INTRODUCTION

• Simply looking at the **individual variables** in the etiology and manifestations of psychopathology is not enough, look for the factors in the **society and culture** responsible partly or wholly, in causation and modifying course & nature of psychopathology.

• The transcultural differences may be alluded to the **pathoplastic** influence of culture, whereas the commonalities may represent the real ‘core’ nature of illness.

• Facilitates greater insight into concept of mental illness and its treatment

DEFINITION

• A special field of psychiatry

• Primarily concerned with **cultural aspects** of human behavior, mental health, psychopathology and treatment

• **At clinical level** – promote culturally relevant mental health care for pts of diverse ethnic or cultural backgrounds

• **In terms of research** – how ethnic and cultural factors influence human behavior and psychopathology as well as art of healing

• On a **theoretical level** – aims to expand our knowledge of human behavior & mental problems transculturally.

Culture

• **Culture** – conceptualized as behavior patterns and lifestyle shared by a group of people, unique and different from that of other groups.

• The totality of knowledge, customs, habits, beliefs & values that shape behaviors, emotions, and life patterns.

• Learned by “**enculturation**” and transmitted over generations. **Acculturation** and **assimilation** when exposed to foreign culture.
• **Ethnicity** – refers distinct group of people sharing a common historical path, affiliated with each other, may share a common language, religion, culture, racial background, other characteristics that make them identifiable with their own group.

• Ethnicity refers to an identified group of people, whereas culture – the lifestyle shared by a group of people

• **Race** : socially & culturally constructed categories, products of historical & contemporary social, economic, educational & political circumstances.

• Ethnicity is a cultural phenomenon, while race is a biological and anthropological phenomenon. (physiognomy)

• **Society**: social institution organized by administrative structure regulated by certain rules or systems.

• **Minority** - relatively smaller group identified against majority in society

• **Primitive /pre-scientific psychiatry** – to focus mental illness in primitive societies- no longer used

• **Ethnopsychiatry / folk / anthropological psychiatry** – psychiatric theories and practices of a particular ethnic group, particularly primitive tribe.

• Folk concepts of emotional disturbances, interpretations of mental illness, and traditional ways of healing those problems.

• **Wittkower** (pioneer of cultural psychiatry) coined “**transcultural psychiatry**” – extends beyond the scope of one cultural unit on to others.

• APA in 1969 described transcultural psychiatry

• **Cross-cultural psychiatry** – comparative analysis of mental disorders among various ethnic or cultural groups

• **Cross-cultural** used more by psychologists to emphasize cross-cultural comparisons whereas **transcultural** used by psychiatrists to stress applications through cultural barriers.

• Recently the term **CULTURAL PSYCHIATRY** is used.
• Wittkower (pioneer of cultural psychiatry) - **cultural psychiatry** as

• a discipline concerned with frequency, etiology, and nature of mental illness & the care and aftercare of the mentally ill within the confines of a “culture unit”

• Though cultural psychiatry recognizes biological factors, it is more oriented to the psychological, social and cultural aspects of behavior and illness – related to social and behavioral sciences

Cultural psychiatry related to

• **Medical Anthropology**: medical aspects of adaptation & maladaptation of human groups to their sociocultural env & ecology, ethnomedicine, med aspects of social systems, illness & cultural change.

• **Medical sociology**: medical issues within framework of society.

• **Social psychiatry**: subfield of general psy like cultural psy.

• Socioenvironmental aspects of human behavior & mental disorders.

• **Minority psychiatry**: clinic work that focus primarily on ethnic minorities

• Underprivileged subgroup of society have sp psychological experiences like discrimination, cultural deprivation or uprooting.

• **Community (public) psychiatry**: mental health care & prevention within a defined community.

• **Psychiatric epidemiology**.

**History**

• **Emil Kraepelin** travelled in early 20\textsuperscript{th} century to Java to find mental illness - mental illnesses were product of civilization & apparently primitive people were immune to mental illness.

• His visit to Java – said to be beginning of transcultural psychiatry

**Beginning of Ethnopsychiatry** (end of 19\textsuperscript{th} century to 20\textsuperscript{th} century)

• Differences in psy conditions among early immigrants to America.

• European psychiatrists discovered unusual syndromes in colonized societies – Culture bound syndromes

• **Pioneer interest in Comparative (descriptive) psychiatry**: Emil Kraepelin described differences in symptomatology and established concept of comparative psychiatry.
Applicability of psychoanalytical concepts in primitive societies: Cultural anthropologists tested Freud’s theory in tribal societies - different child rearing patterns generate different psychological phenomena.

Varied Interests in investigating culture & mental health (1930-50s)

- **Enthusiasm in studying culture and personality**: Anthropologists (Ruth Benedict & others) – cultural configurations (cross-cultural child rearing patterns) of personality.
- **Psychiatrists’ interest in indigenous healing practices**: Jerome Frank (psychiatrist) compared folk healing & modern psychotherapy.
- **Development of Comparative psychiatric epidemiology**: Studies carried out indicating prevalence of mental disorders differs among societies.
- **Emphasis on minority psychiatry disorders**: Impact of cultural influences on minority disorders (neuroses) instead of major disorders (psychoses whose etiology pred biological).

Formal organization of cultural psychiatry & study programs (since 1960s)

- Wittkower - Transcultural psychiatry division at Magill Univ in Montreal.
- HBM Murphy – Transcultural psychiatry within WPA.
- Many national & international organizations, journals, books, health programs.

Emphasis on minority mental health (from 1960s)

- Increased concern regarding minorities in North America & new emigrants to Western Europe.
- Clinical application of cultural psychology to these minorities beyond academic research.

Evidence of broad-minded Cultural psychiatry (From 1970s)

- Cultural research from isolated simple societies to developed complex societies.
- Western-trained, non-Western Psychiatrists’ contribution in their home societies - developed culturally relevant care in different countries.
- Recognition of Cultural psychiatry in Western countries - as psychiatrists has to deal with people from foreign cultures, culture specific syndromes among majority groups in modern Western society.

Formation of Cultural psychology as a special field of Psy (from 1980s)

- Focus of cultural psychology expanded to clinical practice providing culturally relevant care of patients according to their cultural background.
SCOPE OF CULTURAL PSYCHIATRY

• As defined by Transcultural psy Committee of APA (1969)

• Similarities, differences in the form, course or manifestation of mental illness in different societies and cultures.

• Occurrence, incidence, and distribution of mental illness or behavioral characteristics in relation to socio-cultural factors

• Sociocultural factors predisposing to mental health

• The forms of treatment preferred in various cultural settings

• Assessment with adaptation of established psy principles to various sociocultural contexts

• Relationship b/w culture & personality

• Understanding of conflict in persons experiencing rapid cultural change

• Labeling of behavioral deviance

• Psychological & social adaptation of migrants

• Psy aspects of communication b/w individuals, groups from different cultures

• Response to varying culturally based stressful situations

• Cultural determinants of transnational interaction & public policy decisions within nations

COMPARATIVE NOSOLOGY

• ICD 10 has also been revised and updated to account for cultural factors - ambiguous, if not nebulous.

• DCR 10 maintains a separate Annex 2 “culture specific disorders”

• 12 frequently described "culture-specific" disorders have been included in this annex by way of example, together with their clinical characteristics

• Suggestions concerning their placement in ICD 10 categories

• Emergence of new diagnostic systems
  1. Chinese Classification of Mental Disorders
  2. Latin American Guide for Psychiatric Diagnosis
Three additions in DSM IV:

- a mention of “cultural”, together with “age” and “gender” considerations, as part of the text in some (not all) groups of disorders;
- the inclusion of a cultural formulation in Appendix I (next to last) of the manual; and
- the listing of an (incomplete) glossary of “culture-bound syndromes”.

Appendix I in DSM-IV-TR has an outline for cultural formulation:

- Cultural identity of the individual
- Cultural explanations of the individual’s illness
- Cultural factors related to psychosocial environment and levels of functioning
- Cultural elements of the relationship between the individual and the clinician
- Overall cultural assessment for diagnosis and care

DSM-5 updates criteria to reflect cross-cultural variations in presentations,

- 1) gives more detailed and structured information about cultural concepts of distress
  - In the Appendix, they are described through cultural syndromes, idioms of distress, and explanations.
- 2) includes a clinical interview tool to facilitate comprehensive, person-centered assessments
  - This cultural formulation interview guide will help clinicians to assess cultural factors influencing patients’ perspectives of their symptoms and treatment options.
  - It includes questions about patients’ background in terms of their culture, race, ethnicity, religion or geographical origin
- 3) Specific diagnostic criteria were changed to better apply across diverse cultures. For ex, the criteria for social anxiety disorder now include the fear of “offending others” to reflect the Japanese concept in which avoiding harm to others is emphasized rather than harm to oneself.

CULTURAL PSYCHODYNAMICS

CULTURE AS AN ETIOLOGICAL AGENT


- Determining standards of normality and abnormality
- Fostering stressors that exceed individual and societal coping resources
• Creating personality configurations or types, which are unable to meet environmental demands.

• Encouraging particular models of disease causality and control

**Determining Standard Of Normality And Abnormality**

• Every Culture seems to have some conceptualization of good mental health or *optimal functioning* e.g. Western concepts; “Self Actualization”, “sense of Autonomy”, is not automatically applicable to non-western world where greater emphasis is placed on fitting into supraordinate unit of family, community.

• Discrepancies of mind body distinction concepts for optimal functioning (western vs. non-western)

• **Cultural variability: From normal behaviour to neurological disease**

• Normal behavior though obviously a function of biological substrates, has the widened latitude of variability across culture.

• As the *nervous system* becomes more directly implicated, as is the case in neurological diseases, *cultural variability decreases*.

• However even in the most severe neurological diseases or disorders, cultural influence, still occurs since the individuals *interpretation* and *experience* of disorders, its behavioral references and the *social response* to these references is strongly influenced by culture.

• **ETIC-EMIC**

• The *etic* perspective describes syndromes, illnesses and other medical phenomena as scientifically derived , presumably universal, and based upon clearly specified symptoms and processes. The major disorders are held to be culture free.

• The opposing view called the *emic* perspective claims that emotional and behavioural phenomena must be evaluated within the context of the affected person’s ethnic culture. This line of investigation has brought us research on ‘culture bound syndromes’

• Both the etic and emic approaches in cross cultural psychiatry have strengths and weaknesses.

**Stress and Coping**

• Sociocultural environment can create unusual demands upon a given society or individual via certain events:

• Social change, Economic vicissitudes, Acculturations, War, Social catastrophes etc.

• Two other concepts, which are related to stress, are *personality* and *coping*. Both this concepts are *mediators of stress* levels in a given culture.
Culture and Personality

- **Culturally-determined personality attributes** may importantly influence coping mechanisms and mental illness.

- When faced with emotional conflict, a passive-dependent person may be likely to more easily "give up". He may be more prone to break with reality, develop psychotic coping behaviour.

- On account of close ties with the society, he can more easily turn to them to be taken care of. He may also develop hysterical and somatoform disorders, so as to involve other members of the society in its resolution.

- On the other hand, an autonomous individual, on account of his abhorrence of loss of control and rejection of his dependency needs, may try to resolve his conflicts himself - at the intrapsychic level.

- He may keep on battling with the anxiety, unbound, or may convert them into development of neurotic-type distress.

- It is possible that the personality configuration, either individually or culturally shaped may influence the choice made. The subsequent elaboration and proliferation of the symptomatology may depend, to a certain degree, upon the various socio-cultural factors.

Conceptualization Of Illness And Health

- Cultural factors may influence psychopathology through conceptualization of health and disease, which are fostered and maintained through individual attribution about illness, their causes, mental functioning, symptoms, individual attribution regarding personhood e.g. volition, self-control, boundaries of self, social responsibility.

- This plays a critical role in how underlying psychiatric diseases process is expressed in behavior, how it is handled, how long it lasts and how it is shunted about in the social systems.

Encouraging Particular Models of disease causality and control

- Theories of natural causation–infection, stress, organic deterioration.

- Theories of supernatural causation –Mystical causation i.e., fate, ominous sensation, mystical retribution. Animistic i.e., soul loss, spirit aggression and Magical i.e., sorcery, witchcraft.

  *Murdock (1980)*

- Hawaiian and Filipino patients reported more spiritual or magical causes of their disorder than did Caucasian patients (WHO collaborative study).
SIX CULTURAL VARIABLES RELATED TO PSYCHOPATHOLOGY

DEPENDENCY VERSUS AUTONOMY

<table>
<thead>
<tr>
<th>TRAITS OF DEPENDENCE PRONE SOCIETY</th>
<th>TRAITS OF AUTONOMY PRONE SOCIETY</th>
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<tbody>
<tr>
<td>• Interdependence</td>
<td>• Clearly demarcated ego-boundaries</td>
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<tr>
<td>• Strong sense of identity with the primary, filial group</td>
<td>• Control over one’s body, action, thoughts and emotions</td>
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<tr>
<td>• Lesser idea of individuality, of individual rights and responsibility</td>
<td>• Greater self reliance</td>
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<tr>
<td>• Greater differentiation between ‘us’ and ‘them’, with clearly different codes of conduct in</td>
<td>• An acute sense of one’s rights, duties and responsibilities</td>
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<td>dealing with these</td>
<td>• “Guilt prone society”</td>
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<td>• Pity, sacrifice, submission and gratitude as character traits</td>
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<tr>
<td>• “Shame prone society”</td>
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<tr>
<th>• Indian Personality</th>
<th>• Western Personality</th>
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<tr>
<td>• Dependence</td>
<td>• Individual centeredness</td>
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<td>• Identification with primary group</td>
<td>• Compulsivity, pride in doing a job well.</td>
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<tr>
<td>• Personalized codes of conduct</td>
<td>• Activity and work highly valued.</td>
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<tr>
<td>• Lack of fairness</td>
<td>• Highly guilt ridden.</td>
</tr>
<tr>
<td>• Highly shame prone</td>
<td>• Acquisitiveness.</td>
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<tr>
<td>• Traditionalism</td>
<td>• Belief in equality of all.</td>
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<td>• Belief in individual freedom.</td>
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LINGUISTIC COMPETENCE

• *Linguistic “competence”* is the speaker - hearer’s intrinsic knowledge of his language and  
  *Linguistic “performance”* is the actual use of language in a given situation. (Chomsky,1965)
• Linguistic competence is the unconscious knowledge of grammar that allows a speaker to use a  
  language. An innate attribute of mind, enabling the developing individual to “know” the  
  grammar or rules of the language of his speech community after only minimal exposure to it.  
  It is viewed as the tacit rules of a language specifying the set of sentences that could occur  
  in the language.

• In the context of schizophrenia, Arieti (1955) has outlined an innovative, longitudinal view of  
  the mental operations.
• The first stage starts from a period of intense anxiety, panic, confusion and perplexity and  
  culminates in achievement of psychotic insight.
• Language may take over from the intense anxiety and set into motion a reverberating cycle,  
  with increasing elaboration of delusions.
• As the delusions do not fully bind the anxiety, a vicious cycle results causing the delusion to  
  become more and more systematized.
• In Positive schizophrenics, linguistic competence has positive correlation with severity of illness  
  and negative correlation with outcome.
Greater linguistic competence may take over from intense anxiety and set into motion a cycle of increasing elaboration of positive symptoms.

The positive symptoms may, in turn, cause further anxiety and excitement, thus, adding to the vicious cycle, thereby producing more complex and intractable delusions.

This may lead to a severe form of illness and may as well influence prognosis.

In negative schizophrenics, positive correlation was observed between outcome and linguistic competence.

**High linguistic competence** in a patient with negative schizophrenia was associated with low degree of negative symptoms which may have increased chances of recovery.

**Low linguistic competence** in a negative schizophrenic produces high degree of negative symptoms which are not easily amenable to therapeutic change.

**COGNITIVE STYLE**

Represents the ways in which mind perceives the environment interprets it and draws conclusions about it.

- Individuals and cultures differ from each other in cognitive styles.
- The cognitive style can be characterized as "analytical" at one extreme and "synthetic" at the other.
- Analytic – understanding by breaking the things into parts- western mind
- Synthetic – understanding by considering the things in totality- Indian mind.
- This may be related to the Dependency-Autonomy continuum

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<tr>
<th>ANALYTICAL STYLE</th>
<th>SYNTHETIC STYLE</th>
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<tr>
<td>Understand a thing or a phenomenon by breaking it into parts.</td>
<td>Tries to see things or phenomena in the totality and see the relationships between them.</td>
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<tr>
<td>The Western mind is classically analytical.</td>
<td>The Indian mind is synthetic in its cognitive style.</td>
</tr>
<tr>
<td>Prevail in autonomous oriented society.</td>
<td>More conducive to the development of a unitary, holistic concept.</td>
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<td>Consistent with the dependence and loose ego-boundaries in the relationship of individual with society.</td>
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**SOCIAL SUPPORT SYSTEM**

- Differences across cultures in the social support system have been correlated with course and outcome of mental illness.
- The traditional and developing societies which are richer in social support network have been shown to have a better prognosis of severe mental illnesses (WHO 1973, 1979)
- A very fruitful area of research in the field of social network has been that of "expressed emotions".
- Relatives' expressed emotions, especially critical comments and hostility, have been correlated with adverse prognosis
MATERIAL CULTURE

• Culture consists of the beliefs, values, norms and myths and the physical environment which is comprised of artifacts like roads, bridges, buildings, etc.
• It is understandable that the nature of material culture may influence the psychopathology.
• The same malevolent force may be perceived as a spirit of a ghost in a developing society and as X-rays and radio waves in a technologically advanced society.

PSYCHOLOGICAL SOPHISTICATION

• Ability to see conflicts in intrapsychic terms. It involves introspection and translate one’s emotions into words
• In other words, the conflict is perceived as within the mind, or more specifically, between the components of the psychic structure.
• The conflict cannot be ascribed directly, for example, to social prohibitions, external authority or malevolent spirits.
• Psychological sophistication may be related to coping mechanisms and certain types of neuroses, especially hysteria.
• It may also give rise to high introspection as a mental attribute to understand and resolve conflicts.

CULTURE CAN CONTRIBUTE TO PSYCHOPATHOLOGY IN SIX DIFFERENT WAYS (TSENG, 2001).

• previously assumed - culture merely plays a patho-plastic effect on strong central biological pathogenesis of mental disorders
• current understanding - culture has multiple roles in the expressions of psychopathology

PATHOGENIC EFFECTS (cultural influence on the formation of a disorder)

• Culture is a direct causative factor in forming or ‘generating’ psychopathology.
• Cultural ideas and beliefs contribute to stress, which in turn produces psychopathology.
  Ex:
• Dhat Syndrome (loss of semen - produce anxiety, depression and somatic symptoms.)
• Koro (the folk belief that the penis (vulva & breasts) shrinks into the body resulting in death. Found in SE Asia)
• Frigophobia – fear of cold

PATHOSELECTIVE EFFECTS (culture selecting certain coping patterns to deal with stress)

• The tendency of some people in a society, when encountering stress, to select certain culturally influenced reaction patterns that result in the manifestation of certain psychopathologies.
• **Family Suicide** (Japan), **Hwa-byung**- sickness of resentment with fire in Korean women, **Amok**- in Malaysia

• Culture has a powerful influence on the *choices people* make in reaction to stressful situations and shapes the nature of the psychopathology that occurs as a result of those choices. Of course, this only applies to minor psychiatric disorders, particularly of culture-related specific syndromes, not to major psychiatric disorders.

**PATHOPLASTIC EFFECT** (culture modifying the clinical manifestation)

• ways in which culture contributes to the modeling or ‘plastering’ of the manifestations of psychopathology.
• Culture shapes symptom manifestations at the level of the content presented as well as whole clinical picture.
• The content of delusions, auditory hallucinations, obsessions, or phobias are subject to the environmental context in which the pathology is manifested.
• **Taijin Kyofu Sho** (Japan) (fear of human IPRs) - Culturally distinctive social phobia
• Fear of social contact (especially friends)
• Extreme self-consciousness (concern about physical appearance, body odour, blushing), Fear of contracting disease.
• **Brain fag syndromes**

**PATHOELABORATING EFFECTS** (culture elaborating mental conditions into a unique nature)

• While certain behaviour reactions (either normal or pathological) may be universal, they may become exaggerated to the extreme in some cultures through cultural reinforcement
• **Trance and possession** - culturally sanctioned, nearly institutionalized means for experience for ego-dystonic impulses and thoughts
• **Latah**- Malaysian women startle by becoming dissociated & exhibit uninhibited behavior, incl saying sexually oriented ‘dirty’ words, which normally strictly prohibited for women – became a social entertainment to startle women

**PATHOFACILITATIVE EFFECTS** (culture promoting the frequency of occurrence)

• Cultural factors do contribute significantly to the frequent occurrence of certain mental disorders in a society.
• Cultural factors don’t change the manifestation of the psychopathology ie clinical picture shall be recognized and categorized without difficulty in the existing classification system
• Massive hysteria, drinking problems

**PATHOREACTIVE EFFECTS** (culture shaping folk responses to the clinical condition)

• Cultural factors donot directly affect the manifestation or frequency of mental disorders,
• they influence people’s beliefs and understanding of the disorders & mold their reactions to them and then guide them in expressing their suffering.
• In Latin America, a person expressing anxiety, depression or dissociation is interpreted as being lost his or her soul (Susto) & needs to regain

• **Faith healing practices** in India in case of major psychiatric disorders like schizophrenia, bipolar disorders or in OCD. People attribute illness as results of “Black magic”.

• Another prevalent misconception in India is that mental illness is due to the patient ‘not getting married at proper age’, and that marriage will cure his/her sexual frustration or problem and there by cure his/her mental illness.

**CULTURE AND PSYCHIATRIC DIAGNOSIS**

**Cognitive Disorders**

• Less attention – b/c assumption - exclusively by biological factors
• still, show several kinds of social, cultural, and ethnic influences.
• Socioeconomic factors influence the prevalence rates of diseases affecting the brain.
• Low industrialization of a country or the poverty of a particular social group tends to increase the rates of infectious diseases, nutritional disorders, toxic exposures (e.g., lead), head injuries, endocrinological abnormalities, and seizure disorders among others
• So, differences in the rates of the subtypes of dementia, of delirium
• Cultural factors, such as prohibitions against substance use and variations in sexual mores, also affect the rates of alcohol- and drug-related syndromes as well as of AIDS-related organic mental disorders
• Ethnic determinants
  • HTN & strokes have been suggested to be more prevalent among the African-Americans and some Asian groups; so different rates of multi-infarct dementia
  • research on Alzheimer’s dementia - lower rates among the Chinese and the Chinese-Americans as well as the African-Americans
  • The detection and assessment of the cognitive disorders are also influenced by social and cultural factors
  • Social groups that tolerate and even expect substantial decreases in decision-making and self-care among older persons may not be regarded as pathological
  • Educational-level and cultural differences - identification of cognitive impairment with MMSE

Substance Use Disorders
  • Prevalence rates of alcohol and drug abuse and dependence vary significantly across different cultures.
  • Specific local factors - risk for substance-related disorders include patterns of use, attitudes toward substance consumption, accessibility of the drug, physiological reactions to the same drug, and family norms and patterns
  • less affected by cultural factors - comorbidity patterns, the nature of dependence syndromes, the age at onset, and the results of laboratory tests and physical examinations

• Schizophrenia and Related Psychotic Disorders
  • Cross-cultural presentation & course of schizophrenia - best-studied aspects of cultural psy.
  • PREVALENCE: ranging from 1 in 1,000 in the non-Western societies to more than 1% in the West
  • its highest prevalence is displayed in economically advanced, urbanized, and bureaucratized societies (as civilization makes inroads, schiz follows in its footsteps)
  • Later studies – incidence of schiz is almost universal
  • DOSMeD (The study of Determinants of Outcome of Severe mental Disorders). The study had 1379 patients in 12 centres in 10 countries. It gave incidence in the range of 1.5 – 4.2 per 10,000 (both sexes) of population at risk (15-44 years).
  
• Phenomenology varies with cultural setting, with much higher rates of catatonia in India and of hebephrenia in Japan than in the West
  • Catatonic rigidity, negativism & stereotypy – more common in India
  • Pts quieter (less violence & aggression) in India
  • Pts quieter & with more deterioration with affect blunting/ bizarre behavior – in Africa – ‘poor imitation of the European forms’
  • More expressive & more aggressive in Iraq & Italy than pts in US & other Western countries
  • Social & emotional withdrawal, AH, general delusions, flatness of affect occur in all
  • specific content of hallucinations and delusions as well as the prevalence of visual and other nonauditory hallucinations varies
  • Delusions of destructiveness & religious nature – only in Chriistrians & Muslims
  • Delusional jealousy – most frequent among Asians while social hallucinations - in Africa & the Near East
  • Depersonalization in urban & delusion of grandeur in rural pts
- the course and outcome of schizophrenia are markedly better in nonindustrialized countries
- Face discrimination performance was most impaired in the Indian subgroup

**International Pilot Study Of Schizophrenia IPSS :**

- Transcultural longitudinal study conducted by WHO
- Countries- 9
  1. Columbia (Cali),
  2. Taiwan (Taipei)- 5 yr ceased participation
  3. Czechoslovakia (Prague),
  4. Denmark (Aarhus),
  5. India (Agra),
  6. Nigeria (Ibadan),
  7. USSR (Moscow),
  8. UK (London),
  9. USA (Washington)
- Cali, Ibadan and Agra are considered as the centers in developing countries.
- Size- 1,202 (initial), 807 (5yr- 76%)
- Results: at 5 yr follow up-
  - The largest subgroup – paranoid – largest in all except for Agra, Cali & Moscow
  - 2nd largest – schizoaffective – in Agra, Ibadan & Prague
  - In Agra – unspecified being largest
  - High proportion of catatonic schiz in developing countries- Agra
  - Highest proportion of asymptomatic pts- both Agra &Ibadan (1/3rd). d
  - Highest proportions of symptomatic patients - Moscow and Aarhus. D
  - Highest proportion of pts spending <5% of time in a psychotic episode was seen in Agra, Cali, Ibadan, Washington.
  - Agra and Ibadan, London had the highest % with best outcome and lowest with worse outcome. Cali resembles developed countries.
  - Aarhus - worst outcome with 40% of pts - continuously psychotic.
  - Lowest % of severe social outcome was seen in Agra, Cali and Ibadan while the largest % was seen in Aarhus(50%).
  - Episodes were definite schiz episodes in developed than developing (possible) & Aarhus has highest proportion.
  - 52 (4.9%) died during follow up, suicide (38) most common. Agra (9%)> Ibadan (7.1) highest & lowest was Cali (0.8)- developing.
  - Outcome: intermediate outcomes (56%) > good outcomes (26%) >poor outcomes with unremitting psychosis, multiple episodes, or severe social impairment(18%).
  - Striking finding was that developing countries had better outcome than developed at both 2 yr & 5 yr
  - better outcome: female gender, acute onset, schizoaffective disorder, and shorter duration of symptoms before assessment, agricultural economy, little vertical mobility, extended & supporting families
  - Poor outcome: single, social isolation, PM level dysfunction, and poor sexual adjustment.
  - Our population so different from the population used as reference in our diagnostic systems
• little evidence that culture distorts the form of psychoses significantly & 1st rank symptoms of schizophrenia appear to be culture free
• high % of NOS diagnosis made in our pts when we try to fit “Indian patients” in the ICD 10 diagnostic criteria.

Mood Disorders
• cross-cultural diff in sym presentation, affect conceptualization, level of severity, and influence of acculturation (WHO study on Dep)
• Culture and other social factors, such as class and gender, influence the interpretation of and exposure to stressors that predispose to depression
• Depressive mood, dejection, diurnal mood change, insomnia with early morning awakening, decreased social interests – almost universal
• Self neglect & semi mutism- rare among Europeans
• Definite assoc b/w religion & the feeling of guilt
• Christians - +ve correlation b/w intensity of belief & guilt, & self-depreciation – not seen in Hindus & Muslims
• Muslims – less guilt feelings & suicide, but had unusual sym like ideas of influence & possession
• Jewish & Negro- hostility directed towards env rather than the self
• Japanese – higher frequency of despondency & thought retardation, but decreased religious preoccupation, loss of sexual interest, excitement & theatrical grief.
• Culture and gender, influence the interpretation of & exposure to stressors that predispose to depression
• Contrast b/w ‘intra-primitive’ (blame themselves) & ‘irritability’ dep.
• Frequent combination of depression & anxiety noted around the world, particularly in primary care settings (so Mixed Anxiety & Dep)
• higher rate of somatic c/o assoc with depression (& anxiety) among the non-Western groups
• unique symptoms (“heat or water in the head” & “crawling sensation of worms and ants”)
• Similar to Kleinman’s view – shape dep as ‘somatisation’ syn - absence of Cartesian (body-mind) dualism
• Emotional c/o are often present as well but may not be considered the source of distress or impairment
• Neurasthenia (in China), masked depression, suffering from ‘nerves’ for somatisation rather than depression
• the threshold at which dysphoria becomes disorder is affected by cultural factors.
• Also duration (1wk for Hopis in America & 1 mo for Bambuis in Brazil)
• Substantial overlap of depression with anxiety, somatoform, and dissociative disorders implies a higher probability of under-recognition or misidentification of affective disorders in many ethnocultural groups
• Questions prototypical representation & operational criteria of the depressive disorders
• support the phenomenological expansion of the depression categories

Anxiety Disorders
• The effect of culture on anxiety is similar to that on depression,
• cross-cultural studies have shown a marked tendency for anxiety and depression to overlap
• Cultural factors affect precipitants, symptom presentations, pathological thresholds & specific syndrome criteria of anxiety disorders
• DSM IIIR – diagnosis of GAD – chronic pathological anxiety in absence of stressors vs result of recurrent stress in developing societies
higher rate of simple phobia, social phobia, and agoraphobia among the African-Americans, as compared to whites - racial discrimination

Multiple cross-cultural studies point to the coappearance of anxiety, depression, somatoform complaints, and dissociative symptoms among the non-Western groups.

A markedly somatic idiom predominates, often in the form of culturally specific symptoms

culture-bound syndromes- ataque de nervios among the Latinos, koro in the Asian communities, and taijin kyofusho among the Japanese

Somatoform Disorders

mood, anxiety, somatoform disorders, and dissociative disorders - sym run across boundaries of the diagnostic categories

Demarcating somatoform conditions in these settings may create artificial distinctions that confound accurate diagnosis.

Neurasthenia in China and other Asian settings, and nervios in Latin America

use of somatic idioms varies according to intracultural factors

For example, conversion symptoms appear MC in rural and less educated sector of the non-Western societies, and families that allow few opportunities for protest

DSM-III-R and DSMIV- TR do not canvas the rich variety of somatic symptoms reported in other parts of the world, such as the complaints of worms and ants in the head described earlier

Dissociative Disorders

Syndromes characterized by pathological dissociation are common worldwide, but the current concepts of dissociative disorders do not appear to account for their phenomenological variety

A study in OPD clinic in India - 90% of dissociative disorder cases did not fulfill criteria for the specified categories, ironically receiving instead a DSM-III diagnosis of atypical dissociative disorder.

Many indigenous illness syndromes around the world display salient features of pathological dissociation.

Some of these syndromes are characterized by involuntary possession trance—dissociative alterations in identity attributed to the invasion by external spirits or agents—

distinguished from dissociative identity disorder by their episodic and remitting course, the nature and number of their alternative identities, and their gradual response to treatment.

Other dissociative syndromes are characterized by alterations of consciousness and memory, during which the person runs around in an agitated state (Arctic pibloktoq);

attacks others indiscriminately (Malayo-Indonesian amok);

undergoes convulsive movements, screaming fi ts, and aggressive acts toward self or others (Caribbean ataque de nervios);

or lies as if dead, suffering from specific perceptual alterations;

hears and understands what is happening but cannot see or move (“falling out” among the African-Americans in southern US, Bahamian “blacking out,” and Haitian indisposition)

Sexual Disorders

Some cross-cultural studies – paraphilias - determined by specific features of the Western society, such as demographical size and complexity (whereby individuals may escape social sanction through anonymity), the nonavailability of partners, and the primacy of masturbatory activities as sexual outlets

culture-bound syndromes - koro among the Asians (characterized by the fear of genital retraction) or

or dhat in India (involving obsession or anxiety about semen loss),

Eating Disorders
• significant cultural effect on the patterning and distribution of the eating disorders.
• An important determinant appears to be the Western premium on thinness as an esthetic and moral value

Adjustment Disorders
• The effect of culture on the adjustment disorders is pervasive.
• Culturally based interpretations are essential to the appraisal of the repertoire of behavioral and emotional responses that pattern both normal and disordered reactions to stress

CULTURE BOUND SYNDROMES

Culture-bound or culture-specific syndromes cover an extensive range of disorders occurring in particular localities or ethnic groups.
• Behavioral manifestations may or may not correspond to diagnostic categories in DSM-IV-TR or ICD-10.
• Usually considered to be illnesses and generally have local names.
• Also include culturally accepted idioms or explanatory mechanisms of illness that differ from Western idioms & outside their cultural setting.
• Awareness of culture-bound syndromes is important to allow psychiatrists and physicians to make culturally appropriate diagnoses and proper treatment.

<table>
<thead>
<tr>
<th>Name</th>
<th>Geographical localization/populations</th>
</tr>
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<tbody>
<tr>
<td>AMOK</td>
<td>MALAYSIA, INDONESIA, PHILIPPINES, BRUNEI, SINGAPORE</td>
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<tr>
<td>ATAQUE DE NERVIOS</td>
<td>LATINOS</td>
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<tr>
<td>BILIS, CÓLERA</td>
<td>LATINOS</td>
</tr>
<tr>
<td>BOUFFÉE DÉLIRANTE</td>
<td>WEST AFRICA, HAITI</td>
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<tr>
<td>BRAIN FAG</td>
<td>WEST AFRICAN</td>
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<tr>
<td>DHAT</td>
<td>INDIA</td>
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<tr>
<td>FALLING-OUT, BLACKING OUT</td>
<td>SOUTHERN UNITED STATES</td>
</tr>
<tr>
<td>GHOST SICKNESS</td>
<td>AMERICAN INDIAN</td>
</tr>
<tr>
<td>HWA-BYUNG, WOOL-HWA-BYUNG</td>
<td>KOREAN</td>
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<tr>
<td>KORO</td>
<td>CHINESE, MALAYSIAN, SOUTHEAST ASIA, ASSAM</td>
</tr>
<tr>
<td>LATAH</td>
<td>MALAYSIA, INDONESIA</td>
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</tbody>
</table>

CBS in India
Possession Syndrome
• Single/ episodic alteration in state of consciousness
• Replacement of sense of identity, Influence of power, spirit, deity
• Stereotyped, culturally determined behaviours
• Full/ partial amnesia
• Prototypical episode: Onset due to stress/ conflict, Gradual & non specific/ sudden & specific, Dramatic semipurposeful movts, Aggressive/ violent actions, Verbalisations, Emergence of secondary personalities, Outcome: variable
• Epidemiology: Period-prevalence: 0.2% over one year (India)
• 3.5% for involuntary attacks, 0.2% for voluntary episodes
• More common in females (F: M= 2-3:1); Age: 15 – 35 yrs
• More commonly described among Hindus
• Disadvantaged castes, low income, low education, rural residence, widowed persons
• Precipitants: Marked social/ family conflicts; Stressful life transitions;
• Hysterical, histrionic & immature defense mechanisms
• Relationship to psychiatric diagnosis:
  • Schizophrenia: 40 – 59%
  • Manic depressive illness: 11 – 13%
  • Dissociative disorders: 9.5%
  • Relapse rates - unknown
• Psychiatric treatment typically avoided.
• Indigenous treatments – neutralization of conflicts or stress

**DHAT** (India,Taiwan)
• AKA dhatu, jiryan, shen-k'uei(Chinese)
• “**Semen-loss anxiety**” → Misnomer(Spermatorrhea)
• Vague multiple **somatic symptoms** → fatigue,weakness,anxiety,appetite loss,guilt feelings
• Attributed by the patient to loss of semen in nocturnal emissions, through urine and masturbation
• Ayurvedic texts
• Women may be seen as stealing vital energy
• Connection between industrialization and semen-loss syndrome
• Traditional remediesâherbal tonics
• ?F48.8 Other specified neurotic disorders
• ?F45.34 Somatoform autonomic dysfunction of the genitourinary system

**KORO** (SE Asia,China,India)
Head of turtle=koro, Any protruding part of body-nose, ear
• AKA jinjin bemar, suk yeong
• Primary symptoms: penis (in males) or the vulva and breasts (in women) are receding into the body
• Expect consequences to be **fatal**
• More common in **males**; Onset is **rapid, intense, unexpected**
• Inappropriate sex, such as masturbation or sex outside of marriage, illness, exposure to cold
• “Stolen” by supernatural methods
• Spread socially, mass hysteria→epidemics(sociopolitical)
• Clamps, ties, pegs or hooks may be used
• Therapy → Assurance, education, counseling
• ?F48.8 Other specified neurotic disorders
• ?F45.34 Somatoform autonomic dysfunction of the genitourinary system
Non Affective Reactive Psychosis

- Boufée delirante
- Sudden outburst
- Acute, nonaffective and non-schizophrenic psychosis
- Complete remission after an acute episode.
- Under age 30
- Strikes "like a thunderbolt."
- West Africa and Haiti, Caribbean
- Sometimes accompanied by visual, auditory hallucinations or paranoid ideation.
- Episodes may resemble brief psychotic disorder.

Other CBS in India

- **Culture bound suicide** (Sati) Banned in India since 19th century.
- **Ascetic Syndrome** – social withdrawal, sexual abstinence, practice of religion in adolescents and young adults
- **Jhin Jhinia** - bizarre and seemingly involuntary contractions and spasms
- **Bhanmati Sorcery** - in South India
- **Suudu** - “heat” familiar in south India, increase in the “inner heat” of the body often due to dehydration – Rx Oil Massage.
- **Gilhari Syndrome** – small swelling on the body changing its position from time to time as if a gilhari (squirrel) is travelling in the body
- **Mass Hysteria**

Cultural influences on treatment

Pharmacotherapy

- Various cultural differences in the way drugs are prescribed, the way they are metabolized and excreted and the way they respond to a set of medications.
- Many of these variations are secondary to genetic mechanisms.
- In addition, non-genetic factors like medication adherence, drug availability and affordability, explanatory models about illness also play a very important role.
- Cultural factors and beliefs influence pharmacological treatment acceptance and adherence [Kuruvilla 1996]; Non compliance may be rebellion against lifelong dependence

**Pharmacokinetics**

- Process of metabolism which usually lead to variations between individuals of different ethnic backgrounds
- There are ultrarapid metabolizers (UM), extensive metabolizers (EM), intermediate metabolizers (IM) and poor metabolizers (PM)
- The frequency of PMs is much higher in the Asian population than in the Caucasian or African population
- Slower metabolism of drugs in these populations lead to poorer drug response and more adverse effects
- Non-genetic factors which affect CYP450 enzymes include smoking and diet. A diet rich in cabbage and broccoli can increase the activity of CYP1A2 enzyme.

**Pharmacodynamics**

- Genetic polymorphisms involving pharmacodynamic mechanisms can lead to alterations in drug responses between ethno cultural groups.
- E.g. Asian subjects with schizophrenia require lower haloperidol dosages and lower plasma concentration for drug responses than Caucasians, possibly mediated by dopamine receptor related mechanisms
• Indian patients require lower doses, and develop side effects on low doses

**Psychotherapy**

- Cultural values are important to determine psychotherapeutic needs and interventions
- The Western-model psychotherapy in its usual form may not be suited for a diverse culture like India.
- It may have to be modified to suit the need of individual subcultures.
- In addition to these modification in western psychotherapy, one may need to use indigenous models of psychotherapy.
- For example, the guru-chela relationship might be a particularly useful paradigm in India.
- Some proposed modifications to suit the need of Indian patients are as follows:
  - Use of religion or spirituality
  - Family involvement
  - Lower emphasis on individual responsibility and autonomy
  - Superior class of the therapist, paternalistic approach [Lee, 1993, Kuruvilla 1996]
  - Greater active participation by the therapist
  - Single session therapy for the poor and underprivileged [Erna Hoch, 1986]

**Differences in clinical practices**

- Use [? Overuse]of physical treatments – ECTs
- Early intervention, once brought to a health facility.
- Role of family members
- Differences in expressed emotions and life events
- Communicating with patients and families regarding diagnosis, illness and care.
- Concomitant use of traditional therapies.
- Follow up poorer in those whose socio cultural beliefs were contradicted. Not challenging or dismissing supernatural beliefs of community can lessen non acceptance of modern treatment [Pandey et al. 1980]

**Coping with severe mental illnesses**

- Indian patients with schizophrenia use less number of coping strategies as compared to German.
- Indian patients endorsed strategies of avoidance, relaxation and meditation, and waited for situation to change (? Stoic acceptance among Hindus). Germans sought medical help, counseling, problem solving. [Kumar et al., 1994].
- Degree of perceived stress was lower among Indian patients, in contrast to Germans. May be due to better family support.
- Distressing symptoms in schizophrenia were not eating, sleeping and negative symptoms in Indian patients, as compared to aggression and positive symptoms [Gopinath & Chaturvedi, 1991]

**Traditional healing practices**

- Motivational factors – cultural faith, inadequate recovery with allopathic treatment, economic factors, social stigma and easy approachability [Sethi et al., 1977]
- Diagnosis – pher, kartab, shaitani aid, jadu tona, stars positioning, names
- Methods used – tabiz, jhaad, phook, chirag, jap
- Treatment effectiveness rates not mentioned
- Effective liaisons with traditional healers suggested
- Role of understanding concepts, classification, and management of numerous other health systems
Cultural Formulation

- a cultural assessment should be a component part of every complete psychiatric assessment -
  Given in Appendix I of DSM IV TR

Its Purposes are:
- To **enhance the application** of DSM-IV-TR diagnostic criteria in multicultural environments.
- To provide a **systematic review** of individual's **cultural background**.
- To identify the **role of the cultural context** in the expression and evaluation of **psychiatric symptoms and dysfunction**.
- To enable the clinician to systematically describe patient's **cultural & social reference groups** and their relevance to clinical care.
- To identify the effect that **cultural differences** may have on the relationship between the patient and family and the treating clinician, as well as how such cultural differences affect the course and the **outcome of treatment** provided.

FIVE AREAS OF ASSESSMENT:
- **Cultural identity** of the individual.
- **Cultural explanations** of the individual's illness.
- **Cultural factors** related to psychosocial environment and levels of functioning.
- Cultural elements of the **relationship between the individual and the clinician**.
- **Overall cultural assessment** for diagnosis and care.

**CULTURAL IDENTITY** refers to the characteristics shared by a person's cultural group. Identity allows for a self-definition. It includes:
- Ethnic or cultural reference group (including age, socioeconomic status, religion, relationship status, sexual orientation)
- Degree of involvement in culture of origin.
- Degree of involvement in host culture.
- Aspects of identity that are important to them.
- Migration history (if applicable) – reasons for migration, losses, trauma, & previous role within family & society.
- Language abilities, use & preferences

**Cultural Explanations of the Individual's Illness**
- The explanatory model of illness is the patient's understanding of and attempt to explain why he or she became ill.
- It defines the culturally acceptable means of expression of the symptoms of the illness,
- the particular way individuals within a specific cultural group report symptoms and
- their behavioral response to them that are heavily influenced by cultural values.
- The explanatory model of illness includes:
- Patient's beliefs about their prognosis
- Treatment options they would consider.

**Cultural Factors Related to Psychosocial Environment and Level of Functioning**
- An understanding of the patient's family dynamics and cultural values is integral in assessing the patient's psychosocial environment.
- The definition of what constitutes a family and the roles of individuals in the family differ across cultures. This include:
  - **Social stressors**
• **Social supports** – role of religion and kin networks, identify who is a major support for the patient

• **Levels of functioning and disability** – viewed by patient, family & community (previous and current)

**Cultural Elements of the Relationship Between the Individual and the Clinician**

• The cultural identity of the clinician and of the mental health team has an impact on patient care.

• The culture of the mental health care professional influences **diagnosis and treatment**.

• Unacknowledged differences between the clinician's and patient's cultural identity can result in assessment and treatment that is unintentionally biased and stressful for all.

• Culture influences **transference and counter-transference** in the clinical relationship between people seeking psychiatric care and their treating clinicians.

• When the patient and clinician are of **different genders**, culturally ingrained role assumptions may pose difficulties.

**Overall Cultural Assessment for Diagnosis and Care**

• The treatment plan should include the use of **culturally appropriate health care and social services**.

• Interventions also may be focused on the **family and social levels**.

• In making a psychiatric diagnosis the clinician should take into account **principles of cultural relativism** and not fall prone to category fallacy.

• Using classification systems such as DSM-IV-TR, developed for one culture and applying it unquestioningly to another culture where its relevance may not be comparable.

• Many psychiatric disorders show **cross-cultural variation**. Objective evaluation of the multiple possible effects of culture on psychopathology can be a challenging task for the clinician.

**FUTURE DIRECTIONS AND RESEARCH IN TRANSCULTURAL PSYCHIATRY**

• **Perspectives** that offer great promise for future research in cultural psychiatry.

• **(A) Identification of specific fields** in general psychiatry that could be the subject of focused research from a cultural perspective.

• Topics of **epidemiology and neurobiology** could be assessed in this way.

• **Epidemiology** would address issues primarily in the public health arena, including **stigmatization, racism, and the process of acculturation**.

• A number of cultural variables should be considered in conducting cultural psychiatry research, including **language, religion, traditions, beliefs, ethics, and gender orientation**.

**CONCEPTUAL ISSUES IN CULTURAL PSYCHIATRY:**

• Universality vs. Distinctiveness of diagnosis

• Evidence-based vs. Value-based approaches

• What are the “diagnosable” features of culture in psychopathology?

• To what extent does culture apply to diagnosis/treatment/prognosis?

• Cross-cultural applicability of diagnoses.

**OPERATIONAL ISSUES IN CULTURAL PSYCHIATRY:**

• Elucidation of “normality” and “abnormality”

• Choice of cultural variables.

• Culture in the perception of:

• Severity of symptoms

• Disruption of functionality

• Quality of Life changes

• “Strengths” and “Weaknesses” of an individual patient
Usefulness of the Cultural Formulation
• Representativeness of cultural/ethnic groups

Topical Issues in Cultural Psychiatry:

There are five dimensions of the clinical process that are relevant to research in cultural psychiatry. These include the consideration of culture as an
• interpretive or explanatory tool of human behavior
• a pathogenic or pathoplastic agent
• a diagnostic and nosological instrument
• a therapeutic or protective factor
• a service or management element.

The basic assumption is that culture impacts each of these areas, all of which have relevance at different stages of the clinical encounter between patient and clinician.

THANK YOU