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Conceptions of Mental Illness: Cultural Perspectives and Treatment Implications

by Lena Hall

Cultures differ in what is considered normal and what is considered abnormal. Therefore, the conception of mental illness is tied into whether or not members of a culture will seek help, what kind of help these individuals will seek and from whom. It should be remembered that traditional psychotherapy evolved from both the existential and psychoanalytic framework imported from Europe. Sigmund Freud has become a household word, and it was his approach to psychoanalysis that influenced much of the psychodynamic approach that is used today. The humanistic approach associated with Carl Rogers is an offshoot of the European existential theories which were evaluated by American psychologists as being too morbid. Many of these European theorists believed much of the individual's problems are related to death anxiety. The humanistic approach puts emphasis on a more optimistic view of the individual. The therapist focuses on responding to the client with empathy, warmth and positive regard. Irrespective of the approach to treatment, it is important that mental health providers have some concept of what for the client constitutes mental illness (Hall, 2005).

When Nunnally (1960) researched public conceptions of mental illness in the United States, he asserted that he could see only two possible results: (1) that the public was "misinformed" in the sense that the "average" person held numerous misconception about mental illness or (2) that the public was uninformed in the sense that the average person had little information, correct or incorrect, about many of the problems related to mental illness. His research showed that in general, people were not grossly misinformed, (p.232). Rabkin and Suchoski (1967), using Nunnally's conception of mental illness, also reported that teachers were reasonably well informed concerning mental health problems and that the differences between teachers and experts were relatively small. The subjects in the above studies were White Americans. Sue and
others (1976) compared the responses of White Americans on the Nunnally's conception of mental illness questionnaire with that of Asian Americans and found a number of significant differences which they interpreted in the context of Asian subcultural values.

Hall (1985) explored the relationships between ethnicity, the conception of mental illness, and attitudes associated with seeking psychological help among black and white school teachers. The participants were 513 school teachers (325 White and 182 Black). The analysis of the study indicated significant differences between African Americans and Whites in their conception of mental illness. The responses of Blacks reflected a more stereotypic view of mental illness, and those of Whites were closer to those of mental health professionals. African American teachers were more likely than White teachers to believe that the mentally ill look and act differently than normal individuals. They also strongly endorsed the notion that will power can cure mental disorders and that women are more likely than men to suffer from mental illness. Blacks more than Whites believed that mental illness can be controlled by the avoidance of morbid thoughts and that guidance and support of strong persons in the community are needed to maintain mental health. Blacks more so than Whites endorsed the non-seriousness of emotional problems and the etiology of mental illness. Whites were more likely than Blacks to seek counseling for problems related to sexual issues, parenting, and truancy in a school child. So Blacks have a much narrower view of what problems warrant psychological interventions. However, both Blacks and Whites had similar positive attitudes toward seeking psychological help. The major difference between the two cultural groups was what constituted a type of mental illness that necessitated psychological intervention.

Tucker (1979) in her research on underutilization of mental health facilities by African Americans residing in Long Island, New York, reported that 71% of the respondents reported not ever having the need for psychological help. She also reported that a higher number of Whites than Blacks had used psychological services in the past. Of those interviewed by her, 40% of the African Americans believed that the reason they do not seek psychological help is because as a race they are much more tolerant of stress and are a stronger people. Tucker (ibid) explained that this "tolerance and strength" usually focused on the history of Blacks as an oppressed group. This resulted in their learning to endure stress, unlike Whites who "react more catastrophically to it." Seeking therapy might then be perceived as a sign of weakness.

African Americans tend to seek treatment late in the progress of the disease. They first turn to the extended family, and other relationships, as well as their religious minister whenever they are experiencing stress. They find it less humiliating to do so. When all these resources are depleted, then and only then will they seek treatment from the mental health clinic and other services. They tend to mistrust the therapist who is perceived as an outsider and see the role of the therapist as intrusive. African Americans also have concerns about whether or not they will be discriminated against (Yamamoto, James, & Palley, 1968).

On the other hand, Zborowski (1969) pointed out that Italians were more interested in quick relief from pain and tended to overdramatize and exaggerate it. They bear some similarity to African Americans in their inclination to turn to and exhaust family resources before seeking treatment (Rotunno & Mc Goldrick, 1982). It takes them a long time to trust outsiders. The Irish, in contrast tend to minimize and hide their pain. According to McGoldrick (1982), they may also
minimize their symptoms, leading to inaccurate diagnosis. Jewish clients tend to be more interested in finding the source of the psychological problem, while Anglo-Americans attempt to deal with pain by individual efforts and have a great deal of confidence in medical orders and technological type of interventions.

Puerto Rican and other Hispanics underutilize mental health services. According to Padilla and Ruiz (1973), Puerto Ricans express pain through somatic symptoms. They turn to their families in their old neighborhood for relief. Women are more likely than men to be seen as clients. Many of the stressors are related to their traditional role to preserve the family, role conflicts, marital conflicts, problems associated with raising adolescents rejecting parental values and stressors associated with the acculturation process. The physical symptoms they present are often combined with anxiety and depression. Garcia Olivero (1971) noted that Puerto Ricans may equally seek help from a physician or spiritist. Mexican Americans (Miranda & Kitano, 1976) tend to hide mental illness and believe that it may be inherited or that prayers will help or cure it. According to Hoppe and Martin (1986), many depressed and suicidal Mexican American patients reported that they controlled suicidal thoughts and impulses because the Roman Catholic Church teaches that suicide is an unpardonable sin. The stage of acculturation may also determine whether the patient will seek treatment or depend on the resources of the extended family, or the Church.

As reported by McGoldrick, Pearce and Giordina (1982), Polish Americans are least likely to seek psychological treatment unless their problem interferes with their ability to perform. The value of stoicism is very deep. Mental illness is perceived as preventing them from performing, affecting issues of self control, and allowing dependency needs to surface. They mistrust outsiders and mental health agencies and look to the family, friends, priest and the community for help. Seeking help signifies weakness (Mostwin, 1972).

Greek-Americans (Samouilidis, 1978) tend to perceive mental illness as a stigma. They see mental illness as having a negative effect on a permanent basis, not only for the patient but for all family members. They often try home remedies until the situation is out of their control before they present themselves for treatment. When they do, they are reported as somatic problems such as headaches, stomach pains and nerve troubles. The whole family may show interest in hearing what the diagnoses is and what it means. Each family member may blame the other for the problem.

Caribbean individuals bring with them to the United States conceptions of mental illness and attitudes toward seeking psychological help. Carl Hinkle and Moss (1981) have pointed to the interconnectedness of religion and medicine. This relationship, according to these researchers, has extended into areas of both psychological and somatic complaints. They reported that 43 percent of individuals suffering from emotional problems first turn to the clergy for help. The religion involved may not necessarily be Christian. It may be a combination of Christianity and aspects of African folk rituals found in Voodoo (Haiti), Obeah (Jamaica) and Santeria (Cuba). Caribbean islanders here in the United States align themselves to religious practices similar to those in their homeland.
According to Hall (2002), many Caribbean islanders seen in clinical practice in the United States are referred from their jobs, the clergy, youth and family services or the legal system. This is particularly true of the lower socio-economic group. When the mental health system expanded on the islands from the narrow focus of hospitalization of the insane, to outpatient and private practice care, the middle and upper classes were the ones who were more willing to use these services. They also tend to have a wider view of mental illness and attach slightly less stigma to psychological problems. They are more like to seek treatment without having been referred. On the whole, Caribbean islanders tend to have a very narrow view of mental illness. They believe that people should sort out their problems within the context of the family and not expose personal and private information to strangers. When the therapist is from their own country, they generally have a more relaxed attitude, perceive the therapist as a friend, and engage in therapy for a longer time.

**Psychopathology Across Cultures**

Research on culture and mental health focus on one of two orientations. One is the universalist view that holds that there exist similarities in mental disorders across all cultures, but the expression of these disorders varies from culture to culture. Universalist researchers focus on schizophrenia, depression, and somatization. The other view is the cultural relativist approach. This view holds that some disorders are unique to a culture and may only be understood from a cultural perspective (Kirmayer, 1991).

The following list highlights some differences in the way various cultures perceive a few well-known forms of mental illness. The classifications are based on the *Diagnostic Statistical Manual (DSM)* of mental disorders. The *DSM* was first published in 1952 and has gone through several revisions. It is now *DSM-IV-TR* (2000) and is the text revised edition of the *DSM-IV*. It classifies, defines and describes over 200 mental disorders:

**Schizophrenia** as described by *DSM IV* includes delusions, hallucinations, disorganized speech, and flat affect. Studies sponsored by The World Health Organization (1981) researched countries such as Columbia, Denmark, Soviet Union, Taiwan, England, India, Nigeria and the United States and concluded that schizophrenia occurs in all cultures. There were some basic differences. In the United States, once an individual has been diagnosed with this disorder, it remains a permanent diagnosis. When the symptoms are no longer present, the individual is said to be in remission. Additionally, Patients in Nigeria, Columbia and India recovered faster than patients in England, the United States, and the Soviet Union.

**Depression** as defined by the *DSM IV* is a mood disorder described as depressed mood with diminished interest or pleasure in the individual's usual activities, difficulty falling asleep, or sleep interrupted by early rising. There may instead be over sleeping, overeating or loss of appetite, and reduced ability to think or concentrate. The World Health Organization (1983) found that after studying symptoms of depression in Canada, Switzerland, Iran and Japan, these cross-cultural symptoms were similar. Other researchers such as Kleinmann (1988) found cultural variations in the symptoms. These variations include symptom patterns which Marcella (1979) believes has to do with the cultural variations in sources of stress as well as the resources that are available to the participants in these cultures.
**Somatization**, the tendency to experience psychological problems as physical complaints, was once assumed to be cultural. This tendency has been identified among Hispanics (Koss, 1990), Japanese (Radford 1989), and Chinese (Kleinman, 1982). However, more recent studies on Europeans and Americans (Isaac, Janca & Orley, 1996) have challenged this notion. These studies reported that many of the physical complaints by individuals from these groups were psychological in nature. Somatization is therefore considered universal rather than cultural.

**Culture-bound syndromes**, also known as *culture-specific disorders*, refer to mental disorders that are unique to a certain culture. These psychological disorders might be similar across cultures, but they are expressed differently and the names might vary (Goldstein, 2000, p. 205). According to the *Dictionary of Psychology*, culture-bound syndromes are patterns of behavior that do not fit accordingly into normal classifications of mental disorders. They "are entirely or mainly restricted to particular cultural groups" (Colman, 2001, p. 179). Culture-bound disorders came into Western psychiatric literature in the late nineteenth century, when Western physicians made reports of strange and "exotic" disorders they observed while working in Asia, Africa, and South America. They noticed that these disorders were different from the disorders found in Europe and North America. Cases of these disorders were first heard of in the sixteenth century from the journals and reports of European explorers who traveled to far-away places (*Encyclopedia of Psychology*, 2000, p. 407). More than 30 culture-bound disorders have been reported in the clinical and research literature. However only a few receive the most attention and are well known, such as *latah*, *amok*, and *susto*. *Latah* is one of the oldest of these disorders and it is found in the Malaysian and Indonesian cultures. Both males and females can have this disorder and it consists of a "startled reaction with subsequent imitative behaviors and swearing" (*Encyclopedia of Psychology*, 1994, p. 373). *Amok* is found in people from Southeast Asia, and the Philippines. The person with this disorder becomes agitated and violent. This sudden outburst of explosive behavior is then followed by a period of "withdrawal and apathy." Finally, *susto*, also known as *espanto*, is found in Hispanic cultures in South and Central America. It is "a strong sense of fear that one has lost one's soul." It is followed by loss of appetite, weight loss, fatigue, skin pallor and excessive thirst (*Encyclopedia of Psychology*, 2000, p. 408). Every culture has its own and different disorders that may or may not be modifications of the disorders found in the Western world that are said to be "universal": this is why they are called culture-bound disorders (*Encyclopedia of Psychology*, 1994, p. 374). In theory, culture-bound syndromes are those folk illnesses in which alterations of behavior and experience figure prominently. In actuality, however, many are not syndromes at all. Instead, they are local ways of explaining any of a wide assortment of misfortunes (Simons, 2001).

The literature of cultural psychiatry has listed and described a number of these syndromes (Simon & Hughes, 1985). These include:

**Amok** (Leff, 1981) involves wild, aggressive behavior of limited duration (usually among males) in which there are attempts to kill or injure a person. It has been identified in Southeast Asia (Malaysia, Indonesia, and Thailand). It has relations to the Viking behavior *beserker*, practiced before entering battle. *Amok* is a Malay term meaning, "to engage furiously in battle." The terms, "running amok" and "going beserk" are now in common usage.
**Brain fag** involves problems of academic learning. The individual experiences headaches, eye fatigue, and an inability to concentrate. This condition is experienced by high school or university students. It appears widely in West African students just prior to school and university examinations (Prince 1960) and is unknown outside that cultural area. Symptoms include difficulties in concentrating, remembering, and thinking. Students often state that their brains are "fatigued." Additional symptoms center on the head and neck and include pain, pressure, tightness, blurring of vision, heat, or burning (Simons, Murray, McLoyd, Culrona, Conger, 2001). It was first named by Nigerian students suffering from a variety of somatic symptoms in class, especially vision disturbance when reading. Brain fag symptoms have occurred in many African students, independent of intelligence, when exposed to acculturative stress in Western education systems emphasizing theoretical book learning, quite different from the time-honored ways of acquiring knowledge in traditional African societies (Prince, 1985).

**Koro** occurs in Malaysian culture and involves the sensation that one's penis is retracting into the abdomen and the belief that when fully retracted, death will result. There are panicked attempts to keep the penis from retracting. This can lead to severe physical damage (Gaw, 2001).

**Latah** is found in Malaysian and Indonesian cultures and involves imitative behavior (usually among women) that seems beyond control; movements and speech are copied, and individuals in this state are compliant to commands to do things outside their range of behavior (for example, utter obscenities). Its onset is often the result of sudden or startling stimulus. The term *latah* means, "ticklish" in the Malay language (Gaw, 2001).

**Bibloqtoq** involves an uncontrollable urge to leave one's shelter, tear off one's clothes, and expose oneself to the Arctic weather. It has been identified in Greenland, Alaska and the Canadian Arctic and has been linked to both isolated environmental conditions, and to limited calcium uptake during the long, sunless winters (Gaw, 2001).

**Susto** involves insomnia, apathy, depression, and anxiety, often among children, and is usually brought on by fright. Among the people of the Andean highlands it is believed to result from contact with supernatural forces (witches and evil eye) and to result in soul loss (Gaw, 2001).

**Ataque de nervios** is found among Hispanics. It is an out-of-consciousness state resulting from evil spirits. Consciousness may return without memory of the episode (Guarnaccio, 1993).

**Falling out** is found in African American communities. It consists of seizure-like symptoms resulting from traumatic events such as robberies (Gaw, 2001).

**Wacinko** syndrome is found among American Indians (Paniagua, 2000). It is specifically found in the Oglala Sioux, a population of 13,000 people, and involves feelings of anger, withdrawal, mutism, and suicide resulting from reactions to disappointment and interpersonal problems (Paniagua, 2000). Additional symptoms are immobility, depression, psychosis, and psychomotor retardation (Lewis, 1975). This syndrome can also be translated as pouting (James, 1996). The indigenous practitioners recognize the syndrome as a distinctive disorder. However, non-Indian practitioners may not recognize it, even though the symptoms are not culturally bound. Most
cases are diagnosed as reactive depressive illness (Lewis, 1975). Additionally, most patients are misdiagnosed with schizophrenia (James, 1996).

For example, Edith Conquering Bear was brought to the hospital because she would not speak or eat. She became mute and immobile when her daughter left her. In the hospital, her behavior of not eating and speaking continued until one day when she said that she wanted to go home. Her behavior in the hospital was a result of cultural shock and it intensified her illness. Her niece took care of her at home, then she became in good spirits and was ambulate. She recovered in response to her family. Additionally, she was misdiagnosed with schizophrenia in the hospital. However, the indigenous practitioners diagnosed her with *wacinko*. She was pouting because her daughter moved away. She stopped pouting when her daughter came back. She pouted because she did not get what she wanted and the situation was unbearable for her. Other examples of *wacinko* are when siblings do not speak to each other or there is avoidance between relatives, grudges, guilt over mistakes, and suicide after a fight. Additionally, *wacinko* can result from depression and suicide due to hormonal problems. Another example of *wacinko* occurred when a woman committed suicide because no one paid attention to her. Native herbalist *yuwipi* doctors conduct treatment for *wacinko*. Unfortunately, outsiders may not be aware of the behavior patterns of the Oglala Sioux (Lewis, 1975).

*Wind/cold* illness is found in the case of Hispanics and Asians. This is a fear of the cold and wind and involves feelings of weakness and susceptibility to illness resulting from the belief that natural and supernatural elements are not balanced (Gaw, 2001).

*Taijin kyofusho*, found among Asians, involves guilt about embarrassing others. Timidity results from the feeling that one's appearance, odor, or facial expressions are offensive to others (Levive & Gaw, 1995).

*Zar* is an altered state of consciousness, observed among Ethiopians. This is expressed by involuntary movements, mutism and incomprehensible language. This culture specific disorder is derived from the word for "visitation" and refers to being "visited" by a possessing spirit or demon (Boddy, 1989). It is also a ritual among and for women. It is a kind of catharsis for perceived troubles: mental, emotional, and physical, and it is usually done by a female leader, who occupies a "wise woman" role of some sort. This ritual often involves women who know each other and are from the same village (Farrah, 1978).

*Zar* is also known as a trance ceremony of North Africa and the Middle East and is technically forbidden by Islam (El-Shamy, 1980). It is best described as a "healing cult" which uses drums and dance in the ceremonies. It also functions as a sharing of knowledge and charitable society among the women of these very patriarchal cultures. As mentioned above, the leaders and participants are women. The majority of the possessing spirits are male, those possessed are generally female, and the sense of possession is usually, though not exclusively, inherited. It is also contagious and may strike at any time. *Zar* is basically a dance of spirits or a religious dance. These ceremonies provide a unique form of relief to women in strict patriarchal societies where women are not treated as equals. These ceremonies were well established in the Sudan by the 1820s. They were outlawed by *Sharia's* law in 1983. The *zar* of today is practiced more as a relaxation technique and as a spiritual healing for stressed or troubled persons. The sacrificing of
animals may or may not be part of this modern ceremony. The leader of the modern ceremony is called a "Kodia" (Egypt), a Shaykha (N. Sudan), or an "Umiya" (N. Sudan) depending upon the region. The leader herself is also possessed and has come to terms with her spirit and is therefore able to help others. Heritage is considered an important qualification; leadership is often passed from mother to daughter or through female members of the family. Men cannot inherit this spirit.

The zar is not an "exorcism," as people often describe it, because the spirit is accommodated and placated; it is not exorcised (El-Shamy, 1980).

Mal puesto, hex, root-work, or voodoo involves unnatural deaths among African Americans and Hispanics. Unnatural diseases and death result from the power of people who use evil spirits (El-Shamy, 1998).

Ghost Sickness is found among American Indians. This involves weakness and dizziness resulting from the action of witches and evil forces. Ghost Sickness, according to Guiley (1992), refers to "the belief that the ghosts of the dead can cause illness and death" (p. 140). This term is based on the animistic system of beliefs which states that everything has a soul and a conscious life. For instance, rocks, trees, rivers, mountains, and the earth are all thought to possess a soul or animae (Brandon, 1970). For many, it is believed that certain places and objects are sacred and have special powers that may be used to help or hurt people. This is characteristic of many tribal societies around the world. It is thought that the soul of a dead person remains close to their body for a few days until it begins its journey to the land of the dead (Brandon, 1970).

According to folklore, it is during this time that the ghost may be particularly dangerous because it is thought that it may be lonely and seeking company from the living. In many African cultures, the spirits of the dead are thought to survive bodily death and have major effects on all types of human affairs (Kohl, 1992). Additionally, it is thought that a child's soul is weaker or less attached to his or her body, making him or her more susceptible to ghost sickness. For this reason, children of the Kwakiutl Indians of British Columbia are sometimes referred to as adults or even disguised in order to confuse ghosts into thinking that they are older than what they really are (Guiley, 1992).

Interestingly, the fear of the dead has been the cause of many strange practices such as the removal of corpses from homes via a man-made hole in the wall, rather than through a door or window, in order to confuse the ghost or make the ghost's trip back home more difficult. Although ghosts may cause greater fear soon after death, many societies feel that any sighting or sounds of a ghost may carry with it some disease or death, even if some time has passed since (Guiley, 1992).

Karoshi is death by overwork and is a commonly found syndrome among the Japanese (Guaraccio, 1993).

Whakama is identified in New Zealand. It includes shame, abasement, and feelings of inferiority, inadequacy, self doubt, shyness, excessive modesty, and withdrawal (Gaw, 2001).
**Sinking heart** is a condition of distress in the Punjab culture. It is experienced as a physical sensation in the heart or chest and is thought to be caused by excessive heat, exhaustion, worry, or social failure. It has some characteristics of depression but also resembles a cardiovascular disorder (Guaraccio, 1993).

**Windingo**, wind ego or witiko is a culture-bound syndrome of neurotic, obsessive cannibalism, now somewhat dishonored. The syndrome involves disgust for ordinary food and feelings of depression and anxiety, leading to possession by the witikospirit (a giant man-eating monster) and often resulting in homicide and cannibalism. It occurs among Canadian Indians and has been construed as a severe form of starvation anxiety. If a cure is not reached, the witiko sufferer often pleads for death to avert his cannibalistic desire (Berry, 2002). The legend of the wind ego is well known among the Algonquian speaking tribes in America. The legend often varies in details, but the main proposal stays the same: lost hunters or people that have stayed too long in the state of food crisis (especially during the wintertime), turning to cannibalism as a last resource, will become windigos or be occupied by its spirit and then be drawn towards eating people. When this occurs, sufferers become aggressive and antisocial. It is believed that the only way to kill the windigo and the malicious spirit is to burn the body of its host into ashes.

Windigo is usually linked with the winter because of the lack of food during these times and the increased likelihood of cannibalism occurring. Most tales say that the windigo rides with the winter wind, howling inhuman screams, others that the windigo is made of ice and cold, or at least its heart is. Though most tales recount the windigo as being cannibalistic, dangerous, and violent, the host can still try to live far from civilization, deep in the woods, to prevent anybody from being its next victim. Some windigo-inhabited people would even commit suicide to prevent hurting anyone else. The legend also says that when speaking of a supernatural being, the word "windigo" should be capitalized, but when speaking of a cannibalistic human, windigo should be lower cased (Flesher, 1999). There was a case in recent history in which, after a long depression in the winter, an Indian developed a craving for human flesh and acted on it. In modern psychology, there is a condition called "windigo psychosis." The symptoms may include anorexia. There are many other superstitions surrounding the windigo, as many as there are Indian tribes in the cold forests of Canada. Regardless of the specifics, the windigo is always perceived as truly evil and nearly permanent (Flesher, 1999).

Sue and Sue (1990) believe that in order for counselors to be successful with clients from culturally diverse populations, they should have an awareness of the cultural differences between themselves and the client. These differences include conceptions of mental illness, attitudes toward seeking psychological help, and the preferred mode of intervention.

**References**


