Could somebody be judged mad in the context of one culture but sane in the context of another culture?

The interplay between culture and mental illness has been studied intensely over many years and as a result the researchers involved have become aware of a wide variety of culturally sensitive issues surrounding specific forms of mental health problems. Greater demands than ever before are being placed on doctors and psychiatrists; in part due to the current free and easy movement of people between countries which means that they "must treat, patients from a wide variety of cultural backgrounds."(Gaw 2001: 73-74) As a result, some societies are experiencing illnesses previously unknown to them and the diagnostic element of psychiatry is being mired with alternative symptom presentation and alternative manifestations of illnesses.

Cross-cultural understanding has considerable implications when diagnosing culture bound syndromes (CBSs). The International Statistical Classification of Diseases-10(ICD-10) states that CBSs share two principle features: That they are not easily accommodated by the categories in established and internationally used psychiatric classifications; and they were first described in, and subsequently closely associated with, a particular population or cultural area.

The American Psychiatric Associations' (APA) recent inclusion of a glossary of CBSs within DSM-IV (APA 1994a: 844-849) marks an extraordinary leap forward in recognising a class of mental disorders once marginalised as ethnic psychoses or, in the worse case scenario as madness:

"Disordered in intellect; deprived of reason; distracted; crazy; beside ones self; furious….." (The New Webster Encyclopedic Dictionary of the English language 1970)

Despite this, there is still a considerable amount of disagreement about the concrete definition of culture bound syndromes, Humphreys (1999) pointed out that ICD and DSM definitions make clear that the syndromes should be closely associated with one particular population or area, however several CBSs are found in quite a

large number of cultures. As a result, Gaw (2001) attempted to clarify any ambiguity, in doing so he took peoples general understanding and separated it into two different distinctions: The first being the syndromal approach and this assumes that "CBS's are manifestations of a set of universal categories of psychopathology uniquely shaped by specific cultural forms and social structures" (Gaw 2001:84) Based on this idea the syndromal approach looks for a common physiological manifestation between various CBS's and is intimately related with the biomedical model.

The second approach is meaning centred and this broadly characterises CBS's as "constellations of symptoms that together have been categorised as a dysfunction or disease" (Gaw 2001:86) In summary the meaning-centred approach emphasises that CBS's cannot stand apart from their cultural contexts and still be entirely understood; for example Amok – this is a condition which European psychiatry does not attach a label to, as it is only found in South-East Asia, it involves an outburst of aggression followed by a depressive episode. Sometimes the situation only comes to an end after the patient has killed himself or has been killed by another. Koro is another example of these exceptionally culture bound syndromes, found in South East Asia.

Culture-bound syndromes mean that practitioners must be able to recognise these mental illnesses in their own right even out of the patients cultural setting otherwise a misdiagnosis may occur when trying to attribute these symptoms to a illness familiar with that particular practitioner. On the other hand, According to Kiev (1972) some of these illnesses simply appear to be the local name for already discovered mental illnesses:

"Culture-bound disorders are for the most part variants of the severe functional psychoses and of various neurotic syndromes….These are not new diagnostic entities: they are in fact similar to those already known in the West" (Kiev 1972)

This shows that language differences across the world are quite pronounced and a British doctor without cross-cultural training trying to understand how an Asian person was feeling, would be much more likely to carry out a misdiagnosis on the basis of these language differences than an Asian doctor. Despite this, no culture should be seen as superior to another otherwise this would be acting in an ethnocentric manner:

"…. which means that people think their own culture is the best, or at least the most appropriate way to live."(Spradley and McCurdy 1974: 2)

Rather than this we should conclude that particular countries develop vocabularies which encase the matters that are particularly important to that group of people.

As a result of this linguistic element in mental illness diagnosis, it must be addressed whether the experience of distress is the same even if the vocabulary is different. Vocabulary not only serves a communicative function it also focuses, records, verifies and in some cases alters the subjective experience. In order to make a distinction between distress in the mind and distress in the body, we must be able to recognise a clear division between the two entities – this is something we readily accept in Europe, however such a distinction cannot claim a universal recognition. Since language is vital in charting internal experiences then it is possible that the internal experiences of people suffering from mental illness are modified by the vocabulary available.

There are some illnesses which are not specific to one culture; however they still result in the same perplexity and the same problem of some people being wrongly labelled as "mad." Using the example of depression–one of the most commonly diagnosed mental illnesses in the West-we can attempt to clarify the actual scale of the problems facing psychiatrists. There is considerable question about whether depression exists in all countries; this ambiguity arises from the different ways in which people from various countries describe what appear to be depressive symptoms. A Western person would tell of a "low mood" or "feeling sad" whereas Chinese people often refer to "exhaustion of their nerves" and their "hearts being squeezed and weighed down." Nigerians sometimes complain that "ants keep crawling in parts of my brain." (Kleinman & Good 1985) The psychiatrist must try and analyse these descriptions and assess whether each of these methods of presentation refers to depression or another disorder.

Secondly the actual experience of what appears to be depression seems to vary from culture to culture. For example, a British woman describing her experiences would tell of misery, upset, loss of interest and concentration, an inability to sleep and other such symptoms. She would present her mood first and her somantic symptoms either secondly or only on questioning – on the other hand an Indian or Pakistani

woman with the same condition will usually complain of pain and weakness as well as discomfort in the chest or abdomen. The method of presentation here is vastly dissimilar, the Pakistani woman presents her somantic symptoms as a high priority and it is likely that she will not admit to a depressed mood at all. This therefore puts the practitioner in the position of diagnosing a depressive illness without any "apparent" depression. As a result any uninitiated clinician is easily led astray by somatisation. He may place excessive attention on the physical symptoms and this confirms the patient's belief that they are suffering from a physical disorder, as a result, eventual psychiatric diagnosis may be hindered. In order that a wrong diagnosis is avoided, the health professional must be able to recognise that both of these women are in-fact talking about an illness which requires the same treatment.

The reason for these different explanations is not totally clear however, on a basic level it may relate to cultural beliefs about what a doctor is for. Western patients have a prior knowledge of mental illness and realise that the causes may be medical and can be discussed with a medical professional. Most Asians do not go to the doctor unless they have something physical to discuss; simply because in their view this is the prefecture of doctors. If they experience emotional distress as their sole symptom then they will usually rely on the help of family and in some cases, other non-medical sources.

It is also possible that the physical symptoms are the only ones which are acceptable to the non-western patient. In many countries mental health problems carry an even greater stigma than they do in the Western world – this could help to explain over-generalisations such as the term insanity to encapsulate anyone who does not act, feel or compose themselves as the current zeitgeist demands – and as a result only indubitably psychotic behaviour is given the label of "mental illness." Any minor mental health problems are commonly called medical illnesses where the somantics are known as medical and the psychological aspects are left appropriately unlabelled.

This diagnostic confusion can be generalised to most mental illnesses including schizophrenia for which there is no general agreement about the confines of who should fall into this group. There are specific symptoms according to DSM-IV which must be present for a diagnosis of schizophrenia, although it is very unlikely that someone would suffer from all of the symptoms at one time. Usually a diagnosis

would be made on the basis of five or six characteristics, hence problems occur if a person is suffering from only three or four symptoms - two psychiatrists would be likely to disagree here; not inevitably about the symptoms, their causes or the appropriate treatment but simply whether such a case falls into the confines of the term schizophrenia. This is particularly likely to happen between psychiatrists from different countries with different academic conduct.

In Britain, the term schizophrenia is commonly used to imply biological factors; it is assumed that there is some abnormality present which is then triggered by psychological or environmental factors. As a result, a diagnosis of schizophrenia will not be made if the breakdown seems to be the direct result of stress and the clinician believes that the psychological causes can be understood. As a result there are some symptoms which are more likely to lead a diagnosis of schizophrenia than others; these are known as "schizophreniforms." These can lead to massive diagnostic problems in that some of these schizophreniforms may be understandable psychologically in one culture but not in another.

When, as mentioned above there are not enough symptoms to make a clear diagnosis then ambiguity will arise. When distinct symptoms such as delusions, hallucinations and paranoia arise, then it must be considered whether there is anything else which may have caused them, other than schizophrenia. Delusions (false beliefs) are not evidence of mental illness unless the belief is both false and out of keeping with the subject's normal beliefs. For example a British boy who declared that he could see thunderbirds (mythical flying creatures) would be recommended to seek a psychiatric examination, whereas a Chippewa boy would not. It is a matter of how the person is viewed by his fellows not by the person doing the diagnosing. In order to avoid a cross-cultural diagnostic pitfall, an in-depth knowledge of the belief-system of particular cultures is required and few psychiatrists have this depth of knowledge purely due to the immense numbers of cultures and illnesses to study. The converse hazard is to assume that an abnormal belief is in fact normal, this pitfall occurs when a practitioner has developed only some degree of cultural sensitivity and application is ambiguous.

The above material relates to an individual being seen as "mad" in a particular cultural context as a result of: incorrect cultural interpretation of symptoms, Culture-

bound syndromes, language differences and other related explanations. These medically related explanations should not be viewed exclusively when trying to reason with the varying cultural views on metal illnesses. Philip Rack in "Race, Culture and Mental disorder" writes that in the past these cross-culture variations were explained in terms of the so called "primitive" people of Africa and it was suggested that these black people were unable to experience the deep and intense emotions of the white races. This was blamed on the "crude" level of functioning of the black brain; the native's feelings were likened to those of a child. Based on this primitive concept psychiatrists were not surprised to find that depression and other mental illness seemed to be less common in these "early man" cultures. In summary it was assumed that despair, anguish and disturbed thinking were unique to civilised white man and not the "lesser breed."

The modern climate has brought with it disgust at such a thought and post-war studies have found that many mental illnesses can be seen wherever they are looked for as long as the questions are correctly framed. Correctly framed questions seem to provide capacity for some form of manipulation, and this is precisely what Thomas Szasz proposed about the 1960 political rule in the Soviet Union.

He put forward the idea that mental illness was a concept fabricated by man as a way of controlling people whos behaviour threatens the status quo and the current zeitgeist (he expressed this view in his book "The Myth of Mental Illness" in 1961). Labelling someone as mentally ill means they can be hospitalised in order to be "treated" and this means they can be removed from society and placed in secure accommodation. This view which caused colossal outrage at the time seemed to become reality in the late 1930s in the Soviet Union, where psychiatry was used to silence those who opposed the communist system. Under this method of social control thousands of "dissenters" were imprisoned in special psychiatric hospitals simply because they opposed their state. Similarly Dr Samuel Cartwright's report "The diseases and physical peculiarities of the negro race" published in 1851, which set to investigate the "strange" behaviour of African-American slaves unveiled several "diseases" unknown to the white race. One of which was a sensory disease, this made African-Americans insensitive to "pain when being punished." This suggestion clearly served to justify the treatments these slaves received. Another disease was "drapetomania" or "mania to seek freedom" this "disease" causes slaves to escape

from their master however they would clearly have to be caught so that their "illness" could be cured. (Zimbardo et al. 1995) These people would clearly not have been diagnosed with mental illnesses had they been living in a democratic state like that of Britain.

Culture is something which is learnt, that is we learn the correct "categories, plans and rules people use to interpret their world…" (Spradley and McCurdy 1974:3) We tend to have an in-depth knowledge of only our own culture, as has been demonstrated this has distinct implications for cross-cultural psychiatry. A dependable psychiatric analysis cannot be made unless the patient is interviewed in his own language by someone with knowledge of what to look for. Even patients who use English for everyday communication may become less fluent as a result of the stress and confusion of the psychiatric interview.

Although the issue of someone being seen as mad in one culture and not another lends itself to medical reasoning, the political issues put forward by Thomas Szasz must be retained, especially due to the far reaching implications for democracy and political leadership. At present there seems to be no way of altogether preventing culture from influencing mental health diagnosis whether this is due to politics or medical diagnosis and symptom presentation. The APA has gone some way to try and standardise diagnosis using the Diagnostic and Statistical manual. However applying theory in reality is not always an inconclusive success especially due to the already huge expanse of illnesses which are intensifying and altering incessantly.

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