CULTURAL FACTORS IN THE ETIOLOGY OF MENTAL DISORDER AND THEIR IMPACTS ON CLINICAL SYMPTOMS AND INTERVENTION

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INTRODUCTION

The study on impacts of culture on mental disorder has drawn attention of researcher in the field of psychology and psychiatry. Culture has been defined in different ways by different researcher. A number of researcher has defined culture in terms of differences in ethnic groups (e.g. Gossop, 1994). Another group of researcher views culture in a wider perspectives including the aspects of gender and social economic differences (e.g. Ivey et.al. 1993).

The opinion regarding the effects of culture on mental disorder polarizes into two different directions. One argues that culture does not have significant effect on etiology, occurrence, or symptomatology of mental disorder, while the others believe culture has a significant influence (e.g. Opler, 1969; Wallace, 1969). On the basis of this controversy it would be interesting to review research findings in the field to assess to what extent culture may affect mental disorder. The present article is an attempt in that direction.

The relevance of cultural factors on mental disorder can be assessed in four different areas: the etiology of mental disorder, the clinical symptoms displayed, the care and after care of mental patients, and the community attitude toward the mental disorder. From these four areas, the etiology and the clinical symptoms are better understood then the other two areas. Research findings in the field of diagnostics, occurrence and distribution of mental disorder have contributed substantial knowledge to the etiology and clinical symptoms. With regard to the care and after-care of the patients, and the community attitude toward mental disorder, the areas seem to be lacking of empirical evidence for a better understanding of phenomena. Research findings that have been documented in the literature mostly have been based on American culture (for a review see Rabkin, 1972).

Due to the time constraint and the complexity of cultural factors in the way they influence mental disorder, the present article only reviews a small number of studies. The discussions mostly emphasize the effects of culture on the etiology and symptoms. One part of

discussions will review the possible roles of culture in intervention. Discussion on care and after care of mental disorder in this artcile is excluded due to the limitation of space.

METHODOLOGICAL PROBLEMS

Research in the field of mental disorder faces a number of methodological problems which frequently complicate the interpretation of the findings. Two areas that are considered as major problems. The first is how to define the case categorized as mental disorder. The second is how to collect data after the definition of case has been settled.

How to define a case as mental disorder.

The biggest problem in studying mental disorder from cultural view-point is mental disorder is defined differently from one culture to another. The problem arises because of the marked differences regarding the standard of normal behavior. In some cases, certain manifest behaviors that are perceived as abnormal in the Western cultures, have been considered as normal by a particular culture. For example, suspiciousness has been regarded as normal for Dobuans (Benedict,1934 cited from Kiev, 1969), while in Western cultures it is regarded as one of clinical symptoms. In such instance it is difficult to decide what can be defined as normal. Kiev (1969) suggested to use cultural standard in solving this problem. Based on the argument that symptoms of disorder are either distressing to the patient or to the people surrounding him, Kiev suggested, research should be done in order to find the standard of behavior that is fitted to that particular culture. The implication of Kiev's suggestion, from the view-point of the present writer, is that research utilizing universal standard of mental health that classifies any deviant from this standard as a mental disorder, should be abandoned. Secondly, research on any particular culture should be a continuos process, since values in any particular culture may change from time to time which causes the culturally based standard ever changing.

The second problem that always arises regarding the definition of the case is what constitutes the prevalence (the number of cases in any particular time). Using Heller's (1981) classification, there are four ways for defining the prevalence : number of hospital admission, number of person received psychiatric treatment, number of person who are categorized by personality inventories as abnormal, and number of person who admit subjective unhappiness. The problem arises because not any of these criteria is satisfactory. Utilizing mental hospital admission, for example, excludes those who are mentally disorder but do not go to hospital. If the prevalence is based on the admitted subjective unhappiness, then the individuals who do not admit their feelings will be excluded.

Cross cultural studies on mental disorder that have been done so far utilized different criteria in determining the prevalence. For example Enright and Jaeckle (1963) used mental hospital admission. Eaton and Weil (1953) utilized the number of those who received psychiatric treatments. Leighton (1969) based the prevalence on the number of subjective unhappiness admitted. Schwab, Bell, Warheit, and Schwab (1979) used personality

inventory. Due to differences in criteria, it creates problem in integrating the findings of cross-cultural studies. The problems become more complex if the method for collecting data is also different from one study to another study.

Data collection technique

Dohrenwend and Dohrenwend (1974) listed several techniques that have been used in collecting mental disorder cases. The techniques were categorized into two broad categories, personal judgment and objectively scored measures.

With regard to personal judgment, there are two general approaches that have been used in making the evaluations. First, a single psychiatrist or a small team headed by a psychiatrist directly interviewed community residents, and based on the interview a clinical judgment was made. The second approach, a psychiatrist or a team headed by a psychiatrist directly interviewed community resident. In one variation of this approach, a psychiatrist instead of directly interview the resident, he or she requested another psychiatrist, clinical psychologists, or layman interviewers to conduct the interview. Based on the result of the interview, a psychiatrist made the judgment regarding the potential clinical symptoms. The problem with this approach, the one who judged the result of interview tend to be over impressed and overestimated the pathology if working from written records alone (e.g.Gottheil, Kramer and Hurvich, 1966).

Objectively scored measures have been used by a growing number of investigators. The Langer's (1962) 22 item-psychiatric-screening instrument is the one widely used. A rather similar but less widely used measure is a 20 item Health Opinion Survey questionnairre (Macmillan, 1957). Since about half of the items in these instrument were physiological in nature, while the other half were items that best for detecting anxiety and depression, these instrument serve best for studying neuroses but not for psychoses. The utilization of these instrument in clinical studies has created a controversial issue. The proponents support the utilization on the basis of the reliability of the instrument, the ability to discriminate psychiatric and non psychiatric patient and the relatedness of scores with demographic variables. (e.g. Shader, Ebert, & Harmatz, 1971). The instrument have been criticized due to lacking of face validity, over representing distress in some groups, items are compounded with physical illness symptoms. (e.g.Crandell & Dohrenwend,1967).

The utilization of these various techniques produces different estimates of true prevalence of mental disorder. The inconsistencies of the various techniques may cause uncertainty regarding the validity of inference made with regard to the relationship between cultural factor and mental disorder. This uncertainty becomes more pronounced if the techniques that has been used is a mere translation of the western instruments which its validity and reliability for a particular culture was never assessed.

Research paradigm

Mostly studies investigating the effect of culture on mental disorder exclude variables other than cultural variables. Physical settings of the society and genetic factors are among those that were frequently excluded. As has been found in some studies these variables are related to the occurrence of mental disorder. The effects of sunshine, weather, lunar position on mental disorder incidence have been found by a number of studies (for review see Moos, 1976). Genetic factors and its influence on mental disorder have also been demonstrated (for review see Hurst, 1965). Due to the facts that these variables are influential, then, in any cross cultural study of mental disorder these variables should be included. Heller and Monahan (1976) discussed the need to change the orientation regarding the etiology of mental disorder from a single-cause orientation to a multi-risk-factor orientation. The suggestion proposed by Heller and Monahan can also be applied to cultural study of mental disorder. This approach is expected also to give solution to the controversy regarding the role of genetic and environmental factors on mental disorder.

The second feature of cross-cultural study of mental disorder is cross-sectional. this paradigm can not detect the causes of change in incidence rate of mental disorder in a particular culture. For example, Kiev (1969) reported that in 1934, 111 cases of 'imu' (exotic disorder) were found among 17.500 Ainu in Japan. In 1958, in this same area; anly one case was found. This type of phenomenon can only be understood if there is a follow up study. Due to the facts that other variables (e.g. sunshine, weather, lunar position) have effects on the incidence of mental disorder, then a longitudinal study is a better paradigm. In addition, using a longitudinal paradigm, the effects of cultural change can also be assessed. This feature will enable us to detect the development of mental disorder, such as knowing the effect of social mobility on mental disorder.

CULTURE AS ETIOLOGY OF MENTAL DISORDER

In examining the effects of culture on etiology, two different issues attract our attention. First, in what way culture can be etiological factor, and the second, what cultural variables can be categorized as etiological factors.

Why culture can be etiological factor

The answer to this question may be seen from several theoretical, perspective. Psychoanalytic approach may see some aspects of culture as a source of stress and frustration, since they control the demand of primitive impulses. In the language of psychoanalytic theory, culture is the Super-ego which inhibits any demand which is socially unacceptable from the Id. If stress and frustration accumulate to a degree that can not be tolerated by the individual, then mental disorder symptoms develop.

From learning-theory perspective, culture can be etiological factor because culture provide channel for reinforcing the abnormal behavior. Kiev (1969) argued that a certain symptom

of mental disorder develop, because this symptom is rewarded in that particular culture. For example, in Haitian culture there is a kind of ritual activity that lead to trance accompanied by a reduction of higher integrative functions such as articulate speech, social inhibition, and muscular coordination, increase of reflex behavior such as trembling, convulsive movement, muscle twitching and teeth grinding. These behaviors are tolerated and applauded in ceremonies. Those eccentric behavior are culturally recognized and accepted ways of going crazy.

What cultural variables can be etilogical factor

Wittkower and Dubreuil (1964) speculated that there are three broad variables that can be considered as etiological factors : cultural contents refers to all beliefs, values, norms, attitudes, and customs in a people's culture. Social organization is the network of regular and relatively long standing interactions between members of society. Sociocultural change is any change in the cultural content and social organization. Wittkower and Dubreuil did not provide enough evidence to support the speculations made by Wittkower and Dubreuil. In interpreting the research findings, precautious actions should be taken. First, the findings may have artifacts, e.g. the data were not based on true prevalence, the diagnostic technique may not be appropriate for the society under study. Second, the relationship between cultural variables and mental disorder may be mediated by the third variable.

Cultural contents

- *Taboos*. A taboo is an act that is banned in any particular society. Taboos may relate to some basic need (e.g. food, drink), psychological need (e.g. sex, aggression, personal initiative, political and religious need). Lewin (1958) reported that in the culture where women are burdened excessive load of taboos, mental disorders in women tend to be more common.

Social organization

The lack of integration of social organization may create a favorable condition for development of mental disorder. Social disorganization such as unemployment, poverty, and racial conflict have been found to be related to prevalence of mental disorder. One of early studies on social organization was conducted by Hollingshed and Redlich (1953). Based on the data from the treated cases of mental disorder, they found that social economic status was correlated with the incidence of mental disorder. Individuals of low -social-economic status were more likely to be mental patients than individuals of high economic status. The data presented by Hollingshed and Redlich were based on treated case, not true prevalence. From this study we do not know whether people who do not come for psychiatric treatment will have the same tendency. A similar and more extensive study has been conducted in order to know whether there is correlation between social economic status and mental disorder in people who do not go for psychiatric treatment.(Schwab, Bell,

Warheit, & Schwab, 1979). Using a number of dependent measures (a.g. interview, personality inventories) they found the pattern of findings that is similar to the findings of Hollingshed and Redlich. People of low social economic status were more likely categorized as having psychiatric problems.

Although the data regarding the relationship of social economic status and mental disorder is rather consistent , the real cause of this relationship is not clear. To what degree the difference in community tolerance and social economic status have influence on psychiatric diagnose. Similarly to what extent the downward social mobility, or cumulative stress experienced by lower economic status individuals would be the causes of mental disorder. These questions need to be answered in future studies.

Sociocultural change

It is hypothesized that cultural change may increase the incidence of mental disorder (Wallace, 1969). Even though this hypothesis is appealing, however there were only few studies attempted to test it. Probably the reason for the lack of interest in studying the effects of cultural change is that the study needs time to detect the change. The effects of cultural change can not be detected in a short time period.

The first study aimed at investigating the effect of cultural change on mental disorder was conducted by Goldhamer and Marhall (1953). Using the hospital admission record in Massachusetts area between 1840 - 1940, they found that in 100 year period, the rate of functional psychoses remains constant, despite the culture has changed. Several explanation for this findings has been proposed. One explanation argued that there was a possibility that people of 1940 were more tolerant to mental disorder, so the mentally disorder was not always sent to hospital. Second, Massachusetts was an industrial area which had been so advanced in technology in 1840, the 100 year lapse did not influence any change in sociocultural aspects.

If the attention is directed to the effects of sociocultural change in societies where the change is a process of acculturation of the traditional culture, one could find the support for the hypothesis that cultural changes cause mental disorder incidence increased. Shore, Kinzie, Hampson, and Pattison (1973) reported, based on their study on Indian villages, that the occurrence of mental disorder among younger Indians who had been exposed to "white culture" was significantly higher than the older Indian who still preserved the traditional culture. A rather similar phenomenon was also reported by Beaglehole (1969) in reviewing studies on mental disorder among New-Zealanders. Due to acculturation process, the native-born Maoris showed a higher rate of mental disorder, as compared to the Maoris of previous culturated generation. Interestingly this study showed that the sociocultural changes among Maoris produced changes in pattern of disorder. It was reported that between 1953-1957 about 46.9% of Maoris admitted to mental hospital were diagnosed as manic-depressive, and only 23.4 were classified as schizophrenic. With the acculturation process, the pattern of disorder changed dramatically few years later. The data on mental

hospital admissions between 1958 - 1960 incated that the number of schizophrenic cases among Maoris increased to 40.9%, while manic-depressive decreased to 17.5%. However the data did not allow us to know for sure whether this change in pattern was due to the cultural changes or due to changes in criteria of diagnosis.

IMPACTS OF CULTURE ON CLINICAL SYMPTOM

Discussion on this section will be focused on the way cultural factors are related to common mental disorder (e.g. schizophrenia, manic depressive), and culture-bound syndrome. Which specific cultural factors that cause disorders remains unknown. There have been some speculations about the possible cultural factors that lead to different symptoms. However, there is no supporting data for these speculations. So they will be excluded from discussion.

Common mental disorder

Sanua (1969) reviewed hundreds of studies focusing on impacts of cultural factors on clinical symptoms of schizophrenia. One conclusion from the review is that schizophrenia is found in all cultures, and its symptomatology is colored by the culture. Some of the studies reviewed showed that schizophrenia in primitive African societies is quiter than in the Western countries. Among Indian schizophrenics, catatonic, body rigidity and negativism were reported to be very common. Asiatic schizophrenics were said to be more with drawn and less aggressive, while the southern Italian patients showed the reverse of Asiatic symptoms.

Manic-depressive psychosis has been intensively investigated. Murphy, Wittkower, and Chance (1964) reported that symptoms of endogenous depression, mood change during the day, insomnia, diminution of interest in social environment, were commonly found among Europeans. In non European countries the pattern of depression is different from European. Where it is rarely found the feelings of guilt, of self accusation, and of punishment as the ones frequently found in European countries.

With regard to psycho neuroses, some evidences showed that acute anxiety reactions of short duration are more common in primitive societies than in advanced societies (Murphy et.al, 1964). Social economic status, and race also found to be correlated with symptomatology of psychoneuroses. Black Americans showed a higher level of anxiety, depression, and phobia than the white Americans (Schwab, Bell, Warheit & Schwab, 1979).

Culture-bound syndrome

Yap (cited from Leighton, 1969) divided culture-bound syndromes into three types of symptomatology, fear reactions, rage reactions, and dissociation states. Discussion on each type will be presented below.

Fear reactions.

"Latah" refers to a kind of disorder where a patient at the beginning of attack repeat their own words and sentences, then those of others, especially person in authority. Later on patients repeat words and sentences of other surrounding him. At other times the patient do the opposite what the others do. The precipitating factor of the attacks is the word snake, or by tickling. This kind of disorder occurs in Indonesia and Malaysia. A rather similar type is called "imu", the symptomatology is similar but the precipitating factor is the sight of snake. "Imu" is a disorder that frequently happen in Japan.

"Koro" is another culture-bound syndrome that mostly occurs in South East Asian countries. The patient of "koro" experiences a severe anxiety due to being afraid that his penis will with draw into his abdomen.

"Susto" or "magic fright" is a kind of syndrome that has been reported among Central and South American Indian tribes. The Symptoms are intense anxiety, hyper excitability, generalized phobias, depression and somatic symptoms.

Rage reactions

"Amok" is a rage reaction syndrome that was found in Indonesia, Malaysia and Philippines. The patients of "amok" attack almost everything surrounding him. This is a male-type disorder.

Dissociation states

Trance and possession are examples of dissociation-states-mental disorder. The persons who see the patients on attack believe that the spirit of outside agencies such as animal, ancestors, ghost has intruded the patients. The symptom of this disorder are empty face, change in tone of voice, change in manner of speaking, and staring into space. This disorder found in Haiti, Philippines and Indonesia.

CULTURE AS DETERMINANTS OF INTERVENTION

There have been a number of criticism addressed to western oriented intervention techniques. For example Cohen (cited in Lebra, 1976) observed that in making diagnosis and treatment, there a remarkable lack of direct attention to ethnicity, race, and cultural identity. Lack of attention and consideration to these cultural aspects have led the intervention into failures. Yamamoto et.al (Heller, 1981) reported, for example, therapists tend to conduct treatment in accordance with the value system of the middle class. This approach has proven ineffective with and discouraging to lower-class patient. A number of therapists became frustrated because patients did not respond well to this approach. Therapists discouraged patients from seeking continued therapy after the first meeting. In responding to the demand for solution, a new intervention techniques been developed.

Christmast, Wallace and Edwards (1973) suggested that utilizing the indigenous therapists seem to solve the problem. Indigenous therapist can communicate well with the patients probably due to the similarity of cultural background. Another attempt of intervention has also been developed. A sociologically based intervention suggest to provide opportunities to achieve success (e.g. education, jobs) for the lower social economic status persons. This success will eliminate disorders. In support to this claim Odell (1974) did a study on the effects of providing education and jobs on the incidence of delinquency. The findings of his study showed that by providing the education and the jobs delinquency rates reduced tremendously.

Another cultural factor that may be important determinant for intervention is belief about the cause of mental disorder. It has been reported in several studies (Lebra, 1976) people in developing countries tended to attribute the cause of mental disorder to unnatural factors such as magic power, spirit possession or ghost. This same phenomenon also has been reported to be existed in the modern country. Wintrob (Heller, 1981) reviewed studies dealing with the belief system of ethnic minorities within the United States in relation to the causes and appropriate treatment of mental disorder. The findings revealed that there are two principal causes of disorder, natural and unnatural. Natural causes are factors such as genetic predisposition, nutritional imbalance or infection, parental abuse, or stress of poverty. Unnatural causes are spirit possession or malign magic. It was also reported by Wintrob (Heller, 1981) that there is a growing interest among "white-subgroups" about faith-healing, spirit possession or mediumship as an effort to undertand mental illness. Different beliefs regarding the causes of disorder may determine the choice of mental treatment. Research findings reported by Wintrob showed that people who believe that the causes of disorder are unnatural factors tend to recommend to use community healers (spiritist, curers) more frequently than hospitals or doctors.

This finding suggests that belief system can be used as a guide line of intervention. For example, It is a waste of money and time to build community-mental-health centers in the area where people believe that community healers are the best source of help for mental disorder. The present writer is not aware of any study aims to compare the effectiveness of community healers as compared to modern therapists in curing mental disorder in the area where people believe in unnatural forces as the causes of disorder. Certainly it will be a good idea to demonstrate this effectiveness for the purpose of designing mental health service.

The last cultural factor that warrants attention is the pattern of social relationship among people in a particular society. This pattern of social relations may determines the success of intervention. Yamamoto (Heller, 1981) criticized the way American psychiatrist treated patients of Asian origin. Criticisms were addressed on two areas. First, American evaluation of patients is too often a one-dimensional focus on the individual. This way of evaluation neglects the importance of close family ties in Asian culture. Secondly the role that frequently played by therapists is neutral, non jugmental and non critical toward patients. This role is alien to Asian countries. The family unit is headed by the patriarch in Asian

countries. In contrast to American egalitarian values, the relationship are vertical. This vertical family relationship between therapist and patient requires the therapist to be an authority figure. The above criticism suggest that in order to have a better intervention, a more accurate culturally based diagnosis should be matched with culturally sensitive treatments.

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