (2001) found youth with a psychiatric diagnosis were under-treated with differentials in service use by race and gender over time. African-Americans were significantly less likely to receive treatment. The possible explanations were referral bias, low cultural competence of mental-health professionals and cultural differences in the expression and tolerance of symptoms and help-seeking behaviours.

Depression and self-harm

Depression occurs in 1% of older children (girls = boys), which rises to 4% in adolescence (higher in girls). Children have non-specific symptoms, such as physical complaints, irritability and withdrawal, while adolescents present with adult-like symptoms. Young people with depression often have other mental-health problems such as anxiety, behavioural problems or eating disorders. Established causes are life events (trauma/loss), personal predisposition (genetic) and physical illness. Treatment includes management of underlying family, school or social problems, cognitive-behavioural therapy (aiming at changing maladaptive and negative ways of thinking), brief psychotherapy, antidepressant medication and social-skills training (improving self-esteem and interpersonal relationships). The depressive episode usually remits, but there is high risk of relapse (one-third of young people over 2–3 years). In a small proportion of young people, depressive symptoms may become chronic, and there is risk of depression persisting in adult life.

Despite a number of studies in this area, the impact of cultural factors on the presentation and aetiology of depression are inconclusive. Some US studies found an association between depression and ethnic minority status, but this variable was also correlated with socioeconomic deprivation (Wight *et al*., 2005). Stewart *et al*. (2002) found similar prevalence rates and cognitive patterns in Hong and the US, but a different symptom profile, with Hong Kong adolescents reporting more fatigue/loss of energy, and less irritability. Similarly, Fleitlich-Bilyk and Goodman (2004) found similar depression rates in Brazil and the UK. Others questioned whether depression is less prevalent among certain ethnocultural groups (e.g. Chinese-Americans), because of socially approved mechanisms that protect them from stressors (Chen *et al*., 1998), or cultural differences in the expression of grief (Murray-Parkes, 1998).

Vague suicidal thoughts can occur in up to one-third of teenagers, with an annual prevalence of deliberate self-harm (hospital-treated) of about 0.2% in the general population. The lifetime prevalence of deliberate self-harm in adolescence has been found to be between 2 and 3.5% in studies from Europe, and much higher in the United States (about 9%). It increases with age, is more common in females (3:1) and low socioeconomic groups, and is often precipitated by arguments with family, friends or partner. The method is usually either by overdose of analgesics, antidepressants or other medication, or by inflicting lacerations (Hawton *et al*., 2003). There are often associated mental-health problems such as depression, behavioural problems and alcohol/drug abuse. There is high risk of eventual suicide (in up to 10% of the young people who self-harm).

Suicide in young life is rare, although it is possibly an underestimate, because of often being defined as accidental death, i.e. in less than one child of 5–14 years per 100 000 general population, and about ten adolescents/young adults per 100 000 general population (or 14% of all deaths). There is an increasing trend in 15–19-year-old males. In contrast with deliberate self-harm, suicide is more frequent in males, often there has been a history of previous attempts (in 25%–50% of young people), and has no association with social class. Methods tend to be more violent in males, while overdoses are more frequent in females.

Similar trends and causal mechanisms of self-harm ideation and behaviour have been found in different ethnic groups, although the mediating family and social vulnerability or precipitating factors may differ. Wai *et al*. (1999) found young females of Indian origin to be at relatively high risk for suicidal behaviour. The most common reason was adjustment disorder stemming from interpersonal losses and conflicts. Hong Kong and US suicidal adolescents had similar cognitive patters, with hopelessness the strongest predictor (Stewart *et al*., 2005). Lack of acculturation by young people has been found to interact with other risk factors (Lau *et al*., 2002). These patterns indicate the need for different types of interventions for children and their families, which will be discussed in Chapter 32.

Anxiety disorders

The prevalence of all anxiety disorders is approximately 3.3% in childhood and 5.6% in adolescence, with higher prevalence among girls (Meltzer *et al*., 2000). Causes include acute or chronic life events (bereavement, accidents or other traumas), personal predisposition (vulnerability) or a combination of these factors. The presentation of anxiety disorders is broadly similar to that of adults, with the notable exception of separation-anxiety disorders. Findings from non-Western countries vary, possibly related to diagnostic and measurement issues and the nature of the population (e.g. increased in areas of political conflict and social adversity: Palestine – Thabet & Vostanis, 1998; Russia – Goodman *et al*., 2005b). Some studies have found similar rates to those of Western societies (e.g. Brazil – Fleitlich-Bilyk & Goodman, 2004). There is less evidence on underlying culture-related mechanisms, with several interesting theories still to be tested, such as coping with anxiety through well-defined roles and support networks in culturally homogenous groups (Rahim & Cederblad, 1986), culture-specific cognitive schemas (Varela *et al*., 2004), and symptomatic presentation in a country's cultural, religious and political context (Dollinger *et al*., 1996).

In contrast, separation-anxiety disorders are more likely to be affected by culture-related attachment and child-rearing factors (Thabet *et al*., 2000). Separation anxiety is manifest upon separation or threat of separation from attachment persons, usually the mother, and is a normal reaction between 18 months and 3 years of life. Its aim is to attract the caregiver's attention. In a secure mother–child relationship, this reaction gradually weakens as the child grows up and develops peer and alternative attachments relationships. In insecure attachment, separation anxiety may persist into later childhood and even into adolescence. Prolonged separation anxiety may present with physical complaints (sickness, headaches, abdominal pain), nightmares with separation themes and school refusal. Cultural and societal concepts of acceptable child-rearing practices (i.e. for how long an infant or toddler may share the parents' bed or room, if at all), will impact on the perceptions of normal or dysfunction parent–child separation, across different settings (Honjo *et al*., 1992; Mizuta *et al*., 1996).

Unlike the effect of parenting and family issues, there is fairly consistent evidence on the direct impact of trauma on children, across cultures (Sack *et al*., 1997). Exposure to childhood trauma is a vulnerability factor for a range of mental problems. In particular, it is strongly associated with a presentation of emotional symptoms, defined as post-traumatic stress disorder (PTSD). High rates of PTSD have been established in studies with children exposed to natural disasters such as earthquakes, human-induced accidents, war conflict, community and domestic violence, and life-threatening physical illness (Yule, 1999). Post-traumatic stress reactions are characterized by intrusive images or recurrent thoughts about the event, reliving their experience (flashbacks), associated sleep disturbance, physical symptoms, avoidance of stimuli associated with the trauma, emotional detachment or numbing, irritability and poor concentration.

Post-traumatic stress symptoms respond well to brief psychotherapeutic interventions (cognitive or psychodynamic; individual or in groups), as long as the underlying stressors have been removed. There is less conclusive evidence on the effectiveness of psychological debriefing, i.e. verbally re-experiencing the trauma in order to work through its consequences. Families often need to be involved in the intervention, as their own emotional responses may maintain the child's distress (Vostanis, 2004).

Eating disorders

All epidemiological data support the clinical experience that anorexia nervosa is 8–40 times more common in females than in males (also see Nasser in this volume). In studies involving western white groups of young people, the pattern and findings are fairly consistent. For example, in a Spanish adolescent population, Toro *et al*. (1995) found that young people with anorexia nervosa had parents who were better educated than the parents of similar young people who did not have a diagnosis of anorexia. The parents of girls with anorexia were also more likely than other parents to develop affective disorders. The young people themselves also performed better academically but were more socially withdrawn.

Anorexia is rarely observed amongst blacks in the USA, UK or Africa. It is quite common in Japan, where Nishizawa *et al.* (2003) found the rate of eating problems as 11.2% for female and 2.4% for male high school students. Huon *et al.* (2002) found high levels of weight-related concerns among schoolgirls across mainland China. There were few cases which met the criteria for a full diagnoses but this may relate to difficulty in applying the western procedure for categorizing body-mass index. Lee and Lee (1996) found Western patterns of body dissatisfaction and disordered eating attitudes are common among Chinese adolescent females. Caradas *et al.* (2001) found an equal prevalence of abnormal eating attitudes in South African schoolgirls from different ethnic backgrounds. There is some evidence that, outside Western culture, the illness may be restricted to prosperous backgrounds and upper social strata (Steinhausen *et al.*, 2000). However, Blacks in the US and UK are usually westernized so the theory that this might be is related to Western values needs to be questioned. Ricciardelli and McCabe (2001) found that little work has been undertaken on the development of body image concerns and eating disturbances in children, with most work focusing on weight-loss cognitions and behaviours.

Croll *et al.* (2002) found that 56% of 9th grade females and 28% of 9th grade males reported disordered eating behaviours with slightly higher rates among 12th graders (57% and 31%, respectively). Among both genders, Hispanic and American-Indian youth reported the highest prevalence of disordered eating. Risk factors for disordered eating in both genders included cigarette smoking, appearance concerns and alcohol use. Protective factors for both genders were positive self-esteem, emotional well-being, school achievement and family connectedness. While risk and protective factors were similar across gender, they differed across ethnicity, particularly among females. This chapter raises the issue that, for young people, the disorders may not yet have developed but that they are in the process of doing so.

The overall incidence of anorexia nervosa in Curaçao was found to be much lower than in the more affluent societies of the US and Europe (Hoek *et al.*, 2005). Within Curaçao, sociocultural factors appeared to be associated with differential rates of anorexia nervosa. The incidence of anorexia nervosa among the majority black population was almost nil, while the incidence among the minority mixed and white population on Curaçao was similar to that of the US and the Netherlands. The prevalence of bulimic disorders in Caribbean schoolgirls was found to be low but likely to be on the increase, given the shared ideals of slimness and engagement with dieting behaviours (Bhugra *et al.*, 2003).

Different mechanisms may operate for second-generation migrant Asian groups. Mumford *et al.* (1991) found higher prevalence rates of bulimia nervosa in South Asian girls compared to Caucasian girls (3.4% vs. 0.65). Among south Asian girls, eating symptoms were associated with a more traditional cultural orientation and not with greater westernization. They speculated that their findings might reflect the cultural and familial difficulties faced by these Asian girls growing up in Britain. In an Australian study, less acculturated Asian girls appeared to have unhealthier attitudes and psychopathology towards eating (Jennings *et al.*, 2005). Furnham and Adam-Saib (2001) found Asian girls' eating symptoms to be significantly higher than for the White group, but that rates for the Bengali sample were significantly higher than all other groups. Their results suggest that there are important psychological differences between second-generation migrants from different countries on the Indian sub-continent. Unhealthy eating attitudes in Asian girls appear to be linked to high levels of perceived maternal control (Ahmad *et al.*, 1994; McCourt and Waller, 1995). Mujtaba and Furnham (2001) found eating symptoms to be associated with conflict with parents and over-protection in Asian girls. A study comparing British Asian and Caucasian 9-year-olds found both groups revealed a high priority for thinness, even though the Asian girls had a significantly lower body weight than the Caucasian girls. An appeal for thinness in combination with intercultural and intra-familial conflict may strongly influence eating and contribute to the development of eating disorder (Hill & Bhatti, 1995). Thomas *et al.* (2002) found high eating symptoms in Asians and Muslims and for mixed-race young women than among White or African-Caribbean subjects. These were also associated with low self-esteem and depressed mood, as was having only one parent in employment. The findings suggest that effects of cultural and socio-economic stresses on eating disorders may be mediated through depressed mood and low self-esteem.

Substance-use disorders

The precise rates of prevalence of substance misuse across North America and Europe vary somewhat across investigations, according to methods of assessment, definition and population studied (Weinberg *et al.*, 2002). However, there is broad agreement on the key findings which suggest the following:

- Alcohol and nicotine are the most frequently used substances followed by marijuana, solvents, psycho-stimulants, sedatives and hallucinogens next in frequency. Cocaine and opiate use is less frequent.
- About one-half to three-quarters of older adolescents have taken an illicit drug at some time.
- A substantial minority have tried multiple drugs.
- Drug use is uncommon in children under 12 years but becomes more frequent during the teenage years, with the exception of solvent misuse which is used more by younger age groups.
- Drug use is as common in girls as boys but there are marked differences in types of drug used, with alcohol abuse much more common in males.
- Overall drug use increased during the 1990s.
- Associations with social background vary considerably, according to drug type.
- Drug use is more frequent among young people with poor scholastic achievement.

Parry *et al.* (2004) found an increasing number of South African adolescents using alcohol and other drugs, with alcohol being the most common substance of abuse and cannabis being the most used illicit drug. An epidemiological survey in North East India (Chaturvedi and Mahanta, 2004) found high prevalence of substance use (tobacco at 30.9% and alcohol at 30% and opium at 4.8%. The prevalence varied across location, gender, race, age, education and occupation. Certain tribes had high alcohol use related to strong cultural beliefs. Average age of initiation of alcohol use at 12.4 years was significantly lower than tobacco at 17.6 years, and opium at 23.3 years. Obe and Wibberley (2002) found that, whilst patterns of substance use and misuse amongst Asians may be similar in many ways to those for the general population, they occur within a different cultural context.

American-Indian/Alaskan Native teenagers in the US generally report more alcohol use than other youth, use it first at a younger age, greater frequency and amount of use and with more negative consequences. This, in turn, may then also be associated with accompanying risk behaviours. James *et al.* (2000) found that those young people who identified highly with a minority culture were associated with heavy drug use suggesting that social influences may play a larger role in the development of heavy drug use irrespective of the nature and origins of these social influences. Karlsen *et al.* (1998) interviewed 132, 12–13 year-old young people from four ethnic groups attending secondary schools in London. Familial, religious and peer influence closely correlated with ethnicity. Bangladeshi young people showed lower levels of peer and higher levels of religious and familial involvement and lower levels of substance use. White young people reported higher levels of peer, lower levels of religious and familial involvement, and a higher level of substance misuse. Black African and Black Caribbean young people lay between the two extremes. The findings suggested that young people with lower levels of familial and religious influence, or higher levels of peer influence, have higher levels of substance consumption than other young people. There is a need to recognize young people's individual sense of culture. Bangladeshis are the most recent large immigrant group and over time their sense of peer influence may change. Felix-Ortiz *et al.* (1998) found intergenerational discrepancy was associated with more drug use in certain cases in Latino adolescents.

Sami youth showed less risk-taking behaviour as substance and drug use than the Norwegian majority (Kvernmo, 2004). Sami adolescents growing up in Sami dominated areas have a strong bicultural identification, are practising more Sami cultural behaviour and have better mental health compared to Sami peers in marginal Sami areas. This suggests that a strong sense of cultural identity may only be an issue in marginal areas when it may be difficult to express the sense of identify.

Adolescents with behavioural or affective problems, poor social skills, a limited social network and substance abuse during late adolescence are at increased risk for substance dependence in adulthood (Kaminer, 1999). There have been few well-controlled treatment studies in children and adolescents for substance misuse. Individual cognitive-behavioural therapy, family therapy and group education/supportive programmes have been found effective with young people, in conjunction with other strategies such as not having access to drugs, continued education about the social, economic and physical effects of illicit drugs, and the proper identification and management of affective disorders and/or specific learning disorders.

Disorders of attention and concentration

Attention deficit disorders have emerged over the past two decades as a significant issue for child psychiatrists in the US and Europe. The *Diagnostic and Statistical Manual of Mental Disorders* (4th edn, Text Revision) reports the prevalence rate for Attention Deficit/Hyperactivity Disorder (ADHD) as being between 3% and 7% (American Psychiatric Association and APA Task Force on DSM-IV, 2000). Outside of the US, prevalence rates are much lower, even between countries like the US and UK for reasons that are unclear and that may highlight diagnostic differences rather than true prevalence differences. It is generally diagnosed after age 6, and is seen primarily as a diagnosis of childhood, but recently there has been increasing recognition of an adult variant.

Significant disputes exist about the diagnosis and the use of psychostimulants to treat this disorder (Marcovitch, 2004, Coghill, 2004, Wender, 2002) due to the side effects of stimulants and fears about long-term effects of these medications. Recent studies in the US have found that insurance status strongly determines which children will be placed on psychostimulants, and notes that there is a significant racial disparity with white children being more likely to receive medications for ADHD (Zito *et al.*, 2005, Safer *et al.*, 2004). This appears to contradict some earlier reports that children of minority backgrounds in inner-cities were more likely to be medicated (Breggin and Breggin, 1998). Disputes over the use of this class of medication are at the heart of the tension over ADHD and its status as a diagnosis. As with most psychiatric disorders in childhood, there is no simple answer. ADHD is likely to be partially biologically rooted and certainly has an environmental aetiology. The realities of modern education and child-rearing place new demands on children to be attentive, focus on teaching and also allow little space to act in hyperactive ways. Some children are likely to have the ability to work with this environment whereas others cannot.

Recently, the development of a non-stimulant treatment for ADHD known as atomoxetine has allowed many practitioners to actively treat attentional problems without having to utilize stimulants. The efficacy of this medication is widely perceived as being less potent than stimulants, but it does provide an alternative. An extensive review of the pharmacological treatment of ADHD is available (Joshi, 2004).

Globally, the expense of psychostimulants and atomoxetine will pose a significant obstacle to the expansion of ADHD as a diagnostic category. Cultural views of attentional problems and the degree to which this should be considered an object of psychiatry will also slow the expansion of this category. As the neuroscience of attention and concentration continues to develop, it may become easier and clearer to make diagnoses in this domain, and also help to make the diagnosis more understandable to the general population.

Conclusions

As in all other psychiatric specialties, consideration of culture and the social world is important in understanding individuals who present with psychiatric symptomatology. With children and young people, it is also necessary to consider how these are perceived within the context they present, as this varies from culture to culture and from family to family. In clinical practice, it is probably safest to work on the premise that all families are unique and the wider culture and family culture play a role in how and when young people present. Those factors may also influence what symptoms children present with. Whilst over the last two decades research in this area has increased, there is still limited evidence on the nature and severity of mental-health problems and disorders in non-Western child populations and in non-White ethnic groups within Western societies. It is also difficult to compare ethnic populations with majority populations when considering etiology because the social factors which are so important in the development of mental-health problems are so variable for different groups. The impact of experiencing racism, discrimination, trauma and immigration vary for different groups and for individuals within groups. In addition, there is still some concern that some of the differing prevalence rates between ethnic groups are more related with detection methods or practice of mental-health professionals than reflect real differences in psychiatric morbidity. This is most striking when considering the prevalence of schizophrenia. In disorders of attention and concentration, the investment parents place in a disorder may be of greater significance than the child's symptoms. In all the major disorders we have discussed the evidence is mixed. What is clear is that social factors, of which culture is a significant one, play as an important a role as potential biological or genetic factors. We therefore need to breakdown social factors into comparable variables so that we can better understand their impact in different contexts.

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24

Culture and schizophrenia

Thomas Stompe and Alexander Friedmann

EDITORS' INTRODUCTION

Although overlapping, the two chapters on schizophrenia (and its relationship with culture) in this volume are complementary. Stompe and Friedman also start from an epidemiological perspective but shift their focus to rates of subtypes of schizophrenia in different cultures. It is interesting to note that rates of paranoid schizophrenia vary twofold and catatonic schizophrenia was observed more commonly in low income countries. Developing the theme of symptoms and contents of delusions, they point out that religious delusions and delusional guilt are more common in Christian societies in comparison with Hindu and Muslim societies. Significant variations in the frequencies and contents of hallucinations also indicate that contents of abnormal beliefs and experiences are very strongly coloured by cultural values. Their emphasis on descriptions within the epidemiological data indicates that, in order to understand culture–symptom interaction and presentation, clinicians need to explore personal beliefs in the context of culture.

Introduction

The phenomenology of what we nowadays call schizophrenia has been recognized in almost all cultures. The first systematic descriptions of this disease can be found since the beginning of the nineteenth century. In 1899 Kraepelin combined different clinical pictures, characterized by early age of onset and a chronic and deteriorating course, under the term dementia praecox (Kraepelin, 1899). To emphasize the occurring cognitive impairment and the concept of the splitting of psychic processes, Eugen Bleuler introduced the term schizophrenia (Bleuler, 1911). In current diagnostic criteria DSM-IV and DSM-IV-TR, schizophrenia is defined by a group of characteristic positive, negative, psychomotor and disorganized symptoms, deterioration in social, occupational or interpersonal relationships and continuous signs of the disturbance for at least 6 months (APA, 1994, 2000).

Culture and the epidemiology of schizophrenia

Varying incidence and prevalence rates define the 'epidemiological landscape' of a disease. Meta-analysing 161 studies on the incidence of schizophrenia from 33 countries, McGrath *et al.* (2004) found a median value of 15.2 (7.7–43.0) of new cases per 100 000 population. However, compared to somatic diseases like diabetes or cancer, the incidence of schizophrenia is very similar across populations (Saha *et al.*, 2006). Reviewing and meta-analysing 188 studies from 46 countries, the calculated median value for life-time prevalence was 4.0 (1.6–12.1) per 1000 population (Saha *et al.* 2005). The prevalence estimates for 'least developed' countries (median = 2.62) were significantly lower ($P = 0.02$) than those from 'emerging' (median = 4.69) and from developed sites (median = 3.30). These prevalence rates confirm the results of authors like Torrey *et al.* (1974), who investigated the prevalence of schizophrenia in

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traditional cultures like Papua New Guinea. In the mountain districts the prevalence rate was between 0.03 and 0.19 per 1000 population, in the coast districts with a longer tradition of contacts with Australians and Europeans the rates were significantly higher (0.38 and 0.77 per 1000).

Culture and the outcome of schizophrenia

One of the most striking findings of the World Health Organization (WHO) International Pilot Study of Schizophrenia (IPSS) conducted in the 1960s and 1970s was the more favourable outcome for patients in the developing world (Jablensky 1987, 2000; Leff *et al.*, 1992; Sartorius *et al.*, 1986). The original IPSS consisted of 1202 patients with a PSE (Present State Examination) diagnosis of schizophrenia drawn from China, Columbia, Czechoslovakia, Denmark, India, Nigeria, the United Kingdom, the United States, and the Union of Soviet Socialist Republics. The 5-year follow-up showed a broad heterogeneity and a more favourable outcome of the disorder in the developing countries. This result was confirmed by the following cross-cultural studies organized and performed by the WHO: the Determinants of Outcome of Severe Mental Disorder (DOSMeD; e.g. Edgerton and Cohen, 1994) and the International Study of Schizophrenia (ISoS; e.g. Hopper and Wanderling, 2000). The aim of the DOSMeD project was to identify all persons suffering from the first onset of schizophrenia in 13 catchment areas located in ten different countries over a period of 2 years. Like with the IPSS, the most important finding of this research was the existence of consistent and marked differences in the prognosis of schizophrenia between the centres of developed countries and the centres of developing countries (Edgerton and Cohen, 1994; Craig *et al.*, 1997; Jablensky *et al.*, 1992). A series of further studies in India continued the programme of the IPSS. In a multicentre study in Lucknow, Vellore, and Madras of 323 early-course schizophrenic patients (modified Feighner's criteria) the authors found a 66% remission rate at 2-year follow-up (Verghese *et al.*, 1993). Comparable with a similar study conducted in Columbia (Leon, 1989), there was only a 2% suicide rate, and 40% of patients were employed at 2 years. In a second Indian research project, the Madras Longitudinal Study, both positive and negative symptoms showed a significant decline at the end of 10 years. Sixty-seven per cent of the sample showed a good pattern of course, leading to partial or complete recovery (Thara *et al.*, 1994; Thara, 2004). In a Nigerian study stimulated by the IPSS, Ohaeri (1993) conducted a retrospective follow-up of 142 patients meeting the RDC criteria for schizophrenia. During a 7-year follow-up, 50.7% achieved a good outcome and 23.9% a moderate outcome. An acute onset followed by an episodic course with rapid remission in response to treatment was typical. In a 1-year follow-up of 56 patients with schizophrenia from Trinidad, Bhugra found low poor-outcome rates of 19%. (Bhugra *et al.*, 1996). Although most studies showed a favourable prognosis of course and outcome of schizophrenic psychoses in developing countries, this result as well as the possible reasons were discussed as being highly controversial (e.g. Williams 2003; Patel *et al.*, 2006). Patel *et al.*, (2006) pointed at methodological limitations of the three WHO cross-national studies, but also mentioned the lack of evidence on the socio-cultural factors, which apparently contribute to the better outcome.

Culture and the rate of schizophrenia subtypes

Kraepelin performed the first study on schizophrenia in traditional cultures by investigating psychotic patients in Java (Kraepelin 1904a,b). He found all classical clinical features of dementia praecox, however, with different accentuations and frequencies. Initial depression was rare, the psychosis usually started with confusion and agitation; auditory hallucinations, thought influence and hypochondriac delusions played a minor role; delusions were seldom systematized, negativistic stupor was rare (Jilek, 1995).

The first systematic investigation on schizophrenia subtypes in different cultures was carried out by Murphy in the 1960s (Murphy, 1982). Catatonic subtypes were rare among Euro-Americans, hebephrenic subtypes occurred more often in Japanese and Okinawan, simple subtype occurred in Asian patients.

The IPSS was a milestone for our knowledge of the cultural distribution of schizophrenic subtypes (WHO, 1973). Schizophrenic patients, 811 from nine centres (Washington, London, Aarhus, Prague, Moscow, Cali, Agra, Ibadan, and Taipei), were subclassified according to the ICD-9 criteria of schizophrenia subtypes (Table 24.1).

The largest diagnostic subgroup in the total sample was paranoid schizophrenia with 39.8%. It accounted for 75% of all patients in London, 53% in Aarhus and Washington, and 40% or more in Ibadan and Taipei. The hebephrenic subtype was assigned in 10.6% of all patients, with the highest rates in Cali and Taipei. 10.6% were classified as catatonic schizophrenia, with the highest rates in the centres of the developing countries (Agra, Cali, Ibadan). In a transcultural study on schizophrenia, the International Study on Psychotic Symptoms (ISPS) organized by the Vienna International Research Group on Cultural Psychiatry, DSM-IV criteria were applied.

Similar to the IPSS, in most of the investigated sites paranoid schizophrenia was the most frequent subtype (19%–90%), only in Nigeria more often schizoaffective disorder was diagnosed (Table 24.2). In contrast to the findings of studies on schizophrenic subtypes conducted in Africa during the last century (Murphy, 1982), the rate of catatonic subtypes was very similar in all sites. This may be due to DSM-IV criteria of catatonic schizophrenia, a problem which was discussed in detail (Stompe *et al.*, 2002, 2005). While Austria, Georgia and Pakistan show the highest rates of chronic patients (residual and disorganized type), the African countries are characterized by higher rates of acute forms, especially schizoaffective (Nigeria and Ghana) and schizophreniform disorders (Nigeria).

Culture and psychotic symptoms in schizophrenia

Contents of delusions

For the contents of delusions, the personal and cultural system of values of an individual is of particular importance. For example, delusions of grandeur can hardly be found in village communities where it is regarded as reprehensible and dangerous to strive for a given social level (Pfeiffer, 1994; Stompe *et al.*, 1999). While religious delusions and delusional guilt are primarily found in societies with a Christian tradition, these contents are infrequent in Islamic, Hindu or Buddhist societies (Kala and Wig, 1982; Kim *et al.*, 2001; Murphy, 1967; Ndetei and Vadher, 1984a; Stompe *et al.*, 1999, 2006; Tateyama *et al.*, 1998).

Table 24.3 shows the 1-year prevalence of delusional themes reported by schizophrenic patients of the ISPS. Independent of culture, persecution was the most common delusional theme in all sites followed by grandeur. Pakistan, the only pure Islamic country, showed a pattern of delusional contents remarkably different from the other sites with Christian majorities: low rates of religious delusions, delusions of grandeur and delusions of guilt (Stompe *et al.*, 2006). Religious delusions occurred only as persecution by demons or possession by Djins (Stompe *et al.*, 1999). In contrast to the African countries religious grandiosity (‘being an angel or a prophet’, etc.) was not reported by Pakistani patients. Taking into account the different rates of delusional contents in Pakistan and the West-African countries, one has to conclude that the distinction ‘developed’ vs. ‘developing’ countries is an oversimplification with less explanatory value.

Hallucinations

The first large study about the frequency of different kinds of hallucinations in a cross-cultural investigation was conducted in the 1960s (Murphy *et al.*, 1963). One of the central findings was that visual

Table 24.1. The frequency (in %) of schizophrenia subtypes according to ICD-9 in the International Pilot Study of Schizophrenia (WHO 1973)

	Simple	Hebephrenic	Catatonic	Paranoid	Acute	Latent	Residual	Schizoaffective	Other specified	Unspecified
Washington	4.1	–	1.0	52.6	15.5	2.1	6.2	15.5	–	3.1
London	2.0	9.0	3.0	75.0	1.0	–	1.0	8.0	–	1.0
Aarhus	11.3	22.6	3.8	52.8	–	5.7	–	1.9	1.9	–
Prague	6.6	3.9	–	47.4	5.3	2.6	2.6	26.3	3.9	1.3
Moscav	–	–	16.9	14.3	18.2	–	6.5	44.2	–	
Agra	4.0	3.0	21.7	14.9	9.9	–	–	16.8	3.0	26.7
Cali	2.0	19.8	12.9	19.8	28.7	3.0	5.9	6.9	–	1.0
Taipei	1.2	34.9	3.5	41.8	4.7	–	–	9.3	–	3.5
Ibadan	5.8	7.5	8.3	40.8	4.2	–	–	21.7	2.5	9.2

Table 24.2. The frequency of schizophrenia subtypes according to DSM-IV (International Study on Psychotic Symptoms; $N = 1080$)

	Disorganized	Catatonic	Paranoid	Residual	Indifferent	Schizoaffective	Schizophreniform	Brief psychotic
Austria ($N = 350$)	3.7	7.4	70.9	10.4	3.0	4.7	–	–
Poland ($N = 80$)	5.0	3.6	88.8	–	–	2.5	–	–
Lithuania ($N = 73$)	1.4	4.1	90.4	–	–	–	4.1	–
Georgia ($N = 74$)	10.8	8.1	50.0	17.6	–	11.2	1.4	–
Pakistan ($N = 103$)	23.3	2.9	43.7	13.6	16.5	–	–	–
Nigeria ($N = 324$)	6.3	6.3	18.8	2.1	10.4	29.2	27.1	–
Ghana ($N = 76$)	6.6	6.6	40.8	3.9	1.3	35.5	2.6	2.6

Table 24.3. Frequency of occurrence of contents of delusions in schizophrenia during the last year by culture (International Study on Psychotic Symptoms; $N = 1080$)

	Austria ($N = 350$)	Poland ($N = 80$)	Lithuania ($N = 73$)	Georgia ($N = 74$)	Pakistan ($N = 103$)	Nigeria ($N = 324$)	Ghana ($N = 76$)
Persecution	82.1	90.0	98.6	66.2	91.3	77.1	98.7
Grandeur	43.5	41.3	42.5	37.8	10.7	41.7	64.5
Religion	34.7	33.8	30.1	32.4	7.8	37.5	51.3
Hypochondria	17.4	28.8	23.3	3.4	4.9	14.2	27.6
Guilt	13.8	18.8	24.7	5.4	1.0	10.4	9.2
Poisoning	10.7	31.3	32.9	32.4	16.5	29.2	39.5
Apocalypse	8.3	12.5	32.9	2.7	1.0	18.8	9.2
Descent	4.7	12.5	15.1	25.7	–	8.3	10.5
Being Loved	5.5	11.3	4.1	12.2	–	6.3	9.2
Jealousy	2.2	1.3	5.2	6.8	1.9	6.3	2.6

hallucinations as well as tactile hallucinations occurred most frequently in patients from Africa and the Near East. Nearly 20 years later, Ndetei and Vadher carried out a cross-cultural study including patients with schizophrenia from nine ethnicities admitted to a London hospital (Ndetei and Vadher, 1984c). The authors found higher rates of both auditory and visual hallucinations in Non-European patients compared to English and Continental Europeans. To investigate the impact of the culture of origin and the environmental influence of the second home, Suhail and Cochrane compared a sample of patients from Pakistan living in their home country, with a sample of Pakistani, who immigrated to Great Britain, and with patients of white British origin (Suhail and Cochrane, 2002).

Table 24.4. Frequency of occurrence of hallucinations in schizophrenia during the last year by culture (International Study on Psychotic Symptoms; $N = 1080$)

	Austria ($N=350$)	Poland ($N=80$)	Lithuania ($N=73$)	Georgia ($N=74$)	Pakistan ($N=103$)	Nigeria ($N=324$)	Ghana ($N=76$)
Audible	64.7	83.8	82.2	71.6	72.8	85.2	90.8
Visual	38.0	45.0	37.0	9.5	3.9	45.8	53.9
Coenesthetic	35.0	28.8	31.5	20.3	23.3	18.8	48.7
Gustatory	3.6	8.8	13.7	14.0	–	8.3	6.6
Olfactory	8.3	10.0	12.3	6.8	–	8.3	1.3
Tactile	5.0	7.5	11.0	8.1	2.9	14.6	6.6

Patients living in Pakistan reported visual hallucinations and also visualizations of spirits or ghosts statistically significantly more often compared with the two British groups. Acoustic hallucinations were significantly less frequent in the Pakistani group than in the both British groups. These findings underline the major importance of the immediate environment on the phenomenology of hallucinations compared with the influence of culture.

Significant differences in the frequencies of several kinds of hallucinations were found in our study (Table 24.4). The prevalence of visual hallucinations in developing countries was inhomogeneous. As to be expected, in every country, auditory hallucinations showed the highest prevalence. In line with the literature, visual hallucinations were most frequently reported by West African patients (Nigeria, 45.8%; Ghana, 53.9%); the rate for Pakistanis was only 3.9%. As mentioned above, the distinction 'developing' and 'developed' countries seems not to be meaningful. To explain these different rates, one has to separately scrutinize the cultural tradition and the socialization pattern of each country.

Schneider's first rank symptoms (FRS)

Critical of the theoretical complexity of Bleuler's approach to define schizophrenia, Schneider introduced the concept of 'nuclear' or first-rank' symptoms (FRS; Schneider, 1992). They include psychotic phenomena like delusional perceptions, audible thoughts, thought broadcasting, thought insertion, thought withdrawal, commenting and dialogue voices, made volition and somatic passivity. The pathognomonicity of the FRS has been challenged, while their frequency was primarily dependent on the cultural context. The frequency of the FRS in general has been found to be low in a number of non-Western countries: 56.5% in Saudi Arabia (Zarrouk, 1978), 35% in India (Radhakrishnan *et al.*, 1983), 25% in Sri Lanka (Pela, 1982), 26.7% in Malaysia (Salleh, 1992), between 31% and 43% among non-Western immigrant groups in England (Ndetei and Vadher, 1984b). On the other hand, a study from Nigeria reported 60.3% FRS (Gureje and Bamgboye, 1987).

These differences could be due to different definitions of the single symptoms and to the time under study, because the FRS are not as stable as delusional contents. However, they could also reflect true cultural differences. In the ISPS, patients with schizophrenia were asked about the 1-year prevalence of FRS.

At least one FRS across the regions was registered between 100% (Nigeria), 97.3% (Georgia), 96.3% (Poland), 90.4% (Lithuania), 90.3% (Austria), 83.5% (Pakistan), and 81.6% (Ghana).

The frequency of the single FRS varied remarkably in the sub-samples (Table 24.5). Those FRS associated with disturbances of the ego-boundaries (audible thoughts, thought broadcast, and thought insertion) most frequently occur in both West

Table 24.5. Frequency of occurrence of first-rank symptoms in schizophrenia during the last year (International Study on Psychotic Symptoms; $N = 1080$)

	Austria ($N = 350$)	Poland ($N = 80$)	Lithuania ($N = 73$)	Georgia ($N = 74$)	Pakistan ($N = 103$)	Nigeria ($N = 324$)	Ghana ($N = 76$)
Delusional perception	81.5	90.0	69.9	81.1	54.4	72.9	81.1
Audible thoughts	16.0	21.3	13.7	6.8	21.3	33.3	28.1
Thought broadcast	13.5	21.3	8.2	21.6	11.7	43.8	32.4
Thought insertion	35.0	37.5	34.2	28.4	26.2	41.7	36.2
Thought withdrawal	10.2	18.8	11.0	5.4	7.8	12.5	14.0
Commenting voices	31.4	70.0	41.1	56.8	43.7	56.3	52.8
Dialogue voices	19.6	48.8	21.9	52.2	28.2	47.9	52.8
Made volition	23.4	17.5	13.7	19.5	9.7	18.8	21.4
Somatic passivity	15.4	30.0	37.0	5.4	20.4	6.3	14.0

African countries. The acoustic first-rank hallucinations were also most common in Nigeria and in Ghana; however, they were also very often reported in Poland and in Georgia. Somatic passivity was most frequent in Poland and in Lithuania. The rates for delusional perception exceeded the numbers found in other studies to a large extent. This may be due to the fact that this phenomenon is part of the symptomatology of acute psychotic episodes and very rare in sub-acute or chronic states.

Conclusions

Schizophrenia is often considered to be the most universal and homogeneous of all major mental disorders, showing roughly the same epidemiological patterns and phenomenological features in all cultures. However, the large WHO studies and the research on psychotic symptoms in schizophrenia have shown that reality is somewhat more complicated. Culture has a major impact on prevalence and outcome of schizophrenic disorders, as well as on their occurrence and their psychopathology. Despite the fact that many facets of the way in which culture influences mental disorders are still unknown, large parts of the scientific community agree that, in the era of globalization, cultural knowledge and sensitivity are essential qualities of professionals treating foreign as well as native-born mentally ill patients.

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Disorders of ageing across cultures

Ajit Shah and Sheena MacKenzie

EDITORS' INTRODUCTION

Human beings age but the response to age, ageing and the aged is very strongly influenced by cultures. In some cultures 80-year-old males or females marrying partners younger than them barely raise an eyebrow. However, in others, once an individual has reached the age of 60, celebrations to mark the occasion include 'remarrying' their spouse. The respect offered to the aged is dictated by cultural values and social roles. The longevity of individuals varies across cultures consequent to a number of factors including genetic, physical, dietary and other environmental factors. The response to ageing is largely social and cultural, from involving the aged in familial decisions to placing them out of sight in nursing homes. With an increase in longevity, the population of elderly is also becoming larger in many cultures.

Shah and MacKenzie provide not only background information on international and some national demographic changes, but they also illustrate cultural differences in epidemiological findings and related social factors. Use of cognitive tests (developed in Western countries) in individuals from low-income countries, rural areas, different concepts of orientation in time and place in different cultures and preferential use of the Western or traditional calendar all play a role in confounding the diagnosis of conditions such as dementia. The expression of depression across different cultures and also differing vocabulary and language to express emotions and feelings influence the way in which diagnosis can be influenced. Shah and MacKenzie use examples of existing diagnostic instruments to illustrate problems of category fallacy. Prevalence rates of dementia are influenced by several cultural and social factors and the authors indicate that prevalence is lower in low-income countries, although in some settings prevalence of vascular dementia may be elevated compared with Western rates. In the UK the traditional beliefs that the South Asian elderly were being looked after at home by their families is changing because younger family members have different life styles and associated financial factors may also be important. The diagnosis of mental illness in the elderly is often problematic because of biases in diagnosis and use of screening instruments, linguistic problems and differing pathways into care. Clinicians need to be sensitive to changing demographics and also be aware of problems in reaching diagnosis.

Introduction

The elderly population in developed and developing countries is rapidly increasing. Moreover, the population of the elderly from ethnic minority groups in developing countries including the United Kingdom (UK) (Shah *et al.*, 2005a) and the United States (US) (Markson, 2003) is also increasing. Moreover, there is a paucity of epidemiological and clinical information on mental illness among the elderly from developing countries and ethnic minority groups in developed countries (Subedi *et al.*, 2004; Shah *et al.*, 2005b). Therefore, there is a strong case to critically examine issues related to mental illness in the elderly across different cultures. In this chapter, cultural issues pertaining to epidemiology, clinical presentation and diagnosis are examined. The main focus will be on depression and dementia, the two most prevalent mental disorders in old age.

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

Demography

International and some national demographic changes

The elderly population is increasing in most countries (Ogunlesi, 1989; Zhang *et al.*, 1990; Kalachie, 1991; Jorm & Henderson, 1993; Snowdon, 1993; Desjarlais *et al.*, 1995). The number of those over 65 years worldwide is predicted to increase from 50 million in 1990 to one billion in 2025 (Desjarlais *et al.*, 1995), an increase of 100%. Moreover, 72% of those aged over 60 years will be living in developing countries by 2025 (Levkoff *et al.*, 1995). In developed countries, there is a particular increase in the 'old old' (i.e. those over the age of 80 years). It is also estimated that 90 million people live outside the country of their birth (Bohning & Oishi, 1995).

Calculation from the 2001 census data for England and Wales indicated that the proportion of ethnic minority individuals over the age of 65 years has increased from 3% in 1991 to 8% (Shah *et al.*, 2005a). This contrasts with 17% of the indigenous population being over 65 years in 1991 (Office of Population Census and Survey, 1993). Closer political and economic union with Europe may also lead to increased migration of elderly people between neighbouring countries (e.g. English elderly retiring to Spain, France or Italy). In the US, the elderly population in ethnic groups, including African Americans, Hispanic, Asians and Pacific Islanders, is also predicted to increase (Mui *et al.*, 2003). The proportion of non-Caucasians in the US is predicted to increase from 10% to 20% by 2050 (Markson, 2003).

Implications of these demographic changes

The two most common mental disorders in old age are dementia and depression. The prevalence of dementia doubles every 5.1 years after the age of 60 (Jorm *et al.*, 1987; Hofman *et al.*, 1991). Thus, with the increase in the elderly population (particularly those over 80 years), the absolute number of dementia-sufferers will increase throughout the world (Ames & Flynn, 1994; Jorm & Henderson, 1993; Shah, 1992a,b). Prevalence rates of up to 15% have been reported for depression in those aged over 65 years, and this will result in a worldwide increase in the absolute number of cases of depression (Shah, 1992a,b).

Concept of multiple jeopardy

Ethnic elders with mental disorder face multiple difficulties (Rait *et al.*, 1996). The concept of age- and race-related disadvantages was originally described as double jeopardy (National Urban League, 1964; Dowd & Bengston, 1978). A model of triple jeopardy was developed by adding sexism (Palmore & Manton, 1973) and social deprivation (Norman, 1985). A model of multiple disadvantages due to ageism, racism, gender disparities, restricted access to health and welfare services, internal ethnic divisions and class struggle was subsequently developed (Boneham, 1989).

Epidemiology

There are methodological difficulties with epidemiological studies of mental disorders in the elderly in different ethnic groups, including the definitions of age and ethnicity, diagnostic issues, and paucity of validated screening and diagnostic instruments.

Age

Epidemiological studies in developed countries have mainly focused on those over the age of 60 years. Some ethnic groups, particularly from developing countries, have a shorter life span, retire early and assume the role of an elder at a younger age (Rajkumar *et al.*, 1997). Therefore, a younger age cut-off (40 to 55 years) has been used in some studies of UK ethnic groups (Barker, 1984; McCallum, 1990; Manthorpe & Hettiaratchy, 1993) and in some developing countries (Yu *et al.*, 1989; Zhang *et al.*, 1990; Ganguli *et al.*, 1995; Vas *et al.*, 2001). Similarly, old age has officially been defined to commence at the age of 50 years for indigenous Australians

(Commonwealth Department of Health, Housing and Community Service, 1991). However, there are difficulties in ascertaining the precise age in some ethnic groups (Chandra *et al.*, 1994; Rajkumar & Kumar, 1996; Rait *et al.*, 1997).

Race, culture and ethnicity

Race, culture and ethnicity are often erroneously used interchangeably. Race is a phenomenological description based on physical appearance (Bhopal, 1997). Culture refers to shared features which bind individuals together into a community. The definition and identification of ethnicity is problematic (Lloyd, 1992; McKenzie & Crowcroft, 1996; Pringle & Rothera, 1996) because it includes aspects of race and culture, and other characteristics including traditions, language, religion, upbringing, nationality and ancestral place of origin (Rait & Burns, 1997). It is also a personal expression of identity influenced by life experience and place of habitation, and is dynamic and changes over time (Senior & Bhopal, 1994). A useful working definition of ethnic minority individuals is 'those with a cultural heritage distinct from the majority population' (Manthorpe & Hettiaratchy, 1993). This definition is appropriate in countries like the UK where the indigenous population forms the majority. However, it creates difficulties in countries like Australia where the indigenous population is a minority.

Other methodological issues

There is a paucity of epidemiological studies of mental disorders among ethnic elders in a given country (and studies of indigenous populations usually exclude ethnic minority subjects who do not speak the principle language) and from developing countries. Moreover, they are fraught with difficulties listed in Table 25.1.

Table 25.1. Difficulties with epidemiological studies

Ascertainment of age	Rait *et al.*, 1997.
Illiteracy	Lindesay *et al.*, 1997a,b.
Innumeracy	Prince *et al.*, 2003
Small sample sizes	Lindesay *et al.*, 1997b; Rait *et al.*, 1997; Bhatnagar & Frank, 1997.
Inappropriate sample frames	Richards *et al.*, 1996; Richards & Brayne, 1996; McCracken *et al.*, 1997.
Low response rate	Woo et al., 1994; Bhatnagar & Frank, 1997; Lindesay *et al.*, 1997b; McCracken *et al.*, 1997.
Refusal to pariticipate	Bhatnagar & Frank, 1997.
Lack of valid tools to identify and quantify mental illness	Lindesay, 1998; Shah, 1998.
Lack of comparisons with indigenous population	Bhatnagar & Frank, 1997.
Amalgamation of heterogeneous groups of ethnic elders	Bhatnagar & Frank, 1997; McCracken *et al.*, 1997; Livingston & Sembhi, 2003.
Assumption that general practices are accurate	Bhatnagar & Frank, 1997; Lindesay *et al.*, 1997a,b; McCracken *et al.*, 1997.

Diagnostic issues

Mental disorders are difficult to recognise among ethnic elders (George & Young, 1991) and in non-Western cultures because of culture-related factors listed in Table 25.2, which complicate diagnosis. A further issue is the paucity of suitable screening and diagnostic instruments (Shah, 1998). For example, cognitive tests for dementia standardised in one ethnic group may not be appropriate for another ethnic group because they are influenced by factors listed in Table 25.3; similar factors apply to screening or diagnostic instruments for other mental disorders (Lindesay, 1998). Also, screening instruments, like the 15-item version of the Geriatric Depression Scale (GDS-15) (Sheikh & Yesavage, 1986), have sometimes been erroneously used as diagnostic instruments (Woo *et al.*, 1994; Lee *et al.*, 1993, 1994; Liu *et al.*, 1997).

Table 25.2. Cultural factors complicating diagnosis

Communication difficulties	George and Young, 1991; Shah, 1992c, 1997a,b; Livingston & Sembhi, 2003.
Taboo topics	Shah, 1992c.
Stigma attached to mental illness	Barker, 1984; Livingston *et al.*, 2002).
Bias and prejudice of clinicians	Solomon, 1992.
Institutional racism	Solomon, 1992
Unfamiliarity with symptoms of mental illness by relatives	Manthorpe and Hettiarachy, 1993
Illness being viewed as a function of old age	Redelinghuys and Shah, 1997.

Table 25.3. Factors affecting cognitive tests

Culture	Gurland *et al.*, 1992; Chandra *et al.*, 1994; Teresi *et al.*, 1995; Livingston & Sembhi, 2003; Prince *et al.*, 2003.
Education	Chandra *et al.*, 1994; Teresi *et al.*, 1995; Stewart *et al.*, 2003; Kim *et al.*, 2003a, b; Livingston & Sembhi, 2003; Prince *et al.*, 2003.
Language	McCracken *et al.*, 1997; Livingston & Sembhi, 2003; Prince *et al.*, 2003.
Literacy skills	Chandra *et al.*, 1994; Kabir and Herlitz, 2000; Livingston & Sembhi, 2003; Prince *et al.*, 2003.
Numeracy skills	Prince *et al.*, 2003.
Sensory impairments	Lindesay *et al.*, 1997b.
Unfamiliarity with test situations	Chandra *et al.*, 1994; Richards and Brayne, 1996.
Anxiety	Lindesay, 1998.

Cognitive tests

Cognitive tests using the discrepancy between age and date of birth (Bhatnagar & Frank, 1997; McCracken *et al.*, 1997) disadvantage ethnic elders born in rural areas with poor birth registration facilities, and those who have altered age and date of birth to facilitate migration (Rait *et al.*, 1997). Culture-specific questions (e.g. about royalty or politicians) are also problematic (Bhatnagar & Frank, 1997; McCracken *et al.*, 1997), although these can be modified (e.g dates of independence of the country of origin) (Chandra *et al.*, 1994; Rait *et al.*, 1997). Differing concepts of orientation in time and place in different cultures (Escobar *et al.*, 1986; Ganguli *et al.*, 1995; Lindesay *et al.*, 1997b) and preferential use of the Western or traditional calendar (Kua, 1992; Bhatnagar & Frank, 1997; Lindesay *et al.*, 1997b; Rait *et al.*, 1997) can also influence performance.

Expression of depression and other emotional symptoms

Depression and other emotional disorders may present with different clinical features in different ethnic groups (Abas, 1996; Abas *et al.*, 1996, 1998; Lindesay, 1998; Shah, 1999; Livingston & Sembhi, 2003). Emotional expression, including depression, in different cultures is influenced by several overlapping concepts including the context of disclosure, vocabulary and language of emotional expression, selective expression of emotions and definition of self (Lindesay, 1998). Gender, age, family relationship, professional status and religious background can influence the disclosure of distress (Lindesay, 1998) and some examples are illustrated. Females among African Americans and Hispanics express more depressive symptoms (Mui, 1993). Religious denomination can modify the type of depressive symptoms in old age; for example, among Dutch Calvinists depressed subjects scored highly for vegetative symptoms (Braam *et al.*, 2000). Among Koreans, attending religious activities is protective towards depression (Hahn *et al.*, 2004).

The vocabulary and language to express emotions across cultures is variable (Abas, 1996; Abas *et al.*, 1996, 1998; Lindesay, 1998; Shah, 1999; Bhugra & Mastrogianni, 2004). Equivalent vocabulary to express emotions in different languages may not be present (Lindesay, 1998). Furthermore, styles of expressing biological and physical symptoms of emotional disorders including anxiety and depression may be different in different cultures (Abas, 1996; Abas *et al.*, 1996, 1998; Lindesay, 1998). Depressed mood and feelings of sadness are prevalent in some cultures and somatic symptoms and pain in other cultures (Lindesay, 1998; Lindesay *et al.*, 1997b; Livingston *et al.*, 2002). Semi-rural Indian subcontinent origin elders may not regard depression and anxiety as mental illnesses and may perceive them as bodily illnesses with symptoms like fatigue, aches and pains, weakness, tiredness and other physical symptoms (Bhatnagar, 1997); they may consult doctors with physical symptoms or consult traditional healers like Hakims and Vaids, the latter having no boundary between physical and psychological scenarios (Bhatnagar, 1997). Somatic symptoms including sinking feelings in the stomach, attacks of hot and cold feelings, attacks of blushing, pains in the head, pains in the chest and pains in the stomach were more common among UK Gujarati elders than indigenous elders in a population-based study (Lindesay *et al.*, 1997a). The possibility of depression should be considered if Indian-sub-continent elders present with persistent low energy, bodily aches and pains, and gas in the abdomen (Bhatnagar, 1997). Among elderly depressed Cypriots in London, somatic symptoms are more prevalent than in indigenous elders (Livingston *et al.*, 2002). However, somatic symptoms should be seen in parallel with, rather than an alternative to, expression of distress (Lindesay, 1998). Older African Caribbeans in the UK rarely use the terms ‘sad’ or ‘unhappy’ to describe emotional distress (Baker *et al.*, 1995; Abas, 1996; Abas *et al.*, 1996, 1998), but they use other terms including ‘being low spirited’, ‘fed up’ and ‘weighed down’ (Abas, 1996; Abas *et al.*, 1996, 1998). Korean elders in the US express emotions of depression symbolically or physically (Pang, 1998). For example, dysphoria was expressed as a symptom somewhere between a bodily symptom and an emotional symptom as ‘melancholia has been absorbed in my body’. A recent review concluded that somatic symptoms are a common presentation of depression across the world (Bhugra & Mastrogianni, 2004), particularly in the elderly.

Lindesay (1998) divided the definition of self into an ego-centric concept in western cultures and a socio-centric concept in many non-western cultures (Lindesay, 1998). Individuals in the socio-centric model express emotional distress in terms of its impact on relationships with others (Lindesay, 1998). Elders in the Hindu tradition are expected to disengage themselves of worldly economic, social and domestic responsibility and adopt a greater spiritual role (Shah, 1988; Ganguli *et al.*, 1999), and feelings of contentment, disengagement and peacefulness are considered more desirable than feeling of excitement and enthusiasm (Ganguli *et al.*, 1999). Also reflection is considered more appropriate than novelty-seeking (Ganguli *et al.*, 1999). This may lead to false positive responses and erroneously higher scores on standard depression-measurement instruments, and has been observed during the development of Hindi and Chinese Geriatric Depression Scales (GDS) (Mui, 1996; Ganguli *et al.*, 1999). For example, on the Chinese GDS, the item on staying at home may result in a false-positive response because elderly Chinese may consider staying at home a privilege and they may perform useful duties of looking after the grandchildren (Mui, 1996). For similar reasons, the most prevalent items on the Hindi GDS including ‘diminished clarity of thinking’, ‘dropping many of the previous interests and activities’, ‘memory problems’, ‘feelings of worthlessness’, ‘boredom’ and ‘difficulty starting new projects’ may result in false-positive responses (Ganguli *et al.*, 1999). This has prompted modification of items on standard depression screening instruments. For example, in the 15-item Chinese GDS (Mui, 1996), also considered suitable for other Asian elders in the US (Mui *et al.*, 2003), items of ‘getting restless and fidgety’, ‘worry about the future’, ‘feel down hearted and blue’, ‘get upset about little things’ and ‘feel like crying have replaced items of ‘feel helpless’, ‘prefer to stay at home’, ‘wonderful to be alive’, ‘full of energy’, ‘situation hopeless’ (Mui, 1996; Mui *et al.*, 2003). The item ‘Are you hopeful about the future?’ in the Turkish version of GDS-30 (Ertan & Eker, 2000) was problematic because the concept of hope was viewed as economic and social expectation in their personal life and most subjects gave an answer in favour of depression. This item was therefore modified to a question expecting a positive response 'Are you pessimistic about the future'. The Korean version of the 30-item GDS (Jung *et al.*, 1997) was mainly developed from the original English version (Yesavage *et al.*, 1983), but items from Zung Self Rating depression Scale (Zung, 1965), Beck Depression Scale (Beck *et al.*, 1961), the Minnesota Multiphasic Personality Inventory Depression Scale (Hathaway & McKinley, 1943), and the Centre for Epidemiologic Studies Depression Rating Scale (Radloff & Teri, 1986) were added to include somatic symptoms excluded in the GDS because somatic symptoms are frequent among depressed Korean elders (Teja, 1971). The Japanese version of the 15-item GDS (Niino *et al.*, 1991) revealed that symptoms of 'not full of energy', 'felt helpless', 'memory worse than other people's' and 'preferred to stay at home' were most prevalent in Japanese post-stroke patients (Schreiner *et al.*, 2001).

Other disorders

With the exception of one Turkish study (Alici-Evicmen *et al.*, 2003) clinical features of schizophrenia and related disorders in the elderly has not been studied across different cultures. In Turkey, late-onset schizophrenia patients do not have nihilistic delusions, delusions of poverty or guilt, delusions of erotomania, thought withdrawal, thought insertion and thought broadcasting and very late-onset schizophrenia patients do not have grandiose and mystic delusions (Alici-Evcimen *et al.*, 2003).

Symptom profile across different ethnic groups for other functional mental disorders including neurotic disorders has not been critically studied.

Development and validation of new diagnostic and screening instruments

Instruments that account for the influence of factors discussed above need development. Either new instruments can be developed, or existing instruments can be adapted. In general, the second option has been widely adopted (Chandra *et al.*, 1994, 1998; Ganguli *et al.*, 1995, 1999; Hall *et al.*, 1993; Rait *et al.*, 1997), although one study developed a culturally sensitive screening instrument for emotional distress among older UK African-Caribbeans afresh (Abas, 1996; Abas *et al.*, 1996, 1998). There are two formal approaches: a Delphi panel of experts from the culture of interest or a more widespread consultation technique. The Delphi panel method can use structured or semi-structured interviews, questions or vignettes (Rait *et al.*, 1997). The consultation approach involves professionals and/or lay members working closely, sometimes focusing on separate issues initially, and later sharing them (Rait *et al.*, 1997); this approach has been successfully used in developing a depression screening instrument for African-Caribbean elders in London (Abas, 1996; Abas *et al.*, 1996, 1998). Either method should examine each item on the instrument for cultural relevance, translation, adaptation and modification with the aim of producing a culture-fair, education-free and analogous instrument (Hall *et al.*, 1993; Chandra *et al.*, 1994, 1998; Graves *et al.*, 1994; Richards & Brayne, 1996; Richards, 1997). Newly developed instruments should have comparable meaning, difficulty, familiarity and salience.

Translation and back-translation by separate groups of bilingual translators is absolutely necessary to ensure accuracy of translation (Brislin, 1970; Katzman *et al.*, 1988; Yu *et al.*, 1989; Chandra *et al.*, 1994; Lindesay *et al.*, 1997b). Bilingual translators can also ensure that the meaning and significance of the items are preserved as much as possible (Lindesay *et al.*, 1997b); this could also be achieved by the Delphi panel if the panel members originate from the same culture. Translation should ensure content, semantic, technical, criterion and conceptual equivalence with the parent version of the scale for each and every item (Flaherty *et al.*, 1988; Rait *et al.*, 1997). Several rounds of field pre-testing (Chandra *et al.*, 1994; Ganguli *et al.*, 1995) followed by pilot testing to determine the distribution of scores (Chandra *et al.*, 1994; Ganguli *et al.*, 1996; Rait *et al.*, 2000a,b; Stewart *et al.*, 2001, 2002) and their ability to discriminate between mental disorders of different severity (Chandra *et al.*, 1994; Lindesay *et al.*, 1997b) are essential. Newly developed instruments should have their psychometric properties rigorously evaluated and they should be similar to the parent version (Shah & Lindesay, 2000).

Validation against a gold-standard diagnosis of the specific mental disorder is needed where the newly developed instrument is to be used for screening or diagnostic purposes (Shah & Lindesay, 2000; Livingston & Sembhi, 2003). Standardised clinical interview can be used as the gold standard, although the diagnostic accuracy of the 'gold-standard' measure is often difficult to evaluate. One useful method of validating such instruments for dementia is by serial follow-up of dementia cases, whereupon true dementia cases are likely to demonstrate continuing cognitive decline (Shah *et al.*, 1998). Presence of functional impairment is a necessary pre-requisite for the diagnosis of dementia in ICD-10 and DSM-IV. This is problematic because of major conceptual difficulties in the definition and measurement of functional impairment across different cultures (Chandra *et al.*, 1994; Pollit, 1996; Richards & Brayne, 1996). Translated versions of the Geriatric Mental State Examination (GMS) (Copeland *et al.*, 1976) have been used among older Asians, Chinese, Somali, Afro-Caribbean and British blacks in Liverpool (Blakemore & Boneham, 1994; McCracken *et al.*, 1997), Indian subcontinent elders in Bradford (Bhatnagar & Frank, 1997), Chinese in Taiwan (Tsang *et al.*, 2002), and among respondents from India, China and southeast Asia, Africa, Latin America and the Caribbean (Prince *et al.*, 2003). Information from the CAMDEX interview and the Consortium to Establish a Registry for Alzheimer's Disease (CERAD) interview (Morris *et al.*, 1989) have been used by a panel of physicians to make consensus DSM-III-R diagnosis of dementia among Cree Indians and English-speaking Canadians (Hall *et al.*, 1993).

Available diagnostic and screening instruments for dementia

As illustrated in Table 25.4, the Mini Mental State Examination (MMSE) (Folstein *et al.*, 1975) has been developed in several different languages. However, comparisons between these different versions are problematic, as not all studies have followed a rigorous procedure for the development of screening instruments, and/or evaluated the psychometric properties adequately.

A number of other cognitive screening tests for dementia have been developed for use in different cultures. The abbreviated Mental Test Score (Quereshi & Hodkinson, 1974) has been developed in several Asian languages for use among Gujaratis and Pakistanis and in English for use among African Caribbeans in the UK (Rait *et al.*, 1997; Rait *et al.*, 2000a,b). The Alzheimer's Disease Assessment Scale (Rosen *et al.*, 1984) has been developed in Korean (Youn *et al.*, 2002). The MMSE, selected items from the CERAD neuropsychological test

Table 25.4. MMSE in different languages

Language	Reference
Chinese	Serby *et al.*, 1987; Katzmann *et al.*, 1988; Salmon *et al.*, 1989; Yu *et al.*, 1989; Xu *et al.*, 2003.
Korean	Park & Kwon, 1990; Park *et al.*, 1991.
Finnish	Salmon *et al.*, 1989.
Italian	Rocca *et al.*, 1990.
Yoruba (Nigeria)	Hendrie, 1992.
Spanish	Escobar *et al.*, 1986; Anzola-Perez *et al.*, 1996.
Thai	Phanthumchida *et al.*, 1991.
Cree (Canadian Indians)	Hall *et al.*, 1993
Hindi	Ganguli *et al.*, 1995; Rait *et al.*, 2000a.
Punjabi	Rait *et al.*, 2000a.
Urdu	Rait *et al.*, 2000a.
Bengali	Rait *et al.*, 2000a.
Bangla	Kabir and Herlitz, 2000.
Malyalum	Shaji *et al.*, 1996.
Gujarati	Lindesay *et al.*, 1997b; Rait *et al.*, 2000a.
Sinhalese	de Silva and Gunatilake, 2002.

battery (Morris *et al.*, 1989) and the CAMCOG component of the CAMDEX interview (Roth *et al.*, 1986) have been evaluated in older African-Caribbean people (Richards & Brayne, 1996; Richards *et al.*, 2000). Orientation items of the MMSE, selected items of the CERAD battery and the clock drawing test have been evaluated in African-Caribbean elders and normative data is available (Stewart *et al.*, 2001). An approach involving the use of three instruments (the GMS, the CIS-D and the ten-word list-learning task from the CERAD battery appropriately translated into native languages) and an algorithm derived from these instruments has been shown to have high specificity and sensitivity in the diagnosis of dementia in culturally diverse populations from India, China and southeast Asia, Africa, Latin America and the Caribbean (Prince *et al.*, 2003). The Alzheimer's Disease Risk Questionnaire (Brietner & Folstein, 1984), which obtains information on history of cognitive impairment among first-degree relatives, has been translated into Chinese and Spanish, and has been administered by bilingual workers (Silverman *et al.*, 1992). The Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) (Jorm *et al.*, 1991) has been developed for use in illiterate Chinese populations (Fuh *et al.*, 1995). The Community Screening Interview for Dementia (CSI-D), with a cognitive test for the subject and an informant history, has been developed for use among Cree Indians in Canada (Hall *et al.*, 1993, 2000), English speaking Canadians (Hall *et al.*, 1993, 2000; Hendrie *et al.*, 1993) and Yoruba Nigerians in Ibadan (Hendrie *et al.*, 1995; Hall *et al.*, 2000), African-Americans in Indianapolis (Hall *et al.*, 2000), Jamaicans (Hall *et al.*, 2000) and in study populations in India, China and southeast Asia, Africa, Latin America and the Caribbean (Prince *et al.*, 2003). The Chula Mental Test, developed for elderly Thais by selecting and adapting items from several existing screening tests, has been shown to reduce the influence of illiteracy on scores (Jitapunkul *et al.*, 1996). A six-item Rowlands Universal Dementia Assesment Scale has been successfully evaluated for use among several ethnic groups in Australia (Storey *et al.*, 2004).

Available screening and diagnostic instruments for depression

As illustrated in Table 25.5, the 30-item GDS (GDS-30) (Yesavage *et al.*, 1983) and the 15-item GDS (GDS-15) (Sheikh & Yesavage, 1986) have been evaluated in a number of languages and ethnic groups. However, comparisons between these different versions is problematic, as not all studies have followed a rigorous procedure for development of the GDS, and/or evaluated the psychometric properties adequately. Because a considerable number of elderly Chinese in Hong Kong are illiterate a standardised version of the Chinese version of 15-item GDS was developed and this version was

Table 25.5. Geriatric Depression Scale in different languages and ethnic groups

Language and ethnic group	Reference
GDS-30:	
Korean	Jung *et al.*, 1997
Turkish	Ertan and Eker, 2000
Hong Kong Chinese	Chan *et al.*, 1996
Singapore Chinese	Lim *et al.*, 2000
Nigeria	Sokoya and Bayewu, 2003
Hindi	Ganguli *et al.*, 1999
Spanish in Spain	Izal and Montorio, 1993
Mexican American in Spanish	Espino *et al.*, 1996
GDS-15:	
UK African Caribbeans	Rait *et al.*, 1999 Abas *et al.*, 1996, 1998
Hong Kong Chinese	Lee *et al.*, 1993, 1994 Kam and Chui, 1998
Japanese	Niino *et al.*, 1991
Chinese, Japanese, Indian, Korean and Filipino migrants to US	Mui *et al.*, 2003
Israel heterogenous ethnic groups	Cwikel and Ritchie, 1988
African Americans	Baker *et al.*, 1993
Mexican Americans in Spanish	Baker *et al.*, 1993
American Indians	Ferraro, 1997

found to be better than the directly translated versions of 15-item GDS (Wong *et al.*, 2002). The 15-item GDS, Even Briefer Assessment Scale for depression (Allen *et al.*, 1994) and a single question (Do you often feel sad or depressed?) were successfully evaluated among elderly Singaporean Chinese (Lim *et al.*, 2000). Three depression screening instruments including the 15-item GDS, Brief Assessment Schedule Cards (Adshead *et al.*, 1992) and Caribbean Culture Specific Screen (Abas *et al.*, 1998) for UK African Caribbean elders were successfully evaluated against a 'gold-standard' diagnosis of depression on the GMS (Rait *et al.*, 1999). All three instruments showed satisfactory sensitivity and specificity in detecting depression in older Jamaicans with little difference between the three scales. The CCSS was developed 'a priori' by ascertaining terminology used to describe emotional distress using various techniques described earlier (Abas *et al.*, 1996). In general, lower cut-off scores have been suggested on some scales like the GDS for African-Caribbeans in the UK (Abas *et al.*, 1998). GDS-30 and GDS-15 have been used to measure depressive symptoms (Tsai *et al.*, 2005), screen for depression (Tsai *et al.*, 2005) and erroneously to diagnose depression (Lee *et al.*, 1993, 1994; Woo *et al.*, 1994; Liu *et al.*, 1997).

The Zung self-rating depression scale (Zung, 1965) has been developed and used to identify depressive symptoms in a rural Japanese population (Ambo *et al.*, 2001). Symptoms of Anxiety and Depression Scale (Bedford *et al.*, 1976) was developed in Gujarati, Somali and Bengali and was used to measure the prevalence of depression in convenience samples of elderly Gujarati (Ebrahim *et al.*, 1991), Somali (Silveira & Ebrahim, 1995) and Bengali (Silveria & Ebrahim, 1995) in London. The Short Care Interview (Gurland *et al.*, 1984) has been developed and used to evaluate depression in UK elders born in Cyprus, Africa and the Caribbean (Livingstone *et al.*, 2002). A Nigerian version of the the Self-reporting Questionnaire has been developed (Abiodun, 1989).

ICD-10 (WHO, 1992) diagnosis (unclear if clinical or research version) of depression has been used among Nigerians (Sokoya & Baiyewu, 2003; Uwake, 2000a,b). DSM-III-R (American Psychiatric Association, 1987) diagnosis of depression have been used among elders in India (Jhinghan *et al.*, 2001) and Hong Kong (Liu *et al.*, 1997). The GMS has been developed and used to diagnose depression in the following elderly groups: UK Asians in Hindi (Bhatnagar & Frank, 1997); United Arab Emirates in Arabic (Ghubash *et al.*, 2004); Chinese (Chen *et al.*, 2004); Korean (Kim *et al.*, 2004); and Nigerian (Sokoya & Baiyewu, 2003; Uwake, 2000a,b). The concordance between the GMS and clinical diagnosis was high in the Hindi and Chinese versions (Bhatnagar & Frank, 1997; Chen *et al.*, 2004); the same was the case with the Nigerian GMS and ICD-10 diagnosis of depression (Sokoya & Baiyewu, 2003).

Prevalence of mental disorders around the world

Prevalence rates for dementia are influenced by several factors (Suh & Shah, 2001). The overall incidence (and, therefore, the overall prevalence) of dementia will be low in societies where the life expectancy is short because fewer subjects will reach the age of risk. In general, socio-economically less developed societies have shorter life expectancies than more developed societies. The selective survival of those not at risk of dementia may further compound such a trend. It is possible that early mortality selects for genetic and constitutional factors that protect against neurodegenerative disorders. Mortality and survival after the onset of dementia also influences prevalence rates. In societies where survival after the onset of dementia is short, the prevalence will be low even if the incidence is not. Consequently, lower prevalence in some countries may be due to reduced life expectancy, shorter survival after onset, or reduced age-specific incidence.

A recent review of prevalence studies of dementia in African and Asian countries including Nigeria, South Africa, India, Sri Lanka, Israel, Singapore, China, Hong Kong, Taiwan, Korea and Japan reported prevalence rates in the range 0%–13.2%

(median 4%) (Shah *et al.*, 2005b). In general, the prevalence rates were lower than in western countries. However, there were notable exceptions including South Africa (Ben Arie *et al.*, 1983), Singapore (Lim *et al.*, 2003), Korea (Park *et al.*, 1994; Woo *et al.*, 1998; Kim *et al.*, 2003a) and Japan (Yamada *et al.*, 1999), where the prevalence rates were similar to Western countries. Almost universally, the prevalence of dementia increased with age, and generally it was higher in women. This is consistent with integrated analysis of the world literature indicating that the prevalence of dementia doubles every 5.1 years after the age of 60 years (Jorm *et al.*, 1987; Hofman *et al.*, 1991). The prevalence of Alzheimer's disease is generally lower and the prevalence of vascular dementia is generally higher in Asian countries than in Western countries (Hasegawa *et al.*, 1986; Shibayama *et al.*, 1986; Li *et al.*, 1989).

There is a paucity of prevalence studies of depression from developing countries. Prevalence rates for depression in the elderly in the UK (Shah, 1992a), US (Blazer & Williams, 1980; Gurland *et al.*, 1983; Weismann *et al.*, 1988), Australia (Kay *et al.*, 1985; Henderson *et al.*, 1993) and Finland (Kivela *et al.*, 1988) of up to 15%, 15.5%, 16% and 26%, respectively, have been reported. A study of Singapore Chinese reported a prevalence rate of 5.7% for depression (Kua, 1992).

Prevalence of mental disorders among ethnic elders in the UK and other countries

The prevalence of dementia among elders from different ethnic groups in the UK is generally similar to that amongst indigenous elders (Bhatnagar & Frank, 1997; Lindesay *et al.*, 1997b; McCracken *et al.*, 1997). The prevalence of depression amongst ethnic elders, in general, was similar to that amongst indigenous elders.

A population-based study from Bradford, using the Hindi version of the GMS administered to Indian sub-continent elders, reported a prevalence rate of 7% for dementia (Bhatnagar & Frank, 1997). However, using a clinician's diagnosis of dementia, the prevalence was only 4%, and there was poor agreement between the diagnoses by these two methods. The same study reported a prevalence of 20% for depression and 2% for anxiety neurosis; the concordance for depression with clinical diagnosis was high, but poor for neurosis.

A two-stage population-based study from Leicester, using a Gujarati MMSE administered by trained personnel in Gujarati, and a clinical interview and an *ad hoc* translated version of the CAMDEX and the SCAN interviews administered by a Gujarati-speaking psychiatrist, found prevalence rates of 0% and 20% in the 65–74 and 75+ years age groups respectively (Lindesay *et al.*, 1997b). This study included a comparison group of indigenous elders and the prevalence of dementia was higher in the Gujaratis, although this was not statistically significant. The stability of the diagnosis of dementia was confirmed at 27-month follow-up by another Gujarati-speaking psychiatrist using similar diagnostic techniques (Shah *et al.*, 1998). This study reported prevalence rates of 22%, 1% and 4% for agoraphobia, simple phobia and panic attacks (Lindesay *et al.*, 1997a); simple phobias were less prevalent in the ethnic minority group. Although the prevalence of depression was not measured, depression scores were not different between the Gujaratis and indigenous elders.

A population-based study from Liverpool of African, Caribbean, Asian, Chinese and Middle Eastern elders used the GMS either in English or an *ad hoc* translation during interview (McCracken *et al.*, 1997). The prevalence of dementia in English-speaking individuals of black African, black Caribbean, black other, Chinese and Asian origin were 8%, 8%, 2%, 5% and 9%, respectively, similar to the 3% found in the indigenous population. Prevalence in the black African and Chinese who did not speak English was 27% and 21%, respectively. These higher prevalence figures among non-English speakers may be an artefact of communication and translation difficulties. The prevalence of depression amongst black African, black Caribbean, Chinese and Asian groups was 19%, 16%, 13% and 15%, respectively (McCraken *et al.*, 1997) and these figures are comparable to indigenous elders (Shah, 1992a). Lack of social contact was thought to be an important risk factors for developing depression (McCraken *et al.*, 1997).

A population-based study in Islington used the Short-CARE (Gurland *et al.*, 1984) in those born in the UK, Ireland, Cyprus, Africa and the Caribbean (Livingston *et al.*, 2001). The prevalence of dementia on those born in the UK, Ireland, Cyprus, and Africa and the Caribbean was 10%, 3.6%, 11.3% and 17%, respectively. Logistic regression analysis revealed that living in a residential home, age, being African or Caribbean and years of education were the only significant predictors of dementia. The prevalence of depression in those born in the UK, Ireland, Cyprus, and Africa and the Caribbean was 18%, 16.5%, 28% and 14%, respectively. Logistic regression analysis revealed that needing help with functional activities, being female and subjective ill health were significant predictors of depression.

US studies have reported higher prevalence of dementia among African Americans (Still *et al.*, 1990; Heyman *et al.*, 1991; Gurland *et al.*, 1995, 1999; Perkins *et al.*, 1997) and Hispanics (Perkins *et al.*, 1997; Gurland *et al.*, 1995, 1999). A higher prevalence of vascular dementia among African Americans may be assocaited with a higher prevalence of strokes and hypertension in this group (Heyman *et al.*, 1991; Perkins *et al.*, 1997).

Turkish and Moroccan immigrants over the age of 55 years in Holland had a prevalence of 34% and 62%, respectively, compared to Dutch (Van der Wurff *et al.*, 2004). Lower income and physical illness were predictors for depression.

Although there are no population-based studies of late onset schizophrenia, one study reported an increased rate of new contacts with services among African-Caribbeans (Reeves *et al.*, 2001). The incident contact rate for African-Caribbean men and women was 172 and 323 per 100 000 population, respectively.

Other epidemiological issues

Behavioural and psychological symptoms of dementia (BPSD) (i.e. non-cognitive symptoms) including disorders of behaviour, mood, thought content and perception (Foli & Shah, 2000) has been poorly studied in developing countries and among ethnic minority groups in a given country (Shah & Dighe-Deo, 1998; Jitapunkul *et al.*, 1996). Data on BPSD among different ethnic groups are emerging (Shah & Mukherjee, 2000; Shah *et al.*, 2005c), but due to the paucity of data, it is beyond the scope of this chapter to further discuss them.

The concept of pathways to care

Although this approach is based on a UK model (Goldberg & Huxley, 1991), the general principles can be applied to other countries, and the discussion will be supported from international literature. General practitioners (GPs) in the UK, are traditionally the first port of call for patients requiring medical attention and they act as gatekeepers for accessing secondary services. UK ethnic elders and their carers are aware of services provided by GPs (Bhalia & Blakemore, 1981; Barker, 1984; McCallum, 1990) and they have high general practice consultation rates (Donaldson, 1986; Balarajan *et al.*, 1989; Gillam *et al.*, 1989; Lindesay *et al.*, 1997a; Livingston *et al.*, 2002); for example, 70% of Gujaratis in Leicester had consulted their GP in the preceding month (Lindesay *et al.*, 1997a). However, in general, there is a low prevalence of ethnic elders in contact with psychogeriatric services (Blakemore & Boneham, 1994; Lindesay *et al.*, 1997a; Rait & Burns, 1997; Jagger, 1998; Shah & Dighe-Deo, 1998). This has also been reported in Australia for elders of non-European backgrounds (Hassett & George, 2002). Several possible reasons for this discrepancy, as listed in Table 25.6, are systematically examined below using the Goldberg and Huxley (1991) model of pathways into care.

The effect of patient and family factors on primary care consultations in the UK

Patients and family members may not recognise symptoms of mental disorder and dismiss them

Table 25.6. Possible reasons for discrepancy in high general-practice consultation rates but low service prevalence of UK ethnic elders

The prevalence of dementia may be low in those who consult GPs.
Dementia may be less severe and unrecognised.
Dementia may lack BPSD (or BPSD may be modified), which often leads to clinical presentation.
Patient-related factors may influence primary care consultations.
Family-related factors may influence primary care consultations.
GP-related factors may influence primary care consultations.
Secondary care services may lack ethnic sensitivity.

Table 25.7. Reasons for extended family not looking after ethnic elders

Younger family members lead a culturally different life style (Shah & Lindesay, 2000).
Younger family members work long hours and are busy (Barker, 1984).
Younger family members may have lived in the UK longer than their elders (Barker, 1984).
Ethnic elders may have migrated to join younger family members contrary to their wishes (Silveira & Ebrahim, 1995).
There may be family tensions (Boneham, 1989; Silveira & Ebrahim, 1995).
There may be financial hardship.

as a function of old age. Ethnic elders including African Americans, Asian and Latinos in the United States have less knowledge about Alzheimer's disease (Ayalon & Arean, 2004). Younger family members may be unfamiliar with symptoms of dementia and other mental disorders because traditionally very few ethnic elders reach old age (Manthorpe & Hettiaratchy, 1993; Rait & Burns, 1997). All these difficulties may be exaggerated if the patients are unable to communicate their symptoms due to absence of appropriate vocabulary or other language barriers (Shah, 1992c, 1997a,b, 1999; George & Young, 1991). Moreover, family members and patients may believe that little can be done, be unaware of existing services or application procedures (Bhalia & Blakemore, 1981; Barker, 1984; Age Concern/Help the Aged Housing Trust (ACHAHT), 1984; McCallum, 1990; Lindesay *et al.*, 1997a), feel existing services are inadequate, inaccessible and culturally insensitive (Hopkins & Bahl, 1993; Lindesay *et al.*, 1997a), have had previous poor experience of services (Lindesay *et al.*, 1997a), fear the stigma attached to mental illness (Barker, 1984; Manthorpe & Hettiarachy, 1993; Livingston *et al.*, 2002), and may choose to consult a traditional healer (Bhatnagar, 1997). The traditional belief that ethnic elders do not access psychogeriatric and social services and are looked after by the extended family (Barker, 1984; Boneham, 1989; Manthorpe & Hettiarachy, 1993) is changing and the reasons for this are listed in Table 25.7.

The clinical presentation of ethnic elders is influenced by their complex longitudinal personal histories. For example, migration may have been enforced (e.g. due to trauma and hardship) or elective (e.g. to join the family). First-generation migrants may find it more difficult to assimilate with the host culture than subsequent generations, and they may also have greater problems adjusting to the new culture. This may lead to family conflicts and exposure to racist attitudes. Hindu grandmothers in the UK were better adjusted in extended family settings than in nuclear family settings, and they were better adjusted if they had granddaughters who had exclusively 'Indian' or 'Hindu' ethnic identity (Guglani *et al.*, 2000).

The effect of GP factors on consultations

There are several reasons, as illustrated in Table 25.8, why mental disorders may not be identified during a routine GP consultation. These difficulties are also complicated by language and communication difficulties, the age and gender of the assessor, the context and setting of the assessment, attitude and expectations of patients and their families, and status of the patient in the family

Table 25.8. Reasons mental illness not recognised in general practice

1. The prevalence of mental illness among ethnic elders consulting their GPs may be low.
2. If the prevalence is similar or higher in ethnic elders consulting their GP than in the community, the severity of the illness may be lower.
3. BPSD, which often lead to clinical presentations, may be less frequent or different than those in indigenous patients.
4. Data on clinical presentation, diagnostic features and natural history of mental illness among ethnic elders are sparse.
5. GPs may lack the diagnostic skills in ethnic elders.
6. Because ethnic elders with mental illness are seen infrequently, GPs may lack experience in these groups; even psychiatrists experience this difficulty.
7. Paucity of screening and diagnostic instruments.
8. Bias, prejudice and experience of clinicians.

and the community (Lindesay, 1998). A careful informant history and assurance of confidentiality can reduce these difficulties (Lindesay, 1998). Diagnostic difficulties may lead to a lower rate of referral to secondary-care services and this has been demonstrated in younger mentally-ill primary-care attenders of Indian sub-continent origin (Odell *et al.*, 1997; Jacob *et al.*, 1998). Also, African Caribbean patient with first episode of psychosis, were less likely to be referred by their GP and more likely to be referred by the criminal-justice system to secondary care (Morgan *et al.*, 2005).

History from informants can provide valuable information (Shah *et al.*, 1998; Shah, 1999). However, family members may withhold information if they feel it will present a negative view of the patient or fear that they will be accused of failing to honour their moral obligations (Shah, 1997a,b; Shah, 1999).

If mental disorder is identified, it may not be treated because the GP feels that nothing more can be done, believes that ethnically sensitive health and social services are not available, has experienced poor response to previous referrals or is unaware of the procedure to access these services. If dementia is less severe and lacks troublesome non-cognitive features, then the GP may consider referral to secondary care unnecessary. Where the GP is from the same ethnic background as the patient, the GP may feel that he/she can communicate better with the patient. Although the GP may wish to refer patients to secondary care services, the patient and/or family members may be reluctant for reasons similar to their reluctance to consult GPs in the first place as described earlier.

Assessing patients

The usual clinical principle of history taking, mental-state examination, physical examination and special investigations in this strict order should be meticulously followed. This should always be supplemented by a careful and detailed collateral history from other informants such as relatives. Good communication between the patient and the clinician is essential (Bhalia & Blakemore, 1981; ACHAHT, 1984; Shah, 1992c; Jones & Gill, 1998; Shah, 1999) because many ethnic elders do not speak English (Barker, 1984; Manthorpe & Hettiarchy, 1993; Lindesay *et al.*, 1997a). Ideally, the clinician assessing the patient should belong to the same culture as the patient, but this may not always be possible. An alternative is the use of bilingual health workers, but they are uncommon (Phelan & Parkman, 1995). Translation services, therefore, may be needed (Shah, 1997a,b; Phelan & Parkman, 1994). Relatives, non-clinical staff, clinical staff and professional translators (with and without special training in mental health) can be used (Phelan & Parkman, 1995; Shah, 1997a,b). Ideally, professional translators in person should be used. The inherent difficulties and limitations in using translators (Marcos, 1979; Kline *et al.*, 1980; Shah, 1997a,b) are well described. It may be worthwhile conducting a literature search to ascertain information from the literature on clinical features and clinical presentation when the clinician is unfamiliar with the culture as there may be relevant information in the literature.

Some basic rules that should be followed during the assessment include: correction of any sensory deficits; explanation of the nature, purpose and duration of the assessment; use of explicit, clear and simple instructions; use of a calm, reassuring and patient approach; and reassurance of confidentiality (Lindesay, 1998). Audiotapes, videos and diagrammatic representation with cartoons giving information on management and service-related issues can also be helpful for illiterate patients and carers (Lindesay *et al.*, 1997a). Educational videos on dementia have been developed internationally by Alzheimer's Disease International, nationally by the Policy Research Institute into Ageing and Ethnicity, and locally by Alzheimer's Concern Ealing.

Conclusions

There is a paucity of studies of clinical features and presentation of mental illness in ethnic elders in a given country and in many other cultures, but studies are emerging. There is an urgent need to conduct studies on clinical populations and population-based epidemiological studies to ascertain the clinical features and clinical presentation of mental illness in old age in ethnic minority groups in a given country and in many developing countries. Again, there is evidence that such studies are beginning to emerge.

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PART IV

Theoretical aspects of management

Traumascape: an ecological–cultural–historical model for extreme stress

Joop T. V. M. de Jong

EDITORS' INTRODUCTION

The relationship between social factors and mental well-being of individuals is well described. The individual responses to social stressors in the environment can influence outcome and the coping strategies. In addition, the social factors such as geographical distance may prevent individuals and their carers from seeking help. It is possible that the shape of distress changes as the social conditions change and mould individual's distress. The relationships between environment and the individuals are most starkly seen in post-disaster situations, whether the disasters are man-made or natural. Coping strategies in disaster settings include basic survival needs along with psychological trauma.

De Jong in this chapter builds on the concept of traumascape, described as a landscape marked by the need for people to build memorials at sites where massive deaths have happened. The characteristics of these traumascapes are the systemic dynamics of local and international representations and actions around extreme stress. In post-disaster situations, irrespective of the causation, the stakeholders have divergent perceptions, which produce interventions, which are not necessarily related to needs and concerns of the local communities or scientific evidence-based proven professional interventions. De Jong develops an ecological–cultural–historical model for extreme stress in which person is presented as part of a hierarchy of levels of organization. Historically, collective and individual dimensions can be understood. Ecologically, corresponding historical, economic and political processes are identified. There is no doubt that historical factors influence culture. The relationship between the individual on the one hand and ecological factors on the other is significantly influenced by role expectations. De Jong illustrates these interactions by using grief as an example. Grief is universal, but dealing with it varies across cultures and type of cultures. In low-income countries rituals may be important, whereas in high-income countries the individuals demand grief counselling, trauma counselling or terminal care. Each era and culture uses different ways of coping after loss, be it major or minor. In addition, the role of using traumascape in managing vulnerability and resilience of individuals is of significance in managing such individuals.

Introduction

The social theorist Appadurai (1996) uses the suffix 'scape' – for example, in technoscape, mediascape, ethnoscape – as a framework for examining the 'new global cultural economy as a complex, overlapping, disjunctive order that cannot any longer be understood in terms of existing centre-periphery models'. The historian Tumarkin (2005) uses the word 'traumascape' for a landscape marked by the need of people to build memorials at sites where massive deaths happened. She regards traumascapes not simply as locations of tragedies and trauma, but also as mediators between the living and the dead. My concept of traumascape has a wider bearing and I propose to use the term to mean the systemic dynamics of local and international representations and actions around extreme stress. Different ecological levels can interact and produce specific traumascapes. The characteristics of these traumascapes are time bound and can be located on a globalizing vs. localizing continuum. In our current world the conceptualization of distress and

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traumatic stress and the social and power relations related to the cultural construction of these concepts are in constant flux and prone to cybernetic looping. For example, a cascade of events – determined by the media, the role of UN/NGO/government/local stakeholders, funders and health professionals – will often determine the focus, the size and the nature of assistance for a group of survivors of a natural or human-made disaster. Media hypes often followed by geopolitical and voter-dependent considerations may determine whether terrorism, human rights, child rights, quality of governance, gender-based violence (GBV) or child soldiers are the main concern of the international community, and, subsequently, whether funds will go to a specific region or a specific type of disaster, often to the detriment of other catastrophes. For example, currently dozens of mini-gender-based violence projects are set up in the African Great Lakes region, especially in east Congo, making lists of rape survivors at the village level. These projects are donor driven, lack a view on more general psychosocial programming, and focus on gender-based violence (GBV) to the detriment of other problems such as GBV-related consequences in terms of HIV. International views may influence a local traumascape: after the Tsunami, several areas in Asia were invaded by psychosocial programmes – deflecting funds from areas such as Darfur or other parts of Sudan – raising the status of even daily trivialities and hassles to a 'traumatic event'. Another example: after the genocide in Rwanda the international community for the first time in history showed interest in mental health, creating a local traumascape that resulted in a massive influx of NGOs and the invention of a local word for trauma, *guhahamuka*. Or an example of the dynamics of a traumascape in the West: due to cybernetic looping, a refugee requesting asylum in a high-income country may get quickly conditioned to mould distress into symptoms of PTSD, since immigration officers and mental-health professionals may follow the list of DSM or ICD criteria during subsequent interviews.

In a post-war or post-disaster situation, stakeholders have divergent perceptions of the traumascape, eliciting interventions that may be scarcely related to the needs and concerns of the local communities or to scientific evidence-based professional considerations. For example, a local UN office or the military may think that an epidemiological sensible target figure of PTSD or psychosis has to be treated per time unit, as would happen in a communicable disease such as tuberculosis. Christian or Islamic groups may propose daily prayer to solve the problem, even when the local population complains about spirits that remain unharmed by the prayers of foreigners. An NGO may feel that a 3-day training of local professionals will train suitable psychosocial counsellors. Other proponents may cherish the view that talking is a Judeo-Christian invention that does not help (Summerfield, 2000; Tricket, 1995) and should be replaced by concentrating on work, play, theatre or music-making. The stereotype that talking is a Judeo-Christian invention – which one may regard as a post-colonial guise of stating that non-Westerners are psychologically less sophisticated – is often supported by another stereotype or 'cognitive scheme', i.e. that non-Westerners somatize rather than psychologize their distress, even though there is a substantial body of evidence supporting the view that somatizing is universal (Üstün & Sartorius, 1995) and that cultures distinguish themselves in certain preferred patterns of somatization (Kirmayer *et al.*, 2004; De Jong, 2004). These two cognitive schemata have added a third one: the notion that it is impossible to do anything substantial or meaningful regarding massive traumatic stress. This amazing view has resulted in an avoidance of the issue of psychological suffering and its consequences, which in turn has contributed to a 'conspiracy of silence'. There appears to be a degree of universal ambiguity that surrounds the expression of distress when dealing with a traumatic past. People are ambivalent about what they bring forward in their daily discourse and what they actually do or appreciate when it comes to coping with extreme stress. In our experience people feel relieved after verbally expressing distress when interventions are culturally congruent. They may not want to embarrass their fellow survivors by expressing their haunting past, and yet find enormous relief in sharing their memories with others, whether through a *palaver* under the village tree, a self-help group, an individual or family session, or another form of ritualized healing. Understanding these and other factors that result in local traumascapes, and their interaction with other ecological levels including the writings of authors such as myself, will enable us to determine appropriate coping strategies that satisfy universal human necessities while taking the specific sociocultural context into account.

Psychiatrists, psychologists, psychiatric nurses and other mental-health professionals have to bear in mind that debates such as the one about the importance of treating PTSD vs. the relevance of dealing with all kinds of psychosocial, mental or material predicaments, are often dominated by these (inter)national dynamics of the traumascape.

An ecological–cultural–historical model for extreme stress

Within the dynamic framework of the traumascape, this chapter presents a model for understanding and studying the interaction between extreme stress, the individual, social ecology, history and culture. The model has three objectives. The first is to provide an interdisciplinary framework for scholars to study the under-researched domain of the complex interaction between trauma, culture and history. The second objective is to develop policies and practices within a culturally and historically informed public health framework. War and terror – like 'the war on terror' – and disasters often do not recognize national boundaries and are push factors that drive migration and thus create multiracial societies. Therefore, the third objective is to invite professionals to become competent in crossing cultural borders.

The ecological–cultural–historical model for extreme stress presents the person as part of a hierarchy of levels of organization. The person is first presented as an organism composed of inter-related parts of the central nervous system and the body, then on to the level of the family and, finally, the community and society (Fig. 26.1). From a wider ecological perspective, the person is enveloped and interacts with corresponding historical, political and economic processes. Within the historical processes, one can distinguish a *collective* and an *individual* dimension. These two dimensions have a time perspective and interact with each other. The person is embedded in a cultural context as well. The cultural context similarly has a *collective* and an *individual* dimension interacting with each other. The *collective* dimension of culture represents schemes that guide the meaning of such processes as suffering, healing and reconciliation. The *individual* dimension represents cultural influences on traumatic stressors and their appraisal, their modification by protective and vulnerability factors, and their individual expression in suffering, distress, psychopathology, post-traumatic growth and its concomitants of disability, functioning, quality of life and well-being. History and culture are intertwined. In the past both disciplines have evoked debates about the extent in which they should be regarded as separate (Kuper, 1999). The capriciousness of history in the course of extreme stressful events such as wars or disasters warrants a separate discussion. Both collective and individual history challenge culture to an extent that it has to adapt its collective and individual survival strategies and coping styles. This chapter first describes the *individual* aspects of history and culture, followed by a description of the *collective* dimensions.

Ecology and history

Individual

The life history of an individual is embedded in the traumascape of a collective history in a specific era. Both individual and collective histories add a time component to the model outlined in this chapter. Individual and collective histories have a reciprocal relation, as the debate about the nature and origins of PTSD shows. Shay (1991) suggested that elements of the post-traumatic stress disorder could be identified in Homer's *Iliad*. Ben-Ezra (2003) asserts that the symptoms of nightmares, sleep disturbances and increased anxiety have not changed in 4000 years. The symptoms reported in a family trapped in the Bergemoletto avalanche have been quoted as evidence for the disorder's existence in the mid-eighteenth century (Parry-Jones & Parry-Jones, 1994). Dean (1997) identified symptoms of PTSD in the accounts of veterans of the American Civil War. Trimble (1985) concluded that 'this relatively common human problem has been known for many hundreds of years, although under different names'. Young (1995), however, argued that PTSD is a culture-derived diagnosis that only existed in the late 20th century '... glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated and represented and by the various interests, institutions, and moral arguments that mobilised these efforts and resources'. Jones *et al.* (2003) in their study of UK servicemen who had fought in wars from 1854 onwards support the hypothesis that some of the characteristics of PTSD, such as intrusion and avoidance, are culture-bound and that earlier conflicts showed a greater emphasis on somatic symptoms. One may conclude that – as in many other psychiatric syndromes – the symptoms of post-traumatic stress change over time and that a historical era, to some extent, expresses itself in an idiosyncratic way in the presentation of individual suffering.

This idiosyncratic process starts before birth when individuals are equipped with genes that promote resiliency or vulnerability (see Fig. 26.1: sub *Ecology and History, Individual level*). Future studies will likely show that worldwide variations in the human genome equip individuals with different degrees of resiliency against traumatic stress. For example, despite harsh living circumstances, psychiatric epidemiological studies in Ethiopia consistently show low prevalence figures for a range of psychiatric disorders (De Jong *et al.*, 2001; Kebede *et al.*, 2003). Only 9.4% of Israelis met symptoms criteria for PTSD, which is low when considering the nature and length of traumatic exposure, and a majority was optimistic about their personal future (Bleich, Gelkopf & Solomon, 2003). Interestingly, 62% of Ethiopians belong to a genetic subcluster that encompasses a majority of Jews, Norwegians and Armenians (Wilson *et al.*, 2001). It is theoretically possible that the low prevalence rates in Ethiopia and Israel are related to the composition of the genome of this genetic subcluster. Another example: research has identified an allele for the serotonin transporter gene that affects vulnerability to stress. People with the short allele are at increased risk for anxiety and depression. Most people of European descent carry the high-risk allele and are at higher risk of depression. However, studies also show that carriers only develop depression if they are exposed to stressful and traumatic events, especially early in life (Caspi *et al.*, 2003; Kendler *et al.*, 2005).

Similar to genetic vulnerability and protective factors, the next individual historical determinant, sex, is determined with conception. The first influences of the individual's life history start *in utero* with the interaction between a person's genetic make-up and the environment. Birth itself can be a risk factor, especially in war or disaster circumstances, where often poor prenatal and perinatal care are compounded by the collapse of the public healthcare sector. Famine, starvation, nutritional deficiency, environmental health hazards, cerebral malaria, parasites, diarrhoeal diseases and respiratory infections may further negatively influence cognitive and bodily development both *in utero* and later in life (West, Caballero and Black, 2001; Bangirana *et al.*, 2006). Family disruption, parental illness and death, possibly aggravated by the AIDS pandemic, can affect attachment, bonding, separation and socialization and contribute to anxiety, depression, PTSD, attachment disorders of childhood, and antisocial, borderline or traumatic personality development (such as Complex PTSD or DESNOS (Herman, 1992; Van der Kolk *et al.*, 1996). Prior to the onset or during episodes of political violence, the individual may be exposed to positive or negative life

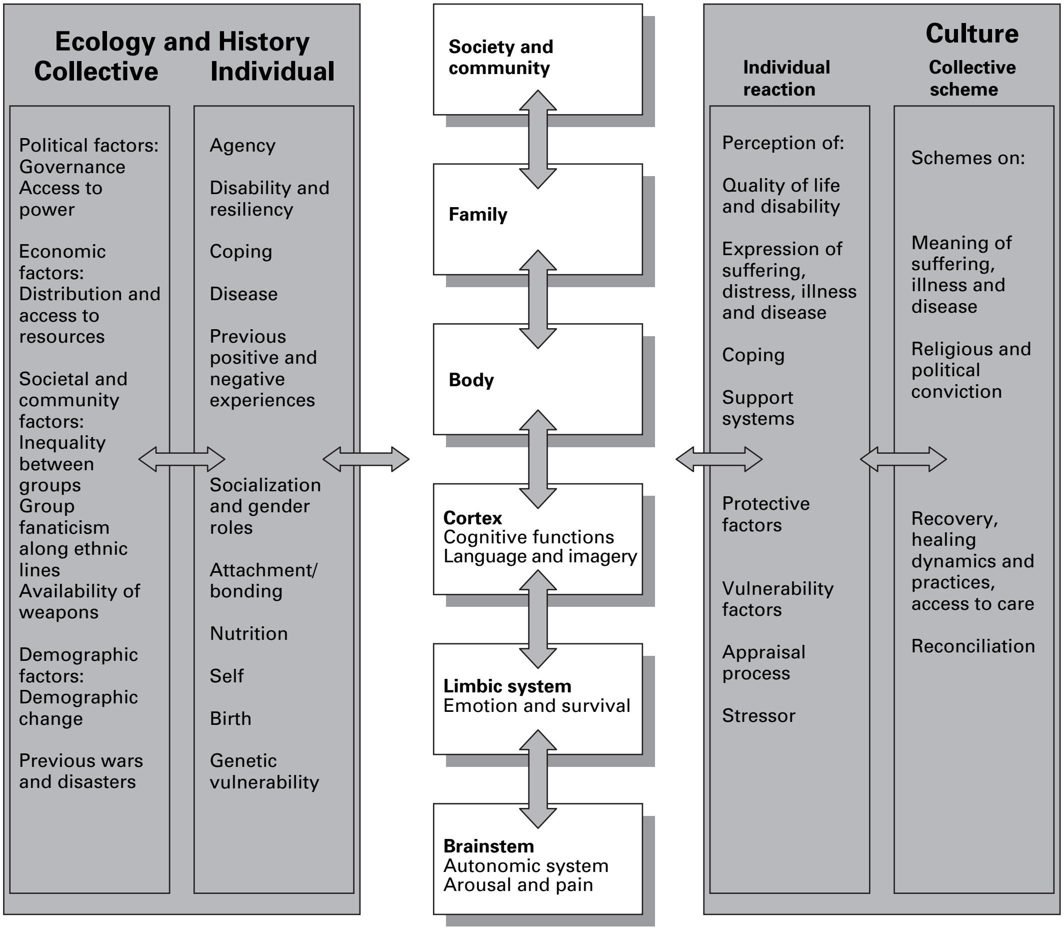

Fig. 26.1. An ecological–cultural–historical model for extreme stress.

experiences that may either contribute to resiliency and post-traumatic growth, or to further vulnerability later in life. Post-traumatic growth manifests itself in an increased appreciation for life, more meaningful interpersonal relationships, an increased sense of personal strength, changed priorities, and a richer existential and spiritual life (Tedeschi & Calhoun, 2004; Aldwin & Levinson, 2004). The interaction of these resiliency, vulnerability and growth factors may result in a proneness to disorder and the development of disability. Alternatively, it may result in a more or less diversified repertoire of coping skills. This may, in turn, influence the ability of the individual to display agency and to survive in an adverse environment.

Culture

Individual

Within current models of stress in psychology and psychiatry, cultural factors modulate the relationship between the events, moderators, mediators and outcomes. Here, some examples of the influence of culture on an individual will be presented by following common stress models with a cultural lens (De Jong, 2002, 2004). These stress models primarily distinguish traumatic stressors as independent variables being appraised by an individual and resulting in psychological and psychiatric problems moderated and mediated by a range of protective and vulnerability factors. Common psychological disorders or more serious mental disorders are regarded as dependent variables, that in turn affect functioning, quality of life, personality growth or disability. Although these models have universal applicability, they can be enriched when we obtain more insight into the transformation of its components by the work of culture.

The traumatic stressor, protective and vulnerability factors, coping, social support, and expression of distress and disability. Threats to survival are at the core of traumatic experiences, as clarified by the revision of the definition of post-traumatic stress disorder (PTSD) in DSM-IV (APA, 1994). However, the perception of threat as traumatic varies across individuals and across cultures. One may even doubt if stressors are ever traumatic *per se* and argue that an event can only become traumatic after appraisal (as mentioned in the second part of the DSM-IV stressor criterion). For instance, was the premeditated loss of thousands of people on a single day on the ancient battlefields perceived as traumatic, and did this differ for those ordering the battle or the individuals surviving it? Is the loss of a child a universal stressor? Based on my experience with mothers across cultures who heard about the (impending) death of their child, I tend to regard the confrontation with the death of a child as a universal traumatic event. Similarly, Einarsdóttir (2004) argues that, despite high infant mortality, there is no normalization of child death among the Papel in Guinea Bissau. Our views contrast that of Schepers-Hughes (1992), who states that high infant mortality in Brazil protects mothers from suffering as compared to countries with low infant mortality. In my view the mothers' wording of their previous loss during an anthropological encounter reflects a useful defence mechanism that may differ from their true suffering when their child died. In contrast to the death of a child in Africa, the death of an older loved person who has children and some accumulated wealth is typically acceptable in African cultures, since it is believed that the deceased will travel to the reign of the ancestors and occupy an intermediary position between the living and the dead.

Is loss of wealth traumatic? Higher levels of socioeconomic status and education before displacement are associated with worse mental-health outcomes (Porter & Haslam, 2005). However, adult Tibetans did not perceive the loss of their personal possessions as traumatic, but the desecration of their religious symbols by the Chinese was perceived as a traumatic loss (Terheggen *et al*., 2001). When a Middle Eastern family realizes that an unmarried female member is flirting with a man, the event can be devastating to the family honour and result in revenge killing. It is the culture-bound appraisal of the flirting, innocent in other cultures, that evokes emotions that result in culturally prescribed action. This example also illustrates how protective and vulnerability factors can depend on cultural context. The concept of honour may function as a protective factor in the context of Middle Eastern cultures by promoting endogamy, chasteness and peaceful coexistence of families and clans. The culturally prescribed revenge killing related to the appraisal of loss of honour can result in positive coping in the Middle East, while the same behaviour may be a negative coping style resulting in social exclusion or imprisonment in a multicultural setting.

Both problem-focused and emotion-focused coping are influenced by culture. Once indigenous coping strategies and resources are identified and understood, salutogenesis can be encouraged as a form of prevention or intervention.

Grief is an essential task of survivors and provides a good example of the influence of culture on coping. There are several dimensions distinguishing cultures regarding grief and bereavement. High-income countries use concepts such as grief counselling or terminal care. In contrast, in low-income countries, people's attention is especially focused on varying supernatural beliefs (a) that the dead communicate with the living, (b) that other people's supernatural abilities such as witchcraft can cause death, (c) that the ghost of the deceased will take revenge if one does not complete proper rituals for the deceased, for example, in cases of suicide or homicide as often happens in conflict settings or ethnic cleansing (d) that verbalizing the name of the deceased is dangerous, (e) that a newborn is a reincarnation of a deceased person, (f) that hearing or seeing the deceased person is normal, and (g) that tie-breaking customs are useful to cope with loss (Rosenblatt, Walsh, & Jackson, 1976; Irish, Lundquist, & Nelsen, 1993; Parkes, Laungani & Young, 1997; De Jong & Van Schaik, 1994). Anger toward the deceased is another difference in grief between African and Euro-American cultures. The common Christian habit is to encourage saying nothing but good about the dead, possibly hindering the expression of negative feelings toward the dead. In African cultures, the expression of emotions such as anger towards the deceased is often permitted in a ritual context. This may be done in a benign and mocking way, since the family needs the help of the deceased – who just rose to the status of ancestor – to cope with life. Later, this ancestor may transmit messages through an elected person whom we might regard as hallucinating. Nevertheless, local culture often deals in a ruthless way with that same anger and despair by accusing the living of causing the death of a family member. The accusation of magic manipulation may involve parents being accused of the death of their own child. It seems that the anger caused by death is expressed in a highly ambivalent way. Both the deceased and his or her family members or co-villagers may become the target of a witchcraft or sorcery accusation. The accusation may correspond with pre-death conflicts or be in line with structural tensions such as that between generations, sexes or co-wives.

The nature of the *expression* or the *presentation* of distress and suffering in response to threats also varies across cultures. Working in post-war circumstances in West Africa, presentation of PTSD symptoms was rare, while patients regularly presented stiff or contracting catatonic bodies, accompanied by bouts of shouting and twisting movements of body parts. I soon realized that these were local idioms of distress in the guise of dissociative reactions reminiscent of scenes of 1890s Salpetrière. From a cross-cultural perspective, it is interesting that one often still comes across expressions of psychopathology in low- and middle-income countries that have gradually disappeared in the West over the past 100 years. The expression of repressed feelings, often related to abuse, greatly varies and evolves over time, resulting in dissociative states such as classical hysteric attacks, spirit possession, hysterical blindness or psychogenic convulsive attacks. An additional problem in diagnosing psychopathology across cultures is that the reactions to trauma are often expressed in narratives that express distress along with explanatory models. Moreover, these narratives are often intertwined with the cultural transitions and losses that confront the survivors resulting in acculturative stress, culture shock and cultural bereavement (Eisenbruch, 1984).

In low-income settings families are often the main provider of social capital and mental well-being. As such, families are a protective factor when a person is confronted with extreme stress. Norris and Kaniasty (1996) showed that, after mass trauma, initial periods of a high degree of social support are followed by a quick deterioration of the support system under the pressure of overuse and the need for individuals to get on with their lives. This problem is compounded when many adults die due to war or AIDS, or when families seek refuge in the houses of other family members, turning a large extended family into a vulnerability factor (De Jong, 2004, pp. 166–67).

Western concepts of disability and social and psychological functioning are often not appropriate in local settings. Research instruments used in high-income countries may not measure the same concepts of disability and well-being in other cultures. Bolton and Tang (2002) developed a useful method for cross-cultural and sex-specific assessment of disability and functioning.

Collective

The individual level of perceiving and dealing with threats interacts with the collective level of the traumascape. The collective level operates its influence through schemata defined as structured cognitive representations of sets of rules of human populations. Culture-based schemata are part of the traumascape. Schemata are dynamic and provide a means for cultural prototypes to be revised as a function of individual experience (Rumelhart *et al.*, 1986; Chemtob, 1996). I will limit myself here to schemes related to recovery and healing, and to religious and political conviction.

Schemes on recovery and healing

Psychiatrists and psychologists tend to apply psychodynamic or cognitive interventions based on Western concepts of autonomy and individualization. This may be out of place with patients with other views of the ego and the self, living in collective societies that promote interdependency. In these cultures, Western interventions promoting for example assertiveness may be perceived as selfish (De Jong, 2004). Two major impediments to the implementation of appropriate psychosocial and mental healthcare programmes are the Janus faces of stigma and dogma. Stigma schemes around deviant behaviour may be a major impediment to develop interventions in the local culture, whereas dogma about the appropriateness of certain interventions among helpers may equally influence the local traumascape. For example, Western helpers may have non-founded views about the effectiveness of all kinds of interventions, ranging from culturally non-adapted versions of EMDR, CBT, family interventions or testimony methods to new-age therapies. Or, they may handle religious or other paradigms that are incompatible with the problems of those they want to assist. Over the last decade, a major step forward is the development of a series of guidelines and books on providing psychosocial and mental healthcare by the UN, WHO, consortia of NGOs and professional societies. These guidelines are obligatory reading for anyone who wishes to enter the 'trauma field', despite the heterogeneity of traumatic events, the lack of empirical support for specific interventions, or the need for adaptations of interventions to local needs and culture (IASC, in press; De Jong & Clarke, 1996; De Jong, 2002; Green *et al.*, 2003; Weine *et al.*, 2002; Eisenman *et al.*, 2006).

An expert panel gained consensus on empirically supported intervention principles that cover the period to several months after a disaster (Hobfoll *et al.*, submitted). The principles consist of schemes of recovery and healing.

(1) Safety on an individual, family, group and community level to prevent situations where reminders contribute to an ongoing sense of exaggerated fear. It includes safety from bad news and rumours (Bryant, 2006; Ehlers and Clark, 2000).

(2) Calming of extreme emotions through interventions such as breathing retraining, muscle relaxation or mindfulness, through a 'normalization' of stress reactions by survivor education about reactions, and by fostering positive emotions including joy and humour.

(3) A sense of self and community efficacy, reinforced by practising increasingly difficult situations in which increments of success build to a reality-based appraisal of efficacy which supports calming as well.

(4) Connectedness, increasing appropriate knowledge, providing social support activities such as problem-solving, sharing of experience and emotional understanding, and mutual instruction about coping. Research indicates that social support is related to better emotional well-being and recovery. Therefore, interventions have to identify those who lack social support and who are socially isolated and promote social support networks in communities (De Jong, 2002b). However, one has to remain sensitive to the potential for social undermining based on racial, ethnic and tribal divisions.

(5) Hope or the expectation that a positive future outcome is possible. Hope for most people in the world has a religious connotation and is

not action-orientated (Antonovsky, 1979). Antonovsky underscored that one's belief that things will work out well is based on past experience (Hobfoll *et al.*, submitted). In view of the protracted duration of several conflicts around the world one may question this statement. On the other hand, even in low-income countries where a whole generation has endured human rights violations or war (e.g. Burma, Cambodia, Kashmir, Tibet(ans), Sri Lanka, Vietnam, Angola, Sudan), people often seem to have internal resources that are beyond the imagination of middle-class Westerners.

Within the global traumascape, schemes on recovery and healing are influenced by divergent views on the value of diagnostic categories, of epidemiology and of interventions. I will briefly elaborate these views and attempt to indicate directions to bridge some of the divergent views.

Nosology and diagnostic categories

The trauma field could further its development by giving up the universalism debate about the validity of a core diagnosis of PTSD (Kleinman, 1977; Young, 1995; Summerfield, 2000). Biological adaptation to extreme stress is necessary for survival in a Darwinian sense and hence it is not surprising that these adaptive reactions are embedded in the brain (Hobfoll, 1998; Panksepp, 1998). Recent insights into the role of brain structures, such as the amygdala in fear response, both in animal models (Le Doux, 1996) and neuroimaging (Shin *et al.*, 1997; Bremner, 2002), changes in neurotransmitters such as norepinephrine (Southwick *et al.*, 1993) and neurohumoral responses such as cortisol (Yehuda, 2002), provide evidence for a biological substrate of PTSD. Moreover, respondents in a variety of countries appear to easily recognize PTSD symptoms in studies that address numerous variables, and explain those symptoms with local explanatory models without any notion of words such as trauma, stress or PTSD (De Jong, 2005). Despite these arguments in favour of a universal experience, Kendell and Jablensky (2003) have convincingly argued that validity is flawed by a lack of boundaries in any psychiatric syndrome. Validity does not mean uniformity across the globe (De Jong *et al.*, 2005). Although scholars do find PTSD in many different cultures, the conclusion that PTSD is similar in all cultures is premature, since studies generally do not look for differences that might have yielded so-far-unknown (sub)types or variations of the disorder. Future interdisciplinary studies should enable the field to parse out the unique and interactive contributions of biology and culture to the PTSD 'syndrome' (Osterman & de Jong, 2006). It will also increase our understanding how PTSD, post-traumatic idioms of distress, traumatic personality development or DESNOS are modified by cultural beliefs and meaning systems (De Jong, 2004). Without a refined inventory of idioms of distress in a variety of cultures, diagnostic errors can occur. Either a clinician can miss the PTSD diagnosis because associated culture-related sociosomatic or socio-physiological features are most prominent, or the associated features can be overlooked because of the presence of PTSD. One of the challenges of the coming decades will be the compilation of a worldwide inventory of local expressions of unusual or 'deviant' behaviour, including traumatic stress reactions, based on a phenomenological approach employing a combination of qualitative and quantitative research methods (De Jong & Van Ommeren, 2002). We expect that such an enterprise would yield a neurobiological and universal core at the biological end of a continuum, with a large variety of culturally induced phenomena at the socio-psychological end of the continuum. In a recent paper we described a series of steps toward constructing such a universal core module to capture the consequences of extreme stress across cultures, with local modules that fit culture-specific expressions of extreme stress (De Jong *et al.*, 2005). One might even go one step further and extend this view to all psychiatric diagnoses, envisioning a global network of researchers that collect and update local expressions and idioms of distress in line with the previous anthropological Human Relations Area File. This requires intensive collaboration between mental-health professionals and social science, especially anthropology. Clarifying the debate around diagnostic categories and nosology will also help to clarify the role of epidemiology and treatment:

Epidemiology

Although epidemiology purports to guide intervention efforts, in post-disaster contexts epidemiological figures often only capture a portion of the true need. Moreover, prevalence figures are often highly elevated and may contribute to the treatment gap that exists in many areas worldwide, even after correction for help-seeking behaviour, medication or disability (Narrow *et al.*, 2002). The post-9/11 efforts to provide services in New York were a vivid example of the discrepancy between epidemiological figures and the availability of adequate intervention models and services, especially for immigrants, in the city with the highest density of mental-health professionals worldwide (Herman & Susser, 2003). But even in normal times there is a huge discrepancy between prevalence rates and service provision. The WHO World Mental Health Survey Consortium (2004) showed that 35.5% to 50.3% of serious cases in developed countries and 76.3% to 85.4% in less-developed countries received no treatment in the 12 months before the interview. These figures are not representative for any current post-disaster area where the treatment gap impresses as invariably larger. In a cross-cultural context, psychiatric epidemiology is often further compounded by the use of non-validated instruments, by including subjects without disability in prevalence counts, or by maintaining algorithms and exclusionary skip rules in epidemiological instruments that produce skewed and often extremely unreliable prevalence rates. Moreover, one has to carefully test a diagnostic or research instrument developed in one culture before applying it another culture. This helps to bring understanding of the concepts underlying the items of the instrument, testing them for their content, semantic, conceptual and technical validity. How to properly adapt instruments has been described elsewhere (Van Ommeren *et al.*, 1999; De Jong & van Ommeren, 2002). Psychiatry and psychology are also flawed by the discrepancy between the wealth of epidemiological figures and the scarcity of attempts to translate these figures into secondary and tertiary preventative efforts. The use of epidemiology in post-disaster settings is further complicated by discussions on focusing interventions when there is a scarcity of means and of evidence-based trained human resources (De Jong *et al.*, 2003b).

Interventions

Disaster-affected populations show high prevalence rates of mental-health problems including acute stress disorder, PTSD, depression, anxiety, incident-specific fears, phobias, somatization, traumatic grief and sleep disturbances. These reactions typically show a gradual reduction over time, yet negative post-trauma reactions including adverse coping styles such as substance abuse or family violence tend to persist in a variety of cultures. The past few years show a growing consensus for the need to include common mental disorders such as depression and other anxiety disorders instead of focusing solely on the treatment of PTSD (Weine *et al.*, 2002; De Jong *et al.*, 2003, Eisenman *et al.*, 2006; De Jong, 2005; Osterman & de Jong, 2006). When selecting priorities for interventions, professionals have to consider to what extent they focus on the needs and concerns of the local population in comparison to 'scientific' epidemiological figures (De Jong, 2002b, pp. 51–52). This will often result in balancing psychiatric needs with public-health and psychosocial needs, such as access to general healthcare, poverty, daily hassles, substance abuse, spirit possession, gender-based and family violence or access to human rights resources. It implies developing intervention models that include mental health within primary care. It simultaneously implies addressing local psychosocial needs by building upon local strength such as family networks, upon resources such as village and women associations or commemoration ceremonies, and by building upon key figures such as community and religious leaders and complementary and alternative medicine (CAM). Whereas prevalence rates remain fairly constant, the overall burden of a population group is related to the ever-changing longer-term psychosocial needs that are often compounded by cycles of violence and its sequelae. Because it is impossible to provide services to all people in need, programmes must assess high-risk groups and track potential modifications in vulnerability over time. Moreover, one has to decide how to allocate funds and human resources to universal, selective or indicated preventive interventions (United States Committee on Prevention of Mental Disorders, 1994). This process may be complicated by stigma, which in turn may shift over time. For example, in the past decade stigmatizing witchcraft accusations in Central Africa have shifted to children who were subsequently killed, because they allegedly machinated the plight of the local population. Massive conversion to healing churches that articulate with previous mass-possession cults must be taken into account in the process of service delivery. Moreover, although healers are regarded as a potential source of psychosocial support, there exists widespread ambivalence towards collaboration, especially among professionals with an academic background who distance themselves from what they consider 'primitive thinking'.

Political and religious conviction

Political and religious convictions are part of the traumascape and moderate the processing of distress. Political conviction can mediate grief or mourning, as has been described in, for example, Gaza (De Jong, 2004; Qouta, 2000; Qouta & El-Sarraj, 2002). Similarly to Albanian Kosovar families who lost a family member in the war in 1999, Palestinians often regard their deceased family members as martyrs. These views can, on the one hand, alleviate loss, while, on the other hand, complicate the mourning process since the family that is applauded for having given a martyr for the common cause may find it difficult to sense its loss and express its grief. A child soldier may be regarded as a human-rights violator, or, alternatively, as a hero who helps his family to survive in harsh economic times. A rehabilitation programme must formulate its objectives and interventions depending on the child soldier's local context. For instance, vocational skills training appears to be a suitable strategy to reintegrate child soldiers in Burundi but not in northern Uganda where their newly acquired skills are already widely available in the local economy. Exposure to the grotesque can be mediated by religious convictions, such as the role of karma in Buddhism in Asia, explaining, for example, the plight of the Cambodian people under the Khmer Rouge regime as the punishment for previously generated karma, or by divine persecution during the Holocaust (Abramson, 2000; Van de Put & Eisenbruch, 2002).

To summarize, culture-based schemata protect the group by moderating the impact of disaster. They provide guidelines for appraisal of potentially traumatic events in local or Western cultural terms. They also guide expected behaviour in terms of response to survival threats such as mobilizing social support or stimulating help-seeking among local or allopathic healers or ritual contexts.

Ecology and history

Collective

Population growth, economic interdependence and ecological vulnerability, combined with the availability of weapons and the contagion of hatred and incitement to violence, make it urgent to find ways to prevent disputes from turning massively violent. In the post-Cold War, wars within states vastly outnumber wars between states. Internal conflicts commonly are fought with conventional weapons and rely on ethnic expulsion or even annihilation. The UN, governments and the non-governmental (NGO) sector use a public-health paradigm to prevent the (re)emergence of violent conflicts. Effective preventive strategies rest on a few public-health principles: uncovering basic knowledge about violence and reacting early to signs of trouble; a comprehensive approach to alleviate the pressures or risk factors that trigger violent conflict; address the underlying root causes of violence; and implement, monitor and evaluate interventions that appear promising (Carnegie Commission, 1997). The World Health Organization (WHO, 2002) divides violence into self-directed violence, interpersonal violence and collective violence. Collective violence is subdivided into social, economic and political violence. Political violence includes war and violent conflicts, state violence, terrorist acts and mob violence. Economic violence includes attacks by larger groups motivated by economic gain, such as attacks carried out with the purpose of disrupting economic activity. Collective violence often is the outcome of steps along a continuum of antagonism (Staub, 1993). Within a historical context, progression of mutual retaliation may start with small acts that escalate, resulting in a 'malignant social process' (Deutsch, 1983). The escalation of conflict is often the result of 'us' – 'them' differentiation (e.g. Aryan–Jew, Tutsi–Hutu, Israeli–Palestinian, Indian–Pakistani, Arab world–US). If the societal self-concept is based on superiority, self-doubt or their combination, it may give rise to war-generating motives (e.g. Germany after the Treaty of Versailles, the Khmer Rouge dreaming of restoring the old Khmer empire). A societal self-concept often designates the territories that are part of a nation and may include some that the nation has not possessed for a long time (China claiming Tibet; Israelis and Palestinians claiming Jerusalem; Iraq claiming Kuwait; Argentina reclaiming the Falklands). Alternatively, a part of the territory may want to split off from a country to which it 'belongs', while the concept of belonging is disputed by those seeking liberation as compared to the country that defines it within its borders (Biafra from Nigeria; East from West Pakistan, Eritrea from Ethiopia; South Sudan from the North; Kurdistan from Turkey, Iran, Iraq and Syria). Groups, like individuals, project unacceptable aspects of themselves onto others; those who are repudiated become 'bad', whereas the group that projects remains pure and good (Pinderhughes, 1979) (the genocide of the Armenians in Turkey; the tensions in Africa/Kinshasa leading to witchcraft accusations and murder; the accusations of 'parasitism' to the Jews in pre-WW-II Europe, to Indians in Uganda, or the Chinese in Indonesia; Mozambique's Renamo claiming to restore traditional values that were felt to be derogated by Frelimo).

Leaders have great power to shape relations between nations. They have the capacity to enlist the loyalty of their citizens, may initiate a cycle of hostility, but they are also the products of the history of their societies. Citizens rarely criticize hostile acts of their own country, but they are aroused to patriotic fervor by hostile acts against their country, even retaliatory ones (Staub, 1993). The process of leadership may produce faulty decision making, such as groupthink (former Yugoslavia).

Risk factors for collective violence

Prevention requires identifying risk factors and determinants of collective violence and developing approaches to resolve conflicts without resorting to violence. A range of risk factors for major political conflicts has been identified and has been listed in Table 26.1 (Carnegie Commission, 1997; Esty *et al.*, 1995; Baker & Ausink, 1995).

An accumulation of risk factors or a critical mass of these symptoms increases the likelihood of collective violence.

The relations between risk factors shown in Table 26.1 are circular and the different categories of indicators influence each other in a systemic way. Although the ingredients of collective violence are universal and global, its prevention and resolution are particular to a local traumascape, context and culture. Preventive policies to reduce the potential for violence conflicts should address civil society and the quality of policy making decisions. Moreover, it should develop legal standards; reduce inequality between groups; develop regimes for controlling destructive weaponry, embrace development strategies that reduce poverty; and develop public (mental)-health strategies to deal with the sequelae as illustrated elsewhere (De Jong, 2002b; Green *et al.*, 2003).

Table 26.1. Indicators of states at risk of collapse and internal conflict with examples and sequelae

Indicators	Signs	Examples	Consequences
Inequality	Widening social and economic inequalities, both between and within population groups. Globalization, failed states, privatization, decline of social safety nets, deprivation, competition for resources, increased availability of weapons and landmines Struggle over access to resources such as oil, diamonds, gems, timber and rivers Struggle over access to drugs	Former URRS and Yugoslavia Angola, Congo, S Leone, Chad, Nigeria, Sudan, Cambodia, Indonesia Afghanistan, Columbia, Myanmar	The state is unable to manage political challenges and to maintain control over the use of force Increased mortality and physical disability, high death rates among civilians National army and rebel/ guerilla forces engage in armed conflicts to secure access to the resources. Manipulation of resource shortages for hostile purposes (e.g. using water as a weapon) Competition for income from narco-traffic
Rapidly changing demographic characteristics	Rapid changes in population structures including large-scale movements of refugees and IDPs High rates of (infant) mortality Excessively high population densities High levels of unemployment, especially among youth Insufficient supply of food or access to safe water Disputes over territory or environmental resources claimed by distinct ethnic groups or governments	Darfur Uganda, Angola, Mozambique, Zepa (Balkans), Rwanda, Burundi Liberia, S Leone, S Lanka, Sudan, Tigray, Eritrea Ethiopia, Eritrea	Pre/post-conflict massive population movements (e.g. refugees, IDPs) and competition for resources in areas into which people move. Environmental degradation Decline vaccination coverage, increase infectious diseases, reduced access to health services Overcrowding, resource depletion, environmental degradation, high exposure to vectors, high risk of HIV infection, poor nutrition, increased risk diseases Discontent, recruitment into rebel forces Conscription or looting of farmers, destruction water and sanitation infrastructure Create a climate of warfare and involve civilian populations
Lack of democratic processes	Violations of human rights Criminalization or deligitimization of the state Corrupt governments, faulty leaders	Bhutan, Cambodia, Iran, Yugoslavia, Guatemala, Iraq, Mozambique, Sierra Leone, Ethiopia	Torture, imprisonment, mutilation High military expenditures Use of violence to survive or to achieve their aims

Table 26.1. (cont.)

Indicators	Signs	Examples	Consequences
Political instability	Rapid changes in regimes Ethnic composition of the ruling elite differing from the majority A legacy of vengeance – seeking group grievance	Somalia, Zaire/Congo, Liberia, S Leone, Angola, Mozambique, Rwanda, Burundi Balkans (Bulgaria, Hungary, Romania, Slovakia)	Failed states Protracted cycles of violence and eruptions of ethic clashes
Ethnic composition of ruling ethnic group different from the population at large or ethnic groups straddling interstate boundaries	Political and economic power exercised – and differentially applied – according to ethnic or religious identity Desecration of ethnic or religious symbols	Rwanda, Burundi, S Lanka, Balkans, Caucasus, Nagorno-Karabakh/Azerbaijan, Afghanistan	Inter-ethnic strife
Deterioration of public services	A decline in the scope and effectiveness of social safety nets designed to ensure minimum universal standards of service		Poverty, deprivation, discontent and subsequent involvement in armed struggle
Severe economic decline	Uneven economic development Grossly unequal gains or losses between population groups or geographical areas resulting from large economic changes Massive economic transfers or losses over short periods of time	West Africa, Great Lakes Region, Africa	Reduces public expenditure on e.g. health and education

Conclusions

From prehistoric times onwards cultures have developed coping strategies to deal with extreme stress. Each era and culture expresses the consequences in semantics, explanatory models and idioms of distress, and develops ways of healing that fit its cosmology. Ever-changing traumascapes show that there are universal similarities and major differences that constitute the 'human' responses to trauma. The concept of a traumascape is presented as the scaffolding to explore the complex global and local interactions among vital systems that define how an individual, a society and a culture respond to emergencies that make up the daily life of many. The model presented in this chapter provides a framework for scholars to study the dynamic interactions of culture, history and social ecology. The factors described in the model contribute to the understanding of vulnerability and resiliency of population groups and individuals. The components of the model will guide us in describing the variety of expressions of human suffering and the way cultures, and individual and families within those cultures, try to cope. The model may also guide us to develop policies and practices and effective interventions to deal with extreme stress.

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27

Sexual dysfunction across cultures

Dinesh Bhugra and Padmal de Silva

EDITORS' INTRODUCTION

Sex and sexual dysfunction are fairly universal behaviours across cultures, ethnic groups and societies. The presentation of sexual dysfunction varies according to the cultural norms. Societies have been described as sex positive (where sex is seen as a pleasurable activity) or sex negative. Thus, within sex-positive societies, sexual activity is more likely to be for pleasure, whereas in sex-negative societies, sex is more for procreative purposes and less for personal pleasure.

Bhugra and de Silva provide an overview of some epidemiological findings of sexual dysfunctions in the West and selected cultures. The gender roles and role expectations also influence how sexual activity and sexual dysfunction are seen and how help is sought. From groups where sex is purely for procreative purposes, it is possible that women are more likely to be referred via gynaecologists and obstetricians. Thus, their motivation for treatment will also vary. Use of indigenous methods of treatment and delays in seeking help complicate matters further. The authors indicate that prevalence of sexual dysfunction will depend upon a number of factors, most of which are environmental and social. Placing sexual dysfunction and its management in the cultural context means that the outcome can be improved. The affective states and cognitive schema also vary across cultures, thereby making the task of the therapist more difficult.

Introduction

Sex is one of the basic human instincts and over the centuries its functions have shifted from procreation to pleasure. Different cultures in different time spans have looked upon sex and sexual behaviour in different tones and shades, sometimes with fear, sometimes as magico-religious experience. An inherent danger in studying sexual behaviour across historical periods is the real or potential inaccuracy of the data (Bullough, 1972). These data are often descriptive and occasionally epidemiological, whereas the attitudes to sex and sexual behaviour and psychosexual dysfunction change according to prevalent social norms and mores and whether sexuality is controlled by the state.

Early writers made assumptions about the function of the sexual act but had to use religious texts, which are one of the richest sources of information on the topic of sexual behaviour (Bhugra and de Silva, 1995). The assumptions about the sexual act and its purpose were greatly influential (Bullough, 1976), perhaps because they had been immortalised in the religious canon. These deeply ingrained assumptions did not change dramatically, although with the advent of new religions and religious coda some modifications occurred. There is little doubt that sexuality is defined within a specific cultural setting and depends greatly on socialisation (Bullough, 1976; Gregersen, 1986; Segal *et al.*, 1986; Bhugra and de Silva, 1993). There is little doubt that a large number of cultures have different sets of standards regarding sexual behaviour across genders. The more powerful gender in a society, i.e. the male, secures control of the social institutions thereby shaping gender roles in ways that accord themselves greater sexual privilege (Reiss, 1986). Male and female patterns of sexual behaviour and sexual orientation are socially learnt with genetic

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encoding. Heterosexual coitus is the most prevalent sexual behaviour for a vast majority of individuals in any given society, although the societies define what is deviant and what is normal (Bhugra 1997; Ford and Beach 1951; Segal *et al.*, 1986). Bullough (1976) notes that societies accepted or tolerated other (other than heterosexual) behaviour only after the tribe had perpetuated itself and perhaps did not face a threat of annihilation.

The variations in sexual behaviour have been studied over the last 60 years or so. Unwin (1934) reported on a cross-cultural study, which tested the relationship between sexual expression and cultural achievement from nearly 80 countries. The literature by anthropologists such as Malinowski (1927) and Mead (1977) among others indicates the role sexuality and sexual behaviour played in different societies.

In this chapter we discuss the relationship between culture and sexual dysfunction. Although we touch on cultures' differences related to homosexuality and paraphilias, the focus in this chapter remains on prevalence and presentation of sexual dysfunction relying on epidemiological data across cultures. The management strategies are presented in Chapter 37.

Role of culture in sexual dysfunction

Until relatively recently, the study of sexual medicine was seen as exotic and prosaic, and the religious and social observations referred to the subject extensively. There are crucial factors which determine any individual's patterns of sexual behaviour and norms. The types of sexual dysfunction can generally be divided across the two genders into the phases of sexual desire, sexual arousal, act itself and post-coital period. Among both males and females, sexual desire and sexual arousal can be raised or decreased. The act of orgasm for males can lead to premature or delayed ejaculation and anorgasmia in females. Post-coitally, both males and females can experience pain either at the time of ejaculation or orgasm. Among females, vaginismus can be seen as another sexual dysfunction. There are, of course, various culture-bound syndromes, which influence sexual performance or performance anxiety, such as *dhat* or semen-loss anxiety (and these are discussed in Chapter 11).

Cultures themselves have been described as sex positive or sex negative (Bullough, 1976). He argues persuasively that sex-positive cultures saw the phenomenon of sex as life affirming and pleasurable, whereas sex-negative cultures saw the act as procreative. He further suggests that this pleasure is influenced by gender roles and in (some) sex-positive cultures sexual pleasure is meant to be experienced by males and this is what dictates how society defines pleasure. In addition, he highlights the role of education and experience, along with how folklore, music, dance and arts influence societies, which in turn influence these forms.

In ancient India, several erotic classics and sex manuals existed and these described various sexual acts for pleasure at great length, along with sex aids. The existence of these classics indicates clearly that the ancient inhabitants were not scared of sex compared with their contemporary Western counterparts, and the themes of strong approval of sex appear early in Hindu history (Bullough, 1976). The text of *Kamasutra* distils the sensual pleasure – the *kama*, which is one of the key human goals or ideals in Hinduism. Magical spells to bind and seduce potential lovers and to hurt potential competitors by inducing impotence are described in the Hindu scriptures – the Vedas (Bhugra and de Silva, 1995).

Meyer (1971) highlights that, in some of these scriptures and texts, sexual pleasure is directed by getting two people (usually in a marital state) together on certain nights at certain times with the right ambience, food and drink. *Kamasutra* describes love as being one of four types – acquired by continual habit resulting from imagination; from belief or from the perception of external objects. To enhance one's attractiveness to potential consorts, unguents and potions along with amulets are recommended. Virility can be increased and use of aids to increase the girth and/or length of the penis are described. Artificial penises (akin to dildoes) with studs, and organised to fit the vagina, were described which could be used in conjunction with, or in place of, the penis. Sexual intercourse was a crucial part of the male/female relationship and males had to be aware of the different phases of functioning in different parts of life. Ayurvedic texts described the formation of semen in stages and emphasised that diet, individual personality traits and season affect the production of semen (Bhugra, 1992; Bhugra and Buchanan, 1989; Thakkur, 1974). In addition, semen was of eight varieties and at least ten different herbs could be used for increasing semen production.

Male impotence, according to Ayurvedic texts, could result from old age, excessive semen loss, penile conditions and dietary causes, along with emotional problems such as anger, grief, fear, apprehension, drunkenness and jealousy. Bhugra and Buchanan (1989) point out that some early writers note primary impotence to result from genetic factors and features of anticipatory and performance anxiety. As part of the positive attitudes towards sex, transvestism was described. Although male aspects of pleasure were described and took precedence, female desire and pleasure was noted to be greater than those of males, and for females this pleasure depended upon education, experience, physical type and stimuli that aroused her. Hindu texts also emphasised the coexistence of the male and the female in each individual, and the two could function well depending upon a number of external factors.

The Chinese, too, saw the world in dualistic terms, bur rather than focusing on the conflict between the spiritual and the material they looked to the inherent unity of the opposing forces. For example, heaven was masculine and the earth feminine. The clouds were the vaginal secretion allowing the heavenly sperm, the rain, into the earth (womb), from the union of which all life force came. The two forces of *yin* and *yang*, respectively, earth and heaven, moon and sun, male and female, came together in sexual union, which is essential to achieve harmony as well as a happy and healthy life. Seasonal illnesses could be lodged in either *yin* or *yang* and any imbalance could produce serious difficulties in functioning. Each time a man had intercourse, he was to try to absorb as much *yin* from the woman as possible, but without giving up any of his *yang* (Bullough, 1976), Buddhist principles, Confucian thought and Mongol conquest all played their part in modifying Chinese philosophy. Later, sex became a secret act which, although sacred, was not to be talked about publicly. Humidity, heat, liver and kidney disease and energy depletion were seen as causes of impotence (Xu, 1990).

Aristotle described animals as those reproducing by sexual means, by asexual means and by spontaneous generation. His teachings could be responsible for seeing the female as a passive receptacle to the male desire and the fact that marriage was seen as being for procreation and not (even) for companionship (Bullough, 1976). Yet early Greeks and Romans appeared to have manuals on sex (King, 1994). King (1994) also noted descriptions of impotence in poetry.

Early Christians changed the attitudes towards sex in the West. This again may reflect a need for the newly formed Christian tribe to survive and thrive in their early stages. Bullough (1976) argues that the subjugation of the body along with attainment of perfection through renunciation may have contributed to negative attitudes. Early Christianity saw justification of sexual intercourse between male and female in marriage and for procreation only. Celibacy was the highest good and goal, and sex was simply animal lust allowed only within the boundaries of marriage.

Although Biblical references to erectile failure (Rosen and Leiblum, 1992) and in Greek mythology (Johnson, 1968) existed, in the Middle Ages the causation was seen as demonic possession and witchcraft. Additional factors, which may have influenced the Christian attitudes towards sex, included the merging of religion and state, and the dissonance in state proclamations and individual experiences contributed further to this change. Sexual acts of masturbation, sodomy and fellatio became offences and everything that medieval people feared came to have sexual connotations and overtones (Bullough, 1976).

This broad overview emphasises that attitudes towards sex, sexuality and sexual behaviour are influenced by a number of factors, including religion and its interpretations. Trying to turn sexual medicine and mores into science rather than art may have further contributed to these attitudes (Foucault, 1981).

Homosexuality across cultures

Although same sex behaviours have been described across all societies and cultures across different times (Bullough, 1979), the response to such an act or behaviour varies across cultures. The legal proscription on same sex behaviour further helps such behaviour to go underground, with no clear evidence of its prevalence.

In ancient Hindu texts and literature, same sex attraction has been described fully (Bullough, 1979; Vanita and Kidwai, 2000; Vanita, 2005). These interpretations have to be seen in the context of the prevalent cultural mores when, as noted earlier, sex was seen as a pleasurable activity. Both genders were noted to have indulged in same-sex behaviours. The sex aids described in *Kamasutra* enable both men and women to have same-sex relationships, indicating that such behaviour was available.

Hinsch (1990) noted that in China 'In many periods homosexuality was widely accepted and even respected, had its own formal history and had a role in shaping Chinese political conventions and spurring artistic creations'. In ancient China, like in ancient Rome and Greece, kings were allowed to keep male sex partners. In ancient Greece, the role of same sex relationships was well noted and described (Bullough, 1979). The availability of such behaviour was accepted not as a phase but as part of the bisexual nature of man.

In Christianity, however, as part of the sexual repertoire, same-sex behaviour was frowned upon and individuals were discouraged from practising it. These attitudes remained fairly static over several hundred years and different Christian groups still argue against same-sex behaviour, citing Biblical sources (see also Vanita, 2005). Removal of homosexuality as a mental illness from DSM-III reflected changing attitudes to same-sex behaviour, although in several national classificatory systems, for example, in China and in Egypt, homosexuality still remains as a mental illness in the classification systems.

The range of sexual dysfunctions experienced by homosexual men and women are broadly the same as those experienced by heterosexual men and women. However, two additional factors – one of perceived or real homophobia and, secondly, of importance of orientation and specific gay subculture within that – may further contribute to distress. Factors related to 'coming out' will influence help-seeking and will be affected by cultural attitudes, which will dictate when and how to come out to others.

Paraphilias across cultures

Paraphilias, also referred to as sexual deviations or sexual variations and distinguished from psychosexual dysfunction reflect a problem of sexual preference and/or direction of one's sexual desire (de Silva, 1995). Those individuals whose sexual interests are of a paraphilic nature are also referred to as 'sexual minorities' (Bancroft, 1989; Money, 1984; Wilson, 1987). Exhibitionism, voyeurism, sadomasochism and paedophilia are some of the common paraphilias. The data on cross-cultural prevalence of paraphilias are scanty. There is a hypothetical possibility that, in societies where the sex act is seen as mainly procreative, the prevalence of paraphilias may be lower.

Another key problem in identifying the rates of paraphilias in any given population is that often these do not come into contact with services at all, largely because if the individuals and their partners are satisfied, unless there is a problem, they would not be identified as such. Most of the clinical presentations may be associated with legal problems. Paraphilias are multifaceted problems and any assessment may need to take into account factors such as deviant arousal, anxiety, skills deficits, gender-role identity problems (Gudjonsson, 1986). Herdt (1987) found that, in the Sambia tribe in New Guinea, young men are expected to perform fellatio with older men as a rite of passage. Transvestism and transgender have different cultural connotations. In countries such as India, transgendered individuals such as *hijras* have cultural value and importance. They will be invited to dance at weddings and also at the birth of a son. Similarly, *berdache* have a social role. In Thailand, ladyboys function as entertainers and the societal stigma towards such individuals is rare. Dressing up can be seen as fashionable or fetishistic, depending upon the individual society where such a behaviour is acceptable or enjoyable.

The management of paraphilias is discussed in Chapter 37. However, it must be emphasised that the role of the sex act, availability of fetishistic objects and the societal attitudes to such behaviour all play a key role in the way paraphilias present are treated and the outcome following interventions.

Jealousy across cultures

In this section, we aim to focus on sexual jealousy. Jealousy is a complex emotion and arouses very strong feelings in the individual who is experiencing it and also in those who are observing it. Morbid jealousy is related to a sense of fear that the partner is having affairs and there is an imminent threat of loss of relationship, irrespective of the truth of the matter. This is, in turn, associated with own self-worth and health of our relationships in terms of sexual fidelity (Clanton and Smith 1977). Jealousy is an emotion that covers the threat of potential loss to a rival and is experienced as fear of loss, anger over betrayal and/or insecurity (Hupka 1984, Mathes *et al.*, 1985; Mathes, 1991). A universal social function of jealousy is the protection of marriage. Motives for jealousy are a product of the culture and vary according to social organisations, economic, political and legal systems and patterns of kinship (Hunter and Whitten, 1976). Hupka *et al.* (1985), in a cross-cultural study of jealousy, found that socialist nations had lower levels of jealousy. Schlegal (1972) studied 66 matrilineal societies and found that, where men have minimal authority over women, adultery of wives was less likely to be punished than where husbands or the brothers had the power. Studying 92 cultures from the Human Relations Area file, Hupka and Ryan (1990) found that severity of reactions to jealousy increased with importance of pair bonding, emphasis on personal ownership of property and limited possibilities of sexual gratification (which may reflect low self-worth). The assessment of any individual with sexual dysfunction must take cultural factors and attitudes to jealousy and paraphilias into account.

Epidemiology of sexual dysfunction

Johnson *et al.* (1994), in a detailed survey of sexual attitudes and lifestyles in the UK, studied 18 876 individuals who were randomly selected for interviews and completed these interviews. For younger men aged 16–19, the mean age for first sexual intercourse was 17, 3 years earlier than among those who were aged 55–59. For women too this dropped to 14 from 16 for women in similar age groups. Racial and ethnic differences demonstrated that those of Bangladeshi, Pakistani and Indian origin were much less likely to report sexual intercourse under the age of 16, whereas this was more likely in Black men and women. The median age for first sexual intercourse for men was higher for Asian groups and lower for Blacks in comparison with Whites. Religion too played a role in this very complex interaction. Respondents belonging to the Church of England or other Christian churches (excluding the Roman Catholic church) were less likely to do so. Factors reportedly associated with first intercourse included curiosity, peer experience, being drunk. A total of 6.8% of men reported that they had paid for sex with a woman at some time in their life and 1.8% had done so within the last 5 years. The frequency of heterosexual sex (defined as acts of oral, vaginal and anal intercourse) showed a very wide variability as measured by the number of occasions in the previous 4 weeks, with a very small proportion of the population reporting a very high frequency of sexual contact. Not surprisingly, age was closely related to the number of acts, with frequency peaking in the mid-20s and thereafter a gradual decline more marked for women than for men. The number of sexual sessions decreased the longer the relationship lasted. Over 93% of respondents were attracted exclusively to people of the opposite sex and a similar proportion also reported exclusive heterosexual experiences. Homosexual behaviour was reported by 6.1% of men and 3.4% of women when asked about any homosexual experience ever, and 1.1% of men and 0.4% of women reported having had a homosexual partner in the past year.

Melman and Gingell (1999) identified over 400 studies which looked at erectile dysfunction and impotence in epidemiological and pathophysiological studies, and confirmed that prevalence of sexual dysfunction of all degrees was seen in 52% of males aged 40–70 with even higher rates with an increase in age. The quality of life was influenced by erectile dysfunction and risk factors such as medication, smoking, ageing, chronic illness, all of which played a role.

Using data recorded between 1987 and 1996 from health insurance agencies, a sample of 124 917 men and women in Germany were studied. Aged between 20–60 years attending hospital services showed a prevalence of 0.1% of sexual disturbances (Geyer *et al.*, 2001). These are contact rates rather than true prevalence, but indicate that there are multiple factors, including physical illness, which must be taken into account. The relationship between ageing and sexuality is important, but most studies tend to exclude older adults. In an unusual study in Australia, Dennerstein *et al.* (2001) recruited 438 Australian born women aged 45 to 55 who were menstruating at base line. Of these, 197 were studied further, with a focus on menopausal transition. Compared with two control groups, these authors found that sexual responsivity declined significantly.

Comparing cultural and biological factors regarding sexual health and marital satisfaction in Germany and the USA, Mazur *et al.* (2002) noted that sexuality declined with age, and neither testosterone levels nor psychological depression could explain levels of sexuality. Sexual health and marital satisfaction were related to sexuality among Americans but not Germans. They concluded that, in both cultural settings, the wife's sexual desire, the subject's ability to maintain an erection and the subject's imagination/fantasy may play a role. Thus, the relationship between ageing and sexual function is multi-layered and complex.

Cognitive functioning is strongly influenced by culture. Audu (2002) noted among infertile Nigerian women the presence of a number of sexual problems. Reporting on data from 97 infertile women using questionnaires to ascertain frigidity (*sic*), 78% of the sample acknowledged with 58% admitting to dyspareunia. Nearly one-fifth had difficulties in arousal and the same proportion had difficulties in reaching orgasm. The study reflects that sexual dysfunction is related to infertility and the sources of data collection influence reported prevalence. Skinner *et al.* (2002) found that Bangladeshi men were six times (12%) more likely to have sexual dysfunction compared with women, although the data was collected from a genito-urinary clinic. Syphilis was commoner in Bangladeshi men compared with controls.

Bancroft *et al.* (2003) studied 987 White or Black African-American women aged 20 to 85 years to measure stress about sex. Using a telephone – audio-computer – assisted self-interviewing with the response rate of 53%, these authors applied weighting to increase the representativeness of the sample. A total of 22% of women reported marked stress about the sexual relationship and/or their own sexuality. The best prediction of sexual distress were marks of general emotional well-being and emotional relationship with the partner during sexual activity. Physical aspects of sexual response in women, including arousal, vaginal lubrication and orgasm, were reported as poor predictors.

In general, the authors felt that predictors of distress did not fit well with the DSM-IV criteria for the diagnosis of sexual dysfunction in women. There are conceptual problems in using the terms such as distress and dysfunction and comparing these. And these results indicate that there are several additional issues in sexual dysfunction which need to be identified. The low response rate does have its problems; however, the strength of this study lies in the inclusion of African-American women as a group.

In order to describe the demographics, presenting problems and physical laboratory investigations in women presenting with vulvo-vaginal disorders, Hansen *et al.* (2002) studied medical records of all cases who presented to the clinic between 1996 and 1999 with vulvar problems. Of 322 women identified, 94% were Caucasians and 64% married. A majority (73%) reported at least one vaginal delivery. Common symptoms reported were vulvar pains (87%), dyspareunia (76%), itching (37%) and skin changes in 18%. Prevalent diagnosis included Bartholin fossa pain, vulvar vestibulitis, restriction and fissuring of postenor labial commissure, vulvodynia and pelvic floor dysfunction. The authors emphasise the heterogeneity of the sample as well as the problems and recommend that physical causation must be ruled out prior to a diagnosis being made.

The rates of sexual problems and their prevalence in women depend upon a number of factors, including the source of the sample, method of data collection and measures for clinical identification of diagnosis.

In a population-based study, Kadri *et al.* (2002) studied 728 women in an epidemiological study from Casablanca. These were aged 20 and over. Using the DSM-IV criteria for diagnosis of sexual dysfunction, 27% were found to have a lifetime or 6-month prevalence of sexual dysfunction. Their most common finding was that of hypoactive sexual disorder. Age, financial dependency, number of children and sexual harassment were positively associated with these symptoms. Interestingly, in spite of their awareness of these symptoms, only 17% had sought help for their symptoms, suggesting cultural bias in help-seeking or the inability to know from where to seek help.

On the other hand, Kantor *et al.* (2002) reported that prevalence of complete erectile dysfunction was 36% in a sample of 268 subjects (out of 334 who were approached in primary-care settings). At the same time, they noted that the prevalence of current depression was 12% and concomitant depression and erectile dysfunction was 5%. Using logistic regression, these authors found that current depressive symptoms were not associated with moderate or complete erectile dysfunction. A similar study using somewhat different methods of reporting from 1250 males in Thailand showed that age was not a significant factor contributing to prevalence of erectile disorder, but diabetes and hypertension were (Kongkanand, 2000). The sample was collected from four sites around the Bangkok metropolitan area, again indicating that there are both similarities and differences in prevalence and association of erectile dysfunction across different nations and different cultures.

In a Belgian study, it was reported that, of 799 men who were interviewed, 60% complained of erectile difficulties (Mak *et al.*, 2002). An age stratified random sample of the male population aged between 40 and 70 years were interviewed, using standardised assessment questionnaires. Of the 799 men (a participation rate of 38%), 10% reported severe, 25% moderate and 27% mild erectile dysfunction. Only 38% reported no problems. Age and absence of sexual activity were the strongest predictors of erectile dysfunction. Other correlates included depression, absence of physical activity and other physical health problems. Among women attending a menopause clinic, Nappi *et al.* (2002) studied 355 subjects aged 46 to 60. The study, based in Italy, used visual analogue scales. The authors reported that 30% of subjects complained of pain during sexual intercourse and 22% complained of low libido and lack of sexual desire, both of which increase with age and years since menopause. Reduction of sexual pleasure/satisfaction was common with age, but was more frequent the longer the time since menopause. By examining the intensity of sexual symptoms according to the presence of other complaints, the authors concluded that physical, psychological and genital well-being significantly affects the components of sexual responses after the menopause. They suggest that lack of fitness, urogenital symptoms, negative self-image and depressive symptoms were commoner in women with sexual complaints. They recommended using a comprehensive approach to assessment of female health around menopause; thus cultural factors may play a less active role in physical aspects of female sexual dysfunction, but not necessarily in seeking help.

The relationship between sexual dysfunction and marriage is multi-factored. Duration of marriage, expectations of marriage, romantic perceptions within marriage all play a role. Liu (2003) raised an interesting question about whether the quality of marital sex increases or decreases with marital duration. Although several studies in the past had highlighted that a decrease takes place, empirical data are lacking. This study examines theoretically as well as empirically the alteration in quality of marital sex in relation to duration of marriage. Theoretically, two effects may influence the change of quality in marital sex: the effect of diminishing marginal utility (the marginal utility of consuming goods or services diminishes as the consumption of those goods or services increases), and the effect of investment in the marriage – specific human capital (including the ‘partner-specific’ skills that enhance the enjoyment of marital sex and the knowledge about the spouse’s sexual preferences, desires and habits). The quality of marital sex could either increase or decrease, depending upon which effect is dominant. Liu used the data from the National Roles and Social Life Survey and found that marital duration did have a small negative effect on the quality of marital sex.

In another interesting study, Mirone *et al.* (2002) reported on men using a free phone call service on information on erectile dysfunction in Italy between 1993 and 1997. Each subject calling was asked if he was affected by erectile dysfunction and, if so, whether he had discussed it with a doctor or partner. Of a total of 12 761 callers, 7265 (57%) acknowledged that they had discussed it with their partner. Not surprisingly, the longer the duration of the problem, the more likely the subject was to discuss this with his partner. Only 48% of subjects had duration less than 6 months and 60% of those in whom the duration was longer than 3 years. Similarly, only 50% had discussed it with a physician, but in those subjects with duration of erectile dysfunction of less than 6 months, only one-third had informed their physician. If the duration was longer than 3 years, the proportion rose to 58%. However, the authors do not clarify the quality or duration of partnerships. It is likely that those who were in a short-term or transient relationship may not have discussed it with their partners, but the evidence of the difficulty would be clear in any sexual activity.

Sexual deviance is often used as a term for individuals whose sexual preferences or mores do not fall into mainstream sexual behaviour. However, this remains a pejorative term so that, by definition, a negative value is being expressed. Bancroft (1989) suggests using sexual minority behaviour as a term. Paraphilia is the current preferred term in psychiatric literature.

Gagnon and Simon (1967) classified sexual deviance as normal, subcultural or individual deviance. Normal deviance includes behaviour such as masturbation, oral sex and premarital intercourse which, legally or socially proscribed in some parts of the world, is practised by large numbers of people, thereby falling within the statistical norm. Subcultural deviance is associated with particular subcultures (for example, homosexual) and will include categories of fetishism, sadomasochism, transvestism and transsexualism. These are often consensual behaviours, and their incidence is difficult to establish because individuals may not acknowledge these patterns and may well not seek help. Table 27.1 illustrates some of the diagnostic categories with possible aetiological factors divided into sociocultural and biological factors and their possible impact.

Sex and Societies by Bullough (1976) provides a classic account of sexual variance and society across different time periods, religions and geographical areas. He argues that male and female patterns of sexual orientation and behaviour (i.e. sex roles) are attributable to acquired learning, therefore, to social and cultural factors. For example, Ford and Beach (1951) found that there was a wide variation

Table 27.1. Types of deviance and sociocultural and biological influences

		Cultural influence	Biological influence
Normal deviance	Masturbation	+++	+
	Oral sex	+++	?
	Premarital sex	+++	?
Subcultural deviance	Fetishism	+	?
	Sadomasochism	+	?
	Transsexualism	?	++
Individual deviance	Exhibitionism	?	
	Incest	?	?

in sexual behaviour in people and cultures and, although there are many similarities, there existed differences too. Different societies, for instance, have had widely different rules and attitudes about masturbation but, regardless of whether the attitude was one of approval or condemnation, at least some adults in all or nearly all societies appear to have masturbated.

For nearly every human society, sexual intercourse is usually preceded by some degree or sensory stimulation and is often accompanied by stimulation, often visual or tactile. Visual stimulation is often of the individual partner, but sometimes this stimulation is related to a body part or part of clothing in achieving sexual excitement. Among societies where a minimum of such activity is carried out, it is possible that fetishistic sexual activity may well be lower. In the absence of concrete data, it is difficult to ascertain whether individual fetishistic behaviours are affected by the proliferate nature of the society or the socio-centrism of the individual. Within each culture and society, there are variations, too, both in pre-intercourse stimulation and foreplay. Some couples may well practise elaborate forms of genital manipulation, whereas others who may have bad feelings about sex or their partner may wish to skip the preliminaries. Breast stimulation and kissing as forms of sexual stimulation are more or less restricted to the human species, whereas preliminary stimulation of genital organs has a more ancient phylogenetic origin (Ford & Beach, 1951).

Sexual attraction

There are few, if any, universal standards of sexual attractiveness. The physical characteristics, which are regarded as sexually stimulating, vary appreciably from one society to another. In most societies, the physical beauty of the female receives more explicit consideration than that of the male. This may go some way towards explaining why men get turned on by objects. These selected female traits include plump body build, small ankles, elongated labia majora, large clitoris or pendulous breasts.

In some societies, bestiality is tolerated (even though seen as unnatural, silly and disgusting, and inferior to normal sexual activity) in the absence of more appropriate sexual behaviour. Such contact is often seen as inadequate and is sometimes allowed for teenage males. There are at least four societies in which animal contacts are practised and do not meet with condemnation (Ford & Beach, 1951). Such a variation reflects the influence of learning and social channelisation.

Similarly, adult masturbation is tolerated in some societies and encouraged in others, but the double standards in response to male and female masturbation remain. The relative infrequency of adult masturbation in some societies is said to be the result of socialisation (Ford & Beach, 1951). In societies which are restrictive in their attitudes to sex, teenagers may suppress their sexual desire but it is unlikely that no sexual activity takes place. Where boys are less carefully watched than girls, it appears that youths are able to circumvent the barriers. In semi-restrictive societies, formal prohibitions exist but are apparently not very serious, and are not enforced. Sexual experimentation may take place in secrecy, but without incurring punishment. Permissive societies have a permissive and tolerant attitude towards sex expression in childhood. In restrictive societies, girls are expected to remain virgins until marriage, whereas in the other two types, such expectations if they exist at all are not obvious. Actual sexual behaviour develops somewhat more rapidly in certain societies than in others.

Culture and behaviour

Intracultural and intercultural behaviours are affected to a degree by learning behaviours. With increasing globalisation, industrialisation and the spread of global media, very few societies and cultures have been left isolated. The attitudes of a society towards certain sexual activities and behaviours are key factors in the way individuals adopt and enjoy a passive or an active role in the sexual relationship. The emphasis on the feminine means that females are encouraged not to take the lead in sexual intercourse and to be passive; they are less likely to experience clear-cut sexual orgasm. Although some patterns of sexual behaviour are reflexive incorporation of painful stimulation (sadomasochistic activity), the culturally accepted patterns of pre-coital play and the type of response to such stimulation are strongly influenced by learning. In societies where sexual excitement is associated with the experience of being scratched or bitten, these feelings become eroticised, and it is possible that limited or no enjoyment occurs without such actions. Similar foreplay techniques in other cultures may not produce similar results.

Paraphilias across cultures

The field of paraphilias across cultures is severely limited. Although a fetish is defined as a magic erotic or love icon, its existence across cultures is by no means confirmed in the sense that individuals can out-perform sexually in its presence. Of the four paraphilias to be considered here, fetishism is probably quite common, although the rates are derived from those who attend clinics. There is general agreement that fetishism is rare in women. The principal categories of sexual signal or stimulus have been considered by Bancroft (1989). These are a part of the body or an intimate extension of the body, e.g. a piece of clothing and a source of specific tactile stimulation. The determinants of fetishism are many, and social learning theory must be seen to play an important role. There is virtually no literature reporting fetishism from non-industrialised countries. It is possible that, because of a lack of resources, individuals do not seek help, because two key reasons for seeking help are legal (once an individual has been in trouble with the law) or personal. As legal systems vary across societies, it is possible that such help-seeking is not encouraged in legal circles. At a more personal level, it is probable that the first or only port of call may be either an alternative practitioner or a primary-care physician, without the individual ever reaching a psychiatric clinic. The second possibility is that the rates are genuinely low because the society's expectations of a male are to procreate, without any underlying notions of pleasure for the self or the partner.

Bancroft (1989) argues that a majority of fetishes can be understood as an extension of the loved one which acquires special importance if there are other factors or causes of anxiety blocking the development of a more appropriate sexual relationship. Under these circumstances, it makes sense that, in societies where sexual love may have amorphous meaning and the individual's concept of the self is socio-centric rather than egocentric, the likelihood of being attracted to high heels, leather, rubber or boots may be low. In cases where fetishes are extremely bizarre and cannot be understood as extensions of the body, but are more likely to be associated with some neurological abnormality such as temporal-lobe epilepsy, the stimulus may be random, and it is possible that cases may occur across cultures. As discussed, sadomasochistic behaviour is more likely to occur across cultures especially if it develops as part of sexual foreplay and individuals accept it.

Of the two remaining paraphilias, transvestism and transexualism are quite interesting. Cross-dressing occurs in most societies and throughout history, and is also less likely to be a true paraphilia. Bhugra and de Silva (1996) postulate that, for uniforms to work as a fetish or individuals to dress in uniforms for sexual performance can be a reflection of fashion or fantasy. The sexual significance of cross-dressing is incredibly complex. Bancroft (1989) divides this group into four types: the fetishistic transvestite, the transsexual, the double-role transvestite and the homosexual transvestite. The sexual relationships of cross-dressers vary accordingly.

In their cross-cultural study of the sexual thoughts of children, Goldman and Goldman (1982) found that 50% of boys and 9.5% of girls expressed aversion to their biological sex. This reaction peaked in adolescence, with 30% of 13-year old boys boys in Australia and 20% in the USA expressing such feelings which, by contrast, were virtually absent in Sweden. Bancroft (1989) suggests that, the more rigid the sex role stereotypes in a society, the greater the likelihood of this gender dysphoria. Thus, rigid expectations could produce anxiety and insecurity about gender identity, for which transsexual ideas would offer one method of coping. Consequently, Australia has a greater number of transsexuals seeking help than Sweden. Similarly, Australian gay males see themselves as more strongly feminine than their counterparts in Sweden (Ross *et al.*, 1981; Ross, 1983).

The heterogeneity of sexual behaviour and societies in which they occur suggests that males are more likely to have fetishistic tendencies and that the development of sexual identity is dictated by social and cultural factors, thereby producing variation in rates of different fetishistic behaviours.

Several authors (Caplan, 1987; Herdt, 1990a,b; Herdt & Stoller, 1990) have argued that intersexes may not be discomfited by issues of sex and gender identity. Yet across cultures this identity may not conform to that coinciding with the Western binary mode of gender assignment. Herdt (1990b), in contrast to the Western notion of binary gender (male vs. female), calls for a three-sex code system because some societies are more flexible about the fit between gender identity and gender classification and emphasise the social context, ideology, socialization and gender development. Such an individual in this cultural milieu is neither a man nor a woman, nor a man wanting to be a woman (or vice versa), but belongs to a distinct third category. Other similar categories based on social and cultural categories have been described (David & Whitten, 1987). Jacobs and Roberts (1989) suggest that (even) three genders may not be enough to capture the complexity of the ethnographic material. Different gender designations are reflected in some Latin American settings (Parker, 1991).

It must be emphasised that gender identity may not bear any relation to sexual arousal. Sexual identity, cross-dressing and sexual orientation are not on a direct continuum but discrete independent categories (Callender & Kochens, 1986). There remain several problems in this classification and, as noted, the binary model is not necessarily applicable to many other societies.

In the Indian subcontinent too, cultural values see sexual adequacy, particularly in males, as the benchmark of masculinity, virility, personal adequacy and fulfilment (Kulhara and Avasthi 1995). The prevalence of sexual dysfunctions in hospital-based psychiatric clinic populations is said to vary from 9.2 to 13% (Nakra *et al.*, 1977; Bagadia *et al.* 1972). However, these are likely to be an underestimate because the prevalence in the patient population really depends upon the clinics from which the data are collected, along with what measure are used to ascertain sexual dysfunction. Bagadia *et al.* (1972) had collected their sample from a psychiatric clinic where they recruited 551 patients, of whom 339 had a sexual problem as a presenting complaint. Of these, the researchers were unable to evaluate 81 patients, and complete assessment was possible on 258 patients. The assessments included physical examination and Rorschach test. Of the sample, 119 were married and in this group 48% of the sample reported impotence, 35% reported premature ejaculation and 44%

reported passage of semen in the urine. In the 139 unmarried patients, the commonest complaint was that of nocturnal emission (65% of the sample) and nearly half (44%) complained of passage of semen in the urine. All the patients had a diagnosed psychiatric condition with anxiety being the commonest, followed by neurotic depression. In addition to the sampling problems, the study did not present the data on Rorschach test and did not explore or standardise definitions of nocturnal emission, passage of semen, etc. Nakra *et al.* (1977, 1978) reported from a psychiatric clinic in North India that 9.2% of all patients attending had impotency (*sic*) problems – impotence being the commonest (reported in 35% of the sample), followed by premature ejaculation (reported by 25% of the sample). Interestingly, the spouses were either indifferent or unhelpful, thereby indicating the female expectations of the relationship. Three-quarters of the sample had practised masturbation and 43% reported guilt as a result of this. Adolescent homosexual contact was acknowledged by 16% of the patients. Kar and Varma (1978), reporting on a sample of psychiatric patients, noted that 48% of the patients ($n = 72$) had failed to perform on their honeymoon, compared with 19% of sex-matched controls. In another clinical sample, Kumar *et al.* (1983) observed that in patients with neurosis, sexual frequency and satisfaction both dropped significantly. Avasthi *et al.* (1994) reported that 30% of cases recruited from a general hospital had erectile dysfunction and 12% had premature ejaculation, though in 45% of the cases these two were combined. Avasthi *et al.* (1995) studied 464 cases in a sexual dysfunction clinic and 30.4% had clinical diagnosis of erectile dysfunction followed by a combination of erectile dysfunction and premature ejaculation in 26.5% of cases. A vast majority (96%) were males. Among females, vaginsmus, dyspareunia and lack of sexual desire were common presenting complaints. In the Indian context, lack of privacy is often associated with premature ejaculation (Nag, 1972).

From Turkey, Uguz *et al.* (2004) reported that prevalence and types of sexual dysfunction were broadly similar to those reported from the West.

In south Asians in Leicester, Bhugra and Cordle (1986, 1988) both found that male partners often spoke on behalf of their female partners. The referrals were more likely to be from secondary care. Shaeer *et al.* (2003) found that 57.4% of men attending a primary care clinic in Nigeria had erectile dysfunction, whereas in Egypt 63.6% of men and in Pakistan 80.8% of men (aged 35–70) reported so. Older age, diabetes, peptic ulcer, prostate disease, depression-related symptoms and caffeine intake were independently associated with increased prevalence of moderate to complete erectile dysfunction. In an unusual study exploring the attitudes and experiences of psychoanalysts regarding their patients in USA, Canada and Australia, Doidge *et al.* (2002) found that mood disorder, anxiety disorder, sexual dysfunction and personality disorder were the commonest reasons for analysands seeking help. Although the numbers are small and response rates poor, the data clearly indicate that neuroses still form a bulk of the psychoanalysts' workload.

Conclusions

Although the epidemiological data are scanty, there is enough clinical evidence to suggest that sexual dysfunction is present across all societies and cultures. However, the prevalence of patients presenting to clinics varies dramatically. This may be due to a number of factors. Furthermore, the role of female sex in the act, their needs and desires are often ignored completely. The prevalence of various types of sexual dysfunction when confirmed is likely to lead to a clear understanding of treatment needs and accurate service planning.

The role of paraphilias, transgender, homosexuality, bisexuality and morbid jealousy also varies across cultures. Cultures determine and define what is normal and what is deviant and are therefore likely to develop pathways into care for psychosexual dysfunction. There is an urgent need for further exploration of social, biological, anthropological and psychological factors in the genesis and perpetuation of sexual dysfunctions and their management. The type of society and culture and the emphasis it places on the role of the sex act is important in understanding how patients and their partners present and how they accept help. Patients in sex-positive societies may have higher levels of paraphilias and yet may readily seek help for their sexual dysfunction, whereas for sex-negative societies the reasons may be an urgent need for procreation rather than for pleasure. It must be emphasised that individual societies and cultures are not static and their characteristics may shift between sex-positive, sex-negative and sex-neutral status. Under these circumstances, the individual attitudes may also shift and their engagement in any therapeutic endeavour may become difficult.

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28

Therapist–patient interactions and expectations

Digby Tantam

EDITORS' INTRODUCTION

Having set the scene in an earlier chapter on the theme of culture and psychotherapy, in this chapter Tantam deals with therapist–patient interaction and expectations of the patients from the therapeutic encounter. There is a distinction between a patient's expectations at the beginning of the encounter and as therapy progresses these expectations change. Expectations will be influenced by previous experience (whether of counselling, which may actually increase the likelihood of continuing with treatment) or other treatments. The expectations that therapists carry with them are also important in therapeutic adherence. The expectations that therapists carry depend upon a number of factors, including their own cultures and their experiences with members of other cultures. The world view of both the therapist and the patient has to have some common values so that therapeutic work can begin. Cultures have unique and common values and some values which are common to other cultures. Similarly, between the therapist and the patient there will be common values and unique value. Empathy as a process by which the thoughts, feelings and emotions of an individual can be understood is a key component of the therapeutic encounter. Becoming more culturally aware of and therein becoming aware of and meeting patient's expectations and dealing with patients in an empathic and compassionate manner will improve therapeutic engagement and outcome.

Introduction

Sir William Osler is often taken as the pattern of the physician, a doctor who was described by his famous pupil Cushing as 'one of the most greatly beloved physicians of all time' (Bliss, 1999). One of his more famous patients was the American poet, Walt Whitman. Whitman was his patient between 1896 and 1890 when he was living in Camden, New Jersey and Osler was Professor of Clinical Medicine at the University of Pennsylvania. Whitman was not altogether pleased with Osler's care. He was upset that Osler seemed less interested in his patients than in academic medicine. He was bothered when Osler did not visit when he had said that he would. Most upsetting of all was Osler's breezy manner. Whitman wrote:

> I confess I do not wholly like or credit what he says – I do not fancy the jaunty way in which he seems inclined to dismiss the troubles. Still, that may all be a part of his settled policy – I do not object to cheer. I don't know if it's from getting down to hard pan or is a theory, but whatever, Osler pursues it . . . Still, I know my own condition – don't need him to tell me about that – can't be fooled (Martens, 1997).

Whitman had had a stroke and Osler, presumably, had nothing specifically therapeutic to offer but believed that his determination to be optimistic would be helpful.

Further on in the article from which this information was taken, Martens goes on to consider the effect on Osler of the First World War, in which he had lost his only son, and the subsequent influenza epidemic and compares it with Whitman's own experiences of being a nurse in the American Civil War. Osler himself referred to the effects in his Presidential address to the Classical Association: 'If

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survived, a terrible infection, such as confluent smallpox, seems to benefit the general health. Perhaps such an attack through which we have passed may benefit the body cosmic.' Osler goes on to sketch a new order, and a revival of old medical values. Osler quotes approvingly from Hippocrates, whom he describes as the 'father of medicine' extolling 'the love of humanity associated with the love of his craft! – philanthropia and philotechnia – the joy of working joined in each one to a true love of his brother' (Osler, 1920).

Whitman the poet, and Osler the bereaved father who had seen the consequences of scientific warfare played out in a convulsion of the civilized European nations, both wanted medicine to rediscover its humanity as well as its science.

In this chapter, I will consider what patients expect from doctors, psychiatrists and therapists as human beings, above and beyond their technical expertise. Of course, the latter is important. A doctor or therapist who is charming and humane, but scientifically inept, is not the doctor or therapist that most of us would wish to have. The older and wiser Osler, and the dying Whitman, would not have wanted that, either. But they expected something more of good doctors and therapists, as do patients themselves. It is that something more which I will consider in this chapter. I shall argue that it is, as Martens contends, linked to humanity and not science; that practitioners who have experienced tragedy or loss themselves may be more able to provide it; and that it involves the recognition that one's own culture whether it is that of science, or of a particular therapeutic modality, or of a particular country, can sometimes get things wrong, even terribly wrong.

Doctor–patient relationships

Does it matter whether or not a patient gets on well with his or her doctor or therapist?

Whitman continued to receive treatment from Osler until Osler took up his post at Johns Hopkins, and moved away. Whitman's disappointment with Osler did not interfere with his therapeutic relationship with Osler, and so far as is known, his compliance with Osler's treatment.

Whitman is unlike most patients. Cancelled appointments do more than disappoint. Cancellation increases the odds of unilateral vs. agreed termination of counselling, as does being placed on a waiting list (Corning and Malofeeva, 2004). In fact, about 30% to 60% of clients drop out of therapy prematurely, most of whom will not have had the time to benefit (Pekarik, 1983) (Pekarik, 1992a). For every early drop-out, there are an indeterminate number of potential patients who either did not show up, or who resisted referral or self-referral. Unwillingness to participate in treatment is therefore a major factor in limiting treatment effectiveness.

The practitioner and the patient viewpoint

Cancellations and being placed on a waiting list may be the consequence of administrative pressures, and the practitioner may argue that these are the inevitable consequences of resource limitations and not a reflection of the practitioner's own care or concern. Moreover, the practitioner may conclude that many patients who drop out do so because their expectations are unrealistic.

This is not how it seems from the patient's side. Most of us as patients do not question our own expectations, but we do know when we are let down, or likely to be. As treatment progresses, we are also inclined to focus more on the treatment that we receive from our particular therapist or therapists and be less influenced by the overall treatment situation, but most of us as patients do not experience this as a change in expectation. We continue to want not only to receive competent care, but to experience feeling cared for, and cared about.

Treatment expectations

Empirical studies have avoided taking either the patient's or the therapist's viewpoint, and instead enquired about patient's expectations, how they match with those of the therapist, and how they relate to outcome. Expectations are influenced by previous experience, and it is therefore not surprising that previous experience of counselling significantly reduces the odds ratio of unilateral treatment termination vs. other reasons for termination. However, counter-intuitively, previous experience of counselling also reduces the odds ratio of mutually agreed termination (Corning, Alexandra and Malofeeva, 2004) as against termination for external reasons or continuing in therapy. The anomaly arises because the predictors of reason for termination change as treatment progresses (in this study, after session 8). Treatment, and treatment aims, become more personal and the factors that influence treatment adherence change. We will consider these later effects in the section below, on therapist – patient interaction.

In another study, of child and adult mental-health services, problem improvement, environmental obstacles, and dissatisfaction with treatment were the reasons most often cited for dropping out. However, all the patients who dropped out rated their therapists as being less satisfactory than did the patients who were continuing in treatment or who had completed by mutual agreement (Pekarik, 1992b).

What do patients expect from therapists?

Therapists have many times been the subject of documentaries, films, novels and other texts. Few people in a Western culture consult a therapist without some expectations of what they will find. Many of these accounts tend to emphasize therapists' human frailties (Gabbard, 2001) but they also shape expectations and these seem generally positive, with the expectations of psychological therapies being more positive than those for psychiatric treatment generally (Noble, Douglas and Newman, 2001). Studies of cultures which are less exposed to the Hollywood film might provide more information about naïve expectations of therapists and therapies. These studies, too, also throw light on one of the important issues in cross-cultural psychotherapy provision: to what extent can traditional Western psychotherapy meet the needs of people from different cultures, and different ethnic groups whose expectations of help may be very different from those of Westerners.

In one such study, in Holland, 82 Turkish and 58 Moroccan attenders at a community mental-health centre were interviewed and asked about their satisfaction with their therapists. Ethnic matching (see below) was only weakly associated with satisfaction, which was mainly determined by perceived clinical competence, and compassion. There were two elements to compassion: shared world view and empathy (Jeroen, 2004).

World view, values and emotions

World view is an Anglicization of the original German 'Weltanschauung', a term to which Freud dedicated a paper (Freud, 1933) in which he castigated what he described as the infantile Weltanschauung of religion. Indeed, he rejected the idea of having a Weltanschauung at all, inasmuch as he considered it to be a 'comprehensive hypothesis, a construction, therefore, in which no question is left open and in which everything in which we are interested finds a place.' He goes on to say that 'It is easy to see that the possession of such a Weltanschauung is one of the ideal wishes of mankind' (*ibid*. p. 92). Freud's view of Weltanschauung was no doubt coloured by the Nazi's annexation of the term, and by his longstanding concerns with social control, and in particular religious control, and its repressive effect. Sociologists have provided some support for the phenomenon, although giving it a different explanation. For example, Pike (Pike, 1986) describes the severe penalties for voting against the majority, for allowing a child to have a tonsillectomy rather than to be traditionally healed, or for committing a shameful act in Mixtec society. He concludes that social rejection and gossip are used to extrude all such people because they challenge the Mixtec world view. From the anthropologist's point of view 'Public approval versus public disapproval can help focus attention on the values of that society and on the mechanisms of enforcement of those values (*ibid*, p. 3048)'.

Freud's account is that people cleave to a world view for emotional reasons; Pike's that they subscribe to one imposed on them by their culture in order to maintain their status within the society whose culture it is.

One possible reason for the discrepancy is the differing focus of psychoanalysis, with its emphasis on emotion, and linguistics, with its emphasis on cognition. Pike was focusing on those beliefs which act as values, Freud on what I shall call in this paper emotional flavour. Both are, as I shall argue in Chapter 29, elements of culture but transmitted differently. Emotional learning occurs at the mother's knee, as a result of discussions as soon as the child can talk about emotions (Mancuso and Sarbin, 1998) and perhaps even earlier, as a result of modelling. Learning about values occurs later, and involves an element of systematic instruction (Prencipe and Helwig, 2002).

Values and expectations

Culture can, as I shall consider in more detail in Chapter 29, be mapped by its effects on the values, norms, and artefacts of a society or social group. Rokeach (Rokeach, 1973) defines a value as 'an enduring belief that a specific mode of conduct or end state of existence is personally or socially preferable' (p. 5). This definition is itself based on Kluckhohn's (Kluckhohn, 1951) definition of values as 'conceptions of the desirable means and ends of action' (p. 395).

Kelly and Strupp (Kelly and Strupp, 1992) used the Rokeach scale, based on this definition, to evaluate to what extent values determine outcome. They hypothesized that similarity of ideological values, and dissimilarity of life-style values, would correlate with a good outcome.

Unexpectedly, they found that many values did not change or even became less congruent to those of the therapist. These were wisdom, social values (equality, freedom, national security, a world of peace and a world of beauty), intellectuality and logicality, cleanliness, politeness and responsibility. There were values that changed, however, including most of the personal goals (valuing a comforting and an exciting life, family security, health, inner harmony, mature love, pleasure, salvation, self-respect, a sense of accomplishment and social recognition) and competency values (including ambition, broadmindedness, capability, courage, imagination and independence).

A belief in salvation seemed different to the other values. Patients who had a conviction about salvation had a poor outcome with therapists who did not have this belief and who were not willing to respect it in clients.

Many other studies support this finding. Patients or clients who have strong religious convictions tend, or so it seems, to explain psychological distress in terms of their spiritual health. Therapists who are not willing to work in these terms cannot get on terms with them at all (Schultz-Ross and Gutheil, 1997). Unfortunately, as the earlier quotation from Freud indicates, psychotherapy has often set itself up as a rival to spirituality and religion. As a result, many people from cultures where spirituality continues to be an important and everyday part of life choose spiritual healers or priests for help, rather than psychotherapists (Kelm, 2006). Spirituality is especially important for people of colour in the US (Cervantes and Parham, 2005) and may be one reason why the uptake and outcome of psychotherapy is particular low in that group.

Kelly and Strupp found that an adequate degree of similarity of values, or values matching, was required for good outcome (Kelly and Strupp, 1992). Too little similarity increased the risk of drop-out (and probably also reduced the likelihood of a person seeking therapy at all). However, leaving aside the particular value of salvation, it did not seem to matter which particular values were similar, almost as if values are like a Velcro sheet – enough similarity, enough contact at any point of the sheet, and there is some adhesion between patient and service.

Culture and values

Cultures, by definition, are defined by their unique values. A therapist and a patient within the same culture are likely therefore to share values that are part of that culture, and to have a basis for the kind of adhesion or, to use another analogy, value matching that increases the chance of a therapeutic relationship being developed.

Cross-cultural therapy, on the other hand, places therapist and patient in a situation in which cross-cultural overlap is reduced. Therefore, finding enough of an overlap between values for the therapeutic relationship requires effort or skill. Guidelines recently published by the American Psychological Association (APA) on 'Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists' (American Psychological Association, 2003) take this into consideration. The APA points out that the previously accepted 'colour-blind' approach in which therapists try to ignore any ethnic, cultural and linguistic differences that may exist between themselves and their clients should be abandoned. Although colour blindness might reduce overt racism or stigmatization, it also means that therapists do not actively explore their own and their patients' values and therefore do not seek out points of overlap.

The APA recommends a 'culture-centred' approach to psychological practice. Psychologists are encouraged 'to use a "cultural lens" as a central focus of professional behaviour. In culture-centred practices, psychologists recognize that all individuals, including themselves, are influenced by different contexts, including the historical, ecological, sociopolitical, and disciplinary.' (*ibid*, p. 380). The 'cultural lens' or the 'culture-centred approach' are devices by which psychologists or therapists can try to transcend their own culturally determined viewpoint or world view. The authors of the guidelines review a substantial amount of relevant literature and propose three strategies for doing this. The first and 'most critical' is for the therapist to become more aware of their own attitudes and values and not assume that these simply reflect how the world is, or how it has to be. The second strategy and third strategies are 'effort and practice in changing the automatically favorable perceptions of in-group and negative perceptions of out-group' by increased contact with members of other cultural groups, particularly with individuals of equal status whose perspective one can take, and with whom one can empathize.

Empathy

Goldie (Goldie, 2003) defines empathy as 'a process or procedure by which a person *centrally imagines the narrative* [italics in original] (the thoughts, feelings, and emotions) of another person' (*ibid.* p. 195). In order to be able to do this imagining, a person needs access to another person's feelings and this is provided directly through a process of emotional contagion. Preston and de Waal in an influential review (Preston and de Waal, 2002) define empathy in terms of emotional contagion or at least in terms of a more general process by which '… attended perception of the object's state automatically activates the subject's representations of the state, situation, and object, and that activation of these representations automatically primes or generates the associated autonomic and somatic responses, unless inhibited.' (*ibid*, p. 4).

It is the inhibition of empathy that is of particular interest in the so-called empathy disorders (Tantam, 1995) but empathy training of clinicians has focused on the later process of imagining what it would be like to be a person experiencing a particular feeling.

There is however an intermediate stage in the development of empathy which occurs in later infancy when infants are acquiring prosocial behaviour (Eisenberg, 2003) and learning to control their own emotions. This socialization process leads children to inhibit emotions that are not considered acceptable by a member of their family, by the family in general, or in their culture. This learning also extends to the child's empathic, emotional responses to others. Empathic responses which correspond to emotions that the child has learnt to inhibit are also inhibited (Eisenberg *et al.*, 1991b). The process may apply particularly to negative emotions. Children whose negative emotions – anger, fear or sadness – are contained by their families without being rejected appear to be more able to empathize with another child showing negative emotion (Eisenberg *et al.*, 1991a; Eisenberg *et al.*, 1994).

Describing these changes as the result of processes makes them seem more determinate than they probably are. I prefer to think of emotional development as consisting of something skin to aesthetic appreciation, in which development consists in finding greater emotional complexity and nuancing in events, objects, relationships, or people (Tantam, 2003) as a result of repeated experience and co-experience, and not as a result of deliberation. This account is consistent with that of the psychoanalysts who have added considerably to the conceptual tools which can be applied to emotional development (Tantam, 1996). Fairbairn, for example, describes in object-relation theory terms how some emotional responses can become inhibited because they are ones that have consistently elicited rejection by a carer; or to use my terms, emotions that are associated with rejection are likely to become unpalatable to the child, and therefore emotional flavours to be avoided.

Learning to empathize more with others is, I would say, not only a cognitive exercise, of imagining more fully what it would be like to have that emotion, but also an aesthetic/affective accommodation to previously unpalatable emotional flavours.

Ethnic matching

In a previous study of patients who drop out of community mental-health treatment, Klerman and I found (Tantam and Klerman, 1979) that patients who did not keep even their first appointment had sometimes come to the clinic, walked in and then walked out again. They said that they simply did not like the feel of the place. I would now say that the emotional flavour of our community mental-health centre was unpalatable to these potential patients. One reason may have been that many of them were Hispanic, whilst our clinic staff was predominantly White. Maybe in the 30 seconds in which they made up their minds whether or not to make themselves known to the receptionist, these potential patients had seen all these white faces or some kind of white emotional flavour, and found it unpalatable.

One possible answer to this is to 'ethnically match': to provide patients with therapists of their own ethnicity. This obviously presents practical problems as there simply may not be enough suitably trained therapists of a relevant ethnicity. It also fails to address the other cultural elements which may lead to unpalatability, such as age, gender, dress code, language, class and so on.

There are two strong arguments in favour of ethnic matching. The first is that the no-show rate for mental-health-related appointments can be as high as 50%. If a proportion of these no-shows are, in fact, people for whom the therapy offered is emotionally unpalatable and if a proportion of this is due to the lack of ethnic matching, then ethnic matching is a way of increasing the accessibility of services.

The other argument is that the unpalability of the emotional flavour of the therapist or the therapy may also influence early drop-out rates, which are particularly high in some ethnic-minority groups accessing White-dominated services, at least in the US. There is a considerable accumulation of evidence for an exposure effect in psychotherapy: the longer people choose to remain in therapy, the more likely that they are to benefit. Compliance may be affected by factors other than choice. For example, many recent studies of psychotherapy in the US have been of outpatients receiving psychotherapy as part of the treatment of their substance misuse. Attendance at psychotherapy sessions may, for them, be linked to avoiding gaol or receiving methadone maintenance. However, in a situation where there is free choice, persistence in treatment is directly, and drop-out rate is inversely, linked to outcome.

Despite the theoretical support for the value of ethnic matching, a recent review (Karlsson, 2005) concludes that 'there is little evidence that ethnic matching leads to better outcomes or greater satisfaction of psychotherapy' (*ibid*, p. 117). One reason may be that the patients who did not enter treatment at all are excluded from the evaluations reviewed. Another may be the practical problems already alluded to, and also considered in this review. Another may be that what matters in the therapeutic relationship is the match between therapist and patient, and matching ethnicity cannot guarantee this nor can a lack of matching on ethnicity be assumed to be a lack of any match. However, perhaps the most important reason that ethnic matching is not effective is that psychotherapy is a human process, in which people adjust. If the patient and the therapist can both accommodate to each other – an accommodation that involves both a respect for other values, and the ability to learn to like new emotional flavours – then ethnic matching may not be important.

Therapist interaction

The ability of therapists to reach out to their patients, either emotionally or by being able to understand and respect their values, is only one facet of therapeutic success. Close relationships of all kinds can only be maintained if there is a device for managing negative emotion which spills over into the relationship itself, as it usually will sooner or later. Men may remain friends over long periods by avoiding areas of possible disagreement (Duck, 1995), but the consequence is a lack of intimacy which is inimical to psychotherapy.

The link between drop-out from therapy and outcome might seem tautologous. It might seem that people continue to attend psychotherapists whilst they are rewarded by an improvement until that reward falls below the cost of attendance, and then they stop. This explanation, though, is based on the presumption that psychotherapy provides continuous incremental improvements after each session. Studies of psychotherapy over time do not often fit this model. There are sudden breakdowns in the therapeutic relationship and sudden gains, improvement is typically seen after a latency period, and there is an optimal treatment dose which differs for different treatment outcomes, exceeding which can result in a poorer outcome. More importantly, there are substantial differences between therapists, which are reflected in the greater likelihood for therapists who have poorer effectiveness to have their patients drop out (Lambert and Ogles, 2004). Clients who are predicted to have a poor prognosis have as good an outcome as those who are predicted to have a good prognosis if they complete the course of therapy – but, of course, many more of them drop out, which is what makes for their poor prognosis (Tantam, 2002; Wampold, 2001).

Training in cultural competence is designed to increase cultural awareness. The methods are considered elsewhere in this book. In one study, even brief cultural-awareness training resulted in a reduction of the proportion of African-American clients dropping out of treatment with therapists who had been trained (Wade and Bernstein, 1991). Cultural awareness does not just apply to making a relationship with the patient in the first place, although this is important, but also managing negative emotion and challenges to personal values. Cultural competency therefore does not just apply to being warm and friendly. It also extends to being able to use culturally appropriate means of resolving conflict and negativity.

Humanities, again

Travel and wide reading are long prescriptions for developing knowledge and sympathy for other peoples and other cultures. Whilst the APA guidelines seemed mainly to be focused on encouraging psychologists to work more with people from cultures other than their own, they could have referred to these values of an earlier age, values which Osler himself espoused.

However, there was a further element in Osler's humanity which did not come from his eclectic reading, nor from his experience of practice in both North America and Europe: his empathy. This, according to Martens (Martens, 1997), was something that Osler conspicuously displayed only late in his career. He gives the example of Osler giving a rose to the mother of an influenza victim that Osler had been treating, and contrasts this with the breezy manner that he had shown to Whitman earlier in his career.

We can speculate that the loss of his own child made it possible for Osler to empathize with another bereaved parent. But more generally, we can speculate that an experience of emotional upheaval, in which our accustomed emotions and emotional reactions no longer seem to apply, may be one route by which therapists and physicians become more open to their patients' own emotional uncertainties and upheavals. This is certainly one of the contentions of the wounded-healer movement (Jackson, 2001).

However, there is the further requirement on the therapist that they have the ability to repair breaches in the therapeutic relationship when they occur. This certainly requires an awareness and respect for the values of the patient, as well as empathy for them. But is also requires a degree of emotional steadiness, sometimes termed the capacity for containment, by psychoanalysts.

Travel, with its own small attendant desperations, and reading, with its opportunity to identify with heroes and heroines stricken by circumstance, might in lesser ways also increase our capacity to empathize. Both travel and reading can certainly open our eyes to other values, and other world views. Can they help to increase our capacity for containment?

Perhaps they can, but only if we have the perspicacity to know that, when we visit a place that has a powerfully negative effect on us, or when we throw down a book in disgust or anger, that is the place or the book that we should persevere with. Perseverance is, however, effortful. Not only does it provoke cognitive dissonance (discussed in cross-cultural terms in Chapter 29) but it requires us to accustom ourselves to previously unpalatable emotional flavours. Doing that requires a degree of emotional comfort.

Becoming more culturally aware, and therefore more effectively meeting and working with our patients' expectations, as well as interacting with our patients in a manner that satisfies them and us, requires effort too. But we can only expend this if we have reserves. If what patients want from us is compassion – and that is what one previously quoted cross-cultural study has suggested (Jeroen, 2004) – then the heart of compassion has its own beat. The compassion of the therapist has its diastole in which care and comfort has to be taken in, as well as its systole. Perhaps, like Osler, we might keep some books on our bedside table that can provide comfort and refuge as well as stimulation and challenge and in both of these ways increase our compassion.

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Developing mental-health services for multicultural societies

Harry Minas

EDITORS' INTRODUCTION

The movement of people across the globe has been at an unprecedented scale in the twentieth century. The impact of migration has been studied more on individuals and migrant groups and less on the societies to which people migrate. The health needs of healthy migrants are different from those who may accompany them. In addition, the impact of such healthcare demands on the societies and their resources has to be studied systematically. The systems of healthcare in multicultural societies are likely to be influenced by the social status of the migrants. The development of services, especially psychiatric ones, has to take into account post-migration stress and stressors.

Minas in this chapter sets the scene for needs of migrant communities and the shape of psychiatric services that can deliver the healthcare that will be effective. Furthermore, the key features of these services for culturally diverse societies have to be effective and equitable. The main characteristics would be jointly defined by patients, carers, community and service providers, who will also determine where services are provided, how capacity is developed and respond appropriately to religious, cultural and communication needs of patients. Mental-health services have to be developed in the context of national, regional and local policies. However, Minas argues, a central requirement for reform is an understanding of the policy cycle, which has six components. These include defining the problem, diagnosing the cause of the problem, making political decisions and implementing them, followed by evaluation. The engagement of key stakeholders is an important step. The accessibility of services has to include the following characteristics: visible accessibility, physical and procedural accessibility and psychological and cultural accessibility. Economic accessibility is also important and services outside the financial capabilities of potential users are inaccessible. The leadership for developing mental-health services is critical. Minas highlights the systems approach where changes in one system will result in changes in one or more other areas. Although standards and guidelines encourage uniformity, the role of multicultural populations in these is less well understood. Mental-health systems should be seen as complex adaptive systems.

Introduction

Over the past century, world wars, the fragmentation of empires, the partition and collapse of states, colonial wars and post-colonial civil disorder have produced population movements on an unprecedented scale (Minas, 2001a). In our own time, the so-called war on terror and the political doctrine of unilateralism and preemption will play out in unpredictable and probably disastrous ways, as is happening in Iraq. The pressures of globalization (structural adjustment, technological change, the globalization of work and trade liberalisation) and the ever-increasing gap between rich and poor, environmental degradation, and the increasing economic non-viability of rural life in villages and towns everywhere will continue to produce massive movements of people from rural areas to the megacities and across borders. In 2005 the number of 'people of concern' to UNHCR was 19.2 million, an increase from 17 million the previous year. In a more positive development, the number of refugees fell to 9.2 million, the lowest number in a quarter of a century (UNHCR, 2006). It will become difficult to maintain the artificial distinction between refugees

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who are subject to political oppression and violence and are protected by international agreements and those who are not – economic and environmental 'refugees'. Already the doors are slamming closed in the face of asylum seekers (Edwards, 2005, McNeill, 2003). Many of the former colonial powers have experienced a massive influx of immigrants from their former colonies in North and Sub-Saharan Africa, Asia, the Caribbean and elsewhere. Poverty and unemployment have resulted in large numbers of temporary labour migrants. People-trafficking is among the most profitable forms of illegal trade. A number of countries have come to rely on remittances from their nationals working overseas and other countries rely on illegal migrants to do work that their own citizens prefer not to do. Patterns of migration, voluntary and forced, are very fluid. The mental health of immigrants and refugees will continue to be shaped by the nature of pre- and post-migration experiences.

Ethnic and cultural diversity, now a prominent feature of most developed nations (Fearon, 2003), confronts nations with numerous challenges (Kymlicka, 1995) and raises important questions concerning national identity, the legitimate role of government, distribution of resources, acceptable and non-acceptable cultural practices, and the purposes, structure and operation of social institutions. Mental-health systems are in the front line in dealing with the mental-health consequences of pre-migration trauma, migration and the rigours of settlement in a new country. Even in those countries where multiculturalism is broadly accepted by government and the majority of the population, health systems have been slow to organise themselves in ways that would enable them to meet the wide diversity of needs in multicultural populations.

Effective and equitable services

Several authors (Bhui *et al.*, 1995, Minas, 1991, Dana *et al.*, 1992, Sue *et al.*, 1991) have set out their views concerning the key features of equitable and effective mental-health services for culturally diverse societies. One such set of defining characteristics of an effective and equitable mental-health system for multicultural societies is shown in Box 29.1.

While some conceptions of effective and equitable mental-health systems (Minas *et al.*, 1996) have influenced, or have been incorporated into, policies (Multicultural Mental Health Australia, 2004) and mental-health service standards (Australian Health Ministers, 1997), they have generally been constructed in isolation from the

Box 29.1. Some defining characteristics of an effective and equitable mental-health service

1. The mental-health service needs of the community are jointly defined by consumers, carers, the community and service providers.
2. The types of services offered, their location and the skills of professionals, are all issues that are determined by the needs of the community to be served.
3. Service agencies recognise that it is their responsibility to develop the capacity to effectively meet diverse needs.
4. Service agencies respond appropriately to religious, cultural and communication needs of service recipients as well as to direct clinical needs.
5. Those who may require the service:
    - 5.1. know of its existence;
    - 5.2. regard it as being appropriate to their needs;
    - 5.3. can gain easy and timely access to the service;
    - 5.4. can communicate adequately with service providers;
    - 5.5. can gain access to the full range of services which are appropriate to their needs; and
    - 5.6. are treated with respect and without prejudice.
6. Outcome indicators demonstrate that the service is achieving the clinical and other goals of service providers and recipients.
7. The quality of outcome is not determined or substantially influenced by factors such as English language fluency or membership of any particular ethnic or social group;
8. Community, and consumer and carer, representatives are involved in the continuing evaluation, and redesign where necessary, of the service.

Source: Modified from (Minas *et al.*, 1996).

broader processes of health system reform, have not been integrated into general reform processes, and have had little sustained impact on the operation of mental-health services (Fernando, 2005).

Because of the great variety of political, economic and cultural contexts and histories within which mental-health systems have developed and currently operate, there can be no single 'best practice' model of mental-health services for multicultural societies. There are now some good accounts of things that have been tried in a variety of countries (Bhugra, 1997; Fernando, 2005; Baarnhielm *et al*., 2005; Lo and Chung, 2005; Ganesan and Janze, 2005). My intention in this chapter is to present a general outline of an approach that is likely to achieve positive system change. One should expect that the specific shape and content of services that emerge from the application of such an approach will differ according to the contexts in which they develop.

Mental-health system reform

Mental-health services that are of appropriate scope and reach, and that are adequately supported and resourced, cannot be developed in the absence of enabling national, regional and local agency policies. The process of improving mental-health systems so that they are capable of providing high quality services to multicultural populations is best seen as part of the broader process of continuing health system reform. Roberts and his colleagues (Roberts *et al*., 2004) have articulated an approach to health system reform that can serve as a useful framework for thinking about how to develop mental-health services for culturally diverse societies. A central requirement for reform is an understanding of the policy cycle (Fig. 29.1), the components of which are (1) problem definition, (2) diagnosis of the causes of problems, (3) policy development, (4) political decision, (5) implementation and (6) evaluation. Acting to bring about reform requires an understanding of the levers for change that can be used to bring about the necessary changes. The approach is grounded in the recognition that health sector reform occurs within a variety of ethical and political contexts.

Ethical foundations

Any effective health system response to population diversity must be based on firm ethical foundations. The theory of justice elaborated by Rawls (Rawls, 1971, 1993) requires that the most disadvantaged in the population are accorded priority in the framing of political and social arrangements (e.g. mental health policy, allocation of funds, health system design and operation, training of clinicians) that are intended to ensure justice. Basic institutions and social arrangements are inherently unjust if they result in systematic disadvantage accruing to some minority sections of the population (Minas, 2001b). Where systematic disadvantage exists, specific attention needs to be paid to redressing such disadvantage by according priority to the needs of such groups (Barry, 1990) and, where necessary, making particular arrangements to meet needs that cannot be met by existing health system arrangements (Kymlicka, 1995).

The Rawlsian notion of justice as fairness requires that a primary goal of health systems, and of health system reform, is equity. Individuals should be able to attain their full health potential regardless of age, gender, race or socio-economic circumstances. Some unequal distributions of health between groups may be considered unavoidable (e.g. genetic disorders, see Chapter X) or, if avoidable, nevertheless fair and acceptable (e.g. mountain climbers breaking limbs). Inequities in health (unequal distribution of health status, access to healthcare, or potential for future good health between social groups) arise when disparities in health status between groups defined by gender, socio-economic status, or ethnicity are avoidable, unacceptable and unfair. 'From an ethical perspective, inequities are intrinsically repugnant; disproportionate suffering offends our innate sense of justice and presents a strong case for limiting it wherever possible' (Evans and Norris, 2000, p. 297).

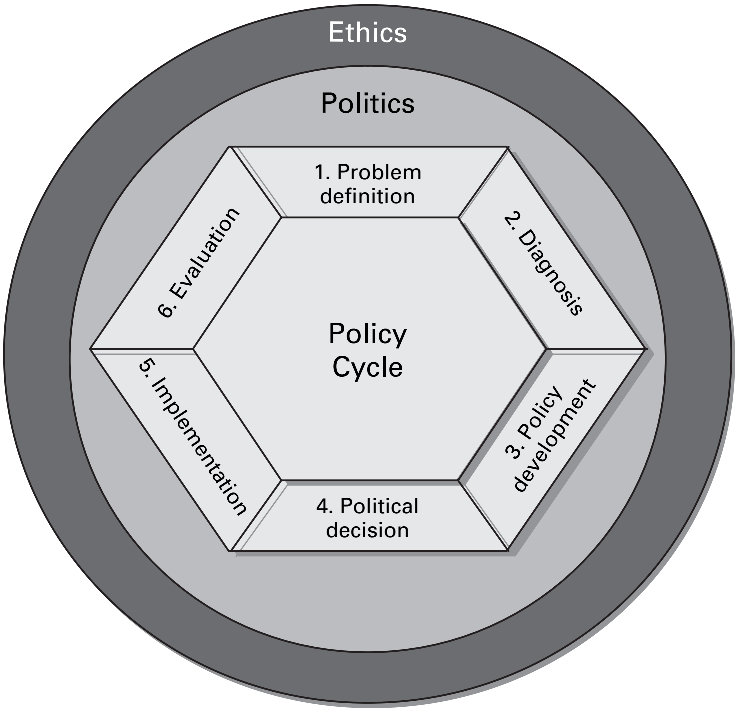

Fig. 29.1. The policy cycle. (Modified from Fig. 2.1, Roberts, *et al.* (2004), p. 22).

Stakeholder analysis and engagement

At the very beginning of a health system reform it is essential to carry out stakeholder analysis (Roberts *et al.*, 2004) and to engage key stakeholders in relevant elements of the process, from agenda-setting and problem definition, through problem diagnosis, policy development, political decision-making, implementation and evaluation. It is necessary to identify the groups and individuals that have a legitimate interest in the process, and in the possible outcomes of the process. Particularly at the stage of political decision-making and implementation, it is vital to assess the political resources and the possible roles of different stakeholders in the political process so as to understand their relative power over the policy issues under consideration. The current position of the various stakeholders on the proposed policy, and the intensity of their commitment to the position, will indicate where support and opposition are likely to come from and the likely force of such support and opposition. When the stakeholder analysis is complete, the proposer of the reform, in consultation with relevant stakeholders, is in a position to develop possible solutions to identified problems and a political strategy that will increase the probability of political acceptability of the proposed reform.

Problem definition

A major impediment to improving mental-health services for multicultural societies is the general lack of clarity in problem definition and the lack of agreed processes for allocating priority to different problem areas. A large part of this is due to lack of data and inconsistent research findings from different geographic regions, from different health systems, and in relation to different communities. There are several possible reasons for the inconsistency of findings (Minas, 2001b), including wide variation in the demographic, cultural and migration profiles of the groups being studied, and in the national and regional mental-health service systems in which the work has been carried out; and major methodological difficulties in cross-cultural mental-health research (Bhui and Bhugra, 2001a,b), such as lack of common definitions of the populations being studied and problems with the concept of ethnicity, problems in sampling ethnic communities, lack of cross-culturally reliable and valid research instruments (Bhui *et al.*, 2003, 2006; Jacob *et al.*, 1997), problems associated with cross-cultural diagnosis, lack of generally acceptable methods for studying culturally derived concepts of mental illness, and wide variations in clinical presentation across cultural groups and health systems. The collection and analysis of health status, health service use, and outcomes data is critical to the task of eliminating inequity. The lack of adequate health information about cultural minority groups renders invisible the inequities that do exist. Box 29.2 shows a list of commonly identified problems.

Such a general listing of problems is of limited usefulness in a specific programme of health system reform. While such a list may be a necessary beginning to indicate the need for action, it is too broad and unfocused for the purpose of guiding specific action. To remedy the problems listed would require major new research strategies and funding arrangements, large-scale community education programmes, education and training of all existing mental health clinicians and students in undergraduate and postgraduate programmes, a substantial increase in numbers of mental health interpreters in those health systems where they already exist and the creation and funding of a new discipline where they do not, new forms of participation of consumers, carers and communities, and much more. Such wholesale renovations of health systems simply do not occur. Effective and sustainable reform can only occur in manageable chunks, usually in chunks that

Box 29.2. Commonly identified problems

- Insufficient information about virtually all relevant aspects of mental health of ethnic minority communities.
- Insufficient data on prevalence of mental illness and mental-health problems in specific ethnic communities, and a frequent failure to include adequate samples of cultural minority groups in large-scale epidemiological studies.
- Lack of knowledge by clinicians and health agencies of the needs of ethnic communities.
- Differing, and poorly understood, cultural conceptions of health and illness and of treatment and care.
- Poor access to service agencies and to the full range of services – particularly the psychotherapies and rehabilitation and social support services – with an inadequate understanding of the factors responsible for underutilisation.
- Poor quality of services
- Poor clinical and social outcomes
- High levels of stigma in ethnic communities
- Inadequate participation by ethnic consumers, carers and communities in policy-making, service design and evaluation, and service reform.
- Inadequate knowledge and skills of clinicians, and inadequate provision of education and training programmes in transcultural mental health.
- Lack of appropriate connectedness of the different components of health systems, and of health systems with broader social systems.
- Failure of mental health promotion and illness prevention programmes to reach ethnic (particularly non-English speaking) communities.
- Significant communication barriers (linguistic and cultural) between clinicians and (non-English speaking) consumers and their families, and inadequate access to skilled interpreters.
- Inadequate information about the quality of interpreting services when they are available.
- Inadequate information on the factors which constitute risks for mental disorders in ethnic minority communities, preventing targeted programmes for vulnerable groups and the development of tailored programmes that address special needs of these groups.
- Inadequate understanding of the factors that influence treatment-seeking decision-making.
- Inadequate support for carers (family and friends) of ethnic minority people with mental illness.

can be achieved in an electoral cycle. Would-be reformers must be passionate and persistent but they must also be patient and realistic.

> Some health-sector planners argue that all one needs to identify problems are good data. But this is not how the world operates. Many reforms move ahead without good data. Many well-documented problems are ignored in reform programs . . . Any policy decision must rely, implicitly and explicitly, on both science and ethics (Roberts *et al*., 2004, p. 24).

It is likely to be strategically useful to focus on problems that: (1) indicate poor health system performance with undesirable health system outcomes; (2) are agreed by key stakeholders to be important; and (3) there is a reasonable expectation that feasible, affordable and politically acceptable solutions can be found. From the extensive list of problems in Box 29.2 it might be useful to focus on one or more of the following critically important health system problems that require attention:

- Lack of adequate information about virtually all aspects of the mental health of ethnic minority communities.
- Poor access to service agencies and to the full range of services.
- Poor clinical and social outcomes.

Identifying the causes of mental-health system problems

Having settled on one or more important problems as the focus for reform, the task is then to identify the reasons for, or the causes of, these problems. Let us take inequitable access to services as an example.

The various domains of accessibility include (Minas *et al*., 1996):

Visible accessibility

Potential users must be aware of the existence of the service. Non-English-speaking communities or black and ethnic minorities generally do not have access to adequate information about available services.

Physical accessibility

Geographic location, availability of transport, etc. Ethnic minority communities may live in deprived parts of cities, or on the outskirts of cities, where mental-health services are generally less available.

Procedural accessibility

The use of particular procedures (e.g. a requirement to complete registration forms in English) may deter some potential service users, as will the characteristics of reception areas and the linguistic and cultural skills of reception staff.

Economic accessibility

Services outside the financial capabilities of potential users are inaccessible. Costs include direct cost of the service, transport and child-minding costs, lost income from work, etc. Immigrant and refugee communities are likely to have less economic means, and may be less likely to have private health insurance than the general community, so that fee-for-service mental-health systems are less accessible.

Psychological accessibility

Aspects of the service that do not conform with expectations and psychological needs will deter use. For example, high levels of stigma associated with mental illness and psychiatric treatment will deter access to mental-health services.

Cultural accessibility

Services that do not accommodate, as far as possible, the potential user's preferred language, values, beliefs and behavioural norms will deter access. Services that are perceived as discriminatory will be avoided.

Problems in each of these different domains of accessibility have different causes and will require different solutions. For the mental-health system in general, or for a particular service agency and particular communities, which of these domains of accessibility are problematic and need to be addressed? Is it all components of the service system that are inaccessible or only some? For example, frequently lack of access is less of a problem for inpatient services and more of a problem for psychological and rehabilitation services that are more language-dependent.

Clarifying causes of major problems in health system outcomes will be the basis for the development of policy options designed to reduce or eliminate the problems.

Development of policy options

As the causes of problems are identified it becomes possible to identify possible options for their solution. This option development process is an essential component of policy formulation. Roberts and his colleagues (Roberts *et al.*, 2004) suggest that, once plausible policy solutions have been developed for identified problems, reform proposals must have three characteristics in order to be accepted: (1) implementability; (2) political feasibility; and (3) political controllability. A policy that, for whatever reason, cannot be implemented is useless. Most policies are not implemented at all or not as intended. Faithful implementation of policies is the exception. The policy proposal must be political acceptable. It must be seen by political decision-makers as dealing with important, clearly defined problems, as politically feasible (e.g. acceptable to powerful interest groups) and affordable. Finally, the implementation of the policy must be politically controllable. It will not lead to runaway increase in costs, or create new institutions or arrangements that are not sufficiently accountable and that are difficult to control.

Political decision-making

Transcultural psychiatry has developed in different directions in different countries due to the varying demographic composition of populations, the particular histories and the different cultural and political commitments of different nations (Kirmayer and Minas, 2000). Countries such as Australia and Canada, that have explicit national policies of multiculturalism, take a different view of the political status of ethnic minorities than do countries such as France, where the republican model of integration privileges the values and interests of the state over the values and interests of ethnic minorities. In France

> no specific epidemiological studies of immigrant and refugee populations have been carried out . . . This absence of epidemiological data mirrors political unwillingness, at the national level in France, to treat the health problems of immigrants and refugees outside the general healthcare system. Thus no national policy for the prevention and treatment of psychiatric illness aimed at these groups has been pursued by the State . . . Only a few independent initiatives have been undertaken to create centres offering psychiatric care for immigrants and refugees (Fassin and Rechtman, 2005, p. 351).

By contrast, in Australia, national mental health policy (Australian Health Ministers, 1992) and the national mental-health service standards (Australian Health Ministers, 1997) specify the obligation of mental-health services to be cognizant of, and to respond appropriately to, the diverse needs of a culturally diverse population. Specific national policies have been developed to improve the quality and accessibility of services for a culturally diverse population (Multicultural Mental Health Australia, 2004). State health departments support specialist transcultural mental health units and services for survivors of trauma and torture that are responsible for improving the quality of mental-health services for immigrant and refugee communities.

The political context, which is different in every country, is of course crucially important in the process of policy-making and in the process of political decision-making. While in general mental health has moved up the list of health priorities over the past several decades, there are major differences across countries in the extent to which mental health, and the provision of high quality mental-health services, is seen as a political priority.

Attempts to develop effective mental-health systems for multicultural societies in the absence of adequate political analysis are bound to fail. Political strategies need to be developed that take into account the players (individuals and groups who are involved in the reform process and who may facilitate or derail the intended reform), the relative power of each player in the political process, the positions taken by each player (support or opposition), the intensity of commitment to the position, and the perception of the proposed policy, including the definitions of problems and proposed solutions, and the consequences for each player of implementation of the policy (Roberts *et al.*, 2004).

Implementation and evaluation

Most policies, including policies that have been intended to improve the mental health situation of immigrant and refugee communities in multicultural societies, fail to be implemented (Ziguras, 1997). It may be that this is due to inadequate preparation during previous phases of the policy development cycle. It may be due to the fact that there are always competing health system priorities. A particular deficiency in attempts to develop equitable mental-health systems for multicultural societies is the lack of adequate economic analysis (both the downstream costs of failing to develop such systems and the estimated economic benefits of developing equitable mental-health systems) of the kind that have been so influential in the general mental health reform arena. (Hickie *et al.*, 2006). However, it is important to remember that implementation is difficult, particularly when the new system requires new skills, new ways of working, new patterns of relationships, and shifts in the relative power of professionals and consumers, and of the different professional disciplines. It is also a common experience that pilot programmes are very difficult to sustain (Fernando, 2005) and to scale up to a level where they have a system-wide impact. Very few transcultural mental health programmes have been evaluated. Those that have been adequately evaluated have frequently demonstrated considerable benefits (Ziguras *et al.*, 2000, 2003; Kirmayer *et al.*, 2003).

Leadership for mental-health system development

A critical ingredient in developing mental health for multicultural societies is leadership. The policy development process outlined above requires leadership in multiple domains and at multiple levels that is clear-sighted, focused and sustained over time. Bringing about major change in social institutions, such as the substantial reform of the Australian mental-health system over the past 15 years (Whiteford *et al.*, 2002; Whiteford and Buckingham, 2005; Hickie *et al.*, 2005; Singh, 2003; Thornicroft and Betts, 2002), solves some problems and creates others (Senate Select Committee on Mental Health, 2006; Mental Health Council of Australia, 2005). The essence of leadership is bringing about change in complex systems (Minas, 2005). Mental-health systems are complex in the everyday sense of being complicated, and in the more formal sense of being complex adaptive systems. Regardless of the composition of complex adaptive systems (e.g. physical, biological, ecological, organisational systems), they share a number of crucial properties, including multiple levels of organisation, open boundaries, rule sets or control parameters that determine the state of the system at any point in time, adaptation and structural coupling, self-organisation, emergence, and non-linear causality (Plsek and Greenhalgh, 2001; Wilson *et al.*, 2001; Plsek and Wilson, 2001). The behaviours of agents in the system are governed by rule sets. The settings, or values, of these rules are the system's control parameters. In human systems, such as health service organisations, the actions of agents (clinicians, managers, hospitals, community mental health centres, NGOs, academic departments, ministries of health) are governed by laws and regulations, and cultural values, beliefs and commitments.

It is now recognised that improving quality of care involves improving whole systems around the clinician–patient interaction and that a key task for quality improvement is the creation of an environment in which excellence in clinical care will flourish (Callaly and Arya, 2005). The interactions within a complex adaptive system are more important than the discrete actions of the component parts. Clinical governance aims to facilitate multi-disciplinary teamwork, partnerships and cooperative working practices. Productive or generative relationships occur when interactions produce new and valuable capabilities that are not possible through individual action of the parts (Plsek and Wilson, 2001).

Progress toward goals that are desirable but difficult to achieve can occur through applying to the system a few simple, flexible rules, sometimes referred to as *minimum specifications* (Minas, 2005). While the tendency in policy implementation and management is to specify in great detail what is to be done at all levels of the system, taking a *minimum specifications* approach makes clear what is essential and irreducible and leaves room for creativity and innovation. They encourage discussion about how they are to be achieved, thereby increasing connectedness and facilitating shared views of what is to be done. If minimum specifications focus on system-wide targets, they encourage generative relationships and the emergence of solutions that are relevant to local conditions. The concept of minimum specifications is being applied to the redesign of health care in the United Kingdom (Plsek and Wilson, 2001). An example of such a set of minimum specifications (Box 29.3) is contained in the Victorian Strategy for Safety and Quality in Public Mental Health Services (Metropolitan and Aged Care Services Division, 2004, Metropolitan and Aged Care Services Division, 2004) and the Commonwealth document *National Action to Improve the Quality of Mental Health Services* (AHMAC National Mental Health Working Group Information Strategy Committee, 2005). I have added some questions that may be asked in relation to the existing mental health system. The answers to these questions will identify both problems and things that are being done well. The setting of minimum specifications (e.g. principles, values, outcomes), and the task of securing the commitment of all players to the achievement of the specifications, is a critical step in development of more appropriate mental-health services.

Making changes in one of these nine areas will generally result in (perhaps unintended) changes in one or more of the other areas. For example, measures to improve safety and reduce risk may result in a negative impact on the cultural appropriateness of the service. Improving cultural appropriateness may in itself reduce risk and improve safety.

That best practices are so slow to be adopted throughout health systems is frequently attributed to resistance to change. If resistance is seen as the reason, then the solution is to battle against and to overcome resistance, wherever it is to be found. However, in complex adaptive systems, behaviour follows attractors in the system. Understanding where the attractors in the system are is part of the art of health system reform. Understanding how a change in system parameter settings can shift the system from the current inadequate state to a more desirable one is a key task of leadership for change. An example of such control parameter change is the creation of financial incentives, linked to training, for the purpose of encouraging general practitioners to take a greater interest in acquiring psychiatric treatment skills and to take the time to apply these to people with mental illness in their practice (Hickie and Groom, 2002; Minas *et al*., 2005).

Standards and guidelines encourage uniformity. This is desirable when we are improving the reliability in application of technical interventions, such as drug prescribing. However, in a system that is far from perfect and looking to continually improve, there is merit also in encouraging diversity, of fostering creativity and accepting locally relevant structures and processes rather than seeking to impose a stifling uniformity. Variation and diversity is a core feature of any complex evolving system. The importance of biodiversity to the health of the biosphere is now well understood. The importance of cultural diversity in social systems is less well understood and less accepted. Diversity in service systems, such as the mental-health system, and to a

Box 29.3. Health system performance

How well is the health system performing in delivering quality health actions to improve the health of all the population? Is it the same for everyone? Are some sub-groups systematically disadvantaged?

Effective	Appropriate	Efficient
Care, intervention or action achieves desired outcome. • Are outcomes the same for immigrant and refugee communities as for the general population?	Care/intervention/action provided is relevant to the client's needs and based on established standards. • Are the needs of different immigrant and refugee communities well understood and are they appropriately met? • Are there established standards that are relevant and applicable to ethnic minority communities?	Achieving desired results with most cost-effective use of resources. • Is the best use possible being made of the resources and skills of the mental-health system, e.g bilingual/bicultural clinicians? • Are the wrong things being done efficiently?
Responsive	Accessible	Safe
Service provides respect for persons and is client orientated and includes respect for dignity, confidentiality, participation in choices, promptness, quality of amenities, access to social support networks and choice of provider. • Are services respectful of cultural and religious commitments? • Do ethnic consumers/carers/communities participate in policy-making, service design and evaluation, service management structures? • Do ethnic minority consumers feel discriminated against or marginalised?	Ability of people to obtain health care at the right place and right time irrespective of income, physical location and cultural background. • Is access to services based on needs that are well understood? • Is there equitable access to services by all communities?	The avoidance or reduction to acceptable limits of actual or potential harm from healthcare management or the environment in which healthcare is delivered. • Are incidences of violence, self-harm, suicide the same for ethnic patients as for the general population of patients? • Does the service have the capacity to carry out accurate risk assessment in cross-cultural clinical situations? • Are families appropriately engaged in risk reduction, particularly when the ill person is discharged from the service?
Continuous	Capable	Sustainable
Ability to provide uninterrupted, co-ordinated care or service across programs, practitioners, organisations and levels over time. • Is continuity of care (number and frequency of consultations and admissions, drop-outs from services, etc.) the same or different for ethnic community service users as for the general population of service users?	An individual's or service's capacity to provide a health service based on skills and knowledge. • Do clinical and other health service staff have the necessary knowledge and skills for effective cross-cultural practice? • Is the service organised in a way that ensures its capacity to provide effective and acceptable services. Does the service actively seek to	System or organisation's capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs (research, monitoring). • Is the service adequately staffed? • Does it have the necessary facilities where they are most required? • Does the service carry out evaluation and research and

• If so, what are the reasons for these differences?	employ bilingual and bicultural clinical and other staff in areas where these skills are most valuable?	evaluation that will inform continuing improvement? • Does the service develop and then drop pilot programmes rather than scaling up those programs that have been shown to be successful?

Source: Modified from (AHMAC National Mental Health Working Group Information Strategy Committee, 2005, p. 22).

certain extent in clinical practice, tends to be regarded with suspicion. This is a critical error, one that can have a very negative impact on the continuing evolution of the service system.

A key component of any minimum specifications approach to leadership for system change is the clear and explicit articulation of the values that will underpin everything else that occurs in the system. It is also critically important that, as far as possible, values are shared by all who are involved in the change agenda.

> Values are deeply held views that act as guiding principles for individuals and organisations. When they are declared and followed they are the basis of trust. When they are left unstated they are inferred from observable behaviour. When they are stated and not followed trust is broken (Pendleton and King, 2002, p. 1352).

In a complex system leadership is required, and is often displayed, at all levels of the system. We do not know what are all the relevant control parameters, and can generally not predict with any certainty the impact of changing those control parameters that we can change – such as increasing or reducing money flowing to certain parts of the system or to the overall system, creating new community mental health teams with new responsibilities and ways of working, and increasing the participation of consumers, carers and communities in decision-making processes.

It is increasingly clear that, in thinking of mental-health systems as complex adaptive systems, and of leadership for change in such systems, command and control styles of leadership are dead. An analogy for the changes that are occurring in our mental-health systems is to be found in economics. In mental health we are doing the equivalent of moving from a command economy to a market economy, with all of the uncertainty and risk that such a move entails.

Conclusions

The need to develop effective and equitable mental-health systems for multicultural societies is now on the agenda in many developed countries. A summary of the key steps in this process is offered in Box 29.4. The lessons that have been learned in general health system reform need to be applied more systematically to the task of improving mental-health services for culturally diverse populations. In addition, the insights that have come from the study of complex systems can be useful to us in framing an approach that is applicable in a very wide range of political, economic and cultural contexts. A complex systems perspective on leadership suggests that a clear definition of minimum specifications for the system to be developed, and a readiness for flexible, context-dependent, emergence of the details of the system, is likely to ensure that the details (which determine whether a system is functional or not) are more likely to be relevant to local needs and circumstances.

In multicultural societies the development of mental-health services that are responsive, accessible, culturally appropriate and effective, should not be an add-on or an after-thought. Attention to issues of cultural competence is not a distraction

Box 29.4. Developing effective and equitable mental health systems for multicultural societies

1. Carry out stakeholder analysis and engage stakeholders in the process of service development.
2. Agree on the set of minimum specifications for the services. Ensure that these are firmly based on clear ethical foundations.
3. Evaluate current services in relation to the minimum specifications (De Jong and Van Ommeren, 2005).
4. Clearly define a small number of important problems that are focused on system outcomes, then analyse the causes – and the causes of causes.
5. Decide where action is required, and is likely to be effective, and set priorities.
6. Carry out political analysis and review stakeholder analysis in the light of what needs to be done.
7. Ensure that policy proposals (proposed solutions to problems) are capable of implementation, politically feasible, and politically controllable.
8. Decide which are the most important system parameters, and which system parameters are most amenable to change, in the current political and service system circumstances.
9. Act collectively, decisively and with clarity of purpose.

from the ‘core business’ of mental-health services. Whether such considerations are part of the fundamental character of the mental-health system is a test of the extent to which a society values justice and equity. Even though knowledge about culture, migration and mental health is partial and sometimes inconsistent, there is enough known about how to provide equitable culturally acceptable services. Working through the process of reforming services so that they are capable of meeting the needs of a culturally diverse society will have the direct benefit of making those services more flexible and responsive to the needs of all members of the community.

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Psychopharmacology across cultures

Shu-Han Yu, Shi-Kai Liu and Keh-Ming Lin

EDITORS' INTRODUCTION

The debate on the use of medication in managing psychiatric disorders focuses on a number of themes. These include availability of drugs, affordability and accessibility of medication, prescribing patterns such as the use of polypharmacy, application of doses across different ethnic groups as well as differences in drug metabolism, pharmacokinetics and pharmacodynamics. With a shift to more drug trials taking place in the Indian subcontinent and Eastern Europe, the question of ethics is beginning to be raised. In cultures where there is a shortage of trained mental-health professionals and drugs are available over the counter, the management of patients with psychiatric disorders becomes even more complex.

In this chapter on psychopharmacology across cultures, Yu and colleagues provide an overview of some of these issues. They observe that the one size fits all approach is problematic to say the least. Both genetic and environmental mechanisms are important in order to determine ethnic/cultural variations in drug responses. These variations are mediated via the pharmacokinetics and/or pharmacodynamics processes, whereas the pharmacokinetic process determines how the organism responds to the therapeutic agent. Absorption, distribution, metabolism and excretion of the drugs determine the fate and disposition of most drugs, and these factors also highlight the differences in group and individual responses. Pharmacogenetics of various enzymes further contribute to variation in response. Pharmacodynamic mechanisms also exert major influences on therapeutic target's response to psychotropics. The sociocultural context of pharmacotherapy for psychiatric disorders is equally important. The role of diet, attitudes to religions and dietary taboos, religious fasting, smoking and intake of caffeine are also important in understanding response to medication. Ethnic and cultural contrasts are superimposed upon inter-individual variations that are typically huge in all human groups. Any drug management must take into account a range of complex factors.

Introduction

The use of psychiatric medication has transcended geographic, cultural and ethnic boundaries during the past several decades. Since the 1950s, soon after the discovery of psychotropics, they have achieved worldwide acceptance as the mainstay for the treatment of mentally ill. However, most psychiatric medications have been developed and tested in North American and Western Europe, typically on 'young, white males'. Although this has been the case for the development of the majority of the medications currently in use, once they are approved for marketing, they soon will be prescribed for patients whose backgrounds often diverge significantly from those originally participating in the studies during the drug development phase. Evidence to the contrary, the efficacy of therapeutic agents, as well as the strategies involved in their dosing, often were assumed to be similar across ethnic and cultural groups.

For a number of reasons, such a 'one size fits all' approach has been seen increasingly as problematic. Populations residing in North America and Western Europe represent only a small fraction of the world's populace (See Fig. 30.1), whose

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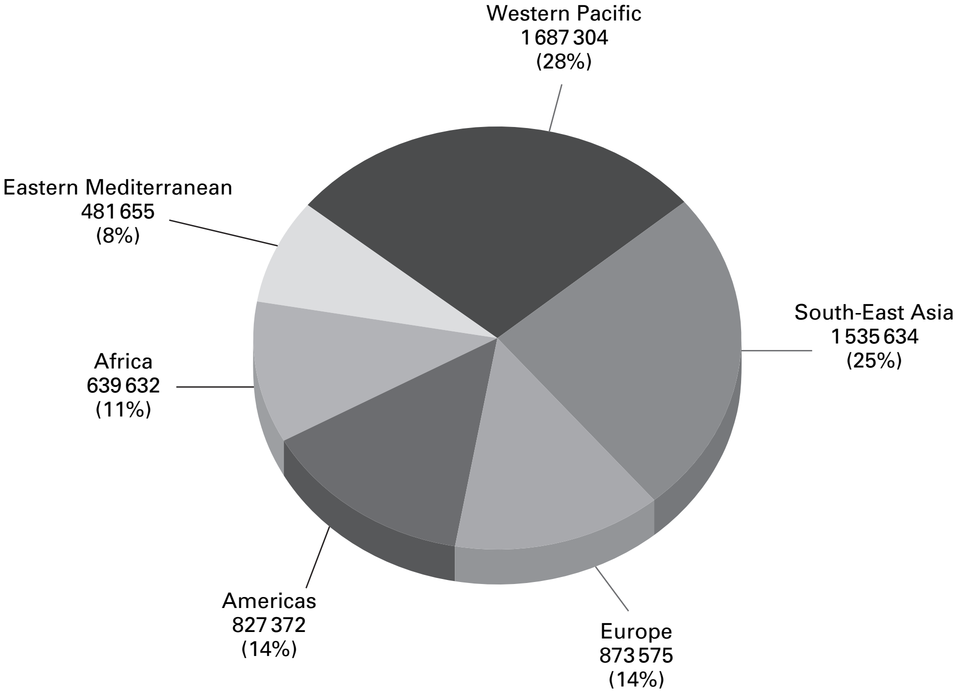

Fig. 30.1. Distribution of the world's populace. (WHO, Geneva: World Health Report, 2001.)

ancestral backgrounds and socio-cultural milieus diverge profoundly from people living in other parts of the earth. As will be shown below, examples abound testifying to the significance of such attributes in determining medication efficacy and dosing considerations. Further, within any specific regions, the populations are rapidly becoming diversified. For example, the 2000 US census showed that around 30% population were of non-Anglo backgrounds (13% Hispanics, 12% African American, 4% Asians and 1% American Indians) (United Nations, 2000). Already, in many American metropolitan areas, there is not a single 'majority' ethnic group. As this trend of diversification is expected to accelerate in all corners of the world, clinicians increasingly will be working with patients of exceptionally divergent backgrounds, and could ill afford to ignore, or be ignorant of, the role of ethnicity and culture in daily practices.

As will be briefly reviewed below, both genetic and environmental mechanisms are important for determining ethnic/cultural variations in drug responses. Such variations are mediated via the pharmacokinetic and/or the pharmacodynamic processes. The former determines how much of the pharmacologic agents is available for its target organ, whereas the latter determines how the organism responds to the therapeutic agent. In the following, ethnic variations in drug responses will be discussed with both pharmacokinetic and pharmacodynamic mechanisms in mind.

In addition, 'non-biological' factors including medication adherence (compliance) and the so-called 'placebo' effects also powerfully determine medication response. It stands to reason that culturally shaped beliefs should play a central role in influencing these important processes as well. However, since they are covered in Chapter 25, they will not be discussed herein.

Pharmacokinetics

Of the four processes (absorption, distribution, metabolism and excretion) that together determine the fate and disposition of most drugs, variability in the process of metabolism is most substantial and is often the reason for interindividual and cross-ethnic variation in drug responses (Lin *et al.*, 1993). Such variations were clearly demonstrated in a number of earlier studies showing substantial variations in drug serum concentrations across different ethnic populations. For example, in a study of 34 normal male volunteers (12 Caucasians and 22 Asians), serum haloperidol concentrations were measured during a 7-hour period after haloperidol administration (0.5 mg given intramuscularly or 1.0 mg given orally), which revealed that after controlling the body surface area, Asians still had higher serum haloperidol concentrations than did Caucasians. These results indicate that the pharmacokinetics of haloperidol, most likely due to differential hepatic first-pass metabolic rates, vary substantially between Caucasians and Asians (Lin *et al.*, 1988a; Lin *et al.*, 1993).

During the past several decades, because of the progress of molecular techniques, there are more and more studies involved in the pharmacogenetics/pharmacogenomics, providing crucial insights illuminating on the mechanisms responsible for interindividual and cross-ethnic variation in drug responses. Some of these findings will be discussed in the following paragraphs.

Among the enzymes involved in drug metabolism, the cytochrome P450s are believed to be most important, and have been most thoroughly studied (Lachman *et al.*, 1996; Ingelman-Sundberg, 2004). Among these, CYP2C9, CYP2C19 and CYP2D6 are highly polymorphic and together account for about 40% of hepatic human phase I metabolism. CYP2D6 is perhaps the most extensively studied metabolizing enzyme in humans; it also was the first P450 to be characterized at the molecular level. Responsible for about 25% of the metabolism of known drugs (Ingelman-Sundberg, 2005), CYP2D6's substrates include many psychotropic medications such as antidepressants (e.g. tricyclic antidepressants, serotonin reuptake inhibitors) and antipsychotics (e.g. haloperidol, risperidone, thioridazine) (see Table 30.1) (Rendic 2002), as well as commonly prescribed non-psychiatric medications including codeine and cardiovascular drugs. Because of space limitation, this article takes the CYP2D6 as an example to explicate the importance of pharmacogenetics in pharmacokinetics of psychiatric medication across ethnic groups.

Table 30.1. Psychiatric medication of which dosage should be adjusted according to CYP2D6 genotype

Tricyclic antidepressants	SSRIs	Other antidepressants	Antipsychotics
Amitriptyline	Citalopram	Bupropion	Aripiprazole
Clomipramine	Fluoxetine	Maprotiline	Clozapine
Desipramine	Fluvoxamine	Mianserin	Flupentixol
Doxepin	Paroxetine	Mirtazapine	Haloperidol
Imipramine	Sertraline	Moclobeminde	Levomepromazine
Nortriptyline		Nefazodone	Olanzapine
Trimipramine		Trazodone	Perazine
		Venlafaxine	Perphenazine
			Pimozide
			Risperidone
			Thioridazine
			Zuclopenthixol

Pharmacogenetics of CYP2D6

Four different levels of activity of CYP2D6 have been identified, through the use of probe drugs which are metabolized by the enzyme. Based on how the probe drugs are metabolized, an individual may be classified as an ultrarapid metabolizer (UM), extensive metabolizer (EM) (Kinnear *et al.*, 2000), intermediate metabolizer (IM), or poor metabolizer (PM). This variation in enzymatic activity is due to multiple allelic variants of CYP2D6 (the gene encoding the protein) (Aitchison *et al.*, 2000). At present, more than 46 distinct polymorphic CYP2D6 alleles have been identified (Ingelman-Sundberg, 2005).

The clinical significance of these genotyping variations has been demonstrated in a number of studies, showing that there is a clear gene-dose effect: PM (two defective genes) and IM (one defective gene or two less effective genes) subjects often have great difficulties metabolizing drugs such as nortriptyline, perphenzine and haloperidol. They also are more likely to suffer from severe side effects when exposed to fairly small doses of these medications. At the other end of the spectrum, UMs (gene duplication or multiplication) are significantly more efficient in clearing these drugs and are likely to experience therapeutic failure when treated with regular doses of these drugs (Daly *et al.*, 1996). In a study of 100 consecutive psychiatric inpatients genotyped for CYP2D6 on admission, the number of adverse effects in patients treated with CYP2D6 substrates was highest in PMs and higher in IMs than in EMs or UMs. The cost of treating patients with UMs or PMs phenotype was greater than those with EMs or IMs phenotype, and the total duration of hospital stays was longer among PMs (Chou *et al.*, 2000).

In different ethnic groups, there are differences in the frequencies of variant alleles (see Table 30.2), resulting in distinct patterns for the distributions of the activity of the enzyme. In Caucasian populations, the frequency of PMs is 5–10% (Steiner *et al.*, 1988; Carrillo *et al.*, 2003), while in Black Africans the frequency is 0%–8% (Masimirembwa *et al.*, 1996), in African-Americans the frequency is 3.7% (Leathart *et al.*, 1998; Wan *et al.*, 2001), and in Chinese, the frequency is approximately 1% (Loub *et al.*, 1975). In Sub-Saharan Africans, the CYP2D6*17 allele is frequent and causes greatly decreased enzyme activity (Masimirembwa *et al.*, 1996). In Asians, the CYP2D6*10 allele causing decreased enzyme activity is prevalent, with an allele frequency of about 50%, while the frequency of this allele in Caucasian is only 0.05%. The effect of *10 appears to be dose dependent, such that heterozygous carriers of *10 may be in the higher activity range of the IM group and homozygous carriers may

Table 30.2. Major human polymorphic variant CYP2D6 alleles and their global distribution

Major variant alleles	Mutation	Consequence	Allele frequencies (%) Caucasians	Asians	Sub-Saharan Black Africans	Ethiopians and Saudi Arabians
CYP2D6*2xn	Gene duplication/ multiduplication	Increased enzyme activity	1–5	0–2	2	10–29
CYP2D6*4	Splicing	Inactive enzyme	12–21	1	2	1–4
CYP2D6*5	Whole gene deletion	No enzyme	2–7	6	4	1–3
CYP2D6*10	Point mutation	Unstable enzyme	1–2	50–70	6	3–9
CYP2D6*17	Point mutation	Altered affinity for substrates	0	0	20–35	3–9

Source: Modified from Ingelman-Sundberg 2005.

For a complete list, see http://www.imm.ki.se/cypalleles/cyp2d6.htm.

be at the lower activity range (Yokota *et al.*, 1993). From the above discussion, it appears that such genotyping and phenotyping variations across ethnic groups should be considered while prescribing psychiatric medication.

Other factors affecting the pharmacokinetics of psychopharmacology

Besides the genetic influences, the activity of drug metabolic enzymes also is determined by non-genetic factors, both internal and external. The external factors include nutrients, various plant products, pharmaceutical agents and other chemicals, whereas internal factors include steroid hormones and other endogenous substances (Anderson *et al.*, 1987; Bolt, 1994). These substances either inhibit or induce the activity of particular enzymes, thereby significantly affecting drug metabolisms, at times leading to unintended, potentially serious clinical consequences. Although these interactions widely exist and affect all drug metabolizing enzymes, the most prominent are two of the cytochrome P450 enzymes, namely, CYP1A2 and CYP3A4.

CYP1A2

CYP1A2 is primarily expressed in the liver and plays a major role in the metabolism of numerous xenobiotics. It is involved in the metabolism of many psychotropic medications, including most typical antipsychotics and some atypical antipsychotics (e.g. clozapine and olanzapine) as well as many antidepressants (especially fluvoxamine). There is evidence demonstrating that the activity of this enzyme is affected by non-genetic factors including smoking and diet. There is a general consensus that smoking is an important health concern among psychiatric patients and it has been shown that, among patients with schizophrenia, the prevalence of smoking is extremely high (70% or greater) (Lohr and Flynn, 1992; Kelly and McCreadie, 1999; Beratis *et al.*, 2001). However, cigarette smoking decreases the steady-state concentration of most psychotropics including the typicals as well as olanzapine (Carrillo *et al.*, 2003) and clozapine (van der Weide *et al.*, 2003). Thus smoking may be one of the major factors responsible for interindividual variation of treatment response or side effect through CYP1A2, and should be considered while prescribing these antipsychotics. In addition to smoking, many foodstuffs have been reported to affect the activity of CYP1A2 substrates. Studies in the past have revealed that cruciferous vegetables such as brussels sprouts, cabbage, broccoli and cauliflower increased CYP1A2-related activities (Loub *et al.*, 1975; Pantuck *et al.*, 1976). After consumptions of a diet containing brussels sprouts and cabbage, it was shown that the AUC of phenacetin, a substrate of CYP1A2, decreased by about 49% (Pantuck *et al.*, 1979). After consumption of a diet containing brussels sprouts and cabbage, it was shown that the AUC of phenacetin, a substrate of CYP1A2, decreased by about 49% (Pantuck *et al.*, 1979). Similar effects have been shown with charcoal-broiled beef, which produces large amounts of polycyclic aromatic hydrocarbons potently inducing CYP1A2 (Anderson *et al.*, 1983; Kappas *et al.*, 1978). In addition, there is a large body of literature showing that high-protein diet (in comparison with those maintained on a diet with high-carbohydrate contents) leads to a significantly higher CYP1A2 activity (Kappas *et al.*, 1976; Anderson *et al.*, 1991).

Differential expression of CYP1A2 secondary to dietary practices might be responsible for cross-national/cross-ethnic differences in the metabolism of a number of drugs. Branch, Salih & Homeida (1978) reported a significantly longer antipyrine half-life among Sudanese living in their home villages as compared to Sudanese residing in Britain and to White British subjects. Similar findings were reported in subsequent studies involving South Asians living in Asia, South Asian immigrants residing in Britain and White British subjects (Allen *et al.*, 1977; Fraser *et al.*, 1979). With clomipramine and antipyrine as test drugs, these studies found that immigrants who continued to follow their traditional vegetarian diet exhibited pharmacokinetic profiles similar to their brethren in Asia. In contrast, those who had switched to a British diet showed significantly faster rates of metabolism.

CYP3A4

CYP3A4 is the most abundant hepatic and intestinal cytochrome P450, and plays a role in the metabolism of many typical antipsychotics, sertindole and clozapine (Ereshefsky, 1996). This enzyme can be induced, inhibited or inactivated by drugs and environmental factors including foods and herbs. A number of foods and spices were identified as CYP3A4 inhibitors. Grapefruit juice is the most widely known example. It exerts such an effect by reducing presystemic metabolism through selective post-translational down-regulation of CYP3A4 expression in the intestinal wall. Since the duration of the effect of grapefruit juice can last for 24 hours, repeated juice consumption can result in a cumulative manner (Bailey *et al.*, 1998). Evidence showed that the mean area under the plasma concentration–time curve (AUC) and $C_{\max}$ of midazolam and traizolam (both are ultra-short acting benzodiazepine hypnotics with high presystemic drug metabolism) was elevated after the administration of grapefruit juice. As a result, the subjects who drank the grapefruit juice showed more drowsiness (Hukkinen *et al.*, 1995; Kupferschmidt *et al.*, 1995). Black pepper, a popular spice in South Asia, and piper cubeba, one of the popular medicinal plants extensively used in Indonesia, were also potent inhibitors of CYP3A4 (Bhardwaj *et al.*, 2002; Usia *et al.*, 2005).

St John's Wort (SJW) has been demonstrated to be a potent inducer of CYP3A4 (Roby *et al.*, 2000; Wang *et al.*, 2001; Gurley *et al.*, 2002; Domschke *et al.*, 2004; Kawaguchi *et al.*, 2004; Wenk *et al.*, 2004). In Europe and the United States herbal preparations of SJW can be bought over the counter to treat a variety of conditions. SJW products may also be prescribed in some European countries. It is commonly consumed for the relief of anxiety, depression (often experienced by cancer and AIDS patients), and inflammation of the skin and blunt injuries. However, medications metabolized by CYP3A4 interact significantly with SJW. The blood levels and the therapeutic effects of CYP3A4 substrates, such as cyclosporine, erythromycin, HIV protease inhibitors and benzodiazepines (e.g. quazepam, midazolam), decrease after combining use of SJW (Mannel, 2004). These findings indicate that caution should be exercised when CYP3A4 substrates and SJW are used concurrently.

SJW is just an example of many kinds of complementary and alternative medicine (CAM) that might have similar effects. Epidemiological studies revealed that over one-third of people in the community had used CAM in the past 12 months (Kim *et al.*, 2000; Graham *et al.*, 2005), and chronic diseases represent one of the most important predictors in such use (Al-Windi 2004). However, over 70% of these users did not discuss their use of CAM with their doctors (Kim *et al.*, 2000). Not only SJW but also many herbal products may interact with Western medicines through CYP3A4 induction or inhibition, potentially causing severe undesirable effects. Dietary consumption of these substances (such as grapefruit juice) and herbs varies from one population group to another, thus the different probabilities of food–drug interactions, or herb–drug interactions across culture should be carefully considered while prescribing medications, especially those that are metabolized mainly by CYP3A4.

Studies suggest ethnic differences in the activity of CYP3A4. An example is a study examining the metabolism of the calcium channel blocker nifedipine (Rashid *et al.*, 1995; Sowunmi *et al.*, 1995). Asian Indians were found to metabolize nifedipine at a slower rate than British Caucasians, as determined by AUC values. Another study reported similar differences between Caucasian and Asian volunteers in the rate of metabolism of alprazolam (Lin *et al.*, 1988). In this study, Asian volunteers had higher plasma levels of alprazolam than Caucasian subjects following intravenous and oral administration of the same dose.

Pharmacodynamics

In addition to pharmacokinetic, pharmacodynamic mechanisms also exert major influences on therapeutic targets' response to psychotropics. In the study described above, Lin and Poland measured the serum haloperidol and prolactin concentration in 34 normal male, including 12 Caucasians and 22 Asians, after haloperidol administration. After controlling for body surface area, the Caucasian had less prominent prolactin responses than did the Asian group, and the ethnic difference could not be fully accounted for by the differences in serum haloperidol concentrations between the two ethnic groups. These results suggested that pharmacodynamic factors (i.e. dopamine receptor-mediated responses) contribute to the differences in responses between Asians and Caucasians (Lin *et al.*, 1988a; Lin *et al.*, 1993). In a subsequent study, Lin *et al.* (1989) demonstrated that Asian schizophrenic patients required lower haloperidol doses as well as plasma concentrations for similar responses, and showed lower threshold for EPS, as compared with their Caucasian counterparts.

The pharmacodynamic mechanism mediating clinical effects (therapeutic and toxic) involve transporters, receptors, and key enzymes in the biosynthesis and catabolism of neurotransmitters. Among these neurotransmitters, monoamines, including dopamine (DA), serotonin (5-HT) and norepinephrine (NE), have been the foci of research attention in psychiatric field. Polymorphisms of genes involving such pharmacodynamic mechanisms have been extensively studied accompanying the development of techniques in pharmacogenetics. Because of space limitation, in the following we will focus our discussion on two most extensively studied genes, namely, the serotonin transporter (5-HTT) and the catecholamine-*O*-methyltransferase (COMT).

5-HTT

The serotonin transporter (5-HTT) is responsible for presynaptic serotonin reuptake, and is the principal site of action for most of the ‘newer’ antidepressants. 5-HTT gene polymorphisms likely have functional significance and might be associated with the risk for psychopathology as well as response to treatment regimens. For example, studies show that the basal transcriptional activity of the 5-HTT is significantly higher in those possessing a long variant in the promoter region of this gene, which results in differential 5-HTT expression and 5-HT cellular uptake (Heils *et al.*, 1996; Greenberg *et al.*, 1998). This serotonin transporter gene-linked polymorphic region (5-HTTLPR) has been studied not only in the association between the polymorphisms and the psychopathology of depression (Rosenthal *et al.*, 1998) as well as alcoholism (Konishi *et al.*, 2004) but also in how the polymorphisms affect the treatment response of antidepressants in obsessive-compulsive disorder (OCD) (Di Bella *et al.*, 2002), and depression (Kim *et al.*, 2000; Pollock *et al.*, 2000; Zanardi *et al.*, 2001; Arias *et al.*, 2003). Of note, the prevalence of the *l* allele for 5-HTTLPR varies substantially across ethnic groups. It is highest among those of African ancestry (70%), which is followed by Caucasians (60%), and is extremely low among East Asians (17%) (Gelernter *et al.*, 1997).

Interestingly, studies on how the 5-HTTLPR variants affect the treatment response of depression also revealed that these influences may behave differently across ethnic groups. Almost all studies conducted among Caucasian patients demonstrated that the *l* allele was associated with significantly better antidepressant response as compared with those with the *s* allele (Smeraldi *et al.*, 1998; Pollock *et al.*, 2000; Zanardi *et al.*, 2001; Rausch *et al.*, 2002; Arias *et al.*, 2003). However, studies focused on the association between the genotype of 5-HTTLPR and treatment responses of antidepressant in Asian depressive patients showed inconsistent results. Two studies conducted in Japanese and Korean patients concluded that serotonin reuptake inhibitors (SSRIs) could be more effective in depressive patients carrying the *s* allele than in ones carrying the *l* allele (Kim *et al.*, 2000; Yoshida *et al.*, 2002). Meanwhile, Yu reported that the *l* allele is associated with better SSRI response in Chinese depressive patients (Yu *et al.*, 2002). The ratio of subjects carried the *l*/*l* genotype were 5%–10% in Aisans, resulting in much less subjects in this *l*/*l* subgroup of these three studies (ranging from 4–13 patients for the *l*/*l* subgroup), which might lead to biases in these studies. The very low prevalence of *l*/*l* genotype in Asians should be taken into consideration in this kind of study, and future studies with larger sample sizes are needed for getting more powerful and consistent results in Asians.

COMT

Catechol-*O*-methyltransferase (COMT) mediates one of the most important pathways for the metabolism of catecholamines, including dopamine and norepinephrine. Lachman *et al.* showed that allelic variations at a genetic locus modulates COMT activity: the COMT H allele, encoding for valine at position 108/158 in the cytosolic/membrane bound form of the protein is associated with high activity, whereas the L allele, encoding for methionin at that location, is associated with low activity. The difference in COMT activity resulting from this genetic polymorphism is threefold to fourfold (Lachman *et al.*, 1996). The L allele frequency varies across ethnic groups, ranging from 18% in East Asians, 26%–30% in Africans, to 50% in Caucasians (Ameyaw *et al.*, 2000).

Many studies focused on the association of this COMT gene polymorphism and the susceptibility of psychiatric diseases, such as panic disorder (Woo *et al.*, 2002; Domschke *et al.*, 2004), schizophrenia, and Parkinson's disease (Kunugi *et al.*, 1997), although the results remained inconclusive. However, this variant allele may predict specific psychopathology of schizophrenia, such as those with treatment–resistant features (Inada *et al.*, 2003), aggressiveness or violent behavior (Lachman *et al.*, 1996; Jones *et al.*, 2001).

The association between the COMT polymorphism and individual differences in response to levodopa therapy was confirmed in clinical studies (Reilly *et al.*, 1980). Rivera reported that patients with COMT genotype H/H suffered more frequently from severe dyskinesia and some motor fluctuations when compared with patients with L/L genotype (Rivera-Calimlim and Reilly 1984). A recent study compared the different frequencies of COMT polymorphism between the PD with doses of levodopa below and exceeding 500 mg/day during the first 5 years of treatment found that the prevalence of L/L homozygotes was higher in the group treated with low doses of levodopa, and suggested that patients with L/L genotype may benefit from more efficient and safer levodopa therapy (Bialecka *et al.*, 2004). Contrary to White people, high metabolic activity COMT alleles dominate in Asian people, which might cause a higher incidence of dyskinesia and higher percentage of poor responder to levodopa in Asian patients with Parkinson's disease (PD) (Rivera-Calimlim and Reilly, 1984). However, several recent studies failed to support the thesis of significant differences in levodopa response between these genotype subgroups (Lee *et al.*, 2001; Contin *et al.*, 2005) in both Caucasian and Asian PD patients.

The sociocultural context of psychopharmacotherapy

We have thus far focused on the biological factors that affect drug responses. However, treatment almost always takes place in the context of interactions among individuals. In these interactions, all participants bring in their own knowledge, predispositions, values, priorities, modes of thinking and belief systems into play. Within this transaction, issues such as patient compliance, 'expectation effect' (including the placebo effect), clinician ideology, and past experiences impact drug responses. These 'non-biological' factors, which are in a large part shaped by culture (both the patient's and the clinician's), powerfully determine the success or failure of any pharmacological treatment, regardless of drug-receptor specificity or drug potency. Because these issues have been discussed in Chapter 25, they will not be addressed further here.

Conclusions

This chapter serves to highlight the significance as well as the complexity of issues surrounding the influence of cultural and ethnic forces on psychotropic responses. Taken together, the literature reviewed above clearly demonstrates the importance of these factors in practicing psychopharmacotherapy. However, it is necessary to remember that ethnic and cultural contrasts are superimposed on inter-individual variations that are typically huge in all human groups, and that ethnic variations in pharmacological responses should not be interpreted stereotypically. The progress in pharmacogenetics or pharmacogenomics will help us to understand the inter-individual variations, and guide the clinicians to make treatment decisions in terms of the choice of psychotropics, strategies for titration, the optimal therapeutic dosage, and the prediction of likely side effects. The non-biological issues such as cultural influences on prescription pattern, treatment adherence, and other factors that determine patients' perception, action and expectation, should also be emphasized as much as the biological factors such as pharmacokinetics and pharmacodynamics. With such an integrative approach, we would be able to define the elements for optimal pharmacotherapeutic practices that would take both cultural and biological diversity into consideration and tailor treatment to individuals' characteristics rather than just relying on global guidelines.

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Psychotherapy across cultures

Digby Tantam

EDITORS' INTRODUCTION

Psychotherapy has been a major part of therapeutic armentatrium in managing patients with mental illness. Often seen as a product of Western Eurocentric tradition, it is argued that not all psychotherapies are suitable for all cultural groups. Cultural norms of different psychotherapeutic interventions are often indigenous but these get ignored when groups move to other cultures. Tantam in this chapter emphasizes that there are clear ethnic and cultural values that are important in determining therapeutic needs and interventions. A person is immersed in a culture but is consigned to a class or ethnic group. Members of a class have specified status, social influence, health and opportunities for wealth creation. Ethnicity and religion are related to organizing principles of status in society. Western psychotherapists and psychotherapy draw on two cultural traditions which are intertwined within Western psychotherapists, and psychotherapy draws on two cultural traditions which are intertwined within Western European thought. The success of causal explanations in aetiology and in therapy has secured their pre-eminence. Personal identity is a common issue in psychotherapy and this varies across cultures as do the concepts of self. Tantam emphasizes that cultural values are affect laden, which must be taken into account in any intervention. Provision of psychotherapy across cultures means that the therapist not only has to deal with unfamiliarity and uncertainty created by novel ideas or situations, but also means dealing with the emotional flavour of the novelties. This will be further affected by the way in which culture transmits emotional flavours. Culture provides individuals with the tools to create meaning but it also limits the meanings that can be created. After all, creating and understanding the meanings is the core of the psychotherapy encounter. Tantam recommends that psychotherapists must strive to reach an agreement with their patients about the focus of the therapy so that the preoccupying concerns of the patient can be addressed. In psychotherapy the single most important emotional flavour is homeliness, which also means exclusive.

Introduction

Culture has been described in many ways. UNESCO's Declaration of Universal Cultural Diversity defined it as a 'set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs'. Culture shapes how each of us acts, particularly when our actions are directed towards expression or communication rather than towards the performance of environmentally determined tasks. Culture therefore has a particular impact on that branch of psychiatry, psychotherapy, which is especially concerned with meaningful rather than causal connections between events.

There are other, similar, influences. Each human language particularly affords its own way of articulating the world, and therefore tends towards some meanings rather than others. Many psychotherapists have stressed that how one says something alters what one says and, eventually, what one thinks. The use of 'self' to refer to what a person really is, which originates in English in the seventeenth century, gradually exerted a hold over psychology

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and psychotherapy in the later part of the twentieth century resulting in, as some have argued, a preoccupation with individuality ('self-development') and autonomy (self-determination). Sampson (Sampson, 1989) has argued that this is culturally divisive because it drains the meaning from intersubjective perspectives for which English has to resort to portmanteau expressions like 'self-in-other'.

English with its plethora of, and reliance on, nouns also tends towards descriptions which, as Schafer argued in his Freud Memorial lectures (Schafer, 1976), suggest that analysands are the victims of powers such as transference, or libido. He proposed replacing these terms as much as possible with verbs, or 'action language'. This would bring psychoanalysis closer to therapies like existential psychotherapy, which are concerned about the intentions that people have, and how they realize them, and not the processes to which they are subject.

Other concepts that are closely related to culture are 'class' or 'ethnicity'. (I prefer to use ethnicity rather than race because of the links of race with spurious and largely non-existent biological differences.) People have class and ethnic identities as they do cultural identities. There are class and ethnic, as well as cultural, values. There may be class and ethnic dialects. For the purposes of this chapter, I will deal with this overlap by considering culture as it applies to a class, an ethnic group, as well as a society. However, both class and ethnicity convey the importance of external circumstance in a way that culture does not.

Culture is something created, as its name indicates, out of the almost limitless capacity of human beings to weave a meaning around themselves. The weaving has both a warp and a woof, a synchronic and a diachronic or historical, element. But it is symbolic in that meaning does not have to cash out in any particular reality.

A person is immersed in a culture, but consigned to a class or an ethnic group. And membership of such a group is not purely symbolic. There are entailments. Class members have more or less status, social influence, health and opportunities for wealth creation depending on the class to which they have been assigned. Ethnicity may carry with it some of these entailments, but may also create expectations by others of personal characteristics that are associated with members of that ethnic group: Englishmen are, for example, supposedly cold and poor lovers, but make good policeman.

Religion is yet another closely related organizing principle in society. One can be born into a religion, but can also adopt it in a way that one cannot so easily adopt culture, class or ethnicity. However, religion is also an important element within culture, and the same religion may take distinct forms within different cultures: one need only think of the evangelical Pure Land Buddhism, open to everyone, and the Zen Buddhism whose exacting meditative practices confined it to a small but influential priesthood. There is a growing literature on religion and psychotherapy; I will not consider it separately here, but only in relation to culture.

Culture and psychopathology

The substantial literature on 'culture-bound' disorders has been considered elsewhere in this book. There has been a shift from taking an alienated perspective, with weird culture-bound syndromes being carefully but distantly documented, to a recognition that there are few syndromes that are restricted to particular cultures, although there are many cultures that are known by their emblematic syndromes. The culture-bound syndromes discovered by colonizing Europeans in so-called primitive peoples, which reinforced European preconceptions of primitive beliefs and lack of self-control – *windigo*, for example, or *amok* – have given way to disorders associated with civilization, for example, neurasthenia in China, anorexia nervosa in Europe, and post-traumatic disorder in groups everywhere who have been caught up in conflict or disaster.

It is worth noting that psychotherapies, too, have cultures, often with their own culture-bound syndromes. Some, like borderline personality disorder, have arisen in one psychotherapy culture – in this case, psychoanalysis – but have permeated other psychotherapy cultures, too. Others, like recovered-memory syndrome, have remained largely confined to the therapy culture, in this example feminist psychotherapy, in which they first emerged. Yet others, like battered-woman syndrome, have become accepted as a result of particularly influential text, but their influence has subsequently waned (Rothenberg, 2002). What determines such 'cultural authority' has been discussed by Schudson (Schudson, 1989).

Twin cultures

Western psychotherapists, and psychotherapy, typically draw on two cultural traditions which are so intertwined within what is called Western European thought that we cannot easily distinguish them, although from time to time intellectuals have called our attention to them. Dilthey, himself influenced by Schleirmacher, distinguished between two kinds of understanding, *vorbeireden* or explanation, which was, he said, proper to the *Naturwissenschaft* ('Natural sciences') and *verstehen*, or 'meaning' which is appropriate to the *Geisteswissenschaften* (social sciences) (Dilthey, 1883). C. P. Snow's famous distinction between the two cultures of the arts and the sciences refers to a similar distinction between fundamentally different holds on to the world. More recently, the distinction has often been made in terms of 'causes' and 'reasons'. I have argued that an important difference between these two is that causes are, as Hume pointed out, events that are both constantly conjoined to, and precede, the events that are their consequences. Reasons are not constantly conjoined and may occur after the event, in which case they act as justifications (Tantam, 1999). This is not to say that reasons may not be the cause of events, but that they are usually not the causes of the events for which they are reasons but the causes of subsequent events, a misunderstanding perpetuated in the influential account of Bolton and Hill (Bolton and Hill, 1996). For example, if I am found guilty of a serious assault and my motive was found to be robbery, then the reason I killed the victim would be taken to be to rob him, and this would be the reason that the judge gave me a particularly long sentence. But suppose I was innocent of robbery, and that the assault was motivated by my knowledge that the victim had robbed me and I wanted my money back. The reason given for my assault would not be the cause of my assaulting the victim, since I did not in fact intend to rob the victim, only get my money back. But the robbery reason would still be the cause of my receiving a long sentence.

Western psychotherapists have to be able to move between both kinds of explanation, both causes and reasons. They may, for example, tell a depressed patient that they are depressed because they have negative automatic thoughts (a presumed causal explanation) but also, in the same session, work with the patient's own account that they are depressed because they feel guilty at not having cared more for their eldest daughter who has now left home (a justification or *post hoc* explanation).

The success of causal explanations in the physical, biological and medical sciences has secured their pre-eminence. This has had the consequence that other kinds of explanation have gone on to the defensive (Luhrman, 2000) and even to a denial by some philosophers that there are important differences in kind between biological and cultural accounts (Gibbard, 2001). Some psychotherapists have tried to re-package as many of their traditional accounts as possible as if they are descriptions of causal processes. A more creative solution has been to argue for a multiplicity of explanations. Postmodernists have taken this process to the extreme of doubting the value of the science's application of testing for truth or refutation and so tried to reduce science to the status of being a colonial narrative of no particular intrinsic merit. However, one does not have to undermine causal explanation to allow a place for reasons; our culture has, as I noted at the beginning of this section, become almost casual in moving backwards and forwards between them.

We are used to there being several causes for one action, but also that each of these causes are interlinked, and that there is one causal sequence which will reproducibly produce the consequence whenever it occurs (I include here those causes which have their effects by influencing the state of reactivity of a system). By contrast, many independent reasons can be given for one action, and they are not necessarily linked. Some are only given once, or only given to one particular person, or group. All of this is legitimate, and we are used to it. A person may become addicted to heroin and tell his or her doctor that it was because heroin calmed them, tell his or her mother that it is because they have never properly recovered from the death of a younger sister, and pray to their God for strength to overcome the temptations of the Devil. It is clearly misconceived to ask which of these is the right explanation, although it may make sense to ask which is right for a particular situation. Since each of these reasons may have causal consequences in the future, it is also appropriate to ask what effect it will have to focus on one of these reasons or another.

Example

Deanna was a young woman with the ambition to become a musical artist but was inhibited by her lack of self-confidence and by a mild stammer. She was seeing a college counsellor for these problems, but there had been little progress. Then she watched a video biography of Jonathan Larson, the composer of ‘Rent’, a cult rock musical loosely based on Puccini’s La Boheme. Larson conceived the idea of ‘Rent’ when he was 29. He worked on the music and the lyrics until he was 32, when it had a studio performance, after which it was substantially revised. He continued to work in a diner to earn his keep, and composed during his free time. The first performance of the final version took place in 1996, when Larson was 35. Larson had chest pains during the final days of rehearsal, and was examined by a cardiologist who told him that he was fit and well, and that he was suffering from nerves. Following the triumphant dress rehearsal, Larson went home and collapsed and died in his kitchen when he was making a snack. A post-mortem showed that he had ruptured a thoracic aneurysm and that he had Marfan syndrome. The young woman was inspired by Larson emerging from obscurity to write a musical that has been staged in many countries of the world, successfully transferred to Broadway and, at the time of writing, had run continuously there for 10 years. She thought that she, too, could be like Larson. All it took was self-belief and hard work. Larson had a physical problem, like her, but he did not allow it to prevent him realizing his dream. She thought of him hanging on to life until he was sure that the dream had come true. She was so inspired that she told many of her friends. Some said that, if he had not worked so hard, he might have lived longer. Others said that, if he had not been so preoccupied with his musical, he might have paid more attention to his health, and perhaps then his Marfan syndrome would have been detected earlier. One friend said that she thought of it like a kind of pact with God: he had paid with his life for the gift of one great creative act. Another, Fatema, said that he had been struck down for the immorality of his work, which had lionized the very people that this friend had been taught were evil doers.

Larson died as a result of a ruptured aortic aneurysm, and the cause of that happening was his Marfan syndrome. Deanna and all her friends accepted that as the cause. Knowing the cause has implications for medical practitioners and others, of course, but not really for these friends, unless they have, or know someone who has, Marfan syndrome. Knowing the reason for the death is much more important because it has moral significance, providing possible answers to such questions as, ‘Is it sometimes better to die early and achieve something memorable than to die later, but to die as a nonentity?’ However, Deanna and her friends did not agree about the reasons for Larson’s death even though they agreed about the cause. Each of them assimilated the death into the cultural system of meanings that they already had or, if it would not be assimilated, making enough of a change in that system to accommodate it. Deanna herself made such a major accommodation that seeing the biography ‘changed her life’, to use her own words.

Cultural tension and identity

Deanna found it easy to accept that if you dreamed enough and were prepared to follow your dream, the dream would come true. The price to be paid for this did not matter. Her friend Fatema did not have the same value. In fact, she found it offensive. To have accepted Deanna's reason would have been to offend Fatema's values. Deanna, for her part, soon fell out with the friend who thought Jonathan had been punished. She realized that she had nothing in common with her any more.

Fatema identified herself as a member of a fundamentally religious culture. If pressed, she would have argued that the values expressed by any member of that culture were also her own, but she strongly identified with these two: that certain behaviours were unacceptable to God, and proscribed by Scripture, and that presenting these practices without censoring them was, in itself, sinful. Deanna did not identify herself strongly with any culture, but did disidentify herself with these values of Fatema. She said that she was 'not the kind of person' to be so intolerant and 'bigoted'.

Personal identity is, like meaning, a common issue in psychotherapy, particularly longer-term psychotherapy. Identity issues include being 'somebody', coming to terms with being very different when intoxicated or under stress, having one's identity stolen or attached and dealing with opportunities to create virtual identities on the net or in fantasy games. Personal identity is determined by all the characteristics that enable us to distinguish one person from another, including their bank account number and their DNA. But John Locke's location of personal identity in consciousness (Locke, 1995) anticipated the principal modern usage of the term identity as a creation produced as a result of narration, particularly narration to oneself.

Fatema found the ideas of her culture about sin and censorship palatable and built them into her story of who she was and of what mattered to her. She identified with them. Deanna found them unpalatable, and rejected them and as a result also rejected Fatema. Had Deanna forced herself instead to hang on to Fatema's good opinion, and to talk disparagingly of Larson, it would have challenged not just Deanna's values, and the norms of her culture, but also her emotional investment in Larson as an inspiration.

Research evidence has consistently supported the power of cognitive dissonance in opinion change, although there are some cultural variations (Hoshino-Browne *et al.*, 2005). If Deanna had aped Fatema's opinions, cognitive dissonance theory predicts that she would have tended to adopt them as her own. Deanna's emotional investment, her identification with Larson, counteracted this. She felt an aversion to pronouncing any negative opinion about Larson and had she tried to overcome this in order to maintain her relationship with Fatema, she might have said, as others do in a similar situation, that she felt dirty by having to say things that she did not believe.

Cultures provide us with values, norms and symbols, but these are not lacking in an affective content. Each is charged with an emotional flavour put there by our emotions at the time that we first encountered the value or the application of the norm or the symbol. Our identification with a culture is a product of the amount of overlap between our personal values, norms and symbols, and those of the culture, and the emotional flavour of these values, norms and symbols.

Asserting a cultural identity means championing the ideas of a culture but also holding on to the emotions with which those ideas are flavoured. Providing psychotherapy across cultural boundaries means not only having to deal with the unfamiliarity and uncertainty created by novel ideas or situations, it also means dealing with the emotional flavour of the novelties. This is likely to be influenced by cultural transmission of emotional flavours. Given our preoccupation with the pressure of immigration, and in the aftermath of colonialism, other cultures, particularly those which are not economically dominant, are most likely to be viewed as potentially dangerous and the flavour of their ideas as unpalatable.

Moving between cultures, exercising what has come to be called cultural competence, involves therefore not just new learning but an emotional process of discovering the palatability of new values and norms. Psychotherapists who talk to colleagues working in a different modality even have to do this. For a psychoanalytic psychotherapist to be able to talk the same language as a cognitive-behavioural therapist may not be quantitatively as challenging as a white UK middle-class therapist finding a common language with a black African upper-class client, but it is not qualitatively different.

Hermeneutics is the common ground of culture and psychotherapy

Reasons are the answer we give to the questions, 'Why?' or 'What does it mean?' So long as we can give reasons for things, we can make sense of them and, if we can make sense of most of what happens to us, we can say that our lives have meaning. The potential universe of reasons is very large, but only a sub-set of them make sense to any particular person, and the membership of this sub-set is, or so some cultural anthropologists have argued, determined by the culture to which we belong. Christopher, for example, writes (Christopher, 2001), 'From a hermeneutic point of view, culture is constituted by those shared meanings that make social life possible' (*ibid*, p. 116).

Psychotherapists, too, have drawn on hermeneutic methods to collaborate with their clients in jointly discovering new meaning in the events of their client's lives (Lang, 1995). There is therefore a natural kinship in the methods of cultural anthropologists and psychotherapists in that both are interested in exploring meaning.

Culture provides us with the tools to create meaning, but it also limits the meaning that we can create, since each culture provides a different repertoire of tools. Most of us draw from several cultures. For many of us these different cultures are really sub-cultures of what constitutes our home culture and therefore our cultural toolboxes contain the same tools and the meaning that we place on our worlds is comparable. It is usual for each of them to have overlapping elements and no one can draw from all of human culture. As psychotherapy is a treatment based on shared meaning between patient(s) and therapist(s), the psychotherapist's culture and the client's culture have to overlap sufficiently for shared meaning to be possible (Qureshi, 2005).

Emic and etic elements of culture

Part of the power of the scientific paradigm is that it claims to be universal and not culture-specific. Dropped stones fall after they are thrown everywhere in the world, with very few exceptions, and every world language has had to find a word like 'fall' to describe the effects of gravity. Culture has a very superficial effect on biology. So most biological descriptions are cultural universals or 'etic' (Pike, 1967). Kraepelin went to Java to find out if dementia praecox was present there as well as in Europe and found that it was, and concluded from this that it was a biological disease as well as a culturally defined illness. Although Javanese culture may not have recognized schizophrenia as a single entity at that time, as European culture had not before Kraepelin's description, the descriptor 'schizophrenia' is an 'etic' one because it maps on to the same state of affairs in Java as it does in Germany. Depression and anxiety are probably etic, too, but not 'love-sick' or 'relaxed' or 'borderline personality disorder'. These are only understandable in a particularly cultural context and are therefore 'emic'.

From the foregoing discussion it will be clear that reasons which add meaning after the event, values, norms and emotional flavours are 'emic' in that they apply only within particular cultures whereas causal explanations are 'etic'.

A psychiatrist who knows that substance X is likely to improve the condition of 80% of her patients with schizophrenia knows this to be true irrespective of the patient's culture. Perhaps, though, substance X comes as a black tablet in which case Westerners might associate it with death, and be reluctant to take it. So the psychiatrist will have to discuss the colour and its significance with the patient, perhaps explaining that it was manufactured by a new drug company in Tanzania, who chose black because among the Masai it is associated with prosperity. Even though psychiatrist X would like to prescribe medication without having to take any account of creed, colour or culture, she would be forced to take this into account, not on grounds of efficacy but on grounds of effectiveness. Only the patients that complied with treatment would benefit from it and compliance would be affected by emic factors, even if the effects of the drug would not.

Has psychotherapy developed independently in cultures other than the Western European?

The 'drug metaphor' model of psychotherapy presumes that the treatment effects of psychotherapy are 'etic', and there is some evidence for this. Some of it comes from studies that compare apparently analogous healing practices in different parts of the world on the assumption that common factors may be 'etic' ones (Tantam, 1993).

Although studies like this contribute to the continuing search for the specific elements of psychotherapy, the non-specific, 'emic', factors are even more important than in other branches of psychiatry. So this kind of study may be less important than would seem at first sight. Such studies have an even larger drawback. They presume that psychotherapy occurs everywhere in the world in some form. But does it?

Preoccupying concern

What happens when someone in Central Asia, or East Africa or Borneo, becomes depressed? Who do they turn to? This question immediately raises a difficulty: there may be no recognition of an illness called depression at all (Kleinman, 2004). The recognition of an illness affords a medical solution (similarly, the availability of doctors affords the perception of interpersonal problems as due to illness). It seems likely that, when a person first experiences physical or psychological symptoms of unease, when they first develop a concern that is relevant to psychotherapy, they find a reason for it. The commonest reason worldwide is spirit possession, followed closely by ill will or witchcraft. But other reasons might include misfortune due to actions undertaken at inauspicious times, the influence of the stars, family conflict, worries or stresses, failure to propitiate the deceased, too much alcohol or drugs, bad character, failure to fulfil spiritual or ceremonial duties, punishment for past sins or crimes, remorse, physical disorder, deficiency disease and trauma. Which reason is chosen will determine what help is sought out. Possible community resources are likely to include a friend, a family member, an elder, a priest, a traditional healer or a doctor. Although traditional healers are often considered the equivalent in many cultures of psychotherapists, they are more appropriately considered the equivalent of alternative and complementary practitioners in the West.

Each of the foregoing formulations of unease can be considered to have at its core a specific 'concern' or, to use Kleinman's term, an explanatory model. Frijda (Frijda, 1986) defines a concern as '... the more or less enduring disposition to prefer particular states of the world. A concern is what gives a particular event its emotional meaning' (*ibid*, p. 100). Elsewhere, I have argued (Tantam, 2002) that psychotherapists who wish to gain the confidence of their patients must reach an agreement with their patients about the focus of therapy and that this must reflect the concern, the 'preoccupying concern', that is uppermost in the mind of the patient when seeking help.

Choice of healer will depend on time and money costs, on reputation and on the importance of hedging one's bets. Many people in rural Zanzibar, for example, consult both the health centre and a traditional healer when a child is ill. But the choice of healer and healing method will also depend on whether the healer is expected to focus on the patient's preoccupying concern. Only those people who see their unease in terms of illness are likely to seek out a doctor or a mental-health professional. How many people in the world do so is changing rapidly as education seems to bring with it an increased awareness of psychological and of psychological factors affecting personal experience.

Ethnic matching

One solution to the importance of matching patient expectation and psychotherapist behaviour is for patients to consult therapists who are from their same cultural group. It is difficult to know what a person's culture is until one gets to know them, and cultural matching is probably most important early on in the therapy or even before therapy begins, when the patient is selecting a therapist. Ethnic matching, which relies on demonstrable markers of ethnicity like name, skin colour, qualifications or neighbourhood may be used as a proxy of cultural matching.

One definition of culture is that it creates the norms, the values and the artefacts in which, and by which, we live. Norms have an influential bearing on the dispositions which, as noted in the previous section, generate the concerns that lead to therapy. That section dealt with the importance of matching the concerns of the patient with the concerns that the healing method highlights. It was noted that the concerns of psychotherapy include a preference for a 'state of the world', which accounts for unease by illness or disorder, and accounts for recovery by reference to mentalistic or psychological explanations.

Congruent values and palatable flavours

I have previously suggested (Tantam, 2002) that treatment adherence, and therefore treatment effectiveness, also requires matching values and 'emotional flavours'.

Values are culturally transmitted. So a congruence of values between patient and therapist is an important consequence of ethnic matching, and value incongruence is a significant barrier to cross-cultural psychotherapy.

Key values that have been described as being potential barriers are a focus on the psychological at the expense of the spiritual; an emphasis on independence and autonomy rather than interdependence and care for others; a focus on the individual rather than the family; and the expectation of instruction.

Values may be explicit. For example, patients from some cultures where a premium is placed on guidance may be confused to be told in the first session that their therapist will not be giving any specific advice.

Values may be implicit in administrative arrangements. Discouragement of family members being involved in psychotherapy may, for example, signal a depreciation of the value of the family as may asking patients not to discuss therapy outside the therapy hour.

Psychopathology also incorporates, and is influenced by, values. Diagnoses may implicitly communicate cultural assumptions. In the Muslim world, the absence of spiritual status from psychopathology is considered a weakness in Western orientated psychopathology, for example. In at least one former Communist country, there has been a clear shift from group-orientated to individually-orientated diagnostic labels, and consequently from group to individual treatments, following the abandonment of Marxist values and the assumption of consumerist ones (Leuenberger, 2002).

Not all values are constructive. Implicit values might include denigratory or racist ones. Patients may have stereotyped views of therapists, and therapists, too, may, without really being aware of this, consider people from other cultures to be unsophisticated, uncivilized or primitive. Peeling away the surface of expressed beliefs about other cultures might include values about the superiority of one's own culture's religious beliefs, or lack of them; about the psychological health or stability of people from one's culture; or about the lack of morality in other cultures.

Negative values may be communicated in many ways, not least by ignorance of what is important in another culture, for example, in relation to diet or religious observance or the manner of speaking to people of the other sex or of a different status.

Palatable flavours

Therapists can learn to address their patients' concerns more effectively with brief training or through experience and so can have their eyes opened to the concerns of other cultures. Values may be harder to reveal or to address.

Challenging a value may feel like questioning a person's identity. However, regular case consultation, or supervision, by psychotherapists provides the opportunity of a safe and confidential environment in which issues like this can be addressed. There is a case for seeking out supervision with an experienced supervisor from another culture when working across cultures, since they are likely to be more aware of implicit racism.

The third factor in cultural matching, emotional flavour, is not so easily dealt with. Cultures live on in their artefacts. What makes artefacts so redolent of cultures is not usually their function, since most functions to which we put objects are culturally universal, but their accidental characteristics such as colour, decoration or embellishment. These accidental characteristics have an emotional flavour which makes us like them, or want them, or fear them. Without necessarily seeing them, every psychotherapist is surrounded by artefacts that are redolent of their culture and its emotional flavour. The contents of our rooms, the presence or absence of paperwork or of a computer, whether our rooms are in a hospital or a domestic environment, the provenance of our pictures and ornaments, the colour of the faces in other offices or in the waiting room: all of these give an immediate flavour.

Perhaps the single most important emotional flavour when it comes to psychotherapy is homeliness or, its converse, otherness. Freud in his paper on homeliness makes the interesting point that homely also means exclusive, because we try to confine our secret wishes and desires indoors. So, by creating a very homely environment, we may also be excluding those for whom it strongly signals the opposite. Heidegger also sees homeliness as a kind of falling away from the anxiety that we inevitably feel when we open our eyes to the strangeness of our existence. Levinas also argues for our willingness to embrace otherness.

Heimlichkeit, homeliness, is, we may conclude, a defensive position, which keeps threat out. Making our consulting rooms, our approaches, our theories and our therapeutic rituals highly emotionally flavoured, highly culturally specific one might say, probably also serves a defensive function. Those in the know feel privileged to be so, and comfortable to be in a familiar place. But the flavour is repugnant to others who are not in the privileged minority and keeps them away.

Empirical findings

The conceptual status of many concepts in this field is so mutable that empirical studies are few and far between, and those that have been carried out have often had limited generalizability. There is no doubt, however, that a smaller proportion of the ethnic-minority groups in the UK and the US take up psychotherapy than the proportion of the white majority who do. There is also persuasive evidence that more patients from ethnic-minority groups drop out of treatment. People from every ethnic group appear to choose therapists of their own culture and probably some do not consult anyone if there is no therapist of their culture available. Increasing the cultural competence of therapists increases retention and therefore outcome.

The implications for service provision have not been translated into UK government policy, probably because psychotherapy is not high on the government agenda. The implications for individual clinicians are considered in the chapter on the patient–therapist relationship.

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Psychological interventions and assessments

Shahe S. Kazarian

EDITORS' INTRODUCTION

Psychology deals with the scientific study of behaviour in different settings such as clinical, occupational, industrial, educational. In every setting culture would be expected to play a role in the behaviour and how it is understood by those who are observing this behaviour. Within clinical psychology, there are several specialties related to age, e.g. child and adolescent, or setting, e.g. forensic. The influence of culture is fairly universal but the interpretations of these cultural influences become relativist. Psychological interventions are affected by the context within which they are developed and their blind application across cultures without understanding the contextual setting therefore becomes problematic.

Kazarian identifies three major periods in the cultural history of psychology. These are construction of the culture of psychology, deconstruction of the psychology culture and reconstruction of the culture of psychology. From the nineteenth century the first period of construction of the culture of psychology used positivism, the scientific method and the quantitative analytic approach to understand the relationship between mind, environment and behaviour. As a scientific professional discipline, psychology emerged in Western Europe and North America. Within this period, psychology embedded the text and the measurement technology and also took a significant role in the development and empirical evaluation of non-medical therapeutic approaches which were humane, ethical, innovative and grounded in scientific theory. The period of deconstruction of the culture of psychology commenced in the 1960s and lasted for three decades. In this period, questions were raised about the nature of psychology, its functions and its ethnocentric origins. Thus the perceived value-free nature of psychology was questioned and psychological testing using tests developed in one culture on individuals from another was challenged. This monocultural individualistic and masculine world view of mainstream Western psychology was explored and social responsibilities of psychology started to emerge in an open manner. The third major period of reconstruction of the culture of mainstream psychology deals with consideration of scientific and professional psychology road maps which enable mainstream psychology to transcend the narrow monocultural individualist masculine frameworks and assume enhanced cultural relevance and inclusivity both nationally and internationally. By doing so, psychology positions itself on the world stage for the betterment of the new pluralistically globalized community, argues Kazarian. The role of psychology in relation to migration, globalization, Westernization and secularization will strengthen interventions at all levels.

Introduction

Psychology is the scientific study of behaviour and the mind, and application of its knowledge base to quality of life. The field of psychology comprises several branches such as clinical, counselling, developmental, forensic and health, and subspecialties within these branches such as clinical child psychology, geropsychology, clinical neuropsychology and clinical health psychology within clinical psychology. Psychologists study mind–environment–behaviour relationships for the ultimate purpose of uncovering universals that benefit both the individual and society.

In the present chapter, the evolution of the contested culture of psychology generally, and clinical

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psychology and health psychology in particular, is examined with a view to identifying the relevance of the field and its clinical assessment and intervention psychotechnologies within culturally pluralistic national boundaries and in cross-cultural contexts in the global village.

Culture of psychology

It is possible to identify three major periods in the cultural history of psychology: construction of the culture of psychology, deconstruction of the psychology culture and reconstruction of the culture of psychology.

Construction of the culture of psychology

The first period can be described as development of the culture of the science and practice of psychology, a period that began in the late nineteenth century. As a scientific and professional discipline, psychology evolved in different countries, notably Britain, France, Germany and North America, and assumed a significant role within its national boundaries and outside.

As a scientific and a professional enterprise, the development of psychology was preoccupied with the three imperatives of positivism, the scientific method and the quantitative analytic approach in efforts to understand the mind–environment–behaviour relationship and to shape an acultural and value-free scientific and professional discipline in the service of the individual and society. On the science side, Wilhelm Wundt opened the first experimental laboratory in psychology in 1879 at the University of Leipzig in Germany and formalized psychology as an academic discipline. Different countries warmed up differentially to the newly founded science of psychology, the United States taking the lead in the establishment by G. Stanley Hall the first psychology laboratory at Johns Hopkins University in 1893 (Rosenzweig, 1994), followed by similar initiatives in other countries including the establishment by W. H. R. Rivers of a psychological laboratory at Cambridge in Great Britain in 1897.

On the professional side, Alfred Binet founded the first laboratory of psychodiagnosis in France and Lightner Witmer inspired the practical application of the science of psychology by establishing the world's first psychological clinic in 1896. Over time, advances in psychological theory, research, methodology and clinical practice in different countries, notably Australia, France, Germany, North America, South Africa, UK and the Netherlands, contributed significantly to the scientific approach to the understanding of normal and abnormal behaviour, and the development of both psychological and educational tests for diagnosis and quantitative assessment of individual differences and evidence-based psychological therapies for the alleviation of individual suffering and personal growth.

In terms of psychological and educational assessment, psychology embedded the test and measurement technology nationally and in receptive countries in which it blossomed such that a test-free world was hard to imagine (Zimbardo, 2004). Psychology's romance with the principles, empirical foundations and applications of the science of psychology and its passion to use psychotechnology to solve practical human problems invoked replacement of prevailing unsystematic and subjective evaluation practices (Bondy, 1974) with proliferated use of diagnostic and assessment strategies that were reliable, valid and standardized with respect to administration, scoring and normative interpretation. Psychological assessments of intelligence (e.g. WAIS in USA and Raven's Progressive Matrices in UK), achievement (e.g. Wide Range Achievement Test in USA), personality (e.g. Rorschach Inkblot Test in Switzerland, TAT and MMPI in USA), neuropsychological functioning (e.g. Halstead–Reitan Neuropsychological Battery) and vocational interests (e.g. Strong Vocational Interest Blank in USA) originated in various countries and applied in a host of settings including schools, mental institutions, health centres, mental-health clinics, counselling centres, private practice, forensics, industry and the military.

In terms of psychological interventions, psychology assumed a significant role in the development and empirical evaluation of non-medical therapeutic approaches that were humane, ethical, innovative, grounded in theory and scientific evidence and cost-effective. Psychological therapies varied in principles and techniques but aimed at the alleviation of suffering associated with various forms of mental-health issues, the promotion of personal growth through a process of self-awareness, and quality of life. In the wake of psychoanalysis and psychoanalytic 'talk therapy', behaviourism and humanistic psychology emerged as the second and third forces, respectively, in psychology and psychological therapies. In terms of behaviourism, assertiveness training and exposure therapies that were based on classical conditioning principles were applied initially in South Africa and England in the 1950s for the treatment of anxiety, phobias, sexual and marital problems, depression and substance use, while operant conditioning principles were applied in the United States at about the same time for the treatment of institutionally warehoused psychotic patients. In terms of humanistic psychology, Carl Rogers's client-centred psychotherapy adopted a theoretical lens that rejected determinism, and emphasized the phenomenological world of the client, and the client's inherent tendency toward self-actualization, in addition to fostering a therapeutic approach that sought to facilitate client growth through the therapeutic essentials of empathy, genuineness and unconditional positive regard.

Psychology generally, and clinical psychology in particular, aimed at an *etic* or a universal academic field and the invocation of psychological intervention and assessment derivatives that were consumable nationally with local spice and adaptable transnationally with cross-cultural garnish. Consequently, the profound and pervasive impact of national psychology reverberated to the international community. In giving away psychology as a premier scientific discipline and a legally sanctioned helping profession to their countries of origin and to the world, psychology also intended to give away a cultural prism that reflected democratic and human-rights values, including liberty of the mind.

Deconstruction of the culture of psychology

The second major period in the cultural history of psychology can be described as deconstruction of the culture of psychology, a period that spanned three decades from the 1960s. In this period, there was analytic preoccupation with the historical development of psychology and its role and universal relevance nationally and internationally. The deconstruction process of the culture of psychology had the benefit of unfolding the socialization of psychology and explicating the inherent assumptions, values and norms of the sociocultural-historical context in which the discipline was nurtured. It is important to underscore that the systematic exposition of the culture of psychology was motivated by the unconditional regard to actualize its scientific and professional potentials rather than diminish its role and universal relevance nationally and internationally.

The study of the culture of psychology proved a disciplinary awakening in that it provided transparency to the dominance of the so-called mainstream or textbook psychology and its embeddedness in the Western European and North American sociocultural–historical context. Thus, psychology had evolved into an ethnocentric Western solitude rather than as presumed or intended, into an acultural or value-free scientific and professional enterprise (Jahoda, 1970; Berry, Poortinga & Pandey, 1997). Key psychological phenomena in mainstream psychology such as health, psychopathology and personality were informed by a Western lens that reflected the primacy of rationalism, empiricism, monoculturalism and individualism, and the hegemony and universality of the values, assumptions and norms of the dominant agency of the white EuroAmerican middle-to-upper class male.

Since their earliest beginnings in Europe and North America, personality theorists who were predominantly white heterosexual male all espoused the primacy of investigative and practice structures, processes and outcomes that were within the purview of the Western individual agency, and relegated family and kin, culture and diversity, and qualitative analytical methodologies to negligible roles. A Western society and a scientific discipline preoccupied with the individual of the West inevitably formulated an individualist Western psychology in which the West was self-embodied in uniqueness, separateness, autonomy and agency, and reliance for self-esteem on self-expression and personal validation (Markus & Kitayama, 1991). Thus, psychoanalytic, existential–humanistic, trait, behavioural and cognitive theories were all preoccupied with the maladaptive behaviours or intrapsychic structures and processes (e.g. individuation, selfhood, self-actualization, quest for personal meaning, belief systems, etc.) of the autonomous individual, overvaluing the mainstream socialization of the person into the masculine traits of independence, freedom of choice, control and rationality, and devaluing the qualities of a self that was motivated by relational interdependence and emotionality, considering the latter as feminine and psychopathological. Even attachment theory with its three core assumptions, that caregiver sensitivity leads to secure attachment, secure attachment leads to social competence, and secure attachment leads to the use of the caregiver as a secure base for exploration of the external world, was preoccupied with the primacy of the mother-child dyad and measures of sensitivity, competence and secure base that were biased toward the Western espousal of autonomy, individuation and exploration (Rothbaum *et al.*, 2000; Weisner, 2005).

Of equal significance was that when the independent self was troubled, Western psychology offered the pained self individually orientated psychological assessments and interventions. Psychological assessments (NEO-PI-R, MCMI, BPI) and therapies (Object Relations Therapies, Brief Psychodynamic Therapies, Exposure Therapies, Eye Movement Desensitization Therapy, Cognitive Behaviour Modification) that were developed during the cultural deconstruction period of psychology were no different in their focus on the individual than those that prevailed during the cultural construction period of psychology. The psychological assessments and interventions of the cultural deconstruction era were also informed by a cultural-deficit-model in which dominant cultural norms in pluralistic host countries were used as yardsticks to make judgements on individuals from non-dominant cultures. Even psychological interventions that were motivated by the fourth revolution in psychology, the family-systems paradigm, were driven by an ethnocentric but universalist normative model of healthy family functioning. While family theorists such as Gregory Bateson and Murray Bowen considered the pained individual a product of a systemic problem, the psychological interventions that were inspired by their family systems theoretical lenses offered therapeutic blueprints that engaged predominantly Euro-American family therapists either in family-blaming generally or mother-bashing in particular for the psychopathology of the mentally ill family member (see Bateson). Alternatively, family-system theorists advocated interventions that espoused the ideal of *parentectomy* or differentiation of the psychologically disordered self from the presumed pathological family. An individuated but orphaned self was a better ideal than a deindividuated but familial self.

The monocultural, individualist and masculine world view of mainstream Western psychology and its invocation of both cultural homogeneity and the hegemony of individualism in psychological theory, research and practice had unintended consequences at national and international levels (Betancourt & Lopez, 1993; Fowers & Richardson, 1996; Guthrie, 1976; Kazarian & Evans, 1998, 2001; McGovern *et al.*, 1991; Schumaker & Ward, 2001; Sloan, 2001; Sue, 2004). On the national level, mainstream psychology's assumption of homogeneity veiled the diversity and cultural pluralism of Euro-American societies. Similarly, mainstream psychology's assumption of universalism contributed to a science and practice that was relevant and advantageous to the dominant heterosexual mainstream group but not ideal to the non-dominant segments of Euro-American communities, notably the so-called ethnic minorities. Finally, mainstream psychology's Euro-Americentric twin assumptions, of the superiority of Western thought and its legitimacy as the only valid source of knowledge and the inferiority of non-Western thought, extolled Euro-American methodologies and practices and dismissed or marginalized non-Western indigenous worldviews and practices within its national boundaries and beyond.

At the international level, the Euro-American psychology community assumed a socially responsible approach to the globalization of the science and practice of mainstream psychology (see Stout, 2004). Thus, Western-based academic and service institutions in many countries of the world hosted and funded psychology departments and Western-trained psychologist academicians and practitioners. There was also a proliferation of local and international collaborative scientific and practice activities within these countries, as was cross-cultural replication research and research (e.g. MMPI-2, Butcher, 2004; NEO-PI-R, McCrae & Terracciano, 2005) that in the main involved importation and validation of Western psychological theories and their assessment and intervention derivatives. Needless to say, consumption of Westernized psychology had the benefit of clarifying its pertinence to the indigenous cultural contexts while also exposing its scientific and practice limitations and prompting rethinking the potential value of more indigenous and culturally relevant methodologies and interventions.

Nevertheless, there prevailed a clash of Eastern and Western psychologies in which the ideals of mainstream and non-Western psychologies were compartmentalized and construed as antithetical. Thus, Western world views and practices and their Eastern counterparts were portrayed as incompatible if not antagonistic rather than potentially complementary and synergistic (Jaipal, 2004; Rubin, 2004). A popular illustration of the seeming incompatibility of the non-Western (Eastern) and Western psychologies was self-construal and the reliable finding of a lack of an isomorphism between the Euro-American individualist view of the self in the West and the relational view of the self in such non-Western cultures as Japan, India, the Hispanic South and Central Americas and the Middle East (Ahmad & Gielen, 1998; Markus & Kitayama, 1991; Roland, 1988). In contrast to the independent Western self, the interdependent non-Western self was embedded in seemingly collectivist societies that evoked and espoused primordial familial, kin and communal loyalties and cultural contexts that were preoccupied with connectedness with others, valuing harmony, cohesion and co-operation, regulating behaviour on the basis of social and contextual factors, and deriving individual self-esteem from relatedness. Thus, a Western-trained individualist psychologist listening to an interdependent-orientated woman talk about her self-esteem in terms of her children's accomplishments rather than her own diagnosed the interviewee as lacking self-esteem. Similarly, the prevailing Western individualist ideals of mental health and individual-based Euro-American psychological assessments and interventions that involved self-reflection, self-analysis and self-disclosure to paid stranger therapists and that espoused a therapeutic outcome of independence were deemed foreign or ill-suited to the pained non-Western relational self, which seemingly required psychological processes and outcomes that were relatedness-orientated and epitomized by interventions that involved and relied on family, kin and native healing and aimed at harmonious connectedness of self with significant others. Thus, refugee adolescents from Middle Eastern countries living in countries increasingly hostile to foreigners developed massive problems including delinquency and drug use. The troubled male adolescent, with an interdependent-self confronted with a Western-trained clinical psychologist negotiating the Western ideals of independent living (e.g. living one's own life and choosing one's own career) and self-actualization, felt baffled, if not suspicious, hesitant, frustrated, defiant and hostile. In addition to not knowing what the psychologist was talking about, the troubled adolescent felt lack of entitlement even to ask questions that were in his mind within the purview of family and kin!

It is important to underscore that the outcome of the globalization of psychology was not uniform such that psychology was valourized less in countries (e.g. India) in which the centrality of the individual was de-emphasized (Jaipal, 2004; Rosenzweig, 1994). In some cases, the perceived 'invasion' of Western psychology evoked collective memories of colonialism (Dwairy, 1998; Jaipal, 2004), and motivated concerted efforts on the part of non-Western indigenous psychologists in the Third World to eschew the Euro-Americanized imperialist psychological perspectives or even to counteract the Eurocentrism or Euro-Americentrism of mainstream psychology with their own Eastrocentrism. Needless to say, there were also proponents of a third egalitarianism model that viewed both Western and non-Western psychological perspectives as valuable, albeit incomplete and offering 'fertile possibilities for cross-pollination'. (Rubin, 2004, p. 259). The egalitarian perspective to the psychologies of the East and the West and the application of their mutually enriching psychotechnologies had the potential for more meaningfully addressing indigenous quality of life issues such as personal suffering and poverty, and combating the negative socio-political and mental health consequences of globalization such as migration, racism, and terrorism.

Reconstruction of the culture of mainstream psychology

The third major period in the cultural history of psychology can be described as reconstruction of the culture of mainstream psychology, a period spanning from the 1990s to the present. The main preoccupation during this period was consideration of scientific and professional psychology road maps that would enable mainstream psychology transcend its narrow monocultural, individualist, and masculine Euro-American framework, assume enhanced cultural relevance and inclusivity nationally and internationally and position itself uniquely on the world stage for the betterment of the new pluralistically globalized community.

While the contested cultural reconstruction of mainstream psychology can be traced to the early 1960s, the call for the cultural makeover of mainstream psychology intensified during the 1970s and 1980s such that a mainstream psychology that was grounded in multicultural and diversity perspectives assumed revolutionary proportions in the 1990s and represented a fifth force or a paradigm shift in the contemporary science and practice of the psychology field. The architects of the multiculturalization and diversization of Euro-American psychology were from the ranks of mainstream psychology and psychologists from various non-Western countries. They advocated the parallel consideration of the multiculturalism and diversity lenses to guide the cultural remaking of mainstream psychology and its subspecialties and to allow meaningful integration of the two historical solitudes of culture and psychology by bringing diversity into the forefront of the science and practice of mainstream psychology.

The cultural reconstruction of mainstream psychology and its subspecialties involved rethinking the science of psychology from the perspective of cultural relevance and inclusivity and reliance on both bottom-up and top-down processes for the infusion of cultural competence and accountability in its practice (Bernal & Castro, 1994; Hall, 1997). On the professional level, historic initiatives from the early 1990s onwards were taken by European and North American Psychological Associations for the codification of ethical principles, codes of conduct and professional guidelines specific to diversity, the implementation of accreditation standards in which effective training of competent professional psychologists was an imperative (e.g. Kazarian, 2004), and the endorsement of guidelines that pertained to multicultural education, training, research, practice and organizational change (APA, 2002; Sue, 2004).

On the academic level, cultural considerations infused mainstream psychology introductory as well as higher undergraduate and graduate level textbooks. In addition, cultural reconstruction sources emerged in clinical psychology (Belar, 1998; Kazarian & Evans, 1998), counseling psychology

(Atkinson & Atkinson, 2003; Pederson, Draguns, Lonner & Trimble, 2002; Ponteretto *et al.*, 2001; Sue, Ivey & Pederson, 1996; Sue & Sue, 2003), health psychology (Kato & Mann, 1996; Kazarian & Evans, 2001) and personality (Triandis & Suh, 2002), as did proliferation of literature on multicultural psychological theory, assessment, intervention and training (Aponte & Wohl, 2000; Cooper & Denner, 1998; Dana, 1993, 2000; Gibbs & Huang, 2003; Gielen, Fish & Draguns, 2004; Hays, 2001; Kurasaki, Okazaki & Sue, 2002; Patel, 2003; Pederson, 1999; Rhodes, Ochoa & Ortiz, 2005; Suzuki, Meller & Ponteretto, 2001; Vernon & Clemente, 2005; Walker, 2005), as well as application worldwide in health care, human rights, poverty, conflict resolution and terrorism (Stout, 2004). Psychological assessments of the cultural reconstruction period were informed by culture sensitivity, relevance, and fairness, the development of new culturally sound diagnostic and psychological assessment strategies, and the challenges associated with the expansion of assessment to testing on the Internet (Naglieri *et al.*, 2004). Similarly, psychological interventions of the cultural reconstruction period were informed by the imperatives of culture sensitivity, relevance and competence (Corey, 2005), and empirically supported psychological treatments, as distinct from generic psychotherapy, for physical or psychological pathologies (Barlow, 2004) even though a disjunction existed between evidence-based interventions and culturally sensitive therapies such that many culturally sensitive therapies lacked empirical support and most empirically supported therapies remained suspect in terms of generalization to non-dominant diversity groups within the culturally pluralistic Euro-American countries and elsewhere in the world (Hall, 2001; Draguns, 2002; Rehm, 2002).

While reflection on the multicultural perspective in psychology invoked that multiculturalism itself was rooted in the morality of Euro-American culture and that its universalization in psychology represented imposition of such values as diversity, tolerance, respect and human rights and dignity on non-multiculturalists (Belar, 1998), the multicultural and diversity lenses of psychology had the positive consequence of shaping a new tapestry of psychological theories, lifespan research programs, assessment tools and psychosocial and skills-based interventions relating to enculturation, acculturation, cultural syndromes, self and social identity, cross-cultural parenting and healthy human development and functioning (Chun, Organista, & Marin, 2002; Cross & Madson, 1997; Diener & Suh, 2000; Kazarian, 2005; Oyserman, Coon, & Kemmelmeier, 2002; Rohner, 2004). The psychological assessments inspired during this period included independent-interdependent self-construals (e.g. Singelis, 1994), the cultural dimensions of horizontal and vertical individualism and collectivism (e.g. Singelis *et al.*, 1995), the cultural orientations of assimilation, integration, separation, and marginalization (Berry, 1998; De Vijver & Phalet, 2004), and ethnic identity (e.g. Phinney, 1992). Significant progress was also made in the consideration of acculturation at the level of individuals and/or host countries and their implications to physical and psychological health, therapist–client communication, ethnic identities, service delivery (Berry, 1998; Kazarian & Evans, 2001) and ethical training of psychologists (Handelsman, Gottlieb & Knapp, 2005). Similarly, policy models and psychological interventions were developed and applied to help cope with physical and mental-health problems associated with a host of negative settlement and migrant experiences in culturally pluralistic Euro-American contexts such as forced assimilation, alienation, ghettoization, individual or systemic diversism (prejudice and discrimination on the basis of diversity), harassment and racial profiling and diversity-motivated hate (Kazarian, 2001).

While the contested multiculturalization and diversization of mainstream psychology broadened the perspective of the science and practice of psychology and its national and international opportunities, the multicultural and diversity psychology lenses and their psychotechnological derivatives seemed less focused on certain cultural/religious groups in their pluralistic societies, most notably those from the Arab Middle East and South Asia

(India and Pakistan), and less attentive to the psychology of non-Western countries exposed to globalization, Westernization, secularization and the consequent erosion or devaluation of their religious and indigenous identities and values. In the wake of the '9/11's in different parts of the world (Moghaddam, 2005), the salience of the psychology of migration and acculturation in culturally pluralistic nations and globalization in non-Western cultural contexts and their implications for citizenry, national security, human rights and individual and communal quality of life invoked the continued need for rethinking the culture of psychology and its psychological intervention and assessment derivatives for the purpose of advancing psychology as a truly international science and a profession informed by an egalitarian diversity lens and deeply committed to the mental-health tapestry of the individual, the family, the community and the global village.

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33

Spiritual aspects of management

Andrew Sims

EDITORS' INTRODUCTION

The cultural aspects of managing a patient must take into account the spiritual models and explanations of the illness as experienced by the patients. For most of the last century, little attention was paid to religious or spiritual concerns of patients and their carers. The reductionist versus holistic approaches in clinical medicine allowed a degree of tension in management strategies, often detrimental to the patient. The religious beliefs were often seen as delusional and of interest to the clinician only in that context whereas spirituality was ill-defined and played an even smaller role.

Having discussed the implications of spirituality on the aetiology and presentation of psychiatric disorders by Lowenthal, in this chapter Sims deals with issues of clinical management and attempts to place spirituality in the centre of psychiatric management, fitting it into the complete picture of treatment of patients. Spiritual healing includes a number of strategies and would include spirituality at its core. Spirituality, according to Sims, has components of looking for the meaning in life, human solidarity (interconnectedness of it all), wholeness of the person and moral aspects, along with the connection between God and man. Spiritual healing in the form of prayer, healing meditation or laying of hands has been noted in every culture. Sims offers a series of questions that need to be asked in taking a religious history from any patient. He emphasizes that ascertaining spiritual belief is also a vital ingredient of mental-state examination of the patient and gives valuable information for assessment and treatment. Being able to explore and thereby give validity to the patient's beliefs allows not only the context within which distress is being experienced to become clearer, but also encourages the patient to be open-minded and accepting of the therapy, especially if it includes spiritual aspects. The range of different types of spiritual healing is immense. Sims suggests that the onset, outcome and treatment for various psychiatric disorders are markedly different, as should be the spiritual aspects of their management. Cognitive behaviour therapy can utilize spiritual aspects of a patient's cognitions readily. Pastoral care is particularly helpful in chronic severe illnesses.

Introduction

The significance given to the religious or spiritual concerns of the patient reflects the *culture* of psychiatry in that place, and time. In Europe and North America, it is a product of the long-term ideological conflict within psychiatry between reductionist tendencies and a philosophy of assessment and treatment that aspires to help the whole person. Both of these extreme positions have made contributions to the effective treatment of patients, and probably some degree of dynamic tension has been beneficial to the academic discipline of psychiatry. Most practitioners have learnt from both schools of thought, and apply an amalgam in their clinical practice. In recent years there has been much more interest in spirituality by psychiatrists throughout the world, and this has been recognised by the World Psychiatric Association as well as at national level (Leon *et al.*, 2000).

There have been major changes within psychiatry towards the concepts of spirituality and religion

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

over the last half-century. For example, in the standard British textbook of psychiatry in the 1950s and 60s (Mayer-Gross, Slater and Roth, 1954, 1960, 1969) there are only two references to religion in the index: '"Religiosity" in deteriorated epileptic', and, 'Religious belief, neurotic search for'. The latter was aimed as an attack upon psychoanalysis but assumed religion is for 'the hesitant, the guilt-ridden, the excessively timid, those lacking clear convictions with which to face life'. The attitudes of those influential in psychiatry tended to regard religious belief in patients as 'neurotic' and in doctors as unscientific. By contrast, the *New Oxford Textbook* (Gelder, López-Ibor & Andreasen (2000), in 2000, had nine references to 'religion' or 'religious'.

This chapter is not an encyclopaedia of different types of spiritual healing. There is currently a vast increase in the methods used under this general category. This account aims to put spiritual aspects of psychiatric management into the context of other types of psychiatric management and cultural psychiatry. Within this section the intention is to demonstrate how spirituality should be included as part of the theory of psychiatric management and how it fits into the complete picture of treatment of patients.

Case examples are given to demonstrate what spiritual aspects of management mean in *clinical* practice. What is meant by spirituality and how it is relevant to the practice of psychiatry is discussed. How spiritual aspects of management complement other conventional methods of psychiatric treatment to benefit the whole person, both with the alleviation of symptoms and an improved ability to function appropriately, is also covered. There is a brief description of some of the vast range of specific techniques used in spiritual healing. *Mental illness* subsumes a number of different psychiatric conditions and the relevance of spiritual aspects for these different diagnostic entities is considered. Pastoral care and user initiatives are explored and conclusions are drawn for the relevance of spiritual attitudes in the treatment of psychiatric patients.

Spiritual management

Spiritual healing is not confined to any one organ or biological system; nor to any one country or culture, or mode of belief. The practitioners would generally agree that faith in the possibility of healing, and trust in the healer, is required by the sufferer. Occasionally, most often when a prominent person or celebrity is healed, this phenomenon hits the headlines, for example, 'Football fans rush to hail the miracle of Marvin's knee' (Lister, 2005). This is an account of many Rangers football supporters attending a small church, Zion Praise Centre, in Scotland, where a famous footballer had been healed through prayer of a career-threatening injury to his knee.

In the field of mental disorder, including substance-related disorders, there have been many dramatic accounts of spiritual healing. This has often been reported in places and amongst populations where no formal psychiatric treatment is available.

The features of such an intervention can be demonstrated best by a case history. Jackie Pullinger worked for many years with severely deprived, usually criminal young men belonging to Triad gangs and addicted to heroin in the 'Walled City' of Hong Kong (Pullinger, 1980). She made no claims for any healing qualification but she told these young men, individually, that God loved them, and invited them to put their trust in Jesus Christ. They were then encouraged to pray 'in an unknown language' and, miraculously, they had no withdrawal symptoms and most remained off drugs subsequently. One of many examples is recounted as follows:

> He hid his surprise at meeting a Western woman quite well, but when I told him that Jesus really loved him, he looked undecided as to whether to accept this. Eventually he concluded, 'It's either jail or Jesus', and took Jesus. Some of the former gang members living there then prayed with him and he began to speak quietly in a language he did not know. We then took him back across the harbour to Third House so that he could withdraw from heroin.
>
> Some of the boys were smart enough to pray immediately and never had the slightest twinge. Others, like Siu Ming, waited until they were *in extremis* before learning

> that God did not want them to suffer at all. He refused to pray, which was understandable since his experience of praying was limited to the session in my house only a few hours earlier. He was in agony with withdrawal pains and did not know how to make a prayer even had he felt like it.
>
> At last he said he could bear no more and in desperation agreed to pray in tongues.
>
> He did not have to think what words to say, God's Spirit gave them. He said he felt wonderful and in 10 minutes was asleep. He slept right through a day and when he awoke had a real confidence that Jesus did love him. Through this he also learned to pray in the Spirit and was freed from heroin painlessly. Although this miracle had been repeated each time with each of the boys, each one of them knew that it was specially for him.
>
> . . . as the year progressed, he began to grow into a person who was kind, trustworthy, hardworking and, most importantly, spiritual. He learned to read and write through the daily Bible studies and was often found praying by himself. Eventually his ministry of serving the brothers and Christ was evident; he was ordained a deacon in the church and became a helper to all the new boys who arrive.

Within the National Health Service in the United Kingdom, Hospital or Community Mental Health chaplains are often employed. They are valuable in many ways, and often contribute to the treatment of patients. Another clinical case history illustrates this issue. A 14-year-old girl of Pakistani origin was referred to a child psychiatrist for school refusal, disturbed behaviour and vivid descriptions of frightening visual perceptions. The general practitioner thought that she might be psychotic.

She and her parents were most concerned about her 'visions'. They had wanted to consult the imam but had discovered that he was out of the country. The child psychiatrist reassured them that she was not psychotic and, with the family's permission, arranged for her to discuss her strange experiences with the hospital chaplain. This seemed to work, as spiritual guidance was given and accepted.

Sometimes spiritual management can be incorporated within the framework of psychiatric treatment, treating the individual patient as a whole person. This was demonstrated in the clinical practice of the late Dr Nagoub Bishay, applying cognitive behavioural principles in the treatment of patients with differing religious backgrounds (Bishay & Ormston, 1996). He obtained an account, both descriptive and historical, of the patient's symptoms, and then allowed his patients to express their religious beliefs in their own words in the context of these symptoms. He then helped each patient, using their own religious belief, to set up an argument within themselves to demonstrate that their pathological response was unnecessary, and false to what they themselves believed to be true. Dr Bishay had the advantage of being a Coptic Christian from Egypt, and earlier in his life he had familiarity with the beliefs of Muslims, Jews and Christians of different persuasions.

Spirituality and spiritual healing

This is a useful, very imprecise word; perhaps useful because it does have varied meanings for different people. Dictionary definitions are not particularly helpful. For instance, the *Shorter Oxford Dictionary* (1973): *Spirituality* is 'that which has a spiritual character, the quality or condition of being spiritual'. *Spiritual* means 'of, pertaining to, affecting or concerning, the spirit or higher moral qualities, especially as regarded in a religious aspect'.

A succinct definition of spirituality from the Dalai Lama is 'compassionate thoughts, feelings and actions'. More comprehensively, from Koenig *et al.* (2001),

> Spirituality is the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community.

In *Values in Healthcare: A Spiritual Approach*, which is a programme for the training of healthcare workers, spirituality in a health context involved 'using inner resources of peace, love, positivity and compassion for the benefit and healing of others and ourselves' (Janki Foundation, 2005). An operational definition of spirituality developed for mental-health use is as follows.

1. *Aims and goals*; looking for the meaning in life, what one regards as essential;
2. *Human solidarity*; the inter-relatedness of all, both doctor and patient; consciously and unconsciously shared beliefs;
3. *Wholeness of the person*; the spirit is not separate from body or mind, but includes them;
4. *Moral aspects*; what is seen as good, beautiful, enjoyable, as opposed to what is bad, ugly, hateful;
5. *Awareness of God*; the connection between God and man (Sims, 1994).

It is not easy to define *spiritual* and *spirituality*, or even describe them with any precision but there is usually an implication of Other, outside or alongside self. Concepts usually include a search for meaning in the world, in relationships with other people and in personal circumstances; ideas about God, religion, meditation, prayer and life after death; and, appreciation of the world of nature and beauty.

Why is spirituality, and spiritual management, relevant for psychiatry? We, as psychiatrists, purport to deal with the whole person, and psychiatrists have sometimes criticised the orthopaedic surgeon who treats 'a knee' in isolation, or the renal physician who cannot see beyond the deranged physiology of the kidney.

> We psychiatrists complain when our medical colleagues cannot get beyond the physical, even when evidence for psychosocial aetiology is quite blatant, but we may be guilty of an equivalent error in almost totally excluding spiritual considerations from the way we understand our patients.

That was written 10 years ago, but it is still to some extent true.

A robust comment on the need of mental-health professionals to take spiritual aspects of their patients into account is made by Swinton, 2001. Our patients are apprehensive of the hostility psychiatry has shown in the past towards their religious beliefs. They want psychiatrists to acknowledge these beliefs and integrate them into our treatment. There is a discrepancy between religious belief in the majority of our patients, but only in a minority of psychiatrists. Mental-health practitioners show consistently lower rates for religious beliefs and practice than either their patients or the general population. In the United Kingdom, 73% of psychiatrists reported no religious affiliation as compared with 38% of their patients, and 78% attended religious services less than once a month (Neeleman & King, 1993). Only 39% of women psychiatrists and 19% of men, believed in God. However, 92% of these psychiatrists believed that religion and mental illness were connected and that religious issues should be addressed in treatment. 42% considered that religiosity could lead to mental illness, and 58% never made referrals to clergy. Thus, in general, British psychiatrists do not have a religious belief themselves and have a somewhat negative view, rather than neutral, of the beliefs of their patients.

There is much encouragement for psychiatrists to work with other disciplines in the care of their patients, both practising in a multi-disciplinary team and collaborating with other external agencies. Religious people and organisations are often very helpful, sometimes the only support, for our patients, and optimum care would, on occasions, involve working more closely with them. This point was made cogently by the Archbishop of Canterbury in an address jointly to the Association of European Psychiatrist and the Royal College of Psychiatrists (Carey, 1997).

Religious belief and practice is associated with better mental health (and physical health) and an improved response to treatment. This will be considered in a subsequent section.

Spiritual healing is a specific type of intervention involving acknowledgement of the importance of the spiritual dimension in the treatment of human illness and malaise.

> Spiritual healing in the form of prayer, healing meditation, or the laying on of hands has been practised in virtually every known culture. Prayers and rituals for healing are a part of most religions. Reports of folk-healers are familiar from legend, the Bible, anthropological studies of traditional cultures, the popular press, and more recently from scientific research (Benor, 2001).

Spiritual healing was recognised as a form of complementary therapy by the House of Lords Select Committee on Science and Technology. In their classification it was placed in 'Group B' of therapies used to complement conventional medicine without purporting to embrace diagnostic skills (House of Lords Select Committee on Science and Technology, 2000). Healing was defined:

> a system of spiritual healing, sometimes based on prayer and religious beliefs, that attempts to tackle illness through non-physical means, usually by directing thoughts towards an individual. Often involves 'the laying on of hands'.

Spiritual aspects in the management of a person with psychiatric disorder

Spiritual management is not an 'add-on' like adding a new neuroleptic drug in the treatment of resistant schizophrenia. It is an essential component of all treatment of all patients. As part of the history-taking it has been recommended that the doctor take a 'religious history' with questions such as those illustrated in Box 33.1.

Patients are more likely to have confidence in their psychiatrists if the latter are sympathetic towards their beliefs. Ascertaining spiritual belief is also a vital ingredient of the mental-state examination of the patient and gives valuable information for assessment and treatment. The psychiatrist therefore needs to give validity to the patient's beliefs. This will imply being able to discuss belief with the patient in the context of their psychiatric symptoms. It may mean a preparedness to confer, at the patient's request, with a designated religious leader. It will mean acknowledging the value of prayer to the patient and of the benefits of a faith community such as a church or mosque.

Box 33.1

- Are religious or spiritual beliefs an important part of your life?
- How do these beliefs influence the way you take care of yourself?
- Do you rely on your beliefs to help you cope with health problems?
- Are you part of a religious or spiritual community?
- Are there any religious or spiritual issues that need addressing?
- Who would you like to address religious or spiritual issues?
- How would you like me to address your spiritual needs? (Matthews & Clark, 1998).

There is now considerable research evidence for the effects of religious belief, or spirituality, upon health and disease. This has been collected by Koenig, McCullough and Larson in the *Handbook of Religion and Health*, 2001.

This reviews and discusses research that has examined the relationships between the patient's religious beliefs and a variety of mental- and physical-health conditions. It covers the whole of medicine, and is based on 1200 research studies and 400 reviews. Research on Religion and Mental Health occupies ten chapters.

Under *research and mental health* are discussed: religion and well-being, depression, suicide, anxiety disorders, schizophrenia and other psychoses, alcohol and drug use, delinquency, marital instability, personality, and a summarising chapter on understanding religion's effects upon mental health. The authors are cautious in drawing conclusions, but the results are overwhelming.

To quote:

> In the majority of studies, religious involvement is correlated with:
> - Well-being, happiness and life satisfaction;
> - Hope and optimism;
> - Purpose and meaning in life;
> - Higher self-esteem;
> - Adaptation to bereavement;
> - Greater social support and less loneliness;
> - Lower rates of depression and faster recovery from depression;
> - Lower rates of suicide and fewer positive attitudes towards suicide;
> - Less anxiety;
> - Less psychosis and fewer psychotic tendencies;

> - Lower rates of alcohol and drug use and abuse;
> - Less delinquency and criminal activity;
> - Greater marital stability and satisfaction . . .
>
> We concluded that, for the vast majority of people, the apparent benefit of devout religious belief and practice probably out-weigh the risks.

Correlations between religious belief and greater well-being 'typically equal or exceed correlations between well-being and other psychosocial variables, such as social support'. That is a considerable assertion, comprehensively attested to by a large volume of evidence, for example, in Brown's studies on the social origins of depression, various types of social support were the most powerful protective factors against depression (Brown & Harris, 1978).

Of the studies, 80% or more reported an association between 'religiousness' and a greater hope or optimism about the future. Of 16 studies, 15 reported a statistically significant association between 'greater religious involvement' and a greater sense of purpose or meaning in life. Of 20 studies, 19 reported at least one statistically significant relationship between a religious variable and greater social support. Of 93 cross-sectional or prospective studies of the relationship between religious involvement and depression, 60 (65%) reported a significant positive relationship between a measure of religious involvement and lower rates of depression; 13 studies reported no association; 4 reported greater depression among the more religious; and 16 studies gave mixed findings. With all the 13 factors, religious belief proved beneficial in more than 80% of mental-health studies. This is despite very few of these studies having been initially designed to examine the effect of religious involvement on health.

The authors develop a model for how and why religious belief and practice might influence mental health. There are direct beneficial effects upon mental health, such as better cognitive appraisal and coping behaviour in response to stressful life experiences. There are also indirect effects, such as developmental factors and even genetic and biological factors.

Most of the studies were carried out in the USA and are based upon Christian or Jewish belief. There is some work from other countries and other religions, and the results are similar. At our present state of knowledge, it is important to have more sophisticated measures of religious and spiritual belief for psychiatric research (King, Speck & Thomas, 2001).

Spiritual healing: a complementary therapy with specific techniques

> 'We do not have a monopoly of loving care in the West and it is far wiser to be open to the contribution that other cultures can make. I feel that there is much to learn from the ways different societies treat their sick.'

This was written by Dr Dewi Rees (2003), a former general practitioner in several different parts of the world and medical director of a hospice, and an acute observer of his patients.

Conventional medicine is not universally effective for all people, for all illnesses and conditions and at all times. That truism being immediately accepted by patients and doctors alike, patients will search for alternative and complementary therapies, sometimes those that conform better with their world view, and it behoves doctors to be open-minded, certainly to give cautious warnings when appropriate, but also to be humble in their claims. On occasions they should co-operate and collaborate for the benefit of patients.

The range of different types of spiritual healing is immense, and beyond the scope of this chapter to describe, or even list. Healing may take place at a distance or by laying on of hands. It involves meditation and prayer from the subject. According to Fulder, the patient is encouraged to see healing as an enterprise towards health and self-discovery, rather than a cure for a specific illness (Fulder, 1984). Benor (2001) lists the following 12 systems of healing, which he has encountered and whose practitioners he has generally found reliable. He gives strengths and limitations for each:

- Spiritual healing in religious settings
- Qigong healing
- Medical dowsing
- Reiki healing
- LeShan healing
- Therapeutic Touch
- Craniosacral therapy
- The Bowen technique
- Barbara Brennan healing
- Polarity therapy
- SHEN healing
- Healing Touch

These are all available in the USA, whatever their country of origin. Rees lists techniques of healing from all over the world, including his own country of Wales. The similarities between some of these methods from places far distant from each other are remarkable.

Overall, the evidence for efficacy of spiritual healing is positive, but only weakly so, not as strong and as unidirectional as the evidence for health benefits from religious belief and practice. Benor lists controlled studies of 'Healing for human physical problems' and 'Healing for subjective experiences' amongst others of less interest to the psychiatrist.

A study showing strongly positive effects of prayer randomised 393 patients admitted to a coronary care unit; 192 received intercessory prayer from Christians outside the hospital and 201 did not (Byrd, 1988). Those prayed for had a significantly lower severity score during their hospital admission.

Significant effects of healing on AIDS was demonstrated in a report of 40 sufferers randomly allocated to treatment and control groups with distant healing for 10 weeks from 40 experienced healers (Sicher *et al.*, 1998). After 6 months the treatment group had significantly fewer AIDS-related illnesses and lower severity of illness with fewer visits to doctors, hospitalisations and days in hospital.

The evidence for benefit from therapeutic touch is ambiguous, partly because studies investigating have been less well designed.

In a study to show the effects of paranormal healing on hypertension, the results were mixed (Beutler *et al.*, 1988). 120 patients were allocated randomly to receiving no healing, receiving distant healing and receiving laying on of hands. There were no clear advantages for any of these three groups. Although there are a large number of accounts of healing for human physical problems, overall the results are equivocal and many of the strongly positive studies have not been published in medical journals, nor replicated.

'Healing for subjective experiences' includes several studies on pain. There are efficacious treatments for pain with conventional medicine but these are not successful on all occasions, and narcotics and related medications have side effects and the risk of dependency. Therapeutic touch was found to have significant beneficial effects in the treatment of post-operative pain in research carried out on 159 patients undergoing major elective abdominal or pelvic surgery (Meehan *et al.*, 1990). Patients were randomly assigned to receive Therapeutic Touch, mock Therapeutic Touch or standard care. Subjects received eight treatments. There was no difference in pain intensity scores, but those who received therapeutic touch had less analgesia and went for longer intervals before requesting it. Several types of spiritual healing have been found to have benefit for the treatment of pain, both acute and chronic, but many of these studies are flawed by their methodology or presentation. There are also several studies for the effects of spiritual healing on anxiety, but unfortunately the same criticisms pertain.

There are also accounts of healing used for depression. For example, 141 patients with chronic, resistant depression were treated with cranial electrical stimulation, autogenic training, photostimulation, brain wave synchronisation and music (Shealy *et al.*, 1993). In addition, patients were randomly assigned to carry either glass or quartz crystals. Significant improvement was shown for the whole group but it is difficult to evaluate individual treatment modalities. The authors comment that no medication has been shown to give such good results after only 2 weeks' treatment.

In reviewing the work on healing for subjective symptoms, it is disappointing that so much has been done with such unclear results. A few well-conducted and objective studies carried out on a large number of carefully chosen subjects, randomised appropriately into treatment from recognised and properly conducted forms of spiritual healing would be much better than the multiplicity of studies at present, that cannot be combined to form any meaningful meta-analysis. Vincent and Furnham (1997) give a clear account of research into complementary medicine, but not many of the studies they report relate to spiritual healing.

Spiritual aspects of management for different psychiatric disorders

The onset, course, outcome and treatment for the various psychiatric disorders are markedly different, and therefore so should be the spiritual aspects of their management. Little attention has been paid to this in the past. For those with mental disorder there is, in general, a better outcome if the patient has religious belief; this is true for most individual psychiatric conditions (Koenig *et al.*, 2001). This pertains, for example, for schizophrenia (Verghese *et al.*, 1989), depression (Kendler, Gardner & Prescott, 1997), anxiety disorders (Koenig *et al.*, 1993), alcohol and drug use (Adlaf & Smart, 1985; Amey, Albrecht & Miller, 1996; Koenig *et al.*, 1994). Religious belief and practice were associated with decreased rates for suicide in 84% of 68 studies, with greater well-being in 79% of reports (Koenig, McCullough & Larson, 2001), with decreased rates of delinquency (Benson & Donahue, 1989), with higher rates of marital stability (Call & Heaton, 1997), lower rates for hostility (Kark *et al.*, 1996), more hope and optimism (Mickley, Soeken & Belcher, 1992), and an internalised locus of control (Jackson & Coursey, 1988). As an example of the association with well-being, a questionnaire was administered to 474 students in the United Kingdom enquiring about religious orientation, frequency of personal prayer and church attendance, alongside measures of depressive symptoms, trait anxiety and self-esteem (Maltby, Lewis & Day, 1999). Frequency of personal prayer was the dominant factor in a positive relationship between religiosity and psychological well-being.

It would be helpful for mental-health professionals to pay more attention to the specific spiritual needs of different types of patients, and for religious leaders, such as hospital chaplains, to take psychiatric diagnosis into account to a greater extent.

A project for improving the quality of life of sufferers from dementia has included a regular meeting at which well-known hymns and prayers are used. Early results would indicate benefit, even for those with no prior religious association. *Patients with dementia* may have specific spiritual needs. These result from loss of awareness and relatedness to God's transcendence, loss of sense of meaning, hopelessness, loss of meaning, purpose and value; and apparent disinterest in the spiritual dimension (Lawrence & Raji, 2005).

Depressed patients may have all pervasive feelings of guilt and self-blame; they may believe that they have committed the unforgivable sin or will be consigned to eternal punishment. On occasions, such religiously inspired beliefs have been dispelled with anti-depressant medication and/or electroconvulsive therapy. On the other hand, depressed people with firm religious convictions, and their relatives, are frequently terrified of psychiatric treatment because they anticipate psychiatric staff being antagonistic to religion and challenging their beliefs. Sadly, there has been justification for their fears in the past.

Religious delusions are not infrequent with schizophrenia and were more so in the past (Klaf & Hamilton, 1961). This does not imply that religion causes delusions but rather that delusions tend to take on the content of the sufferer's prevailing interests and concerns. A skilful clinician will find the middle ground between appearing to accept the delusional ideas and diminishing the patient's self-respect by rejecting them.

Cognitive behavioural therapy and other forms of psychological treatment can work with the grain of religious belief in the treatment of *anxiety disorders*. Using the patient's own beliefs, the patient debates within himself to correct his own negative thinking. Faith, and religious conversion, have proved of great benefit to some people trying to recover from their *addiction to alcohol or other drugs*. A more extended account of the spiritual aspects of different psychiatric conditions is to be found in Swinton, *Spirituality and Mental Health Care* (2001).

Pastoral care: users and carers

Psychiatrists, and other mental-health workers, sometimes fail to realise that they are not the only people trying to help those with mental illnesses to cope better, feel some relief from symptoms and relate in a mutually rewarding way to others in the community. Identified mentally-ill people, *users* in conventional jargon, make an increasing contribution in identifying the sort of services they require. Their close relatives and friends, *carers*, have over the last couple of decades shaped the provision of services and individual patient contact in a beneficial manner. Religious organisations, in the British context especially churches, have always had involvement with the mentally ill and, over recent years, have approached their working with such people in a more systematic and knowledgeable manner.

An example of spiritual management in the contribution that users and carers themselves make to the care of those with mental illnesses is the Association for Pastoral Care in Mental Health. In a recent newsletter, the Chairman queried how

> might we . . . reduce the gap between the most traumatised and the normal person, whoever that might be? Perhaps all we can share is what we have and whom we are, our time and our love, that which is given freely and received freely – all God's gifts. Resolutions without the recognition of God's provision are empty resolutions, like works without faith are empty. We spend millions striving for the perfect manifesto but fail to provide that one essential ingredient that the whole nation is yearning for. 'Love', without which as St Paul says, 'We are nothing'. By listening, ministering, nurturing, valuing and responding to the needs of the spirit, the journey begins – when we begin to walk, that's where the road starts. (Heneghan, 2005).

This is certainly a most important area of discourse. What is the significance of love in the management of the mentally ill? What does *love* mean in this context and how can this be provided by the individual mental-health professional, the National Health Service, users and carers? This is too big a subject to embark on in this chapter but has been discussed elsewhere (Sims, 2006).

Another example of user initiative in this area is the report, 'Knowing Our Minds', published by the Mental Health Foundation, which surveyed 401 people's experience of mental-health services and treatments (Faulkner, 1997). The sufferers are considered to be the 'primary experts' on their own mental health. Those surveyed recommended very strongly that mental-health professionals recognise and take into account the spiritual aspects of mental health and its problems.

Churches in Britain have taken a positive position towards the treatment of the mentally ill in recent years and have taken steps to help such people and co-operate with statutory mental-health services. Addressing psychiatrists, senior churchmen have recommended collaboration between psychiatrists and clergy for the benefit of sufferers (Carey, 1997), and have, noting the move away from a mechanistic view of man, recommended psychiatrists to take more care of their own spiritual and mental state (Hope, 2004). This does not imply any blurring of role between psychiatrists and priests. The current Archbishop of Canterbury has recommended empathic and informed listening to our patients (Williams, 2005). The Church of England has produced a significant book on *The Ministry of Healing* (The Archbishop's Council, 2000), which deals with the whole subject from the theological position.

Conclusions

Spiritual management is not yet another addition to the overburdened menu of possible regimens with which to treat patients, or to the ever-increasing curriculum for hard-pressed psychiatric trainees. It is more an attribute of the physician that is all-pervasive and affects every part of practice. It is particularly reflected in the capacity for insightful listening. Shooter has categorised this as: listening with the ears, listening with the eyes, listening with the heart and listening with the hands, the latter perhaps what takes place in some types of spiritual healing (Shooter, 2005).

Spiritual management is something which should happen as part of the investigations and interventions of conventional medicine, in the same way that the general physician should take a drinking history and reckon to treat the patient taking behaviour into consideration, and the psychiatrist should pay attention to the physical state of the patient. There is also a set of therapeutic techniques outside but complementary to medicine. Finally, spiritual management occurs in the work of other professionals, such as the clergy, with whom the doctor co-operates and collaborates for the benefit of their mutual patient. It is, therefore, an integral and essential part of cultural psychiatry.

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34

Cultural aspects of suicide

Gwendolyn Portzky and Kees van Heeringen

EDITORS' INTRODUCTION

The two chapters on suicidal behaviour in this volume are complementary and offer different perspectives on the subject. Portzky and van Heeringen provide a continental European overview of suicidal behaviour. This is an important facet in this book, in that by and large the ethnicity of people is white and yet there is an enormous variation in the rates of suicide and suicidal behaviour. The variation in the rates in Eastern Europe itself and in comparison with the rates in Western Europe is striking. The authors emphasize that the method of suicide is dictated by cultural factors and the changes within specific cultures are influenced by a number of social factors. The risk factors for males include less adaptive stress response, such as avoidance, denial, distraction and alcohol. In addition, emotional isolation and less social integration may play a role. Another risk factor which must be taken into account is social status. Cultural patterns of suicidal behaviour include strong social integration. Role of family and marriage, collectivist nature of societies, religion, differences in depression and associated different attitudes to help seeking are beginning to emerge as significant factors. The nature of the culture will also contribute to rates of self-harm. Social regulation rather than legal regulation, family and kinship networks, coping strategies which are accepted by the culture will need to be investigated further in order to determine their exact contribution to suicidal behaviour.

Introduction

A vast amount of studies of causes and risk factors for suicidal behaviour has led to a growing understanding of the aetiology of suicidality. It is evident for researchers and clinicians that suicidal behaviour is always caused by multiple factors and that it can be viewed as a consequence of an underlying trait vulnerability including biological and psychological characteristics and more state-dependent factors such as psychiatric and social variables (Mann *et al.*, 1999). As suicide has usually been perceived as a personal tragedy, theoretical explanations have often emphasized the immediate social situation and the individual's social context (Rudmin *et al.*, 2003) as opposed to the larger societal and cultural context. Epidemiological studies have shown, however, that there are broad variations in international suicide rates, and in the incidence of suicide attempts and ideation which indicates a considerable influence of society, social organization and culture on individual suicidal behaviour.

International variation in suicide

An overview of the most recent global gender-specific suicide rates can be found in Table 34.1. The worldwide comparison of male suicide rates shows that the seven highest national suicide rates can be found in East European – former Soviet Union countries, with Lithuania showing the highest male rate of 80.7 per 100 000 inhabitants. In addition, Hungary, Sri Lanka and Slovenia are among the ten countries with the highest male suicide rates worldwide. North America, Australia, India and several European countries have intermediate suicide

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

Table 34.1. Suicide rates (per 100 000) by country and gender (WHO, 2004)

Males		Females	
Lithuania	80.7	Sri Lanka	16.8
Russian Federation	69.3	China	14.8
Belarus	60.3	Japan	13.4
Ukraine	52.1	Lithuania	13.1
Kazakhstan	50.1	Hungary	12.2
Latvia	48.4	Cuba	12
Estonia	47.7	Russian Federation	11.9
Hungary	45.5	Latvia	11.8
Sri Lanka	44.6	Belgium	11.4
Slovenia	44.4	Switzerland	10.8
Japan	35.2	Slovenia	10.5
Finland	32.3	Finland	10.2
Belgium	31.2	Luxembourg	10.2
Austria	30.5	Ukraine	10
Luxembourg	28.6	Croatia	10
Republic of Moldova	27.9	Hong Kong	9.8
Switzerland	27.8	Estonia	9.8
Poland	26.7	France	9.4
France	26.1	Belarus	9.3
Czech Republic	26	India	9.1
Bulgaria	25.6	Kazakhstan	8.8
Cuba	24.5	Austria	8.7
Romania	23.9	Republic of Korea	8.6
Slovakia	22.2	Bulgaria	8.3
Denmark	21.4	Sweden	8.1
Germany	20.4	Denmark	7.4
Bosnia	20.3	Suriname	7.2
Ireland	20.3	Germany	7
Republic of Korea	20.3	Singapore	6.9
Australia	20.1	Guyana	6.5
New Zealand	19.8	Czech Republic	6.3
Kyrgyzstan	19.1	The Netherlands	6.2
Sweden	18.9	Norway	6
Mauritius	18.8	Saint Lucia	5.8
Norway	18.4	El Salvador	5.5
Canada	18.4	Austria	5.3
Trinidad & Tobago	17.4	Canada	5.2
Iceland	17.3	Mauritius	5.2
USA	17.1	Republic of Moldova	5.2
Hong Kong	16.7	Zimbabwe	5.2
Uruguay	16.6	Iceland	5.1
Suriname	16.6	Trinidad	5
Puerto Rico	16	Romania	4.2
Guyana	14.6	TFYR Macedonia	4.2
Turkmenistan	13.8	Ireland	4.3
Spain	13.1	Poland	4.3
China	13	New Zealand	4.2

Table 34.1. (cont.)

Males		Females	
Netherlands	12.7	Uruguay	4.2
India	12.2	Kyrgyzstan	4
Belize	12.1	USA	4
UK	11.8	Spain	4
Uzbekistan	11.8	Slovakia	4
Singapore	11.5	Malta	4
Italy	10.9	Uzbekistan	3.8
Zimbabwe	10.6	Barbados	3.7
El Salvador	10.4	Italy	3.5
TFYR Macedonia	10.3	Turkmenistan	3.5
Chile	10.2	UK	3.3
Israel	9.8	Bosnia	3.3
Costa Rica	9.7	Ecuador	3.2
Barbados	9.6	Argentina	3
Saint Lucia	9.3	Thailand	2.4
Seychelles	9.1	Israel	2.3
Portugal	8.5	Albania	2.3
Venezuela	8.3	Nicaragua	2.2
Brazil	6.6	Costa Rica	2.1
Equador	6.4	Portugal	2
Greece	5.7	Venezuela	1.9
Thailand	5.6	Panama	1.9
Panama	5.6	Puerto Rico	1.9
Malta	5.6	Brazil	1.8
Colombia	5.5	Philippines	1.7
Albania	5.5	Taijikistan	1.6
Mexico	5.4	Greece	1.6
Bahrain	4.9	Colombia	1.5
Georgia	4.8	Chile	1.4
Nicaragua	4.7	Georgia	1.2
Taijikistan	4.2	Paraguay	1.2
Armenia	4	Mexico	1
Paraguay	3.4	Kuwait	0.9
Philippines	2.5	Belize	0.9
Bahamas	2.2	Armenia	0.7
Kuwait	1.9	Azerbaijan	0.5
Azerbaijan	1.8	Bahrain	0.5
Guatemala	0.9	Peru	0.4
Peru	0.6	Jamaica	0.2
Jamaica	0.5	Iran	0.1
Iran	0.3	Guatemala	0.1
Syrian Arab Republic	0.2	Egypt	0
Egypt	0.1	Dominican Republic	0
Dominican Republic	0	Bahamas	0
		Seychelles	0
		Syrian Arab Republic	0

rates (between 20 and 10 per 100 000 inhabitants). The overall male mortality from suicide is low in several southern European countries, Latin America and several countries in Africa and Asia.

Female suicide rates are highest in Sri Lanka, China, Japan, a few East-European countries and several West-European countries such as Belgium, Finland, Luxemburg and Switzerland. Intermediate female suicide mortality is found in Canada, Australia, Iceland and several European countries such as Austria, Sweden and the Netherlands. Low female suicide rates (< 5 per 100 000 inhabitants) are found in the UK, the USA, New Zealand, Latin America, southern European countries and several countries and regions in Africa and Asia. Although there might be differences in the reporting of suicide between nations, it is rather unlikely that these reporting variations alone can be responsible for the immense diversity in suicide rates between countries. These broad variations in global suicide mortality indicate that there is a relevant influence of socio-cultural aspects of societies and nations. The suicide rates indeed appear to be lower in less developed countries, although there are some exceptions such as Sri Lanka (Bhugra & Mastrogianni, 2004). The high suicide mortality in East European countries could be associated with the still continuing transition of these former Soviet Union countries. These rather new countries are experiencing major changes in economy, politics and society, and are still developing their own ethnical identity, which could have an influence on suicide mortality.

The comparison of male and female suicide rates clearly shows that suicide mortality is much higher in males than in females and that there are more variations in international suicide rates of males (e.g. 80.7/100 000 in Lithuania versus 0.1/100 000 in Egypt) than those of females (e.g. 16.8/100 000 in Sri Lanka vs. 0/100 000 in Egypt).

Data regarding methods of suicide show that, in general, women use less violent methods, such as medication and carbon monoxide poisoning, than men, who more often use firearms or hanging (Denning *et al.*, 2000). Epidemiological findings indicate however that there are also cultural variations in the choice and use of suicide method. Analyses regarding methods of suicide have shown a traditionally high incidence of suicide by firearms in the USA (Spicer & Miller, 2000). Previous epidemiological findings regarding suicide method in Australia also showed a common use of firearms (Cantor & Lewis, 1990), but recent reports indicate the decline of firearm suicide rate for Australian males, while there has been a simultaneous increase in suicide by hanging during the last decade (De Leo *et al.*, 2003). A substantial increase in suicide by hanging has also been observed in England and Wales (Wilkinson & Gunnel, 2000). The suicide methods in Denmark between 1922 and 1991 have also shown changes, with hanging initially being the most commonly used method, which was later replaced by poisoning, while recently there appears to be an increasing inclination towards selecting more violent methods. The choice of method in Denmark differs somewhat from that in other Scandinavian countries as there are far more cases of self-poisoning in Denmark (Bille-Brahe & Jessen, 1994). Asian reports of suicide methods indicate that jumping from a height and hanging predominate in all age groups in Hong Kong (Hau, 1993). Recent reports indicate that carbon monoxide poisoning by burning charcoal is becoming prevalent in Hong Kong to such an extent that it is now considered as a new variant of domestic gas poisoning (Leung *et al.*, 2002). Asians who live in America have a less high incidence of suicide by firearms (Lester, 1994). These findings indicate that cultural variations can also be found in the use of suicide method and that several nations have known some differences in suicide method during the past decades with an increasing tendency to use more violent methods in many countries. It can be assumed that societal changes in knowledge and acceptability of certain methods have an influence of individual choices of method.

Aside from distinct differences in the incidence of suicide mortality between nations and societies, it is also important to consider similarities between different countries and nations. One of the most consistent epidemiological findings in suicide is the higher male suicide rate than the female suicide rate. Although there might be some variation in the male to female ratio, most countries show higher suicide rates in males. According to the international comparison of suicide rates and several epidemiological studies, there is only one nation with a male to female ratio lower than one and thus with a higher female suicide rate: China (Pritchard, 1996; Ji *et al.*, 2001). Possible explanations for this gender difference in China will be discussed later in this chapter.

As mentioned by Rudmin and colleagues (2003), it is indeed remarkable that, with the exception of China, all nations show comparatively higher rates of suicide among males, because these countries represent a wide variety of cultures, religions, standards of living, education, mental-health services, reporting criteria and other factors that might have some influence on suicide.

It is suggested that traditional masculinity acts as an important factor in the male vulnerability for premature death by suicide because the traditional male gender-role constitutes three important risk factors (Möller-Leimbühler, 2003). The first risk factor implies the less adaptive stress responses shown by males such as more avoidance, denial, distraction and the use of alcohol. Secondly, males tend to be less socially integrated, have less social support and are emotionally more isolated. A third risk factor consists of the male vulnerability to occupational stressors due to the importance of occupation for male social status. In addition, Canetto (1997) states that surviving a suicide act is culturally evaluated as more inappropriate for males, which could have an influence on the choice and use of more lethal suicide methods in males. Although there has been a recent change in the male gender role in several Western countries, which could possibly have a positive effect on male coping and help-seeking behaviour, it seems, however, that this change also creates a new complication as traditional accepted male attributions from the past are now less positively evaluated and have been deconstructed (Nesbitt & Penn, 2000) but have not yet been replaced by a new interpretation of the male gender role (Möller-Leimkühler, 2003).

Global comparison of suicide mortality also shows that, without exception, there is a strong variation of suicide incidence across age groups. The suicide rates in world countries by gender and age (WHO, 2003) indicate that there are strong variations between countries for the same age groups (e.g. 144/100 000 for males > 74 years in Hungary vs. 2.6/100 000 for males > 74 years in Azerbaijan), but there are also important differences across age groups in the same country (e.g. 144.2/100 000 for males > 74 years vs. 17.5/100 000 for males 15–24 years in Hungary). With the exception of some countries, suicide rates are, in general, more elevated among the elderly than among young people. Although this difference between young and older people is observed in many Western countries, the problem of strongly increased suicide rates among the elderly is even more distinct in China (e.g. 170/100 000 males > 74 years vs. 8.4./100 000 males 15–42 years in rural areas; 88/100 000 males > 74 years vs. 5.8/100 000 males 15–24 years on the mainland). Possible explanations for this difference in elderly suicide rates between East and West are more medical support, better welfare and relative independence of the elderly in the West compared to elderly people in China, especially in rural areas (Yip *et al.*, 2000).

International variation in suicide attempts

Comparison of international rates of attempted suicide is more difficult due to the lack of standardized and structured registration of attempts in many countries. Reliable and valid data can only be obtained from local and regional research initiatives and epidemiological studies from the WHO. The WHO/EURO Multicentre Study of Suicidal Behaviour has been collecting data concerning suicide attempts in up to 45 European cities since 1989 and the use of a common methodology allows for reliable comparisons across cities (Bille-Brahe *et al.*, 2004). An early report of the WHO/EURO study already indicated that the overall attempted suicide incidence varied considerably across the different European sites with a high event-based rate of 414 per 100 000 males in Helsinki (Finland) to a low male rate of 62 in Leiden (the Netherlands). The highest attempted suicide rate for females was found in Pontoise (France) with 595 per 100 000 and the lowest 95 in Guipuzcoa (Spain). The mean attempted suicide rate across all European centres was 167 for males and 222 for females (Platt *et al.*, 1992).

The age distribution of suicide attempts shows similar trends in most participating cities. The highest person-based rates for females are found in the age groups 15–34 years and the highest male rates are found among the 15–34 year-olds. The lowest rates are mostly found in the age groups 55 + (Schmidtke & Löhr, 2004). The methods for attempted suicide were more or less comparable in the various centres and consisted of mainly ‘soft’ methods such as self-poisoning. However, it was found that the ‘car accident’ method is common in German-speaking countries, contrary to the southern European cities (Schmidtke & Löhr, 2004).

The WHO SUPRE-MISS community survey aimed at randomly selecting and interviewing at least 500 subjects in the general population in several sites (in Brazil, China, Estonia, India, Iran, South Africa, Sri Lanka, Vietnam, Australia and Sweden) regarding suicidal thoughts, planning and attempted suicide (Bertolote *et al.*, 2005). The results of the study showed that suicide attempts ranged from 0.4 to 4.2%, suicidal plans varied from 1.1 to 15.6% and suicidal ideation ranged from 2.6 to 25.4%. There was also a strong variation of medical attention following a suicide attempt with only 22.7% in Hanoi and 87.5% in Chennai receiving medical attention.

The cross-national comparison of attempted suicide rates across nine countries (USA, Canada, Puerto Rico, France, West-Germany, Lebanon, Taiwan, Korea, New Zealand) by Weismann and colleagues (1999) showed that lifetime prevalence of attempted suicide ranged from 0.72 in Beirut to 5.93 in Puerto Rico. Similarities were found regarding gender with females consistently showing higher attempted suicide rates than males.

Ethnic minority and immigrant studies

Cultural influences can also be explored by examining the suicidal behaviour of immigrants in foreign countries. The results of a study examining the association between psychiatric immigrant inpatients in Germany and non-fatal suicidal acts showed that Mediterranean immigrant inpatients had a higher prevalence of suicide attempts (15.3%) compared to German inpatients (8.9%) (Grube, 2004). A strongly increased proportion of suicide by immigrants is found in Saudi Arabia with immigrants comprising 77% of the suicide sample with Asian and Indian immigrants constituting the majority of this group (Elfawal, 1999). Leavey (1999) examined suicide mortality of Irish-born people in Britain and concluded that suicide rates are increased when compared to Irish people in their homeland Ireland. A possible explanation of the increased suicide rates are the Irish cultural attitudes towards health and the use of alcohol as accepted coping behaviour. Pavlovic and Marusic (2001) compared the suicide rates in Australia, Slovenia and Croatia with suicide rates of Croatic immigrants in Australia and Slovenia. The results indicated that the suicide rate and method of Croatic immigrants in Slovenia (26.01/100 000; 60% hanging) converged towards that of the host country (31.43/100 000; 76% hanging) which is considered as a possible function of the years elapsed since the migration from Croatia (22.53/100 000; 42% hanging). The cross-cultural breakdown of Swedish suicide rates also points at an overrepresentation of immigrants (Ferradanoli, 1997). Immigrants from several countries such as Russia, Finland, Germany, Denmark and Norway showed increased suicide rates which were higher when compared to their respective country of origin. The suicide risk among immigrants appears to be 1.5 times higher compared to native Swedes.

It can be concluded from these studies that immigrants tend to have an increased risk of suicide. Immigration may, indeed, cause additional stress due to the adaptation process and, in many cases, the motives for the immigration and the immigration itself. The multicultural characteristics of the host-country are also important features in the adaption-process of immigrants. How does the host-country welcome the immigrants? Is there a possibility to integrate in the culture of the host-country while maintaining a sense of one's own authentic identity? A combination of these characteristics will determine the response of immigrants in their new country.

Aside from studying suicidal behaviour in immigrants, cultural aspects of suicide can also be observed in ethnic minority-groups with already many generations living in the new host country. Range and colleagues (1999) examined the prevalence of suicide among the four most important ethnic groups in the USA. African-Americans are found to have a lower suicide rate, with especially African-American women showing a very low suicide rate. The authors suggest that religion, extended family network and the important role of the elderly are among the possible cultural variables, which could be responsible for the low suicide rate in this group. Hispanic Americans also show lower suicide rates than non-Hispanic-Americans. Possible cultural protective factors of the Hispanic-American society are the strong family networks along with the important 'extended' family connectedness and strong Catholic religion associated with the strong emphasis on 'fatalismo', which implies that they have no control of their own with regard to adverse events. The suicide rate in Native Americans is, however, 1.6 to 4.2 times higher than that in the general population of the USA. The authors assume that disruption of the tribal unity, the absence of social integration and alcohol as primary coping response are possible cultural factors associated with this elevated suicide rate. Asian-Americans also have a lower suicide rate, which is explained by the three important Asian religions (Confucianism, Buddhism and Taoism) which de-emphasize the individual compared to the group and by different attitudes towards suicide among Asian-Americans.

As a consequence of the still increasing migration in many countries, several nations are faced with multiple nationalities in one society, which forces them to rapidly evolve to multicultural societies. As ethnical identity is an important factor in self-esteem and may affect social causes of psychiatric disorders (Bhugra & Mastrogianni, 2004), it is rather difficult to predict how new multicultural societies will evolve and whether this will affect psychological well-being. Along with the development of multicultural societies, there is the process of globalization which is now occurring in many countries. Globalization is defined as the process in which traditional boundaries separating individuals and societies are gradually disappearing. Although it is also rather unclear in which way globalization will affect psychological well-being and the occurrence of mental disorders and suicidal behaviour, globalization is likely to influence expressions of distress and pathways to care as the process of globalization is changing the nature of human interaction in many ways and may also possibly affect ethnical identity (Bhugra & Mastrogianni, 2004).

Cultural predictors of suicidal behaviour

Suicide mortality rates show an immense variation, particularly in males, between different nations and countries. This broad variation clearly points to the influence of cultural factors which can either protect a society against suicide or may increase the risk for suicide. A review of studies examining possible cultural influencing factors has made a major theoretical and empirical contribution to the multicultural perspective on suicidal behaviour. Similar to the study of other causal variables of suicidality, the majority of research exploring cultural predictors of suicidal behaviour has focused on identifying risk factors, while only a few studies addressed protective factors. Zacharakis and colleagues (2005) examined the protective factors associated with the low suicide rate in Cyprus, which is the lowest in Europe, and identified strong family support, low social isolation, orthodox religion and the social acceptation of externalization of anger and aggression as social and cultural factors contributing to this low rate. Similar to other countries with low suicide rate, they also found that short distance between communities, long history of the country and cultural uniformity of the population in Cyprus could be associated with a low prevalence of suicide.

The epidemiological findings regarding suicide indicated that suicide rates are low in Latin America, and other studies have also pointed to the lower suicide rate of Latinos in America (Range *et al.*, 1999). A study of the possible protective cultural factors associated with Latinos assessed the 'Reasons for Living' in psychiatric Latino and non-Latino patients (Oquendo *et al.*, 2005). The results show that there is no difference between Latinos and non-Latinos for attempter status, number of attempts and suicidal intent, but also that Latinos have less suicidal ideation and fewer lethal attempts. The results for 'Reasons for Living' identified higher scores on survival and coping, responsibility towards family and moral objections against suicide in Latinos. The authors conclude that self-identification as Latino could be a protective cultural construct.

The study of possible cultural variables associated with a negative impact on suicidal behaviour has had a strong focus on social integration for a long time. This focus originated from the theoretical perspectives of Durkheim (1897 – republished 1952) regarding the influence of social integration on suicide rates. Durkheim was the first to state that low social integration (the extent by which people are joined together by social networks) and low social regulation (the influence of tradition, norms and habits on behaviour) have a negative impact on suicide rates. Several recent studies confirm Durkheim's theory. The case-control study of Duberstein and colleagues (2004) showed that there is a robust association between social integration at the level of family or community and suicide, which is largely independent of mental disorders. The results indicated that suicide victims are less likely to be married, have children and live with family, have lower levels of social interaction and are less likely to engage in community activities or religious practice. The recent observed pattern in several Western countries in which recent birth cohorts exhibit much higher suicide rates at younger ages than earlier cohorts did, is also explained by lower levels of social integration and regulation found in these recent birth cohorts as measured by higher rates of non-marital births and larger relative cohort size (Stockard & O'Brien, 2002). Gunnell *et al.* (2003) examined social integration in Britain between 1980 and 2000 by use of three components: migration, unemployment and being single. This study identified migration as a significant and stable predictor of local suicide rates over the two decennia. Suicide rates in young adults (24–45 years) were negatively associated with living in areas with low employment rate. The results also indicated a decreasing influence of living in areas with a high prevalence of single persons. There was even a positive effect of this component in young people. The general finding of this study comprised the stability in influence of social integration components on suicide rates over decades.

Closely related to globalization, which has been discussed previously, is urbanization, which has been identified as an influencing cultural variable but has also created some uncertainty due to the contradictory character of research findings in different nations. It was generally assumed that urbanization is potentially dangerous for mental health and suicide mortality. Urbanization would result in more distance between families, more crowding, more unemployment and less social support (Bhugra & Mastrogianni, 2004), which could be related to more behavioural problems, depression and anxiety disorders (Kleinman, 1991). A case-control study investigating suicide risk in relation to level of urbanization in Denmark (Qin, 2005) confirms that living in more urbanized areas is associated with a higher risk of suicide compared to living in less urbanized areas. The results also showed that the elevated suicide risk associated with urbanization varies significantly by gender and age and is largely eliminated when adjusted for marital, income and ethnic differences and psychiatric status. There are, however, also several studies indicating a higher incidence of rural suicides compared to urban suicides in several countries. Epidemiological studies in Norway and Lithuania identified higher suicide mortality in rural areas than in urban areas (Mehlum *et al.*, 1999; Kalediene & Petrauskiene, 2004). Results from Scotland indicated a higher risk of male suicide in remote rural areas relative to urban areas but a lower risk of female suicide in accessible rural areas (Levin & Leyland, 2005). The suicide rates in the United States are higher in rural areas than in urban areas and are explained by the scarcity of physicians and mental-health care providers per capita in rural areas (Fiske *et al.*, 2005). The difference between rural and urban suicide mortality is even more pronounced in China with rural suicide rates being three to four times higher than urban suicide rates. Especially suicide by young women is strongly increased in rural areas (Zhang *et al.*, 2004). Hawton and colleagues (1999) examined the geographical distribution of suicides in farmers in England and Wales but the results showed no evidence of geographical heterogeneity of farming suicides according to counties. Moreover, county farming suicide rates could not be related to local general population suicide rates or density of farmers.

Overall, there are several distinct differences between suicidal patterns in Western nations and China. The two major differences imply the higher suicide rates among females compared to males and the highly elevated rates in rural areas compared to urban areas in China. These differences suggest that cultural variables have a relevant and possible stronger influence on suicide in China (Pritchard, 1996; Zhang *et al.*, 2004). Several explanations have been proposed for the high rural suicide rates in China. Zhang (2000) has suggested that easy accessibility to lethal suicide methods in the countryside, less accessible medical or emergency care and the relative deprivation in rural China may be associated with the high rural suicide rate. Other possible explanations for the high (female) rural suicide rate are: poverty, unemployment and limited education possibilities along with the high amount of illiterate women (Yip *et al.*, 2000). Interestingly, Zhang and colleagues (2004) found that there were no differences between rural China and other cultures in risk factors for suicide such as social support, interpersonal life events, psychopathology, socio-economic factors and health.

There are, however, several immense cultural differences between China (and some other Asian countries) and most Western countries, which could account for the important differences in suicide patterns. These differences include the role of family and marriage, collectivism vs. individualism, religion, difference in depression and associated different attitudes regarding mental health. Family and marriage are highly regarded in Chinese society, but there is evidence of Chinese suicides being related to adverse familial and relational triggers (Zhang, 1996). The author argues that the Chinese social importance of family is also related to limited social contacts outside the family. This would especially apply to young rural women who, as a result, are entirely dependent on resources provided by the family. The strong family connectedness is closely linked to the Chinese collectivistic society. Traditionally, Chinese and other Asian societies have been described as collectivistic societies, while Western nations are considered as individualistic cultures. Individualism has been associated with psychological disadvantages and mental-health problems due to the evidence that individualistic values are related to smaller and less satisfying social support networks, less adaptive emotional coping, lower help-seeking behaviour and higher levels of hopelessness and suicidal ideation (Scott *et al.*, 2004). Members of individualistic societies are known to emphasize values such as self-direction, autonomy and universalism, while members of collectivistic societies strongly focus on tradition and conformity. Although China has traditionally been described as collectivistic and Western societies as individualistic, research has identified that Chinese people are indeed strongly collectivistic within family relations and clans but are more individualistic on a community and society level compared to Americans (Zhang, 2000). It can be suggested that

Chinese collectivism is primarily related to strong familial relations and marriage but not to the community, which also implies certain risk factors as larger, community networks and support are often limited. There is evidence of a positive correlation between religion and suicidal ideation even among Chinese adolescents (Zhang & Jin, 1996), but the role of religion in Asian and Chinese society is rather complicated. China is not a religious society and going to church is not popular, which could result in a lack of social support and contact with the community. However, the traditional Chinese culture is based on the three important Asian religions: Buddhism, Taoism and Confucianism. These religions differ strongly from Western religions with regard to after-life, rituals, organization and the existence of one God, and have different attitudes, regarding suicide. For instance, Buddhism considers self-sacrifice for religious reasons as honourable, and although Confucianism does not allow suicide because it deplores damaging physical attractiveness, it does tolerate suicide as an expression of high moral or emotional protest (Zhang *et al.*, 2004). Buddhism and Taoism also imply the reincarnation of the soul, which results in the Chinese belief that the next life is formed by the previous life and that suicide is a way to receive a new, better life. In Japan, suicide is generally considered as a positive, honourable act of self-sacrifice which originates from Confucianism stating that being dutiful, obedient and loyal to the group is more important than the individual (Young, 2002).

Another major difference between Chinese/Asian and Western society is the difference in the occurrence and characteristics of depression and in the attitudes regarding mental health and mental-health services. The clinical presentation and symptoms of depression can show strong differences and it is assumed that culture will not only influence the prevalence of depression but also the emotional or physical expression of depression. Chinese and Asian individuals express more physical complaints and less emotional symptoms when distressed or depressed, and somatization is considered as a cultural equivalent of depression (Bhugra & Mastrogianni, 2004). Shiang *et al.* (1998) argue that the Chinese consider mind and body as intricately linked, while Americans view mind and body as two separate systems, which results in the American belief that 'mind problems' should be treated separately, and the acceptance of mental healthcare. Chinese people are reluctant to seek help and they consider mental-health services as lacking credibility. There is a societal stigma on mental illness, and there is a post-suicide stigma for the survivors and bereaved in certain Asian societies such as Taiwan which is based on cultural themes such as that suicide is inheritable and does not allow reincarnation of the soul (Tzeng & Lipson, 2004).

To conclude the discussion regarding Chinese/Asian and Western cultural differences associated with suicide, it is interesting to mention that the high suicide rate in Chinese females has also been linked to the cultural Chinese norms which inhibit the externalization of aggression by Asian women (Ibrahim, 1995) resulting in an act of moral and spiritual revenge, which gives the female, with an often inferior status in the family, more power than she ever had in life (Liu, 2002).

The cultural dimension of collectivism versus individualism has been linked to other comparisons of suicidal behaviour between nations. Eskin (1995a, 1995b, 2003) compared several aspects of suicidality between Swedish and Turkish adolescents and found a similar prevalence of suicide attempts in both groups, with more liberal attitudes towards suicide among Swedish adolescents but more acceptance towards a suicidal peer and more disclosure of suicidal ideation among Turkish youngsters. These results are, according to the author, in line with the basic sociocultural values of the two countries, as the Turkish culture is described as a culture of relatedness, important relationships with relatives and collectivism, while the Swedish culture is considered to be a culture of separatedness, personal autonomy and individualism.

As there is ample evidence associating suicidal behaviour with mental disorders, it is rather obvious that societal differences in mental-health systems, attitudes towards treatment of mental health and certain risk factors for the development of mental disorders are important cultural predictors of suicide. Local health-system facilities and public-health priorities have an important influence on treatment possibilities and partially determine attitudes towards mental health. Social and societal stigmatization of mental disorders and psychiatric treatment are therefore described as causes for cultural variations in suicide rates. Bhugra & Mastrogianni (2004) argue that there are many cultures with a preference for non-medical, self-reliant management of depression which will inevitably affect suicidal behaviour. Recently, is has been suggested that ethnical variations in response to psychotropic medications, which indicate the possible influence of genetic variables, should also be considered as cultural predictors for suicide (Bhugra & Mastrogianni, 2004).

The influence of cultural variations in alcohol consumption on suicide has been examined in 14 countries by Ramstedt (2001). This study aimed at exploring the hypothesis that a positive population-level relation between alcohol and suicide is more likely in 'dry drinking' cultures (low per capita consumption) than in 'wet drinking' cultures (high per capita consumption). The results support the hypothesis, as a significant positive relation between per capita alcohol consumption and suicide rates was more often found in Northern European countries (= dry drinking cultures) and less often in Southern European cultures with a wet drinking culture.

Other cultural values with a possible influence on suicide were examined by Rudmin and colleagues (2003). This study explored the relation between Hofstede's cultural values Power–Distance, Uncertainty Avoidance, Masculinity, Individualism and suicide mortality in 33 nations. Hofstede (1980) describes the culture of a nation according to four dimensions: (1) Power–Distance implies the extent of social separation in a nation according to differences in status, finance and organizational power; (2) Uncertainty Avoidance describes the preference for stability and predictability; (3) Individualism implies the self-perception of autonomous personalities who are not defined by collective familial of social groups; and (4) Masculinity implies the differentiation between men and women in distinct roles with females and their social and environment concerns having lower status. The results regarding these four dimensions indicated that Individualism facilitates suicide as it was positively associated with suicide, except for young females. Power–Distance, Uncertainty Avoidance and Masculinity showed a negative correlation with suicide. The study also found that 25% of the variance in international suicide rates can be explained by cultural traits.

Conclusions

International comparisons of suicide mortality and epidemiological studies regarding attempted suicide have clearly shown broad variations in the occurrence and characteristics of suicidal behaviour and indicate the strong influence of sociocultural aspects.

Research has identified several cultural and societal variables that can either have a protective impact on suicidal behaviour but which can also increase the risk of suicidality in certain societies. An important factor associated with cultural differences in suicidal behaviour is social integration, along with social regulation. Social integration contains several aspects but cultural differences are mostly related to family networks, responsibility towards family, social isolation and community networks. Culture and society also affect coping behaviour, such as alcohol use and social acceptation of externalization of anger and aggression, and help-seeking behaviour and has a major impact on attitudes towards mental health and health care facilities. Other identified cultural predictors of suicide include religion, cultural uniformity and self-identification of the population and ethnical variations in response to medication.

To conclude, there is clear evidence of cultural and societal influences on suicidal behaviour. However, caution is required when evaluating the relevance of cultural variables in their relation to suicide. Epidemiological findings indicate that suicide occurs in every society and as suicidal behaviour is always caused by multiple – often individual – factors, there are many suicides which are not closely related to cultural factors. Precise empirical and clinical knowledge regarding the limited relevance of cultural factors as opposed to the importance of individual vulnerability is required when assessing suicide risk in individual patients.

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PART V

Management with special groups

Intellectual disabilities across cultures

Jean O'Hara and Nick Bouras

EDITORS' INTRODUCTION

Learning disability, which is still known by the term mental retardation in many parts of the world, carries additional psychiatric morbidity with it. Not only are there implications for the individual but also for the carers and the community alike. Cultural practices such as consanguineous marriages may play a role in the aetiology of learning or intellectual disabilities. Other environmental factors, such as dietary deficiencies, may contribute to its causation. Rarely are these individuals seen as suffering from medical conditions, and thus help-seeking may be delayed. Co-morbidity with infections like cysticercosis and epilepsy make management of such individuals complex. The social relationships and educational attainments may influence outcome.

O'Hara and Bouras use the term intellectual disability as a complex label which involves an interaction between biogenetic and socio-cultural factors. The labelling of the condition is powerful and can result in an individual being excluded from mainstream society. Increased social distance without adequate management strategies with educational and psychological components means that individuals can become further isolated. O'Hara and Bouras point to historical evidence indicating how people with disabilities were seen over four millennia ago. The social response was partly determined by religion. Negative views towards individuals with disabilities have been reported for centuries. As social and gender roles of individuals vary across cultures, the concepts of social inclusion remain simply that – concepts only – in many cultures. Epidemiological data on prevalence of intellectual disability across cultures indicate differences which can be attributed to a number of factors. Mild intellectual disability is much more prevalent. The prevalence of psychiatric disorders in this group increases with increasing intellectual disabilities. Other factors, such as poor education and low socioeconomic status of the carers, make management difficult. It is therefore important that clinicians use models of management which take into account the cultural views of conditions.

Introduction

Intellectual disability, or 'mental retardation' as it is described in ICD-10 (WHO, 1992), is not a psychiatric illness. However, it is a significant risk factor for the development of psychiatric disorders as well as co-morbid conditions such as attention deficit hyperactivity disorder (ADHD), autistic spectrum disorder and epilepsy. In this chapter, the term 'intellectual disabilities' has been chosen to reflect current international literature in this field. It is synonymous with 'learning disabilities', as used in the UK, though the same terminology is used in the USA to mean specific educational difficulties such as dyslexia. To make matters even more confused, advocacy groups prefer the term 'learning difficulties' to describe their situation, whilst 'developmental disabilities' is also gaining international favour.

'Intellectual disability' is a complex label involving an interaction between biogenetic and socio-cultural factors. Deciding whether or not someone has intellectual disabilities requires an arbitrary line to be drawn across a continuum of ability in both social and intellectual functioning. This label is so powerful that it can result in an individual being excluded from mainstream society. It can influence access to a whole range of mental-health services

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and lead to disputes over clinical and funding responsibilities, sometimes because of a difference of one in IQ score.

The assertion of difference between peoples is seldom neutral; it almost always implies some kind of social distance. These differences have mostly been seen in negative terms (Ryan & Thomas, 1987). This chapter explores intellectual disabilities across cultures and summarises knowledge in this area and in the area of mental health in intellectual disabilities.

Understanding intellectual disability – a historical perspective

Classical history

Skeletal evidence and depictions of Down's syndrome have been found from Saxon England and Austria. A figurine believed to be a depiction of a child with Down's syndrome was discovered in Greece, dating from the Neolithic period. There is also skeletal evidence of conditions such as hydrocephaly, microcephaly and anencephaly. Evidence of how people with disabilities were thought about, and how they were treated, began to emerge some 4500 years ago (Berkson, 2004). Although it is unclear when 'mental retardation' as a concept was first described, slow and fast mental states were discussed by Hippocrates, Plato and Aristotle amongst others, and provide the basis for the modern concept of intellectual disabilities as we know it today.

The social response at the time was partly determined by religion. Garland (1995) noted that beauty and wholeness were regarded as a mark of divine favour. It made a difference too, whether disability was congenital or acquired through disease, accident or debauchery. During classical times, the majority of disabled people were children who were disabled or disfigured as a result of contaminated water supplies and diseases such as meningitis, measles, mumps, scarlet fever and smallpox. One of the main causes of acquired disability was malnutrition, which even in the early twenty-first century is a major cause of disability worldwide.

The birth of a deformed child was seen by the Greeks as a punishment inflicted on its parents by the Gods whilst, in Sparta, the abandonment of deformed and sickly infants was a legal requirement. By the mid-fifth century BC, perhaps as the result of a dramatic increase in population, a Roman law was passed which insisted on the killing of the deformed (Garland, 1995). It was only with the onset of Christianity that ideas about human life began to change, with public opinion and the law discouraging infanticide, though this was based more on concern for the parent's soul than for the child's life. Greece and Rome began putting restrictions on infanticide – requiring five neighbours' consent and outlawing killing of first-born sons entirely. By AD 374, infant killing was classified as murder. Constantine (the first Christian Roman emperor) decreed that the state should prevent the exposure, sale and murder of infants and offered financial assistance to families who might otherwise have abandoned or killed their new-born children.

The Middle Ages

In the Middle Ages, there were many myths about changelings (children who were born deformed, handicapped or 'peculiar'), which served to explain why children were afflicted with disorders such as cerebral palsy, spina bifida and Down's syndrome. Folklorists and religious leaders give us some insight into the prevalent attitudes of the time. The Brothers Grimm tell of German legends involving mortal children being stolen and held captive by bands of elves who leave greedy changelings behind in the cradle, wailing for food. Ravenous appetite is frequently mentioned; an indication of how society saw the existence of such children as a threat to the family or community. Similarly, in Scandinavia, healthy mortal infants had to be guarded from covetous trolls; in India, tigers stole mortal children and left behind tiger cubs in disguise, and in Japan children are stolen by fairies. These 'fairytales' are not merely reflections of the past; the belief that the jinn may steal a human infant and put their own infant in its place is still widespread in Egypt (El-Shamy, 1980).

The sixteenth-century preacher, Martin Luther, believed that a changeling was a satanic child without a human soul. This made it easy to justify almost any abuse – being thrown into water, beaten severely, left unfed or placed on a hot stove. However, folklore also tells us that parents sought and received advice and approval from all segments in society before taking such drastic measures.

Coupled with these changeling legends was a recurrent theme within the Christian world that the birth of an afflicted child was the consequence of the evils of mankind. The idea that abnormal children resulted from sexual intercourse between a woman and the devil was also common at the time. Giving birth to a handicapped child was grounds for considering a woman to be a witch.

However, not everyone shared this view. Paracelsus, a Swiss physician, did not blame individual parents but asserted their rightful place in humanity. Moreover, he maintained there was nothing defective in the material supplied by the parents, but suggested there was something wrong in the subsequent processes that are beyond their control.

Around this time there were scattered references to ‘cretins’ – numerous in certain valleys in the Swiss Alps. Their deformed appearance made them seem hardly human but to the local community they were regarded as ‘angels from heaven, a blessing to their families and incapable of sin’. They were well looked after and their status was unique in European history. However, although the link between cretinism, goitres and the iodine-deficient drinking water in these valleys began to appear in the medical literature, it did not encourage investigation into other possible environmental causes. Unfortunately, iodine deficiency continues to be the single largest cause of severe intellectual disabilities in the world, and one largely absent in developed nations (WHO, 1993).

Disability across cultures

Cross-cultural evidence suggests that even those with mild intellectual disabilities are recognised within their communities. They have been documented in the Kashyapa Samhita, an ancient Ayurvedic treatise on childhood diseases through to the Jathaka stories dealing with the life of the Buddha, and the Holy Quran (WHO, 2004).

The major religions of the world imply the existence of negative attitudes toward those with disabilities, but preach love, charity and generosity, intended to protect people with disabilities. In the Christian faith, Jesus was frequently involved with healing the blind, deaf, crippled, demonic, epileptic, dumb and paralytic. Such healing was based on faith and the notion that those afflicted were possessed by evil spirits. Confucius (551–479 BC) admonished that one should be kind and help those of ‘weak mind’, whilst in the Arab world, the ‘feeble minded’ were regarded as people whose minds are ‘in heaven while their grosser part mingles among ordinary mortals’ (Diligio, 2005).

How people with intellectual disabilities were treated varied greatly between cultures. The ancient Romans and Greeks considered it their preordained social role to generate laughter and provide a source of diversion for society. Plato (427–347 BC) describes it as something ‘this otherwise useless group could do to justify its existence’. ‘Imbecilic slaves’ were popular in the late Republican and Imperial periods, and Romans were prepared to pay more for them. Garland (1995) notes that it was the slaves’ obligation to answer to an owner ‘with his or her body for any and all offences, including his unrestricted availability in sexual relations’. However, the majority of disabled people were probably left to fend for themselves by begging. It is interesting to note that a slave who became mentally ill was probably driven out into the streets to wander around and be stoned. The only ancient community known to have made any financial provision for its poor and disabled citizens was Athens.

Whilst some societies inflicted casual cruelties others, including many in Central Asia, India and the Middle East, offered people with intellectual disabilities protected and favoured roles (Edgerton, 1984), considering it a divine blessing to have

Table 35.1. Cultural views on learning disabilities

A punishment from heaven
Caused by spirits or an 'evil eye'
Caused by supernatural forces
Resulting from bad sex
Wrong-doing during pregnancy, e.g. eating bananas
Taboo practice, e.g. wringing washing during a full moon
Innate inferiority of mother
Fate and destiny
A misfortune or curse
A gift from God
A divine blessing

been chosen by God to look after a special child (Table 35.1).

World views, individual life philosophies, religious beliefs, cultural practices, local societal attitudes and economic resources all help to shape one's understanding of, and response to, the challenge of raising a child with intellectual disabilities. However, there is no doubt that the stigma of intellectual disabilities can be shattering and transcends race, beliefs and cultures. It creates profound emotional, practical and psychological experiences for all parents (Shah, 1992).

Middle Eastern cultures regard disability as a punishment from heaven, emanating from the spirits and caused by an evil eye (Aminidav & Weller, 1995). Families may consider it a destiny which they have to live with, or a misfortune and curse. Cheng and Tang (1995) describe the Chinese coping strategies of forbearance, the seeking of supernatural powers and praying to ancestors in dealing with the fate of having an intellectually disabled child whilst Gabel (2004) describes the Hindu belief of 'suffering through' and viewing disability as god's gift (Table 35.2).

Table 35.2. Hindu beliefs towards intellectual disability

In Gabel's ethnographic study (2004) of North Indian Hindu immigrants living in the United States (all well-educated professionals and 'living the American dream'), she noted that Hindu philosophy was a central force in their cultural orientation and beliefs towards intellectual disabilities. Their two main beliefs were:

a. Disability is a god's gift, given as a result of a past life. This reflects the Hindu belief of reincarnation or rebirth. This meant that the disabled person, or someone in the family, had lessons from a previous life that must be learned in the present life.
b. Suffering through –
Suffering is a beneficial, educative experience which one embraces without talking about it, or complaining about it. Ultimately, it is bestowed by god as an opportunity to be released from rebirth. For the majority of people living on the Indian subcontinent, disability is believed to be of supernatural causation (Agrawal, 1994).

Clinicians have often cited fatalism and the search for a cure as reasons why families from some ethnic minority communities are not interested in educational or habilitative programmes. The World Health Organisation reports many parents from South East Asia countries selling their valuables and land on the advice of faith healers, or giving them away to charity, in the hope and belief that they can find a cure. Clinical experience suggests that it is more difficult for parents to accept a label of intellectual disabilities when it is not associated with a known syndrome or obvious external signs of disability.

The concept of intellectual disabilities

Although the full range of intellectual disabilities is recognised across cultures, its prevalence and definition is bound by socio-economic and political considerations, and the extent to which people with intellectual disabilities are valued or devalued varies from one culture to another.

Intellectual disability is defined as 'a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence, usually taken to mean an IQ score below 70), and a reduced ability to cope independently (impaired social functioning)'. Both must be evident before adulthood, and have a lasting effect on development (DoH, 2001).

IQ tests were originally devised to identify children who were unlikely to benefit from the education offered. It was hailed as a great scientific discovery because it provided a supposedly diagnostic instrument, and led to the 'discovery' of many more intellectually disabled people than had been thought to exist. Controversy over IQ tests arises from the view that they are used to reinforce social and ethnic inequalities. It is argued that any differences could have been significantly amplified by the inferior nature of the education received. This may be particularly true of immigrant populations or of indigenous working-class people whose family background and social situation may be in complete conflict with the values and methods of the school (Ryan & Thomas, 1987).

However, eminent psychologists such as Arthur Jensen supported claims that differences in average IQ ratings between different social groups (by the order of one standard deviation, i.e. 15 IQ points) were primarily linked to genetics and ethnicity. Although strongly opposed by many, there has been no explanation offered other than the view that tests are culturally biased against minority groups.

Whilst there are clear limitations, the IQ does have powerful concurrent and predictive powers, particularly at the lower end of the spectrum. A low IQ is considered to be one of the best indicators of 'poor concurrent general competence and of limited future competence' (Berger, 1982). However, it is important to remember that the IQ score is a compound measure, and a similar IQ score does not equate with a similar profile of abilities.

Where there is more controversy is at the higher end of the spectrum, i.e. those with mild intellectual impairment (IQ 50–69). For these individuals, an assessment of social/adaptive functioning is essential in order to make a diagnosis of intellectual disabilities. For example, one might be very streetwise and able to look after oneself in one's own environment, but not do well academically; others might be able to track an animal in the wild and live off the land, but be unable to achieve in tests which assess competence required for everyday living within a technological society. Harris-White (2003) describes a disability concept anchored on the absence of economic skills unique to the locality in rural South India.

Socio-economic considerations also influence whether or not the label of 'intellectual disability' is used. In the USA, the definition was shifted to include everyone with an IQ below 75, and the country found it had significantly more individuals who would be eligible for services. In the UK, intellectual disability services are in danger of shifting downwards, in an attempt to manage finite resources whilst assuming mainstream services will absorb the difference. However, Fujiura *et al.* (2005) reminds us that an individual's impairment only imperfectly defines disability status; the experience of disablement occurs within a social, cultural and political context, and those contexts can be vastly different both within and across national borders.

Social and gender roles are interpreted differently too in different communities. Women in particular embodied a paradox, being seen as threatening because of their 'undisciplined sexuality', yet also sexually innocent and in need of protection (McDonagh, 2000). This view resulted in mandatory sterilisation and prohibition from marriage, both still enforced in the USA in the 1970s. However, in other cultures, the marriage of an intellectually disabled person may serve to provide reassurance to the family and a traditional social role for the individual, despite complex ethical considerations and inter-service tensions which may surface in such situations (O'Hara and Martin, 2003).

Whilst social inclusion, at least as a philosophy, has been broadly accepted around the world, it has yet to be achieved (Special Olympics, 2003). Obstacles cited include the lack of community services, job training and school resources; negative attitudes of others such as neighbours or employees, and the negative attitudes of the media. There are specific differences between countries too, based perhaps on historical legacies. Germany, for example, is reported to have a very positive public perception of the abilities of intellectually disabled individuals compared to Nigeria or Egypt

(Special Olympics, 2003) but one can speculate how this might in part be related to the rise of Nazi Germany in the last century.

Epidemiology of intellectual disabilities

It follows that conceptual and practical difficulties with the definition makes prevalence data for intellectual disabilities between ethnic groups and from communities around the world difficult to establish. Gabel (2004) describes difficulties when there is no Hindu word for the concept; 'disabled means without a limb, so 'learning disabled' would mean without learning'. Other Hindi terms have slightly different meanings, such as 'weak brain' (*dimaagi se kamzori*), 'sick mind or intellect' (*dimaagi bimaari*) and 'slow intellect' (*mundh buddhi*). '*Mundh buddhi'* literally translated applies to a person who has bad desires (*buddhi)* of the heart (*mundh*). 'Bad desires means that the person has wanted and pursued something that is unhealthy, sinful or dangerous'. Clearly, this is not what is meant by intellectual disabilities or mental retardation. Therefore, we may use similar words, but understand them differently; or we may use different words to talk about the same things without recognising that we are doing so.

There are an estimated 170 million people with intellectual disabilities in the world. Whilst epidemiological studies in developed nations yield relatively consistent rates, across the developing world observed rates are higher and more variable, very likely reflecting methodical problems as well as differences in exposure to risk (Fujiura *et al.*, 2005). The WHO (2004) estimate that 2% of the population of India are intellectually disabled and this figure rises to 3% when considering those under the age of 18 years. This compares to prevalence rates of 1.3% in the general population of Thailand. Sri Lanka quotes 12% of primary school children, whilst in Bangladesh 7% of children aged between 2 and 9 years have some form of disability; with severe intellectual disability in this population estimated at 6 per 1000.

Mild intellectual disability is much more prevalent; it is also more common in rural areas, and in low-income groups. WHO (2004) suggest that reasons such as poor access to health facilities, understimulation and under-nutrition could account for this observation.

The overall rate of disability in the US population is 19.4%: the rate is highest for Native Americans (American Indians, Eskimos and Aleuts) at 21.0%; Blacks at 20.0%, Whites at 19.7%, Hispanics at 15.3% and Pacific Islanders and Asians at 9.9%. When disability rates are computed for men only, racial and ethnic differences become even more pronounced, and this is further exaggerated when only adolescents and adults of working age are considered (Bradsher, 1996). Amongst UK South Asian communities the prevalence of severe intellectual disabilities may be up to three times higher than in the general population (Emerson *et al.*, 1997) and it is predicted that this population will increase substantially over the next 20 years, particularly in school-age children and young adults (Hatton *et al.*, 2002).

Intellectual disabilities and mental health

It is also widely acknowledged that individuals with intellectual disabilities are at an increased risk of developing mental-health problems (DoH, 2001). The prevalence is between 10% and 39%, with methodological difficulties around sampling errors and case ascertainment accounting for this variation (Deb *et al.*, 2001). For example, if behavioural disorder, personality disorders, autism and ADHD are excluded, the overall rate of psychiatric illness in adults with intellectual disabilities does not differ significantly from that in the general population, although there does still seem to be a higher rate of schizophrenia amongst adults with mild to moderate intellectual disabilities (Turner, 1989; Doody *et al.*, 1998; Cooper, 1997; Deb, 2001). In practice, however, behavioural problems are a common reason for psychiatric referral.

In the general psychiatric literature too, there is a raised incidence of schizophrenia amongst Black and minority ethnic (BME) communities in the UK and in the US, compared to their White counterparts (e.g. Sharpley *et al.*, 2001 Bhugra *et al.*, 1997; Fearon *et al.*, 2004). Interestingly, rates of psychotic illness are not similarly raised among those still living in their country of ethnic origin, as they are among those who have migrated (e.g. Bhugra *et al.*, 1996).

Research into the prevalence of psychiatric disorders in adults with intellectual disabilities from BME communities has been scant, conflicting in their results and reliant on small sample sizes (Chaplin *et al.*, 1996). However, recent literature suggests that the ethnicity-linked effects present in the diagnosis of schizophrenia are just as apparent in the intellectually disabled adult population as they are in the general population (Cowley *et al.*, 2004; O'Hara *et al.*, 2005; Maitland *et al.*, 2006). Early results also suggest a significantly higher rate of autistic spectrum disorders diagnosed in the adults with intellectual disabilities from BME groups (O'Hara *et al.*, 2005; Maitland *et al.*, 2006). Goodman and Richards (1995) found both psychotic and autistic disorders to be more common in a group of second-generation African-Caribbean patients than in a predominantly white group of patients. Wing (1993) estimated that the rate of autistic spectrum disorders in children of Caribbean origin was 6.3 per 10 000, as compared to 4.4 per 10 000 for the rest of the population. Whether this is due to a real difference in prevalence, or to issues of access for BME communities to early diagnostic and assessment services remains uncertain. In the US, Mandell *et al.* (2002) have reported that African-American children received their diagnosis of autistic spectrum disorder a year and a half later than White children. Littlewood (2006) provides an interesting outline from an anthropological point of view on mental health and intellectual disability.

The needs of carers

The nexus of poverty and intellectual disability, as both consequence and cause, has been long established in the literature and consistently documented in population-based studies conducted in developed nations (Fujiura *et al.*, 2005; Emerson, 2004). Limited research into people with intellectual disabilities from BME communities in the UK suggests they are even more disadvantaged despite their high support needs. Language barriers hinder parental awareness and uptake of services, and services rarely meet the language, cultural and religious needs of South Asian service users (Hatton *et al.*, 1998; Emerson and Robertson, 2002). In the first national UK survey of adults with intellectual disabilities, those from Black and Asian communities reported they were more likely to be unemployed, poor, see their friends less often, have poor health and be sad or worried. In addition, adults with intellectual disabilities from the Asian community had less privacy, felt less confident and felt left out (DoH, 2005).

Parents were more likely to report poor physical and mental health which was reflected by increased use of GP and hospital services. Rates of distress (74%), depression (40.4%) and anxiety (26.5%) were up to ten times higher than comparative UK populations (Hatton *et al.*, 1998). The same survey reported some evidence to suggest that services were not allocating according to need; carers with low household incomes reported higher levels of stress, but carers with higher household incomes received a wider range of services.

Emerson & Robertson (2002) also remind us that many traditional communities are undergoing substantial social transition. Unlike earlier times, it may not be possible for families to care for disabled members without external and professional support and help. The assumption, for example, that extended family networks will meet the care needs of a intellectual disabled family member is a myth perpetuated by stereotypic views of ethnic minority communities. In one study, over 90% of main family carers were Muslim mothers, unable to speak, read or write English (Hatton *et al.*, 2002). Although many needed an interpreter, fewer than half were provided with one. The range of unmet needs reported by parents was substantially higher than those reported in comparable UK research.

Whilst there are, of course, ethnicity factors *per se*, such as different culturally sanctioned behaviours and belief systems, gender and family expectations, there are other factors linked to ethnicity, which may impact on the ability of families from BME communities to cope or engage with services. This can broadly be described as the 'minority experience' and include aspects of everyday life such as living in poorer circumstances, the 'minority status' with at times clashing cultures, dealing with loss and migration/immigration uncertainties, social and language barriers (Sue and Sue, 1999). The double discrimination of racism and stigma are pervasive in the lives of people with intellectual disabilities from these communities, yet there exists a strong sense of ethnic and racial identities amongst them (Azmi *et al.*, 1997). However, there is still only early exploratory data on the social and economic status of intellectually disabled populations in the developing world (Fujiura *et al.*, 2005).

Achieving cultural competence

Addressing the needs of people with intellectual disabilities from BME communities is fundamentally no different from addressing the needs of those without intellectual disabilities. However, they are often one of the most marginalised groups in society. There have been several policy initiatives in the UK to redress this (DoH, 2004, 2005), through a thorough assessment of need, including cultural and religious needs, and a person-centred approach to any care package that is put in place as a result, whilst giving the individual and their families choice and control. Some useful strategies for practice are outlined in Table 35.3.

Improving information and accessibility of information is vital. This starts from access to mainstream services for general health and welfare, through to antenatal and maternity services. When a child with disabilities is born, the disclosure process itself is crucial, not only so the family and the extended family may come to accept their disabled family member, but also as a first step to mobilising formal and informal support networks. People with intellectual disabilities often need lifelong contact with services. Culturally sensitive service supports (O'Hara, 2003) reinforce collaborative relationships between parents and professionals, allowing a partnership to develop that will see the individual through the family life cycle, whilst helping to reduce the burden of care and parental ill-health.

Table 35.3. Strategies for practitioners

Recognise the socially constructed nature of learning disability – without denying the biological reality of impairment
Recognise how different understandings and beliefs influence how people live their lives, the decisions they make for themselves and their children, and the outcomes they hope to see
Recognise that the individual, parents and families are already living with the reality of disability. An additional 'diagnosis', e.g. of a mental illness or epilepsy, may compromise already fragile coping strategies and informal support networks
Dialogue – to elicit not only assessment information but the family's cultural orientation
Use of professional interpreters
Use of cultural interpreters
Take care to avoid stereotyped or 'colour-blind' approaches
Address cultural tensions sensitively. They often involve basic ethics – keeping safe from physical, emotional and mental harm; living dignified lives; living with respect.
Planning and approach to care in a person-centred way
Partnership with community groups
Develop skills in cross-cultural communication – one of the best skills to have is never to assume anything about cross-cultural beliefs until they are learned first hand.

(Adapted from Gabel, 2004; Raghavan and O'Hara, 2005)

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Child psychiatry across cultures

Niranjan Karnik, Nisha Dogra and Panos Vostanis

EDITORS' INTRODUCTION

The practice of child psychiatry is influenced by cultural norms and processes, as are other specialties within psychiatry. The needs of children from different cultures vary and yet within each culture there are individual variations. The earlier chapter by Dogra and her colleagues set the scene in clinical matters related to child psychiatry across cultures. This chapter by Karnik and colleagues provides an overview on management. The childhood behaviours occur in the context of families and cultures and balancing respect for variation and the need for universality is a key challenge.

Karnik et al. *point out that good clinical practice in the West would involve valuing the child's perspective and ensuring their views were heard and accommodated, but how far this would work in other cultures is debatable. Cultural values must be taken into account when planning any intervention and more so in the case of instituting pharmacotherapy. Using attachment theory as an example, they suggest that addressing the child's attachment may take different forms depending upon the context. Children's social networks will differ across cultures and the role of peers is significant in the development of a child's self-esteem and identity. The reduction of stigma is also important and particular attention must be paid to vulnerable and at risk children.*

The management of children in cross-cultural context

Introduction

Practising child psychiatry across cultures is one of the most challenging and yet potentially gratifying areas of professional practice. The challenge comes from the fact that children are dynamic beings whose developmental trajectory causes them to have a large degree of variability of behaviours, and these occur in the context of families with a seemingly endless degree of composition, structure and cultural context. The attentive clinician must therefore not only be careful to observe the child, but also to have a view of the family and the degree to which it is a part of a broader cultural milieu.

Accounting for cultural variation could potentially result in a specific approach to each cultural context for each psychiatric illness. Such an approach may be seen as daunting because the amount of information that needs to be learned far exceeds anything that a single practitioner could absorb. Balancing respect for variation and the need for universality is therefore the core challenge for child psychiatry across cultures. In order to contend with this dilemma, we have favoured a cultural sensibility approach in our teaching and research (Dogra and Karnik, 2003; Dogra, 2005). The stance of cultural sensibility attempts to place the practitioner in a position of learning about the cultural situation of the child and his or her family, and trying to use the clinical space for gaining the important information that will help guide culturally sensitive treatment. A great deal of additional information about the life of the child can also be gained by looking at the artefacts, toys and the nature of play that the child engages with in his or her everyday life (Mukherji, 1997).

Child psychiatry in its existence and approach varies across cultures. In North America and Europe,

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

specialist providers in child psychiatry are available but continue to constitute a relatively limited group. The vast majority of behavioural problems faced by children are addressed by paediatricians, family and general practitioners, social workers and the non-statutory agencies. These structural differences in the professional disciplines providing care for children with psychiatric problems results in a wide variety of approaches.

In considering the management of childhood psychiatric disorders, it is important to emphasize resources. By developing world standards the Western world is embarrassed by therapeutic riches. However, there is the question of whether these are effectively utilized and whether the interventions are as cost-effective as they could be. In developing countries, pharmaceutical interventions may be the most cost-effective and socially acceptable treatments for mental-health problems.

Good clinical practice in child psychiatry in much of North America, UK and Europe would involve valuing the child's perspective and ensuring their views were heard and accommodated when planning the management. It is debatable how acceptable this would be in other parts of the world, where resources may be limited.

In another context, such respect for the child's views, especially if they differ from parental views, may be seen as undermining. Again, the issue of the role that children play in society is essential to consider when thinking about management.

In working with families of diverse backgrounds, Sue *et al.* (1996) suggest the following.

- Different theoretical models may need to be applied and integrated for different contexts.
- There is recognition that therapist and client identities are formed and embedded in multiple levels of life experiences and contexts, and understandably in cultures, therefore treatment needs to take into account the young person's experience in relation to their context.
- Multicultural therapy is enhanced when the therapist uses modalities and defines goals consistent with the life experiences and cultural values of the client.

Of course, the latter may be more difficult if young people hold values that are different from those held by their parents and grandparents. Garland *et al.* (2004) interviewed 170 adolescents, their caregivers and their therapists to identify three desired outcomes for each stakeholder. The most commonly reported desired outcome across all three stakeholder groups was to reduce anger and aggression on an aggregate level. Almost two-thirds of the triads did not agree on even one of the desired outcomes for the adolescent's treatment when desired outcomes for individual cases were compared. Youths and therapists were each more likely than parents to report desired outcomes that related to the family environment; youths were the least likely to report desired outcomes that were related to youth symptom reduction. Essentially, there was a lack of agreement of the desired outcome among key stakeholders or desired outcome priorities for adolescent services. This lack of consensus may limit engagement in treatment and the effectiveness of care.

This chapter does not aim to review all of the available approaches, but instead focuses on the different domains available by the broad systems that children can encounter and the various perspectives that provide a way to understand childhood development and child psychiatry. The divisions between biological, individual, family and social modalities are artificial. Ideally, a combination of these approaches should be employed in order to maximize the potential benefits and outcomes.

Biological and pharmacological approaches

A biological perspective toward child psychiatric disorders is often a good starting point for considering the presentation of symptoms. Many psychiatric disorders have been shown to have strong biological transmission including bipolar affective disorder (Chang *et al.*, 2003a,b) and schizophrenia (Niemi *et al.*, 2005; Rapoport *et al.*, 2005). Even those that lack strong evidence for familial transmission are thought to have a biological component. In most instances a risk accumulation model seems to provide the best explanatory system wherein biological risk factors add to social and individual risk factors to produce psychiatric morbidity (Steiner, 2004).

Children are in the midst of continuous and substantial biological change. The neurobiology of development is complex and has been detailed in a few thoughtful reviews (Post and Post, 2004; Rubenstein and Puelles, 2004). It is clear that there is a complex relationship between biology and environment. Grossman and his colleagues have shown the powerful impacts that environmental factors play on the pruning of neural systems in animal models, and have presented very powerful arguments on the ways that that environment and biology interact to produce psychopathology (Grossman *et al.*, 2003). As the neurobiology of development becomes clearer, the picture that emerges is one of complex systems of interaction with neurodevelopment continuing well into the early twenties, and continuing growth and loss of cells possibly occurring even later in life through systems of gene regulation and expression.

The range of biological interventions available to child psychiatrists is currently limited. The most accessible forms of interventions include pharmacological strategies. For children, the use of medication always requires significantly higher level of consideration than in adults. Not only must the risks and benefits to the child be considered, but the views of the family and their beliefs about medications must also be taken into account. Far from being simply medication management, the approach must be one of pharmacotherapy, where medications are used within a broader therapeutic framework.

Among the most widely used agents for treatment of childhood psychiatric problems are Selective Serotonin Reuptake Inhibitors (SSRIs). These agents as a class have been widely used for the treatment of depression and anxiety disorders in adults. In the US, drugs from this class were approved for the treatment of childhood depression and obsessive-compulsive disorder. In 2004, the US Food and Drug Administration (FDA) followed the lead of the British Medicine and Healthcare Products Regulatory Agency a year earlier, in warning about increased suicidal ideation among children and adolescents taking SSRIs (Vitiello and Swedo, 2004; Wessely and Kerwin, 2004).

The availability of these medications outside of North America and Europe is not as controlled. The costs of treatment for many people make the routine use of these medications difficult. The only antidepressant currently listed on the World Health Organization's *WHO Model List of Essential Medicines*, 14th edn (2005) is a tricyclic antidepressant, amitriptyline. This class of medications, while efficacious, is known to have side effects that are problematic to manage in children, and can be lethal in overdose.

For bipolar affective disorder and schizophrenia in adults, biological interventions work very well and have significantly beneficial effects. Lithium has been the mainstay of treatment for bipolar affective disorder, and is relatively inexpensive and accessible. In addition to listing lithium, the *WHO Model List of Essential Medicines* (2005) also recommends valproate and carbamazepine as medications that countries should make available in their national formularies. Among antipsychotics, haloperidol, chlorpromazine and fluphenazine are all listed. Interestingly, recent data showed that, while newer atypical antipsychotics have fewer side effects and may be safer than typical antipsychotics, adherence to pharmacotherapy was poor across all groups with olanzapine, and risperidone groups having slightly better adherence (Lieberman *et al.*, 2005). In the use of antipsychotics, one predictor of adherence that has been demonstrated in small-scale trials has been if the provider is of the same ethnicity as the patient (Ziguras *et al.*, 2001). This may strengthen the argument that culture is an important variable in helping enable pharmacotherapy.

Cultural values need to be considered when employing any intervention strategy on behalf of children, but may be especially important when considering pharmacotherapy. While medications may be routine to prescribe for some practitioners, their use is likely be a new experience for the child and his or her family. In addition, just as some families view medications as toxic, other families may perceive medications as not only necessary but somehow mystical or magical as well. The variety of views of medications and their role in treatment are likely to be affected by a number of factors in cultures that employ such practices, and as such it is important for the provider to gain some idea of how the family and child understand the medication and its role, including the risks and benefits.

Individual therapeutic approaches

One of the most common approaches to child psychiatric problems is to engage in individual therapy with the child. For children, one-to-one therapy is rarely done exclusively with the child. Families need to be involved regardless of whether the child is seen primarily alone or with parents present. The following sections briefly review a few of the many therapeutic approaches that are available and the ways that these interact with cultural factors.

Attachment theory

John Bowlby pioneered the study of early attachment in childhood. His studies are one of the anchors of modern child psychiatry. He posited that the reciprocal relationship between parent and child form the basis of sound development for the child (Bowlby, 1979, 1988). Mary Ainsworth built on this work and expanded to include the development of a series of typologies of childhood based on the nature of the attachment and early relationship between parent and child (Ainsworth, 1978). Interestingly, Ainsworth developed many of her theories by studying child-rearing practices in Uganda, and drew from these observations to form her theory of attachment (Ainsworth, 1967). For an excellent review of attachment theory and its implications, see the paper by Fonagy (1999).

When considering attachment theory through the lens of cultural psychiatry, it would be easy to hold with Ainsworth that this process is somehow universal. The post-modern turn has brought about a reconsideration of all theories that make this assumption. While it is likely that aspects of the attachment process are universal, there are likely to be cultural variants. In some cultures, child-rearing is a more community and kinship-based process that may have a small handful of parents caring for all of the children of the community. Attachment, in such contexts, is likely to take a different trajectory from that which happens in the Western dyad of mother and child.

Therefore, addressing the attachment of the child might take different forms depending on the context. From a therapeutic standpoint, healing disordered attachment can be a challenging experience for the therapist. To do so in the context of cultural variables makes it even more challenging, but at this point employing a cultural sensibility model can help to ensure that therapy is provided in a sensitive and productive way, especially if that is consistent with the individual family's world view.

Play therapy

The history of play therapy is long and complex, often dated back to Anna Freud, who made specific comments about the meaning of play. Later Melanie Klein, Jean Piaget and D. W. Winnicott all expanded on notions of play and help to establish traditions for interpretation of play in a therapeutic perspective. Children often spontaneously play when they find themselves in a group, but this is not the frame through which play therapy takes place. Instead, play therapy uses this process as a means for children to express their emotional states and concerns, and also a way to try to address these issues by structured play techniques. Cultural meanings of play may differ, and the types and natures of games can also vary. This is why it is important to make the objects, rules, artefacts and, systems of play an object of scrutiny as a few scholars have argued (Mukherji, 1997).

Cognitive-behavioural and psychodynamic therapies

Individual therapy with children can take many forms, including cognitive-behavioural and psychodynamic. The range and types of techniques available are manifold, and the two that we highlight here are simply examples of techniques that are popular in child psychiatry. Cognitive-behavioural therapy (CBT) has good empirical support for its use in children and young people. The cornerstone of this technique lies in identifying disordered patterns of thought that are leading to affective dysfunction, and then showing the child how to reorient his or her thinking to achieve a better affective state. Many protocols exist for CBT, and there are versions that have a manualized form that can be completed in between 6 and 12 sessions. One recent review of the CBT techniques for children and adolescents highlights their utility for anxiety, depression, and disorders of conduct (Erickson and Achilles, 2004).

Psychodynamic therapy for children and adolescents has a long history dating to its genesis with Sigmund Freud. Until the emergence of pharmacological treatments, this modality was the dominant school of treatment in the field of child psychiatry. It continues to exert a strong influence on the field, but the interest in it has fallen as the neurosciences and empirically based therapies have gained ascendancy. Nevertheless, this school of treatment continues to have valuable lessons to teach, especially the ways that therapists and patients interact in the encounter. These have relevance for the study of children. The scope of this form of therapy is too wide to detail here and interested readers should consult many excellent books and reviews that have been written by experts in the field (Fonagy, 2004; Loughran, 2004).

Globally, psychodynamic psychotherapy is likely to be one of the basic theoretical perspectives that all psychiatrists have had some exposure to during their training, even though its implications are culturally bound. Practitioners in this field will be far fewer, and for many providers outside Europe and North America, the applicability of psychodynamic theories may seem limited due to a lack of attention to specific cultural matters. Posed as another universal theory, psychodynamic psychotherapy has been revisited in light of culture, race and ethnicity and its implications have been explored in the context of many psychotherapeutic approaches (Tseng and Streltzer, 2001).

Family therapy

There are different models of family therapy, which have developed over time. These have taken into account the changing roles of families and the changing structure of families within particular societies. It is important to acknowledge that many of the developments in family therapy work have come from Western perspectives. However, more recently, family therapy has been influenced by constructivism and social constructionism. These two are related but different concepts and their links to post-modern theories have recently begun to challenge some of the orthodox thinking and techniques of systemic and psycho-dynamic practice.

The post-modern theories reject the notion that there is a single fixed truth or reality about individual or family process that needs to be developed or established. It suggests that each individual constructs his or her personalized views and interpretations of what the family might be experiencing together. This approach enables the importance of cultural diversity and the multiple realities and the acceptance of a wide range of belief systems to be considered. Constructivism stems from the biology of cognition, which argues that individuals have unique nervous systems that permit different assumptions to be made about the same situation. The argument is that our unique biology means that we respond differently to the same context. Social constructionism is similar in that it argues that there is no such thing as objective reality, but that what we do is constructed from what we observe and arises from the language system, relations and cultures we share with others. This means that there is a more collaborative style of working. The focus is on helping the child or young person examine and reassess the assumptions individuals make about their lives, rather than focusing on specific patterns of family communication or roles. Using these approaches, therapists take the position of uncertainty and not knowing, and join the family to find workable solutions on an equal basis. Because this approach recognizes different values and perspectives that all individuals in the room may hold, it should be applicable to a wider range of contexts. However, if the family expects the therapist to take an expert position, they may be rather disconcerted when the therapist claims to have little expertise.

Family therapy can have a place in the treatment of many child-mental-health disorders and has been shown to be a very effective treatment modality (Stratton, 2005). In major psychiatric disorders it may be complementary to pharmaceutical interventions. It can also help in chronic conditions, helping families to understand how they can find workable solutions to make the best of whatever situation their lives are in. Canino and Inclan (2001) argued that clinicians often find the cultural dissonance between the culture of the families they see and their own culture and theoretical approaches as potential obstacles for appropriate assessment and management. Hampson and Beavers (1996) indicated that functional rather than demographic variables, including ethnicity, were more important in predicting therapy outcome.

Kumpfer *et al.* (2002) argued that very few family interventions have been adapted to be culturally sensitive for different ethnic groups. They reviewed five research studies that tested the effectiveness of the generic version of the Strengthening Families Program (SFP) compared to culturally adapted versions. Cultural adaptations that reduced dosage (that is the number of sessions), or eliminated critical core content to try and be culturally accommodating, increased retention of minority families up to 40% but reduced positive outcomes. However, from this study it is unclear on what basis therapists made these adaptations and the authors concluded that additional research is required. Family therapy has been shown to be effective in helping families from as far apart as South America and Cambodia (Mitrani *et al.*, 2004; Rousseau *et al.*, 2004).

Brief strategic family therapy was found to be effective in Hispanic adolescents with conduct disorders and substance use (Szapocznik and Williams, 2000; Santisteban *et al.*, 2003), whilst multidimensional family therapy was found to be efficacious with unmarried African-American mothers with adolescents with similar problems (Becker and Liddle, 2001). Jung (1984) argued that structural family therapy offers an appropriate treatment model for dysfunctional Chinese families as it enables the cultural emphasis on the family unit to be recognized. It also allows a problem orientated approach as opposed to one in which values are questioned. This was also reported for Puerto Rican families (Bird and Canino, 1982). Tamura and Lau (1992) emphasize that Japanese families might prefer a process of integration, that is, how a person can be effectively integrated into the given system, rather than a process of differentiation.

Family therapy is an effective intervention and there are few contraindications to its use. However, its use may challenge parental views and understandings of their child's problems. In addition, the definition of family and kinship must be understood clearly. The families ought to determine who should be involved in the treatment, whether uncles, aunts or grandparents or others form part of the family. Parents and caregivers may not be impressed with the idea that they may play some part in their child's presentation. However, if the therapist is aware of their own perspectives, they can ensure that they do not impose these on families. This enables them to work with families irrespective of the background of the family, as part of the engagement process should be about finding out the family's views and needs.

Children's social networks and communities

Children grow and develop in context of family, peers, community and broader social networks

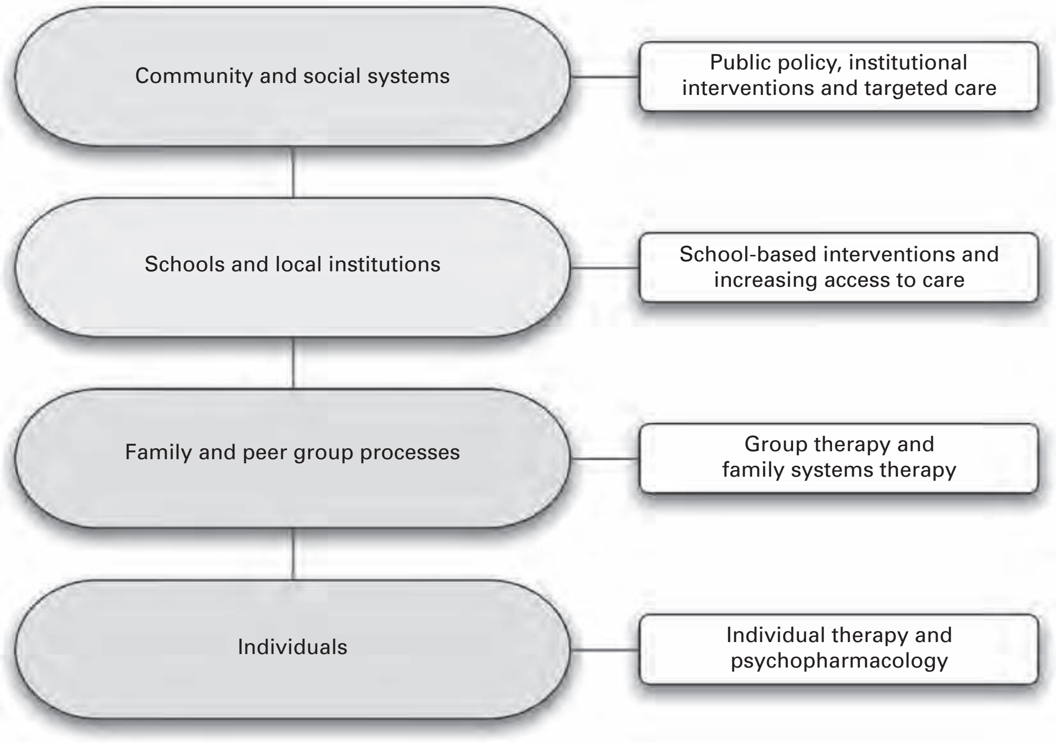

Fig. 36.1. Levels of care and intervention for children.

(Karnik, 2004). These networks are linked to family and group processes, and any attempt to intervene using these approaches must be cognizant of the connections among these levels of intervention (Fig. 36.1). They are not connected in the linear progression as depicted but rather in complex and often overlapping ways.

Urie Bronfenbrenner is among the most widely known of theorists of the social environment that has been recognized within medicine and psychiatry. He divided the social environment into three spheres (Bronfenbrenner, 1979). The microsystem includes the immediate family, peers and local social institutions. A step further out from this level leads to the mesosystem in which he placed larger social institutions and broader cultural influences. Finally, there is the macrosystem which includes the global and internal culture, as well as geopolitical events. Bronfenbrenner recognized that many social forces move between and among these levels and he was quite cognisant of the limitations of such a theory. Along related lines of thought, Lev Vygotsky proposed the idea of the zone of proximal development which he theorized as a time period during which children could be socialized given adequate social interactions (Vygotsky, 1978). Both of these theorists saw children as situated in multiple spheres of influence with family being closer than other social institutions. In children's social development and in the development of their identity, peers play a crucial role. In cultural identity development, schools, universities and other institutions contribute to the way the individuals see themselves.

When considering community factors and social systems, some analysts have chosen to look at example programmes. Felton Earls, in his review of this area of child–community interaction, uses the Project on

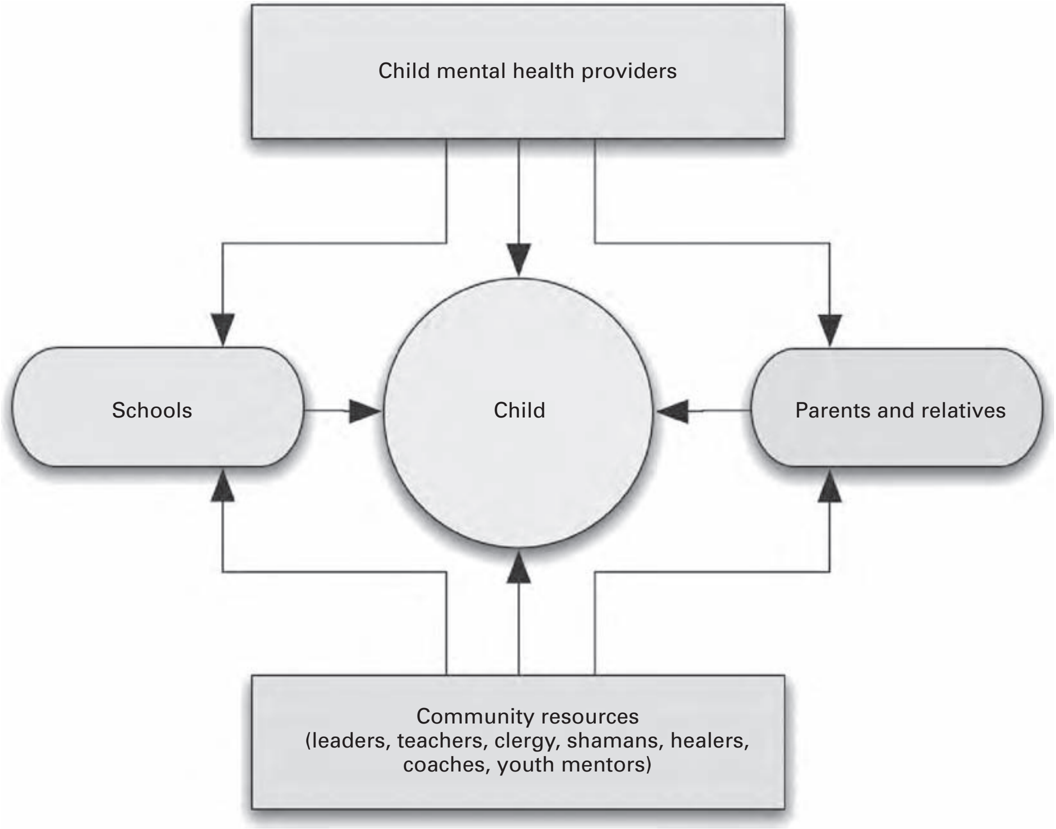

Fig. 36.2. Pathways to supporting children.

Human Development in Chicago Neighborhoods as an example of community-level analysis and intervention (Earls, 2001). Earls found that there was a series of links between 'neighborhood social organization, children's exposure to violence, and maladaptive aggression' (p. 701). He argues for two major pathways to address the needs of communities. One is to extend clinical interventions into the community using schools and other community-based organizations as a base from which to reach children in need of psychiatric care. The second involves a more grassroots approach whereby the capacities of communities to provide for children's needs on an ongoing basis are built and sustained.

Both of these approaches translate well into the complex needs of children across the globe. Cultural differences make it difficult to generate specific recommendations, but the general thesis that there are two paths to helping communities and children continue to hold relevance (Fig. 36.2). Depending on the community, the relevant grass-roots providers may be teachers or clergy, or even shamans and local healers. For example, Elijah Anderson in his detailed ethnographies of the urban metropolis argues that, for the African-American community, the 'old head' was an elder male from the community who was often found sitting outside his home on the street corner and offering advice and guidance to younger men (Anderson, 1978). As the drug culture grew through the 1980s in the American urban life with easy access to crack cocaine, the 'old head' became displaced and the mentoring that he offered was lost (Anderson, 1990). Such shifts have undoubtedly occurred around the world in various cultural contexts. Urbanization, industrialization and globalization have changed roles and functions and the everyday geography of life, and thus community-based interventions need to be geared to the local context.

In parallel, child-mental-health providers need to be working to support community leaders by providing education and specialist knowledge. The range of providers who may be responsible for child mental health will vary by locale. In many countries with limited healthcare systems, the specialist may be a local district nurse, whereas in the US and Europe, child psychiatrists or pediatricians may fill this role. Regardless of the child-mental-health provider, these professionals should be looking for ways to build bridges to local community resources in schools or other local institutions.

Contextual or school-based approaches

The school is by far the most important institution outside of the family that shapes the development of children. Globally, organizations like the United Nations Children's Fund (UNICEF) have placed education at the top of their priority list of action areas because education has broad impacts on child health.

Studies of school-based services have documented their wide-scale efficacy and accessibility (Anglin *et al.*, 1996, Kaplan *et al.*, 1999, Kisker and Brown, 1996, Santelli *et al.*, 1996a, Walter *et al.*, 1995). Students generally support the notion of school-based services and have reported that they find the level of care to be excellent (Santelli *et al.*, 1996b). With regard to child mental health, Flaherty and colleagues have studied the history of the development of school-based mental-health services and have found that these programmes can have positive effects on both mental-health outcomes as well as educational achievement (Flaherty *et al.*, 1996; Weist *et al.*, 1996).

Schools have been used as the key point for the provision of services around the globe. UN agencies, governmental departments, and non-governmental organizations (NGOs) have all adapted and created programmes to provide services through the school systems. Child psychiatrists have increasingly embraced the school-based care model in recent years in the US (Joshi, 2004). The practicality of extending this model to other regions will be dependent on the extent of local resources, since these models do take the professional away from other sites of care.

Child-mental-health service models: similarities and differences across cultures and societies

In trying to establish commonalities in planning and developing service models, one needs to take into account the characteristics of different cultural groups, the structures and strengths of different societies, and the context of their welfare and health systems, including resource constraints (Vostanis, 2005). But can child-mental-health service models apply across different population groups and countries?

The four-level (tier) CAMHS model, which has been widely adopted in the UK during the last decade (Health Advisory Service, 1995), is a good example. This defines CAMHS at four levels. Level 1 is usually the first point of service contact for children with mental-health problems and their families. It consists of health professionals such as school nurses, health visitors, and general practitioners, social workers, teachers, and youth workers or other non-statutory agencies. In other words, level 1 is a broader service concept than primary care within the health service. Level 2 includes individual child-mental-health professionals, who may also be members of a local mental-health service, but working at level 1 (e.g. schools or health centres – usually primary mental-health workers). Level 3 consists of specialist out-patient multidisciplinary teams for a defined locality (geographical area). Level 4 services provide treatment for specific, complex and severe disorders. They include day and in-patient units covering a larger geographical area.

At first look, such a model may be considered prohibitive for developing countries, or indeed for health systems without primary care. To a large extent, the achievement of standards such as access and quick response will rely on available resources (Kelvin, 2005). However, there are more parallels than first meet the eye. Schools in India (Sinha *et al.*, 2003) or Pakistan (Rahman *et al.*, 1998) or paediatric clinics in Nigeria (Gureje *et al.*, 1994) are examples of primary-care-level services that can be equally supported to manage mild child-mental-health problems. The effectiveness of such health structures should be maximized in recognizing and managing less complex child-mental-health problems as much as possible.

In developing countries, non-governmental organizations have a major role to play in working across statutory services. For example, as these are the key agencies to respond to natural disasters or political conflict (Thabet *et al.*, 2002). Limited specialist time can be used sparingly and effectively, through consultation, joint work with primary care staff and brief therapeutic interventions. Training also has an important role to play (Dogra *et al.*, 2005). Specialized (tier 3 or 4) services often overlap with existing paediatric (for children with autism and learning disability) or adult-mental-health services (for older adolescents with severe mental disorders). Even if the autonomous development of mental-health services for children and adolescents is not realistic for some countries in the near future, the above principles can be applied by sharing expertise with key professionals from the paediatric and adult-mental-health sectors.

All such initiatives should be developed taking into consideration the sociocultural beliefs of children, young people and families (Wilson *et al.*, 2000; Dogra *et al.*, 2005; also discussed in Chapter 20); their understanding of mental health (Thabet *et al.*, 2006); their perceived barriers to services; and the characteristics of their communities which could facilitate access and engagement with CAMHS (Owens *et al.*, 2002). It is also important to consider socio-economic factors that may contribute to poor service use through their link with ethnic status (Pumariega *et al.*, 1998; Alegria *et al.*, 2001). Research on families' perceptions of mental health and mental illness, help-seeking attitudes (Cauce *et al.*, 2002; Eapen and Ghubash, 2004), patterns and reasons of service utilization (Sourander *et al.*, 2004), is essential in planning service models based on evidence rather than assumptions. For example, although it is widely established that, even in Western societies, ethnic-minority groups have limited access to child-mental-health services (Zwaanswijk *et al.*, 2003; Burns *et al.*, 2004), there is neither supportive evidence nor policy consensus on how these needs should be best met.

Reduction of stigma of mental illness and stigmatization (Pinfold *et al.*, 2003) is important across all cultural and ethnic groups, although the process may differ to involve local communities, schools, community and religious leaders and groups, as well as the media. Finally, although it is beyond the remit of this chapter to discuss the needs of specific client groups in detail, particular attention should be given to vulnerable and at-risk children such as those exposed to violence and trauma, refugee and asylum-seekers, homeless, and children in public care. These needy groups of children and young people offer an additional challenge to the generic service requirements and previously discussed cultural needs, as these children and young people are mobile, lack advocacy and stability, and have multiple and inter-related social, developmental and educational difficulties (Vostanis, 2004). For this reason, services for these groups of children require clearly laid out international and national policies, joint commissioning between health and social-care organizations, an active role for the voluntary sector, designated and accessible services and applied interventions.

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37

Management of sexual dysfunction across cultures

Dinesh Bhugra and Padmal de Silva

EDITORS' INTRODUCTION

The management of patients from different cultures, especially if the therapist is from another culture, raises interesting questions about the role of perceived and real power embedded in the therapist. Furthermore, the perceptions and expectations of the therapeutic encounter and functions of therapy have to be taken into account. Recognition and understanding of social and cultural factors and their inherent complexities are a useful first step in building blocks of therapeutic alliance between couples and therapists. While individual therapy and couple therapy have many common principles and overlaps, couple therapy brings with it at least two sets of clear expectations (others' expectations, e.g. children's, may be hiding behind the couple) and challenges. Knowing a couple's type of marriage may allow the therapist to explore potential therapeutic obstacles. Satisfaction with marriage is related to the type of marriage.

Bhugra and de Silva in this chapter put forward some strategies in assessment and management of sexual dysfunction. The gender roles and gender-role expectations, particularly the role of women in patriarchal societies, may make it difficult for a couple to accept psychological therapies. Culturally influenced components of therapies may not easily be acceptable to all individuals, especially if their cultures differ from those where these therapies have been developed. The nature of mixed-race couples has to be addressed differently. Specific groups may indeed require specific intervention. They argue that ethnicity and personality of the partner, along with the couple's willingness to communicate on other unrelated issues, will allow the therapist to deal with and potentially to reduce conflict and increase satisfaction within the relationship. This will lead on to a strategy of improving communication skills. Therapeutic techniques have to be appropriate and acceptable. A willingness on the part of the therapist to acknowledge lacunae in their knowledge and ingenuity in exploring cultures will go a long way in building therapeutic alliances.

Introduction

As the rates of prevalence of sexual dysfunction across cultures remain controversial, its management is influenced by a number of factors including cultural perception of sexual dysfunctions, perceived purpose of the sexual act, explanatory models of the dysfunction as well as availability and accessibility of therapies. The management of sexual dysfunctions is as complex as its aetiology.

With demographic shifts, impact of rapid urbanisation, industrialisation and globalisation, the attitudes towards sex, sexual dysfunctions and help-seeking are beginning to shift. There will be biases in treatment availability across the globe and these will depend upon age, gender, economic and political climates. Various types of therapies are available for managing sexual dysfunction but the evidence base for some of them is seriously lacking. In addition, different culturally influenced therapies may be used for managing sexual dysfunction – the knowledge base and therapeutic outcome for those may not be clear either.

There has been a question over whether the therapies developed in one culture for one set of patients

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are suitable for or can be used for patients in other cultures. For example, psychoanalytic theory and therapies were the product of nineteenth-century Europe and America; can these be applied universally and, indeed, if so who should apply them? Hodes (1989) points out that there appear to be two extreme positions at opposite ends of the spectrum. At one end is the universalist position, which dictates that since all human suffering is universal, the application of such therapies is acceptable as there are more similarities than differences in terms of individual development although social and cultural rules may change. The other end of the spectrum holds the position of cultural relativism, which argues that each culture is unique and cannot be embraced by a single universal theory. It is evident that these two positions both entail ideological as well as practical considerations, which have to be understood in terms of the historical and political contexts within which psychotherapies have evolved (Lloyd and Bhugra, 1993). We illustrate some of these key issues with examples from different cultures as applied to management of sexual dysfunction. As has already been described (see Bhugra and de Silva, Chapter 27 in this volume), we do not propose to go through the basic levels of cross-cultural differences in psychosexual dysfunction. It is fair to say that both psychiatry and psychoanalysis have been criticised from a number of perspectives for their collaboration in the domination of a subjunction of groups within Western societies and in other cultures colonised by the west (see Doermer, 1981; Foucault, 1967; Eichenbaum and Orbach, 1982; Porter, 1987 for social histories of psychiatry in the West especially in regards to gender and social class; and see Bhugra and Littlewood, 2000; Littlewood and Lipsedge, 1999; Sabshin *et al.*, 1970; Thomas and Sillen 1972 for commentaries on psychiatry's position and relationship with colonialism and racism). Some commentators have argued forcefully that racial differences have an inhibiting effect on psychotherapy (Griffith, 1977) and others have played down these ideological concerns and attempted to obtain a severe sense of scientific objectivism which may be superficially attractive and indeed seductive to the medical audience but does not represent the full picture (Leff, 1988).

Principles

Assessing a case of sexual dysfunction will involve assessing the couple if possible, with detailed history and appropriate investigations; but the most important question is why here and why now. This has to be clarified especially in context of motivation and degree of commitment to the relationship and consequently to the treatment. In addition, it is always helpful to exclude any underlying physical causations and carry out suitable physical investigations if needed. Furthermore, the distinction between primary and secondary sexual dysfunctions and underlying physical or psychiatric conditions must be explored thoroughly. Alcoholism may contribute to sexual dysfunctions and cultural responses to alcohol and alcoholism need to be understood and taken into account for part of the assessment. For detailed assessment strategies see Bancroft (1989), Hawton (1985), Gillan (1987) and others.

Assessment across cultures

In addition to normal clinical assessment, detailed information may be required of the patient in respect to their cultural values and norms, acculturations and cultural expectations of the sexual behaviour. As noted in Chapter 27, if the basic cultural value of the sex act is procreative and lack of privacy a major issue, then giving the couple sensate focus or body exploration exercises and setting time aside for these is likely to prove counterproductive.

The cultural assessment and cultural formulation have been described by Bhugra and Bhui (1997). These assessments, although originally developed to assess patients from black and minority ethnic groups within the UK, can easily be modified for use elsewhere. If the therapist and the patient are from the same culture, this may still create a conflict because, for their therapeutic interaction, they may bring different expectations, experiences and values to the encounter. Culturally transmitted concerns about sex can affect an individual's sexual functioning. Sometimes these may present with what is seen as culture-bound syndromes (see Bhugra *et al.*, Chapter 10 in this volume) but more often the individual's overall beliefs and attitudes to sex cause or contribute to more generalised difficulties, and the same variables can also affect the attitude and response (as well as the acceptance of the treatment modality) to therapy (Bhugra and de Silva 1993). The role of women, fecundity, need for a son and other similar factors must be explored further in any assessment.

Special issues

Irrespective of specific culture issues, additional factors that may play a role in the acceptance of any treatment include single male, gay and lesbian single individuals or couples. The therapist would need to modify clinical approach in the context of the patients' cultural values and norms.

Single men

Guirguis (1995) notes that the single male can present in any one of the following three clinical conditions: primary impotence, secondary impotence and the widower's impotence. Each of these groups has a different set of problems and expectations. As Anson (1995) points out, in terms of type of complaint and duration of complaint, there were no differences for single men presenting for treatment. Catalan *et al.* (1991) had found that, amongst their female patients seeking help alone, orgasmic dysfunction was more likely and low sexual interest less likely when compared with women presenting with their partners. Around 40% of women attending a family planning clinic (who also had a sexual dysfunction) believed that their partners would not attend for couple treatment.

Cultural factors

For people originating from non-Western cultures, the potential of non-couple therapy will relate to a number of factors including beliefs about the causes of the dysfunction, the prevalence of various types of dysfunction and issues related to attendance of a spouse or partner (Anson, 1995). The beliefs about the notion of physical causation of the dysfunction being masturbation, nocturnal emissions and semen loss in men pose problems for treatment and poor compliance for behavioural therapy (de Silva, 1982). De Silva (1982) also noted a reluctance to bring spouses to the clinic in Sri Lanka as well as an unwillingness of women to come to the clinic to discuss sexual problems. Additional factors of sexual taboos, social expectations, poor levels of education and information have already been touched upon.

Gay and lesbians

Homophobia, societal attitudes to homosexuality and long-term same-sex partnerships will all play a role in acceptance of treatment. Gordon (1986) noted that gay men were more likely to present without partners and Reece (1985) used group therapy as a potential treatment. Malyon (1982) observed that homophobia can play a very strong role in rejection of treatment. The stages of coming out especially in a couple may not be synchronous and the therapist may need to vary treatment options accordingly. The sexual dysfunctions among lesbians are likely to be similar to those in heterosexual females, but their experience of homophobia, societal attitudes and importance of orientation are likely to be similar to those experienced by gay men (Bhugra and Wright, 1995). The therapist must use psychosexual objectivity because homosexuality and heterosexuality have far more similarities than differences (Masters and Johnson, 1979) though Gordon (1986) criticises this approach and, like the debate on ethnic matching between therapist and patient, a skilled sympathetic therapist is seen as more important that one with a similar orientation (Anthony, 1982).

Couple therapy

In addition to individual factors, relationship factors play a key role in the genesis and maintenance of sexual dysfunctions. They will be moulded by the reactions of the partners in the context of circular causations, i.e. the actions of one become the 'cause' of the actions of the other and so on (Crowe, 1995). Thinking systematically in this way has distinct advantages and the sexual relationship is the microcosm of the general relationship. The degree of trust, overprotection, dependency, jealousy and variation in sexual interest may all contribute to the genesis and maintenance of the problem. If the couple are part of an 'arranged marriage' then their expectations of each other, their relationship with each other and the extended kinship will be quite different, and consequently the systems structure will be quite different.

The principles of behavioural systems couple therapy are beyond the scope of this chapter and interested readers are referred to Crowe (1995) and Crowe and Ridley (2000). A hierarchy of alternative levels of interventions can be used by reciprocity negotiation, communication training, role play, tasks and timetabling, paradox and adjustment to the symptom approaches.

In dealing with couples where one individual is from one culture and the other individual from a different culture, different strategies may be indicated, especially if the therapist is of a culture that matches one or the other. This raises questions in managing the sexual dysfunction if the therapist is from one or the other culture (see Fig. 37.1).

Couple relationships

In assessing couples and their needs for psychological treatments, it is helpful for the therapist to consider not only the relationship patterns but also the childhood developmental patterns, especially attachment. Mikulincer *et al.* (2002) propose that sense of attachment security has been identified as a major variable explaining variations in the quality of dating and marital relationships. They build on the observation that every meaningful interaction with significant others throughout adult life is influenced by childhood attachment experiences. Those who have a sense of attachment security are more likely to react to stressful events with lower levels of stress compared with those who score high on avoidance or anxiety domains. The former (i.e. those with secure attachments) are also more likely to cope with stress by seeking support, and are also likely to have more positive expectations about relationship partners than those who score high on avoidance domination. Those more secure in their attachments, not surprisingly, also hold more positive self-views than those who score high on anxiety dimension. Perhaps more intriguingly, this group of individuals is also likely to engage in exploration and affiliation activities and is more sensitive and responsive to their partners' needs. There is indeed a causal relationship between an individual's experiences with his/her parents and their capacity to make affectional bonds in later life. Mikulincer *et al.* (2002) raise methodological issues in both the assessment of attachment as well as marital quality. It is not surprising that patterns of attachment will determine the quality of dating relationships as well as of long-term romantic relationships. These authors conclude that the sense of attachment security is associated with:

(a) positive beliefs about couple relationships;
(b) formation of more stable couple relationships;
(c) satisfaction with dating relationships and marriage;
(d) high levels of intimacy, commitment and emotional involvement within the relationship;
(e) positive patterns of communication and interactions in both dating and married couples.

They postulate that the affective consequences of secure attachment interaction with distress alleviation, positive mental representations of the self and others and secure attachment facilitates the satisfaction of other basic psychological needs (e.g. exploration, affiliation, care-giving) within the couple relationship, which in turn will further increase relationship satisfaction.

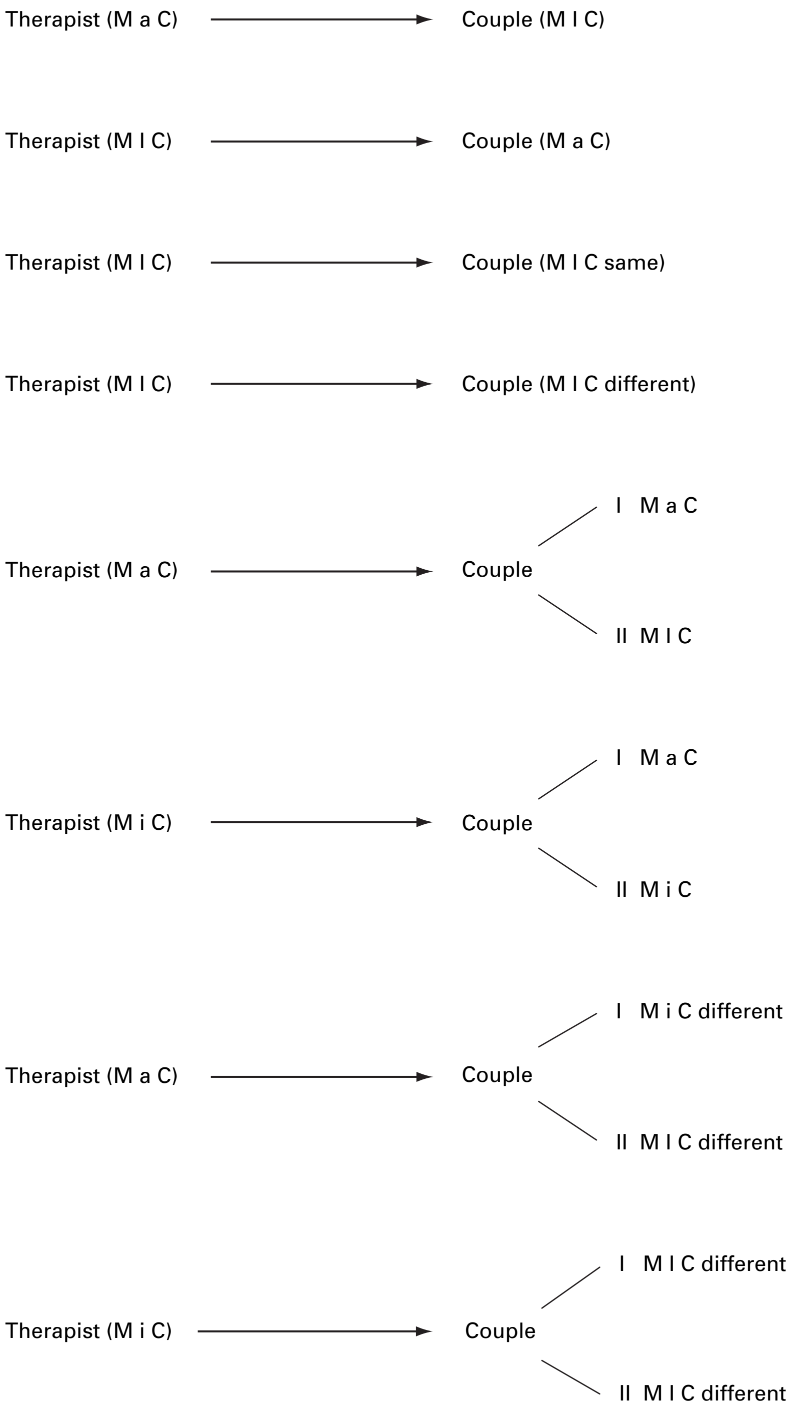

Fig. 37.1. Various scenarios in couple and therapist cultural backgrounds (Ma = Majority, Mc = Minority).

Using a systematic theoretical framework, they suggest that in their model, marital interactions are patterned along intra-psychic and interpersonal regularities, and the structure of the intra-psychic and interpersonal elements in the whole system affects how one element acts with another. Partners, too, influence one another in complex reciprocal and cross-construct ways. These intra-psychic and interpersonal influences are circular rather than linear. Of course, systems are also self-regulating. Mikulincer *et al.* (2002) propose that self-representations are extremely useful and important in contributing to the formation and maintenance of stable and satisfying couple relationships. Securely attached persons, therefore, will feel accepted and valued and this will encourage them to reciprocate this love and further strengthen their willingness to care for their partner in times of need. In addition, these positive representations include a sense of self-efficiency in dealing with threats and life problems, which may lead to the adoption of a more confident attitude towards their relationship obstacles and to the adoption of more constructive interpersonal problem-solving strategies. The models of representations of others may similarly influence the care-giving and maturing of each other. Thus inner resources and previous experiences will play an important role in the dynamic relational process, which categorises different stages of marriage and family development.

From a practical point of understanding, couple relationships and satisfaction within the relationship, attachment has a role to play. As the authors themselves note, the interplay between different factors and the directional nature of this interplay is very difficult to ascertain. Furthermore, integration of research data and family dynamic processes is worth exploring. It will also be helpful both for therapists and couples to ascertain the attachment in later stages of marriage and as the family develops.

Huston (2000) analyses marital relations and suggests that marriage be studied at three levels: that of society, that of individual and that of the process itself. This translates as the macrosocial context, with the spouse's ecological niche, at a 'lower' level the spouse's beliefs and attitudes and, thirdly, marital behaviour in the dyad context. Such an approach obviously allows and encourages the therapist to analyse the relationship at a more inclusive level rather than simply relying on two individuals. Nwoye (2000; see below) confirms this in a different culture.

De Maris (2000) reported from a survey of 3508 married couples on a 5–7-year follow-up that male violence significantly elevated the risk of disruption and that its impact did not appear to differ according to the female partner's socio-economic resources. Verbal conflict was not reported to be a significant predictor of disruption of the relationship, but the style of conflict resolution was. Violence, by men especially, may well have influenced relationship quality for both partners. Co-habitees would be seen as unusual and, therefore, either very conventional in their commitment or very unconventional. Interestingly, the role of violence in dissolution of the relationship did not differ between those who were married and those who were co-habiting.

Wang and Amoto (2000) suggest that post-divorce adjustment in couples is related to income, remarriage, favourable attitudes to dissolution of the marriage before divorce and being the initiator of the divorce. Older individuals appeared to adjust worse than younger ones. The progression of marriage to divorce can occur at different levels and different stages. Hostile and distancing behaviours have been predicted as contributing to marital stress. Using a sample of 97 couples, Roberts (2000) reported that, on assessing marital distress and withdrawal behaviour, spouses' responses were directly related to the level of hostility expressed in the relationship. The primary predictor of marital outcomes for wives was a partner's hostile responsiveness, whereas for husbands it was partner withdrawal. The study highlights some of the key problems in understanding context in which marital distress occurs. Although these are all newly married couples (first marriage) and perhaps relatively inexperienced, it is important for marital therapists to be aware of these findings too, and include some questions on hostility and distance in their assessments.

In an interesting paper, Nwoye (2000) presents the indigenous theory and marriage therapy in contemporary East and West Africa. It is argued in this paper that, in these areas, marriage is based on a theoretical framework, which suggests that obligations/expectations and privileges are taken as being linked to the occupancy of social positions. Harmony and peace result when people occupying such positions perform their expected roles credibly and disharmony and distress occur when these obligations are not met. The traditional model of family therapy in Africa follows the mediatorial session, which involves the presence of a mediating team of elders as the jury, with the couple being litigants. The elders listen to arguments, identify the faults and pronounce judgements, which may well include damages. Thus the elders are not only detectives but allies and advocates as well as judges to uphold the traditions and values of the kinship. They are not neutral observers. Nwoye suggests that marital therapists follow this model where changes in the number of therapists in each session may be required. The process of marriage therapy has the social stage, where the husband presents his side without the wife. The initial hearing again has two components – the first one where the man gives his side and a second where the wife does. The length of the sessions is not dictated by the clock. In the second hearing, which follows one or two days after the intitial hearing, the wife's 'accusations' are presented to the man and this gives the therapist the opportunity to confront the husband and identify misperceptions and expectations about the marriage and the relationship. The wife then has a second meeting with the therapist and the response to her complaints is shared. Faulty logic, unwarranted conclusions and generalisations are all things that the therapist may well be able to uncover. After these meetings, reconciliation is suggested, with a conclusive verdict. This is followed by a re-enactment of unity, where the spouses reflect on their current decision, and prescription of and opportunity for sharing a drink. This follows a ritual where the therapist blesses the couple. Nwoye goes on to acknowledge the patriarchal nature of such therapy, but it would be interesting to have some empirical data on the success of such an approach.

Helmeke and Sprenkle (2000) suggest that clients' perceptions of pivotal moments in the couple therapy are: (a) identifiable from the transcripts of sessions and (b) useful in getting couples to think about disclosure and its impact on the relationship. There is little doubt from the research data and from individual experiences that these moments are highly individualised and highly emotional ones, and that the individuals place varying degrees of significance upon them. These pivotal moments are closely related to presenting problems as well. The changes achieved in the sessions are also linked to clearly identifiable events. Although these findings are based on only three cases and on one therapist, these are interesting developments for the therapist to be aware of.

Marital and family therapy can influence pathways into care and will also affect help-seeking from various professional and non-professional sources. Law and Crane (2000) report from their case-note study data that usage of health-care services dropped by one-fifth after the individuals had received couple, marital or family therapy.

Couples and the therapist

The interaction between the therapist and the couple can be affected in a number of ways. These include, for the couple: race, class, level of education and culture, which can be broadly termed 'external' factors; and self-concept, religious belief and language, which may be termed 'internal' factors. They also include various key factors in the therapist: race, class, gender, language as general background factors, and professional training, experience and preconceptions in the therapeutic setting. Needless to say, in each partner as well as in the therapist, these factors constantly interact. And they also influence, separately and in combination, the therapeutic relationship. However 'objective' a therapist claims to be, the operation of these factors in the therapeutic relationship is inevitable and needs to be acknowledged.

Within such an interaction, there are several scenarios, all of which have implications for the planning and implementation of therapy. Firstly, the therapist might come from the majority culture and the couple from a minority culture. Secondly, the therapist might come from a minority culture and the couple from a majority culture. The first is very common in present-day therapeutic settings in Britain, and the second is an increasingly common situation. Thirdly, the therapist and the couple could both be from the same minority culture. Fourthly, the therapist might be from one minority culture, and the couple from a different minority culture. In today's Britain, with several groups of minorities, this is not a rare situation. Then there are those scenarios where the partners come from different cultures, either the majority culture and a minority culture, or different minority cultures. In each of these situations, the therapist might be from the majority culture or from the minority culture as discussed earlier. In addition, there are situations where the therapist will be of the same minority culture as one of the partners.

Each of these combinations will create a set of expectations and problems, which need to be considered by the therapist while assessing the couple and planning any intervention. Within such a combination, there are three key components which need to be emphasised. The first is the ethnocentrism of the couple, of each partner, of the therapist and of the wider culture surrounding them. Secondly, with the therapeutic interaction, there will be an imbalance of power related to various domains, including communication, both verbal and non-verbal, and the subjective experience of coercion or oppression. The third component is the therapeutic relationship where the therapist and the couple forge an alliance in order to move forward. This alliance is influenced by the presenting problem itself and by the shared world view of the parties, as well as by their different cultural background.

The power relationship between the therapist and the two partners is, in many ways, a microcosm of the society they live in. Power has been given to the therapist by virtue of professional experience and the role they play in the interaction. However, this is also affected by other factors. In commenting on this subject, d'Ardenne (1991) says:

> All therapists have some power over their clients, but the situation between clients from a minority culture and a therapist from the majority culture compounds this power imbalance further. The clients' perception of your age, social class, professional background and cultural skills will also affect your status, and how your clients see it.

As noted earlier, the past experience of the therapist with the clients may influence interactions in such a way that makes therapeutic progress difficult. This is further complicated in the setting of couple therapy where the two individuals come with their separate or different expectations, roles and power relationships. If the couple are from the same cultural background, then the interactions between the couple and the therapist may raise different issues from those that arise if all three members come from different ethnic and cultural backgrounds.

Some additional comments are in order at this point about mixed-race or intercultural couples, as this area has not been widely discussed in the literature. Intercultural couples have two additional sources of difficulty, which other couples do not have. One is society's overall attitude to such relationships, which varies from curiosity to open prejudice, including in the extreme case non-acceptance of the partners by each other's families and cultures. The second stems from the differences in habits, beliefs, values and customs that the two partners have. A greater adjustment is needed by such couples when compared with same-culture couples. Communication difficulties are common, not just verbal but non-verbal as well. The expression of moods may be non-congruent and often misunderstood. The way one partner relates to other males (or other females) may be seen by the other as unacceptable, simply because that is the way one's own culture considers such behaviour. There may also be discrepancies with regard to child-rearing practices and the role of the extended family. These mismatches can cause much couple disharmony and lead to the couple having to seek help. The couple may not always articulate these culturally based difficulties as their problem, but may complain of general incompatibility, one partner's unreasonableness or simply stress. The therapist needs to probe more deeply when such couples come for help, and to do this sensitively and without allowing him/her to be perceived as allying herself/himself with one of the partners. In the scenarios noted earlier, where the therapist and one of the partners belong to the same culture, this is particularly important. The other partner is very likely to feel alienated in such a situation. He/she may perceive a 'coalition' between the therapist and his/her partner. The effects of such a perception are therapeutically negative. The therapist needs to be fully aware of these potential difficulties, and to make every effort to minimise them.

Depending upon the culture and society from which the couple emerges, the notions of self and self-esteem will play an important role, not only in the relationship but also in the help-seeking, as well as in the acceptance of any therapeutic interventions. Cross-cultural definitions of family may well differ. Some couples may be in nuclear family set-ups. Others may be in extended or joint living arrangements. Even in these, the couple may have separate cooking and other arrangements, thereby making 'individuation as a couple' possible. Thus there are varied and complex ways in which a couple operates and functions. The therapist needs to have knowledge and sensitivity about these aspects. This requires study of the cultures of the couples one is dealing with, and training programmes for couple therapists need to include such study in their curriculum (see de Silva, 1999). In addition, practising therapists have their own responsibility to acquire such knowledge as part of their ongoing professional education. We believe that regular discussion among peers, including peer supervision, is a useful component in this kind of education.

Theoretically, the systems approach is the most appropriate strategy for assessment and treatment in these complex settings. The style and content of assessment and treatment have to reflect appropriate components of the culture in question, and the systems approach enables a therapist to do this effectively. The reason for this is that cultural factors, both within the couple and in relation to their interactions with the extended families and wider society or sub-culture, play an important role within the 'system' that one has to assess and try to modify. The systems approach also enables the therapist to look at his/her own relationship with the two partners in the therapeutic triad that couple therapy inevitably is, and at how it affects the couple's interaction, and vice versa. No other therapeutic approach enables the therapist to conceptualise and handle these issues as effectively as the systems approach does (see Crowe & Ridley, 2000).

Couple therapy may not easily be accepted by various cultural and ethnic groups, and the therapist must recognise that, in some situations, it is not the couple but the whole family which may be the best 'target' for therapeutic intervention. Sometimes, while the couple brings an apparent specific problem for help, the wider family has a powerful presence in the background. The key aim is to try and be aware of these factors and to adjust one's strategy accordingly. In order to function effectively in these situations, the therapist needs to be aware of his/her own strengths and weaknesses, including a possible lack, or deficiency, of knowledge of the cultural factors surrounding the couple.

Issues in assessment

Assessment in psychotherapy in general, and in couple therapy in particular, relies on a number of factors. For the sake of completeness, the following is a list of some of the key factors that need to be assessed. They include:

- presenting problems;
- how the problem is defined by the couple/each partner;
- why they are seeking help now;
- expectations, as a couple and as individual partners;

- the nature of the relationship, including roles in home management, finance, children, etc.;
- external sources of stress;
- role of families of origin;
- strength of the relationship;
- past marriages or relationships;
- areas of conflict;
- fidelity;
- physical and mental health.

There are many excellent sources in the literature on the subject of the areas of enquiry (e.g. Crowe & Ridley, 2000).

In the assessment of couples from minority cultures or mixed cultural origins, cultural norms for the couple are particularly important and must be assessed. This assessment includes questions about norms for marriage and expected roles and responsibilities within the relationship. Some of these are listed in Table 37.1.

Table 37.1. Assessment in couple therapy across cultures

- Normative age for marriage
- Why that age?
- Do men have to achieve certain things before getting married?
- When are men/women considered eligible?
- How much free will do they have?
- History of arranged marriage?
  - definition of arranged marriage
  - whose responsibility?
- Do these patterns continue with migration?
- Other basis for mate selection
  - if so, how different?
  - how is it accepted by the culture?
- Role of common interest, mutual attraction, love or lust
- Expected duties of husband/wife
- Gender roles
- Self-concepts
- Division of responsibilities
- Power, alteration of power equation
- Role of families of origin
- Conception of sexual relations
- Do's and don'ts in interactions with outsiders

The assessment in couple therapy generally focuses on the quality of the relationship because that is primarily where the problem lies. Yet additional problems such as sexual dysfunction may underlie or confound the relationship difficulties. The therapist must be aware of, and sensitive to, these in order to elicit details of such problems, which may indeed be the main cause of the relationship dysfunction, or at least a complicating factor. The therapist must be able to ascertain the quality, strengths and weaknesses of the relationship so that appropriate interventions can be put in place. It is imperative that assessment is value free and culturally sensitive so that it paves the way for appropriate treatment to occur. In intercultural unions, often the strength of the relationship may result from factors like more thorough preparation for marriage and greater commitment to the relationship. But, as noted earlier, there are also problems and disadvantages. Some of these are highlighted in Table 37.2.

These possible advantages and disadvantages need to be explored by the therapist as part of the assessment. One often finds in these situations that there is a mismatch in the views of the two partners with regard to these. One partner might, for example, highlight the exposure of the children to two cultural backgrounds as an essentially positive factor, while the other may be more concerned about the difficulties that the exposure to divergent cultural norms has brought about. In the early stages of intercultural marriages the couple tends to be idealistic and very positive about the advantages of such a union. With passing time, and with the experience of difficulties, they tend to become more realistic and even negative in their appraisal of the marriage. This transformation rarely happens at the same rate for both partners.

In the early stages of assessment, the therapist should make an effort to find out the reasons for referral and expectations of therapy. While this is an obvious requirement in all couple therapy, these matters have particular significance when dealing with a couple from a different culture. The threshold for help-seeking, and thus referral, may be higher for some cultures than in the majority culture. This

Table 37.2. Intercultural marriages: some advantages and disadvantages

Advantages	Disadvantages
More thorough preparation for marriage	Less common ground in relationship
Greater degree of commitment	Differences causing doubts
Greater degree of self-other	Sense of loss of self
– differentiation	
– tolerance	
– respect	
– acceptance	
Broader opportunity for learning and growth	Learning and growth interfered with
Greater opportunities for children	Social stigma and non-acceptance
More accepting of differences	Institutional racism

may be because of greater tolerance of disharmony, or a greater reluctance to turn to the established agents of help. Sometimes, the culture may provide the couple with other help/resolution options, such as through the extended family or a key religious figure, so that their eventual referral to a conventional therapy setting may be considerably delayed.

Therapy strategies

Two key strategies in the therapeutic intervention are the educational and the psychological. This suggests that the therapist is primarily an agent with both educative and psychological functions. These strategies are not mutually exclusive; they can and should be used in combination, and in conjunction with other therapeutic approaches. The method of implementing these, needs to take into account the couple's, and each partner's, sensitivities and expectations.

In some situations, the members of a minority culture may have their own indigenous therapies and use these along with the therapist's instructions. This has already been noted in the discussion of the threshold for referral and help-seeking. Indigenous therapies have been used in original form, as well as in modified forms. To cite an example from a different area, working with Indo-Trinidadian clients with alcohol problems, Maharajh & Bhugra (1993) found that brief family therapy with an emphasis on cultural meanings and expectations was successful. Neki's (1973) notion of the *guru–chela* (parent–teacher) roles in psychotherapy also seems appropriate for some cultural groups. There is scope for similar work in couple therapy. Therapies developed in one culture may of course be used in other settings as well (see Lloyd & Bhugra, 1992; Bhugra & Bhui, 1998). Combining different types of therapies is not necessarily contra-indicated in couple work, but therapists must be aware that not enough evaluation research data are available at present with regard to this. While using such additional culture-related strategies, the therapist must therefore try to evaluate the contribution of these to the outcome of therapy.

Pitfalls

Some of the key problems in psychotherapy in general, and couple therapy in particular, are related to issues like 'missionary racism' – there the clinician rather patronisingly conveys to patients that his/her role and goal is to 'save them from their plight', or to take care of these 'poor' people who are unable to look after themselves. Therapists either end up being too controlling or identify too closely with the client. In couple therapy, such a problem is further compounded, so that, if therapists are not aware of their own feelings towards race and ethnicity, they may over-identify with one member of the

Table 37.3. Some common pitfalls

Colour blindness:	Assumption that minority-culture client is the same as majority-culture client
Colour consciousness:	All problems result from the minority status
Colour transference:	Client's feelings result from therapist's race
Cultural counter-transference:	Therapist's feelings towards client result from their race
Cultural ambivalence:	Therapist wishes to help but needs to control to maintain power
Over-identification:	Minority therapist over-identifies everything in terms of racism and defines problems as racially based (same as colour consciousness)
Identification with oppressor:	Minority therapist denies his/her status by virtue of power and because it is painful

couple and become too controlling towards the other. Some of the pitfalls are illustrated in Table 37.3. This is more likely to happen in some scenarios than others, e.g. when the therapist and one partner are from the majority culture, and the other partner is from a minority culture.

These pitfalls are easy to fall into, and many inexperienced therapists often do so (Bhugra & Bhui, 1998). Therapists need to be constantly alert to these dangers, and an examination of one's own responses and attitudes needs to be undertaken. Again, it is necessary to emphasise the need to discuss pitfalls, and how to avoid them, as part of the curriculum in training programmes for therapists. Equally, regular supervision – at least peer supervision – that keeps these issues on the agenda will help the therapist to avoid these pitfalls.

Management across cultures

Patterns of marriage vary across cultures. For example, models of marriage in African-American culture, as in any other group, are strongly influenced by larger social trends such as increased economic pressures, greater participation of females in the workplace and diminished stigma for marital discussion.

Previous research (Fowers & Olson, 1992) indicated that four types of marriages (according to relational levels) existed: vitalised, harmonious, traditional and conflicted. There was also a suggestion that the type of marriage affected the outcome. Those with vitalised marriages indicated most satisfaction with their relationships, whereas conflicted marriages, not surprisingly, reflected low satisfaction and high marital discord. There is little doubt that culture and ethnicity play critical roles in shaping the relationship experience, even more so if the individuals come from minority backgrounds. Ethnicity can be linked to individual as well as to group identity, mate selection, parent–child relationships and social support networks. African-American marriages exhibit much of the economic and social diversity of couples from other ethnic groups.

Allen & Olson (2001) found that there was convincing evidence of five types of African-American marriage, based on an analysis of 415 couples, and that these types were strongly associated with marital satisfaction both at individual and dyadic levels. The five types were similar to those previously observed, namely vitalised, harmonious, traditional, conflicted and devitalised. Harmonious and vitalised couples reported high marital satisfaction and high positive couple agreement on most relationship domains. Age and ethnicity *per se* were not associated with types, but number of children and education were.

Rosenfeld (2002) studied the patterns of marriage of Mexican-Americans and attempted to link these with segmented assimilation. The process of segmented assimilation is related to the fact that assimilation with Whites is no longer the only, or even the nodal, type of assimilation. This suggests that, although integration into middle class White Americans is still a viable option for some immigrant groups, for others, especially those who are non-White, Americanisation usually means joining the inner-city underclass who work in the most menial jobs, live in the heart of central cities, go to school and work with Black Americans who have learnt to reject what they see as the values and ideals of middle-class White America, and poverty along with blocked mobility can lead to an oppositional sub-culture. Rosenfeld (2002) reported on the specific assimilation of Mexican-Americans with non-Hispanic White, specific assimilation of Mexican-Americans with non-Hispanic Blacks and generalised assimilation of Mexican-Americans. When groups migrate, in the initial stages endogamous marriages take place. The group slowly de-emphasises the customs associated with their ancestry but this in itself may not be good enough for purposes of being accepted by the larger society. Using the data from the Census on marital status, Rosenfeld (2002), using the most basic measure of general assimilation percentage endogamy, reported that this percentage had declined from 77% in 1970 to 66% in 1990. However, this measurement has a limitation in that it does not account for group size. It is apparent that smaller groups are likely to out marry more, which is a reflection of lack of opportunity and increased exposure rather than a measure of assimilation. However, when odd ratios take into account not only the odds of marrying within the group, but by controlling for group size, it would appear that some groups remain endogamous. Rosenfeld (2002) concludes that measures of assimilation for the Mexican-Americans are different compared with the Blacks. The social distance between the Mexican-Americans and non-Hispanic Blacks is greater than the social distance between Mexican-Americans and non-Hispanic Whites. Thus the idea of solidarity between the minority groups is not upheld and neither is the evidence for segmented assimilation for Mexican-Americans upheld. This study provides a critical overview of assessing cultural assimilation at a broader group level rather than at an individual level. The social distance model provides an unusual insight into the process of assimilation as well.

For Arab-Americans, a similar study was conducted by Kulczycki and Lobo (2002). They too studied levels of intermarriage among Arab-Americans using the 1990 Census data and observed that 80% of Arab-Americans were married to non-Arab spouses. Logistic regression revealed that, for both sexes, those with past Arab ancestry, the US born, those with strong English-language ability and those who were highly educated were more likely to marry out, as were Arabs of Lebanese ancestry. These authors used a number of variables in their analysis. They propose that many Arab immigrants who may not be initially acculturated are still able to be structurally assimilated into the US economy, given their levels of education and skills. In their sample only 3% of Arabs were married within the same Arab ancestry. Rates of intermarriage among the native born and those with strong English proficiency (two indicators of assimilation) demonstrate that marriage outside the group is more likely. Both men and women who are well educated and have higher incomes are also more likely to marry out and this too may be seen as a measure of assimilation. The authors conclude that Arab-Americans are conforming to the patterns of assimilation of migrant groups. The data do not suggest whether any specific factors such as numbers, education, religion or income are more important than the others.

Management across cultures

The therapists must be sensitive to the patient's difficulties in reporting openly about their problems. Men may be embarrassed, particularly as an open acknowledgement of their sexual problem may be seen as an aspersion on their masculinity and male gender role, which may vary somewhat across cultures. Such individuals may present with embarrassment, anxiety or depression. Although notions and preconceptions of masculinity remain similar across societies, subtle differences in the context of patriarchal hierarchy may further contribute to stress and stigma. Similarly, female gender roles may determine who the primary patient is. Anecdotal evidence suggests that South Asian women in the UK with sexual dysfunctions are likely to be referred by gynaecologists for failure to conceive. In addition, women may not wish to discuss sexual matters openly especially with a male therapist. It is sometimes seen that the male does not wish his wife or partner to discuss intimate matters (which may be seen to reflect badly on him) to outsiders even in therapy (de Silva, 1982; Gillan, 1987). This is likely to change in the early part of the twenty-first century. The therapist has to be sensitive to gender-related issues and take appropriate actions, e.g. using a co-therapist to balance the gender issue and to allow a safe environment for discussions and exploration of sexual and relationship matters. The therapist should reach a robust therapeutic formulation, which will provide the basis for appropriate and successful intervention. To reach such a robust therapeutic formulation, information is needed on predisposing, precipitation and perpetuating factors. Cultural factors will play an important role in all of these and ignoring these facts may lead to an inaccurate and misleading formulation.

Therapeutic techniques used for psychosexual dysfunction must be appropriate. Treatment methods evolved in one culture need to be modified for application in another cultural setting. The use of suitably modified approaches among Bangladeshis in the UK and Bengalis in India has been shown to be successful by d'Ardenne (1986) and Gupta *et al.* (1989), respectively. Bourne (1985) notes that traditional healers may do better with some types of individuals because they may have more time and patience to listen, which may be core to their therapeutic efficiency in contrast with general practitioners or others. In the intimate area of sex, patient listening and spending time with the patient appear to be important factors, which enhance the patient's trust in the therapist, which in turn will improve compliance with the therapeutic instructions. The acceptability of these instructions by the patient is a vital part of the therapeutic interaction. Gillan (1987) noted the difficulties that couples from some non-Western cultures may experience in carrying out some aspects of Masters and Johnson's (1970) type of intervention. As mentioned above, certain expectations and inhibitions may create problems. For example, in some cultures, encouraging the female to take the initiative may well be a major disincentive. If there are cultural inhibitions to any part of the treatment package, suitable modifications must be made along with encouragement to the couple to overcome their hesitations.

The myths and taboos, especially in the field of sex, have a very strong presence and may well be further complicated by a lack of proper knowledge; therapy packages must include components of education. When attitude change is considered to be important, cognitive techniques may be indicated (Baker and de Silva, 1988). We shall illustrate some of these issues by presenting some data from different parts of the world.

The Indian Subcontinent

There are reasonable data on management and outcome of sexual dysfunction in the Indian Subcontinent. Bagadia *et al.* (1959) noted that, in their sample, ignorance of sexual matters, superstition, fear and guilt played an important role. Using group approaches they reported that 50%–60% of their patients improved remarkably. In a case note-based study Singh (1985) reported on 96 patients and found that masturbation was seen as an important and common cause of sexual dysfunction, and a large majority of cases had improved with education and supportive psychotherapy with physical treatment such as minor tranquillisers. It is difficult to disentangle from this data, which component of intervention produced the improvement. When Bagadia *et al.* (1972) studied 258 males attending their clinic, they found that 87 had presented with nocturnal emissions, 32 with masturbation, 91 with passage of semen in the urine, 32 with watery semen and 33 were preoccupied with the size and the shape of their penis. These complaints were accompanied by vague aches and pains, weakness, palpitations, poor appetite, poor concentration and irritability. Their concepts of semen, nocturnal emissions and masturbation were incorrect and contrasted with socially imposed values of abstinence. Thus, for young adults who have masturbated and get married at an early age with pressure to procreate, it produces not only conflict but anxiety, tension, guilt and shame. The sex act may be seen as pleasurable, but pressure to procreate becomes anxiety provoking. This ambivalence therefore puts pressure on the male to prove his manliness by procreating soon after marriage. The pressure on the newly married female is even worse and she may respond with irritation, withdrawal, anorgasmia and dyspareunia.

Agarwal (1970) treated 11 married males who had presented with premature ejaculation and found that, if the therapist contradicted their views on the role of semen, the therapeutic relationship did not work. He would use comments like, 'maybe energy is lost in emission, but the body has got a self-regulatory mechanism which recoups this loss quickly' and found that this seemed to work. The need for physical treatment and explanation cannot be underestimated. A lack of acceptance of behaviour therapy among Hindus in India (Kuruvilla 1984) and among south Asians in the UK (Bhugra and Cordle 1986, 1988) led to high dropout rates from both centres. In a case note-based study over an 8-year period, Bhugra and Cordle (1986) found 32 patients of south Asian origin of whom 14 (44%) dropped out at some point before completion of treatment. The symptoms had been present much longer in men (longer than five years) in comparison with women. Of the 14, four dropped out because their partner had returned to India or had gone on a long holiday. Christopher (1982) noted that, among non-Western couples presenting to her clinic, Indian men were more likely to present at an average older age and three out of four Asian women were referred because of premature ejaculation of their husbands. She noted that Asians missed more appointments, did not inform the clinic of their intended absence and dropped out more often. However, d'Ardenne (1986, 1988, 1991) and d'Ardenne and Crown (1986) present a more optimistic picture for treating Bangladeshi couples. She used drawings and pictures for educating them and involved other members of the family and took a more authoritarian role in therapy.

Gupta *et al.* (1989) reported success in 76% of their male sample presenting with erectile dysfunction and premature ejaculation. In addition to relaxation, they used sensate focus and education and encouraged patients to keep a diary. In the second stage of sensate focus they were given psychoanalytic interpretations. They note that themes of parental dominance and fears of damaging the male organ during sexual intercourse were common. They observe that, where abstinence is glorified as a precondition to the salvation of the spirit, carnal pleasure must be at a discount and marital sex becomes a duty rather than a pleasure. Hindu ideals of purity and contamination may further complicate explanations.

In Sri Lanka, in several studies, de Silva (1982), de Silva and Samarasinghe (1985) and Rodrigo (1992) found that males who presented to their clinics believed very strongly that their problems were due to physical causes, especially loss of semen, and they sought physical treatments. They also showed poor response to behavioural therapy and were reluctant to bring their partners. In addition, lack of privacy and shortage of space made carrying out of home assignments very difficult. These researchers overcame some of the problems by recruiting female therapists, using medication and public education.

Among females, sex may be seen as a chore or gift rather than a right and their own attitudes may be ambivalent. Ambivalent attitudes were seen among the female in a clinic sample with 25% females reporting in-law problems, and those who had married against their parental choice were under greater stress (Agarwal, 1977), although the numbers are small.

Some common themes of male role, female gender role and gender-role expectations, search for physical causes and physical treatments and difficulties in therapeutic engagement emerge from the Indian Subcontinent sample.

The Middle East

Although limited information is available from the Middle East, studies indicate that there are similarities across two populations. Of 70 cases of sexual dysfunction reported from Jordan, only six came with their partners, but the therapist gave recorded information on audiotape for the absent partners and in general outcome was poor (Takriti, 1987). Takriti also reported that tremendous pressure for quick improvement, poor education and low social class were additional factors. A very high level of performance anxiety was noted in that, in one case, a young man developed panic when approaching his nude wife. This intense anxiety leads to avoidance but social and familial pressures to deflower the bride and consummate the marriage puts additional pressure on the male. Basoglu *et al.* (1986) allocated 86 Turkish males with sexual dysfunction to psychotherapy or drug treatment and found that low socio-economic status, erectile failure, shorter duration and higher levels of dysfunction were associated with premature termination of psychotherapy. Demerdash and colleagues (1977, 1978) have identified various factors contributing to sexual dysfunction and their psychosocial correlates, which are not dissimilar to the factors elsewhere.

Cognitive and behavioural therapies

Cognitive therapy offers a potentially useful intervention provided the normative data from the population on cognitions is available and understood by the therapists. Techniques used in cognitive therapy to explore and verify assumptions, which lead to generating alternative explanations, solutions and strategies, are potentially very attractive. For example, the cognitive triad of depression as described and used in the West is not directly applicable across cultures as the definitions of the self differ across cultures. However, it should be relatively straightforward to explore cognitions and work with them. Cognitive behavioural and cognitive analytic therapies can be easily used across cultures.

Although behavioural therapies focus on objections and observable behaviour, cultures do play a significant role in identifying what is normal behaviour and how behaviour is modified. Attempts to use social skills assessment, assertiveness training, dating behaviour and attitudes to sexual education are all areas that can be potentially problematic and produce discord between the patient and the therapist. Any attempts to modify sexual behaviour in the therapist's direction may be deeply offensive or threatening to the patient, and the therapist may risk being offended by culturally determined sexual stereotypes which may contrast with his/her own beliefs (McCarthy, 1988). Under the circumstances, a careful preliminary negotiation of treatment targets and working within the same set of expectations may work better.

Physical therapies

From availability of intracavernosal injections to external devices such as vacuum pumps and surgical interventions such as implants and revascularisations to oral medication such as Yohimbine, Sildenafil, Tadaelafil, various physical therapies have been used. However, virtually no data are available on their usage elsewhere in other cultures. It is imperative that therapists are aware of specific cultural issues related to pharmacodynamics and pharmacokinetics (see Bhugra and Bhui, 1999; and Lin and colleagues in this volume, see Chapter 30). Physical treatments of erectile dysfunction may place too much emphasis on erection, thereby equating it with sexual intercourse. Physical treatments must be offered only after detailed discussion and proper and thorough assessment of the patient and the couple.

The aetiology and management of sexual dysfunction is a complex matter; the clinician must place both these into the context of the patient's and his/her partner's culture and any outcomes also should take these crucial factors into account.

It is possible that, prior to commencing any treatment, the therapist and the patient can agree on a set of ground rules and agreed outcomes. 'Cultural demand for effectiveness of sexual performance' as identified by Masters and Johnson (1970) to focus on erections being sufficient for intercourse is a clear indication regarding the role social factors play in seeking, providing and accepting treatments. A combination of physical and psychological therapies may prove to be successful and effective (Kaplan, 1993).

Conclusions

The challenge for any therapist in dealing with patients with sexual dysfunction is to be aware of the potential pitfalls and to understand the problem in all its cultural complexity. Even if such an understanding is not possible, a clear nod to the patient to state that would be helpful. In discussion with the patients and other significant individuals from that culture and community, it should be possible to gather enough information on cultural aspects of sexual dysfunction. It requires a willingness on the part of the therapist to acknowledge lacunae in his/her knowledge of cultural factors and an element of sensitivity in exploring these is necessary. It also requires ingenuity, as illustrated above, by combining different modalities of treatment from using audiotapes for educating the partner to broader public education. The therapist has to show a willingness to be flexible in applying therapeutic modalities.

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Refugees and mental health

Nasir Warfa and Kamaldeep Bhui

EDITORS' INTRODUCTION

The number of individuals being pushed out of their countries on the basis of their religion or political persecution has increased dramatically in the last couple of decades. With changes in immigration laws across several West European countries, the rules have become tighter and countries less welcoming of refugees as well as of migrants. The trauma of separation and cultural differences in the new settings contribute to stress. Other factors, such as religion, language and poor housing, combined with unemployment, make individuals even more isolated. Psychological distress will be influenced by pre-existing experiences and personality traits. Torture and physical violence may add to vulnerability. In addition to persecution, refugees and asylum seekers have to deal with a series of losses, only some of which are material. Loss of status and emotional loss related to social networks, family and friends add to the stress. Feeling unwelcome in the new country further contributes to poor self-regard and a sense of alienation. This sense of alienation, along with previous experiences of persecution, makes the individual vulnerable.

In this chapter, Warfa and Bhui suggest that depression, suicidality and post-traumatic stress disorder are leading psychiatric morbidities in this population. On the other hand, it has been argued that the impact of trauma should not be medicalized and understood in the context of their cultural experiences. The protective factors against developing depression include employment, personal and social networks and resources. There is little doubt that discrimination and racism may further contribute to external stressors. These insidious and sometimes overt actions may break the individual's resilience and, combined with denying access to health and social care, may lead to psychiatric disorders. The role of the mental-health professional under these circumstances is to try and understand the context without overtly medicalizing human experiences. Religious leaders and community leaders can offer definitions of what is normal. Common risk factors for psychological distress include past experiences as well as coping strategies the individuals may have found to be successful in the past.

Introduction

There has been a rapid increase in the number of people seeking refuge in the world and this has led to an equally rapid interest in understanding their health and social care needs. Once in their country of asylum, refugees receive a variable reception and access to integration programmes. For some refugees, seeking refuge in a new country with new social contracts, customs and cultures may prove all too stressful, particularly if arrival in the host country is followed by limited plans to settle into the new environment (Warfa *et al.*, 2006). Although the experience of complex life circumstances can be stressful for all people, regardless of their background, the situation of unsettled refugees is complicated by additional social problems that other vulnerable groups do not share. For example, many refugees who have language and communication barriers live in social isolations while others will have difficulty coming to terms with past experiences of tragic life events and the separation from their homeland.

In 2005 alone, they were 20.8 million people who were of concern to UNHCR and 40% of this

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population of concern were refugees (UNHCR, 2006). Afghans (2.9 million persons), Colombians (2.5 million persons), Iraqis (1.8 million persons), Sudanese (1.6 million persons) and Somalis (839 000 persons) accounted for the majority of the people who became of concern to UNHCR towards the end of 2005 (UNHCR, 2006). According to UNHCR, 396 400 asylum seekers applied for refugee status in Europe and other developed countries in 2004 (UNHCR, 2005). Between 2000 and 2004, UNHCR estimated that the United States received the largest number of asylum seekers (411 700) and was followed by the UK, which received 393 800 asylum seekers. The majority of these refugees have fled from either war-torn countries such as Somalia, Afghanistan, Vietnam, former Yugoslavia, Iraq and Sri Lanka (UNHCR, 2006). In the UK, the annual number of people who are seeking refuge grew from just 57 000 in 1988 to over 9 79 000 in 2000 (Home Office, 2003). Over the same period, the number of quota refugees going to live in the United States reached approximately 100 000 per year (Newbold, 2002). Quota refugees are those refugees who seek and are granted formal legal status through refugee resettlement programmes.

Who is a refugee?

An ‘asylum seeker’ is a person who has applied for asylum in another country and whose asylum application is still under consideration by the relevant authorities. An asylum seeker becomes a refugee if he or she is granted refugee status by the host country. Almost all refugees are primarily asylum seekers unless they are admitted to the host countries through refugee resettlement programs. Refugee status is normally granted on the basis of fulfilling the 1951 United Nations Convention on the Status of Refugees and the following 1967 Protocol. Within the 1951 Convention, ‘refugee’ is defined as:

> a person who owing to well founded fear of being persecuted for reasons of race, religion, nationality, memberships of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence . . . is unable, or owing to such fear, is unwilling to return to it . . . (UNHCR, 2000)

Almost all countries are among the signatory nations of both the 1951 Convention and the 1967 Protocol related to the Status of Refugees. This means that an asylum seeker who meets the UNHCR criteria is recognised as a refugee, with the same legal, social, education and other welfare rights as that of the host citizen. Such rights are protected by UNHCR. Of the 20.8 million population who were of concern to UNHCR in 2005, 8.4 million were recognised as refugees and therefore granted protection under the 1951 Convention and/or its 1967 Protocol (UNHCR, 2006). In some countries, exceptional leave is granted to persons who do not meet the criteria in the 1951 Geneva Convention but, nevertheless, cannot be returned on humanitarian grounds to their countries. In such countries, applicants who are given exceptional leave to remain (ELR) in the host nations are also entitled to welfare benefits, education, and social-services support. Recently, European countries, like the UK, have introduced an asylum policy in which failed ‘asylum seekers’ would be denied access to basic resources, with adverse social and psychological implications (Refugee Council 2004, 2005).

Mental health of refugees

An increasing body of research into refugee mental health is focusing on the mental-health consequences of pre-migration traumatic life events and post-migration social problems. Refugees experience a good deal of insecurity and change in their circumstances brought by internal and external factors (see Appendix A). Some refugees escape persecution and others flee after long periods of torture and degradation, often during an experience of war and conflict. Ager (1993) reviewed the mental-health issues

Appendix A

Common pre-migration traumatic experiences of refugees	Common risk factors for psychological distress among refugees
• War and deliberate killings • Genocide • Murder of family members/friends/relatives • Witnessing the murder of family members/friends • Prolonged mental and physical torture • Rape of women and young girls • Kidnap of children and women • Long imprisonment and forced labour • Cruel amputations • Food shortage/starvation • Lack of water • Looting and daily robbery • Destruction of personal properties • Destruction of public infrastructures	• Past experiences of traumatic events • Pre-migration health problems • Lack of accommodation/overcrowding • Isolation/loneliness • Lack of supportive social networks • Lack of supportive friends • Family separation • Unemployment status • Lack of access to education • Language problems • Barriers to culturally appropriate health and social services. • Legal uncertainties • Cultural shock and adjustment problems • Substance misuse • Experiences of racism and discrimination • Abject poverty

of refugee populations and identified three distinct phases during which refugee can develop mental disorder. According to Ager (1993), refugees experience severe economic hardships and traumatic life events including family fragmentation, the disruption of civil society, social and political upheavals, torture, repression and persecution in their home country. Although less documented, some of the economic hardships, political and social disruptions refugee groups go through during phase one can affect their psychological equilibrium. In the second phase, separation from homeland is considered a major source for psychological distress among refugees and it is during this flight stage when certain refugees, such as women and young girls, experience further violence including sexual torture, rape and the disappearances of relatives and friends. Phase three alludes to the social and psychological status of refugees once they have arrived in a host country. When refugees come to a safe destination, they reflect on their previous life circumstances, both before their ordeal started and during the traumatic experiences. Some will start searching for news about their loved ones while others will have difficulty coming to terms with cultural shocks, separation from homeland and the loss of community and social networks. This emotional phase is not helped by the experience of unexpected life stressors that are the consequence of their new environment. Such stressors include homelessness, hunger and poverty, adjustment problems, language barriers, fear of deportation, legal uncertainties, loneliness, racism and discrimination, unemployment status and acculturation problems (e.g. for review see Ager, 1993).

A significant number of studies have examined and explored the mental-health consequences of pre-migration traumatic events and post-migration life stressors over the last 10 years or so. These studies found that refugee populations have a wide range of social problems, have higher levels of unmet need and significant levels of mental-health problems including depression, panic attacks, social phobia, general anxiety, suicidal ideation and post-traumatic stress disorder (McCrone *et al.*, 2005; Warfa & Bhui, 2003). Of these, depression, suicidality and PTSD are the most focused psychological problems among refugee populations across the world (the diagnostic criteria for PTSD in ICI-10 are described in Appendix B).

Appendix B

Post-traumatic stress disorder: ICD-10 criteria

B. Persistent remembering or reliving of the event as flashbacks, vivid memories, recurrent dreams, or experiencing distress when exposed to reminders

C. Actual or preferred avoidance of reminders of the stressor, and such behaviour was not present before

D. Either of the following

1. Poor recall for events at time of stressor
2. Persistent symptoms of increased psychological sensitivity and physiological arousal demonstrated by – insomnia, irritability and outbursts of anger, poor concentration, hyper-vigilance, exaggerated startle response

Note: Criteria BCD must be met within 6 months of stressor

Depression and PTSD

Several epidemiological studies (Westermeyer 1989; Mollica *et al.*, 1993, 1998, 2001; Cardozo *et al.*, 2000; de Jong *et al.*, 2001; Lie 2002; Steel *et al.*, 2002; Silove *et al.*, 1988, 2000; Rousseau *et al.*, 2003; Bhui *et al.*, 2003, 2006, to mention a few) found depression and PTSD as the leading psychiatric morbidity among refugees. Mollica and his colleagues carried out a series of epidemiological studies with refugee populations in different countries often investigating the mental health consequences of mass violence. For instance, they investigated the mental-health consequence of mass violence among 534 adult Bosnian refugees who were living in a refugee camp in Croatia and found that 43% and 23% of the participants who were diagnosed with depression and PTSD in Time1 also continued to meet the DSM-IV criteria for PTSD and depression in Time 2 (Mollica *et al.*, 2001). The findings of this longitudinal study suggested that those who experienced mass violence, ethnic conflict and traumatic events were more vulnerable to psychosomatic symptoms, PTSD and depression. Likewise, de Jong *et al.*, (2001) estimated the prevalence rates of PTSD in four developing countries, using the CID-10 criteria for PTSD. According to de Jong et al, the prevalence rates of PTSD were 37.4% in Algeria, 28.4% in Cambodia, 15.8% in Ethiopia, and 17% in Gaza, coming to the conclusion that conflict related trauma, torture, psychiatric history, current illness, death or separations in the family and alcohol abuse were risk factors for PTSD. Similarly, Bhui *et al.*, (2003) measured the association between pre-migration traumatic experiences and mental-health problems of a community sample of 180 Somalis in London, UK. They found that majority of the research participants fled Somalia because of risk to own life (86% of men and 96% of women), risk to family life (62% of men and 61% of women), oppression on the basis of race, religion or politics (23% of men and 7% of women), war (88% of men and 96% of women) and clan rivalry and ethnic cleansing (6% of men and 3% of women). Bhui *et al.* (2003) reported that common experience of traumatic events such as serious injuries, being lost in a war situation, being close to death and suffering, and post-migration social problems of unemployment, language problems and psychoactive substance use (*khat*) were related to the prevalence of PTSD, anxiety, depression and suicidal ideas among this sample of Somali refugees. In another cross sectional survey of 512 Oromos and 622 Somalis in Minneapolis, USA, Jaranson *et al.* (2004) examined the relationship between traumatic events and physical and psychiatric disorders. They found that 44% of the 1134 participants met criteria for torture exposure. Of the 40% survivors, 10% reported experiencing only physical or psychological problems, while the other 90% reported experiences of both. They showed that those who were exposed to and survived traumatic life events had much higher rates of Post-Traumatic Stress Disorder than those who did not experience such events (25% compared to 4%) and that a higher number of traumatic events were positively associated with scores on all problem scales. Torture exposure was also associated with a greater number of psychological and physical problems but not with social problems. The results of these epidemiological studies suggest that PTSD, depression and panic disorders are common among the refugee populations who were exposed to mass violence and torture.

Nevertheless, the significant levels of common mental problems, such as PTSD, often found among refugee populations were questioned from several sources. For example, Zarowsky (2000, 2004) described ethnographic cases in which Somali-Ethiopians who were exposed to extreme traumatic events showed no individual sadness or fear but a collective community anger. According to Zarowsky (2000, 2004), the impact of trauma and violence on Somalis is not explored in the domain of psychological medicine but within the realm of the Somali culture and politics. Zarowsky's ethnographic research suggested that a Somali person's experience of traumatic events is discussed and dealt with by the tortured person's own community or tribe. In this instance, the exposure of violence to individual Somalis is considered as an exposure of violence to the tribe from which the victim of violence is originated. Individual anger and grievance would then become collective community anger and grievance in that all the members of the tribe would collectively respond to these traumatic events through political discussions and community activities. Zarowsky (2000, 2004) therefore proposed that the current medical approaches to psychological distress among some refugee groups are limited. Instead, she suggested that helping individual refugees and communities to deal with psychological distress by helping them to reconstruct their lives collectively is more appropriate and culturally relevant intervention. In spite of these criticisms, the results of the reviewed epidemiological studies suggested that a notable number of refugees who were exposed to trauma before their arrival in the host countries do go on to develop significant mental-health problems and that the psychosocial needs of refugees and victims of torture and mass violence ought to be recognised.

Aside from traumatic life events, depression is linked with other risk factors. Depression does not only affect refugees but also it affects millions of people throughout the world every year. In the UK alone, at any one point in time, 1 in 6 people suffers from depression (DoH, 1998). In addition, the UK Department of Health statistics proposed that 4000 people with depression conditions commit suicide each year, even though the number of patients with severe depression is less than 1% and that most of those 4000 persons who commit suicide each year are under the age of 35 (DoH 1998; Maharaj & O'Sullivan 2000). Depression is triggered off by a wide range of risk factors including unemployment status. With this in mind, employment surveys conducted by community and refugee organisations and local government authorities have all reported high levels of unemployment rates, often more than 70%, among refugee groups (Block, 2002; Carey-Wood *et al.*, 1995). Some of these employment surveys reported that a sizeable number of refugees were still unemployed years after they arrived in Europe (ICAR, 2005). Can the significant levels of depression often reported among refugee groups be partly explained by their experiences of unemployment? Beiser (1999) examined the associations between social problems and the onset of mental-health problems among refugee populations in Canada. He found that refugees who were in employment were less likely to suffer from psychiatric disorders, compared with refugees who had no jobs. Beiser's model of post-migration risk factors for the mental health of refugees shows a complex web of associations between, on the one hand, personal resources, social resources, economic circumstances, discrimination and, on the other hand, the mental-health problems of refugees. According to Beiser & Hou (2002), the ability of Southeast Asian refugees to speak the host nation's language had no effect on employment and depression during their early resettlement years, yet it became a major predictor of depression and employment after 10 years of living in Canada. The 10-year longitudinal study found that Southeast Asian refugees who had social and family support and refugees who were fluent in English had fewer mental-health problems than those who lacked social or personal resources. Similar stressors might act upon other refugee populations to precipitate similar patterns of psychological problems. In other words, the findings of this longitudinal study support the thesis that lack of social support, poor language skills, unemployment and poverty are strong predictors of psychiatric disorders among refugees.

Discrimination, deterrent policies of immigration & mental health of refugees

Although the literature examining the psychological impact of racism and discrimination on refugees is limited, experiences of racism and discrimination are common among refugee groups. These experiences of racism and discrimination and the rise of discriminatory immigration policies towards asylum seekers and refugees in Europe and Australia were linked with the increasing psychological problems of refugees (Silove *et al.*, 2000). For instance, Watters (2001) reported that the unfair treatment of asylum seekers in the UK might have weakened their resilient nature to control or cope with the experience of maladjustment and extreme social adversity, with an associated risk to mental health. The British Refugee Council has been documenting the impact of consecutive British Immigration and Asylum policies on asylum seekers and refugees. In 2003, they carried out research that examined the social and health consequence of Section 55 of the Immigration and Asylum Act. Under this Section, in-country single asylum applicants would not qualify for support services unless they have applied for asylum at the point of entry. The Refugee Council's (2004) findings support the thesis that hostile and discriminatory immigration policies have a detrimental impact on mental well-being among asylum seekers and refugees. Almost 56.8% of the refugee and other voluntary organisations taking part in this Refugee Council survey stated that they assisted asylum seekers who were forced to live in squalid conditions. Of these organisations 65.9% also stated that they served asylum seekers who became ill due to poverty and destitution caused by Section 55 (Refugee Council, 2004). Also, 68.9% reported that they saw asylum seekers who developed psychiatric disorders as a direct consequence of being denied access to basic public resources under Section 55. According to the Refugee Council (2004, 2005), refugees and asylum seekers in UK have faced social exclusion and material deprivation because of the UK's immigration policies and that this is causing a great deal of psychological distress among the new comers.

What can mental-health professionals do to help refugees with mental problems?

As we have described above, refugee groups share multiple risk factors for poor mental health including pre-migration traumatic life events and post-migration social problems. These risk factors were linked with the common mental-health problems found among refugee populations. Most of the common mental-health problems of refugees are potentially treatable using psychotropic drugs and psychological treatments, specifically cognitive behaviour therapy (Warfa & Bhui, 2003). However, these interventions are complicated by language differences and conceptual differences for understanding their experiences as a form of psychological distress (Bhui *et al.*, 2003). For most refugee groups, the demarcation line between sanity and insanity is not clear in that one would either be labelled 'mad' or 'not mad'. In such world cultures, although 'madness' itself is often considered as a serious mental disorder worthy of seeking modern medical treatments, little attention is paid to other forms of mental-health problems. If depression or PTSD is equated with *madness*, and if the diagnosis of madness in some cultures result in social exclusion and stigmatisation, then mental-illness stigma and avoidance could explain the higher prevalence rates of mental disorders often reported in refugee populations. To this end, language, conceptual and cultural differences complicate the mental-healthcare needs of refugees, as highlighted by the following two vignettes (Table 38.1, 38.2):

What further issues would you need to consider in the mental-state assessment of both patients? What are the potential risk factors that could complicate the psychological well-being of the patients?

Table 38.1.

Haille is a 27-year-old from Ethiopia. He has been in the UK for about 2 years. He is currently unemployed and was evicted from his hostel for recurrent fights with other residents. During an initial medical assessment, he stated that he is fine both physically and mentally, although he seemed to have paranoid symptoms. Recently, he has contemplated committing suicide but not in the last few days, particularly since he started chewing *khat* on a daily basis.

Table 38.2.

Sanab is 25 years old from Iran. Over a period of 5 years, she was infrequently detained. During her detention, she was tortured for her political activities. A refugee outreach worker who was worried about her well-being referred her to a local GP. She mentioned to her GP that she is fine, apart from getting some physical pains and feelings of exhaustion. However, the GP thought a psychiatrist ought to see Sanab and so she was referred to your clinic. From a treatment point of view, what would have suggested for Sanab?

Clearly, both patients are emotionally and physically very vulnerable and many social problems are involved in the patients' healthcare needs, all of which warrant urgent attention. Neither Haille nor Sanab have used language or concepts that formulate mental distress as a health problem worthy of seeking treatment from health-care agencies. In such cases, prescribing cognitive-behavioural or pharmacological treatments alone to refugee patients presenting with psychosomatic symptoms and complex social problems including loneliness, immigration, housing, legal issues and substance misuse would be of limited value. This demands a holistic approach to the problem. More than this, if public services give less attention to the complex health and social care needs of refugees, they may hinder the engagement of vulnerable patients in a system that provides adequate care, particular since these vulnerable refugees with mental-health problems may have already experienced numerous system failures (Warfa & Bhui, 2003; Watters & Ingleby, 2004). Crucial to a holistic approach is education, health promotion, and support to negotiate multiple barriers that a native speaker might take for granted. If a psychological treatment were considered, then such an intervention would be more successful were it to be delivered through culturally appropriate clinical settings. Mental-health professionals should also work together more closely and in partnership with community and refugee groups. Refugees with severe mental disorders would require more psychosocial treatment using practical solutions, including medication, but not to the exclusion of social and culturally appropriate psychological interventions (Warfa & Bhui, 2003; Warfa *et al.*, 2006). Employment and educational activities in particular would allow individual refugees with mental-health problems to develop a sense of mastery over their shattered world. This strengthens the call for psycho-educational interventions that allow for culturally determined ways of talking about psychological problems which would reduce the reluctance to seek treatment from mental-health services, and thus the overall prevalence rates of mental-health problems among refugee populations.

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Working with elderly persons across cultures

Carl I. Cohen and Iqbal Ahmed

EDITORS' INTRODUCTION

As the number of people living longer increases around the world, the likelihood of developing conditions such as dementias also increases. The cultural concepts of dementia as normal ageing make it less likely that individuals or their carers will seek help from services. With longevity comes physical frailty and an associated increase in mental illness. Shah and Mackenzie have discussed epidemiological findings in an earlier chapter in this volume.

Cohen and Ahmed focus here on working with elderly people across cultures. They point out that there are a variety of ways in which ageing can be defined from the biological, psychological and social perspectives. Typically, however, ageing is identified with chronological age. In traditional societies, old age is seen as changes in social or economic role, chronology and changes in physical characteristics. The relationship of events and historical context affects individuals in different ways and the social roles are affected by a number of factors. As women over the age of menopause are becoming pregnant in the West, their experiences of ageing are going to be remarkably different from their cohort. There is a variety of ways in which culture may affect the development and course of psychiatric conditions in older persons – direct or indirect effects of the ecosystem and lifestyle patterns and unhealthy living. Social forces such as globalization and urbanization will affect physical and mental health. Lastly, Cohen and Ahmed indicate the fostering of certain personality patterns that may become dysfunctional in later life. Managing mental illness in the elderly involves issues of assessment which will be culturally influenced. The differences in pharmacokinetics and pharmacodynamics across cultures and different psychotherapy approaches will further contribute to issues related to planning management strategies. Family as the critical intervention point, and judicious development of formal systems to supplement informal care are crucial factors.

Introduction

There are compelling reasons to examine transcultural issues among older adults. The number of aged persons in the global population will double from 500 million in 1990 to one billion in 2025 (Desjarlais *et al.*, 1995). Moreover, in 2025, 72% of persons age 60 and over will be living in developing societies (Levkoff *et al.*, 1995). However, even within developed nations there will be marked demographic shifts. For example, in the United States, the proportion of elderly persons who are non-Caucasian will rise from approximately 10% to 20% in 2050 (Markson, 2003). Ethnic elders age 85 and over are the fastest growing segment of the American population (Baker & Lightfoot, 1993). Subedi and colleagues (2004) observed that we know surprisingly little about the true prevalence of mental illness among older adults in developing countries, and even within developed nations there are large gaps in our knowledge concerning the aetiology and epidemiology of mental disorders. In this chapter, we will present an overview of the key concepts that are critical to understanding transcultural issues in the mental health of ageing individuals. We will not undertake an in-depth review of general conceptual and methodological issues that will be covered in other chapters in this volume. Rather, we have

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endeavoured to focus primarily on the interplay of ageing, culture, and psychiatry.

Basic concepts

'Transcultural' or 'cross-cultural' psychiatry addresses issues that are cross-national as well as within national borders. Culture and ethnicity are often used interchangeably, although most of the ageing literature on transcultural psychiatry deals with ethnic differences. Culture refers to a system of values, beliefs and learned behaviours shared across whole populations, whereas ethnicity refers to a group identification based on a common cultural heritage, including beliefs, customs, place of origin, religion, diet, language, dress, self-concept, normative expectations. Neither culture nor ethnicity is a fixed trait. Rather, they are fluid processes that interact with a variety of social factors such as modernization, immigration, assimilation, minority issues, socioeconomic status, gender, and period-cohort and intergenerational issues (Ahmed, 1997).

There is a variety of ways to define ageing: from the biological, psychological, and social perspectives (Ahmed, 1997). Typically, we identify ageing with chronological age. In Western societies, age 65 is used commonly as the cut-off for old age. However, this cut-off has been lowered to some extent based on declining legal ages of retirement. Age 60 has also been used in world demographic data on ageing (United Nations, 2002). A review by Glascock and Feinman (1981) found that, in non-Western traditional societies, there are three ways to identify old age. Change in social or economic role, chronology and change in physical characteristics. Changes in social and economic roles had been the most common way to demarcate old age. However, most societies have multiple definitions of old age that adds complexity and some ambiguity to any categorization. Biological ageing cannot be precisely defined. However, based on markers of disease, disability and functional decline, Hazzard (2001) defined true old age as 'above 75 years'. Dramatic demographic changes occurring worldwide have resulted in many societies having to redefine old age. For example, in many Western societies, persons are taking longer to reach various adult life stages (e.g. marriage, parenthood) and longer to die.

'Life course' is another important concept for understanding ageing in diverse cultures. Life course refers to a sequence of age-graded events and social roles that are embedded in social structure, culture and historical change (Elder, 2001). Much of what is considered age effects in individuals and groups may not be related to the ageing process, but rather to the experiences of the cohort group they belong to. Individual trajectories interact with socio-cultural processes. In societies undergoing rapid change, historical effects may take the form of a cohort effect so that social change distinguishes the life experiences of successive cohorts (Elder, 2001). Thus, coming of age in a time of prosperity will have a different effect on a life trajectory than coming of age during a depression. Cohort effects may impact on all persons in a society or it may impact on certain ethnic subgroups. Each ethnic group has unique historical experiences. For example, Baker and Lightfoot (1993) describe how various events of the twentieth century, e.g., northern migration from the South, the Klu Klux Klan, the Great Depression, the desegregation of the military in the Korean war, the Civil Rights movement, had a differential effect on African-Americans born in the first quarter of the twentieth century vs. those born later in the century. Levkoff and colleagues (1995), in discussing the potential cumulative psychological impact of social change and upheaval cite the example of elderly Chinese who have lived through the imperial era, the warlord years, the occupation by the Japanese during World War II, the Communist revolution, the Great Leap forward and the ensuing famine, the Cultural Revolution and the opening of economy and market reform.

Another important aspect to the life course perspective concerns the variations in social roles by age, e.g. parenting, grandparenting, retirement, and so forth. However, the timing of these social roles is influenced by the interplay of historical events (i.e. cohort effects). Baker and Lightfoot (1993) contend that historical experience and cultural context can have appreciable influence on elders' definitions of medical and psychiatric illness, their expectation of the healthcare delivery system, the time at which a decision is made to enter the treatment system and the persons and/or systems from which treatment is sought.

Finally, the 'survivor' effects must also be considered when comparing older persons in different groups. For example, although all older persons are survivors, there is considerable difference between the 75-year-old person in a developed nation, where half the population lives to that age, and a 75-year-old in a developing nation where the life expectancy is age 60. Indeed, the latter individual may have exceptional physical and psychological traits versus his countrymen or versus persons in the developed world. Unfortunately, the impact of survivor effects is rarely acknowledged in comparisons between elderly groups, both cross-nationally and within countries.

Older persons in developed countries

Our understanding of cultural diversity of older immigrant ethnic minority persons within developed nations has become increasingly more rigorous. Several immigration factors may affect adaptation to the host culture. These include age at immigration, historical events leading to immigration, the degree of familiarity with cultural norms, laws, the institutions in the host country, presence of family, cultural and religious institutions from the immigrant's background and how many generations have passed since immigration.

Sakauye (2004) identified four sub-categories of immigrants based on distance from immigration and level of assimilation. Firstly, there are immigrants who have arrived within the past 10 years, often preceded by their children. They commonly have language barriers, experience social isolation, and cultural shock. Their mental-health problems may include adjustment disorders or even post-traumatic stress disorders, and they may be more apt to display culture-bound syndromes. A second group of immigrants are those who have been in the country for a decade or more. Many arrive when they were young adults and their language skills are better. Their mental health concerns typically focus more on social and health-related issues. Among native-born ethnic elders, there are also two categories. One group, poorly assimilated elderly persons, may encounter problems due to language barriers, poverty, fear of the majority group, social stressors, poor health and inadequate health care. They also may present with culture-bound syndromes. A second native-born group consists of those older adults who are generally well assimilated but who still feel the sociocultural impact of prejudice, discrimination, and even overt racism. Such individuals may have problems with self-esteem, difficulties concerning their racial or ethnic identity, or feel socially isolated, depending upon the demographics of their neighbourhood.

Older persons in developing countries

Several writers (Desjarlais *et al.*, 1995; Levkoff *et al.*, 1995; Sokolovsky, 1997) have noted that, while there has been considerable romanticizing of the role of older persons in non-industrial, non-Western societies, a more realistic appraisal of ageing is needed. Thus, it is important to recognize the following.

(1) A single cultural system may provide highly successful solutions for some problems of ageing but do poorly with respect to others.
(2) Not all non-Western, non-industrial cultural systems provide a better milieu for ageing than is found in the West.
(3) Modernization does not invariably result in a diminished quality of life for elders, but can have a positive impact on well-being. Some countries may provide pensions and healthcare resources that enhance the older person's ability to live independently.
(4) A single cultural system may offer vastly different opportunities for successful ageing depending

on class, gender, ethnicity, and rural urban variation.

(5) Security and life quality are enhanced for older persons when cultures promote both community and kin roles for elders.

(6) There are no geriatric utopias where older persons are free of diseases of ageing such as dementia.

(7) Multi-generational families were actually less common in traditional societies because of diminished life expectancy; hence, multi-generational families may be more likely to exist in industrialized nations.

(8) Gerontocracy may reflect economic factors rather than purely cultural ones. Thus, co-residence with other family members may reflect housing shortages, and decreased economic dependence on inheritances may reduce the amount of care that families provide to their older kin. The power and status of elderly people in developing countries often varies, based on the following dichotomies: ill vs. healthy, ancient vs. older, rich vs. poor, male vs. female. In short, there is inter-and intra-societal variability in the care of the aged.

Ageing, culture and psychopathology – general principles

There is a variety of ways in which culture may affect the development and course of psychiatric conditions in older persons. These factors are not mutually exclusive and there is often interplay of these elements. Firstly, there may be the direct physical or biological impact of the ecosystem or of the lifestyle patterns engendered by the culture. For example, older persons may be more vulnerable to air pollution that can impair respiratory capacity and diminish physical vigour. Similarly, cultures that promote smoking or unhealthy diets result in greater health problems as people grow older. It is well established that health problems are associated with increased rates of psychiatric symptoms such as depression and anxiety.

A second way culture influences mental health is through the impact of various social forces on mental well-being. For example, in our discussion of the impact of globalization and urbanization below, we describe how changes in social forces may affect mental health of older adults. A third way in which culture may affect psychiatric symptoms is through the fostering of certain personality patterns that may become dysfunctional in later life. For example, a person may grow up in a culture that allows for a higher level of suspiciousness, but this may be inappropriate should this person later move to a country where this is not acceptable. This is illustrated in a discussion below regarding paranoid ideation, especially in the African-Caribbean population in the United States. Likewise, in Western countries, the so-called Type A personality configuration – the hard-driving, perfectionistic individual – is socially rewarded, although it may lead to cardiovascular disease and unhappiness as the person grows older. Finally, culture may play a role in the recognition, treatment and the consequences of displaying and experiencing psychiatric problems (Estroff, 1981).

Several theories of ageing and psychopathology may be relevant to our understanding this relationship from a transcultural perspective. One such theoretical model is the 'double jeopardy' hypothesis. In Western societies and many transitional societies, the status of older persons is relatively low vs. other age groups; being old and a member of a minority group is a double disadvantage (Dowd and Bengston, 1978). Older women may be subject to triple jeopardy because they are typically accorded lower status than men, and ethnic minority elderly women who are mentally ill may experience a quadruple jeopardy, resulting from the stigma of mental illness.

Another useful theoretical perspective is the 'Acculturation Stress Hypothesis' (Markides *et al.*, 1990). It is postulated that acculturation of younger generations may have a negative impact on the psychological well-being of their parents. For example, the latter may have come from cultures in which younger persons were expected to care for their ageing parents and, if necessary, to live together with them. In their new environment, this may no longer be possible. Ahmed's (1997) review concluded that acculturation stress interacts with age, race, gender discrimination, language barriers, lower socio-economic status and diminished physical and psychological resources. However, Ahmed (1997) further points out that there are also protective factors for ethnic elders. Thus, ethnic identity may compensate for the identity loss that often occurs with ageing. Moreover, intergenerational solidarity and continued family closeness can enhance life satisfaction and decrease levels of depression.

Desjarlais and his co-authors (1995) and Levkoff and colleagues (1995) have identified several ways in which the economic and structural changes of modernization can potentially affect the mental health of elderly persons in developing nations.

(1) *Life expectancy is increasing and fertility rates are declining*. Several consequences of this trend are apparent. Firstly, this will result in more older persons, and consequently an increase in more age-related diseases such as dementia. Secondly, there will also be fewer children to care for their ageing parents. Thirdly, because men whose wives die often remarry, and women live longer and marry men older than themselves, the number of widows will continue to increase. In developing countries, unmarried women are economically vulnerable.

(2) *Economic changes cause the price of agricultural products to decline relative to manufactured goods*. The means that the traditional social structures that guaranteed that elderly persons would be cared for through the inheritance of land and livestock will become attenuated as the latter become less valuable. Consequently, older persons become less valuable, lose respect, and face isolation or even abandonment. The psychiatric consequences might include low self-esteem, worthlessness, depression, suicidality, or substance abuse.

(3) *Rural to urban migration continues to increase*. Although urban living *per se* may not be associated with higher rates of mental disorders, older persons who move to cities or who have grown old there, live frequently in substandard housing without basic sanitation and with the constant threat of eviction. Such a lifestyle increases stress and results in anxiety, depression, substance abuse, and suicidality. Other persons who have migrated to cities in their youth may now return to their villages in later life. They find inadequate care for older persons, feel isolated, and experience low self-esteem.

(4) *Increased education of the young*. This may result in younger persons devaluing their elders along with their customs and traditions. Among the elders, this may decrease feelings of self-worth and result in depression or anxiety.

(5) *Increased education of the elderly persons*. As the ageing population becomes increasingly better educated, they are able to obtain better jobs and more effectively cope with social change. Their increased financial well-being and self-esteem will help buffer against depression and anxiety.

(6) *Per capita income rises and healthcare improves in some countries*. This reduces mortality, especially among men, and consequently results in a smaller proportion of single elderly women, although their absolute number may rise with increased longevity. Thus, it diminishes loneliness and buffers against depression and anxiety.

(7) War and displacement have occurred in many countries as a consequence of ethnic conflicts and factional fighting. Older people are thought to be less psychologically resilient to rapid social changes.

(8) *Identity systems are changing*. There is increasing pull between modernization forces that create multiple belongings, multi-ethnic communities, long-distance networks and flexible identities, and reactions by communities to reassert their ethnic identities. Bhugra and Mastrogianni (2004) note that ethnic identity has a role in individuals' self-esteem and it can affect the social causes and courses of psychiatric disorders. The consequences of the new pluralist context of multicultural societies for individuals'

> psychological well-being are largely unknown. However, it is likely to have a more negative impact on older members of society who will experience an attenuation of their traditional ethnic identity without fully participating in the positive aspects of the new multi-identity community.

Finally, Levkoff and colleagues (1995) theorize that the family support plays a unique role in acting as both a stress-buffering mediator, i.e. acting as a conduit through which the proposed forces outlined above impact on mental health— as well as having a direct effect on mental well-being.

Specific psychiatric disorders

Dementia

Dementia, which is a disorder primarily of older adults, provides an excellent illustration of how culture and ethnic origin interplay with biological forces. Firstly, prevalence rates of dementia vary between countries and within countries among various ethnic groups. For example, Chang *et al.* (1993) reported prevalence rates of dementia ranging from 0.5 per hundred to 10.3 among seven countries. The wide range in dementia prevalence has been attributed to the low number of very old persons in developing countries, genetic and biological risk factors, the stigma of psychiatric disorder so that it goes unreported, and an inability to identify dementia among the population. An exceptionally well-designed study by Hendrie and colleagues (2001) compared the incidence of dementia among African-Americans in Indianapolis with residents of Ibadan, Nigeria. A strength of the study was the uniformity in the instruments, which were constructed for literate and non-literate populations. The overall incidence of dementia was greater among African-Americans (3.2% vs. 1.4%) as well as for Alzheimer's disease alone (2.5% vs. 1.2%).

Secondly, the prevalence rates of the two principal types of dementia, Alzheimer's disease (AD) and vascular dementia (VaD), vary across the world. Thus, AD is more common than VaD in North America and Europe, whereas the obverse is true in Japan and China (Desjarlais *et al.*, 1995). Within the United States, most studies have found a higher prevalence of AD among African-Americans and Latinos than among Caucasians.

Differences in medical conditions have been thought to contribute to these differences. For example, the higher rates of hypertension, hyperlipidemia and diabetes, all of which may be considered risk factors for both AD and VaD, are found more commonly among African-American elders and may explain their higher rates of dementia versus US blacks and Nigerians (Hendrie *et al.*, 2001). This possibility is heightened by the fact that the presence of the e4 allele of APOE, which is a strong genetic risk factor for late onset AD in Caucasians, does not seem to play as a prominent role among African Americans, and it plays essentially no role among Nigerians (Hendrie *et al.*, 2001).

Racial differences have been reported in the types of neuropsychiatric symptoms seen in dementia. For example, Cohen (2000) found higher rates of delusions and hallucinations among black dementia patients, and higher rates of depression among white dementia patients, even after controlling for various sociodemographic and health variables was well as estimated length of illness. However, it is unclear whether these differences represented the impact of biological factors, e.g. genetic or the more subtle effects of higher rates of physical disorders such as diabetes, hypertension, or strokes – or social factors (e.g. time until recognition of illness, poor access to services, lower SES). Pre-morbid traits may also influence these findings. Older Blacks in the community express more paranoid ideation and psychoses than older Whites, whereas older whites tend to have higher levels of depressive symptoms, although the latter finding has varied among various geographical settings (Schoos *et al.*, 2004). However, whatever the cause, it is not uncommon to see racial differences in the prevalence of neuropsychiatric symptoms among persons presenting to dementias clinics.

There are considerable differences in the way dementia is handled among the world's societies.

Desjarlais and co-authors (1995) note that, in some societies, dementia is treated as an understandable and expected part of ageing. Consequently, families may respond to it as they might to other aspects of ageing such as physical illness and disability. Nevertheless, despite the transcultural differences in the interpretation of dementia, it still is an incapacitating illness in its later stages and requires considerable personal care.

The informal care system is the dominant mode for caring for older persons throughout the world, and women generally assume the caregiver role (Desjarlais *et al.*, 1995). Although informal care is the predominant form in developed countries, there has been increasing reliance on formal systems. However, socio-cultural changes, e.g. migration of younger persons to urban areas, lower birthrates and the increase of women in the workforce, in countries such as China, Japan, Sub-Saharan African and parts of India, are resulting in a decline in the family care of elderly persons. Nevertheless, formal care systems in developing nations are woefully inadequate in both the breadth of care and its quality. For example, among 12 million persons in China who are in need of daily assistance, only 0.05% are in institutional care (Desjarlais *et al.*, 1995).

A fairly consistent finding in the North American literature has been the differential impact of caregiving on persons from different ethnic backgrounds. Both African-American and Latino caregivers are less apt than their White counterparts to place a demented relative in a nursing home (Cohen *et al.*, 1998). Moreover, they are more likely to use family networks for additional support and to report less depression and caregiver burden (Dilworth-Anderson *et al.*, 2002). These findings reflect the interplay of socia1, cultural and economic factors. Thus, among the factors that are thought to contribute to Black caregivers' avoidance of formal help-seeking are: shame and family duties preclude seeking such help; caregiving is viewed as rewarding, an act of love and of positive value; formal services may not be seen as culturally sensitive or relevant; situations may be reframed so that outside help is not seen as an option; dementia is seen as part of normal ageing and not requiring help; appraisal of disruptive behaviour is more benign and there is higher self-efficacy in managing problems (Schoos *et al.*, 2004). When depression occurs among caregivers, both White and Black caregivers rarely receive adequate treatment for depression, although Black caregivers are significantly less likely to receive treatment (Sleath *et al.*, 2005).

Depression and suicide

Bhugra and Mastrogianni's (2004) review of trancultural aspects of depression found that there is growing evidence that somatic symptoms are common, presenting features of depression throughout the world. Moreover, there is evidence that older persons are more apt to express depression and anxiety in somatic terms. For example, Bhugra and coworkers (1997) found that Punjabi women participating in a focus group in London recognized the English word 'depression', but the older women used terms such as 'weight on my heart/mind', or 'pressure on the mind'. A more recent study of ethnic elders in London by Lawrence and colleagues (2006) underscored the importance of being sensitive to the 'language of depression' used by different groups, e.g. 'excessive thinking' in South Asians and excessive worrying in Caribbeans. Bhugra and Mastrogianni note that somatization is a concept that reflects the dualism inherent in Western biomedical practice, whereas in most forms of traditional medicine (e.g. Chinese or ayurvedic medicine), there are no sharp distinctions between the mental and the physical. Consequently, persons from traditional cultures may not differentiate among the emotions of anxiety, irritability and depression, since they typically express distress in somatic terms, and their concepts of depression are different from those in the West. For example, Pang's (1998) examination of how elderly Korean immigrants in the United States express depression revealed that they express emotions symbolically or physically. These physical terms are neither bodily nor emotional, but somewhere in-between. Dysphoria was expressed as holistic symptoms ('e.g. melancholy has been absorbed into my body'). These Koreans were not somatizing; rather, they were using metaphors to express emotion. The author observed that these expressions were congruent with Korean traditional medicine, which designates symbolic functions to each body organ, e.g. the lungs are associated with worry, sorrow and low spirit; the kidneys with fear; the liver with anger. Bhugra and Mastrogianni (2004) speculate that, with increased globalization and urbanization, it is likely that these metaphors will change and different idioms of distress will be used. It is probable that there will be an increase in medicalization of depressive symptoms.

Moreover, work by Lawrence and associates (2006) in Britain suggest that, in Western countries, ethnic elders are somewhat more apt than Whites to view depression within a social rather than a more traditional medical model, although the model used by all ethnic groups was more akin to a social than a biological one. There were ethnic differences in the attribution of depression. For example, Caribbeans were more likely to attribute depression to loneliness, whereas South Asians attributed depression to difficult home environments, and Whites focused on lack of support and contact with family.

There are widespread differences in depression rates throughout the world (Weissman *et al*., 1996; The WHO World Mental Health Survey Consortium, 2004) and, although data on rates among elderly persons are sparse, it seems likely that these differences persist among older adults. Like younger persons, older persons subject to higher levels of stressors exhibit higher rates of depression. For example, the high rates of depression found among elders in Sao Paolo, Brazil were attributed to stressors associated with rapid acculturation, poverty, difficult housing conditions, and the inadequate retirement benefits (Blay *et al*., 1991). In addition to the factors that affect younger adults, the high rates and severity of medical disorders among older persons are noteworthy, since physical illness correlates highly with depression. Thus, like older persons in Western countries, rates of depression in primary-care settings in Northern India were found in up to two-fifths and three-fifths of patients (Gupta *et al*., 1991). Moreover, older persons in developing countries often suffer from malnutrition that may mimic or exacerbate symptoms of depression.

The impact of various risk factors for depression may interact with cultural factors. For example, a study conducted comparing older Black and White persons living in New York City found that the two groups responded differently to life stressors (Cohen *et al*., 2005). As stressors increased, Whites were more likely to manifest depressive symptoms. Moreover, there were differences within racial groups in the factors that were associated with depression. For example, among Blacks, there were ten variables associated with depression, including religious beliefs, older age, being female, acute and lifetimes stressors, coping styles, whereas there were only two variables – acute stressors and financial strain – that were associated with depression in Whites. Thus, factors affecting depression are not uniform across ethnic groups but involve the interplay of culture with health and social forces.

Although global migration, especially to Western nations, has increased dramatically in recent years, there is surprisingly little written about the impact of such migration on older adults. Van der Wurff and colleagues (2004) examined the prevalence of clinical depression among Turkish and Moroccan immigrants aged 55 and over living in the Netherlands. They found exceedingly high rates of depression: 34% and 62% among Turkish and Moroccan immigrants, respectively, vs. 15% among native Dutch residents. The authors pointed out that lower income and physical illness also contributed to depression. Thus, the writers concluded that depression risk for immigrants most likely depends on the interplay of ethnicity, social class and health factors.

Suicide rates vary considerably throughout the world. In Western countries suicide rates increase with age, at least until age 75, whereas the trend is more variable in developing countries. Globally, suicide rates among men are greater than women, but there are some notable exceptions, e.g. in China, rates among older women may exceed men (Li & Baker, 1991). Within countries, there are also marked differences in suicide rates (Sakauye, 2004). Suicide rates for African-Americans and Latino-American elders have been lower than Whites, whereas rates among Japanese, Chinese and Korean American elders are comparable to Whites. Sakauye (2004) suggests that the lower rates of suicide found among some older ethnic minorities vs. Whites, despite their poverty or immigrant status, may reflect stronger family ties, the greater importance of elders in the minority family and more powerful cultural or religious attitudes against suicide.

More recently, there has been increased interest in exploring the racial differences in suicidal ideation in older adults. Researchers have separated passive ideation, e.g. wishing one was dead, vs. actual ideation, e.g. thinking of hurting oneself. In a study in New York City, Colemon and Cohen (2005) found that 4.8% of older persons had thoughts about wishing they were dead but only 0.6% actually thought about suicide. There were no Black–White differences in passive or active thoughts, and there were only minimal differences in the factors that predicted active and/or passive suicide, with depressive and anxiety symptoms having among the strongest associations in both racial groups. Similarly, in a study of death ideation (passive suicidal thoughts) and suicide ideation (thoughts and plans to commit suicide) in a primary care population in a multi-site study, Asian and Latino patients had a higher prevalence of death ideation than Whites and Blacks. On the other hand, while Asians had the highest rate of suicide ideation, Latinos and Blacks had the least (Bartels *et al.*, 2002).

Paranoid ideation and psychoses

There is an extensive literature documenting the cultural differences in the diagnostic interpretation of psychotic symptoms. In the United States, African-Americans have been found to have higher rates of psychotic disorders such as schizophrenia (Keith *et al.*, 1991). Most of the research has focused on younger populations or a broad age sample. A small retrospective study by Coleman and Baker (1994) found that misdiagnosis of older African American patients with schizophrenia was common. They identified four factors that contributed to the misdiagnoses: clinician bias, misinterpretation of psychotic symptoms, biased diagnostic instruments and patient–clinician cultural distance.

Because older persons are more apt than younger persons to ascribe to traditional beliefs and superstitions (Yeo *et al.*, 2001), it is likely that the prevalence of paranoid or psychotic ideation would be greater among the former. A recent study in New York City documented the very high levels of paranoid ideation or psychotic symptoms among Blacks aged 55 and over, particularly among persons born in the Caribbean (Cohen *et al.*, 2004). As compared to Whites, the investigators found Blacks were more than twice as likely to experience paranoid ideation: 21% vs. 9%; three times more likely to report psychoses: 7% vs. 2%; and twice as likely to experience either paranoid ideation or psychoses: 24% vs. 10%. These differences were all statistically significant. Within the Black population, there were appreciable, but statistically non-significant, differences in the expression of paranoid ideation or psychoses with symptoms: US-born Blacks, French Caribbeans, and English Caribbeans reporting rates of 18%, 38% and 18%, respectively. Although there was no association of paranoid ideation and/or psychotic symptoms with impaired daily functioning, there was a significant association with depressive symptoms. This suggested that experiencing paranoid ideation and/or psychotic symptoms was not totally benign but may represent a cultural expression of dyphoria, or alternatively, it may lead to depression.

Diagnostic instruments

One of the critical issues affecting the assessment of older adults is the validity of the diagnostic instruments. It was well known that many of the diagnostic scales and instruments have poor sensitivity and specificity across cultural groups. The World Health Organization has attempted to develop diagnostic instruments that are harmonious and consistent with the cultural, linguistic and educational norms of the subject population. However, instruments such as the Composite International Diagnostic Instrument have not been validated sufficiently in older adults, who may present differently. For example, older depressed persons may present with more somatic complaints than younger persons, or have their symptoms attributed to physical disorders.

In studies of older persons living in New York City (Cohen *et al.*, 1998, 2004, 2005), acceptable internal reliability (0.60 or greater) has been demonstrated for many of the instruments used to assess dementia (e.g. MMSE, Dementia Rating Scale), neuropsychiatric symptoms in dementia (e.g. Neuropsychiatric Inventory, BEHAVE-AD), depression (e.g. Geriatric Depression Scale, CES-D) and psychotic symptoms (e.g. SCL-90 paranoid subscale) among US born and Caribbean born Blacks. However, although these test items appear to be highly correlated (i.e. high internal reliability), it doesn't guarantee that the same concepts are being measured across different ethnic groups. That is, the validity, i.e. the extent to which these tests measures what they are intended to measure among ethnic elderly persons, has not been established definitively. Educational level and cultural background bias tests to assess cognitive dysfunction. Tests that screen fund of knowledge, abstraction, reading ability and verbal fluency are especially prone to cultural and educational biases. Some tests such as the Cross-Cultural Neuropsychological Test Battery (CCNB), as well as translated versions of MMSE and the Cognitive Abilities Screening Instrument (CASI), have been used internationally in studies of dementia (Teng and Manley 2005). Some gerontologists have proposed utilizing assessments of instrumental activities of daily living and everyday memory as a means to overcome cultural biases (e.g. the Community Screening Instrument for Dementia), although it is difficult to determine what 'everyday' is for older men and women within each culture (Sakauye, 2004).

Ethnicity and pharmacology

Lin and Smith (2000) observe that a history of racist misinterpretation and/or fabrication of scientific data have made it difficult to discuss biological diversity among people. Moreover, because there is considerable within group differences, there is potential for over-simplification and stereotyping. Lin and Smith further note that the genetic factors involved in the response to drugs are substantially influenced by culture and ethnicity. They identify a variety of factors that influence medication response that depend on socio-cultural influences: diet and nutrition, smoking, drugs and alcohol, caffeine, exercise, disease and herbs. In addition, culture has non-biological effects on medication response that are due to factors such as patient compliance and placebo effects of medications. The intervening variables in these non-biological effects are related to the patient, the doctor, and the patient–doctor relationship, as well as cultural beliefs about illness and medication, and the actual process of giving and receiving medications (Ahmed, 2001).

Pharmacokinetics, or how a drug moves through the body, becomes increasingly important with advancing age. Age affects the absorption, distribution, metabolism and elimination of medications to varying degrees (Jacobson *et al.*, 2002). Because oxidative liver metabolism is affected by ageing, ethnic differences in liver metabolism can be substantial. For example, there is considerable biodiversity involving the enzymes of the P450 system of the liver. Thus, due to genetic polymorphisms involving the CYP2D6 enzymes, 5%–9% of Caucasians show no activity in the CYP2D6, while more than half of Asians, and approximately one-fourth to two-fifths of Blacks, have slower metabolism involving these enzymes. Mexicans tend to have a more rapid metabolism, while rates of ultrarapid metabolism of 20%–30% have been noted among Arabs and Ethiopians, far more than the 1%–5% rate among Europeans (Lin & Elwyn, 2004). Similarly, due to allele differences, 20% of East Asians (Chinese, Japanese and Koreans), but only 3%–5% of Caucasians show poor metabolism involving the CYP1A2 enzyme. Although genetic polymorphism has been reported in the CYP1A2 and the CYP3A4, their significance remains unclear.

Pharmacodynamics, which is the end-organ responsiveness to medications, is affected by ageing; however, ethnic differences have been less studied than pharmacokinetic changes. On the other hand, the importance of culture and ethnicity have been increasingly recognized with respect to the adverse effects of antipsychotics, such as the development of the 'metabolic syndrome' that includes obesity, diabetes and hyperlipidemia. The baseline risk of metabolic syndrome is substantially higher among all minorities in the United States, except Alaskan Natives, vs. white populations (REACH 2010, 2004). This risk further rises with lower socio-economic status and increased age, affecting more than 40% of people in their 60s and 70s in the United States (Ford *et al.*, 2002). There is evidence that these baseline risks place minorities at even greater risk of developing metabolic syndrome secondary to antipsychotic agents (Henderson *et al.*, 2005).

Psychotherapy

Yeo and colleagues (2001) have delineated four ways in which culture may affect the explanation of diseases and their treatment. They are all relevant to the care of older people.

1. 'Western' biomedicine has its own culture (e.g. knowledge, beliefs, skills, values) based on scientific assumptions and processes, producing definitions and explanations of disease. Older patients, familiar with other health traditions, may rely more on factors such as nature, balance or spiritual interventions to explain physical states.
2. People may identify conditions that do not match those found in biomedical references, yet these conditions can have a direct impact on healthcare, adherence to recommended treatment and full communication between patient and provider.
3. Culturally defined somatic disorders and culture-bound syndromes with their own beliefs about treatment may make the practice of culturally appropriate geriatric care more complex.
4. Contrasting values of independence vs. community/family may result in conflicting expectation of the involvement of others in the provision of care.

Sakauye (2004) has identified a variety of factors that may arise in the therapeutic session with older ethnic elders. There may be issues related to authority figures. Patients may be overly deferential, inhibited or ashamed of revealing personal feelings, or they may be hostile and suspicious. Persons who have not worked, or who had lived, in rural settings may have difficulties adhering to strict time appointments. For new immigrants, their primary psychological issues may revolve around adjustment issues, and these persons may more commonly present with culture-bound syndromes. There is usually a need for bilingual therapists. Established immigrants may have more social and health-related issues. However, even among established elderly immigrants, they may say that they cannot fully express their emotional state in English, and that they can only express the true meaning when they revert to their language of origin (Sadavoy & Lazarus, 2004). This language concern often becomes more pronounced among persons with dementia, since language abilities typically decline during the course of the illness. Finally, therapists must insure that patients do not take refuge in cultural differences in order to explain away all emotional reactions and behaviours.

Transference issues are more complex when working with different cultural groups. Therapists often find that their elderly patients may experience transference at different generational levels: sometimes the therapist is the parent, sometimes the sibling or spouse, and at other times the therapist may be a child or even grandchild. In some ethnic groups with wider family relationships, transference towards the therapist may include aunts and uncles, cousins and other kin.

It is important to heed Sue and Sue's (1990) admonition that the reason minority-group individuals underutilize and prematurely terminate therapy is often because of the services themselves. Such services are typically antagonistic or inappropriate to belief systems and life experiences of culturally different clients.

Summary and conclusions

Kirmayer & Minas (2000) have proposed that cultural psychiatry can be viewed from three perspectives: (1) the comparative cross-cultural study of the form and prevalence of psychiatric disorders; (2) the study of migrant populations and cultural variations in illness within ethnically diverse nations; (3) the cultural critique of psychiatric theory and practice. These three perspectives represent successive stages in the development of the field, with each continuing into the present. As we have indicated in this chapter, work on ageing populations has lagged behind the rest of the field, and is only now emerging as the growth of the global geriatric population has made such research more compelling. The cross-cultural studies of ageing populations both between and within countries have suggested that there are differences in the prevalence of dementia, depression, suicidality and psychoses. Research suggests that physical health, social stressors and community transitions, belief systems, cohort effects and sociocultural effects of role and identity often influence these differences. Moreover, the therapeutic response to these conditions reflects socioeconomic and cultural forces. Levkoff and her colleagues (1995) believe that the family is the critical intervention point in the mental-health care of older adults. Informal support is the mainstay of care in both industrialized and traditional societies because moral norms of assisting elderly persons persist even after modernization. Providing additional support to families makes sense for developing nations, since it is usually the most effective and least costly approach. The judicious development of formal systems to supplement informal care should fall within the economic capability of most developing countries.

Finally, it is clear that Western nosological classification and diagnosis do not adequately capture the array of symptom presentation or provide the most reasonable conceptualization and categorization of symptoms among various cultures. Even within classical Western diagnostic systems such as the DSM and the ICD there have been difficulties in reconciling the diagnostic criteria for ageing individuals. Therefore, it will be a more daunting task to incorporate the effects of ageing into a transcultural perspective. However, regardless of where on the globe an elderly patient resides, a more culturally informed and culturally sensitive approach can lead to culturally competent care of the individual elderly patient (Takeshita & Ahmed, 2004). Indeed, in the ageing field, cultural competence has been included as one of the cardinal principles of the 'patient-centred care' of older persons in which clinicians are encouraged to explore, empathize and be responsive to patients' needs, values and preferences, and to strive to avoid stereotyping and oversimplification (Weissman *et al.*, 2005).

Kirmayer & Minas (2000) believe that globalization is now subtly shaping the dissemination of psychiatric knowledge itself, through the increased movement of people, communication and products throughout the globe. Indeed, we are likely to see a gradual hybridization of the theories of psychopathology and treatment, and within such theories, an increased sensitivity to the burgeoning geriatric population.

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Working in liaison psychiatry

Santosh K. Chaturvedi and Jaideep Thoduguli

EDITORS' INTRODUCTION

Liaison psychiatry or consultation–liaison psychiatry (also known as general hospital psychiatry) deals with psychiatric aspects of physically ill individuals. Occurring both in out-patient and in-patient settings, this specialty within psychiatry has continued to evolve over the last 50 years or so.

In this chapter, Chaturvedi and Thoduguli provide an outline of the history of development of psychiatry and various models which are used. Providing a cultural context, they point out that the patient's perception of their physical disease and means of coping with it are subject to cultural influences in a big way. The treating team's relationship with the patient and carers is likely to be determined by cultural factors. For example, in cultures where clinicians are given tremendous status, the therapeutic relationship may have stronger elements of dependence. In addition, religious and spiritual factors may play a bigger role. Using examples from medical specialties such as cardiology, oncology, nephrology and gynaecology, these authors discuss specific difficulties related to somatization.

Introduction

Consultation–liaison psychiatry is a clinical discipline which deals with biological, psychological and social factors in the causation and management of any disorder, particularly the psychiatric manifestations. The field has its origins in the early nineteenth century, when medicine sought to explain all illnesses as the result of a specific biological cause. Parallel to this was the trend in psychiatry to view the major psychiatric disorders as resulting from biological disturbances. This left those illnesses wherein no specific biological cause was as yet elucidated and the 'neurotic' disorders in which somatic symptoms predominated, without any explanation or means of management. The nascent psychoanalytic movement attempted to provide answers in the form of psychodynamic explanations. At the same time, internists began to view physical illnesses in a holistic manner by integrating psychosocial factors into the management of every patient. Thus, the gap in services to medically-ill patients with psychiatric symptoms was filled by the convergence of these two professional streams. Over the years, the developments in the field have resulted in distinctions being made between consultation psychiatry, liaison psychiatry and psychosomatic medicine.

Consultation psychiatry refers to individuals trained as psychiatrists providing consultations to colleagues from other medical specialties upon receiving a specific referral. Occurring both in in-patient and out-patient settings, the consultation is limited to evaluating the referred patient for psychiatric symptoms and suggesting a plan of management. It involves limited interaction with the referring physician. The psychiatrist is usually not involved in the day-to-day care of the patient.

Liaison psychiatry is a much closer integration of psychiatric services with the medical services. Typically occurring in the inpatient setting, it involves a physician or psychiatrist (the Consultation–Liaison or C–L psychiatrist) being a part of the medical

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

team and seeing all patients under their care irrespective of presence of psychiatric symptoms or referral.

Consultation–liaison psychiatry

Concept, models and contributions

'A consultation service is a rescue squad like a volunteer fire fighter; a consultant puts out the blaze and then returns home. Liaison, however, also includes 'setting up fire-prevention programmes and educating citizens about fire proofing (Hackett & Cassem, 1978). Lipowski (1986) described different developmental phases in Consultation–Liaison [C–L] Psychiatry:

Early phase: circa 1935 – mainly focused on the consultation, i.e. acute treatment of the psychiatric problem in the medical patients.
Organizational phase: 1935–1960: consolidation of C–L services and expansion of teaching to medical specialists.
Conceptual phase: 1960–1975 – development of consultation models.
Rapid growth phase: circa 1975–1980s.

Consultation–liaison psychiatry's growth continued as a specialization in cancer units, ICUs, burns, dialysis, obstetrics and gynaecology, paediatrics, cardiology, neurology units, reaching non-referred populations by screening and triage methods. Liaison psychiatry encompasses clinical, teaching and research activities of psychiatrists in the non-psychiatric divisions of General Hospitals. The liaison psychiatrist seeks to enhance the psychological status of all the medical patients, aims to participate in case detection rather than waiting for referral and provides educational programmes.

Many studies have shown the substantial size of psychological problems in the medically ill. Firstly, around one-quarter of those with major physical disorders suffer from psychiatric disorder or other psychologically determined but 'medically unnecessary' complications, which include adverse effects on quality of life, poor compliance with effective medical treatments and possibly some effects on long term physical morbidity and mortality. Secondly, 'medically unexplained' symptoms are extremely common in primary and hospital care. Thirdly, there is a wide range of behavioural problems including deliberate self-harm, substance misuse, sexual difficulties and eating disorders. Many of these result in persistent distress and disability, are often difficult to treat and are associated with huge use of medical resources. There is consistent and compelling evidence that psychiatric, psychological and educational interventions can be highly effective in improving outcome of clinical problems such as psychological status, quality of life, usage of medical care facilities and mortality.

Models of consultation–liaison programmes

Consultation model

Patients are referred to the psychiatrist for the management. Usually consultation is a one-time service or a couple of follow-ups and does not involve any formal, structured teaching methods to medical specialists. By this model, primarily psychiatric morbidity in the general hospital is identified and referred by the non-specialist physicians.

Liaison model

In addition to consultation, structured teaching, e.g. psychosomatic rounds involving psychiatrist and respective medical specialists. Psychiatrist–teacher often becomes a part of medical/surgical unit helping in case detection.

Bridge model

Psychiatrist is connected with a formal department of psychiatry, but assigned a primary-care site, participates in structured teaching.

Hybrid model

Psychosocial teaching is provided by psychiatrist, psychologist, social worker or primary-care staff.

Autonomous model

Psychiatrist is hired by the primary-care physician, and has no formal connection with a department of psychiatry.

Integrative model

It is a theoretical model based on the aim of C–L psychiatrists for the inclusion of psychological care as a component of patient care as the right of every sick person. The five major components include open-access psychiatric consultation, high-risk evaluation and care, early identification of stress problems, system of triage and quality-assurance monitoring.

Psychiatric consultation has opened the door for the delivery of mental-health care to the medically ill. High frequency of psychiatric morbidity in certain medico-surgical settings, e.g. geriatric units, ICUs, cancer unit, HIV/AIDS units required extension of these services to every patient in these units.

Psychiatric consultation and psychological care of the medically ill reduces the total health-care cost by reducing hospital stay. C–L psychiatry also had resulted in increased recognition of psychosocial factors in physical disorders. The C–L psychiatrist's role in educating medical specialists has helped in better care of the medically ill. The common psychiatric disorders noted in the medically ill during the referral, liaison or consultation services are depression, anxiety, delirium, behavioural problems and somatization.

The late 1990s saw a controversy over what constitutes consultation–liaison psychiatry as applied to general practice. While some were of the view that the integration of psychiatric service with general practice and liaison with the general practitioner constituted C–L psychiatry (Carr *et al.*, 1997), others were of the opinion that such a practice should be termed 'shared care' as the majority of patients seen were not suffering from any physical illness nor from somatization (Gribble, 1998). The underlying debate was once again of funding: whether this particular service should be funded through community psychiatry or C–L psychiatry.

Cultural factors in consultation–liaison psychiatry

The impact of culture on the practice of consultation–liaison psychiatry (CLP) is manifold. The immediate and obvious effect is on the presentation and management of the Axis I and Axis II psychiatric disorders. The patient's perception about physical disease and means of coping with it are subject to cultural influence in a significant way. The treating team's relationship with the patient, the dominance of autonomy or dependence, the role of the family, religious and spiritual factors are all culturally determined. These issues could be the source of friction and discontent in the treating team and the patient and lead to a referral to the mental-health team. The C–L psychiatrist is therefore entrusted with the task of not only understanding the patient, his/her cultural background, the disorders and treatments, but also the cultural variance between the referring team and the patient.

Given this background, it is interesting to study the evolution and practice of consultation–liaison psychiatry in various culturally diverse countries. More often than not, the developmental path illustrates the cultural aspects peculiar to each country. In the following sections, the evolution and current status of consultation-liaison psychiatry in selected countries or regions will be reviewed.

United States of America

Lipowski may well be considered as the founding father of consultation–liaison psychiatry in the USA. He, along with Benjamin Rush, was the earliest advocate for integration of psychiatry and medicine. One key event in the growth of CLP was the provision of grants by the Rockefeller foundation in 1934–35 for the establishment of general-hospital psychiatric divisions. Beginning with the five hospitals that received grants, departments of CLP were established in most teaching hospitals during next three decades. The 1960s and 1970s saw the proposal and development of various models of CLP. At the same time, several journals (*Psychosomatic Medicine*, *Psychosomatics*, *General Hospital Psychiatry*, etc.) devoted to this field were founded and books published, serving to enhance the status of the field. Fellowships in CLP were begun in the late 1970s with grants from the National Institute of Mental Health (NIMH). Budgetary cuts and the emergence of managed care saw a reduction in resources available for CLP in the late 1980s and 1990s. Liaison psychiatry, being more expensive, failed to flourish. However, the advances in medicine with the consequent prolongation of life, emphasis on quality of life, chronic disorders and lifestyle-related health consequences have raised issues that highlighted the role of CLP and have ensured that the field receives its due attention.

United Kingdom

In the United Kingdom, the preferred term for this field is liaison psychiatry. A relatively late entry into the field as compared to USA, it was only in the 1970s and 1980s that C–L services were initiated in most general hospitals. An interesting feature is the existence of the National Health Service and its focus on family and general practice. This has led to the integration of psychological and physical care at the community level. At the same time, autonomy of sectors in organizing healthcare has resulted in wide variation in extent, structure and delivery of service. The national organization for consultation–liaison psychiatrists is the Liaison Group of the Royal College of Psychiatrists, which was started in the 1980s and currently has more than 800 members. However, the majority of those who provide consultation services are general psychiatrists. There are very few full-time consultation–liaison psychiatrists. The group has been very active in coordinating with other professional bodies.

Germany

The development of consultation–liaison services in Germany occurred largely in the second half of the twentieth century. This was largely catalysed by an enquiry of the federal government into the care of psychiatric patients in the Federal Republic of Germany, popularly known as the *psychiatrie-enquetae*. As a solution to the problem of remotely located psychiatric hospitals and lack of services for psychiatric patients with somatic complaints, it recommended the urgent establishment of psychiatric departments in general hospitals. It also explicitly demanded the implementation of permanent C–L services in all large hospitals that cared for patients after attempted suicide. Interestingly, it also recommended the provision of primary prevention psychotherapeutic services for patient in situations of psychosocial stress like dialysis, transplant surgery etc. While Germany has had a long-standing tradition of psychosomatic medicine, internists with training in psychoanalysis had largely contributed to it. The beginning of consultation–liaison services in Germany was in University hospitals as elsewhere in the world. Following the *psychiatrie-enquetae*, psychiatry departments were established in general hospitals.

Since 1992, the field has been officially bifurcated into ‘psychiatry and psychotherapy’ and ‘psychosomatics and psychotherapeutic medicine’. In Germany, virtually anyone interested can get an additional qualification in psychotherapy. This includes physicians, psychologists, teachers, etc. These individuals would then go on to deal with patients with psychiatric problems, mostly in private practice, rather than patients of their primary specialty. Physicians for ‘psychiatry and psychotherapy’, on the other hand, are primarily trained in psychiatry, primarily work in hospitals and see C–L referrals.

Australia and New Zealand

Australia is a multicultural country. In addition to the indigenous cultural minorities, the significant immigrant population poses unique issues in delivery of mental healthcare. The problem is compounded by the fact that those delivering the care are also from diverse cultures. The development of consultation–liaison psychiatry services also reflects this; in the 1970s, centers with US trained psychiatrists were the first to establish and develop C–L services. Slower progress was seen in centres with UK-trained psychiatrists. Although there is no national organization for C–L psychiatry, the section on C–L psychiatry of the Royal Australian and New Zealand College of Psychiatrists plays a pivotal role in all issues related to the field. Interestingly, subspecialty groups have been established: the Australian Society for Psychosomatic Obstetrics and Gynaecology, the Australian Pain Society and the Australian Society for Traumatic Stress Studies. The Royal Australian and New Zealand College of Psychiatrists has made a 6-month rotation in C–L psychiatry mandatory for psychiatry residents.

Japan

Consultation–liaison psychiatry in Japan had its beginning in the post-World War II era. The Japanese Society of Psychosomatic Medicine was founded in 1959 largely due to the efforts of a physician, Ikemi, and a psychiatrist, Miura. This society had mostly physicians and psychiatrists as its members. Not surprisingly, its emphasis was on bio–psycho–social determinants of health and disease and a holistic approach to patients. Initially, consultation services were the mainstay. These would occur in in-patient settings usually in University hospitals, while out-patients were largely not referred. The pioneers in the field, having received their training in the psychodynamic milieu of the USA, employed a psychodynamic approach to patients. Gradually, integration with oriental paradigms resulted in comprehensive models. The field received further impetus from the foundation of the Japanese Society of General Hospital Psychiatry in 1988. This provided a forum for psychiatrists working in consultation–liaison psychiatry. The research studies in Japan focused on prevalence of psychiatric comorbidity in the medically ill in order to impress on all concerned the magnitude of the problem, the need to address it and to advocate increased funding for consultation–liaison services.

Consultation-liaison specialities

The trend of specialization and sub-specialization in medicine has been reflected by the development of subspecialties in C-L psychiatry. This is expected to continue and increase in the coming days, given that each medical sub-specialty brings with it nuances that need to be understood to provide high quality C-L services. Some of these sub-specialties or super-specialties are discussed here.

Psycho-cardiology

Psycho-cardiology is the study and practice of psychiatric aspects of cardiac disorders. The Type A behaviour pattern (TABP) is characterized by time urgency and impatience, competitive achievement, aggressiveness and easily aroused hostility. TABP was initially considered to increase the risk for ischaemic or coronary heart disease. Subsequently, however, conflicting findings have led to a search for other factors that would better capture the essential features of the syndrome. The trait of hostility has received particular attention as a predictor of the development of coronary heart diseases. Autonomic arousal owing to chronic hostility and altered phasic autonomic responses to stressful life circumstances underlie at least a part of association between hostility and coronary artery disease. Such autonomic shifts are hypothesized to increase the likelihood of a number of adverse events including atherosclerotic plaque rupture and ventricular arrhythmias.

Normal emotional reactions to the development of heart disease often include shock, fear, anger, guilt, sadness and grief. Many patients are forced to confront issues of dependence on others and loss of control. They may become less able to contribute to the support of their families, an important source of self-esteem. Sexual functioning may be adversely affected by circulatory impairment, ischaemia, medication or fear and other emotional factors, contributing to a further loss of self-esteem. Smoking, alcohol use, failure to exercise and non-compliance with medication or diet may have contributed to the development of illness and may result in feelings of guilt.

The C–L psychiatrist must evaluate the patient in total, including attention to details of history, physical signs, laboratory findings, and must look for corroborating features to establish psychiatric diagnoses. For example, the coronary heart disease patient with a depressive episode is more likely than a dyspnoeic patient to express self-critical thoughts, suicidal ideation, helplessness and absence of a desire to improve. There is also greater likelihood of a history of prior episodes of depression or a positive family history. Problems in doctor–patient or nurse–patient communication or in the family or other social systems involving the patient may present as depression or anxiety.

Psycho-oncology

Psycho-oncology is the study of psychological, social and environmental factors in relation to cancer, which have been implicated in the development, course, terminal phases and consequences of cancer. Psycho-oncology as a sub-specialty has established its roots in the last 30 years. It is a well-established discipline in the United States, Britain, Australia, Europe and in some Asian countries.

Diagnosis of cancer evokes far greater emotional repercussion than any other diagnosis regardless of mortality rate or treatment modality. Shock and disbelief are the most common initial response, and anger, depression and personal grief may follow this. The normal reaction can vary from person to person. The intensity and duration of emotional distress and the degree to which it interferes with a patient's life seem to determine whether the emotional response is within normal limits.

Following the diagnosis of cancer, patients, may have anxiety, depression and increased suicidal rates. The common emotional reactions in a patient diagnosed to have cancer are shock, denial, disbelief, anxiety, anger, guilt and depression. The major sources of continuing emotional distress are fear of incurability, pain, disfigurement, recurrence of disease and a sense of helplessness over its treatment. Cancer may affect the family in a similar way as it invades the body of the patient. Among the psychiatric morbidity observed in family members of cancer patients are enuresis, school phobia and depression in siblings; conversion reactions, psychosomatic, psychosexual and psychosocial problems in the parents, and anxiety and depression in the spouse. Issues related to communicating with cancer patients like breaking bad news, handling difficult questions and dealing with collusion are quite sensitive to the sociocultural milieu, traditions and practices in the society. Disclosure of diagnosis is hardly practised in countries like Japan and India, and collusion between health professionals and relatives is quite prevalent.

Advanced cancer is associated with greater psychiatric morbidity due to emotionally distressing physical symptoms such as pain, weakness and anorexia; fear of death producing severe emotional distress; psychiatric problems directly produced by the disease process. In active and advancing disease, physical problems become more significant. Depression is associated with increasing levels of physical disability. Cancer pain, which becomes severe in this stage, has concomitant psychiatric morbidity. Once a patient has reached this stage, he is usually aware of the progressive and irreversible nature of cancer. Fear is the most common feeling of this stage. The patient is preoccupied with fear of abandonment by doctors, fear of loss of composure, bodily function and dignity and above all fear of death. Palliative care is becoming popular and a C–L psychiatrist may have a role to play in the end-of-life care or care of the terminally ill patient. Cultural factors pertaining to death and dying, which vary across cultures, need to be respected.

Cancer survivors report adjustment problems, depression, anxiety, low self-esteem, frequent work-related problems including fear, shame, discrimination and a tendency to be secretive about their diagnosis. Many survivors also have persistent somatic or physical complaints like fatigue, pain, and lassitude.

Psycho-nephrology

Patients who develop end-stage renal disease (ESRD) are not, as a group, predisposed to psychopathology and have low incidence of severe psychiatric disorder. They may develop maladaptive styles of coping with illness and thus present difficult problems for the staff such as non-compliance. Rapidly progressive ESRD may cause uremic delirium. Haemodialysis itself may cause delirium in the initial weeks of treatment. Organic mental syndromes occur in patients receiving steroids after renal transplantation.

The stresses faced by dialysis patients are many and of varying severity. The major time commitment of haemodialysis patients, together with less-than-normal health, makes gainful employment impossible for most of these patients. Family members are often involved intensively in the home dialysis and transportation to the dialysis centre complicating patients' support system. Patients awaiting a renal transplant must cope with the tensions of finding a kidney from a close relative or uncertain waiting time for a cadaver kidney. Finally, many patients with ESRD come to feel, at times, that the arduous treatment is not worthwhile and that they would be better off dead. In addition to managing these problems, the C–L psychiatrist may need to take the lead in making the patients, families and staff more competent in dealing openly with the wish to no longer live.

Psycho-gynaecology

Premenstrual syndrome, postpartum disorders and perimenopausal syndromes are the major problems in this specialty. The premenstrual syndrome has been variously described as consisting of tension, irritability, anxiety, bloated feelings, headaches, depression and numerous other symptoms. Reports of occurrence of these symptoms vary from about 30% to 90% of women of whom 5–10% experience severe symptoms. Among aetiological factors, fluid retention and prostaglandin/oestrogen imbalance have been considered important. There is a cross-cultural difference in the prevalence of premenstrual tension and syndromes, with some professionals wondering whether this is a culture-bound syndrome. Currently, a wide variety of treatment approaches have been proposed, but none of them has clearly documented efficacy in controlled studies. Treatments found to be effective include progesterone or sequential combinations of progesterone and estrogens, antidepressants and high doses of riboflavin.

Among postpartum disorders, postpartum blues, depression and psychosis are well known. Postpartum disorders may present with distressing lack of maternal feelings, anxiety and obsessions, irritability, hostility and aggressive impulses, pathological ideas and outright rejection of the baby. A large number of disciplines need to be involved or to liaise in order to understand the problems of mental health in pregnancy and puerperium – psychology, social work, voluntary organizations, midwifery, health visiting, academic nursing, general practice, obstetrics, paediatrics, pharmacology, pathology, and lay people and mothers. The ideal service includes a specialist multidisciplinary team that is capable of treating severe and intractable illness, and undertaking training and research, a community service for home care, in-patient and daycare services for the mothers and infants (Brockington, 1997).

Somatizing patients in medical clinics

Not all patients presenting with somatic complaints to physicians have physical disease. In fact, a sizeable proportion of the medical practices of most physicians consist of patients for whom no objective evidence of a pathophysiological process can be established. Reported prevalence of somatizers varies from 5% to 40% of patients in various specialties. The prevalence of somatizing behaviour is highest when the type of medical practice studied includes patients who complain of vague, poorly differentiated or non-specific symptoms.

The process of somatization is influenced by a variety of personal and socio-cultural factors. Personality type, cognitive style, and difficulty or inabilities to verbalize feelings (alexithymia) are some factors that may influence somatization. Cultures that facilitate somatization are those that accept physical disease as an excuse for disability but which reject psychological symptoms as a valid reason for assuming a sick role. Somatizing patients characteristically present their histories in an emotional manner, often dramatically exaggerating symptoms, and they are usually imprecise as to details such as dates, progress of illness, specific treatments, etc. Most somatizing patients visit several doctors for different complaints at different times and would have been hospitalized multiple times. In retrospect, the indication for hospitalization and surgical interventions often seems vague and poorly defined. Substance abuse or history of psychiatric disturbances is common. They may have received a wide variety of psychotropic medications, and abuse of sleep medications, pain medications or minor tranquillizers is a common finding. Somatizing behaviours are much more common in women than in men. They especially occur in middle-aged females from low socio-economic status with chaotic homes, which are often characterized by divorce, physical abuse and alcoholism.

The concept of the management of somatization disorder is more useful than considering curing it. The most effective management can be achieved by having one primary physician or psychiatrist responsible for the patient's medical care. This reduces the opportunities for manipulation by the patient, and having one physician who knows the patient well is an effective way of evaluating new symptoms. Regularly scheduled office visits for the patient are useful. The focus of these visits should not be on the patient's physical symptoms but rather enquiry should be on life situations and interpersonal relationships. There is often a close relationship between these life events and the patient's development of physical symptoms. The physician can employ a technique of behavioural modification during the office visit by selectively paying more attention to the more important and genuine psychosocial stressors that are being experienced than to the somatic complaints.

It is often useful for the physician to take an active role in providing advice and other supportive care to both patient and family at times of crisis. Supportive psychotherapy aimed at strengthening healthy coping strategies and healthy interpersonal relationships can improve the severity of distress in persistent somatisers.

Future of consultation–liaison psychiatry

Consultation–liaison psychiatry will assume greater importance in the field of psychiatry and in the field of health in general. This is due to the recognition of the large bi-directional overlap between psychiatric and 'physical' illnesses, the trend of integration of psychiatric services with other health services and the inadequacy of general psychiatry. It is also recognized that, in the context of the rapid globalization of majority of countries, C–L psychiatrists will inevitably be called upon to treat patients from various cultural backgrounds. At the same time, the replication of models of C–L services across countries with different cultural backgrounds would be unsuccessful. Thus, on one hand, the C–L psychiatrist will have to be sensitive to the explanatory models and cultural aspects of the individual case, on the other hand the C–L service will have to incorporate the cultural requirements of the population it serves.

The 7th Annual Scientific Meeting of the European Association for Consultation Liaison Psychiatry and Psychosomatics (EACLPP) in Germany recommended the use of screening instruments and computerized systems, training of non-psychiatric physicians in the recognition of psychiatric disorders and psychosocial issues in the medically ill, provision of basic psychosocial support by the medical/surgical team, interdisciplinary case conferences to promote integrated care, a stepped care approach to provision of services, wherein the initial intervention will be made by the primary-care team, integration of inpatient and outpatient C–L services and extension of C–L services to the community. Greater emphasis on C–L issues during training is appropriate and is the need of the hour, as the vast majority of current and future psychiatry trainees will work in general hospital and community settings.

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PART VI

Cultural research and training

Scope of cultural psychiatry

Horacio Fabrega Jr

EDITORS' INTRODUCTION

Cultural psychiatry by definition examines the psychology and behaviour of an individual, which is linked with identity and acculturation and allows an individual to respond to stressors in a way that is sanctioned by the cultures within which he lives and from which he may have emerged. The need for an academic discipline such as cultural psychiatry emerges from the position of relativism that anthropology advocates. The healthy, creative tension between anthropology and psychiatry is discussed elsewhere in this volume, but it is essential that cultural psychiatry leads in understanding the role cultural factors play when meanings of distress are to be ascertained. Furthermore, linguistic, social, ethnic and religious mores embedded in cultures are to be understood in the context of making sense of experiences that form part of psychiatric conditions.

In this chapter, Fabrega examines cultural influences in diverse circumstances relevant to psychiatry. Starting with the question of why cultural psychiatry is special: because, firstly, psychiatric disorders, unlike medical disorders, are not entirely internal but its epistemology is different too, thereby ensuring that the emphasis of cultural psychiatry is synchronic. While it stresses diverse and dynamic aspects of clinical disorders, psychiatry addressed stationary happenings in a specific historic moment. Fabrega notes that, under these circumstances, cultural psychiatry has a daunting task and enormous relevance given movements and mixing of populations across geographic settings and cultural diversity of human populations. In an impeccable argument, Fabrega emphasizes that what cultural psychiatry 'is' and 'does' is certainly not linked to concrete and clinically relevant exigencies. By taking the reader through the history of development of psychiatry, it becomes evident that differences in social structure, culture and political economic institutions of non-Western states most probably account for differences in level and social constructions of psychiatric condition. Using examples from primates, Fabrega points out that philosophical problems related to cultural psychiatry are also linked with historical anachronism. Evolutionary changes are thus related to psychiatric disorders. The theoretical assignment of cultural psychiatry is to develop a corpus of information about how culture and language influence all facets of psychiatric conditions. Thus causes, manifestations, interpretations and behavioural consequences in a patient's personal social world become important in developing the role of cultural psychiatry.

Introduction

A *textbook* implies that there exists a reasonably well-defined area of knowledge, the content of which permits presentation of material to an audience of readers who are interested and aspiring of learning. If the textbook involves a *medical discipline*, it implies that the clinical disorders of the discipline are readily delimited and knowledge about them is well understood and can be organized and presented in a systematic way with respect to basic medical considerations, for example, their causes, manifestations, diagnosis and modes of treatment. *General psychiatry* shares the approach of medicine, for it also encompasses a distinct class of disorders about which there is much clinical and scientific information. Hence, textbooks of general psychiatry conform to a traditional format.

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

However, all too often neglected in general psychiatry, when compared to other branches of medicine, is the special nature of its disorders. While comprising disturbances of brain and general physiological function, manifestations of psychiatric conditions presuppose aspects of psychology and behavior that involve a person's social identity and even moral standing, all of which resonate with *cultural meanings*. This is certainly not the case in the way disorders are conceptualized in general medicine or in clinical neuroscience psychiatry. The important role played by cultural factors, one can argue, is a *necessary component* of psychiatric conditions. For these reasons, *cultural psychiatry* plays a special role: it examines the influence of systems of meaning on traditional, taken-for-granted approaches to psychiatric knowledge and practice. Thus, a textbook on cultural psychiatry addresses questions not ordinarily dealt with in typical psychiatric textbooks.

A basic directive of cultural psychiatry is demonstration of how beliefs, attitudes, values and social meanings in general, in concert with associated social factors, influence the production of psychiatric phenomena. It examines linguistic, social, ethnic and religious background in relation to parameters of psychiatric conditions and, in particular, on how such factors influence when, why and how an afflicted individual makes contact with a clinician, what he or she anticipates from the encounter and how thought worlds and habit patterns of a person influence the way symptoms and signs are perceived, experienced, manifested, responded to in local settings and expectations of treatment. Such considerations are especially relevant in contemporary society where migration, cultural pluralism and globalization are signal developments.

The chapters of this textbook examine cultural influences in diverse circumstances relevant to psychiatry. In the present chapter, it is the scope of a cultural-psychiatry enterprise that is addressed. This entails reviewing its history, charting its intellectual boundaries, defining its *raison d'etre* and examining some of the implications of its basic presuppositions.

What is cultural psychiatry and why is it special?

Given the range of factors affected by cultural meanings, a direct and un-problematic depiction of clinical psychiatry's domain is not easily visualized and never fully achieved. It is uncontestable that neurobiological correlates of psychiatric disorders, changes in brain physiology and anatomy observed by brain-imaging methods, point to disturbances of mechanisms and functions associated with many psychiatric disorders. These include, for example, brain mechanisms and networks involved in attention, cognition, emotion, motivation and behavioural regulation, all of which are of paramount importance and cannot be minimized. In addition, psychopharmacological agents complement the brain-centred focus of contemporary psychiatry. Such data deepen parameters of diagnostic validity and promise improvements in reliability of measurement. However, one must stress that the ideal of objectivity and impersonality clinical neuroscience exemplifies has limitations. Its knowledge base derives from patients who are *socially and culturally selected*. In other words, adverse changes in persons' experience and behaviour, replete with *symbolic and socio-cultural significance*, are important determinants that bring them to clinical attention in the first place and influence selection of experimental groups upon which brain-imaging mappings are measured.

The 'raw', pristine, and natural data of psychiatric disorders still consists, and always will consist, of changes and evaluations of changes in experience and behaviour emplaced in meaning-filled social spaces. In the latter, clinical disorders are not transparent nor sharply etched in an ordinary or clinical sense. What psychiatry involves also comprehends problems of sickness, as in other clinical disciplines. However, its focus is still special insofar as a psychiatric disorder involves complex interplay of mind, meaning, self-identity, phenomenological and bodily experience, and programmes of behaviour. Such characteristics envelop the *social and moral persona* of a patient and are not reducible to neuroscience measures. Rather, they constitute an amalgam, moulded by cultural-meaning systems, which influence where and how a psychiatric disorder emerges as a social, medical 'fact' or 'case'.

This characteristic of psychiatric disorders does not apply for general medicine. As conceptualized there, diseases are *not* enwrapped in basic 'internal' and socially consequential markers of individuals. Person, self and moral and ethical dimensions of sickness are 'off the radar screen' in general medicine but never with respect to what psychiatric inquiries necessitate, even when disorders are conceptualized as purely clinical phenomena (Fabrega, 2000). In addition, in contemporary society, what a psychiatric condition means, and the impact of a diagnostic label about it on the person are radically different from virtually all of general medicine. Determinants and implications of psychiatric stigma are part of the social fabric of modern societies and are insinuated into clinical presentation and conduct and response to treatment of patients. Psychiatric stigma involves a signal cultural dimension of psychiatric conditions.

Basically, what a psychiatric condition 'is' (i.e. its essential characteristics or ontology), and the knowledge one draws on in order to understand and formulate a diagnosis and treatment plan (i.e. its epistemology), differs from typical general medical conditions. Functions of neuropsychological structures and functions and even response to psychoactive agents are not invariant givens that are easily delimited: they are influenced by cultural factors inherent in mind and brain as the many chapters of this textbook illustrate. Neurobiological reductionism cannot erase the essential constitution of a psychiatric condition that differentiates it from general medical conditions. A general medical assessment and treatment can be conducted with little or no information about how a patient construes self and social reality but this is hardly possible in the case of a person who is psychiatrically ill.

Psychiatric conditions manifest in socialized enculturated beings (LeVine, 1990). Cultural meaning systems that influence all facets of experience and behaviour, including conventions about normality, disease, and disability, are learned and insinuated in the brain during development and thereafter. Essential parameters of enculturation bring into play characteristics of persons that are learned and shared, factors that are internal, 'in the head' or 'carried by the mind'; however, they are also external to the individual, in the thought worlds and habit patterns of the significant group wherein persons live and share a distinctive view of the world in terms of which they live in it. Thus, the cultural part of cultural psychiatry underscores the importance of influences on experience and behavior and can be divided into two parts. One is symbolic information, namely, beliefs and doctrines in terms of which a collectivity or people rationalize and make sense of life. The other involves patterns of behavior that are learned and passed on from generation to generation and that reflect the meanings of the cultural symbols. They include such things as conceptions and definitions of self, social situation, cosmology and ideas about significance of normality compared to abnormality of behaviour. Cultural phenomena of this type influence how a psychiatric condition is expressed or manifested, made sense of, and dealt with by person or co-members of a relevant group.

The emphasis of cultural psychiatry is and has been predominantly *synchronic*. While it stresses diverse and dynamic aspects of clinical disorders, when viewed in broad perspective, psychiatry addresses comparatively stationary happenings in a specific historic moment, namely, that involving late modern society. Even within this period, cultural psychiatry has a daunting task and enormous relevance, given movements and mixing of populations across geographic settings and cultural diversity of human populations. However, the parameters that delineate the space of cultural psychiatry and that direct its inquiry are not confined to the present and should not be limited to purely clinical tasks.

Cultural psychiatry exemplifies a unique intellectual and philosophical focus about psychiatric conditions. To fully appreciate its broad reach, a *diachronic* perspective is indicated. The social and cultural construction of psychiatric phenomena entails a consideration of how it has changed across human history. What cultural psychiatry 'is' and 'does' is certainly not limited to concrete, purely contemporary and clinically relevant exigencies. Many factors inherent in psychiatric phenomena as we know it today (e.g. stigma, beliefs/delusions, the mental compared to somatic criteria of disorders) are historically contingent. For example, the significance and play of psychiatric conditions in the 'Great' ancient traditions of medicine, traditions which enveloped such conditions (e.g. Ayurveda in India, Traditional Chinese Medicine, the medicine of the Mediterranean Societies), were very different from those of today. Yet, they should be seen as a necessary ingredient of what psychiatric conditions mean in comparative focus. In short, the logical and semantic dimension of cultural psychiatry's focus brings it into relation with material covered by historical and evolutionary disciplines.

How did cultural psychiatry come into being?

Contemporary psychiatry is based on a doctrine about sickness and healing that is comparatively new. It is true that intellectual life and humoral medicine of the early modern period in Anglo-European societies already displayed a fascination with insanity and madness (Fabrega, 1997). However, as a medical discipline, psychiatry originated during late eighteenth, and especially the nineteenth, century in relation to specific types of problems found in modern, industrial societies. Such problems entered the human imagination as *social phenomena of great public concern* as a result of special political economic and cultural transformations that occurred at the time (Foucault, 1965; Porter, 1987; Scull, 1993). All human populations show psychiatric conditions. They are identified and handled through social, cultural and medical conventions and institutions inherent in a society. However, there is little information about the workings of other major state societies and civilizations during antiquity or the early modern era which suggests psychiatric phenomena surfaced and were dealt with in quite the same way as they were in Anglo-European societies during the modern era. Differences in culture, social structure and political economic institutions of non-Western states most likely account for difference in prevalence and social construction (i.e. as social problems) of psychiatric conditions. Unfortunately, the field of comparative social and cultural history of psychiatry has not, as of yet, advanced to the point where better answers can be given to the interplay of factors that shape how psychiatric conditions are formulated, appraised and interpreted as a species of human problem and suffering and in terms of social and cultural histories unique to other, non-modern, non-Western contexts.

There is a large literature, most of it very critical, about the culture, sociology, history and professional motivations that led to the emergence of psychiatry as a medical discipline in nineteenth-century Europe and England. Ever since its emergence, psychiatry's confinement of its clientele in special establishments termed asylums, and its socially mandated role as an agent and institution of social control of problem populations have marked its standing as a medical discipline. Psychiatry has sought to transcend its image as a discipline enwrapped with negative connotations of madness and insanity and its functions as a political agent of the state and/or its function as police. To this aim, it has continually defined and re-asserted its domain and practice as much as possible under the umbrella of medicine. During the first part of the twentieth century, psychiatry moved out of asylums into social spaces and mental-hygiene clinics. This spread of social influence in community settings and the later insinuation of psychoanalysis into the social fabric as a theory of behaviour and of mental illness, in other words, a dictum about the continuity between normality and abnormality, exacerbated psychiatry's social problematique as a medical discipline (Fabrega, 1989).

In light of psychiatry's general medical and universalistic focus during most of the nineteenth and early twentieth century, something like a cultural psychiatry was not a logical possibility at that time. Early psychiatrists, termed ‘alienists’, defined themselves and the area of expertise they were carving for themselves as medical in nature, with clinical tasks and applications relevant to presumed real, natural and objective conditions of sickness. In a basic sense, the psychiatry of that era applied to Everyman, and considerations of cultural identity and meaning systems and their influence on psychiatric conditions was not a central focus. Slowly, and specially after World War II, psychiatry expanded its focus, moved out of the asylum and into communities as exemplified by Mental-Hygiene Clinics and Community Mental-Health Centers. But, in moving into the community, it impacted on conventions and standards of behaviour that caused it problems.

During the 1960s, in association with major changes in the society and culture in the USA and Western Europe, there took place a new critique of psychiatry. The explosion of knowledge and importance of the social sciences, particularly labelling theory and ethno-methodology in sociology and culture and personality in cultural anthropology, was one factor. It challenged not only the a-cultural universalistic assumptions inherent in the psychiatry of the antecedent period but also the medical legitimacy of its objects. Such criticisms were echoed in the writings of ‘anti-psychiatrists’, important clinicians who at the time also reacted negatively to medicalization and emphasized the essential human, experiential implications of persons labelled as mentally ill. The roots of cultural psychiatry are found in some of the insights of the social sciences as these consolidated in the 1960s. Although even nineteenth-century German psychiatrists had shown an interest in mental illness beyond the confines of European societies, they did not generally consider implications of culture on the actual ontology and epistemology of disorders as cultural psychiatry has and must continue to do.

Criticisms of the medical authenticity of psychiatry prompted leaders of the profession to re-energize their efforts towards medical and biological incorporation. They influenced federal agencies to set aside monies to study the biological bases of psychiatric conditions. They helped give momentum to phenomenal developments in brain sciences and the result is that now psychiatry is construed as more authentically medical. The growth of neuroscience and psychopharmacology constitute major accomplishments during the last decades of the twentieth century that anchor psychiatric knowledge and practice; however, cultural and political economic factors (e.g. definitions of disorder and power and control) are important determinants and consequences of such developments. Cultural psychiatry gained momentum as a focus of knowledge partly to counter strict neurobiological reductionism.

Where are cultural psychiatry’s exemplars to be found?

Were a physician to examine the domain of general medicine across cultures and forwards or backwards in time, he or she would find that its objects of interest would differ little from today (Fabrega, 2000). Criteria of health and sickness would involve pain, physiological malfunctioning, and impaired physical well-being. Signs and symptoms would be similar in virtually all populations and so would the underlying pathological anatomy and physiology. The time-travelling physician would diagnose and treat in more or less the same way. Of course, the clinician will find sick persons sporting differences in the way their medical condition is construed, for example, its causes and implications in the life space of the person. Understandings and practices about health problems of the population in question would differ greatly from those of contemporary Western societies. All societies and cultures manifest distinct ethno-medicines, and this obviously would have been the case in earlier and faraway societies for general medical conditions.

The experience of a time-travelling cultural psychiatrist searching for his domain would be quite different. Even though local language and culture were understood by the psychiatrist, what such conditions looked like 'on the ground' would be difficult to spot. This is hardly surprising since many psychiatric disorders of today go unrecognized and never make it into the mental-health system in the first place. In most instances, the disorders the psychiatrist would identify in the culture/society itself using external ('etic') criteria would be enshrouded in cultural material and formulated in a cultural ('emic') idiom (e.g. views about self, social reality, the nature of experience), and not necessarily encompassed by its ethnomedicine. Stated baldly: a travelling general physician's object of interest would be *medically transparent*: patient, co-members, and person consulted would share a medical consensus. However, the travelling psychiatrist's condition would be different: its interpretation, meaning, and enactment would be *medically opaque*. The psychiatrist would note that any of several social institutions, not just those of medicine, came into play, incorporating the condition into the workings of society. The cultural meanings and values and social conventions about normal and abnormal behaviour would provide the attire in terms of which the condition would be interpreted and handled.

Searching for the earliest exemplars of cultural psychiatry

Introduction

The cornerstone of cultural psychiatry is: *psychiatric conditions are universal (but are culturally constructed)*. Studies in genetics, epidemiology, evolutionary psychology and cultural anthropology establish this. The assumption applies to all human populations and societies, each one of which displays a *cultural exemplar of psychiatric phenomena*. One way of illustrating the logic of cultural psychiatry is to examine its exemplar in populations that preceded humans. What this was like for communities preceding species *Homo* can be approximated by analysis of observations on behaviour among non-human primates with whom *Homo* share common ancestors. The question here is: what might 'ape' psychiatric conditions have looked like and what were their consequences for group living? Hints about this are provided by many primatologists who have described aberrant behaviour among non-human primates, including monkeys and specially chimpanzees (for review see Fabrega, 2002). The researchers characteristically equate such syndromes with psychiatric conditions.

Case illustrations

Among captive primates, infant abuse is not uncommon. A mother's abusive behaviour towards her infant is a relatively common sequela of a prior separation experience (or trauma) that had deprived her of contact with her own mother. However, such abusive behaviour on the part of a mother is associated with generally impaired maternal behaviour and other major developmental deficiencies. Thus, the co-existence of abuse behaviour and adequate prior maternal care on the part of a female monkey is unusual. Troisi and D'Amato (1984) describe a female 'patient' ('Okame') which was brought from the wild who presumably was normal, having no record of aberrant development or behaviour. The 'psychiatric condition' involved erratic and repeated abusive behavior toward her offspring alternating with 'normal' caring and mothering.

Observations regarding the response of group mates to the behaviour of Okame are interesting and provide insight into this 'ape' exemplar of cultural psychiatry. Researchers report that the group was clearly affected by the Okame's maltreatment of offspring. Most monkeys avoided her when she abused her infant. The alpha male stayed and displayed obvious conflicted behaviour (yawning, scratching, threatening the observer). Observations suggested that the form taken by Okame's psychiatric condition had a measure of 'content and meaning': it was 'noticed', responded to emotionally, and produced negative effects on group integration, although no efforts were made to calm or redirect Okame.

There is substantial literature that in the context of handicaps of behaviour (e.g. produced by blinding of infant monkeys, in context of developmental abnormalities) group members can actually favour and support sick, aberrant conspecifics (for review see Fabrega, 2002). This suggests that, provided comparatively un-stressful ecological conditions prevail and a psychiatric condition does not involve overtly aggressive, divisive behaviours, even if the conditions hamper adaptation, individuals who show them are provided with forms of care and 'healing'. However, this is not always the case.

Goodall provides a cultural psychiatry exemplar among chimpanzees (Goodall, 1986). It involves a case of brutal infanticides followed by cannibalism perpetuated by Passion and her daughter, Pom. Goodall describes Passion as a 'loner' for she had no close female companions. Among males she was characteristically tense, restless and uneasy. She was also a poor mother ('cold', 'intolerant', 'brusque') and rarely played with her young infant. Passion and Pom attacked mothers in order to use their infants as meat, which they then consumed, behaviour Goodall describes as bizarre and pathological. Following possession of the babies, aggression directed towards the mothers ceased. Most instances of infanticide in non-human primates are due to the acts of males directed at the offspring of competitors during the appropriation of females and, furthermore, these instances of infanticide are not followed by cannibalization of the infants. In the present case, the mothers of the victims continued to react with fear at the approach of Passion but apparently could not communicate to others the basis of this fear. Many of the females of this group were fearful and avoidant of her for the rest of her life. Buirski and Plutchik (1991) provide further support for a 'diagnosis' of the psychiatric condition of Passion. They developed a chimpanzee version of the Emotions Profile Index that was originally used to study the emotional distribution of human adults. Passion's 'personality' and behaviour showed increased depression aggressiveness, and distrust as well as less control, timidity and gregariousness. Passion thus 'presented' as a disturbed, isolated, aggressive individual exhibiting features of a 'a paranoid spectrum of traits' (Buirski and Plutchik, 1991, p. 208). This variety of psychiatric condition thus hardly elicited support and care since its make-up consisted of divisive, fractious, antisocial behaviour, a fact that highlights the unusual status of such markers of mental illness in human populations and across evolutionary and human history (Fabrega, 2002).

Theoretical quandaries

Scepticism about an evolutionary position is understandable. Natural questions include the following. Are ape varieties at all relevant to psychiatry, especially a cultural psychiatry? Do apes really show psychiatric conditions? In some respects, of course, they cannot: ape 'conditions' have been constructed on the bases of biased modern perspectives about human behaviour and they lack the mental equipment that is needed to show psychiatric conditions as we understand them. Conventions based on Western culture (e.g. social reality, religion, philosophy as well as medicine) have moulded our concept of psychiatric disorder. Besides an obvious psychiatric stigma, a conceptual bias about the nature of mind and body, and about the meaning of experience and behaviour in a culture-specific context, has coloured the looking glass or slant through which primatologists of today observe and analyse ape behaviour. This bias, one could argue, has set apart something that merely resembled our conception of psychiatric phenomena.

Thus, formulating an ape exemplar of a psychiatric condition exemplifies philosophical problems and conceptual biases. Two obvious ones are speciesism and anthropomorphism: of not only applying to one species a paradigm or phenotype derived from another but also, in this case, of attributing to animals allegedly uniquely human behaviours and conditions. Theoretical objections to these problems have been countered by the dictum of evolutionary continuity of behaviour and empirical observations and interpretations of primatologists and comparative psychologists of normal and abnormal behaviour in natural communities of non-human primates, the living human ancestors (Goodall, 1986; DeWaal, 1996; Fabrega, 2002). Another problem is that of cultural relativism; namely, that viewed in local contexts of meaning, psychiatric phenomena do not conform to Western biases, for example, of mind compared to body bias or to psychological/behavioural compared to a medical one. A related bias is of historical anachronism. Thus, in a strict sense, formulating a psychiatric condition in a broad context involves biases of using modern conceptions to explain phenomena across species, time and cultural lines. These are dilemmas inherent in generalizing about the meaning of behaviour to other worlds and species, based on knowledge that establishes the universality of psychiatric conditions (Fabrega, 2002).

Unpacking biases of modern conceptions

On the stage of Anglo-European society, where varieties of psychiatric conditions were played out, 'madness' and related labels offered a promissory note to the burdened individual that a medical cure was possible. However, in the process the label also tarnished their soul, psyche and personal and social identity. Another way of putting this is to say: in Anglo-European societies especially, a *distracting cultural, experiential and behavioural* noise was added to the phylogenetically inherited ape variety of psychiatric condition. Part of this noise devolves from the obviously different exigencies of social life in evolved societies that include, for example, the nature of human cognition, what individuals said and thought and how they behaved in social contexts, and the meanings and symbols derived from the culture that had negative sociological implications (e.g. disfavour, invalidation, confinement, restriction). Put baldly, cultural psychological and behavioural material constitute the what, why and how of psychiatric conditions as we understand them today.

What would happen if one could reverse biases exemplified in a search for ape exemplars? One way to appreciate what an answer to this question entails is to draw upon presumed 'ape understandings' of their psychiatric condition as a model for making sense of our varieties (McGrew, 2004). Apes would be given the task of trying to find out what lies behind the behaviour of humans when they (i.e. humans) variously describe and react to individuals who appear to show disturbances that match their psychiatric conditions. If one endowed an ape with a capacity to know or understand something about the emotional and behavioural disaffections of some of their own conspecifics (an arguable proposition among many primatologists), and provided we could communicate with them (an obvious impossibility), they could tell us how human analogues of their conditions looked to them as they visited this new culture.

Our ape 'humanologists' would note enormous differences in how psychiatric conditions analogous to theirs were conceptualized and handled in Anglo-European societies. Only a few highlights of this thought experiment will be mentioned. Most basically, a 'humanologist' would agree that gross forms of behaviour that transgressed publicly observable patterns, contravened conventions, and/or that hindered success in mating and making a living also served as important criteria for how humans seemed to respond to and conceptualize psychiatric conditions. Our mythical 'humanologist' would be puzzled by the importance humans attached to verbal babblings of 'mentally ill' individuals. They would surmise: much noise and many grunts about little observable and tangible in behaviour. Such gibber and chatter appeared to have something to do with how individuals of the human culture saw the world and those around them, and what they felt about it. While this shaped how observers perceived and behaved towards the 'mentally ill', the latter did not seem to be causing any group disruption, the hallmark of their condition. Apes would, of course, note that as a result of breakdown, many things might befall human cases, incorporating them into different types of institutions and places of confinement. At this point, they might remember to tell us that many individuals of their society with psychiatric conditions were in fact banned, ostracized, or simply didn't make it. They might suggest a trade-off took place between the direct and harsh punishment of their society and the indirect, more insidious punishment befalling the mentally ill in this new culture.

Our humanologist would comment on the *special status* which individuals that resembled their own cases of psychiatric condition appeared to acquire in this new culture. He or she would report puzzlement that such individuals could be dealt with as though abnormal and discredited even when their behaviour and social relations seemed organized and not overtly disruptive. They would tell us that they themselves are witnesses and react to differences in personality and temperament among co-members all the time, without considering pathology. They simply adjust their behaviour accordingly, dealing with the behaviours in question in the natural course of social relations, even in group-ordered ways (DeWaal, 1996). However, in their 'study population' the result of merely having shown breakdown in the past (and sometimes simply different, eccentric behaviour at that) carried over to circumstances in which no obvious malformation of behaviour was evident.

Our humanologist might conclude that individuals who met their criteria of behavioural pathology (as per fitness and reproduction) also engaged in a myriad of situations, activities and interactions with group mates and areas of work and leisure that did not appear to directly undermine fitness in any way, yet they were still dealt with disapproval. In such individuals, they might surmise, behaviours either proved maladaptive in the long run or were correlated with other behaviours that in a different context directly did so, but this would be hard to establish. Upon careful observation an insightful ape 'humanologist' might conclude that, with respect to diverse social activities, to them seemingly unrelated to the important marker of fitness, subtle differences tied to personal preferences, temperament or personality had a large influence in how their 'subjects' used the concept of mental illness.

What this thought experiment suggests is that, from the standpoint of ape exemplar, in human societies much more than observable disturbances of behaviour and strict considerations of fitness and reproduction come into play when considering psychiatric phenomena. This highlights differences between, and evolutionary and cultural/clinical slants on, psychiatric conditions (Fabrega, 2002). It goes without saying that there exist obvious differences in manifestations of psychiatric condition across the ape/human divide that stem from characteristics traditionally equated with vaunted human capacities involving language and culture (e.g. warped social emotions, delusions, obsessions, irrational thinking, emotional 'hang-ups'). The number of types of the human psychiatric condition expands when one takes into consideration the range of domains of experience and social, interpersonal space to which modern construct of mental illness applies.

Cultural attires for ape exemplars

A scientifically based hypothetical description of *early human* exemplars of psychiatric conditions would show how ape exemplars changed as hominids came to acquire language and symbolic culture following the pongid/hominid split of five or so million years ago. There are three interrelated ways in which evolution of culture and language can be conceptualized. The first involves acquisition of a biological capacity that was naturally selected and gave rise to a unique way of behaving compared to earlier varieties of species *Homo*. Some describe this as involving acquisition of *shared intentionality*, a natural disposition to share feelings with conspecifics and engage in collaborative activities, that presumes mental states in other and involves shared goals and the learning of the knowledge a group has accumulated (Tomasello, 1999). This special capacity helps explain why *constructs* of self, experience and behaviour figure so prominently in interpretations of psychiatric conditions, a factor that puzzled the ape 'humanologist'. The second involves the origin of a truly symbolic way of life. It led to syntax, propositional thinking and communication and a 'symbolic niche' that included co-operative interactions, a sense of group identity via relations of obligation, entitlements, and social contracting, and development of abstract constructs fully realized in myths and played out in public rituals of emotive power (Knight, 1991). As per reactions of our mythical humanologist, this highlights the texture of meanings and social relations that provided the 'hidden' conventions in terms of which human varieties of psychiatric conditions were understood and dealt with. The third formulation of evolution of culture and language involves changes that have occurred since anatomically modern humans first evolved. In other words, how human communities and the cultures they necessarily embody have changed, starting with the earliest fully human communities (e.g. hunters and gatherers), continuing on through sedentary, agricultural communities, pre-modern states and civilizations up until contemporary times. This factor would help our humanlogist understand why and how individuals sporting analogues of their psychiatric condition were dealt with through so many different social practices, institutions and organizations.

One's quest for an understanding of how ape exemplars of psychiatric phenomena have changed through human history would take one through these three aspects of biological and cultural evolution. It involves formulating in a hypothetical and scientifically informed way what such phenomena consisted of and how the problem was handled as a species of human problem. For example, what did psychiatric condition look like when hominids evolved a biological capacity for culture? It is obvious that, compared to the last common ancestor of pongids and hominids, once the latter split off and came into view as a discrete species of *Homo* (say in the case of *Homo erectus*, around 1–2 million years ago), they would have more information about psychiatric condition (and about sickness, predator habits, subsistence practices, etc.) as a function of sharing accumulated knowledge. They would have a more intuitive and better-defined sense of self, theory of mind and aspects of emotion and behaviour in terms of which to begin to make sense of what was involved when group mates behaved abnormally and counter-productively. The same logic would be followed once earlier varieties of species *Homo* evolved human language and culture as we know it.

Understanding the *lineage of psychiatry* involves comparison of how psychiatric conditions were configured, understood and dealt with among early hunter and gathering peoples (although contestable, generally assumed to present earliest exemplars of human groups), followed by early agricultural peoples, archaic and pre-modern states, and finally modern societies. In each case one would seek to understand what were essential characteristics of psychiatric conditions as understood, played out and dealt with across human groups. This involves characteristics of a group's behavioural ecology (i.e. behaviour patterns considered in relation to challenges posed by physical environment); social differentiation and organization (i.e. groupings and hierarchies across population); cultural beliefs and traditions (i.e. constructs and values about behaviour, normality, healing, cosmology, and moral caring); and sociological, political economic, and institutional structures (i.e. governmental and related organizations and corporations involved in keeping the society going). One seeks to examine psychiatric phenomena not only in individualistic terms, namely, how they impacted on and reflected an individual's fitness, but also in societal, institutional, and ideological terms.

Texts describing psychiatric conditions go back to ancient societies of the Mediterranean basin. They exist also for pre-modern India and China, where historians have been able to document that, within academic literate traditions, and in the culture at large, psychiatric conditions have served to attract general intellectual and medical attention. Thus, through recorded history, especially Western history, psychiatric conditions such as our 'madness', 'insanity', 'melancholia', 'hysteria', and 'phrenitis', and India's *unmada* and China's *kuang*, have been long-standing preoccupations of Western and non-Western societies. When compared to modern conceptions, ancient, traditional constructs help sharpen understandings of human behaviour, normality, abnormality, the nature of self, personhood, and the divine, and the conceits, high points and low points of human striving. Intellectual ramifications of the Western idea of psychiatric condition were modified during Middle Ages (e.g. Christian conceptions of sexuality and sin), Renaissance (e.g. folly, melancholia, holy fool), and applied to existing problems and put into effect to control them during the nineteenth century in Anglo-European societies.

Summary: the domain of cultural psychiatry

The *practical assignment of general psychiatry* involves addressing the clinical needs of patients by means of knowledge stores that the discipline has acquired and to use it for purposes of helping patients. In most instances, this task is un-problematic because clinician and patient share a cultural and linguistic background, and communication about relevant topics between them is comparatively easy. For example, they share understandings of social reality, of what 'mental' or emotional problems or disorders consist of, of what a psychiatrist is suppose to inquire about, and about how to talk and make sense of whatever problems beset the individual who seeks help. The *practical assignment of cultural psychiatry* is similar but also quite different because of differences involving the ontology and epistemology of psychiatric disorders and most pointedly, because language and culture of patient and of clinician often differ, and communication about relevant topics is problematic. The clinician then has the chore of learning the patient's view on matters relevant to the evaluation and using this information to accomplish the necessary clinical tasks.

The *theoretical assignment of cultural psychiatry* is to develop and refine a corpus of information about how culture and language influence all facets of a psychiatric condition. This includes, for example, its causes, manifestations, interpretations (e.g. by patients and significant others), and behavioural consequences in the patient's personal and social world. All these factors come packaged in, and are replete with, distinctive symbols and meanings and values. A tenet of cultural psychiatry is that there exists a correspondence between, on the one hand, meaning-filled elements of the psychiatric condition as represented cognitively in the patient, and on the other hand, meaning-filled elements that shape the patient's social relations, circumstances, situation, associated problems of living and actual signs and symptoms. A patient's social background, ethnicity, religious affiliation and level of religiosity, and view of self and social situation are taken into consideration for purposes of understanding how the psychiatric condition is constructed: what it means in the thought world and the life space of patient, how it impacts on, and fits into, the social world of the patient, and what about that world needs to be taken into consideration in treatment for purposes of making the patient's life better.

The term *psychiatric phenomena* is used to refer to an ideal, abstract category. It covers everything and anything that is relevant for an understanding of disturbances of general behaviour (e.g. psychological, somatic) relevant to a comparative cultural psychiatry. Such phenomena constitute a universal property of *Homo sapiens*. Psychiatric phenomena are attributes of all human populations. In theory, any specific, empirically distinct human or humanoid population has associated with it a portion of psychiatric phenomena. The variation of such phenomena among human populations is not known, but it can be assumed that all human populations share substantial portions of it. Across human history, each population has carried psychiatric phenomena along with it.

Emotional disquietudes and disarrangements of behaviour are universal and recurring in all human populations. As a result of genetic vulnerabilities and social pressures and hardships, an individual's level of adaptation, habitual way of thinking, feeling and handling affairs, is thrown off kilter. The effect of this composite syndrome is that the wavy line that describes the individual's everyday experiences and behaviour on the radar screen begins to wobble and deviate from its expected course, however slightly. In real life, the individual displays its discomfiture and perturbation through negative changes in feelings, thoughts and performance of ordinary actions and in social relations. Cognitive, emotional, visceral somatic and related behavioural problems an individual may develop and display were termed *psychiatric conditions* if they are noticeably prominent and sustained. This means that, in any historical, contingent population, psychiatric phenomena are apparent (become 'real') as cognitive, emotional, behavioural and visceral somatic disturbances and their manifestations (e.g. symptoms and signs). Such psychiatric conditions are not just possible but actual or veridical in any and all human populations: they are human universals.

To the individual and group mates, a psychiatric condition does not necessarily have to stand out as aberrant or nonsensical and may not be given special attention as an abnormality or illness. When bodily disturbances are prominent, illness is a likely interpretation. When they are not, the individuals' psychological and behavioural changes may be viewed as a normal or expectable reaction to existing economic and political circumstances; a phase of human striving and expectable forms suffering; an intensification of religious doubt; frustrations of marriage; the break-up of a relationship; or a loss of loved one. Yet, were a time-travelling cultural psychiatrist to conduct a careful examination, mental suffering, bodily dysfunctions or a sense of social disarticulation would be uncovered. At least at first, a psychiatric condition can be woven into the normal, expectable or predictable fabric of the individual's thought world and life ways. In light of the centrality of cultural psychology, a meaningful idiom (involving expectations, beliefs, values and feelings) will shape and express the individual's emotional state, behavioural dispositions and actions and altered bodily feelings and functions. All cultures provide individuals with such models, patterns and constructs in terms of which they gauge their sense of self, well-being and adaptation to their circumstances and this is evident when emotional and thought-related difficulties supervene.

This line of thought leads to two generalizations. All peoples (i.e. societies, cultures) have experienced tokens of psychiatric conditions in different guises and amounts. And all individuals, some more than others as a consequence of genes or traumatic, harmful developmental residua, carry a portion of a population's psychiatric phenomena within themselves and are vulnerable to its realization as psychiatric conditions. How the latter are understood and dealt with depends on a people's understandings about social life, bodily experience and behaviour.

Psychiatric phenomena include the pool of behaviour disturbances and psychiatric conditions that any population is vulnerable to. Such disturbances come about as a result of the *dialectical interplay* of innate genetic propensities with social, cultural and ecological contingencies. Psychiatric phenomena and the conditions they encompass include, but are not identical to, what contemporary clinical neuroscience psychiatry defines as *psychiatric disorders*. In a general frame of reference, the latter merely refer to the way psychiatric conditions are named and conceptualized by professionals who happen not to live in contemporary Anglo-European societies. It is assumed that an indeterminate portion of psychiatric phenomena has yet to be identified, for example, because of current inadequacies in clinical and basic sciences of psychiatry, or because some possible results of the biology–society dialectic have not yet materialized (as psychiatric conditions or disorders), but might/will do so in future in relation to changes in the dialectical interplay of biology, culture, society and ecology.

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Coping with stressors: racism and migration

Brendan D. Kelly and Larkin Feeney

EDITORS' INTRODUCTION

Migration is the process by which individuals move to another culture or geographical area for a more or less permanent stay. The experiences of migration are as important in the genesis and maintenance of psychiatric disorders as is the process of migration itself. The views of many researchers and opinion makers do not move beyond the notions of racism, where almost every experience is seen as caused by/influenced by/coloured by racism. Racism is not a recent phenomenon although race itself was identified in the eighteenth century to differentiate between the colonized and their masters. However, Cicero in the fourth century BC was describing the British as lazy and stupid and advising his employer not to employ slaves from Britain. The inherent institutional racism in the Hindu caste system has been going on for millennia without clear clinical and research evidence that rates of psychiatric disorders are raised among lower castes.

Kelly and Feeney explore the challenges of racism and migration to patients, researchers and service providers. For patients, racism and migration do act as stressors to perpetuate (or precipitate) social problems. Their argument follows from epidemiological studies which demonstrate variable rates of various psychiatric illnesses in different ethnic groups. They highlight the ethical and methodological challenges for researchers, especially the problem of definition and cultural adaptation of research tools along with interpretation of findings outside the social and cultural context without community consultation. They point out that there is a paucity of studies examining the precise inter-relationship between biological factors and sociopolitical factors in the aetiology of specific psychiatric illnesses. Ethical issues in cultural psychiatry research deserve a wider discussion and agreement. The research base is necessary but the aim should be to build this appropriately and sensitively.

Introduction

Psychological stressors such as racism and migration present specific challenges in the context of trans-cultural psychiatry. The aim of this chapter is to explore the particular challenges that these kinds of stressors present to service-users, service-providers and, in particular, mental-health researchers. For mental-health service-users, stressors such as racism and migration may perpetuate social problems, precipitate psychological symptoms or complicate pre-existing psychiatric disorders. For service-providers, racism and migration present formidable challenges to the provision of effective mental healthcare that meets the increasingly diverse needs of service-users. For mental-health researchers, the study of stressors such as racism presents both methodological and ethical challenges that need to be addressed at all stages of research.

This chapter (1) provides a brief overview of the effects of stressors such as racism and migration on mental health and mental-health services, and establishes the importance of addressing methodological issues in this area. (2) We then look specifically at the methodological and ethical challenges that face mental-health researchers working in the field of trans-cultural psychiatry and lastly, (3) we

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aim to provide suggestions for future work and developments in this field.

The relevance of social stressors to mental health and mental-health services

Social stressors and mental health

The association of socio-economic and political factors, including racial discrimination and migration, with physical and mental ill-health is well documented (Kelly, 2003). Racism may operate at either an institutional or an individual level, leading to problems such as stereotyping, rejection, prejudice, devaluation of culture, threats and attacks (Bhugra and Ayonrinde, 2001). Such discrimination has been linked to physical health problems such as hypertension (Karlsen and Nazroo, 2002; Williams and Neighbors, 2001), respiratory illness (Karlsen and Nazroo, 2002) and low birthweight (Collins *et al.*, 2004). Racism also affects mental health (McKenzie, 2003), with increasing evidence of associations between perceived discrimination and rates of common psychiatric disorders (Karlsen and Nazroo, 2002), as well as delusional ideation levels in the population (Janssen *et al.*, 2003). In addition, parental responses to racism appear to have measurable effects on the mental health and behaviour of children (Caughy *et al.*, 2004).

Migration has been consistently associated with increased rates of a range of physical disorders (Gleize *et al.*, 2000) and mental disorders (Nazroo, 1997; Gavin *et al.*, 2001). In the United Kingdom, individuals from Carribean, Irish and Pakistani communities have significantly increased rates of deliberate self-harm (Nazroo, 1997), while those of Egyptian and Asian origin have increased rates of bulimia and anorexia nervosa (Bhugra and Jones, 2001). Schizophrenia is up to six times more common in African-Caribbeans living in the UK compared to the native population (Harrison, 1990) and four times more common among migrants to the Netherlands (Selten *et al.*, 1997). While the reasons for this are incompletely understood, one compelling piece of evidence is that the increase in risk of schizophrenia shows an inverse relation with the size of the migrant group within the general population (Boydell *et al.*, 2001) – a finding that is more consistent with a social rather than a biological explanation. This finding, however, is not consistent across studies (Cochrane and Bal, 1988) and requires further examination.

Schizophrenia, indeed, provides a particularly good example of the interaction between biological factors and social factors in determining the clinical features of psychiatric illness. There is now clear evidence of a substantial biological basis to the aetiology of schizophrenia, involving combinations of genetic factors (Straub *et al.*, 2002; Harrison and Owen, 2003), disturbances to prenatal development (Murray *et al.*, 1992; Weinberger, 1996; Kelly *et al.*, 2005), obstetric complications (Cannon *et al.*, 2002) and various other factors, such as cannabis misuse (Arseneault *et al.*, 2004). At the same time, there is a growing body of evidence indicating that social, economic and political factors also help to shape the presentation, clinical features and prognosis of the illness (Kelly, 2005). For example, individuals from lower socioeconomic groups present with schizophrenia at an earlier age (Mulvany, *et al.*, 2001) and have longer durations of untreated psychosis (Clarke *et al.*, 1999) compared to those from higher socioeconomic groups. These are important associations because both early age at first presentation (Bellino *et al.*, 2004) and long duration of untreated illness (Addington *et al.*, 2004) are associated with more severe illness. Moreover, in addition to socioeconomic group, various other socio-ecological factors may also have a significant effect on mental health: reduced social capital (Putnam, 2000), for example, is one possible explanation for the inverse relationship reported between size of migrant group and increased risk of schizophrenia amongst migrants in London (Boydell *et al.*, 2001).

Despite these provocative findings, there is still a marked paucity of studies examining the interrelationships between biological factors and social, economic and political factors in the aetiology, treatment and outcome of mental illness. While there is considerable research interest in specific areas (such as the relationship between migration and psychosis), other areas (such as racial discrimination in health services and the effects of globalization) receive considerably less attention.

Globalization, racial discrimination and mental-health services

The advent of 'globalization' has increased the importance of issues related to migration, racial discrimination, sexual discrimination and political discrimination in the context of mental-health services. 'Globalization' refers to the dismantling or opening of social, cultural and political borders between countries, continents and peoples; examples of this trend include increased ease of travel, improved communication technologies and deregulation of commercial and economic activity (*Economist*, 2001).

The effects of globalization on mental-health services include the emergence of a wider range of attitudes and beliefs about mental illness, increased ethnic and cultural diversity amongst service-users, and increased ethnic and cultural diversity amongst service-providers, resulting in a broader range of approaches to mental healthcare (Kelly, 2003). In developed countries, increased rates of inward migration may also result in increased rates of certain mental illnesses associated with migration (see above), while in rapidly developing countries, there may be increased rates of mental illnesses associated with social change, economic change and life events. From the perspective of the service-providers, it is likely that globalization of health-services planning will result in a sustained emphasis on the implementation of international protocols, directives and recommendation in relation to psychiatric training, mental-health policy and the protection of human rights (United Nations, 1991; Institute of Medicine, 2001; Lavikainen *et al.*, 2001; World Health Organization, 2001).

The advent of globalization emphasizes the effects that social factors (such as migration and racial discrimination) can have on mental health and highlights the multiplicity of challenges that increasingly face service-providers and researchers in this area. Racial discrimination presents a particular problem in medicine (Bhopal, 2001), as evidenced by reports of significant racial discrimination against overseas doctors and medical students from ethnic minorities (Coker, 2001). In terms of patient care, there is evidence of poorer access to care, differences in service provision, and differences in treatment outcomes amongst patients from ethnic minorities (McKenzie, 1999). Racial issues are also relevant in the context of mental healthcare (Cope, 1990), as evidenced by reports of 'race thinking' amongst psychiatrists, which may lead to inappropriate diagnosis and management of mental illnesses (Lewis *et al.*, 1990). Racial issues may also have significant effects on service provision, with, for example, evidence of over-representation of Black people in secure psychiatric facilities in the United Kingdom (Lelliot *et al.*, 2001; Bhui, 2001); this phenomenon may be related to non-engagement with treatment options in less secure environments or to a perception that Black patients are more dangerous, despite lower ratings of psychopathology (Bhui, 2001).

In summary, migration, racism, discrimination and globalization present important issues for mental-health-service users, service providers and service planners. These social, economic and political factors present particularly urgent challenges to researchers who seek to enhance the evidence base for mental-health interventions aimed at meeting the increasing diverse needs of service users. The challenges are both methodological and ethical, and psychiatry's response to them is likely to have far-reaching effects on psychiatric practice and mental-health research in the future.

Methodological and ethical challenges for researchers

The ethical perspective

Medicine and medical research have a long history of engagement with the concepts of 'race' and 'ethnicity' (Kuper, 1975: Cruikshank and Beevers, 1989). A substantial proportion of this research is now considered to be unethical, racist and/or invalid (Kuper, 1975; Stepan, 1982). In recent years, therefore, there has been renewed interest in addressing the ethical issues inherent in studying ethnicity and race in relation to disease (Bhopal, 2001). One of the most prominent developments in this area is the use of self-described 'ethnicity' rather than externally defined 'race' for the identification of groups for study or comparison; this is a generally positive development, albeit that some confusion between terms still persists.

In terms of overall ethical standards, it is fundamentally important that research projects should be valid and useful, and designed so as to optimize the likelihood of producing a clinically significant result. As Bhopal (2001) points out, much research in health and ethnicity falls into the category of 'black-box epidemiology', which means that the research may succeed in identifying a statistically significant association (e.g. associating a specific aspect or risk of disease with a specific 'ethnicity') but fail to identify the precise causal mechanism that links the disease to the ethnic group. This approach treats ethnicity as an unknown 'black box' and fails to dissect out the precise biological processes that account for the observed association. This approach is especially regrettable because certain studies or disease and ethnicity (e.g. migrant studies) offer unique opportunities to elucidate the causes of certain diseases (e.g. schizophrenia), but this potential will not be realized if ethnicity is simply regarded as a 'black box' and no attempt is made to identify precise causal mechanisms.

In addition to this central ethical consideration, the study of race and ethnicity also raises several other issues in relation to the established principles of medical ethics; i.e. autonomy, non-maleficence, beneficence and justice (Beauchamp and Childress, 2001). A full consideration of these issues is beyond the scope of the present chapter, but it should be noted that the history of research in this field provides considerable cause for concern (Kuper, 1975: Stepan, 1982; Cruikshank and Beevers, 1989). Central issues relate to participants' provision of informed consent for research; the obligation on researchers to avoid harm and promote health; the obligation on researchers to ensure that participants enjoy the benefits of research; and the obligation to ensure that the burdens and benefits of research are distributed in a manner that is equitable and just. Various accounts of the Tuskegee syphilis study in the United States provide an educational reminder of the need to rigorously observe the centrality of ethical principles in the design, conduct and appraisal of research studies (Thomas and Quinn, 1991; Corbie-Smith, 1999; Reverby, 2000). For historical reasons, these issues are especially acute in relation to research attempting to examine relationships between health and ethnicity or race. An awareness of the likely dissemination pattern and public impact of results (e.g. in the popular media) is also important.

Methodological challenges in cultural psychiatry research

In addition to the 'black box' problem and various ethical issues, research into ethnicity and disease presents a range of important methodological challenges for researchers. These include: (a) providing appropriate training and supervision for researchers and psychiatrists; (b) defining terms such as 'ethnicity' and 'race' for research purposes; (c) cultural adaptation of research tools; (d) identifying and adjusting for confounding variables; (e) interpreting findings and putting research into practice. These broad issues will each be considered in turn. Other more specific methodological issues include the selection of valid study samples, the selection of control groups, the balance between 'etic' approaches (from outside a system) and 'emic' approaches (from within a system), and the consideration of cultural 'equivalence'; these issues are discussed by Berry *et al.* (2002).

Training and supervision in trans-cultural psychiatry and research

The provision of training and supervision for researchers and workers in transcultural psychiatry presents a range of challenges that are, at once, formidable and urgent. Dogra and Karim (2005) emphasize that overall policy in this field needs to place a strong priority on education, and that training programmes should have a sound evidence base, appropriate evaluation programmes, and identifiable outcome measures. They also highlight two different models for teaching cultural competence: one based on cultural expertise and the other based on cultural sensibility (Dogra and Karim, 2005). Multicultural training in psychiatry is, however, a complex undertaking, and trainers may encounter resistance and emotional reactions that can take multiple forms, including passivity, avoidance and anger (Jackson, 1999). These responses may be related, at least in part, to individuals' previous experiences as mental-health workers, their personal experiences of racial discrimination, or their lack of experience in these areas.

The lack of appropriately trained personnel to train both psychiatrists and researchers is a fundamental issue in this field. This problem will only be addressed in a systematic and lasting way when basic psychiatric training broadens its remit in response to the demographic realities of rapidly globalizing service-user populations (Kelly, 2003). As part of this process, the World Psychiatric Association is developing a core curriculum which places substantial emphasis on trans-cultural issues and which should help redress some of the imbalances in current training curricula (www.wpanet.org). There is a need, however, for ongoing emphasis on trans-cultural issues, not only during basic training in psychiatry, but also throughout programmes of continuing professional development (CPD) and continuing medical education (CME) for more experienced practitioners.

Defining 'ethnicity' or 'race' for research purposes

The definition of 'ethnicity' or 'race' for research purposes requires careful consideration, especially in light of the history of medical research in this area (Kuper, 1975: Stepan, 1982; Cruikshank and Beevers, 1989). This issue has an important ethical dimension (as outlined above), as well as important methodological dimensions. The term 'ethnic type' has been recommended to researchers, in place of the previously used term 'race' (Stepan, 1982), although this suggestion has not been without controversy (Senior and Bhopal, 1994). Whichever term used (e.g. ethnicity or ethnic group), the term needs to be clearly defined in order to optimize consistency and comparability both within and between studies. The terminology also needs to be non-discriminatory and acceptable to study participants, researchers and those who ultimately implement the research findings in clinical practice. In this light, the trend toward using self-defined 'ethnicity' is likely to be more acceptable to participants in research but may raise issues about consistency, especially if ethnic categories are not clearly defined in the research materials.

Given the 'black box' criticism of much research in this area, it may be more scientifically useful to investigate some health issues that may be related to ethnicity through prisms other than that of ethnicity itself. For example, studies of the excess risk of schizophrenia in migrant populations have tended to focus on specific mechanisms that might mediate the excess risk, such as rates of schizophrenia in the country of origin (Hickling and Rodgers-Johnson, 1995), rates of obstetric complications (Hutchinson *et al*., 1997) and size of migrant groups (Boydell *et al*., 2001), rather than focusing on a broad and arbitrarily defined concept like 'ethnicity' as a possible explanation. In general terms, a more scientifically grounded approach is likely to optimize the scientific value of these kinds of studies and to maximize their relevance not only in terms of understanding the increased rates of illness amongst migrant populations, but also in terms of the overall aetiology of the given illness.

Cultural adaptation of research tools

In order to achieve meaningful results from research, the measures used must be valid and culturally relevant. Some basic mental-health concepts may not be applicable to certain migrant populations. For example, high expressed emotion has not been found to be a predictor of relapse in schizophrenia in Asian families living in the United Kingdom (Hashemi and Cochrane, 1999). Standard measures used to assess post-traumatic stress disorder have also found very widely varying prevalence rates among different migrant populations, thus calling into question the validity of the concept of post-traumatic stress disorder when applied to certain populations (Abeug and Chun, 1996; Van Ommeren *et al.*, 2001).

Research instruments in mental health generally take the form of questionnaires or structured interviews. It cannot be assumed that the validity and reliability of such instruments will be maintained across different populations. In psychiatry, gold standards for comparison purposes are generally the diagnoses made by clinicians who are trained in the use of semi-structured diagnostic interviews such as the Structured Clinical Interview for DSM-IV (SCID) (First *et al.*, 1998). In order for such a standard to be applied to migrant populations, there needs to be evidence of measurement validity and reliability in the context of that particular population. For many instruments, this evidence is not available and, as a result, certain instruments used to conduct mental-health research in migrant populations cannot be relied upon.

Where research instruments are employed, further problems may arise as a result of translation from the original language. Commonly used English terms such as ‘the blues’ or ‘butterflies in the stomach’ cannot be literally translated if the instrument is to retain content validity. Translators need to have an adequate understanding of how such concepts are expressed in the original language and in the language the instrument is being translated into.

Particular populations may also have quite different ideas about similar conditions. For example, an important component of panic disorder among Khmer refugees is catastrophic cognitions of ‘wind overload’ (Bhui *et al.*, 2003). Again, mental-health researchers need to have access to detailed local knowledge regarding the population they wish to study if they are to achieve meaningful results.

In summary, research instruments to be used must have cross-cultural equivalence, and local knowledge needs to be employed in the development of such instruments; and such instruments need to be administered by clinicians who are trained in their use. These tasks may prove both expensive and time-consuming, but without such a considered, methodological approach, research results will lack validity.

Identifying and adjusting for confounding variables

Research in cultural psychiatry is commonly complicated by multiple cross-cultural challenges to understanding; by personal, institutional and methodological biases; and by a particularly broad range of confounding factors. Studies of racism, for example, can be confounded not only by the usual confounders identified in epidemiological studies (age, gender, socio-economic group), but also by additional factors such as community size, ethnic sub-groupings and differing social and cultural arrangements (e.g. family structure, diet, etc.). Migration studies, too, are particularly prone to confounding by socio-economic group (McGrath *et al.*, 2004).

In designing studies in this area, it is important to identify potential sources of bias and confounding prior to data collection. Rather than simply controlling for these factors from the very outset, however, it may be useful to examine and evaluate each factor not only as a potential confounder but also as a potential causal factor. For example, there is now substantial evidence that migration is associated with increased risk of schizophrenia (Harrison, 1990; Selten *et al.*, 1997), but the causal mechanism for this association remains unclear (Hickling and Rodgers-Johnson, 1995; Hutchinson *et al.*, 1997; Boydell *et al.*, 2001). If researchers designing studies in this area indiscriminately ‘control’ for a large number of poorly understood ‘confounding’ factors, they run the risk of inadvertently controlling for the very factor they seek (the causal factor) and thus rendering their study incapable of producing a valid result. Some potential confounders, then, need to be evaluated not only in relation to the methodological criteria for confounding but also in relation to the epidemiological criteria for causation (Van Reekum *et al.*, 2001).

In addition to racially based biases, studies in cultural psychiatry may also be prone to other forms of bias, including cultural biases, selection bias, observer bias and various other methodological biases. Many of these problems can be overcome through rigorous design, execution and analysis of studies. Methodological pluralism has also been recommended as a form of overcoming some of these problems; Harrison *et al.* (1997), for example, argued that the link between migration and psychosis required support from multiple studies from multiple sites using various different methodologies, in order to produce a valid and reliable overall finding. Multi-level analysis can also help overcome some of these methodological challenges, especially in the context of research that addresses factors at both individual and group levels (Karlsen *et al.*, 2002).

Interpreting research findings and putting research into practice

Issues of race, culture and ethnicity are increasingly recognized as having a significant influence on psychiatric practice and mental-health care (Schultz, 2004). The central aims of research in trans-cultural psychiatry are to bring an awareness of trans-cultural issues to the service-planning and service-delivery processes, and to help bring an end to racial discrimination in existing mental-health services (Kmietowicz, 2005). The interpretation and implementation of findings from trans-cultural research is a critical step in this process.

Once research is completed, the effective interpretation and implementation of findings may prove challenging. These challenges may stem from a range of factors, including pre-existing organizational structures, inflexible organizational cultures or rigid decision-making styles (Berry *et al.*, 2002). The prevailing political context is also relevant, especially if the motivation to address trans-cultural issues is derived chiefly from transient political concerns, rather than more substantive demographic or epidemiological realities. The interpretation and implementation of findings may also differ significantly across different ethnic and sub-ethnic contexts, especially as the emphasis placed on individual approaches and collective approaches to health varies across groups.

At the outset, it is essential to establish that research findings are truly appropriate to the social, political and medical contexts in which they are to be implemented. This process may be complicated by the fact that idioms, cognitions and expressions of distress are likely to vary significantly between different cultural groups (Bhugra, 2005). Nonetheless, these variations may provide opportunities to (a) develop a more fine-grained understanding of psychological distress in different groups; (b) identify commonalities as well as differences between groups; and (c) develop a greater understanding of opportunities for intervention. It is similarly important that the implementation of findings takes account of existing health beliefs and practices. In this context, the examination of the various pathways used to access mental-health care (Van Os and McKenzie, 2001) may help locate the precise relevance of novel findings in the specific contexts in which proposed interventions are to be developed.

Racial discrimination and other issues related to race may present particular difficulties when implementing the findings of trans-cultural research. Not only are there strong links between racism and physical illness (Williams and Neighbors, 2001; Karlsen and Nazroo, 2002; Collins *et al.*, 2004) and racism and mental illness (Karlsen and Nazroo, 2002; McKenzie, 2003; Janssen *et al.*, 2003), but there is also evidence that even being worried about being the victim of racial harassment can have a negative effect (Karlsen and Nazroo, 2004). This latter finding emphasizes the importance of addressing issues in the psychological environment that may have a critical influence on people’s fear of racial discrimination and, in turn, a significant influence on their health. In addition, there is an ongoing need to address issues of racial discrimination in the fields of medical education and medical practice (Coker, 2001) in order to ensure that trans-cultural research findings are implemented, and trans-cultural services are developed, in a fashion that is non-discriminatory, equitable and acceptable to service users and service providers alike.

Future work and developments

Social and psychological stressors such as migration and racial discrimination present considerable challenges in the context of trans-cultural psychiatry. As outlined above, there is now strong evidence of increased rates of certain physical and mental illnesses (e.g. schizophrenia) amongst migrant populations and there is similarly strong evidence that racial discrimination has a significant and adverse effect on mental health. Despite these findings, there is still a marked paucity of studies examining the precise inter-relationships between biological factors and socio-political factors (e.g. migration) in the aetiology of specific illnesses, and there is a similar paucity of studies examining the relationships between racial discrimination, mental health and mental-health service uptake.

The advent of 'globalization' has added to the importance of many of these issues in recent years and has brought new urgency to researchers' efforts to enhance the evidence base for interventions aimed at meeting the increasingly diverse needs of mental-health service users. It, of course, important to note that existing mental-health services can, on occasion, respond very well to these challenges, with some service users providing positive assessments of relevant aspects of services (Madhok *et al.*, 1998). Nonetheless, the process of globalization has highlighted a clear need to address cultural issues in a more systematic, explicit and evidence-based fashion in the future. The challenges are, at once, ethical and methodological.

In the first instance, there is an ongoing need to address the ethical issues presented by demographic, epidemiological and cultural changes, bearing in mind that ethical principles may vary between ethnic groups, especially as the emphasis placed on individual rights and collective rights varies across cultures. These differences point to the need for an ethical dialogue that is inclusive, respectful and pragmatic and is focused on the identification of explicit, agreed goals for mental-health services.

In terms of methodology, both qualitative and quantitative approaches are needed, with qualitative studies playing a particularly important role in opening the 'black box' that can lie at the heart of some epidemiological studies. An increasing focus on causal and biological mechanisms, rather than arbitrarily defined concepts such as 'race', would also help develop a more fine-grained understanding of the interactions between overtly biological factors and socio-economic factors in the aetiology of specific illnesses. Other challenges include the provision of appropriate training and supervision for researchers and service-providers; more consistent uses of terms such as 'ethnicity' and 'ethnic group' in both health research and policy spheres; cultural adaptation of research instruments; more systematic analysis of confounding variables from the perspectives of both confounding and causality; more careful interpretations of research findings; and more appropriate integration of research findings into existing models of service delivery. In this context, there are particular needs for the identification of the pathways to care currently used by different ethnic groups (Van Os and McKenzie, 2001) and for the revision of existing models of service delivery to reflect these new cultural practices and demographic realities.

In terms of overall approach, there is a number of different overall measures that might help improve the standards of both research and clinical practice in trans-cultural psychiatry. Bhopal (2001) argues convincingly that increased participation of ethnic minorities in designing policy and conducting research is one way to improve the ethical standard of research into ethnicity and disease. A more explicit discussion of methodological issues is also needed, along with a closer examination of the extent to which current institutional structures may or may not act to discriminate against certain areas of research. In this light, the recent discussion about possible or perceived editorial racism in psychiatry is both valuable and refreshing (Tyrer, 2005; Timimi, 2005).

Ultimately, social and political phenomena such as migration, racism and globalization present increasingly important challenges to mental-health service users, service providers and mental-health researchers alike. Psychiatry's response to these challenges is likely to have far-reaching effects on mental healthcare and mental-health research in future years. A solid, pragmatic research base is essential to this response. If properly constructed, this research-base will help service-providers and service-users to build mental-health services that are effective, equitable and appropriate to the needs of our increasingly diverse, increasingly globalized, societies.

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Cultural psychiatry: the past and the future

Dinesh Bhugra and Kamaldeep Bhui

Introduction

As is evident, cultural psychiatry deals with the relationship between culture and mental illness and how idioms of distress are portrayed and acknowledged within cultures. The role of cultures in moulding an individual's personality and growing up, along with social-support systems, determines not only the diagnosis of disorders but also management strategies. It is imperative that clinicians are as aware of cultural factors as they are of biological factors, which are also influenced by culturally determined patterns such as diet.

The future of cultural psychiatry will influence how psychiatric conditions present themselves and how help is sought. With changes in global movements of people, their ethnic and cultural identities will change and that will determine the distress and its expressions. The degree of change will be determined by a number of factors – individual personality traits, relationships and contacts within the kinship, and broader societal factors. The changes may be transient, semi-permanent or permanent.

Ethnic identity depends upon the cultural or physical criteria, which set the group apart and, wherever we go, we take our identities with us and with inter-racial marriages and relationships these will change. The ethnic group may set itself apart using superiority or inferiority on the basis of real or alleged physical characteristics (Feagin, 1978) and placed on cultural physical criteria which set the group apart (Thompson, 1989). Racial identity refers to a sense of group or collective identity, based on one's perception that the individual shares a common racial heritage with a particular racial group (Helms, 1990). This differentiation is helpful in trying to understand some of the identity-related issues, but it can also be criticised for helping to create stereotypes and over-generalisations, thereby further compounding the complexity of the problem (Helms, 1990). Future researchers need to look at this distinction. Berry (see Chapter 13) recommends using the teams' ethno-cultural identity, which may be a step forward.

Beliefs, disbeliefs and cultural identity

No matter where they move to, individuals do not leave their beliefs or idioms of distress behind. These beliefs influence their idioms of distress and how these idioms are then used to express symptoms and employ help-seeking patterns.

With acculturation, some aspects of identity are more likely to change than others. The identity structure analysis includes appraisal and current expression of identity and identification and the formation and development of identity (see Chapter 4 by MacLachlan) (Weinrich, 1989). A person's identity is defined as the totality of one's self – construal in which how one construes oneself in the present expresses the continuity between how one construes oneself as one was in the past and how one construes oneself as one aspires to be in the future (Weinrich, 1989). Ethnic and cultural identities form part of one's identity, and changes due to

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acculturation will change the construction of identity. Gender, familial and socio-economic identities are also part of the identity of the self. In some ways, these form the core of what can be understood as cultural psychiatry, especially at an individual level.

Cultural Psychiatry in the UK

Cultural psychiatry does not yet feature in the UK as a separate discipline. There has always been a concern that, if this were a separate discipline, it might eventually lead to segregation of services, of populations and of policy. This is opposed on ideological grounds but also due to financial constraints, as each cultural group cannot be provided with a separate service.

History of cultural psychiatry in the UK

In the 1970s, some psychiatrists began to promote the need for a cultural psychiatry and a Transcultural Psychiatry group which was multidisciplinary was set up. In the 1980s, research papers began to be published which referred to the need to address the effects of racism on the mental well-being of Black and minority ethnic people, and of migrants.

In the 1980s the practice of psychiatry in diverse cultures was informed by anthropologists and psychiatrists, bringing different perspectives to cultural psychiatry. Two papers, one by Littlewood (1990) and one by Leff (1990) in the *British Journal of Psychiatry*, summarised the key conceptual, theoretical and practical issues. Kleinman (1980) emphasised the patients' world view and what of it needed integration into the practice of psychiatry. Specifically, a debate about universals and relativism emerged. This had major implications for services, clinical practice and research. The emphasis on racism and migrants has remained and is still a key feature of the UK form of cultural psychiatry. However, cultural psychiatry has now embraced epidemiological principles, sociological and anthropological critiques; and policy-makers and service-developers are also increasingly knowledgeable about these issues.

Cultural psychiatry in the UK was originally seen as a branch of social psychiatry, and to be concerned with community care, stigma, de-institutionalisation, and with spiritual and religious aspects of psychiatric care. There is also more emphasis on asylum seekers and refugees, and the effects of environments, including geography, ethnic density and area on the well-being of minorities. However, more recently, cultural psychiatry has become stronger and in some ways is beginning to replace social psychiatry. It is increasingly being seen as relevant to and makes use of many aspects of other disciplines, including philosophy, cultural studies, epidemiology, sociology, psychoanalysis and anthropology. There have also been other changes in the culture of healthcare in the UK.

In the early 1990s, the Transcultural Special Interest Group of the Royal College of Psychiatrists was formed (see http://www.rcpsych.ac.uk/pdf/bulletin_winter05.pdf).

Social and political processes and research evidence

More recently, the proportion of people from ethnic groups in the UK has risen as it has in other developed countries.

There have been complaints from some ethnic groups that psychiatric practice is dangerous for them. The main findings in the UK show a higher incidence of schizophrenia among Black people of Caribbean origin, although this may be true of immigrants in general (see Chapters by Stompe & Friedmann (24) and Jablensky (16) in this volume). Caribbean-origin Black people are more often detained, whilst South Asian people are less often seen in services. These differences are given many interpretations, one of which is institutional racism, and others include differences in expressions of distress and needs for care across ethnic groups. Ethnic variations in access to services may be determined by health beliefs, attitudes to psychiatric care and use of traditional or lay healers. Increasingly, services are adapting to offer the treatments that patients think are helpful and that are evidence based.

Recent events in the UK have re-emphasised the need for improvements in public services when they provide a service to ethnic groups.

UK policy

Two policy frameworks in the UK are important. One focuses on cultures and the other on race equality.

First, 'Inside/Outside: a National Policy to Improve Services for Black and Minority Ethnic Groups' (March 2003; http://www.nimhe.org.uk/downloads/inside_outside.pdf). This aimed to:

- reduce and eliminate ethnic inequalities in mental-health service experience and outcome
- develop the workforce
- engage the community and building capacity
- develop organisations, improve suicide prevention, lead to culturally capable research, and service development.

There then followed 'Delivering Race Equality and Government Response to David Bennett' (2005; http://www.dh.gov.uk/assetRoot/04/10/07/75/04100775.pdf). This:

- shifted emphasis from cultures, to inequalities to racism and race equality (Bhui, *et al.*, 2004)
- encouraged appropriate and responsive services: including cultural capability
- proposed Community Engagement as a useful process
- electronic collection of information, and more research and evaluation.

The two national policies propose that all health and social-care professionals are expected to be culturally competent. This has come as a bit of a shock to most practitioners who had not considered their own cultural background before, but now were being asked to consider ethnicity and culture and race as key variables in the provision of care. This is where cultural psychiatry and associated disciplines become relevant.

Cultural competency for all!

However, there are no agreed standards, quality indicators or consistent definitions in the UK. There are good reviews and best practice guides in the US, Canada, Austarlia and UK, which are not being used. However, there are some international models of care. The cultural consultation model (Kirmayer *et al.*, 2003) has been well described, and similar models were used in Bradford in the 1980s by Phillip Rack. There is a commissioned cultural competency pack of 2 and 6 hours' duration for the NHS, but clearly this is not really going to achieve the cultural competencies as understood by cultural psychiatrists. Cultural competencies take time to nurture and develop, and toolkits and didactic teaching will not achieve the desired outcomes, without an experience of other cultures and the limitations of our nosologies and practices becoming evident.

The lessons from the UK can be shared across the globe. The multi-cultural model followed here can be compared with the rainbow-society model in Canada and the melting pot in the USA.

Acculturation

Coming in contact with another culture may allow the individual to adapt by giving up some aspects of their own identity, whereas others may choose to become further alienated from the new majority culture. The processes of acculturation encourage the individual to develop an identity which makes such an individual reasonably comfortable across the two cultures. On the other hand, deculturation may lead to pathological responses, both at individual and group levels. Acculturation is intimately related to ethnic, racial or cultural identity and one can be measured from the other. Acculturation measures may be used only to assume measurement equivalence between and within study groups (Trimble, 2003). These deserve further exploration and attention.

The acculturation can occur at a psychological level as well as at a cultural level, as discussed by Berry and others in this volume. Persistent problems in cultural adaptation are associated with a higher risk for long-term mental-health problems. Effects of pre-migration trauma, post-migration factors such as loss of social roles, confidants, attitudes, etc.; socio-demographic factors such as age, sex, education and economic status; and effects of cultural orientation (e.g. assimilation, separation, biculturalism and marginalisation and acceptance from the host society) play a key role in the process of acculturation (Organista *et al.*, 2003). Within ethnic identity, role of spirituality and religiosity has to be understood (Gong *et al.*, 2003). Assessing the relationship between acculturation and mental health poses important theoretical and empirical challenges to clinicians.

National character and types of cultures

Inkles (1997) sees national character as a particular way of looking at the coherence of culturally defined values or behaviour patterns – referring to personality patterns which are common or standardised in a given society. National character needs to be studied on the basis of collective policies and products, rituals, institutional structures, folklore, media, mass communication – psychological analysis of which can contribute significantly to the overall psychological characterisation of society (Inkles, 1997) using knowledge of collective behaviours, child-rearing systems, collective adult phenomena (e.g. political behaviours, institutional practice, religious idea systems, religious rituals).

A further important point that needs to be taken into account is that of Hofstede's descriptions of cultures (Hofstede, 1980, 1984) as individualistic or collectivist. Individualism refers to a society where the ties between individuals are loose and everyone is expected to look after himself/herself and his/her immediate family, whereas collectivism refers to a society to which people from birth onwards are integrated into strong cohesive in-groups which throughout their lifetime continue to protect them in exchange for unquestioning loyalty (Hofstede, 1980). Hofstede (1984) suggests that individualistic societies emphasise 'I' consciousness, autonomy, emotional independence, individual initiative, right to privacy, pleasure seeking, financial security, need for specific friendship and universalism. Collective societies stress 'we' consciousness, collective identity, emotional dependence, group solidarity, sharing, duties and obligations, need for stable and predetermined friendship and group decision.

These are paralleled at individual psychological level by idiocentrism and allocentrism, respectively (Triandis, 1985). Markus and Kitayama (1991) called these independent and interdependent views of the self. These subdivisions are crude and not sophisticated enough but need to be studied. For individualism, the key principles are regulation, rules and laws and the characteristics are individuation, self-fulfilment, uniqueness, autonomy, freedom of choice and assertiveness. On the other hand, for collectivism the three key principles are roles, duties and obligations, and characteristics include self-cultivation, interdependence, nurturance, succourance, common fate and compliance (see Kim *et al.*, 1994). As societies and cultures and individuals change, these rules and principles will have to be revisited.

Globalization and culture

Thus globalization and its threats arise from the individualistic societies and the dread is that it will turn collectivist societies into individualistic societies. Although the societies remain heterogeneous, this generalised process is seen as dangerous. Furthermore, it is not as if individualistic individuals are not seen in collectivist societies or vice versa. It is theoretically possible that, under the onslaught of individualism, the traditional societies become more rigid and inflexible.

Interestingly, Kagitcibasi (1994) draws a parallel between the continuum of collectivism and individualism and the continuum of modernism and traditionalism. The individualism–collectivism evolution reflects social organisational changes where individualism becomes more compatible with social organisations, economic development and cultural and social complexity (Inkles, 1969). The great similarity between core modern characteristics derived from 1960s individual modernity research suggests that collectivism may be replaced by individualism as a result of a process of modernization (Triandis, 1984).

In many less developed countries, the 1950s and 1960s map the beginning of the end of colonial power; the economic and social changes leading to urbanization, industrialization and exposures to mass and global media and urban lifestyles. In this context, the psychological characteristics conducive to modernization led to positive attitudes towards achievement rather than to ascription. These changes also included freedom from primordial ties and parental authority, participation in secondary groups, openness to innovation and self-reliance and a sense of personal efficacy, belief in science (rather than religion), future time orientation and punctuality, individualistic orientation, positive attitude towards education and information, optimism, flexibility, risk taking, preference for urban life and exposure to mass media (Berry, 1994). The ecological changes related to cultural variables will include settlement patterns, mean size of the local community, political satisfaction, social stratification, and family type.

Cultural psychiatry can provide a valuable insight into how different cultural groups and individuals respond to migratory stress, how their stress leads to mental illness and how their identities are formed/changed in order to deal with this stress.

Cultural elements change slowly. In societies with a long tradition of collectivism, elements may continue to persist in spite of increased individualism, especially following urbanization and the impact of globalization. Important antecedents of individualism, in addition to cultural complexity, are having a frontier, having substantial numbers of immigrants and having rapid social and geographical mobility, all of which tend to make the control of the in-group (e.g. family, band, tribe) less certain (Triandis *et al.*, 1985) and deserve further attention. People in individualistic cultures have greater skills in entering and leaving new social groups, whereas those in collectivist cultures have fewer skills and the quality of friendship is quite different. In individualistic cultures, the number of in-groups is quite high and superficially individuals appear more sociable but quality of intimacy too is superficial.

Hofstede (1980, 1984) created dimensions in understanding cultures at individual, group and institutional levels using power distance, masculinity/femininity of the culture among various variables which need to be studied in epidemiological settings. Schwartz (1994) further described mastery, hierarchy, conservatism, harmony, autonomy-intellectual or affective and egalitarian commitment. Not surprisingly, the People's Republic of China scored high on mastery and hierarchy and other Western nations, such as France, Israel, Portugal and Switzerland, scored highly on autonomy, conservatism and egalitarian commitment. These factors can then be further analysed and understood in the context of understanding aetiology and perpetuating factors across cultures.

Ethnic diversity vs. ethnic identity

Rosenberg (1962) described dissonant religions in context in high schools in New York. After stratifying populations of public schools, the students were given three questionnaires. Respondents were asked about the religious affiliations of the neighbourhood they lived in the longest and found the experience of living in a dissonant religious context had certain psychic consequences for the individual exposed to it. In every case, Rosenberg (1962) found that students who had been raised in a dissonant social context were more likely than those who had been reared in consonant or mixed religious environment to manifest in terms of psychic or emotional disturbance. Catholics raised in non-Catholic neighbourhoods were more likely than Catholics raised in predominantly Catholic or half-Catholic neighbourhoods to have low self-esteem, to feel depressed and report many psychosomatic symptoms. The results suggest that whether everyone in the neighbourhood is of one's group is less important than whether there are enough of them to give one real or perceived social support – a finding of belonging and a feeling of acceptance. An additional factor was that those in the minority were more likely to be discriminated against and feel alienated.

This example of religious dissonance can form a part of cultural identity. The deleterious effects of contextual dissonance on self-esteem may also be mediated by the nature of dissonant communications and cultural environments and comparison reference groups. Low self-esteem has been well demonstrated to be linked with depression, but it is likely that this may also be a pathway into the genesis of other psychiatric disorders if other vulnerabilities – biological, psychological or social – exist.

Using similar terms as socio-centric/egocentric, Kusserow (1999) argues that this bipolar dichotomy is overdrawn and unrealistic, not only for the Eastern concepts of the self but also that of the Western self. These are not trait-like identities that occur in the context of behaviours, attitudes as well as cognitions. She argues that Western individualism does not preclude socio-centrism. However, this debate has a further fallout. It is possible that individuals who are socio-centric may hold beliefs that are more in line with their in-group and they may find it difficult to break away. Thus, when explanatory models are being inquired into, the nature of socio-centric/egocentric or collectivist/individualistic and allocentric/idiocentric dimensions must be taken into account. The formation of beliefs about self and the illness are to be related to these factors.

Although it can be argued that no egocentric individual is absolutely independent, it is the nature and the beliefs that uphold such dependence have not been studied at all and should be in order to understand the individual's intra psychic experiences. Berry (1997) proposes that, in understanding beliefs related to processes of acculturation, social and cultural levels have to be understood in the context of variables at length of the individual's physical and psychological acculturation. Bearing in mind Spiro's (1993) and Kusserow's (1999) observations, it must be emphasised that different notions and components of self across different cultures are worth studying, but these have to be embedded in specific cultures. Thus there are fresher fields for cultural psychiatry to understand and conquer in understanding the aetiology and management of distress and disorders across cultures.

Conclusions

The type of society, and national character, individual and group acculturation all provide a link to the way an individual deals with stress, creates social networks or buffers and survives. The theoretical implications for studying identity, beliefs and distress are many. Independence and formal education (both of which can be contributing factors) are culture-specific goals of development (Greenfield, 1994) and cultural values are internalised in a way that these travel with individuals into new societal contexts. The majority dominant view consists of both assimilation and accommodation. Cultural adaptation therefore must be studied at both individual and group levels. The heterogeneity of the individuals, and the societies they came from, are useful indicators in trying to understand the impact of migration and development and changes in cultural identity. Cultural identity is fluid and is likely to be influenced by a number of factors that clinicians must bear in mind.

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