CROSS CULTURAL PSYCHIATRY:
CONTEXT AND ISSUES

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INTRODUCTION

Culture influences fundamental parts of our identity and social functioning by shaping our cognitions and conations. It also affects the way we experience pathology. Culture defines what is normal and what is deviant. Cultural psychiatry encourages the clinician to examine the patient in a cultural perspective and not purely biomedical perspective. With globalization and the consequent migration, cultures across the world have come closer together and led to multi-cultural societies. Cultures are rarely homogeneous so within the same setting individuals have to be assessed in a culturally appropriate manner. A psychiatrist needs to be culturally competent both at the individual and organizational level.

Culture is an integral part of humanity reflected in our lifestyles, ways of thinking and working. It is an important factor in the formation of self identity and is visible at both the macro and the micro level in the individual. There is no doubt that culture affects individuals, who affect the culture through interactions among themselves and with those from other cultures. Similarly it is well known that culture can influence the presentation of psychopathology in individuals. Culture is fundamental both to the causes and course of psychopathology and also to the access and acceptance of systems of health care delivery. Culture makes one look through a "lens" and affects one's world view and colors one's perceptions because of various cultural stereotypes and biases. The world is an amalgam of various cultures and so studying mental illness in one culture alone is not sufficient. It is also important to look at how cultural differences exist between different mental illnesses and how one copes with them or various other management issues.

CULTURE AND PSYCHIATRY

Culture has been variously defined as a systematic body of learned behavior which is transmitted across generations and a complex phenomenon including knowledge, beliefs, art, morals, laws, customs and other habits and capabilities acquired by man as a member of society[1]. Triandis distinguished objective and subjective culture[2]. "Objective culture" includes concrete and observable elements such as artifacts, institutions and social structures. "Subjective culture" on the other hand, includes categorizations (language), beliefs, attitudes, stereotypes, expectations, norms, ideals, roles, and values. Knowing a particular culture's chief source of power (social, political, mythological, religious) allows one to predict its beliefs about the causes of illness and how it treats various illnesses including psychiatric. The relationship between culture and psychiatry is multi-pronged. Each individual carries with them their own unique culture ingrained from birth, in the family and the society that he/she comes from. Experiences add to cultural layers and gender; specialism and other factors contribute to this further.

Cultural psychiatry is concerned with the ability to reflect various clinical phenomena so well that even simple cultural differences in the mode of complaints and in various lay or folk meaning attached to symptoms do not mislead the average competent clinician away from the diagnosis[3]. Cross cultural diagnosis involves various theoretical considerations as diagnostic categories, pathoplasticity of psychiatric disorder, and differential reporting of symptoms and expression of signs from one cultural group to another. Important clinical issues include distinguishing cultural belief systems from delusions and understanding the special problems of minority, migrant, and refugee patients[3]. The latter group of individuals has recently caught attention of psychiatric researchers and scholars as they provide them with a rich sample wherein cultural effects on presentation of stress can be studied. Cross-cultural psychiatry has given rise to some important concepts like *emic* and *etic*, which are derived from the discipline of linguistics and coined by Pike[4]. *Emic* is a concept that is said to arise from within the culture and is unique to that culture (intracultural), while *etic* is a concept which can be found in most, if not all, cultures (cross-cultural). Berry et al outlined three theoretical orientations to the relationships between culture and psychology as under, but these are also applicable to psychiatry[5]:

1) *Absolutism*: this position assumes that human phenomena are basically the same (qualitatively) in all cultures; thus implying that any mental illness is exactly the same in all cultures. This position

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which was dominant in the 18th century negates any influence of culture on human characteristics or illness and has somehow gone into oblivion with the emergence of various scholars stressing on the effect culture has on mental illnesses.

2) *Relativism*: this position assumes that all human behavior is culturally patterned, thus one can look for explanations of human diversity within the cultural context in which people have developed. This approach was prevalent during the later part of the 18th century till the early 20th century and gives importance to the values and meanings that a cultural group gives to a phenomenon.

3) *Universalism*: emerged in the middle of the 20th century and takes a position midway between the earlier two positions assuming that culture influences the development and display of basic psychological processes that are common to all members of the species. This approach thus permits discovery not only of behavioral similarities (universals), but also of differences (cultural specifics) across human groups.

Currently although all three perspectives can be found across cultures, it is the latter two that are more dominant [6]. These approaches become important both clinically and for research purposes. From the absolutist perspective, 'depression' is 'depression', no matter where one observes it and thus according to this approach, depression throughout various cultures can be assessed using standardized instruments (or their linguistic translations), without looking at the cultural influences. Relativism approach will however refrain from making any such comparisons and assessments as they are judged to be conceptually problematic and considered ethnocentric; thus the depression will be understood in the cultural context in which the patient has developed. The universalist approach does assess depression but by using measures developed in culturally meaningful versions [5].

CULTURE AND PSYCHOPATHOLOGY

Cultures define what is normal and what is deviant. Cultures can dictate what is meant by sick role and how long an individual can be off sick without a sick note. The way people express emotional distress and deal with it is dictated by culture and differs widely throughout the world; covering a spectrum from pathogenic through pathoplastic effect to pathofacilitating one[7]. It is possible that a culturally sanctioned behavior in one culture may be looked at as an illness behavior in another culture. Thus one has to be aware of the sociocultural aspects of various behaviors and refrain oneself from labeling a behavior as an 'oddity'. An interesting argument proposed in this context is that almost 90% of DSM-IV diagnostic categories are culture-bound to America and Europe, and yet the "culture-bound syndrome" label is only being applied to other "exotic" conditions outside of the Euro-American society [8].

In this context one can take the example of *koro*, which is a psychiatric disorder, characterized by a debilitating fear that one's genitals are retracting into the body and that once they are fully retracted death is bound to be certain. One doesn't find many instances of *koro* in Western societies. But *koro* epidemics have been known to break out in Malaysia, North East India and it seems to be at least partly based on a set of culturally specific beliefs about sexuality. It has been seen that most *koro* sufferers are young men, who may engage in a lot of auto-erotic activity, and then later on suffer extreme guilt and anxiety. Culturally conditioned views about sexuality thus seem to play an important role in causing their guilt and anxiety to express them in a specific way. Similarly, spirit possession is common in many parts of the world. It may be a way for disadvantaged people to gain status in the society.

Research by Ritter et al has shown that important cultural variations in different psychiatric disorders exist even in basic mental health beliefs[9], wherein Pakistani patients reported magic-religious oriented mental health beliefs more frequently in contrast to Austrians' beliefs which were more often in line with the bio-psychosocial explanations of Western medicine, thus underscoring the importance of cultural background rather than the subjective experience with a distinctive mental disorder.

The WHO epidemiological studies, International Pilot Study of Schizophrenia (IPSS) and Determinants of Outcome of Severe Mental Disorders (DOSMeD)[10], demonstrated that schizophrenia existed across different cultures on one hand, but that its prognosis varied in different countries. Various ethnic minority groups are at increased risk for all psychotic illnesses but African-Caribbeans and Black Africans appear to be at especially high risk for both schizophrenia and mania[11]. Not only does the risk of psychoses, but also the content of psychotic symptoms show cultural variations. For instance, guilt related symptoms are more often seen in Judeo-Christian cultures and Schneiderian First Rank Symptoms are also reported at a lower frequency outside of Western countries[12].

Mood disorders can also be viewed in a similar light under the cross-cultural lens with all spectra of mood disorders existing in different cultures. However the presentation and symptom variation may be seen, for instance, depression in some cultural groups is more likely to be with symptoms of somatization while in others it may present with the classical mood changes and anhedonia symptoms. Nambi et al reported that unexplained somatic symptoms were associated with common mental disorders, and a majority of patients held strong beliefs that their symptoms were caused by physical disorders and not psychiatric ones[13]. This may reflect explanatory models which may not distinguish between mind and body dichotomy or may reflect an un-

derstanding where mind affects body and vice versa. A similar picture is reported among Japanese individuals[14]. Neurasthenia or chronic fatigue syndrome (CFS) is more frequently diagnosed than depression in Japan, as the latter diagnosis may carry certain negative connotations. However with globalization, the scenario may be changing and needs a review. Symptoms of depression such as guilt, shame and loss of libido vary across cultures[15]. In their study on various Hispanic ethnic groups, Oquendo et al found highest rates of depression among Puerto Ricans and Whites[16]. Similarly, suicide attempt rates ranged from 9.1% for Puerto Ricans to 1.9% for Cuban Americans. Puerto Ricans had higher suicide attempt rates compared with other groups. One can postulate the effect that the process of migration and acculturation may have on the differences in major depression and suicide attempt rates across ethnic groups.

Cultural influences can be very well seen in case of substance use disorders. An interesting confluence occurs at the point of culture, religion and substance use especially since traditionally psychiatrists and psychologists have under-emphasized religious issues in their work[17]. A number of ethnic groups in the UK have higher levels of alcohol use and alcohol related morbidity and mortality than the general population[18, 19]. Sangster et al had pointed out that individuals from Black and other minority ethnic groups may present to health services at a late stage of drug use, thus making it difficult to estimate the number of people from such minority groups using substances but not accessing services[20]. White had highlighted the increase in heroin misuse among Bangladeshi men living in London to levels proportionally higher than those for equivalent White populations[21].

Few studies also focus on other disorders like eating disorders[22,23], personality disorders[24], self-harm[25-28], sexuality and sexual dysfunction[29, 30] eliciting cultural differences in rates and possible explanations of these differences.

CULTURE AND MANAGEMENT ISSUES

Culture runs through, from the point of access to health services, diagnosis and therapy till recovery is complete. The cultures that patients come from shape their mental health and also affect their health service utilization. Similarly, the culture of the clinician and the service system affects the diagnosis, treatment and the health services delivery. It is essential that all mental health professionals understand cultural aspects of mental illness, including the widespread cultural beliefs and patterns of help seeking behaviors' in order to provide culturally sensitive health care. Social networks including cultural groups are a critical part of healing and recovery as patients continue to participate in society rather than becoming isolated, which is usually seen in more developed nations. It is important not to focus only on the symptoms of the patient, but also the context in which they occur. It may be worthwhile to ask the patient how he or she interprets the symptoms and how the culture from which the patient comes thinks about such symptoms rather than being blinded by what one has learnt. Psychiatrists also need to be trained in issues related to cultural diversity[31].

There are certain ethnic differences in the metabolism of drugs, both pharmacokinetic and pharmacodynamic. For instance, in a study by Lin et al, Black inpatients had higher blood levels per milligram of chlorpromazine compared with the White in-patients[32]. Similarly, data is also available for antidepressants[33] and lithium[34, 35]. Spiritual or religious objections to medications are an important issue that needs to be taken care of before starting the patient on any psychopharmacological agents.

Psychotherapy may not be a much used treatment modality in some cultures and indeed may not be accepted in an ego-centric way but religious understanding and spiritual leanings may direct the patient to seek help from other sources. Tyler et al point out that a universalist perspective is a major problem in psychotherapy, wherein the therapist aims to look at the commonality of experience between himself or herself and the patient, and ignores the socio-cultural influences on the illness behavior[36]. However, the particularist view highlights the importance of cultural influences on the patient's illness and seems to be a better alternative to follow in a multi-cultural society.

CONCLUSIONS

With globalization and migration cultures are coming closer together and multi-cultural societies are fast emerging. The impact of cultural milieu on mental illness is thus magnified and cannot be ignored. Psychiatrists need to be both culturally sensitive and willing to learn more about different cultures and their notions of normality or abnormality. Health professionals need to refrain from cultural stereotyping of any illness. A cultural perspective can help clinicians and researchers become aware of the hidden assumptions and limitations of current psychiatric theory and practice and can identify new approaches appropriate for treating the increasingly diverse populations seen in psychiatric services around the world. It is also important for the service providers to take the needs of minorities into account while planning services in order to attain a balanced mental well-being for the population at large.

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