Culture and Mental Health: 
a Symbiotic Relationship

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Introduction

Debate about the influence of culture on an individual’s mental health has sparked a division among psychologists; with one side viewing the common human physiology as evidence of common manifestation of psychopathology and the opposing side posturing that culture has a powerful impact on the development of the individual, and thus psychopathology must be understood within the context of its manifestation (Alarcon, 1996; Thakker & Ward, 1998). This divides the psychologists (albeit crudely) into universalists and relativists respectively. This raises the question, what are the implications for mental health? The universalist approach is most prevalent, due in part to the popularity of nosology and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). The most recent text revision and the newest edition\(^1\) attempted to incorporate culture, yet there is much criticism for the ethnocentric Western perspective, giving precedence to disorders common in the west (set as universals) and labelling disorders found elsewhere as culture bound. Given the attractiveness of a universal classification system, where does this leave culture when evidence has been found to support its impact on mental illness (MacLachlan, 2006). Schizophrenia, once thought to be a universal disorder has been revealed to vary across cultures in onset, course, symptoms and recovery (Thakker & Ward, 1998), so providing evidence of cultural influence. It could be argued that mental illness has never been the same the world over or in the past, either in prevalence or in form; that it is shaped by the symptom repertoire (Short-

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1 The DSM-V was in preparation when this manuscript was written and so there is only a brief mention of the changes made regarding culture in the new edition.
er, 1997) or symptom framework of the culture.

Culture

Little consensus has been met regarding a definition of what is meant by the term culture. Kroeber and Kluckhohn (1952, as cited in O’Dell, 2004) illustrated this diversity of definition by reviewing 161 definitions of the concept and Allen (1992, as cited in MacLachlan, 2006) later distilled these into seven broad conceptual categories. Historically, culture has been defined in a myriad of ways but is generally considered a framework through which people can relate to each other, or a set of guidelines for living in the world (MacLachlan, 2006). Brislin (1990) defines it as a medium for transmission of ideas from generation to generation without there being explicit instruction. It has also been postulated as learned systems of meanings, providing people with a distinctive sense of reality to shape their behaviour, values, beliefs and emotional responses (Fabrega, 1991; Triandis, 1972). Individual experience and existence is permeated by culture and understanding this is integral to the study of cultural psychology. MacLachlan (2006) emphasises that culture is essentially pragmatic and ultimately provides a means of communicating with those around you.

Shweder, one of the major proponents of the field, stated cultural psychology was the study of how “psyche and culture, person and context (...) require each other (...) dynamically, dialectically and jointly make each other up” (Stigler, Shweder, & Herdt, 1990). Shweder postulated that the content of the human mind is not essentially the same across the world and different cultures create different mentalities, there are no global traits and one cannot generalise across contexts. No sociocultural environment is independent of the human beings who glean meaning from it, likewise, an individual’s mental life is transformed and constructed through the meanings and interactions with the sociocultural environment (Shweder, 1995). Shweder goes even further to describe the psyche as the intentional person and the world as the intentional world, they are “interdependent things that get dialectically constituted and reconstituted” through the activities and actions that make them up. The question posed is, what does this imply for health and more specifically mental health (It should be noted that Shweder is not alone in this view, although his stance leans to the side of extreme relativism).

Universalists Vs. Relativists

A prominent debate in the cross-cultural study of mental illness and psychopathology is the conflict between those who support universality in psychology and those who, like Shweder, support relativism. Universalists seek similarities across cultures to form form cross-cultural gener-
alisations; they pose that variation in symptoms across cultures is superficial. Thakker and Ward (1998) state that Universalists are more interested in their own cultures than those of others as they use them as a testing ground for Western ideas. Relativists in contrast aim to understand psychopathology within the cultural framework in which it manifests itself. There is an assumption that the culture may have a significant impact on mental illness and so is heterogeneous just as cultures are. This division echoes the split between the biomedical and biopsychosocial health models. Where the biomedical model focuses on purely biological factors, and so assumes that the entire organism could be explained in terms of its parts (Fava & Sonino, 2007), whilst the biopsychosocial model proposes that any clinical investigation must include the individual, their body and their surrounding environment as essential components of the total system. The model advocated the need to include consideration of function in daily life, productivity, performance of social roles, intellectual capacity, emotional stability and psychological well-being. The universalist position and the biomedical model are the most dominant in Western culture however, given the prominence of the classification of mental illness.

The Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV; American Psychiatric Association, 1994) is considered invaluable in psychiatry and its common usage has surpassed the International Classification of Diseases (ICD-10; World Health Organization, 1992) in some countries (Lewis-Fernández & Kleinman, 1995). This could be problematic as the DSM is a Western construct and many mental disorders in it are rarely found outside the West (e.g. eating disorders Alarcon, 1995). Following criticisms of the DSM-III-R (American Psychiatric Association, 1988) for not being sufficiently applicable to different, non-Western cultures and ethnicities, the fourth edition was compiled with cross-cultural applicability in mind. The DSM-III-R included two paragraphs on culture, cautioning clinicians that using the DSM with other cultural groups could lead to misdiagnosis and they should be sensitive to differences in language, morals and conduct (Rogler, 1996). The DSM-IV, in comparison, pays greater attention to culture, remarking on cultural difference in relation to disorders; the introduction highlights the importance of culture in clinical practice and an appendix is devoted to a glossary of culture bound syndromes (Kleinman, 1997). This was not the revolutionary text anticipated by the Task Force (Thakker & Ward, 1998) set with the charge of enhancing the DSMs applicability internationally. In a quantitative analysis, Alarcon (1995) estimates, as little as 27.5% of the suggestions made by

**Diagnostic and Statistical Manual of Mental Disorders – The Popular Choice**
the Task Force made it into the DSM-IV. Researchers have argued that the inclusion of a diluted and less effective cultural element perpetuates the perceived superficiality of difference (Thakker & Ward, 1998).

The most recent edition of the DSM, DSM-V has however met with controversy for several reasons, one of which was the fact that the criteria for disorders are based on consensus rather than objective laboratory measures as other medical disorders are (Insel, 2013). Those opposing the use of the DSM as the ‘gold standard’ (Kapur, Phillips, & Insel, 2012), state that the diagnostic system has to be based on the emerging research data (genetic, imaging, physiologic, and cognitive data), not on the current and arguably outdated symptom-based categories (Insel, 2013). Criticisms were also made concerning the increasing tendency to pathologise patterns of behaviour and mood that are not considered to be particularly extreme (Frances & Widiger, 2012). These detractors of the most recent edition may herald a modern and contemporary nosology but it remains to be seen whether this will benefit the relativists in cultural psychology. One problem with universality and the DSMs cross-cultural applicability is an assumption at its core, its biomedical model that poses that all mental disorders have a fundamentally biological basis (Follette & Houts, 1996). This implicit assumption is then, given our common physiology, that our psychopathology is homogenous and perceived difference is superficial. A criticism of this is that most mental disorders have not yet been found to have biological correlates (Thakker & Ward, 1998). This focus on individualist model (locating the origin of psychopathology in the individual) does not take cultural factors into account (MacLachlan, 2006).

**Schizophrenia – A Universal Disorder?**

Schizophrenia is a well-researched example of a disorder varying significantly across cultures. Initially thought to support the universality of mental disorders (Defenerson & Kraepelin, 1902), over a century of research has followed, emphasising more difference in onset, course, symptoms and recovery across cultures than originally considered. On first investigation there appeared to be a correlation between schizophrenia and Western influence; researchers uncovered that Western influence appeared to increase rates of schizophrenia (Thakker & Ward, 1998).

When researched cross-culturally, there has been a trend observed, schizophrenia is prevalent in urban areas and in individuals who recently moved to cities from rural areas (Burton-Bradley, 1969). In a large cross-cultural study by the WHO (World Health Organization; Sartorious, Shapiro, & Jablensky, 1974) one of the main findings was that the outcome for schizophrenics in developing countries...
was significantly better than the outcome for those in developed countries. The results were supported in another cross-cultural study building on these findings, the course of the syndrome in patients from less industrialised cultures was significantly better than in the industrialised West (Sartorius, Jablensky, Korten, & Ernberg, 1986). There was distinct brevity observed in the schizophrenic patient’s course.

Culture appears to have influenced mental health through cultural expectations and community (Thakker & Ward, 1998). In non-Western cultures, where there are larger families and more supportive community environments, there is less excessive emotionality (EE) which is thought to act as a stressor for the schizophrenic so perpetuating the illness (Kymalainen & Weisman de Mamani, 2008). The lower levels of (EE) are thought to be a correlate of the supportive community environment where responsibility is shared; the patient is encouraged to reintegrate with the community and family, and expectations for recovery are higher, which is thought to encourage recovery (Luhrmann, 2007; Waxler, 1979).

The chronicity of schizophrenia is thought to be a result of the social responses and reactions to the illness. Myers (2010) writes that the culture that helps people manage their stress may promote better prognoses through the promotion of resilience. Schizophrenics in developing countries are more likely to be married than in the developed countries as their families know this will be a protective factor and shield from the stigma of having the disorder (Myers, 2010).

As was earlier noticed by Burton-Bradley (1969), symptoms of schizophrenia varied across cultures, in developing countries they could manifest acutely and disappear quickly and were more likely to be as result of a stressful life event (Kleinman, 1988). This form of schizophrenia appears to have a rapid onset following a traumatic event and is associated with complete recovery. How the symptoms manifest in the individual, is another cultural difference. Research has illustrated with various cultural samples that schizophrenic symptoms appear to be particularly influenced by culture. One study in India (Kulhara, Mattoo, Awasthi, & Chandiramani, 1987) reported significantly more cases of catatonia and persecutory delusions. Similar studies have shown a prevalence of auditory hallucinations in Europe, visual hallucinations in West Africa and ceneesthetic hallucinations were common in Ghana (Bauer et al., 2011). Researchers have also shown ethnic-minority groups to be less symptomatic than non-minority groups (Brekke & Barrio, 1997).

This is a significant body of evidence for the variability of the disorder schizophrenia. Onset of disorder appears
to have differing triggers, the symptoms manifest themselves differently for each culture and the environmental variables of family and community can significantly affect recovery, either hampering or improving it. The universality of this considered universal disorder has not been proven empirically (Thakker & Ward, 1998). On the basis of this research it could be concluded that Shweder’s statement was correct, there is significant support for the symbiotic relationship between culture and psyche.

**Culture Bound Syndromes**

What is provided by the universalism of the DSM-IV is not sufficient in light of Shweder’s statement and culture bound syndromes are an illustration of this. The separation of the culture bound syndromes in the DSM-IV can be criticised as all syndromes are influenced by the context in which they occur, not only those viewed ethnocentrically, which are deemed odd or unfamiliar from the Western perspective (MacLachlan, 2006). By differentiating culture bound syndromes there is an implication that all others are uninfluenced by culture and so universal, for example depression (Malik (2000), argues that the notion of depression is not an adequate description of mental health issues for indigenous Pakistani and first-generation British Pakistani). This is a dangerous assumption and as MacLachlan (2006) states, the clinician is also influenced by their own cultural context. The DSM-IV also recommends some culture bound syndromes to be deciphered and interpreted in terms of those DSM categories considered universal. This involves “shoehorning” or adapting a syndrome to fit into an already existing category, which may not be able to accommodate it. Presuming universality is misguided, as some of the syndromes in the DSM-IV are culture bound to Western culture and are not identified as such: anorexia nervosa, type A behaviour, obesity, agoraphobia, kleptomania and exhibitionism (or exposing oneself; list as detailed in MacLachlan, 2006). It is this ethnocentric position of universalism, focused on Western diagnostics that has overlooked the influence of culture.

All syndromes are influenced by the culture and context in which they occur (Sutker & Adams, 2001), as Shweder stated, “psyche and culture are seamlessly interconnected” (Shweder, 1995). MacLachlan (2006) states, all syndromes have both an order and function, in other words within the cultural context they make sense and have a purpose. This can be seen in numerous examples of syndromes considered foreign and indiscernible, for example, pibloktoq (Arctic hysteria), a condition found in the Inuit women of Greenland where they ran wildly across the tundra, screaming incoherently, tearing at their clothing and eating excrement. This behaviour would appear to be disturbed, yet on further investigation it was
postulated to be a reaction to the sexual abuse the women had suffered at the hands of explorers, the behaviour is now seen to make sense as a reactionary response and served the purpose of a defence by dissuading the men from attacking them again. The women’s behaviour is an expression of their psychological distress precipitated by the stress and change (Dick, 1995 cited in MacLachlan, 2006). For the relativists like Shweder, the experience of mental illness is highly subjective. The expression of the symptoms depends largely on the society or culture that the person is a part of and what is deemed acceptable or unacceptable. This above behaviour is a corollary of the Inuit women’s psychic distress, it is not universal and cannot fit into any universal classification system and so needs to be looked at from a culturally sensitive position to be correctly understood.

Researchers have referred to historical cases of psychopathology that do not manifest themselves anymore, or perhaps have changed their symptoms and manifestation (Davison, 2006; Roffe & Roffe, 1995). The mind is drawn toward the symptoms that effectively communicate its distress at the given time and in the appropriate context. Symptom repertoire is defined as a range of physical symptoms available to the unconscious mind for the physical expression of psychological conflict (Shorter, 1986). This does not mean that these symptoms or illnesses are not real, or that those suffering deliberately shape their symptoms to fit a certain cultural niche, rather it indicates that a mental illness is an affliction of the mind and must be understood in light of the ideas, habits and predispositions and so the idiosyncratic cultural trappings of that particular mind.

A modern example of the concept of symptom repertoire is the case of anorexia in Hong Kong (Kam & Lee, 1998; Lee, 1995a, 1995b; Ngai, Lee, & Lee, 2000). Anorexia nervosa (AN) was initially considered a Western, culture bound, entity. A type of food refusal was observed outside of the West, but cases were rare and did not meet DSM criteria for AN. The DSM-IV criteria for AN require: body-image distortion, an intense fear of gaining weight and fear of fat. Lee (1995b) found that the Chinese patients did not have the same motivation as typical Western AN patients, exhibit the same symptoms nor fit the diagnostic criteria. The Chinese patients had not heard of the diagnosis of AN and their symptoms where predominantly somatic.

Since Lee’s paper in 1995 (1995b) the prevalence of AN has risen in Hong Kong and cases of the Western typical formation are on the rise (Kam & Lee, 1998; Ngai et al., 2000), particularly among young females in high-income Asian societies such as Singapore, Japan, Taiwan and Hong Kong (Lee, Ng, Kwok, & Fung, 2010). These AN patients are now exhibiting the
psychopathological patterns historically described in Western cases. Lee et al., (2010) highlights that the clinical presentation in China has gradually (since the 80s) conformed to the patterns seen in the West. They relate this to the “rigorous media promotion of slimness”, fuelling a phobia of fatness and the concomitant weight control behaviour. There is a new social pressure towards slimness in Chinese youth culture. Lee et al., (2010) asserts that culture shapes our psychopathology, the modern culture which publicises eating disorders could be establishing the symptom repertoire and people could unconsciously and organically choose/use eating disorders as their symptom to express their psychological conflict. The Western formation of AN was not prevalent in the past as it was not part of the culture and/or the times’ symptom repertoire.

**Conclusion**

Shweder’s statement “psyche and culture, person and context (...) require each other (...) dynamically, dialectically and jointly make each other up” raises a problem for the universal cross-cultural approach to mental health. The body of research on cultural relativism is growing, and there is increasing evidence of problems with cross-cultural applicability. The DSMs previous attempts at incorporating culture into their nosology have not been sufficient. If the implications of Shweder’s statement are to be incorporated into the treatment of mental health, culture would be seen as a legitimate partial cause of disorders, then each culture “may have its own particular, although overlapping, types of mental disorders” (Thakker & Ward, 1998). For a mental illness to be understood, if must be investigated within the relevant social context, from a culturally sensitive position. Individuals use what is deemed acceptable/unacceptable in their culture and what is likely to be understood, their available symptom repertoire to express their inner conflict.

**References**


