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Enw'r Person Dynodedig sy'n awdurdodi'r sganio: **Alison Harding**

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Enw'r Awdur: **Cromby, John, Harper, David & Paula Reavey**

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Name of Designated Person authorising scanning: **Alison Harding**

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Learning outcomes

By the end of this chapter you should:

- 1 Have a working definition of culture
- 2 Understand the difference between emic and etic approaches to mental health and distress
- 3 Know the different prevalent rates for diagnosed mental disorders across cultures
- 4 Understand how various societies view mental health and distress and the differences between some of them

Introduction

Psychological approaches to mental health and distress aim to provide insight into the experiences, emotions, behaviour and states of mind that can contribute to the cause and/or maintenance of mental health problems. Psychologists and psychiatrists are scientifically trained to reach agreement about what problems look like, what to call them, how best to measure and eventually 'treat' them. However, let us pause for a moment to consider some of the issues relating to Lala and Simon; though we may be able to reach agreement on whether their behaviour is unusual or distressing to them and others, we may not be as confident about agreeing a standardized definition of the behaviour, or comparing the two sets of experiences. Do Lala and Simon both 'have schizophrenia' or a form of psychosis? When we look at culture and mental health, must we have a universal set of assumptions and questions about human experience? Is it the case that a Western orthodox understanding of mental health and distress is universally recognizable? Are the behaviours and states of mind described in Western medicine and psychology actually found throughout the world? Despite assurances by some traditional texts about the universal application of psychological and psychiatric models, several questions appear to remain.

Guiding questions

- 1 To what extent do variations or similarities exist between cultures, in terms of the prevalence, incidence and course of traditionally defined mental 'disorders'?
- 2 Do different societies draw the same line between well-being and distress, sanity and madness?

The first substantial question addressed in this chapter is 'To what extent do variations or similarities exist between cultures, in terms of the prevalence, incidence and course of traditionally defined mental "disorders"? We will address this by looking at a broad range of data, including the World Health Organization studies on 'schizophrenia'. It has been argued that if we were to find strong similarities in the prevalence, incidence and course of a disorder like 'schizophrenia', this would lend more weight to biological (or pathoplastic) models, which propose that while culture may shape the content of the symptoms of this disorder, the form of the symptoms remains the same. Incidence is a measure of the risk of disease, injury of death at any given time period (e.g. over the course of a year) and the occurrence of this within a population. Incidences are often expressed in terms of percentages. The biological model prioritizes a biological (neurological, brain structural and

physiological) explanation for the causes and maintenance of mental health problems. 'Pathoplastic' refers to the various influences (biological, social, cultural, psychological) on the form of a disease once it has developed.

According to the pathoplastic model, for example, people still have the illness 'schizophrenia', they may just attribute different meanings to it and it may manifest in different ways, according to cultural customs. Conversely, significant variations in the prevalence, incidence and course of 'disorders' in some societies invite us to ask whether we are measuring the same 'disorder' at all.

The second question is, 'Do different societies draw a line between well-being and distress, sanity and madness in the same way?' Perhaps some societies genuinely express distress and madness in ways that would not necessarily be recognized by Western medical definitions and diagnoses and perhaps there are emotions, bodily states, behaviours and states of mind that hold completely different meanings (Littlewood, 2002). If the variations between cultures are too great, does this make a universal model of mental health and distress problematic?

The vast literature on culture and mental health has developed largely within the disciplines of medical, cultural and social anthropology, and transcultural or cross-cultural psychiatry (Tseng, 2001) and psychology, but we will use this literature here to address issues specifically relevant to psychology. Before turning to each of the questions in turn, we must first address how different societies have made sense of issues relevant to the study of mental illness. It soon becomes clear that the different approaches can begin with quite different assumptions, leading to different questions and, ultimately, different answers.

What is culture?

Defining culture has never been easy and the debates between and within anthropology, psychiatry and psychology continue to rage. Too broad a definition of culture can often obscure some of the key differences between people within the same culture, and a too narrow definition can blind us to important similarities. According to social psychologists Kenrick, Neuberg and Cialdini (2010), a definition of culture can include the set of beliefs, habits, customs and discourse shared by people living in close proximity and time. Cultural anthropologists have also described how culture 'shapes' experience, interpretation, and action [and] orients people in their way of feeling, thinking, and being in the world' (Jenkins & Barrett, 2004, p. 5). Cultural practices often involve symbols, language, rituals, dress and objects that signify a way of life for a society and a set of principles that make up systems of belief, moral codes and legal doctrine. This can also be cross-cut with differences in religious customs. An example from South Asia would be the noticeable differences in religious beliefs and rituals that exist between the Sikh, Hindu and Muslim religions. Thus, even though 'South Asian' cultures may share particular beliefs regarding selfhood, the family and marriage, for example, there would remain religious variations that would represent significant differences between these groups (Loewenthal, 2007).

The term 'culture' is often misused and is often put forward as a variable to be measured and compared. However, as

Arthur Kleinman, a leading US psychiatrist and medical anthropologist (2004, p.952) argues, culture is not a 'thing':

[I]t is a process by which ordinary activities acquire emotional and moral meaning for participants. Cultural processes include the embodiment of meaning in habitus and physiological reactions, the understanding of what is at stake in particular situations, the development of interpersonal connections, religious practices, and the cultivation of collective and individual identity. Culture is inextricably caught up with economic, political, psychological, and biologic conditions. Treating culture as a fixed variable seriously impedes our ability to understand and respond.

Can we then say that a unanimous 'culture' is embraced by all who live in the same society or by those share the same geographical location? Not always; some societies contain a diversity of 'cultures' that may share certain moral or political beliefs, but diverge, say, on religious issues. British society, for example, contains a number of different cultural groups that can be further divided by religion and/or ethnicity. When studying culture and mental health, it could be argued that particular attention must also be given to the more specific domains of family, religion and spirituality, ethnicity, class, gender and sexuality within the overarching definition of culture, as these can have a dramatic impact on the organization of emotions, beliefs and norms of acceptable behaviour (Pilgrim & Rogers, 2002; Addlakha, 2008; Pilgrim, 2009). Furthermore, many 'sub-cultures' can exist within a society whose distinct set of behaviour and beliefs differentiate them from the larger cultural group as a whole, of which the sub-cultures are a part. Due consideration must also be given to issues of culture and migration, where it is possible for migrating groups to partly or fully retain their original beliefs and customs whilst living in a culture with a differing set of values on certain issues (Bhui, Bhugra, Goldberg, Sauer & Tylee, 2004).



Some parts of North American society are heavily influenced by Christian morals and ideals. How does this impact on what we define as culture?

It is clear, then, that defining culture is a complex affair. In textbooks, 'cultural differences' are often studied using geographical location as a way to distinguish differences between cultures. Furthermore, some cultural anthropologists have noted that the distinctions between 'industrialized' and 'developing' societies often operate under the implicit assumption that 'developing' nations refer to members of a

society over 'there' and 'developed' nations refer to members of a society 'here', namely Europe and North America (Hopper, 2004). **Developing countries** are (broadly) countries of lower economic wealth, usually matched by less industrialization and technology. **Industrialization** is the shift from a broadly agricultural and rural society to an industrial and urban one, signalling technological and economic advances. However, there is no universal definition of this term. For the purposes of this chapter, we will stay largely within the bounds of 'geographical cultures', to avoid some of the more complex issues that warrant in-depth and prolonged discussion, which we do not have space for.

In addressing issues of culture in the context of mental health, we must ask questions relating to the particular customs and habits of a given culture and how they may play a role in the development of specific mental health problems; whether all cultures are equally mentally 'healthy'; whether specific behaviours and states of mind are found only in certain cultures and, lastly, whether being 'mad' or 'distressed' in one culture may lead to a better outcome. Furthermore, where migration has occurred, we need to ask how this experience impacts on an individual's mental health, especially when the 'host' culture has discriminated against the migrant or failed to accept their particular cultural beliefs (Fernando, 2003).

'Professional' cultures

'We have truth but they have customs' (Pascal, cited in Littlewood, 2002, p. 19).

It is worth noting that any discussion of culture and mental health must consider not only the wider cultural beliefs of a society, but the professional disciplines that are sanctioned by that society to measure and treat mental health and distress. This is because cultural beliefs regarding mental health are informed and shaped by professional experts who claim to know what causes mental distress and how best to manage or treat it. With the growth of psychiatry within the discipline of medicine in the early 19th and 20th century, distress and mental health became increasingly more medicalized in industrialized societies, with a whole set of human experiences (misery, anxiety, breakdowns) translated into terms such as 'illness' and 'disorder'. This has also begun to have far-reaching effects on countries undergoing economic development and rapid industrialization, where Western notions of mental health have grown in popularity, due to a number of factors, including the adoption of certain Western ideals (see Box 3.1).

The introduction of pharmaceutical companies into developing countries is another potential reason for an increasing interest in Western psychiatric views. In Europe and North America, mental health is still largely treated and measured as a health and illness issue, although the emphasis on biology and medication is much greater in North America than it is in Europe (Littlewood, 2002). Psychiatry has remained a sub-discipline of medicine and is largely in charge of the management of mental health issues in these societies. Unsurprisingly, the remaining dominant view (but not the only one) in mental health services is that mental distress is an 'illness' or 'disorder' to diagnose and primarily (but not exclusively, as psychological interventions are also recommended) treat with physical therapies (drugs). Thus, psychiatry has its own cultural practices and rituals that can shape the individual behaviour and

attitude of each psychiatrist and client, such as standardized measurements, medication, institutionalization, consultations and codes of professional conduct. Clinical psychology also has its own culture, which at times is able to work alongside a psychiatric one, as it must operate in the context of a mental health team, while at other times may oppose psychiatry and create a new set of rituals and practices that can work independently (though, of course, clinical psychologists are still by and large employed by medical institutions).

What is often missing from references to culture and mental health in psychology texts is the recognition that the very idea of measuring people's distress using scales and defining mental distress according to an illness model has emerged from Western assumptions regarding mental health problems and the origins of the problem in the individual (in their genes, their history or personality). Rarely is there any discussion in these texts about how Western culture itself operates and defines what it means to be a person and part of society (Cole, 2005). Indeed, Kim Hopper, one of the cultural anthropologists working as part of the DSM-IV task force to include cultural features in the manual argues that it is rare for Western practitioners and researchers to acknowledge the assumptions regarding individualism and illness informing their work. **Individualism** as a philosophical tradition is concerned with the properties of the individual (deficits, illness, distress).

Furthermore, the DSM task force on culture reported feeling disappointed by the lack of more general discussion of cultural issues in the finalized DSM-IV (Kleinman, 1997). As Bentall notes (2003, p. 139) 'this (DSM) enterprise is, itself, culture bound. It represents the efforts of [certain] members of one particular culture to make sense of human behavioural breakdowns'. Thus, psychiatry and clinical psychology have developed their own set of traditions, which have particular historical origins and politics. This professional culture, in turn, then impacts on the beliefs of a society regarding the nature of mental health and distress. In China, for example, though rates of clinical depression are still lower than in the West, rates have risen sharply over the last 25 years, due to the introduction of Western-influenced diagnostic and assessment tools (Kleinman, 1991). However, psychiatry and psychology are also affected by shifts in wider cultural beliefs regarding what is normal or abnormal. It would be highly unusual nowadays for a psychiatrist or psychologist to take seriously the 19th century diagnosis of drapetomania (an uncontrollable urge to escape slavery, often observed in African-American slaves). This is due to a shift in social attitudes regarding slavery, as opposed to a shift in scientific thinking. Ian Hacking, a philosopher of science, argues that professional cultures not only affect culture with the knowledge they produce, they in turn are affected by the cultural beliefs of the society they exist within. This can apply equally to sub-cultures – the removal of homosexuality from the DSM was strongly associated with political campaigns led by lesbian and gay activists.

The DSM-IV-TR has now been translated into 22 languages, including Chinese and Arabic, and continues to be regarded as an international template for the classification of mental disorders across the world. It is, therefore, unsurprising that wider societal beliefs about mental health and distress are in turn shaped by the language introduced by professional disciplines. Of course, Western psychiatry and psychology are not the only disciplines to shape local beliefs regarding mental health and distress. Traditional healers, for example,

remain powerful figures in many non-industrialized societies; officially sanctioned traditional healing and medicine is legally recognized and is often the first place that many individuals turn to in times of distress (Jilek, 1993). Traditional healers have a well-established professional culture of their own (often dating back before the advent of modern psychiatry and psychology) including a set of culturally specific forms of assessment and treatment. Although traditional healers (who operate in a number of sub-Saharan African societies) may not adopt Western systems of diagnosis, for example, they do have an alternative version of diagnosis, known as **divination**. **Divination** is a process or ritual carried out by a healer to read signs of illness or possession. The healer may look at patterns in liquid or observe supernatural activity by achieving an altered state of consciousness. Unlike the individual consultations that take place in the average industrial nation, divinations may be performed publicly, especially if the patient's complaint is believed to be the result of collapsing social ties (Tseng, 2001). The healer then interviews the patient's family and relatives and, in doing so, builds a picture of his/her social field. Divination can be carried out by mixing specialist herbs or peering into medicated water to assess the ancestral roots that may have contributed to current social tensions (Laine, 2007). The healer may then see or hear the voices of dead spirits or witches who may have occupied the bodies of the relatives who are in conflict with the patient and are thus responsible for their illness. One treatment may be a public exorcism, where members of the community gather to witness the withdrawal of the evil spirit from the patient's body. This would be accompanied by dance and song, as a way to purify the patient and her/his wider community (Turner, 1974).

Studying culture in the context of mental health and distress

In addition to the contribution of professional cultures, how we make sense of the relationship between culture and mental health must depend on our understanding of people (psychology) and mental health more generally (Kazarian & Evans, 1998).

In non-Western societies, moral and community issues are more commonly addressed in the context of understanding



Despite a shift to industrialization in a number of non-Western societies, a sense of collective tradition still remains

BOX 3.1 Professional cultures in Zambia

When studying culture, it is always necessary to consider the interplay between the general cultural customs of a society towards unusual behaviour or distress, and the professional culture that has been developed to deal with them. The two may not resemble one another, but may variously be used by members of that culture. On a recent field trip to Zambia, one of the authors (Reavey) discovered there to be 42,000 registered faith healers and only four registered psychiatrists amongst a population of 11 million. There are a handful of clinics that offer cognitive behaviour therapy but this is extremely rare. Zambia is largely a rural country, where traditional medicine is still widely practised by faith healers to treat mental and physical illnesses. The origins of mental illness are believed to be medical, spiritual or religious, or a combination of these. Traditional medicine can involve the use of herbs, animal skins and tissue (fat, internal organs) to relieve symptoms, and

the healer will be paid for each visit. Faith healing can also include specific ceremonies where evil spirits or dead souls are exorcized by the faith healer, who is trained to go into altered states where she or he can communicate with the spirits. Furthermore, faith healers connected with Christianity can perform ceremonies where the patient is exorcized according to Christian doctrine, in the presence of the religious community. Both traditional healers and psychiatrists are responsible for treating mental health and distress and are officially recognized by Government bodies. In addition, the Zambian government has sought to increase the role played by medical practitioners (following Western principles of medical treatment) by developing a scheme that trains 'clinical officers' who are employed to perform a similar diagnostic and treatment role to psychiatrists, largely in outpatient clinics (there is only one psychiatric hospital in Zambia). The clinical officer is trained to use the DSM diagnostic system and to medicate patients. They are trained for only two years, following high school (this is roughly equivalent to UK A-levels).

The idea behind the use of clinical officers is that larger numbers of them can be trained to deal with mental health caseloads, by following the descriptive model of the DSM and prescribing established (Western) medications. The assumption is that following a well-established biomedical model will lead to more cost-effective and successful management of mental health problems, because they can be treated using standardized medical knowledge. The cultural picture for mental health and distress is, therefore, mixed. On the one hand, there is a strong belief in traditional medicine and the Christian faith, and on the other hand, there is a move towards establishing a psychiatric culture that resembles physical medicine involving short consultations (to monitor medication – case management) or, in extreme circumstances, short-stay hospital treatment. Other ethnographic reports suggest that most individuals living in sub-Saharan African societies rely on *both* traditional and Western psychiatric/psychological systems of support to tackle a variety of needs (Lefley, 1999).

the causes of mental distress, seeking an explanation in outside forces, rather than the individual's personality or possible biological dysfunction (Littlewood, 2002). In Western psychiatry and psychology, moral issues are usually replaced with concerns over symptoms of illhealth or 'states of mind' because the emphasis is on the search for a problem with the person's health, rather than their moral standing in the community. Furthermore, it has long been noted in anthropological writings that a positive belief in individualism is a key feature of Western societies, in which autonomy, independence, 'personality' and free-will are credited with greater significance than collectivity, religiosity, morality and dependency, which are more common to non-Western societies (Triandis, 1989, 1995; Bharati, 1985). In non-Western societies, collective concerns may, in fact, overshadow individual needs.

Self and culture

Western societies have long been associated with the ideals of individualism and personal autonomy. **Individualism** is more often associated with liberalism and a form of 'I-consciousness' (Hofstede, 1984). **Liberalism** is the belief in the importance of equal rights in society.

According to theories and empirical studies in cross-cultural psychology, Western societies, personal life histories, internal beliefs, desires, commitments and thought are believed to provide the information we require to understand ourselves (Hofstede, 1980; Sadler, 2005). Another key assumption in Western culture is the existence of a 'unified self', based on the idea that we have stable and coherent personalities.

A national survey conducted in the US, for example, found that 97% of Americans believed strongly in 'being responsible for your own action's and 89% in 'being able to stand up for yourself'. They also believed that 'being in good health' and 'being able to express your feelings' was essential to good mental health (Cherlin, 1999, cited in Keyes & Ryff, 2003). Social psychological studies have also revealed how views on the self can actually moderate psychological well-being. For example, studies that have established a relationship between increased self-esteem, overall life satisfaction and psychological well-being have been unable to fully replicate these findings in collectivist societies (Ritter, Chaudry, Aigner, Zitterl & Stompe, 2010; Suh, Diener, Oishi & Triandis, 1998).

In **collectivist** (mainly non-industrial or developing) societies, selfhood may be more invested in community and family activities (though it is right to exercise caution here, as non-industrialized societies may adopt some individualistic values – see Box 3.2) rather than personal history and self-esteem alone. Collectivist societies are more often associated with traditionalism and a form of 'we-consciousness' (Hofstede, 1984). Selfhood is more widely dispersed, and grounded in shared activities and values. Having high self-esteem may not be valued, therefore, if as a result the individual stands out and appears to separate from the rest of the group. Such societies may also seek the attribution and resolution of certain experiences or problems, not in the individual's mind or body, but the community, and in particular, the family. This contrasts with much Western psychiatric or psychological intervention. Despite these differences in models of the person and the attribution of the cause of mental distress, psychiatry

BOX 3.2

Economic growth and the rise of eating disorders in Japan

The number of reported cases of **eating disorders** (anorexia and bulimia nervosa) has increased substantially in Europe and North America in the last fifty years. The term refers to a group of 'disorders' characterized by unusual eating habits, including restrictive or excessive food intake, which may have negative consequences for mental or physical health.

In fact, there was some discussion as to whether eating disorders should be included as culture-bound syndromes in the last version of the DSM, because almost no cases had been reported in developing or non-industrialized societies until fairly recently. The pursuit of thinness is reported by those diagnosed with these conditions, as the core feature is an intense fear of fat and poor self-image. The vast majority of cases are young females, a fact that has been attributed to a crisis in female identity, following conflicting demands for women's success in education and industry and their continued

submissiveness and dependency in the domestic sphere. The increasing pursuit of individualism and personal success, along with the fragmentation of family ties, is also believed to be contributing to the growing number of eating disorders in these countries. Developing countries were thought to be immune because non-industrialized societies were more collective in outlook, had less access to food and supported strong family bonds (conditions opposite to those that foster eating problems). However, since the 1990s, cases of eating disorders have been reported in countries as diverse as Denmark and Nigeria. Why is this? One reason may be the growth of industrialism in previous non-industrialized societies and the adoption of consumer culture and individualism (although the simplistic view that non-industrialized societies merely mimic their industrial counterparts should be avoided).

Consumer culture refers to societies in which the purchasing of material goods is driven by *desire* rather than need. One's social status and relationships are in part defined by how much one owns and has access to economic wealth. Greater wealth is desirable and affords greater social status. Ultimately, part of

our identity is written into our success in acquiring wealth and goods.

A particularly interesting case is Japan, often considered to be the most economically developed society in Southern Asia. Since the Second World War, some of the conditions that have led to the increase of eating disorders in industrialized societies have arisen there, including individualism, conflicts between traditional and contemporary female roles and the growth of consumerism and the media in influencing and shaping public attitudes. Changes in the economic and industrial climate in Japan, as well as shifts in cultural attitudes, are believed to play a role in the sharp increase in eating disorders, according to leading experts (Nasser, Katzman & Gordon, 2001). Even though figures do not match US or European rates, anorexia has risen from virtually no reported cases in the mid-20th century to around 30 per 100,000. Another factor is the rapid growth of Western psychiatric diagnostic assessments and treatments, which may also explain why the number of cases identified by professionals has risen sharply. Despite this, it is unlikely that this alone would explain the sharp increase in eating disorders countrywide.

and psychology are still aiming for universalism. Attempts to compare individual symptoms across cultures are still pursued because the assumption is that, despite cultural differences in the content of symptoms and beliefs about the self, certain life events, genetic dispositions and stressors can still produce similar symptoms. According to this view, Lala and Simon could still initially be classified psychotic, regardless of the difference in the cultural ideas surrounding their behaviours and beliefs.

For example, if we were to treat 'schizophrenia' as a disease (that is, qualitatively distinct from the rest of human experience and one which runs its course regardless of human input or cultural content), our study of culture and mental health will probably involve some objectified and reliable measurement of schizophrenia. This standardized measurement can then be used to make comparisons across cultures, as in the study of medical conditions. Standardized definitions are also key to the development of certain (largely quantitative) methodologies.

Quantitative research adopts standardized measurements of phenomena so that the relationships between elements can be measured and analysed mathematically. **Qualitative** research is interested in the meanings given by individuals to their beliefs, experiences and behaviours; the aim is not to standardize or mathematically measure meaning but to prioritize the individual's subjective meaning-making process.

In epidemiology, for example, it is necessary to establish an operational definition of a disease in order to measure its prevalence, course and outcome across different settings.

Epidemiology is the study of health and illness patterns in and across societies: it is a form of evidence-based medicine designed to identify risk factors for disease, usually based on large-scale quantitative methods.

Defining diseases, drawing causal chains for disease and the formulation of specific health strategies are important aspects of epidemiology and have been used in psychiatric research to establish prevalence, course and outcome across cultures. The assumption is that we are comparing like with like: only the cultural setting is considered to be variable, not the 'disorder' itself.

On the other hand, if we believe that cultures themselves define the terms of human experience, imposing different meanings on behaviours, thoughts, emotions and experiences and applying a universal name to them may not be possible. For example, the cultural psychologist Geertz claims that though all human cultures have some notion of what it is to be a human being (unlike, for example, an animal, rock or plant) the individualistic notion of self found in Western cultures is not universally recognized, as what it means to be an individual and a self is tightly bound by cultural convention and depends upon culturally specific language (Geertz, 1983; Cole, 2005). Emotions, behaviours and states of mind, therefore, may not be culturally equivalent, due to different language conventions (Leff, 1973). The Western understanding of depression, for example, does not translate readily into non-Western cultures, where there are different models of self (Pilgrim & Bentall, 1999). In the Western literature on depression, there

has been a great deal of work linking particular self-constructs (the discrepancy between the ideal and actual self, for example) with depression (Hammen, 2005), but do these constructs resonate across all societies? A classic counter-example to a Western perspective on self can be found in Japan, in the syndrome *taijin kyofusho*, in which the individual is extremely fearful of her/his acceptability to others. If one considers the Japanese proverb '*the nail that stands out gets pounded down*' we can see that a DSM diagnosis of social phobia would miss the cultural subtleties and meanings that provide the context for that behaviour (Markus & Kitayama, 1991).

On a visit to an AIDS hospice in Lusaka, Zambia, one of the authors (Reavey) met patients described by the (extremely rare) local cognitive behaviour therapist as 'depressed'. Cognitive behaviour therapy (CBT) is a therapeutic practice aiming to change or modify and individual's thought processes and behaviour. When speaking to these people, Reavey found that asking questions about individual feelings and self-esteem (as one might do in the UK) had little resonance with these patients from rural communities, though, interestingly, the more educated urban dwellers were more able to address the question. Although anecdotal, this last example illustrates how differences between urban and rural communities can be crucial.

Emic versus etic distinctions

In practice, cultural studies of mental health and distress have been carried out by two different groups of researchers, who start out with different assumptions (Bentall, 2003). These can broadly be divided into the **emic** and **etic** perspectives. The former refers to an approach that prioritizes the meaning the person under observation attributes to their beliefs, experiences and behaviours, using their own cultural reference points. An etic approach gives greater priority to a universal definition of beliefs, experiences and behaviours, offered by a scientific observer. The main aim of this approach is to be culturally neutral and objective and apply observations and measurements across cultures.

The etic or 'outside' perspective (as some anthropologists refer to it) follows in the tradition of behavioural psychology (Skinner, 1938), transcultural or cross-cultural psychiatry and anthropological approaches that link cultural practices to external or antecedent conditions, such as economic, social and ecological factors that may or may not be part of the vocabulary, beliefs or explanatory system of the inside group. This 'experience-distant' approach encourages the researcher to standardize categories and diagnoses, which can then be used to carry out cross-cultural comparisons. In methodological terms, this translates into the generation of hypotheses, used in large epidemiological or smaller experimental studies. Nevertheless, this perspective welcomes the exploration of cultural differences, in terms of the *content* of particular behaviours and symptoms. However, the assumption is that the *form* of the problem under investigation remains the same – depression is the same disorder, whether in India or North America.

The emic or insider perspective follows in the tradition of psychological studies of folk beliefs (Wundt, 1888) and in cultural and social anthropologists' pursuit of the 'native' participant's point of view (Malinowski, 1927; Sapir, 1924;

Mead, 1928; Sullivan, 1938) and, later, Kleinman & Kleinman, 1995). This 'experience-near' perspective privileges the participant's account of his/her experience, avoiding any unnecessary intervention or standardization of response by the researcher (Jenkins & Barrett, 2004). It often involves understanding mental health problems as extensions of normal human experiences, rather than as qualitatively distinct categories of disorder or illness, emphasizing the continuity between the ordinary and the unusual or 'extraordinary' (Sullivan, 1962). In methodological terms, this could take the form of an ethnographic or qualitative study, which would not involve testing a prior hypothesis, or a quantitative or experimental study of *specific* behaviours and experiences, rather than beginning with broader diagnostic categories. Emic knowledge is essential for a more empathic and complex reading of culture and psychological processes more generally.

There are differences between cross-cultural psychiatrists and psychologists, who adopt the invariant model of 'disorder' (typical of etic approaches), and anthropologists, who argue that important variations exist, resulting in a fundamentally different kind of experience (typical of emic approaches). According to the emic view, standardized measurement would be problematic. However, the emic and etic distinctions are not always strictly adhered to, as a number of psychiatrists and anthropologists have argued that careful emic knowledge is required *before* hypotheses can be developed, implying that neither approach should be used in isolation (Morris, Leung, Ames & Lickel, 1999; Cheng, 2002). In this chapter, we will draw on both emic and etic forms of knowledge, to address each of the substantive questions in turn.

Are the boundaries between mental health and normality similar or different across cultures?

In order to address the first question – 'To what extent do variations or similarities exist between cultures, in terms of the prevalence, incidence and course of traditionally defined mental "disorders"? – we must first discuss what is meant by mental health and distress across a variety of cultural contexts.

Definitions of mental health problems rely largely upon definitions of normality, as the former are often identified via the impairment of a person's social or occupational status – in short, when there is some sort of disruption to normal social behaviours (Warner, 1996).

Definitions of normality, like definitions of health, vary widely across societies and depend upon a range of possible perceptions by members of that society or culture towards certain social behaviours (see Helman, 2000 & 2007, for an extensive discussion). Some distressing behaviours and thoughts involving a religious or spiritual dimension, for example, may be misinterpreted when standard Western categories of illness or disorder are adopted – see *Neurasthenia*, below. The use of a standard psychiatric category may miss important features of a particular cultural belief system that would be useful to explain, treat and, eventually, 'heal' the person (Loewenthal, 2007). In Japan, for example, 'fox possession' is a commonly recognized experience that can lead to distress and voice-hearing: the person believes they are possessed by a fox spirit who enters

and speaks to them. Shamans, rather than psychiatrists, are commonly consulted and often perform religious rituals that enable the person to understand the nature of the possession by eventually establishing harmony with the fox spirit. This can even lead to the person becoming a Shaman themselves and carrying out religious rituals of the kind used to treat their own distress.

As well as unusual behaviours being read in different ways in different cultures, emotions can be constructed and experienced differently. In some African languages, for example, 'anger' and 'sadness' are not viewed separately and, in Japan, dependent emotions (honour, obedience, deference, selflessness) are viewed more positively than in the West (Leff, 1973). In Western psychology, emotion and cognition are often studied independently, indicating the assumption that thoughts and emotional states are distinct (consider the contrast between 'thought disorders' such as schizophrenia and 'affective disorders' such as depression). Despite there being significant similarities in conceptualizations of emotions across cultures, there are significant differences in the way in which emotion is seen to interact with mind and body processes (Leff, 1977).

Across different time periods and in different societies there have been countless recordings of 'odd', 'abnormal' or 'unusual' behaviours: behaviours, emotions or states of mind that do not appear to fit with majority perceptions or actions (Littlewood & Lipsedge, 1982). Furthermore, it is clear that in every society what people consider 'normal' or 'abnormal' social behaviour can differ widely (Helman, 2000). In spite of this, there do appear to be behaviours and experiences that appear throughout the world, and that are considered to be problematic. These can include intense sadness (for no apparent reason), problems with eating, body dissatisfaction and culturally inappropriate beliefs, all of which are common everywhere (Nasser et al., 2001). Arthur Kleinman argues that the universal existence of human suffering underpins cultural displays of distress; the existence of abuse, poor communication, hostility, trauma and stress may lead to mental distress and/or poor mental health. Though most might agree that these behaviours, emotions and experiences are indeed universal and troubling (if they lead to social impairment), there is still a great deal of dispute about how to label them and whether the meanings assigned by different societies and cultures actually amount to the same thing (Littlewood & Lipsedge, 1997). If a local healer in Malaysia, for example, hears voices and interprets them as spirits who instruct her healing practices, should we use the same label for her behaviour as we would for a British-born man living in London who hears the voice of Christ? Although both individuals both share the form of behaviour or 'symptoms' (hearing voices), can they be regarded as equivalent, and should they necessarily be considered 'ill' or 'distressed'? In order to begin to address these kinds of questions we will be drawing on studies using both etic knowledge with a Western (often diagnostic) definition of mental disorder to measure 'abnormal' behaviours or experiences found across the world, and emic knowledge that has concentrated on the more local experience-near features. How we assess whether mental health and distress are universal may largely depend on the types of knowledge we draw on and the tools we use to measure them. Even then, definitions and eventual diagnosis used within the same 'culture' (Western culture) may

differ across countries, due to differences in professional and clinical practices (see Box 3.1).

Prevalence rates across cultures

At the beginning of the 20th century, a number of investigations revealed different rates and forms of mental diseases in Western and non-Western societies. This is not surprising when we consider that the study of culture began with observations on the British temperament: in particular, the tendency towards repression and melancholia because of the climate (Jenkins & Barrett, 2004).

Since then, research has moved on to draw comparisons between 'developing' and 'developed' societies. One of the first to do this was Kraepelin (1904/74), in his study of the psychoses (including dementia praecox and manic depressive psychosis) in Java and Europe. Kraepelin compared the Javanese and European symptoms of these 'diseases', finding some similarities, yet also key differences. For example, he reported that there were fewer examples of delusions and hallucinations in the Javanese, which he attributed to an impoverished language system and greater reliance on sensual imagery for thought (Kraepelin, 1904/74). In fact, the view that European displays of madness and/or abnormality were less likely to occur in societies deemed 'primitive' or 'closer to nature', due to a lesser capacity for higher thought, was widely held, and was accompanied by anthropological studies that documented physical differences (e.g. skull size) between racial groups as a way of measuring intelligence and personality across cultures.

A study investigating the African mind, commissioned by the World Health Organization (WHO) in 1952, for example, went as far as to suggest that the underdeveloped frontal lobes of Africans could account for their poorly developed personality and primitive tendencies. It is clear that in the first half of the 20th century, cultural differences were observed through the lens of colonial and racist stereotypes, rather than by systematic scientific investigation.

Current practice in cross-cultural psychiatry and psychology is to count cases of mental disorder using objective and standardized measures, rather than relying on emic descriptions of distress and mental health found in qualitative anthropological studies. Prevalence rates can be measured with a range of instruments, including standard DSM or ICD diagnostic criteria or other recognized assessment tools such as the Present State Examination. The **Present State Examination** was designed in the 1960s to assess an individual's present mental state (questions refer to the past month only) in order to identify any mental disorder. The test includes a standard checklist of items, with some flexibility permitted in questioning.

It is important to note that different studies measure different populations for rates of mental health problems. Populations may consist of clinical samples (inpatient and outpatient services; GP or mental health services) or community samples. Accurate estimates are disrupted by differential access to services (leading to varying rates of formal diagnosis) and by different levels of acceptance of Western forms of diagnosis and assessment measures. This makes the determination of 'true' incidence difficult. However, a limited number of cross-cultural studies exist that reveal variations in mental health diagnoses across cultures.

The World Health Organization Collaborative Study on Psychological Problems in General Health Care (Ustun & Sartorius, 1995), for example, was an epidemiological cross-cultural study designed to examine the frequency, recognition and outcomes of psychological disorders in general health-care settings across cultures. Prevalence rates for a range of ICD-10 diagnoses varied significantly across different cultures (see Table 3.1). The authors of this study discussed some of the predictors of such variation, including health beliefs, help-seeking behaviour, diagnostic practices and patterns of response. A follow-up investigation (using a meta-analysis

of the original results) of the cultural factors involved in the different prevalence rates produced several findings (Maercker, 2001). Current depression was less frequent in countries where values of self-mastery and personal strain were valued (e.g. Japan, China and Zimbabwe). In addition, generalized anxiety was negatively associated with countries that valued conservatism (e.g. Greece & Brazil: countries showing social control by the peer group and a preference for hierarchy). These findings also correspond to certain social theories that predicted higher rates of personal irritability in societies that value personal freedom (see Foucault, 1961).

Table 3.1 Prevalence of mental disorders and presenting health complaints in the WHO general practitioner study

Prevalence of most common ICD-10 diagnoses presenting complaints of patients attending health care facilities (per 1000)							
	Any ICD-10	Current	Gen	Dep			
	Mental disorder	Depression	Anxiety	Alcohol	Psychological	Fatigue	Pain
Rio de Janeiro	35.5	15.8	22.6	4.1	7.6	5.1	42.1
Paris	26.3	13.7	11.9	4.3	11	8.4	25.3
Gronigen (Holland)	23.9	15.9	6.4	3.4	12.8	5.7	28.2
Athens	19.2	6.4	14.9	1.0	2.2	5.1	21.9
Berlin	18.3	6.1	9.0	3.7	3.7	5.2	32.3
Ankara	16.4	11.6	0.9	1.0	2.6	5.6	40.5
Seattle	11.9	6.3	2.1	1.5	2.6	1.6	17.0
Verona	9.8	4.7	3.7	0.5	6.4	3.7	25.9
Ibadan	9.5	4.2	2.9	0.4	2.3	9.0	51.4
Nagasaki	9.4	2.6	5.0	3.7	1.3	9.5	21.3
Shanghai	7.3	4.0	1.9	1.1	0.2	13.3	26.2

Source: Ustun and Sartorius (1995, tables on pp. 324, 326, 352).

BOX 3.3 Differences in psychiatric diagnosis in England and France

A study by Van Os and colleagues (1993) revealed significant differences between diagnostic and clinical practices in England and France, although both these countries are 'Western', industrialized or developed nations. Major differences were found between the way 92 English psychiatrists and 60 French psychiatrists conceptualized the cause, diagnosis and management of schizophrenia. In particular, each group of psychiatrists appeared to be influenced by their

theoretical and philosophical traditions, which, in turn, directed their diagnostic and clinical work. In England, the tradition was that of Anglo-Saxon empiricism (the pursuit of truth through scientific experiments), while in France, it was continental rationalism (the pursuit of truth through thought and interpretation). This meant that in England, greater trust was placed in biological (neurobiological and genetic) and behavioural theories, and, in France, in psychodynamic theories (that emphasize parenting) and familial dynamics. Incidence rates in the two countries were also different. France had higher rates of schizophrenia in individuals under 45

years of age and lower rates in those over 45. In France, there was a greater reluctance to diagnose schizophrenia after the age of 45 and a number of other problems ('pseudo psychopathy') were identified that English psychiatrists would not have recognized under the label schizophrenia. Cooper and his associates have also revealed differences between British and North American psychiatrists in the diagnosis of bipolar disorder and schizophrenia (Cooper, Kendell, Gurland, Sartorius & Farkas, 1969). These studies clearly point to key differences in incident rates, diagnosis and clinical practice in two Western cultures.

The World Health Organization studies of schizophrenia

In 1967 the WHO commissioned a series of studies investigating the incidence and course of schizophrenia, using broader local descriptions and Western (Schneiderian) criteria (see Chapter 2). **Schneiderian** refers to the work of Kurt Schneider, who described the symptoms of schizophrenia that differentiate the condition from other psychotic disorders as **first rank symptoms**, which mainly comprise a variety of hallucinations and delusions.

Since then, nearly thirty research sites in nineteen countries (Western and non-Western) have participated in such a study (Hopper, 2004). The WHO went to great lengths to include 'developing' and 'developed' countries in order to establish stable prevalence rates across the world. The three main studies – the International Pilot Study of Schizophrenia (IPSS, beginning in 1967), the Determinants of Outcome of Severe Mental Disorder (DOSMed, beginning in 1978) and the recently completed International Study of Schizophrenia (ISOS, beginning in 1982) – with follow-up periods ranging from two to five years (and in some sites, ten) have reported similar incidence rates across the world (between 0.7 and 1.3). DOSMed started with twelve sites but eventually reported from seven (Aarhus in Denmark, Chandigarh – rural and urban – in India, Dublin in Ireland, Honolulu in the US, Moscow in Russia, Nagasaki in Japan and Nottingham in the UK), in order to make cross-cultural comparisons of incidence rates and outcome. The ISOS study completed data collection in follow-up interviews of both the original ISOS study (24 years after the episode of inclusion) and the DOSMed cohort.

These studies report equally distributed numbers of individuals liable to schizophrenia (though we shall see that the course and outcome were significantly different across countries). Subsequently, the results have been used to gather further support for biomedical theories claiming that schizophrenia is a culturally invariant (in terms of prevalence and form) and genetically based disorder (Jablensky et al., 1992). If the prevalence rates of the WHO studies are correct, only the content of the 'symptoms' of schizophrenia can be considered variable, rather than the rate and quality of their form. However, there have been a number of criticisms of these studies, which point to definitional problems and poorly described inclusion and exclusion criteria (Kleinman, 1991). Firstly, Bentall has argued that it was inevitable that the initial IPSS study found consistent rates of schizophrenia across cultures, as only patients meeting the Western diagnostic criteria were included in the final cross-cultural comparisons (Bentall, 2003). Secondly, when examining the data from the second study (DOSMed), there were statistically significant differences of incidence across sites when a broader (as opposed to a Schneiderian) definition of schizophrenia was used (Jablensky et al., 1992). Thirdly, there are clear reported differences in the course and outcome of psychosis between developing and developed countries. Does this pose serious questions for a Western medical approach that claims to be able to measure and treat equivalent illnesses across cultures? If the course and outcome of psychosis varies markedly, are we talking about the same problem, or is the same 'disorder' better dealt with in some societies?

Cross-cultural differences in the course and outcome of schizophrenia

The findings of the WHO studies suggest significant differences between 'developed' and 'developing' countries in terms of the course and outcome of schizophrenia over time. In the initial ISOS study, 27% of patients from developing countries experienced a single psychotic episode, followed by complete recovery, compared to 7% of patients from developed countries. At the end of the follow-up period, this advantage extended to levels of disability, with 65% of patients in developing countries, compared with 56% of patients from developed countries, experiencing little or no long-term social impairment.

The DOSMed and ISOS studies later confirmed these initial observations, although the ISOS study suffered from the eventual inclusion of only India to represent the developing nations (note that Hong Kong was removed from this category following its substantial industrialized growth during the study's 15 year period). The later DOSMed was explicitly designed to investigate the link between culture and the course and outcome of schizophrenia (Jablensky et al., 1992), the final results making a strong case for the persistent and powerful effect of culture. After a two-year follow-up period, 37% of patients from developing countries experienced one



The rise of industrialization in certain cultures can be accompanied by an increase in certain forms of distress, such as eating problems and sadness and worry

psychotic episode, compared to only 16% in the developed world. Approximately 16% of patients in the developing countries experienced social impairment compared with approximately 42% of those in developed nations.

These results appear robust, even when attrition (drop-out rates), groupings (the distinction between developed and developing nations), diagnostic ambiguities (the removal of 'non-affective acute remitting psychosis') and gender and age and outcome measures are controlled for (Stevens, 1987; Hopper, 2004). Given that such findings appear stable and ultimately compelling, it is now time to turn to some of the reasons given for these persistent cross-cultural differences.

The task of measuring cultural differences is often complex and is commonly overshadowed by the requirements of a large-scale study to standardize measurement and operationalize terms. This is why a number of anthropologists have been openly critical of the WHO studies that have largely failed to provide emic knowledge of cultural practices, instead choosing to assign culture to a geographical location only (Kleinman, 1987; Hopper, 2004). Indeed, as the authors of the DOSMed study themselves lament, neither IPSS nor DOSMed was designed to 'penetrate in sufficient depth below the surface on which the impact of this unknown factor (culture) was established' (Jablensky et al., 1992, p. 89). Despite such shortcomings, several explanations, taken from three sub-studies of the DOSMed, have been assembled to explain the more favourable outcome among developing countries. Among these explanations are three key topic areas: (i) family relationships and expressed emotion, (ii) a lack of social stigma and employment opportunities and (iii) marriage and long-term relationships (see Hopper, 2004 for a fuller discussion of these factors).

Family relationships and expressed emotion

Expressed Emotion (EE) is the amount of emotion displayed in a family, and has long been found to have adverse effects on the course and outcome of individuals diagnosed with schizophrenia and bipolar disorder, especially in terms of relapse rates (Leff & Vaughn, 1985; Butzlaff & Hooley, 1998). High expressed emotion refers to the existence of hostility (the patient is blamed for the problem), emotional over-involvement (family members blame themselves and pity the individual with the problem) and critical comments (combining hostility and emotional over-involvement). High expressed emotion has been linked to a poorer prognosis for individuals with mental health problems and to the risk of developing certain mental health problems in the first place, and protective factors and a lower risk of relapse were found in families low in EE and high in emotional warmth (López et al., 2004).

The direction of this relationship (causal or maintaining), however, is still open to debate (Bentall, 2003). It is not clear, for example, whether EE causes the initial distress or whether living with a family member with high levels of distress significantly contributes to familial unrest and disruptive communication patterns (in other words, EE). The frequency and intensity of individual types of EE have been found in the WHO and other studies to vary across cultures, with the proportion of high EE among relatives of individuals with schizophrenia defined by the Western operational criteria, ranging from 8% in rural India (Wiget et al., 1987) to 67% in urban US (Vaughn, Snyder, Jones, Freeman & Falloon, 1984). Despite these claims,

some researchers have questioned the validity of Western definitions of EE. It has been pointed out that what counts as criticism, hostility and emotional over-involvement is culturally defined (Jenkins & Karno, 1992); further studies should adopt a combined emic and etic approach, using longitudinal designs (McGruder, 2004; Cheng, 2002).

Employment opportunities and social responses

The WHO and other later studies have largely shown that the family members of those with severe mental health problems in developing countries tend to be more supportive and proactive. Instead of being placed in psychiatric institutions or isolated community settings, those with problems tend to remain with their families, where employment is provided and a sense of purpose more likely (Warner, 1994). Here, the family is considered to be responsible for social and emotional welfare, and in some cultures, the entire social network may be involved in treatment and rehabilitation (Helman, 2000). Industrialized nations are not as well disposed to those who cannot contribute to the economic system and families tend to be less extended and more isolated (Warner, 1994). It has been argued that higher levels of social support, familial warmth and low stigma in some developing countries positively mediate the individual's emotional response towards their 'problem' and ultimately improve their outcome (Warner, 1996; López et al., 2004). This evidence from these powerful culturally mediating factors is compelling and makes it difficult to argue that mental health problems have a 'natural' course to follow.

Marriage and long-term relationships

In a subsequent analysis of marriage rates in the WHO studies, Hopper has recommended further investigations into the potential benefits of marriage or long-term partnerships in the study of psychosis (Hopper, 2004). For example, the long-term marital prospects of the participants in the developing countries are in stark contrast to those in the developed world. Jablensky & Cole (1997) have even argued that the data from the DOSMed point to how marriage may actually delay the onset of psychosis. In the ISOS study, 73% (74% of men and 71% of women) of the Indian cohort remained married at follow-up, compared to only 38% (28% of men and 48% of women) in the developed country cohort. Although the inevitable differences within cultures that result in various splits, due to class, gender, religious and caste distinctions, it is argued that the overall picture indicates the success of the social ethic Hindu Indian society (Shweder, 1990).

In support of the view that partnership may play a positive role in the course of schizophrenia in developing countries, other studies have also revealed the more universal buffering effects of long-term relationships and marriage. For example, married women with a diagnosis of schizophrenia in developed countries tend to fare better overall than men, as they tend to continue their relationships and participate in parenting (Jenkins, 1992). Rather than advocating marriage as a type of therapy (especially as domestic violence and abuse against women is far from uncommon in marriages, leading to significant mental distress), these results nevertheless point to the detrimental effects of isolation and seclusion in relation to the onset, course and outcome of schizophrenia and other

mental health problems. Indeed, service users often report that stable long-term relationships are a positive force in buffering the effects of mental distress (Cherlin, 1999).

These lines of investigation remain speculative and require substantive and longitudinal evidence before conclusions regarding the exact nature of this positive relationship between developing countries and schizophrenia outcome can be understood. Furthermore, some authors, following a systematic review of the WHO data and further studies, have argued that the picture of better recovery rates in developing countries is not as straightforward as originally thought. For example, in a review of 23 studies in 11 low- and middle-income countries, Cohen, Patel, Thara & Gureje (2008) have argued that there is (a) greater variation of outcome and course across developing countries (e.g. good in India and poorer in Brazil and China), (b) levels of disability vary among developing countries (e.g. good in India and Indonesia but poorer in Nigeria) and (c) social functioning and family relationships have so far not been examined in sufficient depth to determine whether developing countries as a whole provide better support for those diagnosed with schizophrenia (there being evidence of varying responses by families to 'mental illness' across developing countries). In sum, these authors conclude that further ethnographic and qualitative work is required to examine the quality of relationships and social support available across countries. They also argue that we should remain cautious about stating that those diagnosed with schizophrenia will always fare better in developing countries, before a more nuanced examination of the difference between countries is carried out.

Different cultural emphases, different problems?

In this section, we will discuss a range of different experiences and behaviours in order to assess whether some forms of mental health and distress are bound to specific cultures in particular ways. This focus will assist us with the second question raised at the beginning of the chapter, namely, 'Do different societies draw the same line between well-being and distress, sanity and madness?'

'Culture-bound syndromes' is the term for a unique set of behaviours and experiences recognized by members of a particular culture, and treated by them in a locally specific manner (Helman, 2000). They remain controversial, some arguing that such behaviours and experiences are merely different ways of expressing an underlying illness, and others that they cannot be inserted into existing Western diagnostic categories, given their symbolic and meaningful status in a society. These syndromes are characterized by behaviours that make sense and follow a given pattern in a population (Rubel, 1964). Of course, contemporary anthropologists have argued that all distress can be viewed as 'culture bound', as the expression of distress is always socially prescribed and never independent from human action (Littlewood, 2002).

The fourth edition of the DSM recognizes 'culture-bound syndromes', but only in a marginal sense, as they sit in the manual like an exotic enclave, dedicated to behaviours and beliefs that do not fit a traditional Western diagnosis. This is despite the existence of a DSM task force set up to advise and gather evidence on a variety of culture-bound syndromes

(including Western ones). However, we will not confine ourselves in this section, to a discussion of exotic beliefs from distant lands. Instead, we will look at a range of experiences, beliefs and behaviours that raise questions about the relationship between cultural emphasis and mental health more generally.

In the following sections, we will begin to see how certain behaviours can be viewed in a different light, according to their connection to particular cultural and religious beliefs on the nature of rationality and imagination, and of mind and body.

In order to illustrate this more fully, two main areas will be explored. First, we turn to different cultural constructions of dissociation and psychosis. **Dissociation** is the partial or complete disruption or disintegration of an individual's conscious or psychological functioning. It can be a response to trauma or drugs and can be adaptive in the short term, for example as a means to distance the individual from an unbearable experience. Over time, however, dissociation can dominate or even replace the individual's conscious perception of reality, especially at times of distress.

Dissociation Identity Disorder has often been associated with US culture and particular therapeutic practices there, and is characterized by the individual's display of a number of distinct identities or personalities (sometimes known as alters or alter egos), each with its own unique perspectives and ways of behaving. This diagnosis used to be called Multiple Personality Disorder.

We will examine the link between particular cultural beliefs on trauma and selfhood and the emergence of DID in the late 20th century. In addition, dissociation connected to particular religious and spiritual practices will be explored in order to assess the different ways in which these 'altered states of consciousness' are regarded in different religious and cultural communities (Clarke, 2010). Finally, we will examine how certain non-industrial societies have regarded psychotic states (e.g. hallucinations) as meaningful, and how resistance to psychiatric views of psychosis has also emerged in some European industrial societies (hallucinations are a sensory experience in which a person can hear or see something that others cannot).

We next explore the idea that different cultures have a variety of ways of expressing distress. Traditionally, examination of the various cultural 'idioms of distress' led some to claim that non-Western societies were more likely to express mental distress through the body – a process known as **somatization**: psychological stress or distress that leads to physical complaints.

The somatization thesis was often used to explain essential differences between Western and non-Western societies in the expression of distress, such as why South Asian patients presented with physical symptoms such as 'an aching heart' when depressed (see Lowenthal, 2007, for an excellent review of evidence relating to the somatization thesis).

The thesis has also been put forward as an explanation for why diagnoses of depression have traditionally been less common in the Eastern hemisphere, whilst diagnoses of 'neurasthenia' (nervous exhaustion) – that may resemble depression – have largely been higher (Kleinman, 2005). These two main areas illustrate how the lines between well-being, madness and distress can not only be drawn at different points but can lead to vastly different outcomes.

BOX 3.4 Some 'culture-bound syndromes'

Koro (Malaysia, China, Africa). This is a belief in fatally retracting male genitals, or a belief in genital theft. It can cause widespread social concern or can remain the preoccupation of an isolated individual.

Wendigo psychosis (North America, Canada). The Wendigo (a malevolent spirit) is part of the traditional belief systems of various Algonquian-speaking tribes in the northern United States and Canada, most notably the Ojibwa/

Saulteaux, the Cree and the Innu/Naskapi/Montagnais. Common to all these cultures is the conception of Wendigos as cannibalistic supernatural beings of great spiritual power. A person suffering from Wendigo psychosis craves human flesh, and believes that the evil Wendigo spirit possesses them.

Brain fog (West and South Africa). A condition mainly found in male students. It generally manifests as difficulty in concentrating on study and in somatic (physical) symptoms, including general fatigue and depression. It has similar symptoms to the Trinidadian illness *studiation madness*, whose main features include anxiety and depression.

Jinn (Middle East, North Africa). In Arabian and Muslim folklore, jinns are evil and grotesque demons with supernatural powers that they can give to people and then use to control them.

School refusal syndrome (UK). A behaviour identified in children who refuse to attend school.

Attention hyperactivity deficit disorder (mostly UK and US). This syndrome, involving hyperactive behaviour and a lack of concentration, has been found in increasing numbers, mostly in children, and is treated with prescribed medication (Ritalin).

DSM-IV-TR (2000)

Dissociation: spiritual enlightenment or illness?

Western professional practice is based on the assumption that what is rational can be clearly distinguished from what is irrational, and what is apparent (the real) from what is not (the imagined) (Littlewood, 2002). That is why states of dissociation and psychoses are often presented as prototypes of 'madness' in Western societies: they represent the opposite of the highly prized idea of a unified identity and self and adherence to the rational and the real (Hacking, 1996). Dissociation, according to Western diagnostic criteria, denotes a state of acute mental **decompensation**, in which certain thoughts, emotions, sensations, and memories are sectioned off, due to their often traumatic content; it represents the functional deterioration of a previously working structure or system in the human body and can occur as a result of trauma, fatigue, di/stress, disease or ageing.

Decompensation is a key feature of the Western bound disorder Dissociative Identity Disorder (DID: formerly known as multiple personality disorder) and is present in Post-traumatic Stress Disorder and other dissociative disorders listed in the DSM-IV. These disorders are considered to be signs of an underlying pathology, although significant questions have been raised about the cultural specificity of DID in particular, as this is rarely reported in Europe, in comparison with North America (Hacking, 1996; Littlewood, 2002). But is it always the case that individuals who experience dissociation are ill? To answer this question, we must move beyond Western scientific understandings of the real and the rational to discuss issues of religion, morality and spiritualism, as it is there that the boundaries between the real and the imagined not only shift but may crumble altogether.

Dissociation and multiple selves: Dissociative Identity Disorder in the US

Eric had suffered serious abuse as a child, and in psychotherapy began to reveal different personalities: 'quiet, middle aged Dwight, the hysterically blind and mute Jeffrey; Michael, an arrogant Jock, the coquettish Tian ...' To the therapist's astonishment, a total of 27 personalities were gradually

revealed, Eric shifting personalities as many as nine times in a one-hour session. Some of the personalities would not talk to the therapist, whereas others would; some were aware of each other, and some were very reflective and insightful about Eric (based on Corner, 1999; cited in Lowenthal, 2007, p.105).

Although there is support for the idea that the self is made up of a 'community of internal voices' which resemble previous experiences and conversations (sometimes referred to as a 'dialogical self' – see Vygotsky, 1978; Thomas & Leuder, 2000; Osatuke et al., 2005), the idea that there is a unitary and consistent self is more familiar to Western professionals and lay people alike. The notion that several voices or personas can exist within one person is, therefore, often treated with suspicion in certain societies, and may only be openly addressed when some form of discrepancy or traumatic association between the various voices or personas exist. This explanation resembles the traditional Western approach to dissociation, in which an individual who experiences a series of traumatic events (commonly child sexual abuse in the case of DID) may avoid future pain by defending him or her self from painful memories by repressing them and splitting the self into a number of different **alters** (the distinct personalities displayed in DID).

A diagnosis of DID is more common in women than men (Hacking, 1996; Haaken, 1998). The alters can be regarded as fantasy-based characters or as different versions of the self. They develop in order to carry the burden of the painful memories and perform different roles, such as the protective adult alter who emerges in a situation that is stressful or volatile. One alter may be unaware of the behaviour or thoughts of another, which is why many 'multiples' (individuals diagnosed with DID) claim not to remember what some of their other alters have done. This is because they have split off aspects of their personality into separate components, and switches between alters may occur in different situations. DID can thus be understood as a strategy used by individuals with a history of trauma to cope with and defend against further pain. But how culturally specific is this coping strategy? Do all survivors of severe child sexual abuse behave in this way? The short answer to this is no. Socio-cognitive theorists (Spanos, 1994) have argued that DID has emerged out of certain cultural beliefs that legitimize the expression of difficult memories and experiences into separate

components of the self. Psychotherapists can contribute to this process by providing further professional legitimization to this form of expression and by encouraging the client to see the different versions of themselves as distinct and separate personalities. According to this view, the disorder is a construction of therapist and client interactions, and not a naturally occurring phenomenon. Although such views regarding the construction of DID are controversial (Coons, Bowman & Milstein, 1988), it is interesting to note that DID is rarely diagnosed in Britain or Europe. Hacking, in a detailed exploration of this issue (1996), has suggested that hundreds of cases of multiple personality disorder emerged in the US within a relatively short period (beginning in the 1980s) and from a small number of therapists. This view was supported by Modestin (1992), who found that DID cases were reported by only 0.1% of the professional population. Spanos (1994) has also argued that if DID were a naturally occurring condition, there would not have been such a large increase in reports during the 1980s.

In short, DID may be considered less a 'condition' than a culturally specific social movement, supported by a small number of professionals and clients.

Despite the overwhelming focus on disruptive and highly culturally bound diagnoses in psychiatric and psychological literature, dissociation is not uncommon either in children (Bliss, 1980), or adults (Dorahy & Lewis, 2001) across all societies (Clarke, 2010). This includes dissociation related to coping with trauma, as well as dissociation related to religious or spiritual experience. The interesting thing to note is that the existence of dissociation *per se* does not lead to poor mental health, but, rather, the interpretation and purpose for which it is used. The question we must ask is whether in some societies and/or religious communities, states of mind that are considered dissociative in one culture may be viewed very differently, even positively, in another.

Dissociation and religious experiences

My first experience of speaking in tongues was truly amazing. I had been a Christian attending a Baptist church for some time and had always wanted to connect with the holy spirit. The pastor in my church had always said that once you could speak in tongues, you had secured a special place in the kingdom of heaven. As the church orchestra began to play, I felt a presence taking over me, lifting me, running through my body. I felt light and I began to hear the voices of a thousand angels inside and outside my head. Everyone in the congregation was participating. Their eyes were closed, hands outstretched and then, some people began speaking in an unrecognizable language. I too began to join in, speaking in a language that I did not recognize. I felt euphoric, drunk almost, and overwhelmingly happy, as if my body was no longer my own, like I had been possessed by God himself. I was told by a friend that my trance lasted for about ten minutes, though it felt like it was hours before I came round again (description of glossolalia in a British Baptist church; personal correspondence).

In certain societies, what we might consider to be dissociative may in fact be connected to culturally or religiously specific states. Possession states share with DID the feeling that the core self is being substituted with another that contains

new knowledge and motives. This can include possession by a spiritual entity or alteration of consciousness through a trance-like state (Loewenthal, 2007). Case studies from Singapore (Ng, 2000), Colombia (Pineros, Rosselli & Calderon, 1998), Senegal (Bullard, 2005) and other African societies (Helman, 2000) have shown possession and trance states to share certain features with dissociative states, such as amnesia, multiplicity and a loss of touch with reality. Possessions may also result from personally stressful and traumatic experiences such as isolation or abuse, although this is not always the case. Possession and trance states are often more connected to particular religious beliefs, such as the belief in reincarnation and spirits. But how useful is it to consider these experiences as a clear and stable form of mental disorder?

Witzturn, Grisaru & Budowski (1996) describe states of Zar (spirit possession), common in parts of Africa, Asian and the Middle East. Despite being considered by some as a psychiatric or neurological disorder, Zar has been described as a culture-based syndrome that fulfils certain functions in a community, including the reinforcement of cosmological beliefs, the psychological manipulation of women, and when an exorcism is performed, the re-establishment of group ties (Al-Adawi, Martin, Al-Salmi & Ghassani, 2001, cited in Loewenthal, 2007). Like DID, it is women who appear to be more susceptible to spirit possession; possession is only accepted when the person thinks they are possessed and community members endorse this (Lewis, 1971). Although possession is considered to be abnormal and undesirable in certain circumstances (especially where the person is withdrawn or distressed), it is nevertheless endorsed by members of some societies and culturally normative (Helman, 2000). The solution or treatment can be a community-involved exorcism of the spirits, involving music and dance and a general acceptance of the person.

Glossolalia (speaking in tongues) is also a common feature of certain religious practices in parts of North America, India, Africa, the Caribbean and many Pentecostal churches across Europe and the US. It is an activity that usually takes place in church and is associated with higher spirituality and a closer connection to God. It involves a trance-like dissociative state in which the individual rolls or closes their eyes, tears at their clothes and may scream and fall over. Though considered dissociative in form, glossolalia is only considered to be abnormal when it is uncontrollable (Littlewood & Lipsedge, 1997). It is once again clear that different societies set different standards regarding what is acceptable, and many clinicians believe that religious practices should be taken into account when assessing the likelihood of there being underlying mental distress as the route cause of dissociation (Helman, 2007; Clarke, 2010). In the case of some religious communities, dissociation through glossolalia itself is not necessarily problematic; what matters is whether the person is able to control it or not. Even so, it is clear that cultural and religious metaphors run through these experiences and behaviours, including the example of Dissociative Identity Disorder in the US (many individuals who have been diagnosed with DID have claimed to have taken part in satanic rituals). Just as spirit possession and glossolalia cannot be understood without reference to the cultural and religious contexts in which they are embedded, neither can DID be comprehensible without reference to its emergence in particular therapeutic contexts and within particular (cultural) constructions of selfhood.

Are the boundaries between madness and sanity similar or different across cultures?

We are already well acquainted with the Western psychiatric (and variously) psychological view that psychotic behaviours – delusions and hallucinations – are clear signs of disorder and disease, or what we have euphemistically come to regard as *madness* (mainly contained as the symptoms of schizophrenia) (Bentall, 2003). However, this interpretation of hallucinations may not be universal, as some societies do not have such a clear public dividing line between imagination and reality or between spiritual and real consciousness (Al-Issa, 1995). Cultural anthropologist Erika Bourguignon, for example, found that hallucinations played a role in the ritual practices of 62% of the 488 societies she studied and were not necessarily considered to be a sign of illness.

Behaviour that is considered psychotic or mad according to Western psychiatric standards may be treated with respect and reverence and considered to be legitimate signs of authority and/or higher consciousness. Shamans and traditional healers (holy individuals who are believed to experience higher consciousness) may be initiated into their profession through a 'psychotic' experience (i.e. hearing voices), believing that this experience has led to a higher and more positive state of consciousness.

Communicating with spirits that are not visible to others could be considered a sign of a psychotic mental illness. However, many anthropologists would argue that there are noticeable differences between many shamans and healers and psychotic individuals (Krippner & Achterberg, 2000). American anthropologist Richard Noll, in comparing a DSM-III diagnosis of schizophrenia with shamanic behaviour, found the major difference to be the ability of the Shaman to voluntarily enter and leave his or her altered states of consciousness. The degree of organization and self-control required by shamans and healers would not necessarily be evident in



The role of the Shaman varies across African and South American societies. Generally, the shamanic practitioner is considered to have access to the world of spirits and perform a number of healing rituals. Here a Zulu witchdoctor throws his bones on a straw mat, and by reading their layout receives messages from dead ancestors, which he relays to the Chief and rest of the tribe

an individual experiencing a full-blown psychotic episode, as diagnosed by a Western practitioner. Moreover, to equate the states of mind evidenced by shamans and healers with psychotic states or madness (as understood diagnostically) would be to deny the contribution they clearly make to their communities and cultures, on a practical and symbolic level. Often it is necessary to be aware of the symbolic content of unusual experiences and thoughts in order to pass reasonable judgment on them and to understand the constructive meanings underlying these kinds of experiences and behaviours (Littlewood, 1998). Despite such noticeable cultural differences in the values placed upon those who enter altered states of consciousness, it should be remembered that most people who hear voices or experience delusional states (people who would be diagnosed psychotic) in industrialized nations often do not come into contact with psychiatric or psychological services (Bentall, 2003). This indicates that the distinction between the imaginary and the real is more a prerequisite for Western psychiatric and psychological practice, rather than a simple reflection of what people in various countries experience or how they act upon such an experience (see Box 3.5). In other words, psychotic cases described in the Western literature are largely those who are known to psychiatric services, rather than a true reflection of those experiences in society (Clarke, 2010).

In all cultures, it appears that there are people who enter the realm of the imaginary (e.g. hearing voices) on a daily basis who may live independent lives, without any intervention by mental health services. Some societies clearly create valued roles for those who would otherwise go unnoticed (if they did not approach services) or be deemed sick or dysfunctional in Western societies. As in the experience of the shamans and healers, it appears that those individuals who believe they can control their experience, or are stronger than their voices, will probably not be distressed by them in Western countries and remain absent from professional psychiatric and psychological accounts (Romme & Escher, 1993).

Body, mind and society

A continuing theme in the mental health literature is the extent to which different societies (specifically, Western and non-Western) express mental health problems and distress in different ways. Many observers have pointed to the traditional Western emphasis, originating in Descartes's philosophical meditations, on mind-body distinctions (Cartesian dualism). Western models of mental illness typically locate causality either in the mind (e.g. cognitive models of depression) or in the brain (e.g. depression as a result of low levels of serotonin, dopamine or noradrenalin), as well as distinguishing both mind and body from the environment. Current treatments for mental illness address either the brain (psychiatric medication) or the mind (psychotherapy, counselling, CBT and all 'talking cures'), without much attempt to explain how either system operates in the context of the environment.

Eastern traditions have tended not to distinguish mind from body, but have instead emphasized the interdependency between mind, body and environment (Krause, 1998). Most Asian and Pacific cultures take a more holistic approach to mind, body and environment, with a more widespread

BOX 3.5 Professional and lay interpretations of psychosis in European societies

In the early 1990s, the Dutch psychiatrist Marius Romme was challenged by one of his patients to accept an alternative view of the voice-hearing experience. After failing to accept his psychiatric interpretation of her voices (that hearing voices was a symptom of a mental illness), she described to him how in Ancient Greece, voice-hearing was part of normal experience. After Romme and his patient appeared on Dutch television, 450 voice-hearers called in, many of whom had never attended a mental health consultation. Around one third of callers reported being distressed by their voices. The main difference between those who had become patients was that they perceived the voice to be

stronger than they were, whereas the non-patients did not feel this way. As a result of this patient intervention, Romme and journalist Sandra Escher organized a national network for Dutch voice-hearers, where voice-hearers could meet, discuss their experiences and support each other, outside of psychiatric services. This organization, known as *Resonance*, takes the position that voice-hearing is part of normal human variation, rather than a sign of mental illness. The ethos of the group is self-advocacy, rather than professional intervention. Wherever possible, members are encouraged to avoid psychiatric services and accept their voices, by understanding why the voices may have emerged, and to create a dialogue with them. Many voice-hearers report troubled, stressful and traumatic events in their lives that lend meaning to the content of their voices. The purpose of these self-advocacy groups is to provide members with the space to explore their

lives and eventually to exercise more control over their experiences.

In the UK, the Hearing Voices Network (HVN) is a registered charity and has a number of local branches across the country, as well as a national helpline. A number of psychologists and psychiatrists in the UK are supportive of HVN, though it remains marginal in relation to statutory mental health services.

These self-advocacy groups provide individuals with the space to accept and respect their experiences. According to these networks, voice-hearing, when it is seen as part of normal human variation rather than an illness that requires a cure, can be integrated, understood, supported and respected.

Networks such as these demonstrate how lay views can create sub-cultures of their own. They also signal how it is possible for professionals to change their minds on certain issues, when presented with a viable alternative.

recognition that there is a symbolic correspondence between these elements, wherein natural substances and energies, as well as supernatural forces, are *indistinct* from mind-body processes (Marsella & White, 1982). Greater emphasis is also placed on the body in relation to the environment, which means that psychological processes (personality, feeling states), although considered to be important, may not be regarded as the *origin* of the problem. Although differences in cultural traditions still exist (see below for the diagnosis of neurasthenia), it is important to note that Western psychiatric and psychological professional cultures have been shown to shift non-Western perspectives on mind-body relationships towards a more Cartesian and hence Western medical view (see Krause, 1998).

Somatization

The term somatization refers to the existence of physical symptoms that have no identifiable organic cause. A popular proposal is that non-Western societies tend to view distressing experiences as physical symptoms – **somato-psychic**, in contrast to Western societies who take the view that psychological distress causes physical symptoms – **psycho-somatic** (Angel & Guarnaccia, 1989; Marsella & White, 1982). However, somatic complaints with no identifiable organic origin, are common in both Western and non-Western societies (Dubovsky, 1987), the difference being that the *expression* of distress through the body is accepted and even encouraged more readily by non-Western societies, due to a general belief in the lack of separation between mind and body.

In the mental health literature somatization is sometimes referred to as one of the 'idioms of distress', whereby mental distress is communicated through the body as physical complaints and/or symptoms. But what are the origins of

these observations, and are they correct? The proposal that non-Western societies are prone to somatizing mental health problems has a long history. Kraepelin, for example, argued that the Javanese people tended towards more sensorial expressions of illness, due to a deficit in higher thought functioning. Littlewood & Lipsedge (1997) argue in *Aliens & Alienists* (1982) that the history of the somatization proposal is based on a set of naïve and racist assumptions regarding the inability of non-Western people to recognize higher thoughts and feelings within themselves. In this section, we will consider the evidence regarding somatization and the extent to which it is *more common* in certain societies, or *more commonly acknowledged as a legitimate mode of expression*. A commonly held view in the psychiatric and psychological literature is that physical symptoms that have no organic origin are common across the world and reflect an individual's mental state (Kleinman & Kleinman, 1985). Stress, trauma, loss and physical and mental oppression can all lead to somatization, in any culture. The psychological mechanisms contributing to somatization are often viewed as dysfunctional responses in Western psychiatry and psychology, perhaps because of the emphasis on open expression of thought processes and the residing focus on the individual (as the source of the problem). Denial ('I don't have a problem'), suppression ('I can deal with it later') and repression ('I need to get that off my mind so I can concentrate on other things') (Dubovsky, 1997) are all believed to be the main mechanisms through which somatization develops.

We will discuss aches and pains and exhaustion and fatigue, as these complaints have been commonly discussed in literature with reference to their resemblance to Western models of depression and anxiety.

Common questions raised in psychiatry and psychology have been whether certain societies have a greater incidence of somatization or whether there are simply different ways

of diagnosing and treating them. It is clear that in Eastern professional and lay cultures, somatization is accepted and considered to be a legitimate form of expression. But is it the case that somatization is less common in non-Western societies more generally?

A World Health Organization study (1997) collected data from 15 centres across Europe, Africa, Asia and North and South America (Gureje, Simon, Ustun & Goldberg, 1997). 25, 000 primary care attendees were screened and interview data were collected from 5, 438 people. The interesting finding was that chronic pain was related to psychological distress across all of the centres, despite some variation. Furthermore, independent studies have not found higher rates of somatization in South Korean (see above) or Ghanaian samples (Ofori-Atta & Linden, 1995).

In the UK, Perkins & Moodley (1993), studied 60 acute admissions into psychiatric wards, finding that nearly 60% of those admitted did not think they had a psychiatric complaint and 40% believed they had a somatic complaint or that their problems were social in origin. In another British study, Bhui et al. (2004) compared symptoms in Punjabi (2006) and white English (173) participants attending a primary care clinic in London. Contrary to previous work, where South Asians have been commonly perceived to have a tendency to somatize distress, somatic complaints were equally prevalent in the Asian and white British sample. Furthermore, depression was higher among the Asian participants, which again fails to support the common view about Asian individuals and their tendency to express distress through somatization. Further studies have confirmed higher rates of depression in South and East Asian women in the UK, based on a household survey of 10,000 adults (Meltzer, Gill, Petticrew & Hinds, 1995 – report 1). This finding does not support the proposal that somatization in Asian populations, *replaces* or *poses an alternative* to psychological presentations of distress.

Culturally specific forms and diagnoses of somatization?

Although somatic complaints appear to be common in all societies, what is often missing from Western psychological accounts is the extent to which different cultures encourage somatization, and thus the extent to which it would be viewed as *dysfunctional* or *functional* in different cultural settings. One society, for example, may value a *more indirect* expression of unpleasant feelings, than another that places values on self-expression and emotional or individualistic accounts of adversity.

For example, consider the example below:

Over the past two years, Mrs Lin's physical symptoms have worsened and she has frequently sought help from physicians of both biomedicine and traditional Chinese medicine. When questioned by me, she admits to more symptoms – difficulty with sleep, appetite and energy, as well as joyfulness, anxiety and feelings that it would be better to be dead. She has an intense feeling of guilt about the stillbirth and also about not being able to be helpful in practical ways to her paraplegic brother. During the past six months she has developed feelings of hopelessness and helplessness, as well as self-abnegating thoughts. Mrs.

Lin regards her life as a failure. She has fleeting feelings that it would be better for all if she took her own life, but she has put these suicidal ideas to the side and made no plans to kill herself.

From Mrs Lin's perspective, her chief problem is her 'neurasthenia'. She remarks that if only she could be cured of this 'physical' problem and the constant headache, dizziness and fatigue it creates, she would feel more hopeful and would be better able to adapt to her family situation. For a North American psychiatrist, Mrs Lin meets the official diagnostic criteria for a major depressive disorder. The Chinese psychiatrists who interviewed her with me did not agree with this diagnosis. They did not deny that she was depressed, but they regarded the depression as a manifestation of neurasthenia, and Mrs Lin shared this viewpoint. Neurasthenia – a syndrome of exhaustion, weakness and diffuse bodily complaints believed to be caused by inadequate physical energy in the central nervous system – is an official diagnosis in China; but not in the American Psychiatric Association's latest nosology.

Case example from
Arthur Kleinman's research in China

Arthur Kleinman is the leading expert on somatization and mental distress in China. It is evident from his example that a diagnosis of neurasthenia is particular to Chinese (and East Asian) society and is used to *explain* the origins of low mood. This is contrary to a Western perspective, where a diagnosis of depression would actually be used to *explain* the physical symptoms. A diagnosis of neurasthenia is still commonly used in Chinese and East Asian societies, even though the diagnosis is not included in Western diagnostic manuals. Why is this? Is it because somatization is generally higher in Eastern societies? According to a study by Yen, Robins & Lin (2000), this idea is not supported, as *non-clinical* samples revealed no significant differences between the incidence of somatization in the Far East and the US. The difference appears to lie in the number of clients reporting somatic complaints to professionals and the manner in which the complaint was received.

Kleinman & Kleinman (1985) have argued that China is a more collectivist culture, where interdependency and social ties and bonds are valued over individualism. In many parts of Chinese society, individuals do not report feeling depressed or sad but express feelings of boredom, discomfort and symptoms of pain, dizziness and fatigue (Kleinman, 2004). Kleinman argues that interdependent individuals are more likely to express their distress in somatic complaints like exhaustion, so that social bonds and ties are maintained and the possibility of stigma is reduced. If an individual openly expresses distress ('I am unhappy about this relationship'), this is considered to be disruptive of social ties, especially when difficult social ties are likely to be the cause of the distress (Keyes & Ryff, 2003). In Japan, for example, Lock (1988) found that women with somatic complaints were more likely to receive interpersonal counselling, rather than a diagnosis of mental or physical illness. Furthermore, in a comparative study of the US and South Korea, Keyes & Ryff (2003) found an equal prevalence of somatic symptoms, the difference being that somatizers in South Korea did not also have symptoms of depression, as it was understood that this indirect expression of distress was socially supported and acknowledged. Conversely, somatizers

in the US felt depressed and frustrated at the lack of support they received for their physical complaints and felt stigmatized and misunderstood by professionals.

In sum, this study and others have demonstrated that somatization in a collectivist culture such as South Korea and other East Asian societies is viewed as a constructive response to mental distress, whereas US participants, in a more individualistic culture, tend to report depression more often, due to feeling unsupported, undervalued and stigmatized. Studies on somatization raise questions for psychology and mental health, because the way in which certain cultures view the relationship between mind, body and environment affect how mental health and distress is experienced by the individual, how the practitioner diagnoses it and the types of treatment on offer. Sensitivity to different cultural traditions is necessary if the boundaries between mind and body, and consequently mental illness and health, are variable across cultures.

Migration

Migration refers to the movement of a group of people (sometimes large groups) from one place to another, sometimes over large distances. This can be either voluntary or involuntary, as in the slave trade or via human trafficking. The reasons for migration range from seeking better employment, educational opportunities or marriage to escape from war and/or oppressive regimes in the migrants' own country. Migration has contributed a rich texture to many developed societies, leading to an increase in the diversity of cultures, races and ethnicities in those societies (Bhugra & Becker, 2005). In the UK, the majority of permanent immigrants are members of ethnic minority groups and in the last British census (2001), those belonging to ethnic minorities had reached 4.6 million or 7.9% of the population. The largest ethnic minority population in Britain is Indian, then Pakistani, followed by mixed ethnic backgrounds, Black Caribbeans, Black Africans and Bangladeshis (cited in Bhugra & Becker, 2005). In this section, we will explore the relationship between trans-national migration (as opposed to urban-rural migration) and cultural identity with reference to mental health and distress.

Individuals who migrate tend to experience significant levels of stress and there are several hypotheses linking higher rates of diagnosed disorders such as schizophrenia in migrant groups. However, the reasons why some groups are more often diagnosed with particular difficulties are complex.

A number of reasons for these higher rates of diagnosis have been proposed, including racist and/or culturally insensitive professional practices in the UK, the stress of migration itself and difficulties with cultural bereavement and cultural identity.

Cultural identification; psychosis and African-Caribbean men

A number of studies conducted in the UK have shown higher rates of schizophrenia diagnoses in African-Caribbean groups (Bhugra, 2000). Several critics have put this down to the existence of racism in psychiatric practices (Fernando, 2003) and a propensity to misdiagnose African-Caribbean men (in particular) due to anti-social behaviour. Indeed, African-Caribbean men are significantly more likely to be

compulsorily detained in psychiatric hospitals and to be given medication, than their white counterparts (Pilgrim & Rogers, 2010). In order to examine this issue, researchers at the Institute of Psychiatry invited a Jamaican psychiatrist, Fred Hickling, to reassess their diagnoses of schizophrenia (using detailed case notes) for African-Caribbean men to establish whether white psychiatrists were more likely to over diagnose this group. The study revealed broad agreement between the diagnoses made by Hickling and the British psychiatrists, suggesting that racism alone could not account for the elevated rates of schizophrenia diagnoses among African-Caribbeans in the UK. Furthermore, a community sample also found higher rates of psychosis among African-Caribbeans living in Nottingham (Harrison, Amin, Singh, Croudace and Jones, 1999). Given this evidence and the fact that there are lower incidence rates for psychoses in the Caribbean than in the British African-Caribbean community (ruling out a genetic vulnerability), several authors have explored the significance of migration in the development of psychosis, not only amongst first-, but second-generation African-Caribbeans in the UK and several European societies (Bentall, 2003). Furthermore, recent large scale meta-analyses of the data appears to support the role of migration as a significant risk factor for psychotic diagnoses (namely schizophrenia; see Cantor-Graae & Selten, 2005).

Ethnic density and parental absence

Several reasons emerge to explain these incidence rates in both first and second generation migrants. First, a recent study in London revealed that non-white people living in predominantly white neighbourhoods were more likely to be psychotic than non-white people living in predominantly non-white neighbourhoods. In one study, for example, equal rates of schizophrenia were found among Asians and whites and, interestingly, large numbers of Asians were living close by, leading to protective effects and greater levels of social support (Bhugra, 2004). Racial tension and isolation, therefore, may explain why higher rates of psychosis are found in some ethnic minority groups and not others (Boydell et al., 2001). Experiences of isolation, alienation and racial discrimination can lead to a number of negative emotional states, including poor self-worth and hypervigilance, all of which can affect psychological processes, such as attributions or self-representations (known to play a role in paranoia, psychosis and mania). **Hypervigilance** is a general sensory state referring to an individual's exaggerated sense of, and behaviours used to check for, perceived threat. This heightened awareness of threat usually results in fatigue.

Second, in an attempt to explain why the children of African-Caribbean immigrants were more vulnerable to psychosis, Dinesh Bhugra and colleagues found that out of 38 African-Caribbean hospital patients (diagnosed with schizophrenia), 12 (34%) had been separated from their mothers for a period of four years or more during childhood, and 19 (53%) had been separated from their fathers for a similar period (Bhugra et al., 1997). This suggests that migration may make it more difficult for some families to provide the sustained care and support that could protect their children from the adverse effects of significant life stressors (including racism), though more research is required to explore the relationship between parental absence, migration and childhood experiences. Third, challenges to cultural identity have been found to increase

feelings of social isolation, experiences of discrimination, low self-esteem and alienation. **Acculturation** refers to a process of psychological transition when an individual moves from one culture to another. It also refers to the exchange or merging of cultural values, behaviours and feature that occurs when different cultural groups come into direct contact (e.g. by living in the same country). Although the groups remain distinct, each may alter over time as a result of its contact with the other.

Psychologist John Berry has described four outcomes of this process, which depend on whether the culture of origin or the host culture is identified with (see Table 3.2). The four outcomes are as follows:

- 1 *Integration* – the individual identifies with and adopts characteristics of both cultures
- 2 *Assimilation* – the individual rejects her culture of origin and embraces the host culture
- 3 *Separation* – the individual rejects the host culture and embraces his culture of origin
- 4 *Marginalization* – the individual does not commit to either culture.

If an individual is caught between two cultural identity groups, and rejected by both, a dissonance between the original and surrounding concept of self can then ensue, according to Berry. This is more likely to be experienced by the children of migrants, and can lead to marginalization, the most stressful of the four outcomes (Bentall, 2003; Bhugra, 2004). This, together with an increased risk of unemployment, a lack of social support (e.g. living in isolation from one's cultural

Chapter summary

The relationship between culture and mental health and distress is ongoing and complex. In this chapter, we have discussed a number of issues that speak to this debate more generally, but in particular, we have discussed issues that speak more specifically to the role of culture in psychological approaches to mental health and distress. This is not a straightforward project, given the complexity of the definition and uses of culture in different research and practice traditions, in which particular views on measurement and methodological approaches differ.

Returning to the first major question raised in this section, 'To what extent do variations or similarities exist between cultures, in terms of the prevalence, incidence and course of traditionally defined mental "disorders"?', we can respond by discussing the differences in prevalence rates and the course of traditionally defined mental disorders between cultures, using the available evidence from large-scale studies.

However, it is also clear that increases in the use of Western diagnostic criteria and Western mental health professional cultures across the world may lead to more cases being identified. Furthermore, an increase in industrialization in previously non-industrialized societies may result in greater numbers of specific mental health problems, due to the growing appropriation of Western values (see the example of the growth of eating disorders in Japan). In exploring issues of dissociation, madness

group), poverty and discrimination can result in a higher risk of long-term mental distress (Bhugra, 2004; Hwang & Wood, 2010). Furthermore, when an individual comes from a collectivist society it may be a significant challenge to their cultural identity to have to move to a society where individualism is held in high esteem, especially when he cannot make contact with members of his cultural group because of geographical isolation. When the stress of these experiences becomes overwhelming, distress can escalate and have a bad effect on self-esteem (Crisp & Turner, 2011).

Table 3.2 The four types of acculturation

Identification with culture of origin	Identification with host culture		
		Yes	No
	Yes	Integration	Separation
	No	Assimilation	Marginalization

Source: Adapted from Berry & Kim (1988).

The available evidence indicates that the children of immigrants are at particular risk of mental distress. However, more research is needed to establish the range of factors contributing to this: life events, racial and socio-economic discrimination, parental attachment and separation, employment and educational status, all deserve significantly greater attention if the relationship between migration, cultural identity and mental health and distress is to be understood.

and the relationship between body and mind in the second half of the section, we were able to address the second question 'Do different societies draw a line between well-being and distress, sanity and madness in the same way?' Once again, it is clear that different societies (and cultures) appear to have assigned a variety of meanings to states of mind and body. These are cut across with differences in religious practices and beliefs, as well as values associated with particular forms of expressions of mental states (see the example of dissociation and psychosis). Although somatic complaints (without any organic cause) are common throughout the world, for example, cultural labels and values are given to them, affecting the individual's own personal relationship to them and the treatment offered (for example, see diagnoses of depression and neurasthenia).

This brings us to another important point about the role of professional cultures in the measurement, diagnosis and treatment of mental health and distress across societies. A number of professional cultures may operate in a given society, but the one that may have the most impact, in terms of diagnosis and treatment, is often the one assigned the highest authority to speak on behalf of clients and patients. This can be due to government and industrial support (for example, from drug companies) for particular kinds of funding and clinical practice. And yet, in the case of the Hearing Voices Network in Holland and the UK, it is also clear that sub-cultures can develop as a means to resist the dominant point of view, leading to the creation of alternative reference points for users of the mental health system.

The last section, on migration, indicates that the study of culture is far from just a study of different geographical societies. A number of cultures contribute to European and North American societies, divided as they are by ethnicity and race and influenced by a number of religious practices. Issues of religion and spirituality are, therefore, clearly important in making sense of a particular cultural group, given the variety of religious and spiritual beliefs about the nature of mind and altered conscious states that exist.

In summary, culture is not a 'thing' that can easily be measured and controlled for. Culture is a way of life affecting us all. In psychology, we often forget that our beliefs about mental health and distress are shaped by wider cultural beliefs about the mind and body, what it means to be a person, a self and an individual (Ritter et al., 2010). We also tend to forget that the history of psychology as a discipline is such that the methodological traditions of psychology (as well as psychiatry as a continuous presence in some psychological research on mental health) affect how we look at the world and at people, how we measure them and ultimately understand them.

End of chapter questions

- 1 If different cultures have different standards for assessing psychological distress, what does that tell us about universal measurements?
- 2 Why do certain countries have better recovery rates for psychological distress (even for the so-called 'serious' psychotic states?), despite having less or no access to psychiatric treatments such as medication?
- 3 Does how we understand the mind and body affect the way we experience and professionally treat psychological distress?

- 4 Could a combination of quantitative and qualitative forms of assessment that do not rely on diagnostic categories produce a more accurate picture of rates and recovery from psychological distress?

Find out more

- Helman, C. (2007). *Culture, Health and Illness* (5th edn). London: Hodder Arnold.
- Jenkins, J. H. & Barrett, R. J. (Eds) (2004). *Schizophrenia, Culture and Subjectivity: The Edge of Experience*. Cambridge: Cambridge University Press.
- Kazarian, S. S. & Evans, D. R. (Eds) (1998). *Cultural Clinical Psychology: Theory, Research and Practice*. Oxford: Oxford University Press.
- Krause, I. B. (1998). *Therapy across Culture: Psychotherapy and Cultural Diversity*. London: Sage.
- Littlewood, R. (2002). *Pathologies of the West: An Anthropology of Mental Illness in Europe and America*. New York: Cornell University Press.
- Sadler, J. Z. (2005). *Values and Psychiatric Diagnoses*. Oxford: Oxford University Press.
- Warner, R. (1994). *Recovery from Schizophrenia: Psychiatry and Political Economy*. London: Routledge.

Novels

- Head, B. (1974). *A Question of Power*. Portsmouth NH: Heinemann International Literature & Textbooks.

In this autobiographical novel, Bessie Head describes slipping between psychotic hallucinations that torment, and wakefulness. Head explores these themes in the context of difficult social relationships and in the context of her being an exiled woman with a young son.