To my daughter

Culture, Health and Illness

An Introduction for Health Professionals

Third edition

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Contents

10

Cross-cultural psychiatry

Cross-cultural psychiatry is the study, and comparison, of mental illness in different cultures. It is one of the major branches of medical anthropology, and has been a valuable source of insight into the nature of health and ill-health in different parts of the world. Historically, research into the subject has been carried out by two different types of investigator. First, Western-trained psychiatrists who have encountered unfamiliar, and what seemed to them bizarre, syndromes of psychological disturbance in parts of the non-Western world, and who have tried to understand these syndromes in terms of their own Western categories of mental illness such as 'schizophrenia', or 'manic depressive psychosis'. Secondly, social anthropologists, whose main interests have been the definitions of 'normality' and 'abnormality' in different cultures, the role of culture in shaping 'personality structure', and cultural influences on the cause, presentation and treatment of mental illness. Although these two approaches have led to different perspectives on the subject, they share a concern with two types of clinical problem:

1. The diagnosis and treatment of mental illness, where health professional and patient come from different cultural backgrounds.
2. The effect on mental health of migration, urbanization, and other forms of social change.

The focus of cross-cultural psychiatry is mainly on mental 'illness' – rather than on mental 'disease'. That is, it is concerned less with the organic aspects of psychological disorders than with the psychological, behavioural and socio-cultural dimensions associated with them. Even when the condition clearly has an organic basis – as in neurosyphilis, delirium tremens, or dementia – anthropologists are more interested in how *cultural* factors affect the patient's perceptions and behaviour, the content of his hallucinations or delusions, and the attitudes of others towards him.

In general, the relationship of culture to mental illness can be summarized as:

1. It defines 'normality' and 'abnormality' in a particular society.
2. It may be part of the aetiology or cause of certain illnesses.
3. It influences the clinical presentation, and distribution, of mental illness.
4. It determines the ways that mental illness is recognized, labelled, explained and treated by other members of that society.

'Normality' *versus* 'abnormality'

Definitions of 'normality', like definitions of 'health', vary widely throughout the world; and in many cultures, these two concepts overlap. Mention has already been made in Chapter 4 of some of the medical definitions of 'health' that are based upon the measurement of certain physiological and other variables that lie within the 'normal range' of the human organism. At its most reductionist, this approach concentrates mainly on the physical signs of brain dysfunction, before diagnosing mental illness. In this chapter, some other ways of looking at the problem will be examined, especially the *social* definitions of normality and abnormality. These definitions are based on shared beliefs within a group of people as to what constitutes the ideal, 'proper' way for individuals to conduct their lives in relation to others. These beliefs provide a series of guidelines on how to be culturally 'normal' but, as will be described below, how also to be temporarily 'abnormal'. Normality is usually a multi-dimensional concept. Not only is the individuals' behaviour relevant, but also, for example, their dress, hairstyle, smell, personal hygiene, posture, gestures, emotional state, facial expression, tone of voice and use of language are all taken into account – as is their *appropriateness* to certain contexts and social relationships.

Some of the many dimensions of social behaviour are illustrated in Figure 10.1. This represents the range of possible *perceptions* – by members of a particular society or culture – of a particular form of social behaviour: whether they see it as 'normal' or 'abnormal' for their society, and whether it is controlled or not by the norms of that society. It also reflects the fact that all human groups recognize that there are certain times, and places, when people can be allowed to behave in an 'abnormal' way – provided that they are seen to conform to the strict guidelines (explicit or implicit) laid down by

their culture for this type of situation. In this case, even if their behaviour is bizarre or unconventional, it is still to some extent 'controlled' by social norms. By contrast, most cultures disapprove of forms of public behaviour that are obviously *not* being controlled by the rules of their society: and which they usually label as either 'mad' or 'bad'. Thus in Figure 10.1 there are four possible 'zones' of social behaviour (A, B, C, D) according to the perceptions of that society – or of groups, or individuals, within that society.

It should always be emphasized, however, that these zones, and the definitions of behaviour they encompass, are *not* static. Rather they are a series of fluid categories, a spectrum of possibilities, that is likely to change with time and circumstance, and the particular perspective of the onlooker. Thus behaviour seen as 'bad' in one generation, may be seen as 'mad' in the next; 'normal' behaviour in one group of people, may be regarded as 'abnormal' in another. Alcohol consumption, for example, has – at various times and places (sometimes within the same society) – been seen as 'normal', as morally 'bad', as a symptom of psychological disorder, and as an accepted part of certain ritual or religious occasions. Furthermore, these broad social categories do not necessarily take into account *individual* factors, such as personality, motivation, experience, emotional state, or physiology. Their focus is not primarily on an individual's perspective, but rather on that of society as a whole – or, at least, of a section of that society. However, in the case of 'controlled normality' (A), 'uncontrolled normality' (D), and 'controlled abnormality' (B), it is assumed that the individual is at least *aware* (consciously or not) of what the social norms are – whether they conform to them or not.

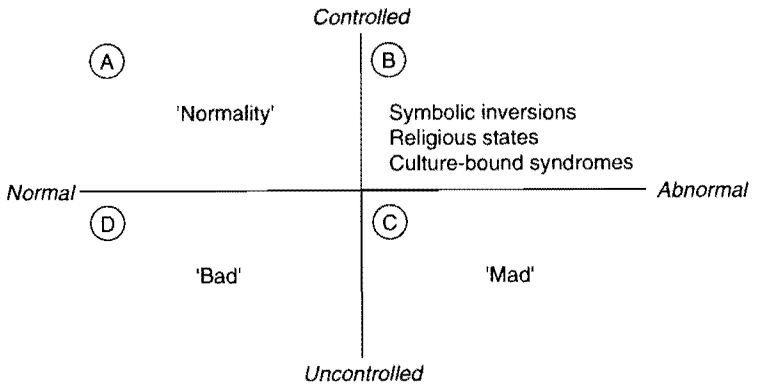

Figure 10.1. Perceptions of social behaviour

The social definition of normality (A) is not uniform within a population. Most cultures have a wide range of social norms which are considered appropriate for different age groups, genders, occupations, social ranks and cultural minorities within the society. Attitudes towards foreigners or minorities often include stereotyped views of their 'normal' behaviour, which may be seen as bizarre, comical or even threatening. Furthermore, most societies, especially those with rigid codes of normal behaviour, often make provision for certain specified occasions where these codes are deliberately flouted or *inverted*, and 'abnormal' behaviour becomes the temporary norm (B). Anthropologists have described many of these 'rites of reversal' or 'symbolic inversions', which Babcock[1] defines as: 'any act of expressive behaviour which inverts, contradicts, abrogates, or in some fashion presents an alternative to commonly held cultural codes, values and norms be they linguistic, literary or artistic, religious, or social and political'.

These special occasions – such as certain festivals, bacchanalia, parades, *mardi gras* and carnivals (like those in Brazil, the Caribbean, and London's Notting Hill Gate) – sometimes involve an inversion of normal behaviour and roles. For example, in their study of the carnival in St Vincent, West Indies, and 'belsnickling' (a form of Christmas mumming) on La Have Islands, Nova Scotia, Abrahams and Bauman[2] describe how they both involve 'a high degree of symbolic inversion, transvestism, men dressed as animals or super-natural beings, sexual licence and other behaviours that are the opposite of what is supposed to characterize everyday life'. In a Western setting, such temporarily abnormal social behaviour is often found on New Year's Eve, April Fool's Day, at fancy dress balls, university 'Rags', on Halloween, as well as on vacations far from home. Similar alterations or inversions of 'normal' role behaviour are found in some of the spirit possession cults of African women, described by Lewis,[3] where women who seek power and aspire to roles otherwise monopolized by men 'act out thrusting male parts with impunity and with the full approval of the audience'. All these forms of 'abnormal' behaviour in public by large crowds of people are, however, also strictly *controlled* by norms, since their timing and location are clearly defined, and structured in advance.

On a more individual level, displays of behaviour that are 'abnormal' by the standards of everyday life, must also be seen against the background of the culture in which they appear. Like the crowd behaviour at a 'rite of reversal', they are also controlled (to a variable extent) by implicit cultural norms, which determine how and when they may appear. In many cultures, especially in the

non-industrialized world, individuals involved in interpersonal conflicts, or who are experiencing feelings of unhappiness, guilt, anger or helplessness, are able to express these feelings in a standardized 'language of distress' (see Chapter 5). This may be purely verbal, or involve extreme changes in dress, behaviour or posture. To the Western-trained observer, some of these 'languages of distress' may closely resemble the diagnostic entities of the Western psychiatric model. For example, they may involve statements such as, 'I've been bewitched', 'I've been possessed by a spirit (or by God)', or 'I can hear the voices of my ancestors speaking to me'. In a Western setting, people making this type of statement are likely to be diagnosed as psychotic, probably 'schizophrenic'.

However, one should remember that in many parts of the world people freely admit to being 'possessed' by supernatural forces, to having spirits speak and act through them, and to having had dreams or visions that conveyed an important message to them. In most cases this is *not* considered by their communities to be evidence of mental illness. One example of this is the widespread belief, especially in parts of Africa, of 'spirit possession' as a cause of mental or physical ill-health. Women especially are the victims of 'possession' by malign, pathogenic spirits that reveal their identity by the specific symptoms or behaviour changes that they cause. In these societies, notes Lewis,[3] possession is a normative experience, and whether or not people are actually in a trance, they are only 'possessed' when they consider they are, and when other members of their society endorse this claim. That is not to say that spirit possession is normal, in the sense that most people expect to be possessed during their life. Rather, it is a culture-specific way of presenting, and explaining, a range of physical and psychological disorders in certain circumstances. In these societies,

> belief in spirits and in possession by them is normal and accepted. The reality of possession by spirits, or for that matter of witchcraft, constitutes an integral part of the total system of religious ideas and assumptions. Where people thus believe generally that the affliction can be caused through possession by a malevolent spirit (or by witchcraft), disbelief in the power of spirits (or of witches) would be a striking abnormality, a bizarre and eccentric rejection of normal values. The cultural and mental alienation of such dissenters would in fact be roughly equivalent to that of those who in our secular society today believe themselves to be possessed or bewitched.[3]

Possession, then, is an 'abnormal' form of individual behaviour,

but one which conforms with cultural values, and whose expression is closely controlled by cultural norms. These norms provide guidelines as to who is allowed to be possessed, in what circumstances, and in what way, as well as how this possession is to be signalled to other people.

Another form of 'controlled abnormal' behaviour is *glossolalia*, or 'speaking in unknown tongues'. To those who believe in it, it is thought to result from a supernatural power entering into the individual, with 'control of the organs of speech by the Holy Spirit, who prays through the speaker in a heavenly language'.[4] It is a dissociative, trance-like state in which the participants 'tend to have their eyes closed, they may make twitching movements and fall; they flush, sweat and may tear at their clothes'. It is a feature of religious practices in parts of India, the Caribbean, Africa, Southern Europe, North America and among many Pentecostal churches in the UK (including those with West Indian congregations). There are believed to be about two million practitioners of glossolalia in the USA in various denominations, including some Lutheran, Episcopalian and Presbyterian churches. Glossolalia usually takes place in a specified context (the church) and at specified times during the service. It can be seen as a form of 'controlled abnormality' which, to a Western-trained psychiatrist, might seem evidence of a mental illness. However, there is no evidence that this is the case; on the contrary, there is some evidence from various cultures that 'in any particular denomination, those members of it who speak in tongues are better adjusted than those who do not'.[4] In one study, a comparison between a group of schizophrenic patients from the Caribbean and West Indian Pentecostals suggested that the Pentecostals believed that the patients 'were unable to control their dissociative behaviour sufficiently to conform with the highly stylized rituals of glossolalia in church'.[4] Although both groups might appear to practise similar glossolalia, it was the culturally *uncontrolled* form that was regarded as mental illness by members of that community.

In every society there is a spectrum between what people regard as 'normal' and 'abnormal' social behaviour. However, as the examples of glossolalia, spirit possession and carnivals illustrate, there is also a spectrum of 'abnormal' behaviour, from *controlled* to *uncontrolled* forms of abnormality. As with the 'abnormal', uncontrolled drinking behaviour (drunkenness) described in Chapter 8, it is behaviour at the *uncontrolled* end of the spectrum that cultures regard as a major social problem, and that they label as either 'mad' (C) or 'bad' (D). As Foster and Anderson[5] put it: 'there is no culture in which men and women remain oblivious to

erratic, disturbed, threatening or bizarre behaviour in their midst, whatever the culturally defined context of that behaviour'. According to Kiev,[6] the symptoms that would suggest mental disorder include uncontrollable anxiety, depression and agitation, delirium and other gross breaks of contact with reality, and violence (both to the community and to self). In one study by Edgerton,[7] lay beliefs about what behaviour constitutes 'madness' or psychosis was examined in four East African tribes: two in Kenya, one in Uganda and one in Tanzania (Tanganyika). It was found that all four societies shared a broad area of agreement as to what behaviours suggested a diagnosis of 'madness'. These included such actions as violent conduct, wandering around naked, 'talking nonsense' or 'sleeps and hides in the bush'. In each case the respondents qualified their description of psychotic behaviour by saying that it occurred 'without reason'. That is, violence, wandering around naked and so on occurred without an apparent purpose, and in the absence of any identifiable and acceptable external cause (such as witchcraft, drunkenness or simply malicious intent). Edgerton notes how this catalogue of abnormal behaviours is not markedly at variance with Western definitions of psychosis, particularly schizophrenia. In these cultures, as elsewhere in the world, behaviour is labelled as 'mad' (C) if it was 'abnormal', was not controlled by social norms, and had no discernible cause or purpose. Rarely, the label of 'temporary madness' may be also applied – usually to cases of mass hysteria, intoxication by alcohol or drugs, or 'crimes of passion' (in some European countries).

Certain other behaviours, uncontrolled by social norms, are still regarded by society as being 'normal' – even though they are classified as socially undesirable, and often illegal. These are the behaviours classified as 'bad' or 'criminal' (D): in this case, the person convicted of a crime would be regarded as 'guilty', but as 'normal'. The issue debated in their trial by lawyers and forensic psychiatrists would be the accuseds' *awareness* – or lack of awareness – of what the social norms (or laws) of their society are: whether they had 'insight', were 'responsible for their actions', and 'knew right from wrong'.

As described above, the 'abnormal' behaviours at the controlled end of the spectrum (B) frequently overlap with religious and cosmological practices – as in glossolalia, spirit possession and the use of hallucinogens in religious rituals (see Chapter 8), but also the healing rites of the *shaman*. The latter is a form of sacred folk healer who is found in many cultures, and has been more fully described elsewhere in this book. The shaman, often known as a 'master of spirits', becomes voluntarily possessed by them in controlled

circumstances and, in a divinatory seance, both diagnoses and treats the misfortune (and illness) of their community. To a Western psychiatrist, the behaviour of the shaman during his trance may closely resemble that of the schizophrenic. However, as Lewis[3] points out, shamans in their ritual performances act in conformity with cultural beliefs and practices and, in the selection of shamans, frankly psychotic or schizophrenic individuals are screened out as being too idiosyncratic and unreliable for the rigours of the shamanic role.

At various points along the spectrum of 'controlled abnormal' behaviours (B), the different *culture-bound* mental illnesses can also be located. These conditions, described below, are all under the control of social norms to a variable extent. For example, their timing and setting may be unpredictable, but the clinical presentation of their symptoms and behaviour changes are not chaotic, but patterned by the culture in which they appear. Also, unlike the severe uncontrolled psychosis in the East African example (C), a culturally explicable *cause* for them can usually be found: such as *susto* following an unexpected accident or fright, or *evil eye* resulting from, for example, an extravagant lifestyle that was bound to attract envy. These conditions do not occur in the formalized setting of temple or ritual, but cultural factors influence their presentation, recognition and treatment.

The comparison of psychological disorders

Given the marked variation in cultural definitions of 'normal' and 'abnormal' throughout the world, can one make meaningful comparisons between mental illness in different groups and societies? Landy[8] has summarized two of the questions faced by medical anthropologists and cross-cultural psychiatrists who have examined this problem:

1. Can we speak of some aspects of behaviour as normal or abnormal in a panhuman sense (that is, specific to the human species)?
2. Are the psychoses of Western psychiatric experience and nosology universal and transcultural, or are they strongly shaped by cultural pressures and conditioning?

The answers to both these questions are important, since they determine whether one can adequately diagnose and treat mental illness cross-culturally, and whether the prevalence rates of mental illness in different cultures can be compared. They would also shed light on why some forms of mental illness seem to be more common

in some parts of the world than in others.

In examining notions of 'abnormality' in the section above, most of the emphasis has been on abnormal *social behaviour*, rather than on organic disorders or on emotional state. For most medical anthropologists the social and cultural dimensions of mental illness are the main area of study. This is because cultural factors influence the clinical presentation, and recognition, of many of these disorders, even those with an organic basis. In addition, in many parts of the Third World (and elsewhere) mental illness is perceived as 'abnormal action' rather than 'mistaken belief'.[9] Diagnosing mental illness by psychological state (such as the presence of a delusion) may be difficult where the content of the delusion is shared by other members of the society. For example, in some cultures a person who accuses a neighbour of having 'bewitched' him may initially be perceived as acting in an acceptable, rational way for that society. He will only be viewed as 'mad' or psychotic if his accusations are then followed by 'mal-adaptive personal violence rather than the employment of the accepted communal technique for dealing with sorcery'.[9] In this case, the diagnosis of mental illness by a Western-trained doctor would depend not only on his own clinical observations, based on assessment of the affected person's behaviour, biological changes (such as anorexia, insomnia and loss of libido), and response to certain psychological tests, but also on how the affected person's *behaviour* is perceived by his *own* community. The problem therefore – in comparing mental illness in different societies – is whether to compare Western clinical evaluations of patients in different cultures, or the perceptions by various cultures of those that they regard as mentally ill.

Those who have examined this problem, have tended to take one of three approaches.

The biological approach

This sees the diagnostic categories of the Western psychiatric model as being universally applicable to mankind, despite local variations due to cultural factors, since they have a *biological* basis. In Kiev's[10] view, the *form* of psychiatric disorders remains essentially constant throughout the world, irrespective of the cultural context in which they appear. For example, 'the schizophrenic and manic-depressive psychotic disorders are fixed in form by the biological nature of man', while the secondary features of mental illness, such as the *content* of delusions and hallucinations are, by contrast, influenced by cultural factors. On this basis, Kiev[11] is able to classify the various 'culture-bound disorders' within the diagnostic categories

of the Western model. For example, *koro, susto* and bewitchment are forms of 'anxiety', the Japanese *shinkeishitsu* is an 'obsessional-compulsive neurosis', *evil eye* and *voodoo death* examples of 'phobic states', and *spirit possession, amok* in Malaya and *Hsieh ping* in China are all examples of 'dissociative states'. In Kiev's opinion, these conditions 'are not new diagnostic entities; they are in fact similar to those already known in the West'. This approach, which is similar to the view of 'diseases' as universal entities (see Chapter 5), has been criticized for the primacy it gives to the Western diagnostic and labelling system. In addition, Western categories of mental illness are also 'culture-bound', as well as being the product of specific social and historical circumstances, and are therefore not necessarily 'panhuman' in their applicability. For example, Kleinman[12] has criticized the WHO International Pilot Study of Schizophrenia, which compares schizophrenia in a number of Western and non-Western societies. He points out that the study enforces a definition of schizophrenic symptomatology, and that this definition may distort the findings by 'patterning the behaviour observed by the investigators and systematically filtering out local cultural influences in order to preserve a homogeneous cross-cultural sample'. Applying the Western model of, say, schizophrenia to other parts of the world may therefore be an example of what Kleinman[13] terms *category fallacy* – that is, 'the reification of a nosological category developed for a particular cultural group that is then applied to members of another culture for whom it lacks coherence and its validity has not been established'. The danger of 'category fallacies' is therefore implicitly in much of the biological approach, and in its attempt to fit 'exotic' illnesses into a universal, diagnostic framework.[14]

A further critique of the biological approach is that the same mental illness may play *different* social roles in different societies. For a fuller understanding of an episode of that mental illness in another culture, one must always know something of the *context* – social, cultural, political and economic – in which it has taken place. For example, in some small-scale societies a psychotic episode may be viewed as evidence of an underlying social conflict, which must be resolved by a public ritual, while the same psychosis is unlikely to play so central a role in the life of a Western, urban community.

The social labelling approach

This perspective, developed by sociologists, sees mental illness as a 'myth', essentially a *social* rather than a biological fact, and one

which can appear with or without biological components. Society decides what symptoms or behaviour patterns are to be defined as 'deviant', or as that special type of deviance called 'mental illness'. This 'mental illness does not appear until it is so labelled, and had no prior existence. Once the diagnostic label is applied, it is difficult to discard. According to Waxler,[15] mental illness is only defined relative to the society in which it is found, and cannot be said to have a 'universal' existence. She notes how, in Western societies, social withdrawal, lack of energy and feelings of sadness are commonly labelled 'depression', while in Sri Lanka the same phenomena receive less attention and very little treatment. The definition of mental illness is thus 'culture-specific'. The process of labelling involves a first stage where an individual's minor deviant behaviour is labelled as 'mental illness'. There are, however, certain 'culture-specific contingencies' under which potential deviants are immune from this labelling, and these include the individual's power relative to the labeller (based on his or her age, sex, race, economic position etc.). Once individuals are labelled as 'mentally ill', they are subject to a number of cultural cues which tell them *how* to play their role, that is, 'the mentally ill person learns how to be sick in a way his particular society understands'. Once labelled, the individual is dependent on the society at large for 'de-labelling' him, and releasing him from the sick role. In some cases he may never be able to free himself from this role. The value of the social labelling perspective is that it sheds light on the *social* construction, and maintenance of the symptomatology of mental illness. Since this mental illness only exists by virtue of the society that defines it, 'mental illness' is a relative concept and cannot easily be compared between different societies. This perspective has been criticized for its neglect of the biological aspect of mental illness, especially in those conditions where this is a definite feature (such as brain tumours, delirium tremens, or dementias). It also ignores the more extreme psychoses, which do seem to be universal in distribution.

The combined approach

This utilizes elements of both the biological and the social labelling perspectives and is the one most medical anthropologists would agree with. In this view, there *are* certain universals in abnormal behaviour, particularly extreme disturbances in conduct, thought or effect. While there is wide variation in their form and distribution, the Western categories of major psychoses, such as 'schizophrenia' and 'manic depressive psychosis', *are* found throughout the world, though of course they may be given different labels in different

cultures. An example of this, the similarity to Western definitions of psychosis of folk categories of 'mad' behaviour in four East African tribes, has already been described above. The major psychoses, therefore, as well as disorders arising from organic brain disease, seem to be recognized in all societies, though their clinical presentations are usually influenced by the local culture. For example, a psychotic in a tribal society may say that his behaviour is being controlled by powerful witches or sorcerers, while a Western psychotic may feel controlled by spacemen, Martians or flying saucers. Those who suffer these extreme psychological disorders are usually perceived by their own cultures as exhibiting 'uncontrolled abnormal' (C) forms of social behaviour. To a variable extent their clinical pictures can be compared between societies. Foster and Anderson[5] have suggested that this comparison should be between their *symptom patterns* rather than between diagnostic categories (such as 'schizophrenia'); on this basis, the problem of trying to fit other cultures' mental illnesses into Western diagnostic categories can be overcome.

The comparison of symptom patterns can also be carried out for the 'culture-bound disorders', to be described below, many of which could be classified as 'neuroses' or 'functional psychoses' in the Western psychiatric model. These conditions, especially those with a preponderance of neurotic or somatic symptoms, are probably more difficult to compare than are the major psychoses. Many of them seem to be unique clusters of symptoms and behaviour changes, which only make sense within a particular context, and within a particular culture, and have no equivalent in other societies. The specific symptom patterns of *susto*, for example, are unlikely to be found in the UK, at least not among the native-born population. Not only does culture closely pattern their clinical presentations, but the *meanings* of these conditions for the victim, their family and community are difficult for a Western observer to evaluate or to quantify. Nevertheless, anthropologists like Rubel[16] believe that these folk illnesses have a fairly constant clinical presentation within a culture, and can therefore be quantified and investigated using standard epidemiological techniques (see Chapter 12).

Cultural influences on psychiatric diagnosis

Before psychological disorders can be compared they have to be diagnosed. In recent years a number of studies have indicated some of the difficulties in standardizing psychiatric diagnoses, particu-

larly among psychiatrists working in different countries. Variations in the clinical criteria used to diagnose schizophrenia, for example, have been found between British and American, and British and French psychiatrists, and among psychiatrists working within these countries. Some of the diagnostic categories in French psychiatry – such as 'chronic delusional states' (*délires chroniques*) and 'transitory delusional states' (*bouffées delirantes*) – are significantly different from the diagnostic categories of Anglo-American psychiatry.[17] A further example was the diagnostic category 'sluggish schizophrenia' in Soviet psychiatry, which was virtually limited to the former USSR.[18] All of these discrepancies in diagnostic behaviour among psychiatrists are important, since they affect both the treatment and prognosis of mental illness, as well as the reliability of comparing morbidity statistics for these conditions between different countries.

Part of the reason for these differences lies in the nature of psychiatric diagnosis, and the categories into which it places psychological disorders. Unlike the diagnosis of medical 'diseases', there is often little evidence of typical biological malfunctioning, as revealed by diagnostic technology. Where biological evidence does exist, it is often difficult to relate this to specific clinical symptoms. Most psychiatric diagnoses are based on the doctor's subjective evaluation of the patient's appearance, speech and behaviour, as well as performance in certain standardized psychometric tests. The aim is to fit the symptoms and signs into a known category of mental illness, by their similarity to the 'typical', textbook description of the condition. However, according to Kendell,[19] the way that psychiatrists learn how to do this may actually make diagnostic differences among them more likely. He points out how the majority of patients encountered by trainee psychiatrists do *not* possess the 'typical' cluster of symptoms of a particular condition. They may have some of the symptoms but not others, or have symptoms 'typical' of another condition. As a result, trainee psychiatrists learn how to assign diagnoses largely by the example of their clinical teachers: 'He sees what sorts of patient his teachers regard as schizophrenics, and copies them'. So while young psychiatrists see many 'typical' cases of various disorders during their studies, their diagnostic behaviour tends to be modelled on that of their teachers, rather than using the stricter criteria of their textbooks. As a result, 'diagnostic concepts are not securely anchored. They are at the mercy of the personal views and idiosyncrasies of influential teachers, of therapeutic fashions and innovations, of changing assumptions about aetiology, and many other less tangible influences to boot'.[19]

Among these influences, Kendell[20] cites the personality and experience of the psychiatrist, the length of his diagnostic interview, and his styles of information-gathering and decision-making. To this list one can add his social class, ethnic or cultural background (especially its definition of 'normality' and 'abnormality'), his prejudices, his religious or political affiliations, and the context in which diagnosis takes place.

An example of how these influences work in practice was provided by Temerlin's[21] classic experiment in 1968. Three groups of psychiatrists and clinical psychologists were each shown a videotaped interview with an actor who had been trained to give a convincing account of normal behaviour. Before the viewing, one of the audiences was allowed to overhear a high prestige figure comment that the patient' was 'a very interesting man because he looked neurotic but actually was quite psychotic'. The second group were allowed to overhear the remark, 'I think this is a very rare person, a perfectly healthy man', while the third group was given no suggestions at all. All three audiences were asked to diagnose the 'patient's' condition. In the first group of 95 people, 60 diagnosed a neurosis or personality disorder, 27 diagnosed psychosis (usually schizophrenia), and only 8 stated that he was mentally normal. In the second group, all 20 people diagnosed the 'patient' as normal, while only 12 of the 21 members of the third group also diagnosed normality: the other nine diagnosed neurosis or personality disorders.

Another factor enhancing the subjective element in psychiatric diagnosis is the diffuse and changeable nature of the diagnostic categories themselves. Kendell[22] points out that many of these categories tend to overlap, and ill people may fit into different categories at different times, as their illnesses evolve. Each category or syndrome is made up of the 'typical' clinical features, but as he notes:

> Many of these clinical features, like depression and anxiety, are graded traits present to varying extents in different people and at different times. Furthermore, few of them are pathognomonic of individual illnesses. In general, it is the overall pattern of symptomatology and its evolution over time that distinguishes one category of illness from another, rather than the presence of key individual symptoms.

However, psychiatrists differ on whether to adopt this 'historical' approach, or whether to focus mainly on the individual's current mental state – as indicated by the degree of 'insight' displayed, or

behaviour at the clinical interview. There is also a difference of opinion as to what 'explanatory model' should be used to shape this diffuse clinical picture into a recognizable diagnostic entity. Eisenberg[23] notes that Western psychiatry is not an internally consistent body of knowledge, and includes within it many different ways of viewing mental illness. For example, its perspective on the psychoses includes 'multiple and manifestly contradictory models', such as the medical (biological) model, the psychodynamic model, the behavioural model, and the social labelling model. Each of these approaches emphasizes a different aspect of the clinical picture, and proposes a different line of treatment. The choice of explanatory model, and of diagnostic label, may sometimes be as much a matter of temperament as of training.

Political and moral considerations also play a part in the choice of diagnosis. In some cases, psychiatrists may be called upon to decide whether a particular form of socially deviant behaviour is 'mad' or 'bad'. In the Western world this is common as part of the judiciary system, but has also been applied to such conditions as homosexuality, alcoholism, truancy or obesity. Szasz[24] has argued also that confining lawbreakers to psychiatric hospitals, ostensibly for treatment – that is, labelling them as 'mad' rather than 'bad' – is just another form of punishment, but without the benefits of a proper defence and trial. Psychiatrists making these decisions are likely to be under the influence of social and political forces, the opinions of their colleagues, and their own moral viewpoints and prejudices. In some societies, many forms of political dissent are labelled as 'mental illness'. The state and its supporters are assumed to have a monopoly of truth, and disagreement with them is considered to be clear evidence of psychosis. Wing[25] has described a number of these cases in different countries where state psychiatrists have labelled dissent as 'madness', especially in the former USSR, where, according to Merskey and Shafran,[18] political dissidents were often diagnosed as having 'sluggish schizophrenia'.

In their study of mental illness among immigrants to the UK, Littlewood and Lipsedge[9] also suggest that psychiatry can sometimes be used as a form of social control, misinterpreting the religious and other behaviour of some Afro-Caribbean patients, as well as their response to discrimination, as evidence of schizophrenia. By contrast with the high rate of schizophrenia among Afro-Caribbeans, depression is rarely diagnosed, and the authors suggest that 'whatever the empirical justification, the frequent diagnosis in black patients of schizophrenia (bizarre, irrational, outside) and the infrequent diagnosis of depression (acceptable, understandable, inside) validates our stereotypes'.[26] In dealing with

immigrants and the poor, they warn against psychiatry's role in 'disguising disadvantage as disease'. Other researchers, however, while agreeing that ethnic and racial prejudices do exist among UK psychiatrists, dispute that this alone leads to an over-diagnosis of schizophrenia among Afro-Caribbeans. Lewis *et al.*,[27] for example, in their study of 139 British psychiatrists, *did* find evidence of stereotyping and 'race-thinking' towards Afro-Caribbean patients: judging them as potentially more violent, less suitable for medication, but more suitable for criminal proceedings than white patients. Presented with identical vignettes of black and white patients, they were more likely to diagnose cannabis psychosis and acute reactive psychosis among the black patients, but *less* likely to diagnose schizophrenia. Thus, while confirming the role of prejudice in psychiatric diagnosis, they found no evidence of a 'greater readiness to detain patients compulsorily or to manage them on a locked ward merely on the grounds of "race" '. Thomas *et al.*,[28] in a study of compulsory psychiatric admissions in Manchester, found that second-generation (UK-born) Afro-Caribbeans had nine times the rate of schizophrenia of whites. However, this could largely be explained by their greater socio-economic disadvantage, with poor inner-city housing and higher rates of unemployment – all of which have been correlated with high rates of schizophrenia – rather than by psychiatric misdiagnosis. They therefore suggest that 'efforts aimed at improving social disadvantage and the provision of employment for ethnic minority groups may improve the mental health of such groups'. Wesseley *et al.*,[29] too, found higher rates of schizophrenia among Afro-Caribbeans in south London, irrespective of their place of birth, compared to other groups, but these differences could also mostly be explained by the greater social adversity they suffered, rather than by their ethnicity. However, many of these studies have not yet been replicated in ethnic minorities throughout the UK, and some aspects of their methodology can be seen as problematic. It is difficult, for example, to define the precise inter-relationships of 'race', 'culture', 'ethnicity' and 'social class' within a society. Furthermore, the classification of people by ethnic group – such as 'Afro-Caribbean', 'Asian' or 'white' – is in itself problematic, since each of these groups is not homogeneous, and contains within it people from very different backgrounds. Rates of a particular psychiatric diagnosis in a particular community are also not the whole story; the political and socio-economic *context* in which this diagnosis takes place, and the meanings attached to it, are equally important. A final, relevant issue is the degree to which different communities have been offered equal access to treatments such as

psychotherapy, and whether this psychotherapy was culturally appropriate or not.

Eisenberg[23] mentions another example of how deviant behaviour can be given a moral ('bad'), or medical ('mad') diagnosis. The same constellation of symptoms and signs (including weakness, sweating, palpitations, chest pain on effort) can, in the absence of physical findings, be diagnosed either as 'neurocirculatory aesthenia' or 'Da Costa's syndrome' (and thus as a medical problem), or as the symptoms of 'cowardice' if they appear in a soldier during battle. This is illustrated also by the gradual shift, since the turn of the century, from moral definitions of 'cowardice' or 'weakness' among military personnel, to more recent medicalized definitions such as 'shell shock', 'battle fatigue' or 'post-traumatic stress disorder'. More recently, Blackburn[30] has also suggested that the psychiatric definition of the 'psychopathic personality' is 'little more than a moral judgement masquerading as a clinical diagnosis'.

Looked at in perspective, there are thus a number of factors which can affect the standardization of psychiatric diagnostic concepts between different societies. These include the lack of 'hard' physiological data, the vagueness of diagnostic categories, the range of explanatory models available, the subjective aspect in diagnosis, and the influence of social, cultural and political forces on the process of diagnosis. Some of the differences in diagnosis between psychiatrists in different countries, and within one country, are illustrated in the following case histories.

Case history: Differences in psychiatric diagnosis in the UK and the USA – 1

Cooper *et al.*[31] examined some of the reasons for the marked variations in the frequency of various diagnoses made by British and American hospital psychiatrists. Hospitals in the two countries differ in their admission rates (as noted on the hospital records) for the condition 'manic-depressive psychosis'. In the UK, for some age groups, admission for this condition is over ten times more frequent than in US state mental hospitals. The authors posed the problem: 'Are the differences in official statistics due to differences between the doctors and the recording systems, or do both play a part?' That is, was the actual prevalence of manic-depressive psychosis different in the two cities (London and New York), or were the differences in admission rates due to the diagnostic terms and concepts used by the two groups of hospital psychiatrists? At a mental hospital in each city, 145 consecutive admissions were studied, in the age range

of 35–59 years. These were assessed by the project psychiatrists, and diagnosed according to objective, standardized criteria. These diagnoses were then compared with those given by the hospital psychiatrists. Hospital staff in both cities were found to diagnose 'schizophrenia' more frequently – and 'affective disorders' (including manic-depressive psychosis and depressive neurosis) less frequently than did the project psychiatrists. Both these trends were more marked in the New York sample. While differences in the incidence of the various disorders *were* found by the project staff between the cities, these differences were less significant than the hospital diagnoses suggest. The hospital psychiatrists appeared to exaggerate these differences by diagnosing schizophrenia more readily in New York, and affective illness more readily in London. The study does not reveal, however, how the cultural differences between the two groups of psychiatrists affected their diagnostic behaviour.

Case history: Differences in psychiatric diagnosis in the UK and the USA – 2

Katz *et al.*[32] examined the process of psychiatric diagnosis in more detail, among both British and American psychiatrists. The study aimed to discover whether disagreements among these diagnoses were 'a function of differences in their actual perception of the patient or patients on whose symptoms and behaviour they are in agreement'. Groups of British and American psychiatrists were shown films of interviews with patients, and asked to note down all pathological symptoms and to make a diagnosis. Marked disagreements in diagnosis between the two groups were found, as well as different patterns of symptomatology perceived. The British saw less pathology generally, and less evidence of the key diagnostic symptoms 'retardation' and 'apathy', and little or no 'paranoid projection' or 'perceptual distortion'. On the other hand, they saw more of the symptom 'anxious intropunitiveness' than did the Americans. Perceiving less of these key symptoms led the British psychiatrists to diagnose schizophrenia less frequently. For example, one patient was diagnosed as 'schizophrenic' by one-third of the Americans, but by none of the British. The authors conclude that 'ethnic background apparently influences choice of diagnosis and perception of symptomatology'.

Case history: Differences in psychiatric diagnosis in England and France

Van Os *et al.*[33] studied the concepts of schizophrenia held by a

sample of 92 British and 60 French psychiatrists. They found major differences in how each group conceptualized the aetiology, diagnosis and management of the disorder. Overall, they seemed 'to have been particularly affected by the traditional divide between Anglo-Saxon empiricism and continental rationalism – between trying to reach the truth through experiment and trying to reach it through ideas'. In France, psychoanalytic theories – emphasizing the aetiological role of family dynamics and parental factors – have been more influential, while in the UK psychiatry has been more linked to physical medicine, has focused more on neuro-developmental and genetic causes. Similarly, in treatment, the British preferred more biological and behavioural approaches, compared to the French. The study also found major differences in the incidence of schizophrenia in the two countries. In France, first admissions to psychiatric hospitals for this condition under the age of 45 years was much higher than in England, but much lower after 45. Also, rates of first admission for the period 1973–82 were rising in France, but falling in England. These apparent differences in the incidence of schizophrenia could largely be explained by the cultural and conceptual differences between the two groups of psychiatrists, and differences in the diagnostic criteria used. French psychiatrists were reluctant to diagnose schizophrenia after 45 years, and before that age the French concept of schizophrenia encompassed a number of other chronic psychological states (such as *heboidophrenic*, or 'pseudopsychopathic' schizophrenia), which in the UK would not be included under the diagnosis of 'schizophrenia'.

Case history: Differences in psychiatric diagnosis within the UK

Copeland *et al.*[34] studied differences in diagnostic behaviour among 200 British psychiatrists, all of whom had at least 4 years in full-time practice, and possessed similar qualifications. They were shown videotapes of interviews with three patients, and asked to rate their abnormal traits on a standardized scale, and to assign the patients to diagnostic categories. There was fairly good agreement on diagnoses among the sample, except that psychiatrists trained in Glasgow had a significant tendency to make a diagnosis of 'affective illness' in one of the tapes, where the choice of diagnosis was between affective illness and schizophrenia. In addition, psychiatrists trained at the Maudsley Hospital, London, gave lower ratings of abnormal behaviour on the patients than the rest, while older psychiatrists – and those with psychotherapeutic training – rated a higher level of abnormalities than did younger psychiatrists. The authors point out that rating behaviour as 'abnormal' is 'likely to be affected by the rater's attitude towards illness and health and what is normal and abnormal'. The survey illustrates therefore that differences in these attitudes are associated with differences in postgraduate psychiatric training, as well as with age.

Cultural patterning of psychological disorders

Each culture provides its members with ways of becoming 'ill', of shaping their suffering into a recognizable 'illness entity', of explaining its cause, and of getting some treatment for it. Some of the issues raised by this process, in the case of physical illness, have already been discussed in Chapter 5, and they apply equally to cases of psychological disorder. Lay explanations of these conditions fall into the same aetiological categories: personal behaviour and influences in the natural, social and supernatural worlds. Mental illness can therefore be explained by, for example, spirit possession, witchcraft, the breaking of religious taboos, divine retribution, and the 'capture' of one's soul by a malevolent spirit. Foster and Anderson[5] point out how these types of 'personalistic' explanations for mental illness are much more common in the non-Western world; by contrast, the Western perspective on mental illness emphasizes psychological factors, life experiences and the effects of 'stress' as major aetiological factors.

As with physical illness, cultures influence the 'language of distress' in which personal distress is *communicated* to other people. This 'language' includes the many culturally specific definitions of 'abnormality', such as major changes in behaviour, speech, dress or personal hygiene. When it includes the verbal expression of emotional distress, including the description of hallucinations and delusions, it usually draws heavily on the symbols, imagery and motifs of the patient's own cultural milieu. For example, in Littlewood and Lipsedge's[35] study, 40 per cent of their patients with severe psychoses who had been born in the Caribbean and in Africa structured their illness in terms of a religious experience, compared with only 20 per cent of the white patients born in the UK. Similarly, Scheper-Hughes[36] points out that in rural Kerry, in western Ireland, psychiatric patients showed a greater tendency to delusions of a religious nature, including the motifs of the Virgin and the Saviour, than would occur among American schizophrenics, who would be more likely to have 'secular or electromagnetic persecution delusions'. While possession by a malign 'spirit' may be

reported in parts of Africa, possession by 'Martians' or 'extraterrestrials' is more likely among Western psychotics. Each culture thus provides a repertoire of symbols and imagery in which mental illness can be articulated – even at the 'uncontrolled abnormality' end of the spectrum. As with the ritual symbols described in Chapter 9, the symbols in which mental illness is expressed show 'polarisation of meaning'. On the one hand they stand for personal psychological or emotional concerns; on the other they stand for the social and cultural values of the wider society. Where the mentally ill person comes from a cultural or ethnic minority, they often have to utilize the symbols of the dominant majority culture in order to articulate their psychological distress and obtain help.[37] That is, they have to internalize (or appear to internalize) the value system of the dominant culture, and to utilize the vocabulary that goes with these values. This process is illustrated in the following case history.

Case history: 'Beatrice Jackson'

Littlewood[38] describes the case of 'Beatrice Jackson', a 34-year-old widow, daughter of a black Jamaican Baptist minister, who had lived in London for 15 years. She lived alone with her son, and worked at a dress factory far from home. She was often lonely and depressed, and felt guilty about her long estrangement from her father back in the Caribbean. She was very religious and frequently attended church. After her father died she became increasingly guilty, constantly ruminating over her past life. She developed pain in her womb, and persuaded a gynaecologist to do a hysterectomy, so 'clearing all that away'. The pains now shifted to her back, and she continued to ask for further operations to remove the trouble. Her psychotic breakdown was precipitated by her son's criticism of the white police during a riot, which she bitterly contested. The following day she was admitted to a mental hospital, talking incoherently and threatening to kill herself, shouting that her son was not hers because he was black, and that black people were ugly although *she* was not as she was not black. In hospital she became more attached to the white medical and nursing staff, helping them as far as she could and taking their part against the patients in any dispute. By contrast, she kept on getting into arguments with the West Indian staff, refusing to carry out requests for them which she readily agreed to if asked by a white nurse.

Closer analysis of the case revealed that she saw the world literally in black and white terms. According to Littlewood, she had internalized the dominant racialist symbolism of both colonial

Jamaica and of the England she had encountered, where 'black' represented badness, 'sin, sexual indulgence and dirt'. In her religion, black also represented hatred, evil (evil people were 'black-hearted'), devils, darkness and mourning. By contrast, 'white' was associated with 'religion, purity and renunciation'; it also stood for purity and joy, and both brides and angels are dressed in white. In the Caribbean, popular magazines often advertise 'skin lightening creams and 'hair straighteners', and a lighter coloured skin is a highly valued social asset. She had internalized this dichotomy, and had hoped to become 'white inside' by strict adherence to religious values, but could not match this by social acceptance from the white world outside. She felt that part of her remained 'black' (and therefore evil, unacceptable) and located the trouble in her sexual organs, blaming these for the carnal feeling which 'is in conflict with that part of her which seems to have managed to become white'. Her son's repudiation of the police, the representatives of white society, seemed to threaten her category system of white = good, black = bad and she could no longer reconcile her inner symbolic system, the outer social reality, and her emotional relationships. Thus 'her system collapses'. In hospital she attempted to restate her value system, identifying once again with the white staff, and blaming her psychotic episode on the machinations of the (black) Devil. Littlewood suggests that at each stage of her life problems, she attempted to adapt to, and make sense of, the outer reality of her life in terms of the black/white symbolic system that she had internalized. Eventually, though, it became increasingly difficult to reconcile external reality with her system of explanations, and a psychotic episode was precipitated.

Somatization

A problem frequently encountered in making psychiatric diagnoses cross-culturally is that of *somatization* (see Chapters 5 and 7), the cultural patterning of psychological disorders into a 'language of distress' of mainly physical symptoms and signs. This has been reported from many cultures world wide,[39] and from lower socio-economic groups in the Western world. It is particularly a feature of the clinical presentation of depression. These depressed patients often complain of a variety of diffuse and often changeable physical symptoms: such as 'tired all the time', headaches, palpitations, weight loss, dizziness, vague aches and pains, and so on. They frequently deny feeling depressed, or having any personal problems.

Hussain and Gomersall,[40] for example, describe how depression among Asian immigrants in the UK often manifests primarily as somatic symptoms, especially generalized weakness, 'bowel consciousness', exaggerated fear of a heart attack, and concern about the health of genital organs, nocturnal emissions, and the loss of semen in urine (known as *dhat* or *jiryan*[41]) – though the presence of these specific symptoms does not, of course, always mean depression.

Kleinman[42] points out how different cultures and social classes pattern unpleasant affects, such as depression, in different ways. For some, somatization represents a culturally specific way of coping with these effects, and functions to 'reduce or entirely block introspection as well as direct expression'. Unpleasant affects are expressed in a non-psychological idiom: 'I've got a pain' instead of 'I feel depressed'. He points out that in the USA this is more common among poorer social classes – blue-collar workers with a high school education or less, and who have more 'traditional' life styles – while *psychologization* (seeing depression as a 'psychological problem') is more common among upper middle-class professionals, and executives with a college or graduate school education.

In many cases, however, the distinction between 'somatization' and 'psychologization' is more theoretical than real. As illustrated in the case history by Ots (below), ostensibly 'somatic' symptoms may actually carry a powerful *emotional* message, clearly understood by both healer and patient. In a study in the UK, Krause *et al.*[43] found that although Punjabi immigrants tended to somatize, they *were* able to articulate their distress in psychological terms, and even where somatic symptoms were present these were considered to express psychological, as well as physical distress. Furthermore, even though 'psychologization' – the use of psychological terms or concepts to describe subjective mental states – is the notional opposite of somatization, it is also often couched in a somatic or non-psychological idiom. In everyday English, for example, emotional distress is often expressed in a somatic idiom: examples of this include: 'broken hearted', 'a pain in the neck', 'full of joy', 'can't stomach something', 'a painful experience', and 'hungry for attention'. In my own study[44] in Massachusetts, USA, patients with psychosomatic disorders often described their emotions and feelings as if they were tangible 'things' that somehow entered them and caused damage to their bodies: 'I tend to hold lots of things inside ... Anger, tension, hostility, any kind of fear – I think of them as being crammed into my colon,' 'I put negative feelings inside myself ... Doctors often say anger gets stored in the colon'. This Western view of certain emotions (especially anti-social ones such as anger, fear, or envy) as 'pathogens' or 'forces' that cause ill-health – and which originate either within the self, or in the outside world – has become increasingly common. In many cases they are believed to somehow 'accumulate' within the individual, causing distress or illness, unless they 'can get it all out'. In its modern form this echoes the remark by Henry Maudsley, the famous nineteenth century anatomist that 'The sorrow that has no vent in tears makes other organs weep'.[45]

In Taiwan, Kleinman[42] describes how somatization is extremely common. He describes how, in both Hokkien and Chinese, the two languages spoken on the island, there is an impoverishment of words referring to psychological states, and often words meaning 'troubled' or 'anxious' express these emotions in terms of bodily organs. Self-scrutiny is not encouraged, and as an American psychiatrist working there he found it 'extremely difficult to elicit personal ideas and feelings' from his Taiwanese patients. This use of somatization as a 'language of distress' expressing a psychological disorder, and the complex interweaving of psychological, physical and social states, is illustrated by two other Chinese examples: one from Hong Kong, the other from the Peoples Republic of China.

Case history: Depression in Hong Kong

Lau *et al.*[46] studied 213 cases of depression (142 females, 71 males), presenting to a private general practice in Hong Kong, in a period of 6 months. The chief complaints that had prompted them to consult their doctor were: epigastric discomfort (18.7 per cent), dizziness (12.2 per cent), headache (9.8 per cent), insomnia (8.4 per cent), general malaise (7.5 per cent), feverishness (4.7 per cent), cough (4.7 per cent), menstrual disturbances (3.3 per cent) and low back pain (3.3 per cent). Somatic symptoms were complained of initially by 96 per cent of the sample. Practically no depressed patient mentioned emotional distress initially as the chief complaint. Many of the sample had pain as the sole or co-existing complaint – 85 per cent in all had pains or aches of some description. Headaches, for example, were present in 85.4 per cent of the sample. The authors warn of the dangers of missing the diagnosis of depression, because of the facade of somatic symptoms.

Case history: Psychosomatic symptoms in Nanjing, Peoples Republic of China

Ots[47] studied 243 patients, many of whom had 'psychosomatic

disorders', attending a traditional Chinese Medicine (TCM) clinic in Nanjing. He points out that in China, as in Taiwan and Hong Kong, the open expression of emotion is not encouraged. Instead, the main 'medical care-seeking behaviour' of people suffering from severe unhappiness or psychosocial stress is the presentation of physical complaints: mostly of the 'liver' and 'heart'.

Unlike Western medicine, TCM is not dualistic, and does not strictly separate emotions and physical functions: both are seen as part of the same phenomenon. That is, 'specific emotional changes and specific somatic dysfunctions are viewed as corresponding with each other and often as identical'. Although TCM ostensibly focuses on the abnormalities of a particular organ – such as those of the 'liver', 'heart' or 'kidney' – these diagnoses must be understood as not referring (in most cases) to an actual physical disease, but to *metaphors* for certain emotional states.

Each diagnosis (such as 'liver disease') is really 'a metaphor whose primary referent is not a particular organ but an emotion diagnosed via the patterns of somatic symptoms'. Thus although TCM emphasizes *physical* symptoms (and treatments) rather than psychological ones, the practitioners are able to 'read' these somatic symptoms as essentially an emotional message – and thus identify the underlying psychological problem.

In the nosology of Traditional Chinese Medicine, 'liver' is a metaphor for anger, 'heart' for anxiety, 'spleen' for depression and 'kidney' for a decline in reproductive powers. In the clinic, about 80 per cent of the liver-related diagnoses given did *not* relate to actual physical diseases of the liver (such as hepatitis), but rather to aspects of *anger*. For example, a diagnosis of 'liver-*yang* flaring up' meant that the individuals were suppressing their anger, and this had affected their body, particularly their liver. If not treated, it might even lead to 'liver attacking spleen' – a disorder of the spleen. In other words, anger turned inwards might eventually cause depression.

Therefore, Ots points out that although traditional Chinese practitioners focus mainly on *somatic* symptoms, they do *not* ignore emotional states, whatever their cause: to them 'emotions are merely understood as pathogenic factors which cause disturbances of the organs and their functions'. Treatment here would consist not of psychotherapy or catharsis (which cultural norms would not permit), but would aim instead 'to harmonize the emotions by harmonizing bodily functions'. In the case of 'liver-anger', it is the liver itself which is treated – usually by a combination of 10–15 herbal medicines.

Ots suggests that Western models of 'psychosomatic disorders' may not be easily applied to China, since the culture there gives both patients and practitioners a different 'body awareness', and the Chinese 'are culturally trained to "listen" with their body' – in a way unfamiliar to Western medicine.

'Cultural somatization'

Somatization often takes the form of vague, generalized symptoms, such as tiredness, weakness, fever, or 'pains everywhere'. However, in some cultural or social groups a special form of somatization takes place: the selection of *one* particular organ as the main focus of all symptoms and anxiety. This phenomenon may be termed *cultural somatization*, and the organ chosen often has a symbolic, or metaphoric significance for the group concerned – such as the 'liver', 'spleen', 'kidney' or 'heart' in Ots's study in China. Other examples include the heart in Iran ('heart distress'), and in the Punjab ('sinking heart'), the liver in France (*crise de foie*), the bowels in the UK[48] (and other countries), and the penis in some Chinese groups (*koro*). In each case, not only do individuals suffer from a particular symptom, but they also become the 'embodiment'[49] of core cultural themes of the society in which they live.

This shared focus on a particular organ or body part must be differentiated from the more personal, idiosyncratic forms of somatization described by Western psychoanalysts. For example, Freud and Breuer's[50] model of 'hysteria' suggested that certain localized physical symptoms (such as pain or paralysis in a limb, or body part) could be the expression of a particular intra-psychic conflict, unique to that individual. In this case, the selected body part had a special, symbolic significance for the person concerned. Researchers on 'psychosomatic' disorders have adopted a similar approach in trying to understand the reasons for 'organ choice' – that is, why one organ in an individual is selected as a 'target organ', while another is not.[50] In many individual cases, though, and irrespective of the cultural context, the choice of 'target organ' is likely to be based on both cultural *and* individual criteria.

Culture-bound psychological disorders

The 'culture-bound disorders' are a group of folk illnesses, each of which is unique to a particular culture or geographical area. Each is a specific cluster of symptoms, signs or behavioural changes recognized by members of those cultural groups, and responded to

in a standardized way (see Chapter 5). They usually have a range of symbolic meanings – moral, social or psychological – for both the victim and for those around him. They often link an individual case of illness with wider concerns, including his relationship with his community, with supernatural forces, and with the natural environment. In many cases they play an important role in expressing – and resolving – both anti-social emotions and social conflicts, in a culturally patterned way. The conditions in this group range from purely behavioural or emotional disorders to those with a large somatic component. Among the dozens that have been described[51] are: *amok*, a spree of sudden violent attacks on people, animals and inanimate objects, which afflicts males in Malaysia; *Hsieh-ping*, a trance state among Chinese, where the patient believes himself possessed by dead relatives or friends whom he had offended; *koro*, a delusion among Chinese males that the penis will retract into the abdomen, and ultimately cause death; *mal ojo* or *evil eye* among Latin Americans (and other groups) where illness is blamed on the 'strong glance' of an envious person; *latah*, a syndrome of hyper-suggestibility and imitative behaviour, found in South East Asia; *voodoo death*, in the Caribbean and elsewhere, where death follows a curse from a powerful sorcerer; *Shinkeishitsu*, a form of anxiety and obsessional neurosis among young Japanese; *windigo*, a compulsive desire to eat human flesh, among the Algonkian-speaking Indians of central and north-eastern Canada; and *susto* (or 'fright'), a belief in 'loss of soul', in most of Latin America.

Culture-bound syndromes are by no means all as 'exotic' as this list suggests. Elsewhere in this book it has been suggested that a number of common behaviours, idioms of distress, perceptions of bodily states and also certain diagnostic categories, can all – in certain contexts – be regarded as Western culture-bound disorders. These include obesity, anorexia nervosa, pre-menstrual syndrome and the Type A coronary-prone behaviour pattern. In a review of this subject, Littlewood and Lipsedge[52] have added to this list a number of other conditions common in the contemporary UK, including: *parasuicide* (an overdose with medically prescribed drugs), *agoraphobia* ('The Housewives' Disease'), *shoplifting* (by well-off, middle-aged women), *exhibitionism* (or 'flashing'), and *domestic sieges* (where a divorced man, denied access to his children, holds the family hostage in their home). In each of these, the authors see certain recurrent patterns of public behaviour, each of which encapsulates some of today's core cultural themes and values. Like the conditions mentioned earlier, they can therefore be regarded as *culture-bound*. Housewives' agoraphobia, for example, can be seen as both a ritual display of – and a protest against – the cultural pressures and injunctions on women, especially those which state that 'a woman's place is in the home'. By 'over-conforming' to this stereotype, the woman is able to dramatize the situation, mobilize a caring family around herself, and at the same time also restrict her husband's movements, by forcing him to stay at home and look after her.

In addition to these specific syndromes, both non-Western and Western, a more diffuse cultural patterning determines the 'language of distress' in which certain types of psychological or social disorder are expressed in each society. In these cases, the mode of *presentation* is culture-bound, though not the exact pattern of symptomatology. Examples of this, quoted above, are the somatic presentation of depression among Chinese in Taiwan, Hong Kong and the Peoples Republic of China, Asian immigrants in the UK, and working-class Americans.

It could be argued that *all* syndromes – whether physical, psychological or social – are to some extent 'culture-bound'. That is, there is always some unique, local cultural perspective on the condition, even if it is a standard biomedical 'disease'. However, with their dramatic changes in behaviour and mental state, absence of clear physical changes and many symbolic meanings attached to them, the conditions mentioned above *do* constitute a specific class of phenomena of great interest to medical anthropologists.

In the following case histories, an example of a well-known, and widely spread culture-bound disorder from Latin America is described, as well as another syndrome afflicting some Latino immigrants to the USA.

Case history: Susto *in Latin America*

Rubel[16] has described the characteristics of *susto* (or 'magical fright'), which is also known as *pasmo, jani, espanto, pédida de la sombra*. It is found throughout Latin America, in both rural and urban areas, among both men and women, and among both Indians and non-Indians. It is also found among Hispanic Americans, especially those in California, Colorado, New Mexico and Texas. It is based on the belief that an individual is composed of a physical body and of one or more immaterial souls or spirits which, under some circumstances, may become detached from the body and wander freely. This may occur during sleep or dreaming, or as the consequence of an unsettling experience. Among Indians it is believed to be caused by the soul being 'captured' because

wittingly or not the patient disturbed the spirit guardians of the earth, rivers, ponds, forests or animals. The soul is believed to be held captive, 'until the affront has been expiated'. Among non-Indians this 'soul loss' is usually blamed on a sudden fright or unnerving experience. Its clinical picture consists of:

1. Becoming restless during sleep.
2. During waking hours the patient complains of depression, listlessness, loss of appetite, and lack of interest in dress and personal hygiene.

The healing rites, carried out usually by a folk healer or *curandero*, consist of an initial diagnostic session where the cause of the specific episode is identified and agreed, and then a healing session whereby the soul is 'coaxed and entreated to rejoin the patient's body'. The patient is massaged, rubbed and sweated to remove the illness from the body and to encourage the soul to return. Rubel relates the incidence of the condition to a number of epidemiological factors (see Chapter 12), including stressful social situations, especially where the individual cannot meet the social expectations of his own family and cultural milieu.

Case history: Ataques de nervios *among Latinos in the USA*

De La Cancela *et al.*[53] have described *ataques de nervios* ('attacks of nerves') among Puerto Ricans and other Latino immigrants in the USA. These attacks are a specific and 'culturally meaningful way to express powerful emotion'. They usually have an acute onset, with a variety of physical symptoms including: shaking, feelings of heat or pressure in the chest, difficulty in moving limbs, numbness or tingling of hands or face, a feeling of the mind 'going blank', and sometimes a loss of consciousness, or abusive behaviour. These acute episodes usually follow the gradual build-up of *nervios* ('nerves'), from the general problems of one's life, especially with family relationships, housing or money. An 'attack' is then usually precipitated by some specific stressful event. The authors point out that for most Latinos it is not seen as an 'illness' needing medical attention, but rather as an expression of upset, anger, frustration or sadness at the stressful event – as well as a temporary escape from it, and a way of getting sympathy and help from other people. However, they suggest that one cannot only understand this disorder at the micro-level. One needs also to examine the social, political and economic status of Latinos in the USA, and 'the sense of hopelessness, helpless, and lack of control' many of them experience. Stressful experiences in the countries of origin (especially in Central America), coupled with the effects of migration – such as the disruption of family life, unemployment, discrimination, over-crowded housing and changes in gender roles – are all part of this wider context. Added to the sense of social and political helplessness, are the constant 'demands to submerge cultural identity and assimilate to the United States culture', and the lack of respect accorded to their cultures of origin. The authors suggest, therefore, that as well as treating individuals with this condition, and their families, attention must also be paid to wider socio-economic realities, because 'in the long run *ataques* may be more effectively dealt with in the sociopolitical arena'. Therefore health providers 'need to engage in social action and advocacy focusing on the social problems and material conditions that give rise to *ataques de nervios*'.

As the examples above illustrate, culture-bound disorders can only be fully understood by looking at the wider *context* in which they appear. In some cases, this context may include many of the political, economic and social issues of the wider society.

Cultural and symbolic healing of psychological disorders

In many non-Western societies, particularly in rural or small-scale communities, mental illness is often considered to be more of a *social* event, one which intimately involves the patient's family, friends and community. In many cases, both mental and physical ill-health are interpreted as indicating conflicts or tensions in the social fabric. Kleinman[54] uses the terms *cultural healing* when healing rituals attempt to repair these social tears, and 'reassert threatened values and arbitrate social tensions'. Healing takes place at many levels: not only is the patient restored to health but so is the community in which he or she lives. The aim of the healer – like the Ndembu *chimbuki* described in Chapter 9 – is to resolve the conflicts causing the patient's illness, restore group cohesion and integrate the patient back into normal society. Unlike in the Western world, emotional disorders are often seen as *useful* to the community. For example, Waxler[15] notes how in many small-scale societies mental illness can be useful, even necessary: it incurs obligations between people (such as the obligations of family, friends and neighbours to attend and pay for a public healing ritual), and this has an *integrating* function – strengthening the ties

within and between groups. In these societies, few other specialized institutions (such as a centralized legal, political and bureaucratic organizaion) exist to promote integration, and deviance – such as mental illness – can play this role. This usually occurs within a shared cognitive system, where everyone shares similar views of the aetiology of misfortune and ill-health. If mental illness in one individual is ascribed to sorcery or witchcraft from someone in another group (family, clan or tribe), the offender's group have incurred obligations to the victim's group, which must be repaid in a public ceremony. This helps recreate the ties between groups, and also reasserts the boundaries between them, and in the process, the mentally ill person is reintegrated into society. According to Waxler, this process, and the key role of the family in caring for the patient, means that in traditional, non-Western societies mental illness seems to be more easily cured, and much more short-lived. She contrasts this with the West, where psychiatric treatment does not have this integrating function (which is fulfilled by the political, bureaucratic system and so on), and mental illness serves to *alienate* the sick individual even further from society. It establishes boundaries around the patient, and does not create or re-establish social ties between kin and other groups (except perhaps within the nuclear family), or make clear the boundaries between groups. The Western schizophrenic is assumed to have a chronic, relapsing disease process which may always recur – and is 'a schizophrenic in remission', rather than 'a person who had schizophrenia'. She therefore relates this lack of an integrating function with the long illness careers, and poor prognosis, of Western psychotics.

However, Kleinman[54] points out that 'cultural healing' may heal social stresses 'independently of the effects they have on the sick person who provides the occasion for their use'. In some cultures, the resolution of social conflicts may not be as beneficial to the mentally ill patient as Waxler suggests; it may involve imprisoning, killing or driving him from the community. For example, in the past those 'possessed' by evil spirits in the New Hebrides and Fiji were routinely buried alive. However, in many non-industrialized societies, the mentally ill are usually well cared for within their families or communities.

In more traditional societies, mental illness is usually dealt with by folk healers, such as the *tang-ki* in Taiwan, the Ndembu *chimbuki*, the Latin American *curandero*, the Moroccan *fqih* or the Zulu *isangoma*. Some of the practices and psychotherapeutic functions of these ritual healers have already been described. Perhaps the most famous is the *shaman*, who appears in many different cultures, from Alaska to Africa, and whose Western

equivalents are 'mediums', 'clairvoyants' and 'channellers'. Like the mentally-ill person who is 'possessed' by spirits, the shaman also allows himself to become temporarily possessed by certain spirits. Lewis[55] points out that, by contrast with the patient, his possession is 'controlled' during the healing seance and thus occurs when and where he chooses. in this condition of 'controlled abnormality' the fact that he is able to master or neutralize the spirits is of great reassurance to the community. He is also able to identify, and exorcise, malign spirits possessing the ill person, and in the process alleviate anxiety, fears, guilts and conflicts. Murphy[56] has described some of the psychotherapeutic aspects of shamanism, as part of his ritual of 'cultural healing'. These include: working within the shared beliefs of the group, and thus reinforcing them; involving the individual as well as the community in the ritual, during which time the patient remains surrounded by familiar friends and relatives; by becoming 'possessed' he illustrates his mastery over the other spirits causing ill-health. In his seance, he identifies the cause of mental illness (such as breach of a taboo) and prescribes the appropriate expiatory acts, which are believed to effect the cure, and then demonstrates that the patient has indeed recovered. That is, 'through suggestion and the patient's personal involvement in the cure, these visible acts further promote in the patient a psychological realization that he is returning to a state of health'. According to Lewis, by the wide role that he plays in the religious and social life of his community, 'the shaman is not less than a psychiatrist, he is more'.

Symbolic healing

'Cultural healing' – with its focus mainly on the social dimensions of healing – is really only a special form of what anthropologists have called *symbolic healing:* that is, healing that does not rely on any physical or pharmacological treatments for its efficacy, but rather on language, ritual and the manipulation of powerful cultural symbols. As well as the more traditional folk or religious healing described above, it also includes the various types of 'talk therapy' common in the West – such as psychoanalysis, psychotherapy and counselling.

This section examines a number of key questions, raised by symbolic healing. How does it work? What are its effects on mental illness? Does it have common features, in whatever society it occurs?

In understanding this phenomenon, much of the previous discussions of the placebo effect (Chapter 8), ritual healing

(Chapter 9), folk healers (Chapter 4), illness narratives (Chapter 5) and even the 'total drug effect' (Chapter 8) are all relevant. In addition, the innovative work of Dow,[57] Kleinman,[58] Csordas,[59] and others are particularly useful in helping to identify certain basic themes that seem to underlie virtually *all* forms of symbolic healing – whether sacred or secular, and wherever they occur.

Before this type of healing can take place – involving a particular healer, client and community – a number of conditions must be fulfilled. These apply both to secular healing such as the Western 'talk therapies', and to the more religious forms of healing.

1. The healer must have a coherent system of explanation, or frame of reference, for the origin, and nature, of the problem, and how it can be dealt with. Dow[57] calls this the *mythic world* – 'a model of experiential reality', whose elements 'represent solutions to personal human problems', and which is composed of culturally specific beliefs, metaphors and idioms. It may consist, for example, of a belief that malign 'spirits' (or 'intra-psychic conflicts') are responsible for all mental illness and extreme emotional states. In many cases – especially in small-scale societies – the mythic world is common to most members of the group: but it may also be created *de novo* by some charismatic healer or cult leader, or be shared by only a tiny group of adherents – as in the new cults, religions, life styles, 'talk therapies' and healing systems that are now proliferating in Europe and the USA.[60] The mythic world may exist only in an oral form, or be standardized in certain texts (or textbooks). It may take many forms, sacred or secular: for example, as a religious cosmology (Ayurveda), a folk tradition (spirit possession), a theory of personality (Freudian psychoanalysis), or a scientific model of the body (biomedicine).

2. The mythic world must include what Kleinman[58] describes as a *symbolic bridge* between personal experience, social relations, and cultural meanings'. That is, suffering individuals in that society must be able to understand their own situation, and its resolution, in terms of its imagery and symbols (such as 'spirit possession', or 'intra-psychic conflict'). In many cases, these symbols are already familiar to these individuals, since as Finkler[61] puts it, they 'emerge from the depths of their cultural experience and ... reach the bearers of that culture at the most profound levels of their existence'. They represent 'the deep cultural grammar governing how the person orients himself to the world around him and to his inner world',[61] and serve to link the individual to the social world, and often to the supernatural world as well.

3. When a suffering individual consults a healer, the healer aims

to activate this 'symbolic bridge', by *convincing* the clients (if they require convincing) that their own particular problem *is* explicable in terms of the symbols of the mythic world. That is, the patients have to be persuaded that their suffering can be re-defined, or 're-framed' as, for example, evidence of 'spirit possession', 'neurosis', or 'evil eye affliction'. Thus the healer's aim at this stage is to get 'the patient to accept a particularization of the general mythic world as a valid model of the patient's experiences'[57] – and to achieve this they may use many different theatrical, or rhetorical techniques.

4. Once patient and healer have reached this consensus, the healer needs to get the patient *emotionally* – as well as intellectually – 'attached' to the symbols of their mythic world. That is, before therapeutic change can take place, patients must first become more self-aware, must feel emotionally involved in the healing process, and must see these symbols (whether they are 'spirits' or 'intra-psychic conflicts') as relating to them personally, and to their situation. This is done, for example, by interpreting a patient's excess rage as evidence of 'possession' by an angry, evil spirit, or of severe inner 'conflicts' dating from childhood, or by interpreting feelings of depression as being due to 'soul loss' (as in *susto*). In each case, the aim is not only to relate the patients' emotions (including their hopes and fears) to the symbols of the healer's mythic world, but also to link the individual patients thereby to wider social, cultural and cosmological concerns.

5. The healer now begins to guide *therapeutic change* by manipulating the symbols of their mythic world. For example, having identified the 'spirit' possessing the patient, he goes through a complex ritual of exorcism – at the end of which the anxious patients are reassured that the 'spirit' has left them, and they can now resume their normal life. Or, they may be re-assured by a psychotherapist that they have at last 'worked through' certain archaic, inner conflicts. Or, as in the case of *susto*, they may be told after a ritual that their soul has, at last, been safely returned to their body. In each case, Kleinman[58] points out that the 'healing, as a sacred or secular ritual, achieves its efficacy through the transformation of experience'. The patients learn to re-evaluate, and 're-frame' their past and present experiences. Furthermore, Kleinman[58] sees this process, and the symbols used within it, as a way of linking the patient's 'self' (both psychological and physical) to the social relations and cultural concerns of the wider society. Thus a successful transformation will affect not only their emotional state, but also their physiology, their relationships with other people, and their relationship to the culture at large. In many

cases, the symbols that achieve this are not only the conceptual symbols of the mythic world, but also the more tangible 'ritual symbols' described in Chapter 9.

6. The 'healed' patients have acquired a new way of conceptualizing their experiences in symbolic terms, and a new way of functioning – both of them confirmed by the healer. In the process, they have also acquired a newly fashioned *narrative* of their past and present, and their likely future. Whether this narrative is short (as in spirit exorcisms) or lengthy (as in psychoanalysis) it summarizes *post hoc* what had happened to them, and why, and how the healer was able to restore them to happiness or health.

Symbolic healing thus often takes place at many levels simultaneously: psychological, physical, social and cultural. As with the placebo effect, the exact mechanisms of its effects on physiology (for example, relieving muscular tension, reducing pain sensation, or lowering blood pressure) are not clearly understood; nor whether they are mediated by the autonomic nervous system, the endocrine system, the immune system or the neuropeptide (endorphin) system.

Secular symbolic healing: the 'talk therapies'

In the Western world most forms of 'talk therapy', with the exception of family therapy, focus mainly on the individual patient – as do many of the alternative/complementary therapies described in Chapter 4. Whatever their ideology, the majority of 'talk therapists' will see their individual clients as the main 'problem', and their emotional state, behaviour, insights and delusions as the main areas of concern. Most of their treatments will take place in specialized settings, such as a psychotherapist's office, far removed from their social milieu, and characterized by both privacy and confidentiality. Where patient and therapist come from similar backgrounds, they may share many assumptions about the likely origin, nature and treatment of psychological disorders. However, the proliferation of new 'talk therapies' has meant that, in many cases, the patients may have to *learn* this world view gradually, acquiring with each session a further understanding of the concepts, symbols and vocabulary that comprise it. This can be seen as a form of 'acculturation', whereby they acquire a new mythic world couched, for example, in terms of the Freudian, Jungian, Kleinian or Laingian models. This mythic world, shared eventually by patient and therapist, is often inaccessible to the patient's family or community, who in any case are excluded from the consultation.

Psychoanalysis

Psychoanalysis is a special and influential form of symbolic healing, found almost exclusively in the Western world, and providing the basis for many of the other 'talk therapies'. To Dow,[57] it is 'probably the most significant psychotherapy in Western culture'. Stein[62] has argued further that its concepts provide a useful way of understanding the universal characteristics of the human condition, whatever the cultural or social context. As a form of therapy, though, it has specific features very different from most forms of 'cultural healing'. Its focus is only on the individual, irrespective of home environment and socio-cultural background, and healing sessions involve only a solitary analyst and a solitary client. The sessions take place in a specified place (the analyst's office), and at a specified time, and in most cases they last exactly 50 minutes. Lying on a couch in this office – with the analyst out of sight, sitting silently behind them – the clients are encouraged to 'free associate', to 'say anything that comes into your head'. As a form of healing, its emphasis is on phenomena believed to originate *within* the individual psyche as they emerge during the analytic session – especially the meanings given by the client to their past experiences. In the session, as Dow[57] puts it, 'transactional symbols are developed by the analyst from the content of the mythic world constructed by the patient', and these will form the basis of the therapeutic stages outlined above. Above all, psychoanalysis' emphasis is on the treatment of the individual, rather than of the social domain. As one analyst[63] puts it 'the wish for further insight in order to discover the unconscious meaning of unsatisfactory life situations or incomprehensible symptoms implies acceptance of the fact that ultimately the causes of psychological symptoms *lie within oneself*.'

Anthropologists have argued that, whatever the reasons for its efficacy, the practice of psychoanalysis can also be understood as the expression of certain core Western cultural values[64] – especially those of the educated middle-classes. One could include here the emphasis on self-awareness, insight, 'personal growth', individualism, privacy and confidentiality; the high value placed on language, and the ability to verbalize one's distress; and the location of 'conflicts' (especially sexual ones) deep within the psyche, rather than in the social world outside. Its metaphors of the psyche are often spatial (as well as dualistic): an 'inner' psyche, hidden within an 'outer' body, and the consequent need for 'insight'. Its view of time is, to some extent, paradoxical: on the one hand, a rigid adherence to Western 'clock time', enforcing the 50-minute consultation, on the other hand, an open-ended period of

therapy, sometimes lasting for many years. As in some other forms of symbolic healing, analyst and client share in the creation of a personalized *narrative* of misfortune, and one embellished and re-fashioned over many years.

By contrast, more traditional forms of symbolic healing tend to be less structured, last a shorter time, take place in the presence of other people, and be linked more to the social or supernatural aspects of daily life. They do not seek 'insight' from the patient, or aim at their 'individuation' or 'personal growth'. These differences, as Kleinman[65] points out, 'illumine the radical differences between egocentric Western culture and sociocentric non-Western cultures, and disclose that culture exerts a powerful effect on care'.

The setting of symbolic healing

Symbolic healing usually takes place at specified times, and in specified places. As described in Chapter 9, the *setting* itself plays a crucial role in the healing process; setting the stage, creating a mood of expectation, and giving information to the clients about the healers – especially their interests, background, the source of their power and what they believe in. For example, patients entering Sigmund Freud's consulting rooms in Vienna or London, would find the desk and shelves filled with artifacts from ancient Greece, Rome and Egypt, reflecting his interest in his clients' early, hidden childhood experiences, and his remark that the analyst's work 'resembles to a great extent an archaeologist's excavation of some dwelling-place that has been destroyed and buried'.[66]

In religious healing, the setting may be a church, a temple, a shrine, a tomb, the home of a religious leader, or a sacred place of pilgrimage. For example, El-Islam[67] describes how, in many Arab countries, the families of people with severe mental problems (frequently blamed on 'evil eye', sorcery or possession by *jinns*) often turn first to forms of ritual healing. These may include visits to the tombs of famous *sheikhs*, consultations with a respected *sheikh* or master (*Al-Asyaad*), the use of amulets containing holy verses, and purification rituals (*Mahuw* or *Mahaya*) – which involve drinking or washing in water that has been washed off Koranic verses, written on a plate.

Whether symbolic healing is sacred or secular, the setting in which it occurs – and the ritual symbols used within it – are both crucial parts of the healing process; playing an essential, though non-verbal, role in the creation of the mythic world, in terms of which healing will take place.

The efficacy of symbolic healing

It is difficult to evaluate the efficacy of different forms of symbolic healing, since definitions of therapeutic success vary among them. Some seem to relieve one type of psychological distress, but not another. For example, in a detailed study of healing in a spiritualist temple in rural Mexico, Finkler[68] found that it was ineffective for the psychoses, but useful for 'neurotic disorders, psychophysiological problems and somatized syndromes'. It enabled patients to abandon their sick roles, return to normal behaviour, and eliminate the feeling of 'being sick'. Similarly, in a study of therapeutic outcomes from a Taiwanese healer or *tang-ki*, Kleinman[69] found that symbolic healing was mainly effective for episodes of neurosis and somatization, and its value more in healing the 'illness' than in curing the 'disease'. It was effective in fitting the illness episode into a wider context – explaining it in familiar terms, mobilizing social support about the victim, and reaffirming basic values and group cohesion – thus reducing anxiety in both the victims and their families. Most anthropologists agree therefore that – for whatever reason – many people *are* helped by symbolic healing, whether religious or secular.[58]

'Healing', however, is not identical to 'curing', especially in the case of severe psychosis, or physical disability. Individuals, and their families, may feel that they have been 'healed', even though they have not yet been 'cured' in conventional psychiatric or medical terms. This distinction is clearer in some forms of religious healing, such as 'faith healing'. As Csordas[70] points out, there are crucial differences between secular healing (with its mind–body dualism), such as medicine or psychotherapy, and religious healing (with its tripartite division of mind–body–spirit). In his study of Catholic Charismatic healing in the USA,[71] he describes their four distinct types of healing: *physical healing* of bodily illness, *inner healing* of emotional scars or mental illness, *deliverance* from the adverse effects of demons or evil spirits, and *spiritual healing* of the soul injured by sin – primarily by means of the Sacrament of Reconciliation (confession). Even if the first three fail, in a particular case, and the person remains mentally or physically ill, spiritual healing is still possible – as what Csordas calls 'a hedge against the failure of healing prayer'.

It should be pointed out that, as described in previous chapters, *all* forms of healing, including medical and surgical treatments[72] have some symbolic component to them. Both Western medicine and psychiatry are symbolic systems, as well as technical ones. With the gradual diffusion of their concepts and techniques world wide, there is an increasing likelihood of complex interactions, or

conflicts, between the different 'mythic worlds' of traditional and psychiatric approaches to mental illness, as illustrated in the following case histories.

Case history: A case of 'fox possession' in Sapporo, Japan

Etsuko[73] describes the case of Michiko, a 43-year-old single woman complaining of possession by a fox spirit (*kitsune-tsuki*), a common idiom of mental disorder in Japan. Her illness began after her parents died, when she became distressed and 'strange voices and noises came to my ears. I felt very uneasy.' She was seen by psychiatrists but 'the medicine was no help, but it's natural that spirits can't be cured by medicine. And doctors would never understand spirit possession'. To get relief, and an explanation for her symptoms, she consulted in turn seven different shamans. At the seventh one, a shaman of the Shugendo sect of Buddhism, a series of seances confirmed that she was possessed by an evil fox spirit, because – among other reasons – she and her ancestors had killed many foxes in their previous lives. After several rituals, Michiko claimed that the fox spirit had told her important facts: in particular, that she was really of noble birth, and that her misfortune was not her fault, but the result of her being born under an unlucky star. Gradually, the fox evolved from a possessing spirit, to be her personal deity; at the same time, she became transformed from being a client, into being a shaman in her own right. Her psychological state improved markedly, as 'the illness of possession was replaced by a shamanistic ability brought about by her steady effort in religious practice'. At the same time as this improvement was taking place, the psychiatrists judged her condition to have deteriorated, to have gone from 'auditory hallucinations' and 'possession state', to 'delusional perceptions', 'grandiose beliefs' and signs of 'chronic schizophrenia'. This case illustrates, therefore, the discrepancy between being 'healed' and being 'cured' – at least from a psychiatric perspective.

Case history: Psychiatric and religious healing in Jerusalem, Israel

Bilu *et al.*[74] describe how secular (psychotherapy) and sacred (Jewish mysticism) forms of healing can intersect in a medical milieu in Jerusalem, Israel. By using hypnosis, 'guided imagery' and conventional psychotherapy the therapists were able to treat Avraham, a religious psychotic patient, by working *within* his own 'mythic world', and its complex metaphors and symbolism – drawn largely from Jewish mysticism. By encouraging him, under hypnosis, to confront the black 'demon' that was persecuting him, and chase it away ('Go, go, go away because you do not belong to our world!'), they were able to greatly improve his emotional state and social functioning. During the therapy sessions Avraham was symbolically led through a desert, until finally he found peace in a quiet green oasis – a manifestation of Paradise, and the Garden of Eden – filled with 'pure springs, sweet odors, beautiful gardens, and particularly pious inhabitants'. His personal cure was thus linked to the wider cultural themes of Exodus and redemption in Jewish tradition and theology, already familiar to the patient.

Case history: Spiritist healing in Porto Alegre, Brazil

Greenfield[75] examines the healing practices of a new syncretic religion, a Spiritist group known as *Casa do Jardim*, in Porto Alegre, southern Brazil. Its imagery is an unusual fusion of Afro-Brazilian folk religion, and ideas drawn from medical science: several of its healers are themselves physicians. They believe in two parallel worlds – one material, the other spiritual – with communication possible between the two. Each human being has a spirit, as well as a body, and under some circumstances that spirit can also get ill. In that case, the healers will 'uncouple' it from the body, and send if off to the spirit or astral world, where teams of 'spirit doctors' will diagnose and treat it in a 'spirit hospital' called the *Amor e Caridade* – before returning it, healed, to its body. Mental illness is believed to be due to disincarnate evil spirits from the astral plane imposing themselves on the living. Its treatment is by 'disobsession' – the healer 'incarnating' the offending spirit, lecturing it on the error of its ways, and then sending it back to the astral plane. Like other healing groups, the *Casa do Jardim* provides social support, practical help and psychotherapy, especially for 'unaffiliated individuals who face the increasing uncertainty and insecurity of life in disorganized, anomic, urban Brazil'.

Anthropology and family therapy

Anthropology is essentially the study of groups, rather than of individuals, though sometimes individuals are studied within the context of certain groups. In all human societies, the primary social group is always the *family*. The composition of the family varies greatly between cultures, as does the role that it plays in the lives of

its members. Outside the urban areas of the industrialized world, where the nuclear family (a couple and their children) is often the norm, the extended multi-generational family (usually a couple, together with one or more married children, and their children and spouses) is one of the commonest kinship patterns found world wide. In poorer parts of the world, this larger family unit, though linked to the wider society, often acts as a miniature and self-contained community, or self-help group, whose members share many of their resources, and many of the tasks and responsibilities of everyday life. In whatever form it takes, and in whatever culture it appears, the family is always a *social*, as well as a biological unit, and it always includes members who are not biologically related to it. As well as marriage partners and their families of origin, it may also include honorary relatives or 'fictive kin', such as close friends or neighbours, or even health professionals.

In recent years there has been an increasing overlap in interest between medical anthropologists, family therapists and some psychiatrists. All three are interested in widening the definition of 'patient' beyond the individual, to include their family – and where relevant, their community as well. For many clinicians, like some of the folk healers described in Chapter 4, the family – and not the individual – has become the main focus for both diagnosis and treatment.

One obvious problem is that the definition of 'family' is not universal. There is wide cross-cultural variation in patterns of kinship, and anthropologists have described many different types of family structure. Children in different parts of the world may be the result of different forms of marriage: monogamy (one wife, one husband), polygyny (one husband, several wives), or – more rarely – polyandry (one wife, several husbands).[76] As well as extended families and nuclear families, there are joint families (a household composed of married siblings, spouses and children), and one-parent families (usually mother and child). In recent years, a number of new types of family structure have also appeared, especially in Western countries. These include adoptive or fostering families, childless marriages by choice, communes (organized like large extended families), lesbian and gay couples, and the complex combinations of step-children, step-parents and in-laws that have resulted from high rates of divorce and re-marriage.

However constituted, it is useful to view the family as a small-scale society, or even as a small 'tribe', with its own distinctive organization and 'culture'. In many ways, what one may term this *family culture*[77] is very similar to that of the wider society, but it also has certain unique and distinctive features of its own. As

described at the beginning of this book, a culture includes a set of implicit and explicit guidelines telling one how to view the world, how to experience it emotionally and how to behave in it – especially in relation to other people, to the natural world and to supernatural entities or gods. Families, like larger cultural groups, also have their own particular view of the world, their own codes of behaviour, their own gender roles, their own concepts of time and space, their own private slang and language, their own history and their own myths and rituals. They also have ways of communicating psychological distress to one another, and to the outside world.

This 'family culture' can be either protective or pathogenic to health, depending on the context. For example, certain types of family structure may contribute to the development of alcohol abuse among their children later in life (see Chapter 8), while others may protect against this.

The family can also be seen as a 'system', in which the pattern of inter-relationships can have important influences on both health and disease.[78] This 'systems theory' or cybernetic model suggests that family dynamics are often aimed at maintaining a state of equilibrium between these various relationships, even at the cost of psychologically 'scapegoating' one of its members. For example, Minuchin *et al.*[79] have shown how certain types of family structure are more likely to cause psychosomatic disorders – such as anorexia nervosa – in some of its members. These 'psychosomatic families' maintain their cohesion, continuity and sense of equilibrium, not only by producing this disorder in one of its members, but also by helping to maintain it. The recovery of the 'identified patient' (in this case, the anorexic young girl) may well cause the break-up of such a pathological family. In this case, as in others, focusing only on the individual, and not their family, makes a fuller understanding of the problem difficult to achieve.

Byng-Hall[80] has described the concept of *family script*, which is transmitted from generation to generation. These 'scripts' are ways of behaving, of viewing the world, and of reacting emotionally to it. As with culture in general, most of these scripts are outside of conscious awareness. Their role is to provide a sense of stability and continuity, and a set of guidelines for performing the daily 'drama' of a family's life. They often function to avoid potentially dangerous conflicts within the family. Each generation of the family knows its allocated role within this continuing drama, and sometimes this role may determine when, and how they get ill, or even die. The script may also influence the clustering of certain symptoms within a particular family, and how these symptoms are passed on from parents to children.[81] Family scripts can be

maintained by the family's own myths and folklore, which are passed on from generation to generation; in some cases, these myths may have originated centuries before the birth of its present members.[80] Many years later, these family myths may still be exerting a negative effect on both the mental and physical health of its members.

The relation of *culture* to family dynamics is complex, and to some extent controversial. McGoldrick *et al.*[82] have provided a comprehensive selection of mini-ethnographies of the family cultures of different ethnic groups in the USA – such as 'the Irish family', 'the Italian family', 'and the British American family' – and the problems that family therapists face when dealing with each of them. Although it is certainly possible, and useful, to make some generalizations about, say, Italian families, and the cultural themes they have in common, the danger of stereotyping *all* Italian families – mentioned in Chapter 1 – still applies. Furthermore, listing the supposed cultural traits of families from different ethnic groups often ignores major differences *between* families (based on region, economic position, social class, education etc.) even if they come from the same ethnic group. Maranhao,[83] in his critique of McGoldrick's book, has also argued that 'family oriented ethnic groups' are sometimes described in it as if their differences from the Anglo-Saxon family type (with its emphasis on individual, rather than family goals), were pathological by definition. Overall, in his view, knowledge of the cultural background of a family is useful, but not essential for therapy to take place – 'the interviewer does not have to know anthropology, but just be a sensitive family therapist'.

DiNicola[84] has suggested two alternative ways of describing the relationship between a family's mental health, and its culture of origin. *Cultural costume* is 'the particular set of recipes the individuals or families of a community have to give meaning and shape to their experiences and to communicate these experiences through shared ceremonies, rituals and symbols'. It is therefore the repertoire of cultural beliefs and behaviours of which each 'family culture' is a particular (and sometimes unique) expression. The cultural costume becomes *cultural camouflage* 'when culture is invoked as a smokescreen to obscure individual states of mind or patterns of interaction in the family'. That is, the family claims that pathological behaviour patterns within it are only normal expressions of its 'cultural background'. DiNicola quotes, as examples of this: 'My husband drinks very hard, he's Irish,' or 'My son had a breakdown because he stopped going to the Orthodox church and lost the Greek way.'

Lau,[85] like Maranhao, points out how West European or North American family therapists may misdiagnose family patterns from other cultures as 'pathological' or 'deviant'. This is especially likely where the family structure is less familiar to them, as in one-parent families (among some West Indians), or in multi-generational extended families (among Asians, Chinese and Greek Cypriots) who are living in the same household. She points out that in many cultures outside the Western world 'breaks are not expected between the generations and continuity in the group depends on the presence of three generations'. Notions of individual autonomy and differentiation therefore have a different meaning in these groups, from the Western nuclear family model. In dealing with the families from ethnic minorities, Barot[86] has further suggested that a focus on their culture may be insufficient, for one also requires a wider analysis of the institutional and structural factors, such as unemployment, racial discrimination, poor housing, inadequate social and health care facilities and the effects of migration, which may also adversely affect their lives. Furthermore, these external factors may act to weaken the traditional culture and cohesion of those families, so that 'culture' is no longer a viable explanation for many of the pathological breakdowns in family life.

From an international perspective, several detailed studies have shown fundamental variations in family culture between different parts of the world: though, as noted above, these broad generalizations do not take into account variations *within* each country or community. Tamura and Lau,[87] for example, have contrasted Japanese and Western (particularly British) family structures. In Japan, the culture stresses the *interconnectedness* of relationships, especially within the family. A high value is placed on the unity and well-being of the group, and the 'family self' – the 'basic, inner psychological organization' of the Japanese – 'involves intensely emotional intimacy relationships, high levels of receptivity to others, strong identification with the reputation and honour of the family and others'. The individual is thus seen as part of a 'web of interconnectedness', rather than as merely a 'skin-encapsulated ego'. The core of a Japanese family is the mother–child dyad, rather than the husband–wife dyad in the West; because children are firmly in the woman's domain, many Japanese men may be reluctant to accompany their wives to a therapist, if their children have problems.

By contrast, family structure in the UK (and the USA) stresses the *separateness* of individuals – their degree of autonomy, and individuation from one another – rather than their interconnectedness. Westerners are expected to see themselves as autonomous,

independent, individual units, with sharp boundaries between themselves and others. Human growth and emotional development in the family life-cycle is seen as a process of individuation: while in Japan it involves the transition from one form of integration to another. Tamura and Lau thus warn against imposing the Western notion of 'hyperindividualism' on Japanese families, or to misinterpret connectedness as 'enmeshment' or inadequate individuation. Japanese therapists tend to see family problems as resulting from *too little* connectedness, rather than too much, and therefore aim to strengthen integration of the family unit, rather than to fragment it. In carrying this out, their clients expect them to be authoritative, directive and also 'connected' – almost as if they were a senior family member. Finally, Japanese families may avoid seeing a therapist because of feelings of shame and guilt for their inability to deal with the problem within the privacy of the family, and thus having to reveal it to outsiders.

In India, Shankar and Menon[88] stress that the traditional extended or joint family is a key resource in the care of people with serious mental illness, such as schizophrenia. Given the widespread poverty and unemployment – as well as the paucity of psychiatric hospitals, trained mental health professionals, and social welfare benefits – therapists planning interventions with families of schizophrenics therefore 'need to take into account the complex matrix of social, economic, cultural, and infrastructural factors that exist in the country'. Thus the majority of the seriously mentally ill are managed by their families, who represent 'the cornerstone of client care in the community'. Because these families (unlike many of their Western equivalents) 'have at no time received the label of being etiological agents of the illness', they do not feel any sense of guilt if asked to participate in their relative's therapeutic programme. In dealing with Indian schizophrenics, Shankar and Menon therefore suggest that no attempt should be made to blame the family for either causing the illness, or for any relapses. Instead, they should be treated as an ally in treatment, not as a potential enemy. The therapist should be sensitive to their needs, as well as those of their ill relative, and should aim to strengthen their positive role in the care of the patient. They should be given ample information on schizophrenia, and encouraged to supervise the patient's medication, and to identify any early signs of relapse.

El-Islam[67] has listed 'certain widely shared features of general relevance to psychiatry' in the Arab world, while also emphasizing the enormous cultural diversity within those communities. He describes the strong extended family structure which favours

'affiliative behaviour' at the expense of 'differentiating behaviour': that is, 'traditional child rearing instils behaviour oriented towards accommodation, conformity, cooperation, affection, and interdependence rather that behaviour oriented towards individuation, intellectualisation, independence and compartmentalisation'. Also, in more traditional communities, women 'are at a socio-cultural disadvantage in relation to men': polygyny is still practised, arranged marriages are common, and divorce is more easily obtained by men than by women. In this setting, conflicts may arise between older family members and a more Westernized younger generation, especially over attitudes to sexual behaviour, education, and the choice of marriage partner. However, El-Islam notes that, for those of its members who have a mental illness (such as schizophrenia), the extended family provides a more therapeutic setting, and with a better prognosis, than would institutionalization.

As this section illustrates therefore, family therapy provides one of the most fruitful areas of cooperation between psychology, psychiatry and medical anthropology – especially in understanding the family's role in both the cause and cure of mental illness – and research in this area is likely to increase in the future.

Migration and mental illness

Studies done in various countries have indicated that immigrants often have a higher rate of mental illness than either the native-born population, or the population in their countries of origin. This is indicated by higher rates of admission to mental hospitals, and higher indices of alcoholism, drug addiction and attempted suicide. Some of these studies on immigrants to the UK, such as Asians, West Indians, Africans, Irish, Poles and Russians, are described in the next chapter. Some immigrant groups appear to be more vulnerable to some illnesses than to others; for example, Irish immigrants to the UK have significantly higher rates of alcoholism, while West Indians have the highest rate of schizophrenia of all the immigrant groups. In his study of mental illness among immigrants to Australia, carried out in Victoria, Krupinski[89] found that depressive states were particularly common among British and East European migrants, and the latter group also had the highest rate of schizophrenia. Overall, immigrants showed a much higher rate of psychological instability than exists in the Australian-born population.

Cox[90] has summarized the three hypotheses that seek to explain

this high rate of mental illness associated with migration:

1. Certain mental disorders incite their victims to migrate (the *selection* hypothesis).
2. The process of migration creates mental stress, which may precipitate mental illness in susceptible individuals (the *stress* hypothesis).
3. There is a non-essential association between migration and certain other variables, such as age, class and culture conflict.

In the first group, restless and unstable people are believed to migrate more often, in an attempt to solve their personal problems. In another study in Australia, for example, Schaechter[91] found that 45.5 per cent of non-British female immigrants, admitted to a psychiatric hospital within three years of migration, had had an established mental illness prior to migration. If 'suspected cases' of mental illness prior to arrival were added, the figure rose to 68.2 per cent. Other studies, from different parts of the world, have shown that a certain percentage of immigrants *do* have a history of previous mental disorders in their countries of origin. The other, *stress* hypothesis, described in Chapter 11, emphasizes the role of changes in the migrants 'life space', where the basic assumptions on which his world is founded can no longer be taken for granted. Littlewood and Lipsedge,[92] in their study of mental illness among immigrants to the UK, point out that these disorders result from the complex interplay of many factors, including both 'selection' and 'stress'. These include material and environmental deprivation such as overcrowding, shared dwellings, lack of amenities, high unemployment, low family incomes, as well as racial discrimination, and conflict between immigrants and their local-born children. Language difficulties also play an important part, especially among female immigrants who arrive later in the country than do their menfolk, and who are often confined within the home and family. For example, a study in Newcastle[93] found that 58 per cent of Pakistani women spoke little or no English, and 15 per cent of men and 66 per cent of the women had received little or no schooling and were entirely illiterate. These socio-economic factors, coupled with the stress of culture-change, and the influence of selection, explain much of the increased rates of mental illness among first-generation immigrants. A further factor, mentioned earlier, is that diagnostic and admission rates in psychiatry may reflect moral or political prejudices, and misinterpret the immigrant's cultural beliefs, and reactions to his plight, as evidence of 'madness' or 'badness'.

Within both immigrant populations and ethnic minorities, certain groups seem to have different rates, and forms, of mental illness. According to Littlewood and Lipsedge, 'there appear to be no simple explanations for the different rates of mental illness applicable to all minority groups'. Some factors seem more significant in some groups than in others, and the best way to compare groups would be to add up all these negative factors (selection, stress, multiple deprivations, language difficulties, loss of status – both social and professional, clash between old and new cultural values, and so on) to find a 'score', indicating the risk factors for that community. For example, they note how West African students seem particularly vulnerable, due to dissatisfaction with British food, weather, discrimination, economic and legal difficulties, experience of the 'typical British personality', sexual isolation, more mature age, middle-class aspirations, and fear of withdrawal of their grants if they fail their examinations. Those with the lowest rates of mental illness – the Chinese, the Italians and the Indians – have in common a great determination to migrate, migration for economic reasons, an intention to return home, little attempt at assimilation, and a high degree of 'entrepreneurial' activity. Immigrants who were forced to leave their countries as refugees, and who cannot return, are by contrast likely to have a higher rate of mental illness. Krupinski[89] has examined some of these variables among immigrant groups in Australia: he relates their high rates of mental illness to the fact that many are single young men migrating from the UK and Western Europe, among whom are a proportion of already unstable persons (including some chronic alcoholics arriving from the UK). The stresses of migration seem to affect migrants from Southern and Eastern Europe especially, particularly those in the latter group who had traumatic experiences in the War, or who had suffered loss in occupational status in Australia. Seventy per cent of East European migrants with university degrees now belonged to a lower socio-economic class, compared with only 20 per cent of British graduates. Krupinski also found that schizophrenia occurred most frequently among male immigrants 1–2 years after arrival, while in females the peak was found after 7–15 years. The late onset among females was ascribed to the onset of menopause, and the ending of the maternal role with the departure of grown-up children. In addition, a high proportion of female non-British immigrants could not speak English even after many years in the country, especially those from Southern Europe. As with the Pakistani women in Newcastle, their social and linguistic isolation was believed to contribute to their high rate of mental breakdown.

Looked at in perspective, migration (both between countries, and within a country) seems to carry with it the increased risk of mental illness – though the reasons for this are complex, and not fully understood. However, as some authors[94] have pointed out, studies of the mental health of immigrants are difficult to interpret unless one controls for such factors as age, social class, occupational status and ethnic group on one hand, and culturally biased diagnostic methods on the other; unless one does this, one cannot demonstrate clearly that there is a significant association between migration and the rates of mental illness among migrants.

While most of the studies of this problem have concentrated on the immigrants, and their response to their condition, the cultural attributes of the host community are just as important. Such factors as xenophobia, discrimination, racial prejudice[95] – both personal and institutionalized – are all likely to contribute towards the immigrant's mental and physical ill-health, as are the economic and political conditions prevailing in the host community.

Within many immigrant and ethnic minority communities, certain cultural traits (such as family cohesion, and religion) may protect against mental illness, while others are likely to contribute to an increase. These may include a rigid division among the sexes, the social isolation of women, multiple religious taboos and prescriptions, residential patterns which encourage several generations of a family to live in the same house, inter-generational conflicts, and pressure on children to succeed financially or academically. Some of these examples of 'culturogenic stress' will be reviewed in the next chapter.

Cross-cultural psychiatric diagnosis

This chapter has illustrated some of the complexities in making cross-cultural psychiatric diagnoses – and especially the problems of defining 'normality' and 'abnormality' in the members of other cultures. A further problem is that clinicians may *over*-emphasize 'culture' as an explanation for patients' behaviour, and thus ignore any underlying psychopathology.[96] In making cross-cultural diagnoses therefore, the clinician should always be aware of:

1. The extent to which cultural factors affect some of the diagnostic categories and techniques of Western psychiatry.
2. The role of the patients' culture in helping them understand and communicate their psychological distress.
3. How the patients' beliefs and behaviour are viewed by other members of their cultural group, and whether their abnormality is viewed as beneficial to the group or not.
4. Whether the specific cluster of symptoms, signs and behavioural changes shown by the patients are interpreted by them, and by their community, as evidence of a 'culture-bound psychological disorder'.
5. Whether the patient's condition is indicative or not of mental illness, but rather of the social, political and economic pressures on them.[95]

Recommended reading

Dow, J. (1986) Universal aspects of symbolic healing: a theoretical synthesis. *Am. Anthropol.* **88**, 56–69. A comparison of common themes between Western psychotherapy, religious healing, and shamanism

Gaines, A. D. (ed.) *Ethnopsychiatry*. Albany: State University of New York Press. A collection of essays on the cultural construction of Western psychiatry, and of indigenous forms of therapy for the mentally ill

Kleinman, A. (1988) *Rethinking Psychiatry*, New York: Free Press. A survey of the contributions of the social sciences to the theory and practice of contemporary psychiatry

Littlewood, R. and Lipsedge, M. (1989) *Aliens and Alienists*, 2nd edn. London: Unwin Hyman. A study of mental illness among ethnic minorities in the UK, and the influences on how these illnesses are diagnosed

Simons, R. C. and Hughes, C. C. (1985) *The Culture-Bound Syndromes*. Dordrecht: D. Reidel Publishing Company. A comprehensive survey of culture-bound syndromes in many parts of the world