The Role of Cultural Backgrounds in Mental Disorders and Illnesses

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When discussing mental health, one of the more important issues to be taken into consideration is the concept of the norm and the illness. It is difficult to talk about it without referring to a specific culture. Behaviour is perceived as exceeding the norm applied by a given community and the standards used in it. Culture impacts the way a person talks about emotions, mental health difficulties or an illness as well as the way he or she experiences them. Often, emotional states experienced by someone may not be explained without referring to the social or cultural context, which will be explored further on in this article.

The objectivity of a mental illness

What are the associations with a mental illness? They often include diagnosis, treatment, pharmacology, i.e. medicine (psychiatry). But is it all? Can you place pneumonia, tumour and a mental illness next to one another on the same terms? Thomas Szasz[1], an American psychiatrist, emphasises that psychiatric categories can make us believe that we are talking about an objective field of medicine, which is why we fail to notice a very important dimension of this matter. All kinds of evaluations of man's mental functioning are in fact value determinants concealed using the objective language of science. These are social rules that determine whether a given kind of behaviour is abnormal. They define the scope of what is admissible. So, without a social and cultural perspective, it is difficult to conduct an analysis of mental illnesses and disorders.

Psychiatrists' pursuit of universal classifications

Maybe, the best solution would be to define the criteria for the norm and the illness with a close reference to culture and social norms applied by it? Unclear and vague

criteria could lead to numerous cases of abuse and misinterpretation and, in consequence, even threaten the members of a given community. For example, uncontrolled, violent and dangerous behaviour is almost universally considered a manifestation of mental disorders. If we tried to make it a norm in any community referring to cultural considerations, we would thus legitimise the situation when human life and health are in danger as a standard. So, it seems justified that psychiatrists strive for the universal classification of disorders. But, it must be remembered that without taking the cultural background into consideration, it is impossible to be able to see the whole picture of the health condition and the status of a given kind of behaviour.

How can cultural factors influence mental health?

Many mental disorders are universal in their nature – they are diagnosed in a variety of cultures. It should be remembered, however, that human biology does not work in vacuum. Cultural requirements modify human activity and may become a source of stress. An example might be an oppressive society where punishment is often applied. It is highly likely that in this kind of a situation man will be exposed to a lot of stress, which will make him or her more susceptible to disorders than a person functioning in a society that offers awards and social support. The socio-cultural conditions in which fear accompanies many situations, e.g. wars, hunger, natural disasters, persecution or mass displacement, may be particularly burdensome for children and make them more susceptible to mental health problems. This is why professional psychological assistance and support should be provided to the groups that suffered as a result of the abovementioned situations. Financial support in this kind of situations is usually not sufficient and only partially responds to the needs of a given group.

Depression: does it mean the same everywhere?

Mood disorders, including depression, have long been present in the awareness of Western societies – Hippocrates described the symptoms of melancholy as early as in the 5th century. Very often, in the Western world, depression is an individual's reaction to stress, accompanied by a strong feeling of guilt. Does it have identical symptoms of similar intensity everywhere?

The symptoms of depression were studied in 30 countries in the 1960s[2]. In 20 countries the symptoms observed included a lowered mood, mood swings, insomnia and no interest in the surroundings. In 9 others that, by and large, did not belong to the Western culture, the symptoms were usually somatic and included tiredness, the loss of appetite and lowered libido. The studies were repeated after 20 years and produced the same results. Why are there such differences?

The rare feeling of guilt might be explained by cultural differences in the way of interpreting feelings. Some researchers suggest that in other cultures than the Western culture an individual has a tendency to blame others instead of himself or herself. This might be related to the focus on an individual (individualism) or a group (collectivism) in a given society. The Western culture places great emphasis on individualism and the responsibility of an individual for his/her actions while in collectivist cultures, e.g. Asian ones, man ascribes his or her successes and failures not just to himself or herself but also to the groups of which he or she is a member, e.g. a family or co-workers. This is why the Chinese with depression will have a smaller feeling of guilt and slightly higher self-esteem than Americans in an identical situation. The same is true for Australian Aborigines for whom the feeling of guilt and self-incrimination is alien and suicide is rare. Researchers link it with the fear of death, characteristic for this culture, and determined efforts directed against the enemy in a threatening situation. It is more likely that Aborigines direct their hostility against others rather than against themselves in an attempt of suicide.

Africa and Papua New Guinea

Africa is another continent where the trends in the incidence of mood swings are completely different from the ones observed in the West. While depression is common in the US and manic disorders definitely rarer, the trend is reversed in Africa. One researcher, Carothers[3], explained it by not ascribing failures to oneself. His observations of the natives of Kenya conducted in the 1950s demonstrated that every member of the community was, to a large extent, determined by the group, which impaired his or her feeling of responsibility and the scope of choices made. At the same time, the aims he or she would set for himself or herself would be easy to achieve, which minimised the risk of failure and stress related to it. Living in difficult natural conditions, the natives of Kenya were prepared for the situations in which nothing could be changed. This is why misfortunes were consistently blamed on external factors. This enabled them to maintain self-esteem on a satisfactory level. It

must be mentioned, however, that the aforementioned process applies only to traditional African communities and not those that are under great Western influence. The greater the influence of the Western civilisation, the greater the similarity as regards the incidence of specific mental illnesses.

Another cultural group studied by Schieffelin[4] is the Kaluli people who live in the tropical forest of Papua New Guinea. In the process of socialisation both men and women were taught not to suppress their emotions. Manifesting anger or sadness performed a certain function: it was a tool used to exercise your rights or shift responsibility for what happened to one person upon another individual. Here, just like in traditional African cultures, blame for one's own failures is not ascribed to oneself. Thanks to the externalising of emotions, depression, understood as directing aggression inwards, appeared very seldom. In the Kaluli language there was even no word for depression. So the occurrence of depression as it is understood by the Western world was highly unlikely. Among the Kaluli, it might manifest itself as somatic symptoms such as a headache, low energy level, stomach problems or pain in various body parts. The likelihood of their occurrence would rise in situations in which expressing negative emotions and exerting your rights would be considered unjustified and unacceptable.

Cultural convictions underpinning mental disorders

In some communities there are syndromes of disorders or symptoms that are closely linked to a given culture. In Japan, mainly in the countryside, one such syndrome is kitsunetsuki. People with this disorder believe that they are possessed by foxes and their faces will take on a fox's mask. This phenomenon is sometimes true for entire families, which may even be banished by the local community.

Indian hunters from the Algonquin tribe experience windigo – a fear reaction when they start to feel anxiety and agitation at the thought that they might have been charmed. This is accompanied by fear that a monster of insatiable appetite for human flesh may change the person into a cannibal.

In Indonesia and Malaysia, middle-aged women experience latah – hypersensitivity to stimuli that cause sudden fright. The woman persistently repeats words (echolalia) and activities performed by other persons (echopraxia), she may also fall into a trance.

Taijin kyofusho and *koro* – cultural anxiety disorders

An interesting form of an anxiety disorder shaped by cultural norms is taijin kyofusho, which occurs in Japan. People who experience it are afraid of social situations and relationships with other people, which is slightly similar to the Western social phobia. But there is a distinct difference between the two – people with taijin kyofusho fear one thing, a blush on the face or eye contact that might offend their interlocutor and make him or her feel awkward. This fear of insulting other people leads to avoiding social contacts. The abovementioned symptoms are closely linked with the Japanese cultural norms according to which people who openly establish eye contact with others are considered insensitive and aggressive. Children are taught not to look the other person in the eye, which might hurt him or her, but in the neck area. So, in social contacts, the attention is on the reaction of others to your behaviour, which necessitates the control of body posture or face expression. In these conditions, even the tiniest awkwardness in a conversation may turn into a social, or even moral, failure.

Young men who live in southern China may experience an anxiety disorder known as koro. A man starts to fear that his penis is shrinking and hiding in his abdomen, which ultimately may lead to death. Most koro episodes happen at night and, along with fear, manifest themselves with a feeling of imminent death, palpitations and sometimes tingling near genitals. The need to examine and touch your genitals to make sure they exist and have not changed their size appears. This fear is related to the cultural conviction about the existence of two life energies: yang – representing the male element, and yin – the female element, which should be in equilibrium to maintain good health. Masturbation and nocturnal emissions are seen as the loss of yang, which is dangerous for health. So, the background of koro is related not just to anxiety linked with sexuality but also to cultural convictions.

Culture-dependent or universal?

Is there a satisfactory and final answer to the question about the objectivity of mental disorders and illnesses or their dependence on culture? Both among theoreticians and practitioners there are advocates of the universal approach as well as relativists and those who try to reconcile the two perspectives. All, however, agree that the cultural background of a given person impacts his or her experience of the illness, its

dimension ranging from the linguistic structure used by the person to communicate through hallucinations or fears. The same disorder may have different manifestations in different cultures, which does not exclude the fact that the same mechanism may underpin it, such as the fear of the deformation of one's own body (koro) or anxiety in social situations (taijin kyofusho).

In the globalised world, where the representatives of various cultures may move around freely and change the place of residence, the need to take into account cultural factors when assessing the mental health of a given person seems especially important. So the process of diagnosis, treatment, therapy and providing social support should involve not just the physical or physiological aspects of a given disorder but the human being as a whole, including the culture he or she comes from.

References

1. D. Bhugra, Severe mental illness cross cultures [in:] Acta Psychiatra Scand 2006: 113, pp. 17-23.

2. K. Bhui, S. Dinos, Health Beliefs and Culture [in:] Disease Management and Health Outcomes 2008: 16 (6), pp. 411-419.

3. G. Canino, M. Alegria, Psychiatric diagnosis – is it universal or relative to culture? [in:] Journal of Child Psychology and Psychiatry 2008: 49(3), pp. 237-250.

4. R. C. Carson, J. N. Butcher i S. Mineka, Psychologia zaburzeń [*The Psychology of Disorders*], Gdańsk 2003.

5. W. F. Price, R. H. Crapo, Psychologia w badaniach międzykulturowych [*Psychology in Intercultural Studies*], Gdańsk 2003.

6. T. Szasz, Psychiatry: the Science of Lies, New York 2008.

Endnotes:

1 See T. Szasz, Psychiatry: the Science of Lies, New York 2008.

2 W. F. Price, R. H. Crapo, Psychologia w badaniach międzykulturowych [*Psychology in Intercultural Studies*], p.163.

3 W. F. Price, R. H. Crapo., Psychologia w badaniach międzykulturowych [*Psychology in Intercultural Studies*], Gdańsk 2003, p. 376

4 W. F. Price, R. H. Crapo, Psychologia w badaniach międzykulturowych [*Psychology in Intercultural Studies*], pp.163-164.