ONLINE READINGS IN PSYCHOLOGY AND CULTURE
International Association for Cross-Cultural Psychology

Unit 10 *Health/Clinical Psychology and Culture*
Subunit 2 *Culture and Mental Illness*

Article 1

1-1-2012

Revisiting the Mutual Embeddedness of Culture and Mental Illness

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Recommended Citation
Sam, D. L., & Moreira, V. (2012). Revisiting the Mutual Embeddedness of Culture and Mental Illness. *Online Readings in Psychology and Culture, 10*(2). https://doi.org/10.9707/2307-0919.1078

 ISBN 978-0-9845627-0-1

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Abstract

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

Case examples

Case A

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

Case B

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

Case C

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

Case D

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

From above case(s) discuss the following questions:

1. What can be this bizarre behavior that resulted in the family seeking help from a local “expert” on this person’s behavior?
2. What are the similarities and differences in the family's response and the manner of treatment to the bizarre behavior of the man?
3. Is this “local expert” on bizarre behavior the same or different kind of person in the different regions presented in the case(s)?
4. Are we dealing with the same or different phenomena? What makes you think so?
5. From your background and perspective, can any one approach taken to deal with the man's bizarre behavior be more justified than the other, and if so which one?
6. Can you think of reasons why "spirits" play such a dominant role in the examples drawn from all the regions presented here except Western Europe? To what extent are "spirits" responsible for one's "bizarre behavior" in your native society?
7. What is the role or significance of culture in the different approaches taken here?
8. Is it possible to see in the examples the mutual embeddedness of culture and mental illness? How?
9. How will the man's bizarre behavior be explained and treated in an imaginary society that does not have culture?

Introduction

The last three questions introduce us to the crux of the present chapter, namely the inextricable relationship between culture and mental health problems. We believe it is inconceivable to imagine a society that does not have a culture, and equally incomprehensible to imagine how a society devoid of culture will deal with such a bizarre behavior. Without a “culture” we will not be in the position to determine what is bizarre, and the inability to determine what a “bizarre” behavior is also makes it difficult to know how it can be treated. In this article, we propose that culture should be seen as an inherent part of mental illness. Culture does not just influence mental health and illness; it is an essential part of it. Failure to see it as such leads to a myopic view of the onset, expression, course and prognosis of mental health problems. In this article, we will discuss how mental illness and culture are embedded in each other.

In the first part of the article, we briefly present some theoretical orientations that dominate the field of the link between culture and behavior, followed by a brief review of current research in (cross-) cultural psychology relating to mental illness. Finally, we present a critique of the current research approaches to (cross-)cultural mental illness and the way forward. A recurrent issue in this chapter is the degree of universality of the expression of mental illness across cultures with reference to depression, schizophrenia, and culture-bound syndrome.

A major challenge when discussing mental illness is that there are many different ways in which mental disorders can be classified, with no one way necessarily better or

more correct than the other (Thakker, Ward, & Strongman, 1999). This challenge comes to the fore because the experience of mental disorder is highly subjective, and making sense of it depends in part on how articulate the person with the disorder is in expressing his or her feeling, thoughts and the manner in which the behavioral aspects expressed are acceptable (or unacceptable) in the society in question (Angel & Williams, 2000).

A closely related challenge is how to develop a reliable classification system. Mental disorders become prevalent at particular times and/or fade away with time because of cultural changes and new knowledge about disorders. Homosexuality is one such example, where this form of sexuality was removed from the diagnostic manuals in the 1970s as a disorder. While homosexuality is an acceptable form of behavior in many Western countries, some sub-Sahara African countries, such Uganda considers it as abnormal and criminal, punishable by up to 14 years of incarceration (Wikipedia, 2011). Why are there such huge differences? Is it simply differences in cultural values or something else?

Indeed, to understand mental illness is to understand culture and understanding culture makes mental illness comprehensible. The two concepts – culture and mental illness – are intrinsically linked to the extent that the definition of ill-health depends on the manner of being, and of thinking, or more specifically, on the culture (Bruner, 2001). Mental illness varies therefore in time and place. In the Western world, mental illness is conceptualized from a bio-medical model that is independent of culture. The biomedical model views mental illness to be

> fundamentally biological in origin, and … psychopathology [as] essentially homogeneous with only superficial variations in presentation across peoples (Thakker & Ward, 1998, p. 502).

While the bio-medical approach to mental illness is linked to an individualist ideology where mental illness is diagnosed and treated as something purely individual, Marsella and Yamada (2000) are of the view that mental illness are very much rooted in ones culture, poverty, helplessness, and racism backed by powerful socio-political and economic structures. The concern with culture was recognized over a century ago by Emil Kraepelin (1904/2000), who is credited as the father of modern psychiatry, when he proposed the development of a comparative psychiatry. Nevertheless, the diagnosis and the treatment of mental illnesses, has to a large extent ignored the inherent role of culture to mental illness. The lack of cultural cognizance is amply clear in Berne's (1956) position when he noted that

> major psychoses take the same form in many regions, regardless of race, physical environment, cultural background and socio-economic situation (p. 198).

In cases where culture is taken into consideration, it is often marginalized and construed as an independent variable similar to the status given to culture in cross-cultural psychology with its inherent limitations (Moghaddam & Studer, 1997). The marginalized

status of culture to the understanding of mental illness is due in part to the dominant position medicine enjoys (Marsella & Yamada, 2000). As a scientific discipline, the bio-medical ideology has been powerful enough to keep the diagnosis and treatment of mental illness in the biological realm. This area is also deeply linked to the use of psycho-pharmaceutical drugs, which is of great economic interest to the large and ever growing pharmaceutical industries.

Theoretical Orientations

The appropriate way of studying human behavior has been a debatable issue for several centuries dating back to the time of Greek philosophers (Adamopoulos & Lonner, 1994). One side of the debate was laid down by Aristotle (384-322, BC, Metaphysica, 1062b 13 – translated by Wheelright, 1960) when he suggested that it was possible to objectively study human behavior devoid of culture and the influences of ones surroundings. The other side of the debate was evident in Protagoras stance in his suggestion that the conceptions and explanations that we generate about ourselves are intricately linked to our own experiences (Protagoras ca. 480-411 BC, – translated by Wheelright, 1960).

This ancient debate has, in our present day, taken the form of whether in explaining psychological processes, we assume the existence of substantial commonalties in the psychological makeup (i.e., a psychic unity) of human beings, and commonalties in human experience and behavior (i.e., psychological universals). Or whether we assume that studying human behavior outside the context in which it occurs is impossible, and that behavior can best be understood in the context in which it occurs. This latter assumption is that behavior occurs within certain social environments or cultural contexts, and these need to be taken into consideration when studying behavior.

While these discussions previously took the form of three categorical positions – absolutism, relativism and universalism (Berry, Poortinga, Segall, & Dasen, 2002), Berry, Poortinga, Breugelsman, Chasiotis, and Sam (2011) currently conceptualize them along two dimensions because the positions are less polarized. The issue is the extent to which psychological functions and processes are common to humankind (i.e., universalism) and the extent to which they are unique to specific cultural groups (i.e., relativism).

Absolutism

The absolutist's position assumed that human behavior is basically the same (qualitatively) in all cultures: 'honesty' and 'depression' are respectively 'honesty' and 'depression' irrespective of where one observed it (Berry & Sam, 2007). This position also assumed the existence of an "absolute truth" regarding human behavior and its manifestations, where culture was thought to play no part in either the connotation or demonstration of human characteristics. The absolutist position is currently seen as ethnocentric in perspective and its assumptions as only a logical possibility without any supporting evidence (Berry et al., 2002).

Relativism

The relativist position is rooted in anthropology, and is attributed to Herskovits (1948), although its roots come from Boas (1911). The position assumes that all human behavior is culturally patterned. One of its goals is to avoid all forms of ethnocentrism by trying to understand people in their own terms without placing any value judgments, and having preconceived ideas. This position seeks to avoid derogating, describing, categorizing, and understanding other people from an external cultural view point. Understanding people in their own terms entails using the group's own categories and value system when the group is being described (Berry et al., 2002).

In extreme forms of relativism (i.e., extreme relativism), all psychological reality is regarded to be dependent on one's own understanding or interpretation. As such, so-called "facts" derived from research are constructions that cannot reveal an objective reality outside of the person, as our understanding and interpretation inevitably entail some important distortions (Berry et al., 2011, p. 8). Many researchers accept the view that there are observable regularities in human behavior and that one's interpretations are not entirely subjective. This acknowledgement has resulted in a milder form of relativism, referred to as "moderate relativism". This form of relativism emphasizes that psychological functions and processes are the outcome of interactions between organism and socio-cultural contexts in contrast to the extreme form of relativism described above.

Universalism

The third position – "moderate universalism" (to distinguish it from absolutism or extreme universalism) is a position lying between the absolutist and the (moderate) relativist positions. It assumes that basic human characteristics are common to all members of the species (i.e., constituting a set of biological givens), and that culture influences the development and display of basic human process. From this position, the meaning of behavior is dependent on the cultural context in which it occurs, while at the same time a behavior can also be understood in common terms across societies (in an objective way). The various theoretical positions entail different methodological approaches, but discussions of these are beyond the scope of this chapter.

A main distinction between the moderate universalism and moderate relativism positions is that whereas the former position regards culture to be an exogenous force that exerts its influence on behavior and mental illness, the latter position sees culture as an integral part of human behavior and mental illness, and as inseparable. From both positions, one cannot speak of mental health illness without taking cognizance of culture; they both assume that culture shapes and defines normality and abnormality, and culture makes behavior comprehensible. From the position of moderate universalism, culture can be manipulated and studied objectively. This view fits very well with the bio-medical scientific model, and has therefore gained more credence, and has directed much of the research effort on mental illness, especially from cross-cultural psychological perspective.

Current (Cross-) Cultural Research in Mental Health

Where is culture in depression?

Depression is perhaps the single most common mental health problem affecting some 121 million people globally. In 2000, depression was the leading cause of disability as measured by Years Lived with Disability, and was the 4th leading contributor to the Global Burden of Disease measured as Disability Adjusted Life Years (DALYs) (WHO, 2011). Presently, depression is the 2nd cause of DALYs in the age category 15-44 years for both sexes combined. Considering its ubiquity, the disorder serves as a good illustrative example when discussing the role of culture on mental disorders, and its universality.

The approach taken in many studies exploring this question is the use of standardized instruments exploring the extent to which different symptoms are present in different national groups who reportedly have depression or other forms of distress. A historical landmark in research on depression was a series of studies sponsored by the World Health Organization (WHO) between 1973 and 1986 (Draguns, 1990; Sartorius, 1983). In addition to identifying some symptoms that were present in at least 75% of the samples in all the societies, the studies concluded that patients from Western countries tended to express guilt feelings more spontaneously than their non-Western counterparts. The latter group of patients, non-Western patients, on the other hand, reported bodily complaints more spontaneously. Interviewing 100 Chinese patients suffering from *shenjing shuairuo – SRSJ – an abbreviation for shenjing shuairuo* (i.e., neurasthenia in ICD-10 classification – WHO, 1992), Kleinman (1986) concluded that 93 of them might be suffering from depression based on DSM-III criteria. However, instead of spontaneously reporting dysphoria, ideas of insufficiency and the other well-known symptoms of depression, these *SJSR* or "depressed" patients spontaneously reported headaches (90%), sleep problems (87%), and dizziness (73%). In a study carried out almost two decades after Kleinman's among 139 Chinese patients visiting a primary care unit (the very clinical setting as Kleinman's study), Chang and her colleagues found that while 30.6% and 22.4% of the SJSR patients could respectively be re-classified as suffering from DSM-IV category of *Undifferentiated Somatoform Disorders* and *Somatoform pain disorders*, nearly half (44.9%) did not qualify for a core DSM-IV diagnosis (Chang, Myers, Yeung, Zhang, & Zhao, 2005).

These findings raise some critical questions about the universality of depression, whether, for instance, the Chinese patients were suffering from *depression*, *SJSR* or *somatoform*, as modern Western nosology would call it, following the spontaneous responses of headaches, dizziness, and the like. Does depression exist everywhere and share common symptoms? Where does Schieffelin's work (1985) fit with the universality of depression when in his 20-year work among the Kaluli people of New-Guinea he could not find a single case of what Westerns would call depression among them?

A closely related question is whether somatoform and disorders such as *SJSR* are a particular cultural group's way of expressing depressive disorders, or it is a separate form of disorder. Regarding the latter question, the notion of *category fallacy* becomes

important. This is the situation when researchers and clinicians impose the illness categories of their culture on other cultures. This fallacy underscores using an external point of view or another society's categories to describe and/or classify people, something which relativism seeks to avoid. Here, universalism may be victim of category fallacy.

Whereas Jadhav (1995) questions the validity and the appropriateness to use the term "depression" for symptom patterns that bear little resemblance to Western depression, Marsella (1980) is of the view that "depression does not assume a universal form" (p. 260), and that "the psychological representation of depression occurring in the Western world is often absent in non-Western societies" (p. 261).

To assert that depression is universal, we should be able to logically account for the differences in symptom expression. To this regard, a number of theories have been put forward to do exactly that. These include aspects of family structure (extended families providing more elaborated social support, close mother-child relationships, and reduced risk of loss of loved ones); and mourning rituals (low depression may result from ritualized and overt expressions of grief).

Marsella (1980) has also introduced the notion of a cultural dimension of "epistemic orientations", which involves objective vs. subjective orientations. In relatively "objective orientation" cultures, there is an abstract language, and individuated self-structure; in contrast, there is a metaphorical language and more communal structure in "subjective" types of culture. Depression, it is argued takes a primarily affective and cognitive form in cultures with objective orientations (and is experienced as a sense of isolation), while it takes a primarily somatic form in cultures with subjective orientations.

In line with the WHO studies on depression, most observers (e.g., Tanaka-Matsumi & Draguns, 1997, p. 455) believe that, there is a "common core" of symptoms of depression (which includes anxiety, tension, lack of energy and ideas of insufficiency) allowing the disorder to be recognized in all cultures. In addition, there are some aspects of depression that may differ across cultures (e.g., more frequent somatic symptoms in some cultures: Ulusahin, Basoglu, & Paykel, 1994), and this may be rooted in the culture. In a phenomenological study that sought to understand the meaning of depression in Brazil, Chile, and the United States, Moreira, (2007a & b, 2008, 2009) did not find important variations in the symptoms in the three countries. However, the symptoms were related to the participants' subjective cultural experiences. The symptoms were also related to cultural changes, including economic and psychosocial oppression in their life, and these contributed to the appearance and maintenance of their depression.

In conclusion, what constitutes depression, and how it is expressed may be very much rooted in culture. The fact that some core symptoms have been identified in all the societies where the disorder has been examined, albeit some local variations in its expression, and the fact that these can be linked to some cultural beliefs, values and traditions of the society, make us concur with Berry and his colleagues (2011) that depression most likely is moderately universal. However, the frequent reliance on biomedical approaches to the study of depression, and the populations studied may have affected the conceptualizations of the disorder and thereby limited the conclusions that we

can be drawn. Acknowledging that culture is implicated in the disorder makes moderate relativism position also tenable, but more research is still needed.

The case of schizophrenia

Although much less common than depression, schizophrenia[1] is the most debilitating mental disorder in the world. The disorder is highly stigmatized partly because of its poor prognosis[2]. In spite of evidence suggesting a biological etiology (e.g., Hall, Gogos & Karayiorgou, 2004) there is still lack of complete knowledge about the local prevalence rates and prognosis, as well as variations in symptom presentation (Tandon, Keshavan, & Nasrallah, 2008). Following Spiro's (1984) position that "thinking and feeling are often determined by culture" (p. 324), and the meaning of schizophrenia as "a split between thought and feeling", we are very likely to be limited in our understanding of schizophrenia (and nearly all other mental health problems) if culture is eliminated from the diagnostic equation.

A phenomenological study of the experience of schizophrenia in Brazil and Chile with patients diagnosed with paranoiac schizophrenia in public psychiatric hospitals showed some important differences (Moreira, 2009; Moreira & Boris, 2006; Moreira & Coelho, 2003). While the meaning of the experience of bodily alterations (present in outbursts of schizophrenia) is attributed to brain illness in Chile, in Brazil the same experience is attributed to *Umbanda* (i.e., to spirits). However, no significant differences were found between the two groups of patients in relation to their sense of space.

Over the years WHO has undertaken several major studies on the expression, course, and prognosis of schizophrenia in several countries, including Colombia, the former Czechoslovakia, Denmark, England, India, Nigeria, the former Soviet Union, Thailand, and the United States. Using standardized instruments, researchers have identified a set of symptoms that were present across all cultures in the schizophrenic samples. Just like with the depression studies, symptoms as lack of insight, auditory and verbal hallucinations, and ideas of reference, are thought to be the “core” symptoms of schizophrenia. The WHO studies nevertheless found differences in symptom profiles from study center to study center, where for instance, schizophrenics in the USA differed from their Danish and Nigerian counterparts on the extent of how much they lacked insight and experienced auditory hallucinations. Schizophrenics in Nigeria also reported more of "other hallucinations" than the USA and Danish schizophrenics. Given this "common core" (and the partial reduction of variation in diagnosis when common instruments are employed), it could be argued that schizophrenia should be viewed as a moderate *universal* disorder,

[1] The term ”schizophrenia” comes from Greek and literally translates as *schizein,* “splitting”; *phren,* “a breath and soul” and the suffix *-ia,* implies disease.

[2] In 2002 the term for schizophrenia in Japan was changed from *seishin-bunretsu-byo* (disease of disorganized mind) to *Tōgō-shitchō-shō* (integration disorder) in order to reduce the stigma associated with the disorder, and hopefully improve prognosis (Kim & Berrios, 2001). Unlike in many Western societies where the original Greek meaning of the term is unknown, the term is very much embedded and implied in several Asian languages such as in Chinese and Japanese, and is readily understood by lay laymen.

and as a disorder that is recognizably present in all (studied) cultures, but the disorder appears to respond to different cultural experiences in prevalence rates and modes of expression.

Perhaps the most interesting finding from the WHO studies is that patients from developing countries showed better prognosis compared with their peers in developed countries (Williams, 2003). However, the factors underlying the better outcome of schizophrenia in developing countries are still not fully understood. Jablensky (2000) points to interactions between genetic variation and specific aspects of the environment as one possible reason. Differences in prognosis have also been related to what constitutes stressors in different societies. A number of studies (e.g., Corcoran et al., 2003) have found a link between stress and the onset of schizophrenia and its relapse. A link has also been found between schizophrenia and more subtle everyday factors such as daily hassles (Norman & Malla, 1993). One form of daily hassles – expressed emotion (EE), which refers to family members' negative emotional reactions to patients – may be relevant as a stressor in psychosis relapse in schizophrenia. Schizophrenia patients returning to families with high criticism and emotional involvement levels have about 50 percent chance of relapse, compared with 15 percent in patients returning to low-EE families (Butzlaff & Hooley, 1998; Corcoran et al., 2003).

Where do culture-bound syndromes fit?

Culture-bound syndromes are patterns of behavior considered to be abnormal or psychopathological, and are found only in a particular cultural group. These disorders have not found their way into the main body of the diagnostic manuals widely used in western countries such as the ICD-10 (WHO, 1992). In the DSM-IV (APA-2000), examples of these syndromes can be found in the Appendix. One example of culture-bound syndrome is *dhat*, a semen-loss or semen-lacking anxiety disorder. The disorder refers to the clinical condition in which the patient is morbidly preoccupied with excessive loss of semen from an "improper form of leaking" such as nocturnal emissions, masturbation or urination. The underlying anxiety is based on the cultural belief that excessive semen loss will result in illness. The importance of semen can be discerned in Ayurvedic texts regarding the production of semen as:

> food converts to blood, which converts to flesh, which converts to marrow, and the marrow is eventually converted into semen. It . . . takes 40 days for 40 drops of food to be converted to one drop of blood, 40 drops of blood to one drop of flesh, etc. (Bhugra & Buchanan, 1989; cit. in Sumathipala, Siribaddana & Bhugra, 2004, p. 204).

Dhat-syndrome has been reported on the India sub-continent, and may be closely related to another culture-bound syndrome – *koro (i.e.,* the genital-retraction anxiety disorder). Castillo (1991) has pointed out that western trained psychiatrists regard *dha*t-syndrome as

major depression. However, the majority of these patients (64%) have failed to recover when exclusively treated with anti-depressants (Singh, 1985).

The biomedical tradition from the West with its underpinnings in universalist position assumes that mental health categories found in either the DSM-IV (APA, 2000) or ICD-10 (WHO, 1992) apply to everyone, and those that are not readily recognized in the West are culture-bound syndromes. As such, the relatively lack of Anorexia nervosa in non-Western Asians has not sufficed to regard it as a culture-bound syndrome of the west, but a disorder with full-fledged status in the western diagnostic manuals. It is nevertheless important to note that the same diagnoses of mental illnesses may appear in different cultures, but their etiology may have different characteristics, as is the case with anorexia. In the West it is associated with a self-image of fatness and to the fear of becoming overweight, while in non-Western cultures anorexia has nothing to do with weight or body mass, but rather to religious beliefs linked to fasting for spiritual purification (Moreira, 2007a). Against this background, should anorexia still qualify as a (moderate) universal disorder, or a culture-bound syndrome?

A Critical Approach to the Problem

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

> cross-cultural psychology has been quick to put on the white lab coat of the scientist as though it had forgotten about culture. It is clear that the researchers have not forgotten culture as an independent variable, as something that could be assumed to be a cause and affect behavior. But who knows that they neglect culture as the manufacturer of the 'mechanisms of central processing' (Moghaddam & Studer, 1997, p. 197).

Restricting the concept of culture to causal occurrence has serious ideological ramifications, albeit the cross-cultural researcher is seen as ideologically neutral. The question of neutrality is part of the limitation of traditional clinical psychology and psychiatry which, from within an individualist ideology, ignores the social, political and cultural contexts of those in need of psychological treatment. Many cases of mental illness diagnosed in day-to-day work in medical and psychological offices of the developing countries of Latin America, Africa and Asia question the neutrality of the treatment both from ethical and ideological points of view. This is particularly relevant when an illness, to a greater extent, is related to experiences of political violence and social oppression than

to biological factors to be treated in an individualist perspective of the problem. As Lira (2000) states, "neutrality is not ethically possible in such cases" (p. 85).

According to Kleinman and Good (1985) one major limitation to gaining full realization of cross-cultural studies in psychopathology is the lack of a sophisticated anthropological view of culture. These authors emphasize the anthropological and relativist perspective in the studies of psychopathology, which resembles a phenomenological focus of research that searches for the meaning of an experience as lived out by the subject. Tatossian (1997) points out that a fundamental error in classical western cross-cultural psychiatry is its a-priori assumption that western psychiatric categories are universal, and that culture modifies the contents through a 'pathoplastic' action. The pathoplastic view of cultural roots of mental illness sees culture as antecedent to the individual. This view is different from the anthropological view of culture as an integral part of an individual's make-up. As it is, "psychiatry" is the way Western society chooses to regulate the problem of its 'disorders'.

However, there are other ways to do this where each culture could have its own "psychiatry" as our case examples at the start of the paper portray. The Western approach (i.e., psychiatry) should neither be seen as privileged nor as better than the other approaches involving the use of a shaman or a witch-doctor. It is also important to note that cultures can regulate the problems without constituting "psychiatry" or its equivalent, because the notions of mental illness, of etiology, and of treatment are not universal.

One risk cross-cultural researchers take is to translate, adapt, and transport the methodology of psychological tests, with the aim of discovering universal truths through testing of hypotheses among groups from different cultures (Moghaddam & Studer, 1997; Moreira, 2009). This is both serious and questionable as it involves stripping the value, evidently of ideological character of the role of culture in the constitution of behavior, of mental health and mental illness. Rather than including issues of power and ideology into the concept of culture, culture is reduced to a simple independent variable that does not require any deeper thought about its meaning. Perspectives from critical psychology show that mainstream psychology is ideologically individualistic in nature and perpetuates a situation of inequality and social injustice (Fox & Prilleltensky, 1997; Sloan, 2001).

It would, however, be a great loss if those studies in cross-cultural psychology were to reinforce this perspective, when they themselves have the potential for critical understanding of mental health and illness, as well as psychology in general, at an anthropological, sociological and political level. Even though a critical approach of psychology recognizes its link to cultural studies (Sloan, 2001), the enormous critical potential of (cross-) cultural studies is lost when psychologists 'psychologize' the concept of culture and thus characterizes it as such. Consequently, studies that are limited measuring symptoms in different cultural settings flourish.

While criticizing studies arguing that depression and schizophrenia to a large extent are based on the individualistic ideology in mainstream approaches of psychopathology, we acknowledge that these studies are cognizant of culture, albeit from a myopic view where culture is still "outside" the individual. Grounded in Merleau-Ponty's phenomenology, we propose a "worldly" understanding for psychopathology (Moreira,

2002, 2007a & b, 2009,). In this perspective we regard human beings in a worldly way, defined through "multiple contours", which interweave and mutually constitute themselves as expressed by Merleau-Ponty through Cézanne's painting (Moreira, 2007c).

Therefore, we defend the understanding of psychopathology not only as a field of study, but as the experience of mental pathology, necessarily including its cultural dimension, as well as the endogenous and situational dimensions that exist in mutual constitution (Moreira, 2002). When we propose that culture be understood as a constituent of mental health, it is important to recover not only the anthropological definition of the concept put forward by Kleinman and Good (1985) as *the intersection of meaning and experience*. It is equally important to transcend the concept by explicitly incorporating the inherent political aspects. This deals with a concept which is necessarily **not** naïve (Freire, 2000) but de-ideologized (Martin-Baró, 1985). Culture as a fundamental constituent dimension of mental health deserves to be understood as an anthropological, historical, social, and political concept, including, fundamentally, an ideological discussion on its constituents. As Rovaletti (1996) affirms:

> one does not become crazy as he wishes, but rather as the culture foresees. At the heart of neurosis or psychosis, through which we try to escape, culture still tells us what personality of substitution we should adopt (p. 125).

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Questions for Discussion

1. Once culture is eliminated from the diagnostic equation, one loses the capacity to recognize important social and cultural variables involved in the etiology and manifestation of mental disorders. Discuss.
2. Discuss how eliminating culture from mental illness will result in a limited understanding of the onset, manifestation, course and outcome of mental illness.
3. All mental health problems should be viewed as a culture-bond syndrome.
4. How ascertain whether an individual on a remote isolated place that your cultural group has never heard of before is suffering from depression or schizophrenia?
5. To what extent can we assume that the core symptoms of depression and schizophrenia identified by the WHO studies are "culturally neutral"?
6. Identify some aspects of your own culture that could be constituents of mental illness. Discuss how these aspects may influence mental illness.
7. Discuss the difference between the idea of culture influencing mental illness against the mutual embeddedness of culture and mental illness.
8. Choose a mental illness as described in the DSM-IV or ICD-10 and discuss it onset, expression and prognosis from your cultural point.