The Youthdale Series

CULTURAL ASPECTS OF PSYCHIATRY

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This book has been written for family doctors, nurses, social workers, therapists, medical technicians as well as other service providers in the community in order to give greater understanding of culture and how it affects treatment of patients in general, and children and adolescents with mental health and psychological problems in particular. It is our hope that professionals, for example, child psychologists, will direct patients to this booklet when they think the information contained and the easily accessible way it is presented, will be helpful to the patient/client. For some, reading the last chapter (chapter 9) on treatment first, may provide a context for the rest of this book. We would recommend this approach for clinicians and educators.

Index

1. Introduction and Definition of Culture, Race and Ethnicity

Every individual has culture. We are all born not with culture but into a culture. It is our culture which influences the way we are brought up and the manner in which we think and respond.

DEFINITIONS:

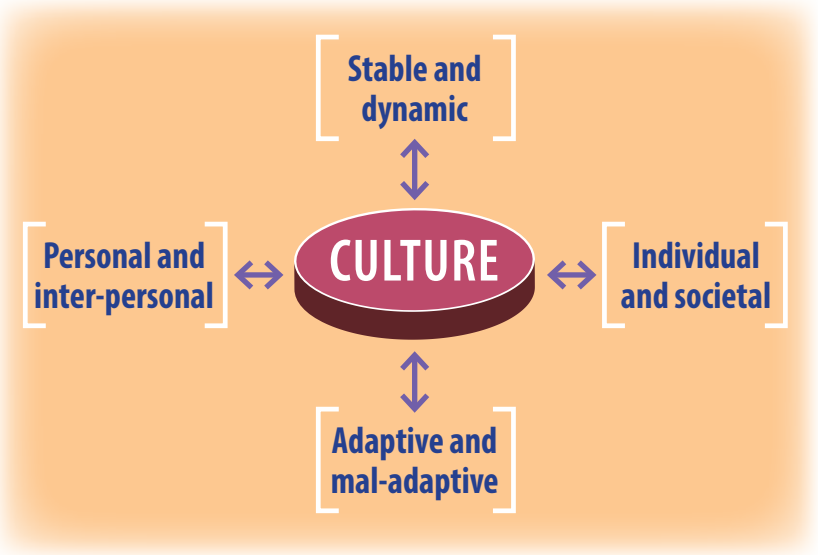
Culture:

The term culture dates back to the late 18th century and refers to the complex components which include knowledge, beliefs, morals, art, law, custom and other habits and capabilities that individuals learn as a member of their society. Culture constitutes a number of learnt patterns that are influenced by external factors such as ideas, values and attitudes. Cultures are never static; they influence individuals who in turn have an impact on their culture. This two-way process is important in understanding the manner in which individuals learn about culture, which then becomes a way of life. Culture has both implicit and explicit components. Implicit aspects deal with internal values and ideas, and explicit compo-

Culture influences individuals and individuals have an impact on culture

nents deal with attitudes and behaviours. Culture is thus stable and dynamic; individual and societal; adaptive and mal-adaptive; as well as personal and inter-personal. Culture precipitates an individual developing unique behavioural patterns which are shared with others from the same culture. It is characterized by a set of behaviours that have been influenced by attitudes and beliefs. It is their attitudes and beliefs which make an individual's behaviour understandable. Culture is transmitted inter-generationally and provides meaning to an individual. There are multiple sub-cultures and cultural identities in each culture. Culture is a recognizable social and institutionally patterned behaviour.

FACTORS THAT INFLUENCE CULTURE



Cultural identity:

Sociologists have classified culture as ego-centric (individualistic) or socio-centric (collectivist) pertaining specifically to masculine or feminine. Detailed classifications also include distance from the source of power, avoidance of uncertainty, and long term orientation. Using these categories, specific characteristics of cultures can be identified. Ties between individuals in different cultures vary and can influence an individual's role in that particular society, as well as cultural expectations of the individuals and their roles. Any changes in roles may lead to pressures on the individual and the way they respond to stress. Cultural identity influences the way in which idioms of distress are deployed.

Race and Ethnicity:

Race is a biological concept focusing on physical characteristics of individuals such as skin colour, face shape, colour of hair or eyes or physical size. Anthropologists have developed the concept of geographical race to define human beings who are inhabitants of a specific geographical area and over centuries have developed specific physical characteristics. This is a biological classification and is usually not helpful in psychiatry.

Ethnicity is often self-ascribed and refers to groups who distinguish themselves from other groups by group identities, common language, culture, race, etc. Ethnicity thus refers to shared common cultural features while culture refers to perspectives and meanings related to the experience. Out of the terms race, ethnicity and culture, only culture is likely to change as a result of an individual's experiences.

RACE

Refers to a person's physical appearance, such as skin colour, eye colour, hair colour, bone/jaw structure etc.

ETHNICITY

Relates to cultural factors such as nationality, culture, ancestry, language and beliefs

CULTURE

Depicts customary beliefs, social forms, and material traits of a racial, religious, or social group

***Acculturation*:**

This is the process by which an individual acquires new attitudes, beliefs and ideas which then go on to influence their behaviour. This may be a result of direct or indirect contact between two cultures. This process often occurs once individuals have already obtained and settled into their primary cultural values. The process of acculturation can lead to assimilation, bi-culturalism or deculturation. Assimilation occurs following contact between two cultures whereby the individual assumes proportionately significant features of a second culture i.e. not their original culture. Biculturalism is the process in which the individual is able to straddle both cultures without either culture taking precedence and the individual feeling comfortable with both. Deculturation is the phenomenon in which an individual or group is pushed towards giving up their own culture and losing their cultural values without necessarily gaining another. This can take place by force or by accident.

CASE VIGNETTE #1

G is an 18-year-old high school senior. He was born in the U.S. but his parents had emigrated from Egypt in the 1970s. They were Coptic Christians and spoke Arabic at home. His father had worked very hard and now owned a diner and a couple of bars in the town the family lived in. Although they were not socially isolated, they preferred to stick mainly with other Egyptians and Coptics. G was almost 6 feet tall, played football and had an good academic average of 'B' grades. He had many friends but among his social circle, nobody shared the same cultural background as him. He often complained of feeling different and resented his Middle Eastern roots. His relationship with his father was complicated. He admired his strong work ethics but hated his short temper and alcohol use. He also resented his rude behaviour towards his wife, G's mom, and wanted her to divorce his father and move away, just as some of his friends' parents had done. In the last year his relationship with his father had become worse and they barely spoke to each other. He had been experimenting with marijuana and when his father had found out, had restricted him from seeing any of his American friends. Having no Egyptian friends left G essentially friendless at this point.

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Case Vignette #1 continued from previous page

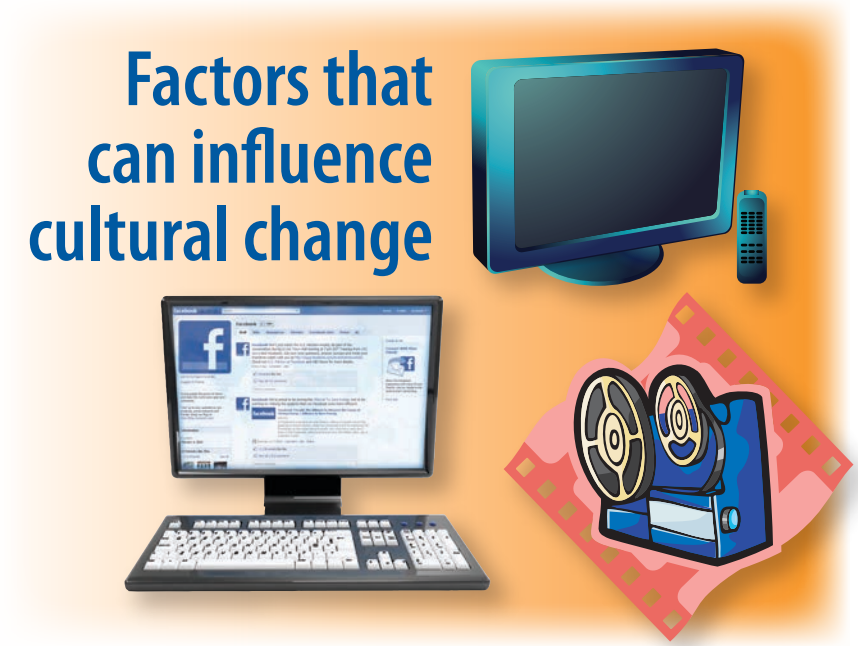
He was seen in our outpatient clinic after he had told his football coach that he felt like he wanted to die or hurt somebody else out of anger. His coach talked to a guidance counselor and he was referred to us. We invited the family for a meeting which was attended by his parents and our treatment team (comprised of the psychiatrist, social worker and nursing staff). During the meeting the father expressed a lot of anger towards G's friends and American culture in general, saying that "everybody is a drug addict here". He said that he provided everything G could imagine or wish for, stating that "if he asked for a guitar I would buy him two". He went on further and said that he is willing to do everything for G provided that he listens to him and stop seeing all his friends who had a "bad influence on him". During this meeting his wife kept a soft reconciliatory tone but supported her husband in saying that the "grounding" was totally justified, however she was willing to negotiate between them if G showed some willingness to respect family wishes and stay away from "those bad kids".

In the above case vignette we see two value systems and two generations in conflict with each other. The parents have not been in touch with what is happening in their child's life and suddenly woke up to realize how distant he has grown from them. They are not able to see the drug abuse, mood changes and conflicts in the relationship as part of a probable mood disorder such as depression, nor are they able appreciate the developmental changes that come with teenage growth. They are resentful of the local culture yet fail to keep up with the changes that their son is going through. There is hypocrisy in the father's behaviour and his treatment of his wife which may be reminiscent of growing up in a male-dominated traditional society, which is now driving his son further away.

This vignette emphasizes the clash of two cultural reference points in a family

2. Cultural Evolution and Impact

Cultural changes can occur indirectly, especially through media. Some of these sources include the internet, television, cinema and social media such as Facebook, Second Life, etc. Cultural change can be bi-directional. Individuals cope with the processes of acculturation in a number of ways and these influence patterns of child rearing and upbringing. Furthermore, contact with other cultures are inevitable as a result of globalization. Some cultures, in order to protect themselves, take on more extreme positions, such as returning to their cultural roots instead of assimilating. These cultural behaviours can be ideal, stereotyped, actual or deviated and may create difficulties.



Media such as social media on the internet, television and movies, all influence culture

Culture has an impact on mental health which manifests in a number of ways. Perhaps the most important of these is by the cultural definition of what is normal versus abnormal. Cultures also produce stress with regards to expected roles and duties as well as relating to cultural demands and restrictions.

Culture can directly precipitate emotional distress and generate psychopathology through *culturally formed anxiety, culturally demanded performance and culturally expected roles and duties*. These influencing factors may be unique to a specific culture. An example of this would be semen-loss anxiety, which may lead to somatic symptoms and depression. It is inevitable that culturally related factors will present as certain types of psychopathology, as exemplified by amok or neurasthenia (see appendix 1). Cultural issues may lead to the escalation of symptoms and distress, such as concerns with body weight. Cultures determine how these symptoms are expanded upon and understood within the social context.

Culture can modify the symptoms by shaping the contents of symptoms; these become the perpetuating factors. For example, until the 1980s, it was very common to see patients whose delusional content included the smell of mustard gas in psychiatric hospitals in the U.K. Cultural factors can ensure that some symptoms and conditions are more prevalent in some cultures than others during specific historical contexts. Cultural factors may also contribute to labeling or elaborating on some disorders. Conditions such as conversion disorder are changing in their prevalence, which may reflect better understanding of the underlying pathology of the individual or altering cultural responses to the behaviours themselves. (Conversion disorder was formerly known as "Hysteria". Patients suffer physical or neurological symptoms such as numbness, paralysis, blindness, and inability to talk in the absence of any organic cause. It is usually in response to life difficulties and or stress).

3. Attitude, Expectations and Response to Treatment Across Cultures

Culture influences the development of personality. It is culture that will dictate what is normal and what is deviant. It is by these guidelines that, for example, the anti-social or psychopathic personality will be defined. In addition, although national characteristics and stereotypes of culturally influenced personalities have been described, care must be taken that these cultural stereotypes are not used as shortcuts to diagnosis. It is crucial that clinicians are aware of pitfalls of using national characteristics even when these are helpful indicating factors. It is erroneous and potentially dangerous to assume that everyone from one culture is similar to everyone else in that culture. There are sub-cultures and social conventions which may influence patterns of behaviour and character. Cultural psychology helps to inform our understanding of what dictates normal behaviours and child-rearing patterns of or within a specific culture. For example, models of ego development developed in psychoanalysis should not be used blindly across cultures. Not all cultures will follow the same cognitive patterns and behaviours. Similarly, cross-cultural comparisons of dreams and visual perceptions indicate that there are indeed cultural differences in their content and explanations. **Furthermore, although emotional responses can be very similar across cultures, they are often expressed in different ways and must be understood in specific relation to the culture in question.**

CASE VIGNETTE #2

Z is a 17-year-old girl born in Somalia who lived in Saudi Arabia until the age of six and had moved to the States with her parents around that time. Her father is a cabdriver in town and her mother is a housewife. Z is the oldest of three siblings and enjoyed a good relationship with her family. In the last few weeks she exhibited symptoms such as overly religious ideas and claiming to be a known prophet. The identity of this prophet kept changing from Ibrahim (Abraham) to Musa (Moses) to Esa (Jesus). She also claimed that a peer from her high school was in love with her and they were soon going to start dating.

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Case Vignette #2 continued from previous page

The boy in question was the most popular kid in the school and denied any such relationship with her. She had a major decline in her grades and was often seen reciting something in a foreign language by some classmates which turned out to be Arabic, and mainly verses from the Quran (Koran). The family said that these were not full verses and sounded like mixture of gibberish combined with some authentic Quranic verses.

Her father was becoming increasingly annoyed with her and thought that she was doing all of this to put pressure on her parents to let her date the popular guy from her class. This was unacceptable for them since they were observant Muslims and they did not want her to set a "bad example" for her sisters. There were several fights between her and the family in which she tried to run away and threatened to hurt herself. At one point the father decided to take her to Somalia and leave her there with their extended family – to teach her a lesson and protect her from dating a guy.

In the meantime her behaviour got worse. She started to walk around with a towel wrapped around her head claiming to be the Queen Nefertiti. Her attempts to run away grew more intense. She stopped eating and her personal hygiene declined, her speech became louder and filled with grandiose claims, religious ideas and sexual innuendos. Her mother decided to go see her family doctor who referred her to psychiatric services in a nearby hospital. The girl was diagnosed with bipolar disorder and treated with medications and was later discharged with some follow-up aftercare.

It is interesting to note that her parents did not see her behaviour to be odd and bizarre but attributed it to be the manifestation of a rebellion against their cultural values. This family responded quite well to education that was provided to them about the illness and it was much easier for them to accept an explanation of chemical imbalance rather than accepting Z's condition resulting from a "moral corruption". They seemed content with their idea that this episode will be over soon and wanted to believe that there will never be a recurrence of the symptoms.

This vignette emphasizes how a particular behaviour can be differently interpreted based on cultural background

Epidemiology becomes an important factor in a culturally-relevant diagnosis. Blindly transplanting instruments developed in one culture for use in other cultures can lead to errors in rates and diagnoses of psychiatric disorders. This can occur by increasing both false positive and false negative cases. Comparing incidence and prevalence rates of psychiatric disorders across cultures can lead to problems if the cultural context in the epidemiology is not taken into account.

In managing **the mental health of patients** whose cultures may differ from those of the clinician (particularly when there is a discrepancy between the two individuals as to whether they come from minority or majority cultures) will bring specific challenges. This applies not only in understanding the distress and psychopathology but also engaging them in therapeutic alliance. All kinds of therapeutic interventions and their acceptance are influenced by culture.

Egocentric **psychotherapies** (such as psychoanalytic therapies) may not be easily transferable across cultures even if a commonality of some core foundation aspects can be identified. In some cultures patients expect a more direct approach while in others they would expect a more collaborative approach. Cultural matching of the therapist and patient may influence initial engagement but not necessarily long-term outcome. Similarly, in cognitive behavioural therapies, it is critical that cultural norms are explored as cognitions that are influenced by cultures. For example, in some cultures notions of guilt will be more prominent, whereas in others shame will play a more significant role. Other talking therapies, such as inter-personal or mentalization-based therapies, will have to be used accordingly. Occupational therapy, especially social skills training or aids to daily living, will require modification according to cultural norms and expectations. Group therapies will have to be adjusted according to cultural norms and matters related to confidentiality.

There are different modalities of psychological change – meditation being one

Psychological and spiritual models need to be explored and used in an appropriate manner. Similarly, other forms of talking therapies in therapeutic communities or elsewhere will require appropriate changes. Using an interpreter brings in other factors. Drug therapies across cultures also deserve detailed discussion and exploration. Racial and ethnic factors will influence absorption and metabolism of drugs (see below).

Pharmacotherapies play an important role as well. The pharmacogenomics and pharmacokinetics of drugs vary across cultures. Use of alternative and complementary medicines, religious taboos and rituals as well as dietary and other factors will influence acceptance and response to medication. Pharmacodynamics refers to the way in which drugs work on specific target organs, whereas pharmacokinetics deal with factors such as absorption, distribution, metabolism and then excretion of medicines in the individual. Some races have genetic variations in the presence or absence of certain enzymes, leading to increased levels of medications in the blood and the system. Attitudes to medicine, its role in the general explanatory model of illness and mode of administration will all influence acceptance of treatment. The role of medicine needs to be explored with the patient and their families (see chapter 9 for an overview concerning treatment).

In this graphic a simple question for which the doctor may expect a 'Yes' or 'No' answer has lead to a long discussion. Clearly much information has been lost in the use of an interpreter

4. Culture-Bound Syndrome and Idioms of Distress

"Idioms of distress" may be defined as the ways in which members of sociocultural groups convey affliction. These idioms vary across cultures, depending on the salient metaphors and popular traditions that pattern the human biological capacity for experiencing distress, including conditions that are sufficiently severe to meet criteria for psychiatric disorders. Cultural groups, for example, may describe distress in more psychological or more somatic physical terms, or may cluster syndromes in different ways, connecting symptoms together in a way that other cultures do not acknowledge as related. This leads to substantial diversity in culturally-defined syndromes across groups. Our common human biology, however, constrains the range of idioms of distress to a finite number of expressions. Idioms of distress focused on feared heart pathology, for example, are ubiquitous yet can differ substantially, as evidenced by the differences between the fear of "heart attacks" among Manhattan executives versus concerns over "heart distress" in Iran. The former associates stress and overwork in hypercompetitive, frequently male, professional environments with chest tightness and fear of sudden death, while the latter is predominantly an idiom used by working-class women to describe "irregular heart sensations believed to be caused by emotional or interpersonal problems, by childbirth, pregnancy or contraception, or by a variety of diseases." Alternative modes of expressing distress are perhaps used by those who have a weak social support network and limited opportunities to ventilate feelings and seek counsel outside the household. Alternative means of expressing psychosocial distress are taken. Somatization, (i.e. the description of physical ailments as a "legitimate" way of responding to psychological pain, is

SUICIDE IN DIFFERENT COUNTRIES

When people feel extremely stressed they may consider harming themselves. At times like this it may be to send a sign to others and to recognize their distress. Typical behaviours may be taking an overdose of tablets (common in, for example, the U.K. and the U.S.A.), attempted drowning (common in Holland - jumping into the canal) or jumping off a first storey building (common in the Middle East). The key issue is that the risk of significant subsequent self-harm is much greater if the first self-harm attempt is culturally incongruent for that society. A person in the U.K. who shows distress by jumping off a building, for example, must be taken more seriously.

focused upon as an important idiom through which distress is communicated. Idioms of distress are considered as adaptive responses in circumstances where other modes of expression fail to communicate distress adequately or provide appropriate coping strategies.

In today's multicultural society, assuring quality health care for all requires that physicians understand how each patient's socio-cultural background affects his or her health beliefs and behaviours. Socio-cultural differences, when misunderstood, can adversely affect the cross-cultural physician–patient interaction. Such misunderstandings often reflect a difference in culturally determined values, with effects ranging from mild discomfort to non-co-operation to a major lack of trust that disintegrates the therapeutic relationship. At the interface between culturally-shaped illness and biomedical disease, there is significant potential for misunderstanding between the patient and the clinician. Cultural competence helps to promote communication and cooperation between doctors and patients, improves clinical diagnosis and management, avoids cultural blind spots and unnecessary medical testing and leads to better adherence to treatment by patients. Patients may hold views related to traditional practices of 'hot and cold', notions of Yin-Yang and Ayurveda, cultural healing, alternative medicine, cultural perception of body structures and cultural practices in the context of women's health. Each culture has certain core beliefs about the body, mind and soul and also health. Hence the western concepts often may not be applicable directly and should not be used out of context. In many non-western cultures, the 'mind body' division is not important.

COMMON NON-WESTERN SYMPTOMS

Body / Mind / Sexuality	Neuresthenia (fatigue or weakness)
	Dhat (specific to Indian Subcontinent)
Men	Excessive nocturnal emissions (other terms 'swapna dosha', dhatu, 'hasta maithuna')
Women	Leukorrhoea (vaginal discharge) is a symptom associated with many cultural meanings and multiple etiologies. Prevalent etiological notions of leukorrhoea include a dissolving of bones, loss of dhatu (vital fluid), and overheating. Leukorrhoea may represent a culturally shaped `bodily idiom of distress', in which concerns about loss of genital secretions reflect wider issues of social stress. Problems may arise when a symptom with deep cultural meaning is misinterpreted in a purely biomedical framework
Food related	Intake of food with hot properties with that of cold properties (thanda garam)
	Certain type of foods may have psychological effects. For example, excessive eggs or beef may lead to hypersexual behaviour or nocturnal emissions in men, and acne (manifestation of heat) in women
Cardiovascular	Blood Pressure high or low
	Dharkan (palpitations)
	Sinking heart syndrome: "Sinking heart' is an illness in which physical sensations in the heart or in the chest are experienced and these symptoms are thought to be caused by excessive heat, exhaustion, worry and/or social failure. The Punjabi model of sinking heart does not exactly correspond to medical models of heart distress. The sinking heart model bears closest resemblance to a western model of stress. The similarity between these two models is in the form rather than in the content
Other	Respiratory Shortness of Breath or "Cannot breath at all"
	Multiple aches & pains "ainthan"
	Headaches, low back ache (khinchao)
	Skin – sweating
	Genito urinary – stream, colour
	Gastro intestinal – gas "gola", constipation, digestion, Irregular bowel movements
	Neurological – pulling of nerves, sensory, giddiness

Listening to the cultural music of symptoms

When medical investigations fail to provide an explanation, physicians may view patients as somatizing. In fact, the patients may be aware of the social and emotional antecedents of their bodily distress from the start. Many patients with somatic cultural idioms of distress will acknowledge the social problems that exacerbate their symptoms *if they find a sympathetic listener.* Diagnostic systems are also cultural artifacts.

As a culturally available idiom, somatic symptoms express discomfort and distress in ways that are intelligible within the individual's social milieu but may have different meanings to outsiders. Consequently, a patient's narrative of his or her illness may include a significant subtext, linking his or her physical distress to social predicaments, moral sentiments, and otherwise unexpressed emotions.

Meanings of Somatic Symptoms
Index of disease or disorder
Symbolic expression of intrapsychic conflict
Indication of specific psychopathology
Idiomatic expression of distress
Metaphor for experience
Act of positioning with a local world
Form of social commentary or protest

TRADITIONAL CHINESE MEDICINE (TCM) IN THE CONTEXT OF IDIOMS OF DISTRESS

In western medicine the mind and body are considered separate entities. Mind and body are integrated and inseparable in TCM. Accordingly, any change of the mind will inevitably affect the body and vice versa. Psychological problems are frequently considered the causes of physical disorders. Western medicine relies heavily on laboratory tests; TCM does not. Consequently, "medically unexplained symptoms" do not exist in TCM. Diagnosis in TCM is based on four techniques (observing, listening and smelling, asking, and feeling the pulse) and four types of pathologic change (Qi (air), blood, yin-yang, or an organ inside the body). Using the four techniques, TCM practitioners collect information on the possible pathologic changes that could explain patients' symptoms and would allow them to provide treatment to alleviate the symptoms.

Classical Western Psychiatrist	Patient from Indian sub continent
No experience of acculturation stress	Experience of acculturation stress
Upbringing in western well off mileu	Upbringing in non-western traditional mileu
Inner directed orientation	Tradition directed orientation
Belief in individual solutions	Belief in collective solutions
Intrapsychic conflicts seen as most relevant	Extrapsychic (social) conflicts seen as most relevant
Emphasis on scientific knowledge (rational)	Emphasis on magic knowledge (*arational* not irrational)
Disease primarily seen as phenomenon of nature, devoid of moral implications	Disease frequently seen as phenomenon of the supernatural, full of moral implications
Physical and mental illness seen as distinct entities	No essential distinction made between physical and mental illness
Treatment viewed as "profane" and "scientific"	Treatment seen as "sacred" and "magic"
Tendency to explain the incomprehensible by Psychopathology	Tendency to explain the incomprehensible by traditional / supernatural powers
Social rank predominantly seen as depending on education and income	Social rank predominantly seen as depending on age, birth and inherited status
Social obligations mainly towards nuclear family	Social obligations towards extended family, clan & tribe
Few, if any, ceremonial functions considered indispensable	Numerous ceremonial functions indispensable
Outlook geared towards future: experimentation & innovation seen as desirable	Orientation towards past; preservation of old techniques and guidance by traditional experience seen as desirable
Individual geographic mobility high, therefore few and short term commitments	Individual geographic mobility very low, therefore numerous and long term commitments
Therapist paid by insurance plans according to service time without reference to patient's circumstances	Indigenous healer paid by patient or relatives according to success and to patient's wealth and status

5. Immigration: its Process and Effects on Physical and Mental Health

In the last few years there has been a change in the demographics of many countries because of immigration. Whether it be legal, illegal or as a refugee, immigration is a traumatic and stressful experience fraught with hardships, fear of the unknown and social disruption. Additionally, some refugees have had to deal with the consequences of exposure to violence and political oppression. This can have severe and lasting impacts on their health and mental well-being. The World Health Organization broadly defines 'health' as a state of complete physical, mental and social well-being. Without mental health there is no health.

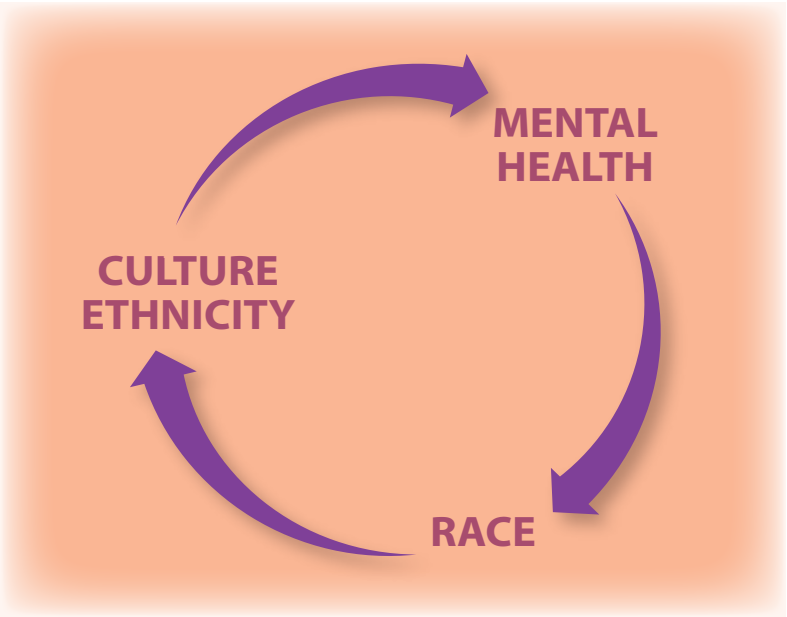
Health is determined by factors and conditions in the socioeconomic and physical environment as well as early childhood experiences, personal health practices, biology and health services. Gender and culture are further contributing factors to overall health as well as the availability of care.

"Minority status, experiences of prejudice, social and economic disadvantages and communication barriers become a lamentable part of daily life adversely affecting the immigrant's mental state."
(Dr. Saeed Islam)

In many western countries, immigrants do not use health care services to the same extent as a native Caucasian population. There are also differences in their expectations, requirements and health needs. They may have higher than expected psychiatric morbidity. As noted above, how people behave, express and manifest their psychological distress is largely determined by their culture and ethnicity.

Culture is defined as a set of beliefs, traditions, customs, and habits that provide a social and historical background to a person's identity and behaviour.

ASSOCIATION BETWEEN CULTURE, RACE AND MENTAL HEALTH

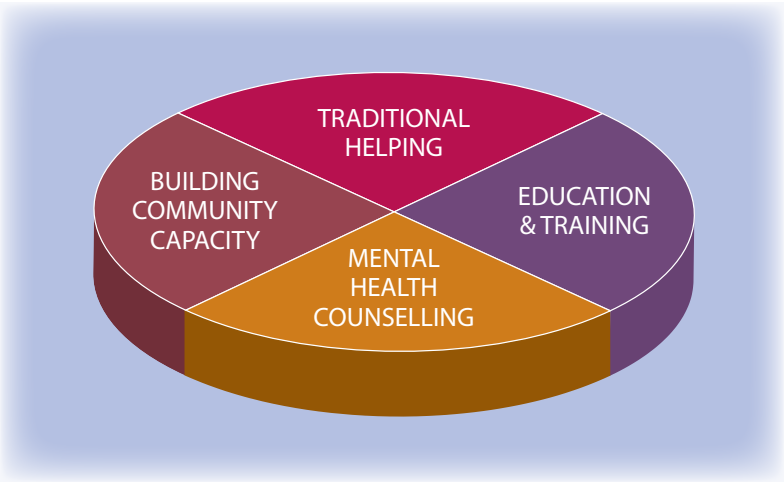


Race is a biological concept, but it does play an independent role in influencing mental health. For example, African Americans are often stigmatized and as a result certain disorders are more prominent in them, compared to whites. Thus it is important to understand the larger social context of other groups to identify mental health problems

Culture fulfils four main functions:

- Culture enables individuals to represent at different levels of functioning (representational function)
- Culture develops entities and describes functional norms (constructive functions)
- Cultural norms have an impact on people's lives and direct their behaviour (directive functions)
- Culture evokes emotions and sets rules for how to feel at a certain point (evocative functions)

Cross-cultural issues and an awareness of them have received a considerable amount of attention. Pediatricians and other health-care providers have been confronted with families who represent different backgrounds. It is important to understand families and their cultures when diagnosing treating them.



There are a variety of avenues for immigrants to enter the main stream of healthcare. Making these different roads explicit can be helpful

CASE VIGNETTE #3

M is a 15-year-old boy who was born in Afghanistan but moved North America when he was five or six years old. His family belonged to the Hazara ethnic minority and faced some difficulties at the hands of the Taliban. His father was put in jail by the Taliban on charges of treason and at that time the family moved to Pakistan and then to America. The father joined them several years later upon his release from prison. During this period M was raised by his mother and her distant relatives who were settled in the Chicago area. They faced financial hardships and lived in fear of his dad dying in prison. M was a light-skinned, brown-haired kid who had a medium build and enjoyed soccer and listening to music on his Ipod.

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Case Vignette #3 continued from previous page

He was religious and followed the Shiite Islam religion but did not express his religious views in public. He had an overall tolerant world view despite his background.

He had an argument with his mother over excessive computer and Ipod use which resulted in a lot of yelling and screaming. M ended up taking an overdose of acetaminophen and had to be taken to an ER. He was later admitted to the adolescent psychiatric in-patient unit. When we met with M and his family we found out that they had noticed many changes in his behaviour such as irritability, poor appetite, social withdrawal and spending all of his time watching TV, on the computer or playing endless games on his cell phone. We further found out that the family was very isolated and both parents barely spoke any English; their children usually translated for them. He was often called a terrorist in school and around the neighborhood and was shunned even by Muslim kids who were born in USA; they did not want to be identified with him. He told us that his social isolation and dependence on media for entertainment was due to these circumstances but he admitted that his hopelessness and pessimism was exaggerated since he was now beginning to make friends and felt that some people were now ignoring his background and see him as a person. Unfortunately this family signed him off AMA (Against Medical Advice) because they did not want psychiatric hospitalization on his record.

It is clear that in M's case there were a lot of stress factors including war trauma, refugee status, his father's imprisonment, economic difficulties, cultural alienation from his original society as well as from the adopted one. Pressures from middle school, bullying and the failure to fit in caused him to further spiral downwards before he snapped. The parents' isolation and language barrier made our work more difficult and their lack of trust in the mental health system of a western country did not allow them to obtain the help that could have made a significant difference in their son's life. Gaining trust of a family like this can be very tricky and calls for a great degree of sensitivity and understanding of the cultural values and individual circumstances.

There is considerable reason to think this adolescent is depressed. We have found it helpful to provide another booklet in this series called 'Detecting Depression in Children and Adolescents' to parents. We ask them to read the short booklet and to come back in one to two weeks to discuss how it may relate to their child. This has very often helped parents to overcome their reluctance about the treatment of depression in their child. This booklet is available on the website www.sleepontario.com.

This vignette emphasizes a cascade of events that can lead to depression and self-harm stemming from a culture gap

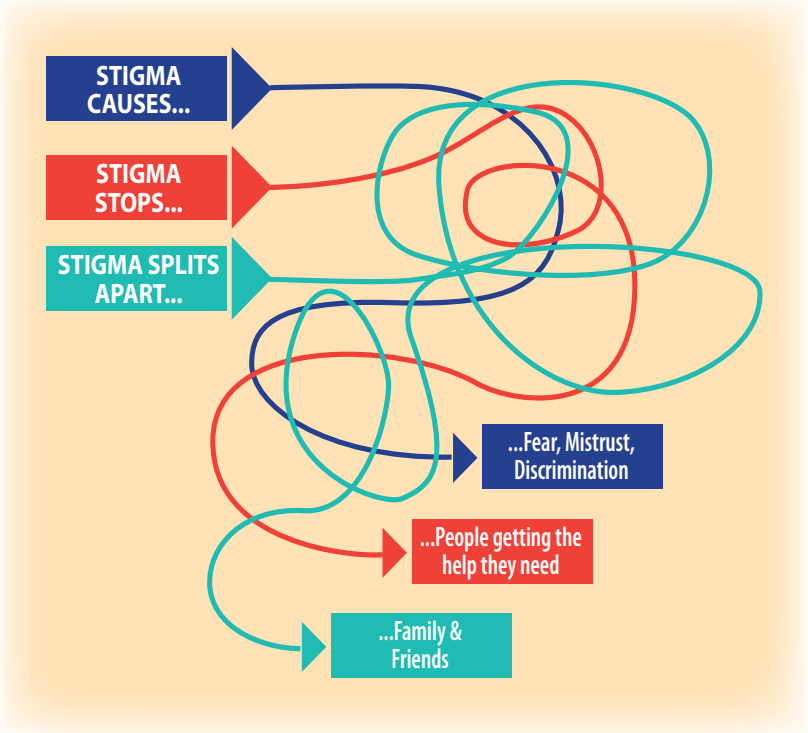
6. Stigma Related to Mental Illness and Cultural Differences

***Definition*:**

The term 'stigma' is of Greek origin and refers to a scar burnt or cut into the body, signifying that the bearer was a slave, or had an immoral status such as being a criminal.

The stigma of mental illness is that mental illness is associated with negative qualities. For example, a person with a mental illness may be wrongly viewed (or even view themselves) as being weak or 'damaged', leading to feelings of shame and/or embarrassment. Stigmas associated with having a mental illness may prevent a person from seeking out help or support from others.

IMPACT OF STIGMA



In causing, for example, fear in limiting help and in fragmenting families, stigma compounds the problem of mental illness. This can have a strong cultural component – especially in groups and communities that do not accept mental illness as valid.

The stigma attached to mental illness, and to the people who have it, is a major obstacle towards receiving adequate or better care and to the improvement of the quality of the sufferer's life.

An anxious adolescent often isolates herself from her peers

SOMATIC IDIOMS OF DISTRESS

"SINKING HEART, FEELING HOT, GAS"
India, Pakistan

"Jesmi metkasser (BROKEN BODY), Tabana (I AM TIRED), sadri dayeq alayya (MY CHEST FEELS TIRED)"
Dubai

"THE HEART IS POISONING ME, AS THERE IS HOT WATER OVER MY BACK, SOMETHING IS BLOCKING MY THROAT"
UAE (Hamadi et al 1997)

"SHENJING SHUAIRUO (NEURASTHANIA)"
Chinese

"HEAT IN THE HEAD, BITING SENSATIONS ALL OVER THE BODY, HEAVINESS IN HEAD"
Nigeria

As noted in chapter 4, there are different cultural expressions of distress

THE ROLE OF CULTURE

Supernatural, religious and magical approaches to illness and behaviour exist. This may induce a strong stigma in some cultures whereas in other cultures this may be normal. As noted previously in this booklet, the arbitrary distinction between mind and body is not significant in Asian cultures.

In certain cultures there is a strong belief that the person is "possessed" and treatment is not sought; rather the families go to traditional faith healers or shamans.

Dissociative phenomenon and a restricted sense of consciousness, verbal and motor behaviour governed by a possessing agent; a God, the devil or an ancestor's spirit, is a common presentation of someone being possessed. In certain cultures, patients suffering from a psychotic disorder (such as schizophrenia) often encounter delays in getting to the point of receiving treatment because of either

a lack of awareness or because of the stigma of being labeled as mentally ill. This is culturally sanctioned in many societies and induced for religious or therapeutic purposes. However it is not uncommon to see these possessive states occurring in popular temples where an emotional climate of a crowd fosters a dissociative phenomena. These beliefs and behaviours can complicate the maze of getting to an appropriate treatment.

Ideal treatment in a reasonable period may be blocked for reasons of stigma and culture

Another common aspect in traditional societies is the importance of familial orientation, group centeredness and interdependence. These factors place high value on group harmony in place of autonomy and individualism.

According to Kirmayer, a well-known expert in the field: "Where the person is conceived in terms of the family or a larger social unit ... stigma of illness affects the entire unit and demands a collective response". As a result, stigma may be more severe because it is attached to the family as a whole.

CASE VIGNETTE #4

T is a 16-year-old girl who came from Lahore, Pakistan only 2 years ago when her family emigrated to America. They belonged to a Catholic minority in Pakistan and had a middle class socio-economic status there. The father had a job at a social welfare NGO and the mother was a high school teacher in Pakistan. T went to a Catholic school in Lahore and had dozens of friends from her own community as well as from the mainstream Muslim society; the majority of children in Catholic schools in Pakistan are Muslims.

She had experienced some bullying at her new school in the States and was often called names due to her dark skin and accented English (T had an accent that reminded one of colonial subcontinent). It took her some time to drop "u" from "color" while writing and pronounce schedule with "sc" instead of "sh". This family saw some difficult times due to emigration and settling down in a new culture however they did not report any major hardships. She had two older brothers who were both in college and had part time jobs and her father worked two jobs to make ends meet. Mother remained unemployed and later had to leave America due to visa-related issues. T felt increasingly isolated. She would talk to her mom on skype for hours and had difficulty sleeping and would often cry herself to sleep. Her brothers were very busy and did not notice any changes in their sister. She started to cut her arms and remained locked in her room. Father attributed this to her mom's absence and did not feel any need for intervention; he had not noticed the cut marks on her arms. She then took an overdose of over-the-counter sleeping pills and slept for 2 days straight. This made the father very angry since he thought this to be pure laziness. One day she fainted while going up the stairs in her house and had a minor cut on her forehead. She was taken to the ER for stitches and there she reported suicidal thoughts and hopelessness during a routine ER assessment. She was then sent for a psychiatric assessment and was diagnosed with depression. In this case her father admitted that he never thought depression could look like this nor did he think his daughter needed emotional support since nobody in her family ever saw a psychiatrist or a therapist. They were used to praying, ignoring the symptoms and hoping those feelings would go away. The only occasion for which they would see a doctor was when they had a physical symptom. T was perhaps trying to get her father's attention to get her some help when she was overdosing and cutting. Her isolation from family further aggravated her sense of alienation. The lack of emotional support and not having the right coping skills made her vulnerable to suicide. Pakistani culture in general is not open to getting psychological help and the stigma is greater for girls than it is for boys, since parents see this as a potential threat to marriage prospects for their daughters.

This vignette emphasizes issues of social isolation

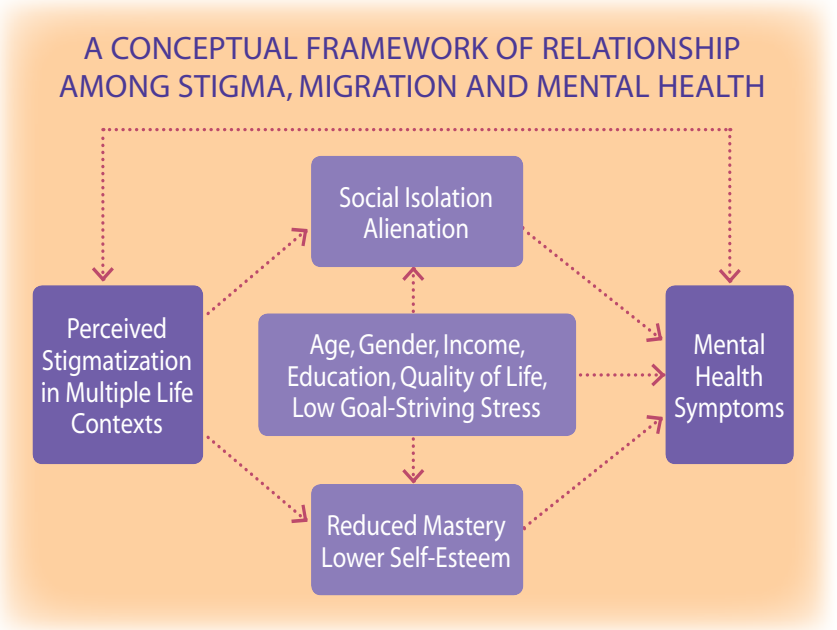
ROLE OF IMMIGRATION

Immigration and the stress of settling into a society may cause a mental health problem or perpetuate one. The figure below illustrates this relationship.

EDUCATION ABOUT MENTAL ILLNESS

Mental illness is the same as having any other physical illnesses such as diabetes or hypertension. Mental disorders such as anxiety, depression, eating disorders, drug and alcohol misuse, dementia and schizophrenia can affect anyone.

However, as compared to physical disorders, patients with mental disorders are considered more dangerous. There is more fear, hostility and rejection towards them. This in turns results in the delay in seeking help and treatment and increases stigma.



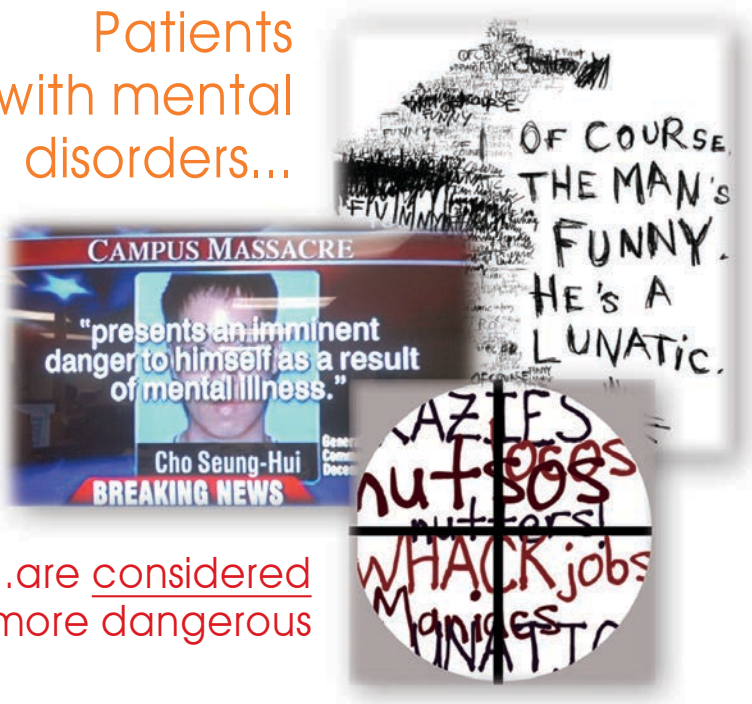
How stigma interacts with obtaining mental health treatment

It is important to educate populations about the various causes of mental illness. The common causes are: a chemical imbalance (which is also seen in diabetes), family and personal issues as well as genetics. Similar to hypertension and diabetes there are medications that can be of help to treat psychiatric disorders. Psychotherapy is also a type of treatment option.

Acceptance towards the presentation of mental illness in Asian and non-western societies is not the same as in many western societies. These are influenced by complex factors associated with culture, religion, values, and social orientation.

It is important to understand and look into social, cultural and religious values of the people and families with mental illness when educating and treating them, as explained in chapter 9.

Patients with mental disorders...



...are considered more dangerous

7. Role of Families

In the last few decades there has been a large increase in the South Asian population. This broad definition can be divided into four major groups: East Asian (Chinese, Japanese, Korean), Pacific Islander, Southeast Asian (Vietnamese, Thai) and South Asian (Indian, Pakistani).

Similarities exist amongst these cultures but those working with these cultural groups need to remember their different origins, ecological adaptations, history, immigration and refugee history. To understand this, there has been an increase of interest in looking at the role of families and cultural influence in the field of health and mental health as they apply to these cultural groups. The help-seeking behaviour and presentation of symptoms varies across different cultures and families. It is therefore difficult to diagnose and treat them without understanding the frame of reference of the person and the family seeking help.

People differ in the way:

- *They experience pain*
- *How they communicate about their pain or other symptoms*
- *Their knowledge , beliefs and attitudes about them*
- *What treatment they want or expect*

The manifestation of illness is governed by cultural values and roles. Symptom presentation can be different and the understanding of that symptom can differ across cultures. As a result, diagnosis and treatment need to be conceptualized and understood from the family's and the patient's perspectives.

Belief systems also vary among families and every family has their own unique belief system which may include religion, self help groups, close friends and family members.

It is also important to understand roles of different family members within different cultures.

CHARACTERISTICS OF THE TRADITIONAL ASIAN FAMILY	
	Hierarchical in structure, with males and older individuals occupying a higher status
	The role of the male is to provide for the family. One's primary duty is to be a "good son"; obligations to be a good husband and father are secondary to your duty as a son
	Patriarchal husband-wife relationships
	Respect for ancestors and the elderly (Past-present time orientation)
	Loyalty to authority figures
	Collectivism

Children learn early in life that the **family is central** and represents the primary unit. The behaviour of individual members is a reflection on the entire family. Family problems are hidden from public and handled within the family.

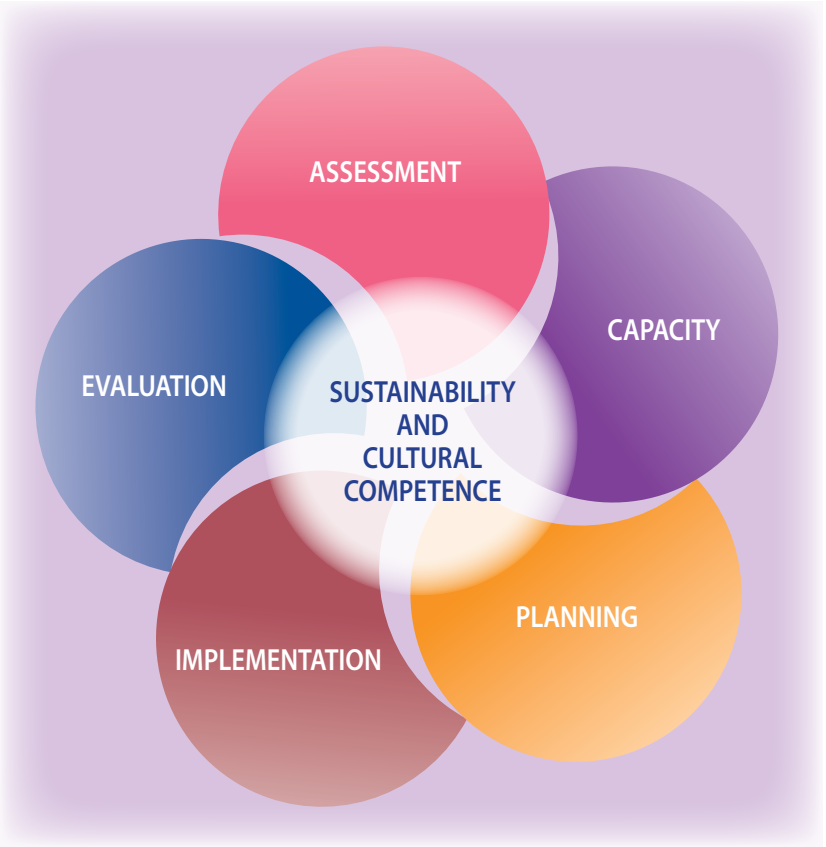
There is stigma related to mental illness; it is shameful and is viewed as representing family failure. The presentation, knowledge, attitude and beliefs towards mental illness are different from western society. The initial pathways towards seeking help are either within the family network or through religious healers/ shamans. Emotional problems are not seen as being important. There is minimal open display of emotion. Control of emotion is considered a sign of maturity and self-control. The favoured way of solving problems is to defer them to the authority figure in the family or extended family. South Asian clients consider decision making to be the prerogative of the head of the household, generally the eldest male. The typical South Asian client is more familiar and comfortable with the concepts of collectivism and family interdependence over autonomy. However this should not be a generalized attribute as there may be variations depending on the level of acculturation and individual presentation.

These characteristics should be kept in perspective in order to understand, diagnose and treat patients. It is therefore important to learn about South Asian families and not stereotype them. They should be allowed, guided and encouraged to make their own choices, facilitated and supported by the health care professionals.

8. Needs Assessment and Establishing Services

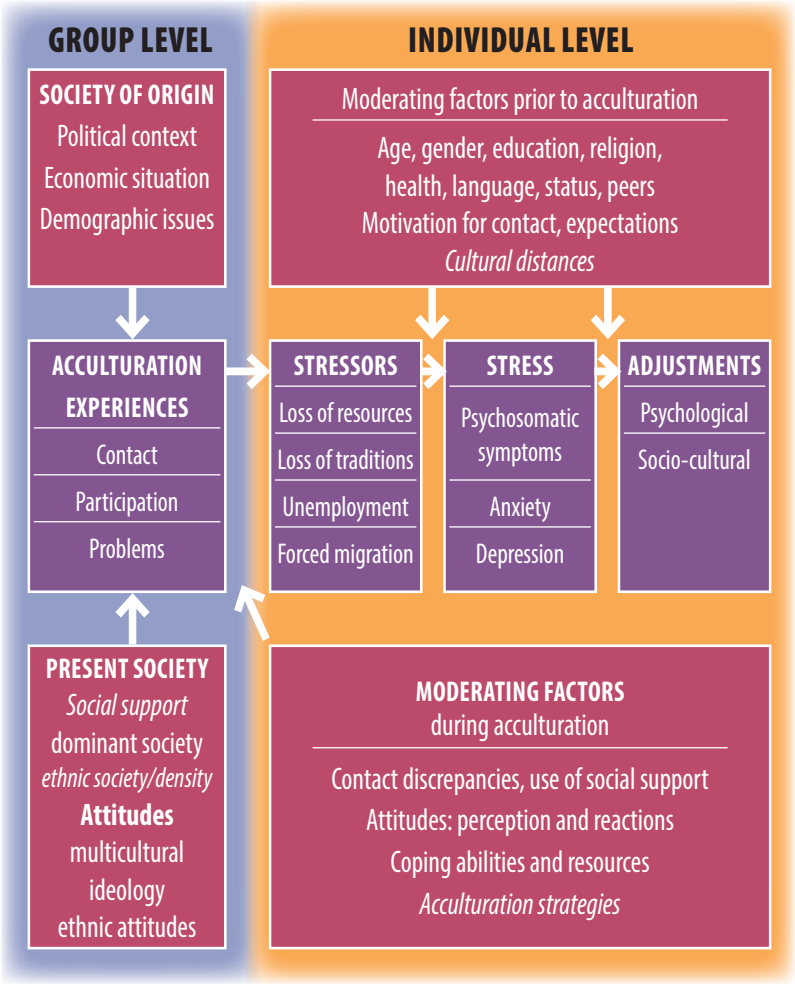
Needs assessment is defined as "a systematic process to acquire an accurate, thorough picture of a system's strengths and weaknesses, in order to improve it and meet existing and future challenges."

The youth of a community are the bearers of its future, and as such it is imperative that the community and society at large promote their well-being.



Components in considering setting up a service

Mental health promotion amongst youth is an especially important task to take on. In order to do this, it is first necessary to know what the mental health issues are, devise intervention programs to address the concerns and to then implement these programs. In addition to intervention, it is equally important to plan and develop effective prevention programs in order to reach youth and their families before they reach the simmering stages. Unfortunately, it appears that South Asian families and their children underutilize these services of crisis in many places, for example in Canada.



Factors influencing mental health

How people behave, express and manifest stress and illness is largely determined by their culture and ethnicity. Mental diseases, especially depression, go largely undetected in immigrant populations. Strong faith and spirituality in Muslim culture deems mental illness as the weakness of the soul, where keeping silent in the face of suffering is the norm, and to persevere is pious. Muslims tend to underseek professional help as the stigma and shame of mental health is worse than their anguish. They usually end up in primary-care settings with vague pain and symptoms, where they are either under or misdiagnosed. In children and adolescents they have difficulties at school either academically or in terms of the behaviour.

Past research studies have not shown that South Asian youth are less susceptible to having mental health issues; in fact, many may be even more vulnerable, as their developmental struggles are further compounded by the experiences of resettlement, acculturation, and even war trauma in some cases.

Therefore it is essential to understand the needs of the community, their attitude towards health and mental health, to identify the barriers, and then to establish services to cater those needs with the aim of lowering the barriers to accessing mental health.

Some key recommendations are:

- **Agencies and organizations need to lower the language and cultural barriers by having more staff who are representative of the various South Asian communities.**
- **To educate existing community workers to improve their ability to detect mental health problems and to make appropriate referrals.**
- **Educational workshops in the community.**

9. Treatment: Psychological and Pharmacological

CULTURE AND PSYCHIATRIC TREATMENT

Culture is part of the environment that has been created by humans. It encompasses tangible objects and mental products: knowledge, belief, values, ways of communication, philosophies of life, rituals and socially prescribed behaviour patterns. Illness is a universal phenomenon but the experience and expression of emotions, distress and suffering are shaped by the culture(s) we identify with. As we grow up we acquire an understanding of the world shared by our cultural groups. From a health perspective, "enculturation" involves acquiring knowledge about health and illness, about "normal" and "abnormal" and learning how to act in and react to distress and sickness. Sickness behaviour, the theories about the cause of suffering and the ways to alleviate it therefore are integral part of culture.

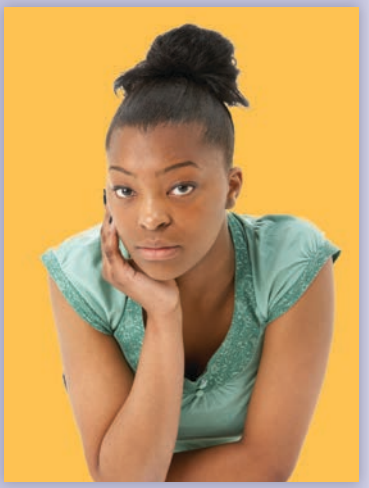
What every Clinician needs: Cultural Competence

Within Canada's multi-cultural population, for example, and in many western countries today, cultural competence of clinicians is an essential component for an effective treatment process. Cultural competence involves cultural awareness, cultural sensitivity, cultural knowledge and skills that the clinician actively employs to provide culturally safe treatment - environment for patients.

A. CULTURAL AWARENESS

The first step towards mastering cultural competence as a treatment provider is to understand how our own cultural identities (socio-economic status, race, ethnicity, age, gender, sexual orientation, spiritual beliefs, educational background); the culture of our profession

(nursing, social work, counseling, medicine, psychology) and the federal or provincial health care systems shape the treatment opportunities, forms and content we provide.

FACTORS THAT MAY LEAD PROFESSIONALS TO PRECONCEIVED NOTIONS ABOUT PATIENTS	FACTORS THAT INFLUENCE PATIENT'S IDEAS ABOUT THE SOCIAL WORKER, PSYCHOLOGIST OR DOCTOR WHO IS TREATING THEM
	
Name	Gender identity
Appearance	Sexual orientation
Manner	Immigrant status
Voice	Race & Ethnicity
Accent	Other social factors

In contemporary mainstay North-American culture and western societies, mental disorders are conceptualized as medical illnesses. Those suffering from a 'sickness of the brain/mind' are provided treatment based on this medical model, although

the cultures of mental health professionals are different in terms of their breadth and focus of intervention. The mental illness is assumed to be a disorder of the individuals even if the primary issues of the illness include a conflict between the person and the environment. Individuals are assumed to be autonomous beings exercising control over their destiny. Based on these assumptions the intervention is some form of treatment that usually takes place in a health care setting; either as inpatient care or over a course of time-limited appointments, between the treatment provider and the individual. The most often employed treatment modalities (medication and psychotherapy) are cultural products embedded in a network of expectations. Beliefs about the effectiveness of these treatments are likewise embedded in the culturally shaped interpersonal context of treatment delivery. We have to be aware that these professional beliefs and practice systems are cultural products and may be fundamentally different from the world views of our patients. One needs to be cautious in taking them for granted. Furthermore, we have to be mindful that we form assumptions about our patients even before we meet them. Sometimes preconceived responses may be triggered: Examples include seeing their names or reading their previous health care records and in the moment we first meet them (based on their appearance, manner, voice, accent etc.). We need to understand what these assumptions are based on (or biased by) and be aware how our own cultural identities impact on this process. Similarly, it is important to be aware that patients form assumptions about us as their treatment providers based on our professional status, sex, skin colour etc and these assumptions will shape what they choose to disclose and how they will cooperate in treatment (see figure on page 41).

Cultural knowledge involves acquiring knowledge on cultural beliefs, ways of communication, norms and traditions as they relate to health and illness, non-usual psychological and behaviour patterns and healing. It also involves understanding how socio-economic status, income, living environment, gender identity, sexual orientation, immigrant status, race, ethnicity and other social factors may limit patients' access and adherence to treatment. It is important to be aware that individuals have multiple cultural identities and we should never assume which cultures patients identify with or what their dominant identities are. Often the tension between cultural identities perpetuates psychopathology, for example orthodox religious and homosexual identities or dual role identifications in immigrants.

Cultural skills are required to create a culturally safe treatment environment for patients. Agreement concerning problem conceptualization (definition, cause, maintaining factors of presenting problems), cooperative goal setting (what we want to achieve with the treatment) and agreement in the method of interventions between patients (and others making decisions for/with the patients) and health-care professionals are essential for successful treatment implementation.

As opposed to the western, medical conceptualization of mental problems, a widespread theory found in Asia, Africa and Latin America is that illness is a result of disharmony among physical, social and spiritual spheres. This imbalance between yin and yang or cold and hot elements may be caused by individual weakness, exposure to adverse environmental forces (inadequate food, cold, etc,) or brought upon the individual by supernatural powers such as spirits of ancestors, animal spirits, saints or evils. The culturally competent clinician learns about and respects these explanations, integrating them into a problem-formulation that makes sense for the patient and at the same time allows consensus of goals and interventions.

In many societies mental health is seen as the balance of opposing forces

Explicit discussion of treatment goals with a clear understanding of the expectations as well as defining "measures" of successful treatment is an integral part of culturally competent treatment. Individual well-being, self-actualization, increased autonomy and independence are common treatment goals based on western views of the self that may not be in agreement with the goals of patients with diverse cultural backgrounds. In many cultures the smallest unit of identity is the family or community; if the individual is sick then the whole family/community is sick and the goal of intervention is to establish the harmonious relation of the person to others so that the family/community prospers. The misunderstanding of patients' goals and evaluation of the treatment process may lead to rejection of treatment or patients may alter the treatment regimen to fit their goals and lifestyles without informing the clinician.

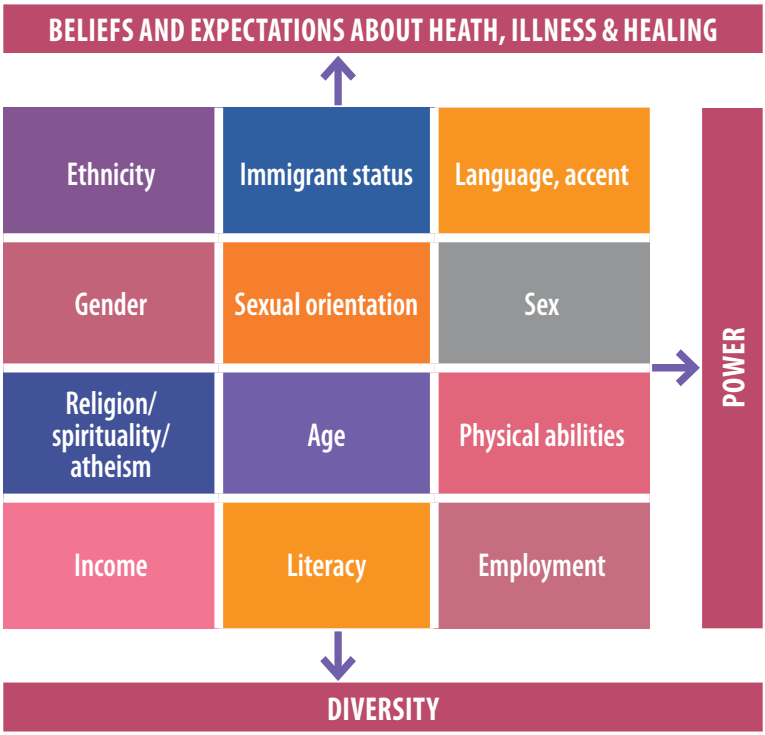
After a consensus in problem formulation and treatment goals is achieved, cultural skills are required in the treatment choice and delivery. Unfortunately, in research studies supporting evidence-based psychological and pharmacological treatments, unprivileged socio-cultural groups are generally underrepresented. This means that we don't have sound evidence to support the assumption that

these treatments are equally effective for cultural minorities. In this respect cultural competence means that the clinician chooses the best available treatment that is the most relevant for the individual and then can adjust it to achieve the best results in the person's cultural context.

The absorption, distribution, metabolism and excretion of medications are influenced by race, ethnicity, age, sex and environmental factors that sway gene expressions. Beyond these biological factors, cultural beliefs surrounding medications have a psychological impact on the effectiveness of pharmacotherapy. This placebo effect is usually considered to be an "artefact" of medications that does not contribute to their "real", unique effectiveness. However from the cultural psychological perspective, it is an important component of medication treatment. In cultures where getting medications is part of the social ritual in response to sickness behaviour, the placebo effect of medications may be stronger than in others in which medications are less frequently used. This is due to the positive expectations of both the patients and doctors and the learned associations between the treatment ritual involving medications and recovery. On the other hand, in many cultures, western medications are considered to be too powerful and, if taken over the long term, toxic; therefore herbal and traditional remedies are preferred, especially for long-term treatment. Even the color, mode of administration, or

The doctor's thoughts and the patient's thoughts about what a treatment may do, won't always marry well

the ingredients of medication (whether they are derived from plants or contain alcohol) can have a psychological effect on the patients' response. For example, in one study, Caucasians believed that white placebo pills were analgesics and



There are many factors which influence the cultural interaction between the therapist and the patient/client

black pills were stimulants whereas African-Americans thought that white pills were stimulants and black pills were analgesics.

Psychotherapy can be flexibly adapted to the client's cultural identities, values, goals and expectations if it is provided by clinicians with cultural-clinical expertise. However, it is important to know that in many cultures a holistic sense of self prevails where body, mind, the community and the natural environment are inseparable; therefore individuals express distress with physical symptoms or in terms of a sense of disharmony and find it difficult to talk about their thoughts and emotions. Communication is a core element of psychotherapy. As was alluded to above, both client and therapist form assumptions deriving meaning via non-verbal communication channels. Eye contact conveys the meaning of connection and paying attention in North America and Western Europe. Those patients who avoid eye contact may be perceived as inattentive, shy, anxious or untruthful. In many cultures, however, patients avoid eye contact to show respect towards the clinician and, if the therapist attempt to hold eye contact the client may feel he or

she is being punished or find the clinician's behaviour sexually provocative. The expression of emotions is also shaped by culture and clients from different ethnic backgrounds may express emotions in a more subtle (e.g. Eastern Asians) or explicit way (e.g. Latinos, Gypsies). Additionally, cultural rules shape males' and females' emotional expressions. When either the therapist or the client is not a native English speaker, the subtle, symbolic meaning of words or phrases may be not fully grasped or can actually be misunderstood. Also, the clinician may draw incorrect conclusions about patients' emotional or mental state from their pace of speech or tone of voice if they speak English as a second language. Even those patients who have been speaking English for years may speak slower or take longer to respond as they search for the correct words. People whose first language or intonation is more guttural than English (e.g. Arabic, German) may be misperceived as angry or harsh by the native English speaker therapist, whereas those who speak more softly may appear to be shy and non-confident to the clinician. Culturally infused psychotherapy facilitates culturally valued coping behaviours in a culturally safe therapeutic environment.

We hope you have found this booklet useful in understanding the role of culture in the treatment of mental health. This booklet is easy to read and understand with illustrations and vignettes. It highlights the role of families, and how symptoms and illness can present differently. We have discussed the importance of both treatment and of cultural competence in order to identify, address and treat mental illness.

Appendix 1

There are many culture-bound specific syndromes. These are highly informative and in many situations very relevant. These syndromes are:

CULTURE-BOUND SYNDROMES

Amok or mata elap: (Malaysia)

A dissociative episode characterized by a period of brooding followed by an outburst of violent, aggressive, or homicidal behaviour directed at people and objects. The episode tends to be precipitated by a perceived insult or slight and seems to be prevalent among males. The episode is often accompanied by persecutory ideas, automatism, amnesia for the period of the episode, exhaustion, and a return to your usual state following the episode. Some instances of amok may occur during a brief psychotic episode or constitute the onset or exacerbation of a chronic psychotic process. Similar to cafard or cathard (Polynesia), mal de pelea (Puerto Rico), iich'aa (Navaho), and syndromes found in Laos, Papua New Guinea, and the Philippines.

Anorexia mirabilis or holy anorexia: (medieval Europe)

Severe restriction of food intake, associated with experience of religious devotion. Often considered normal within the culture.

Boufee deliriante: (West Africa and Haiti)

Sudden outburst of agitated and aggressive behaviour, marked confusion, and psychomotor excitement. It may sometimes be accompanied by visual and auditory hallucinations or paranoid ideation. Similar to DSM-IV brief psychotic disorder.

Brain fag or brain fog: (West Africa)

A condition experience by primarily male high school or university students. Symptoms include difficulties in concentrating, remembering, and thinking. Students often state that their brains are "fatigued". Additional symptoms centre around the head and neck and include pain, pressure, tightness, blurring of vision, heat, or burning. "Brain tiredness" or fatigue from "too much thinking" is an idiom of distress in many cultures. May resemble anxiety, depressive, or somatoform disorders in DSM-IV.

Bulimia nervosa: (North America, Western Europe)

Binge eating followed by purging through self-induced vomiting, laxatives, or diuretics; and morbid fear of obesity. May overlap with symptoms of anorexia nervosa.

Dhat: (India)

Semen-loss syndrome, characterized by severe anxiety and hypochondriacal concerns with the discharge of semen, whitish discoloration of the urine, and feelings of weakness and exhaustion. Similar to jiryan (India), sukra prameha (Sri Lanka), and shenkui (China).

Falling out or blacking out: (Southern U.S. and Caribbean)

Episodes characterized by sudden collapse, either without warning or preceded by feelings of dizziness or "swimming" in the head. The individual's eyes are usually open, but the person claims inability to see. The person usually hears and understands what is occurring around him or her, but feels powerless to move. May correspond to DSM-IV conversion disorder or dissociative disorder.

Ghost sickness: (American Indian groups)

Preoccupation with death and the dead, sometimes associated with witchcraft. Symptoms may include bad dreams, weakness, feelings of danger, loss of appetite, fainting, dizziness, fear, anxiety, hallucinations, loss of consciousness, confusion, feelings of futility, and a sense of suffocation.

Grisi siknis: (Miskito Indians, Nicaragua)

Symptoms include headache, anxiety, anger, aimless running. Some similarities to pibloktoq.

Hi-Wa itck: (Mojave American Indians)

Insomnia, depression, loss of appetite, and sometimes suicide associated with unwanted separation from a loved one.

Hsieh-ping: (Taiwan)

A brief trance state during which one is possessed by an ancestral ghost, who often attempts to communicate to other family members. Symptoms include tremor, disorientation and delirium, and visual or auditory hallucinations.

Hwa-byung or wool-hwa-bung: (Korea)

"Anger syndrome". Symptoms are attributed to suppression of anger and include insomnia, fatigue, panic, fear of impending death, unhappiness, indigestion, anorexia, dyspnea (difficulty breathing), palpitations, generalized aches and pains, and a feeling of a mass in the epigastrium (the middle of the abdomen). See also bilis and colera.

Involutional paraphrenia: (Spain, Germany)

Paranoid disorder occurring in mid-life.

Koro: (Malaysia)

An episode of sudden and intense anxiety that the penis (or in the rare female cases, the vulva and nipples) will recede into the body and possibly cause death. The syndrome occasionally occurs in local epidemics. This syndrome occurs throughout South and East Asia under different names: suo yang (China); jinjinia bemar (Assam); and rok-joo (Thailand). It has been identified in isolated cases in the United States and Europe, as well as among ethnic Chinese or Southeast Asians across the world.

Latah: (Malaysia and Indonesia)

Hypersensitivity to sudden fright, often with echopraxia, echolalia, command obedience, and dissociative or trancelike behaviour. The Malaysian syndrome is more frequent in middle-aged women. Similar syndromes include: amurakh, irkunii, ikota, olan, myriachit, and menkeiti (Siberian groups); bah-tschi, bah-tsi, and baah-ji (Thailand); imu (Ainu & Sakhalin, Japan); and mali-mali and silok (Philippines).

Locura: (Latin America)

A severe form of chronic psychosis attributed to an inherited vulnerability, the effect of multiple life difficulties, or a combination of the two. Symptoms include incoherence, agitation, auditory and visual hallucinations, inability to follow rules of social interaction, unpredictability, and possible violence.

Pibloktoq or Arctic hysteria: (Greenland Eskimos)

An abrupt dissociative episode accompanied by extreme excitement of up to 30 minutes' duration and frequently followed by convulsive seizures and coma lasting up to 12 hours. The individual may be withdrawn or mildly irritable for a period of hours or days before the attack and will typically report complete amnesia for the attack. During the attack, the individual may tear off his or her clothing, break furniture, shout obscenities, eat faeces, flee from protective shelters, or perform other irrational or dangerous acts. The syndrome is found throughout the arctic with local names.

Qi-gong psychotic reaction: (China)

An acute, time-limited episode characterized by dissociative, paranoid, or other psychotic or nonpsychotic symptoms that occur after participating in the Chinese folk health-enhancing practice of qi-gong. Individuals who become overly involved in the practice are especially vulnerable.

Sangue dormido: (Portuguese Cape Verdeans)

Literally "sleeping blood". Symptoms include pain, numbness, tremor, paralysis, convulsions, stroke, blindness, heart attack, infection, and miscarriage.

Shenjian shuairuo: (Chinese)

Equivalent to now-defunct diagnosis of "neurasthenia". Symptoms include physical and mental fatigue, dizziness, headaches and other pains, difficulty concentrating, sleep disturbance, and memory loss. Other symptoms include gastrointestinal problems, sexual dysfunction, irritability, excitability, and various signs suggesting disturbances of the autonomic nervous system. Many cases would be DSM-IV criteria for a major depressive disorder or an anxiety disorder.

Shenkui: (Chinese)

Marked anxiety or panic symptoms with accompanying somatic complaints for which no physical cause can be demonstrated. Symptoms include dizziness, backache, becoming easily tired, general weakness, insomnia, frequent dreams, and complaints of sexual dysfunction (such as premature ejaculation and impotence). Symptoms are attributed to excessive semen loss from frequent intercourse, masturbation, nocturnal emission, or passing of "white turbid urine" believed to contain semen. Excessive semen loss is feared because it represents the loss of one's vital essence and can thereby be life threatening. Similar to dhat and jiryan (India); and sukra prameha (Sri Lanka).

Shin-byung: (Korea)

A syndrome characterized by anxiety and somatic complaints (general weakness, dizziness, fear, loss of appetite, insomnia, and gastrointestinal problems), followed by dissociation and possession by ancestral spirits.

Shinkeishitsu: (Japan)

Syndrome marked by obsessions, perfectionism, ambivalence, social withdrawal, neurasthenia, and hypochondriasis.

Spell: (Southern U.S.)

A trance state in which individuals "communicate" with deceased relatives or with spirits. At times this is associated with brief periods of personality change. Spells are not considered medical events in the folk tradition, but may be misconstrued as psychotic episodes in a clinical setting.

Tabanka: (Trinidad)

Depression associated with a high rate of suicide; seen in men abandoned by their wives.

Taijin kyofusho: (Japan)

A syndrome of intense fear that one's body, body parts, or bodily functions are displeasing, embarrassing, or offensive to other people in appearance, odour, fa-

cial expressions, or movements. Similar in some respects to DSM-IV social phobia, and included in the official Japanese classification of mental disorders.

Windigo or witiko: (Algonkian Indians, North East U.S. and Eastern Canada)

Famous syndrome of obsessive cannibalism, now somewhat discredited. Wendigo was supposedly brought about by consuming human flesh in famine situations. Afterwards, the cannibal was supposed to be haunted by cravings for human flesh and thoughts of killing and eating humans.

Zar: (Ethiopia, Somalia, Egypt, Sudan, Iran, and elsewhere in North Africa and the Middle East)

Experience of spirit possession. Symptoms may include dissociative episodes with laughing, shouting, hitting one's head against a wall, singing, or weeping. Individuals may show apathy and withdrawal, refusing to eat or carry out daily tasks, or may develop a long-term relationship with the possessing spirit. Such behaviour is not necessarily considered pathological locally.

CULTURE-SPECIFIC SIGNS OF DISTRESS AND DISEASE:

Ataque de nervios: (Latin groups)

An idiom of distress principally reported among Latinos from the Caribbean, but also among many Latin American and Latin Mediterranean groups. Symptoms include uncontrollable shouting, attacks of crying, trembling, heat in the chest rising to the head, and verbal or physical aggression. Ataques de nervios frequently occurs as a result of a stressful family event, especially the death of a relative, but also a divorce or fight with a family member.

Bilis and colera: (Latin America)

Part of a general Latin American idiom of distress and the explanation of physical or mental illness as a result of extreme emotion, which upsets the humors (described in terms of hot and cold). Bilis and colera specifically implicate anger in the cause of illness.

Mal de ojo: (Spain and Latin America)

The Spanish term for the evil eye. Evil eye occurs as a common idiom of disease, misfortune, and social disruption throughout the Mediterranean, Latin American, and Muslim worlds.

Nervios: (Latin America)

Idiom of distress, refers to a general state of vulnerability to stressful life experiences and to a syndrome brought on by such stresses. Symptoms may be very broad, but commonly include emotional distress, headaches, irritability, stomach disturbances, sleep disturbances, nervousness, easy tearfulness, inability to concentrate, tingling sensations, and dizziness. Similar to nevra (Greece).

Rootwork: (Southern U.S. and Caribbean)

A set of cultural interpretations that explain illness as the result of hexing, witchcraft, voodoo, or the influence of an evil person. Similar to mal puesto or brujeria (Latin America).

Susto: (Latin groups)

An idiom of distress principally reported among Latinos in the U.S. and Latin America. Susto is an illness attributed to a frightening event that causes the soul to leave the body, leading to symptoms of unhappiness and sickness. Symptoms are extremely variable and may occur months or years after the supposedly precipitating event. Alternate names include espanto, pasmo, tripa ida, perdida del alma, and chibih.

This information comes from the University of California at San Diego website. More information and links about culture-bound syndromes can be found at the site.

Dr. Azmeh Shahid graduated in medicine from the Dow Medical College, University of Karachi, Pakistan. She immigrated to Toronto and started her Fellowship in sleep medicine at the University of Toronto, University Health Network and also in child psychiatry at the Youthdale Treatment Centre. While living in Toronto - and being an immigrant herself - she developed an interest in cultural psychiatry which led her to continue her exploration of the cultural aspects of psychiatry and the role of immigration. She has also conducted numerous educational workshops on mental health issues. She is currently working as a staff child psychiatrist and sleep specialist at the Youthdale Treatment Centre and the Toronto Western Hospital, University of Toronto.

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