

Chapter 10 Cross-cultural psychiatry

CASE STUDIES

Case study: differences in psychiatric diagnosis in the UK and the USA – 1

Cooper and colleagues³⁶ in 1969 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 10 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 caused by the diagnostic terms and concepts used by the two groups of hospital psychiatrists? At a mental hospital in each city, 145 consecutive admissions in the age

range of 35–59 years were studied. 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 study: differences in psychiatric diagnosis in the UK and the USA – 2

Katz and colleagues³⁷ in 1969 examined the process of psychiatric diagnosis among both British and American psychiatrists in more detail. 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 make a diagnosis. Marked disagreements in diagnosis between the two groups were found, as well as

different patterns of symptomatology perceived. The British psychiatrists saw less pathology generally, less evidence of the key diagnostic symptoms 'retardation' and 'apathy', and little or no 'paranoid projection' or 'perceptual distortion'. Conversely, they saw more 'anxious introversion' than did the American psychiatrists. 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 American psychiatrists, but by none of the British psychiatrists. The authors conclude that 'ethnic background apparently influences choice of diagnosis and perception of symptomatology'.

Case study: differences in psychiatric diagnosis within the UK

Copeland and colleagues³⁸ in 1971 studied differences in diagnostic behaviour among 200 British psychiatrists, all of whom had at least four 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.

Case study: differences in psychiatric diagnosis in England and France

Van Os and colleagues³⁹ in 1993 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, which emphasize 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 and has focused more on neurodevelopmental and genetic causes. Similarly, in treatment the British psychiatrists preferred more biological and

behavioural approaches compared with the French psychiatrists. The study also found major differences in the incidence of schizophrenia in the two countries. In France, the number of first admissions to psychiatric hospitals for this condition under the age of 45 years was much higher than in the UK, but much lower after 45 years. Also, rates of first admission for the period 1973–1982 were rising in France but falling in the UK. 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 study: depression in Hong Kong

Lau and colleagues⁵³ in 1983 studied 213 cases of depression (142 females and 71 males) presenting to a private general practice in Hong Kong over a period of 6 months. The chief complaints that had prompted patients 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 coexisting 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 thus warn of the dangers of missing the diagnosis of depression because of the possible facade of somatic symptoms.

Case study: psychosomatic symptoms in Nanjing, Peoples Republic of China

Ots⁵⁴ in 1990 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 prob-

lem. 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 that is treated, usually by a combination of 10–15 herbal medicines.

Ots suggested, therefore, 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.

Case study: *susto* in Latin America

Rubel²⁰ in 1977 described the characteristics of *susto* (or 'magical fright'), which is also known as *pasmo*, *jani*, *espanto* and *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:

- becoming restless during sleep
- during waking hours, complaining 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 15), including stressful social situations, especially where the individual cannot meet the social expectations of his own family and cultural milieu.

Case study: *ataques de nervios* among Latinos in the USA

De La Cancela and colleagues⁷³ in 1986 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 buildup of *nervios* (nerves) from the general problems of 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 suggested that this disorder cannot only be understood at the micro-level; 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, need to be examined. 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, overcrowded 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 suggested, 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*'.

Case study: amafufunyana and ukuthwasa in South Africa

Swartz⁷⁴ in 1998 described two common culture-bound disorders among Xhosa- and Zulu-speaking African people in South Africa. Both are forms of spirit possession, though one is considered negative, the other positive. *Amafufunyana* is a form of hysteria, with agitated and uncontrolled behaviour and sometimes suicide attempts. It is believed to be caused by possession by malign spirits, sometimes sent by sorcery. Among the Zulu, according to Ngubane,⁷⁵ possession is sometimes by 'a horde of spirits' from different ethnic groups. It can occur in individuals, or in larger outbreaks, such as in a girls' school. Like *nervios* or 'nerves' (see Chapter 11), it afflicts mainly people (especially women) who are in a relatively powerless social and economic position, especially at times of major social change and disruption. As such, it helps to draw attention to their suffering and to mobilize a caring network around them. Treatment is usually a ritual of exorcism by a traditional healer. In contrast, *ukuthwasa* – a similar form of

spirit possession – has a more positive outcome. It is 'the state of emotional turmoil a person goes through on the path to becoming an indigenous healer'. Here possession is a necessary sign of the victim's 'calling' to be a healer. It signals a positive relationship to the ancestors, who will one day help them in their healing task. However, as Swartz points out, neither of these conditions forms a discrete or standardized entity. While the labels *amafufunyana* and *ukuthwasa* do have meaning, 'these meanings shift in different circumstances', and in different contexts. Like 'nerves', they can cover a variety of conditions and human situations. *Amafufunyana*, in particular, offers victims a way of explaining *post hoc* what has happened to them, as well as placing blame for it elsewhere. Similarly, the definition of *ukuthwasa* 'lies partly in the experience of the person undergoing it, and partly in the way these are handled by existing healers'. However, where somebody with this condition fails to become a healer, they may be rediagnosed by the community as having *ukuphambana*, or madness.

Case study: Religious healing among a Hasidic Jewish community in London, UK

Dein⁹⁸ describes attitudes to health and healing among orthodox Hasidic Jews of the Lubavitch movement in Stamford Hill, London. In dealing with illness (as well as conditions such as infertility), the community combine pragmatic with symbolic healing. They consult medical doctors and complementary practitioners, but also use religious healing if the condition is severe, long-lasting or unresponsive to treatment. This can include prayer, reciting the Psalms (*tehillim*), carrying out good deeds (*mitzvot*), giving to charity (*tzedakah*), consulting a rabbi

for advice or checking religious artifacts in the house, such as the phylacteries (*tefillin*) for flaws, which would make them invalid, and therefore less protective of the individual. Before his death in 1994, seriously ill or troubled people – or their families – would write or fax to the *Rebbe*, the head of the movement in New York, for his advice or blessing. After his death, some continue to write to his tomb, asking for a blessing. This study illustrates, therefore, how medical pluralism can exist even in a relatively small community, and how people can freely combine biomedical and symbolic healing in dealing with illness and other misfortune.

Case study: a case of 'fox possession' in Sapporo, Japan

Etsuko¹⁰⁸ described 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. With 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 study: psychiatric and religious healing in Jerusalem, Israel

Bilu and colleagues¹⁰⁹ described 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 study: spiritist healing in Porto Alegre, Brazil

Greenfield¹¹⁰ examined 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 and 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 it 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 caused by 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'.