CULTURE-RELATED SYNDROMES: PERSPECTIVES FROM MEDICAL ANTHROPOLOGY

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Abstract

Culture-related syndromes are mental conditions or psychiatric syndromes whose occurrence or manifestation are closely related to cultural factors and thus, warrant understanding and management from a cultural perspective. The present paper provides a comprehensive list of various culture-related syndromes and also attempts to broadly classify them. The various socio-cultural factors that explain these syndromes are also discussed.

Keywords: Culture-related syndromes, culture, psychiatry, medical anthropology.

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Introduction

Every culture has its own way of describing the illnesses. The way illnesses are identified understood, classified, interpreted and responded to are cultural and not biological. Anthropologists and psychiatrists have long been interested in illnesses which are found in specific societies and regions of the world. These illnesses are commonly referred to as 'culture-bound syndromes'. They are defined as "episodic and dramatic reactions specific to a particular community-locally defined as discrete patterns of behaviour" (Littlewood and Lipsedge, 1985). Prince and Tcheng-Laroche (1985) argued that all the physical and psychiatric illnesses are bound to culture but the concept of 'culture-bound syndromes' is particularly important for medical anthropologists and transcultural psychiatrists whose interest lies in understanding of interrelationship between symptom pattern and cultural processes. Tseng (2006) mentions that the cultural influences on psychiatric syndromes can occur in six ways: pathogenic effect (cultural influence on the formation of a disorder); psychoselective effect (culture selecting certain coping patterns to deal with stress); psychoplastic effect (culture modifying the clinical manifestation); pathoelaborating effect (culture elaborating mental conditions into a unique nature) psychofacilitating effect (culture promoting the frequency of occurrence); and psychoreactive effect (culture shaping folk responses to the clinical condition).

Levine and Gaw (1995) criticised the use of term 'culture-bound syndromes' as these syndromes may not specifically be bound to one culture but may be wide-spread to other cultures also. Balhara (2011) emphasised the need to relook and relabel the 'culture-bound syndromes' in the mainstream diagnostic categories for better understanding and management of these conditions. The suggestions have been made to rename them as 'culture-related specific psychiatric conditions' (Tseng and McDermott, 1981) and recently the term 'culture-related specific syndromes' (Tseng, 2001), to indicate more accurately the meaning of issues addressed. The other terms like 'folk illness', 'culture-reactive syndromes', 'exotic psychoses', 'atypical psychoses', 'esoteric disorders' and 'hysterical disorders' are also used in literature to refer to culture-related syndromes. However the terms like, 'exotic', 'rare', 'uncommon', 'extraordinary' or 'unclassifiable' mental disorders are also used. These syndromes are informed by relative cultural assumptions, sorcery, breach of taboo, intrusion of a disease-causing spirit, or loss of soul. They are caused and maintained by culture-related psychological factors such as beliefs, values and attitudes. There are three major reasons for focussing research on culture-related syndromes, (a)

increasing cultural diversity of persons seeking mental health care; (b) to understand the illnesses which are culture-specific; (c) inclusion of some culture-related syndromes in Diagnostic and Statistical Manual of Mental Disorder (DSM-IV) and International Classification of Disease (ICD-10). These two documents have incorporated culture as a factor in the diagnosis of psychiatric condition but have not suggested the ways to learn about cultural factors involved and the ways to incorporate the cultural factors in treatment process for better understanding.

Culture-related Syndromes: Attempts for Classification

Several different systems have been proposed to classify culture-related syndromes. Yap (1967) suggested sub-groups based on cardinal symptoms of prototypical case: primary fear reactions (including malignant anxiety, *latah*, psychogenic or magical death); morbid rage reaction (*amok*); specific culture-imposed nosophobia (*koro*); and trance dissociation (windigo psychosis). Tseng and McDermott (1981) proposed sub-grouping the syndromes according to how they might be affected by cultural factors. Simons and Hughes (1985) categorised culture-related syndromes by 'taxon', that is, a group defined by a common factor. The categories included, startle matching taxon (including *latah* and *imu*); the sleep-paralysis taxon; the genital-retraction taxon (*koro*); the sudden-mass-assault taxon (*amok*); the running taxon (*pibloktoq*, *grisi-siknis*, Artic hysteria); the fright-illness taxon (*susto*); and the cannibal-compulsion taxon (*windigo* psychosis). Tseng (2001) divided specific syndromes into several groups: culture-related beliefs as causes for the occurrence (such as *koro* or *dhat* syndrome); culture-patterned specific stress-coping reactions (such as *amok* or family suicide); culture shaped variations of psychopathology (such as *taijinkuofusho* or brain fag syndrome); culturally elaborated unique behaviour reactions (such as *latah*); culture-provoked frequent occurrences of pathological conditions (such as mass hysteria or substance abuse); and cultural interpretations and reactions to certain mental conditions (such as *hwabyung* or *susto*).

In the present study, an attempt has been made to classify culture-related syndromes into four categories: anxiety and aggressive behaviours; fear or sudden fright; spirit possession/conflict/attack and evil eye; and sexuality.

Culture-related Syndromes Characterised by Anxiety and Aggressive Behaviours

Individual behaviour is shaped by the environment and culture. The major reasons of culture-related syndromes characterised by anxiety and aggressive behaviours include ecological

conditions, social structure of the community, nutrition and social practice of cannabalism as in case of *kuru* among the Fore of New Guinea, family problems, sex role stress, economic problems and general life stress as in case of *nervios* and child rearing practices and social dependency as in case of hysteria among Eskimos.

Kuru disease is an acute, progressive and degenerative disease of central nervous system found among the Fore of the New Guinea highlands. The prevalence of the disease was found to be quite high in the community and it accounted for almost half of the deaths that occurred among the Fore. The *kuru* disease was explained as a geographical isolate and found only among the Fore. The disease causation was attributed to ecological conditions, social structure of the community (as the disease was more in women and children, and less in men due to marked physical and social separation), nutrition and toxicity. The ethnographic fieldwork in 1961 to 1963 by anthropologists Robert Glasse and Shirley Lindenbaum helped to reveal that the *kuru* disease emerged in 1920 and might have been transmitted by ritual consumption of infected portions of the brain of the deceased relative. After the abandonment of cannabalism in 1950s, the incidence of *kuru* began to decline because this disease had a long period of incubation, new cases continued to appear for many years. Now, the researchers who tested the *kuru* survivours suggest that *kuru* imposed strong balancing selection, and this might have happened more than once in human history.

Parker (1962) attempted to relate the child rearing practices among the Eskimo to the appearance of convulsive hysterical attacks in adult life. The study found roots of adult hysteria in three social situations: (a) a child rearing process that does not prepare the children for crisis situation, (b) institutionalised religious practices which provide socially sanctioned outlets for hostility and role models for hysteria-like behaviour, and (c) social dependency.

Similarly, *nervios* which is a psychosocial discomfort and anxiety is wide-spread in Costa Rica. The roots of *nervios* lies in the family problems, sex role stress, economic problems and general life stress (Barlett and Low, 1980). Among Mexican-Americans families, the concept of *nervios* serves as a culturally meaningful illness category for a wide range of conditions including schizophrenia disorders diagnosed according to psychiatric criteria (Jenkins, 1988).

The detailed list of various culture-related syndromes related to anxiety and aggressive behaviours is given in Table 1.

Table 1 Culture-related syndromes characterised by anxiety and aggressive behaviours

Syndrome	Region/Populations affected	Description
Amok	Malaysia	Dissociative episode characterised by a period of brooding followed by an outburst of violent, aggressive or homicidal behaviour
Artic hysteria	Alaska natives	Abrupt dissociative episode accompanied by extreme excitement and frequently followed by convulsive seizures and coma
Boufee delirante	Haitians	Sudden outburst of aggression, agitation associated with confusion, psychomotor excitement and symptom resembling brief psychotic disorder
Brain fag	West Africa	Symptoms include difficulties in concentrating, remembering and thinking
Chakore	Ngawbera of Panama	Wandering or fleeing aimlessly
Colera	Hispanics	Anger and rage disturbing body balances leading to headache, screaming, stomach pain, loss of consciousness and fatigue
Empacho	Mexican populations	Stomach distress as a result of wrong food eaten at a wrong time
Gila babi	Rural Malaysia	Sudden outburst of anger
Grisi siknis	Miskito of Nicaragus	Wandering or fleeing aimlessly
Hikikimori	Japan	Acute social withdrawal
Hwabyung	Korea	Anger syndrome as a result of long-standing suppressed anger
Hysteria	Eskimos	Convulsive hysterical attacks in adult life due to child rearing practices
Kuru	The Fore of New Guinea Highlands	An acute, progressive and degenerative disease of central nervous system due to social practice of cannabalism
Locura	Latin America	Chronic psychosis
Nervios	Costa Rica	Psychosocial discomfort and anxiety
Neurasthenia	Europeans especially Dutch	Depressive disorder
Sangue dormido	Potuguese Cape verde	Pain, numbness, paralysis and convulsive stroke

	islanders	
Saora	India	Memory loss, fainting and inappropriate crying or laughing
Shenjing shuairuo	China	Physical and mental fatigue, dizziness, headache, concentration difficulty, sleep disturbance and memory loss
Suudu	South India	Painful urination often described as pelvic heat due to increase in inner hear of body
Wacinko	Oglala Sioux	Anger, withdrawal, mutism, immobility which may lead to suicide

Culture-related Syndromes Characterised by Fear or Sudden Fright

There is a convincingly strong interrelationship between fear and occurrence of certain culture-related syndromes. Fright refers to sudden fear or shock. *Latah* is the most common example. It is a biobehavioural state noted in Malay and Indonesia since the 19th century. It is a well-known cultural pattern and is a symbolic representation of marginality. It occurs largely among women in a socially and psychologically marginal situation (Kenny, 1978). Starting with the Hildred Geetz's discussion of the *'latah* paradox' in which she described though *latah* is culturally specific to Malaysia, similar forms of hyperstartling behaviour are found in other cultures also (Geertz, 1968). Simons (1985) points out that individuals in all cultures vary in how they respond to startling and some individuals respond with brief periods of *latah* like behaviour in Malaysia. Although a hyperstartle response may be viewed as part of human nature, cultural patterns and social influences elicit these responses. The behaviours and their meanings comes not from biology but from socially conditioned performances that are learned and exhibited in specific relations. The phenomena similar to *latah* include mimic psychosis referred to as *mali-mali* found in Philippines and *imu* found among Ainu of Japan. The detailed list of various culture-related syndromes related to fear or sudden fright is given in Table 2.

Table 2 Culture-related syndromes characterised by fear or sudden fright

Syndrome	Region/Populations affected	Description
Bah-tschi	Thailand	Sudden fright
Frigophobia	China	Excessive fear of catching cold
Imu	Ainu of Japan	Psychosis due to spirit possession

Latah	Malaysia and Indonesia	Startling behaviour, sudden fright, obscenity and mimesis
Lycanthropy	Babylon, Iraq	Fear of being transformed into an animal
Malgri	Aboriginals in Australia	Territorial anxiety
Mali-mali	Philippines	Mimic psychosis
Miryachit	Siberia	Sudden fright
P'a-leng	Chinese populations	Wind illness with fear of cold and wind
Taijinkyofusho	Japan	Fear of human beings
Windigo	Native Americans, Central and North East Canada	Morbid state of anxiety with fear of becoming a cannibal
Yaun	Myanmar	Sudden fright

Culture-related Syndromes Characterised by Spirit Possession/Conflict/Attack and Evil eye

Spirit possession/conflict/attack and evil eye are the conditions unrecognised by biomedicine but remarkably widespread throughout many societies. Possession is the belief that an individual has been entered by an alien spirit or other parahuman force, which then controls the person or alters that person's actions and identity (Littlewood, 2004). Spirit possession is an important culture-related syndrome and some of the most important causes of spirit possession include conflicts, contradictions and tensed social ties as in case of *grisi siknis* (Johan, 2012) and impairment of social functioning as in case of *zar* found especially among the women, immigrants and marginalised individuals (Grisaru et al., 1997) and *jinn* possession (Khalifa and Hardie, 2005). The other reasons include deity curse as in case of *kamidaari* (Shimoga and Miyakawa, 2000) and spirit attack in case of *susto* (Rubel et al., 1985). The understanding of culture-related syndromes related to spirit possession and related issues is important from a medical anthropological view point as they incorporate a number of socio-cultural beliefs to explain its occurrence and for its treatment. The detailed list of culture-related syndromes related to spirit possession is given in Table 3.

Table 3 Culture-related syndromes characterised by spirit possession/conflict/attack and evil eye

Syndrome	Region/Populations affected	Description
Anfechtung	Hutterites of Canada	Intense guilt because of spiritual conflict or insufficient faith
Bhanmati Sorcery	South India	Somatisation and conversion disorder
Ghost illness	India	Range of alternate states, possession of individual by ghost
Ghost sickness	American Indians	Weakness, dizziness, fainting, anxiety, hallucination and confusion
Ifufunyane	Xhosa Zionist community of South Africa	Spirit possession
Jinn possession	Saudi Arabia	Long-term illness with unclear medical diagnosis
Kamidaari	Japan	Deity curse, possession and psychosomatic disorder
Mal de ojo	Spain and Latin America	A common idiom to describe disease, misfortune and social disruption caused by evil eye
Ode-ori	Nigerians	Sensation of parasites crawling in the head, feeling of heat in the head, paranoid fear of violent attacks by evil spirits
Phii pob	Rural Thailand	Spirit possession
Saladerra	Peruvian Amazon	Form of constant and continuing misfortune
Susto	Latin America	Lack of appetite and sleep disturbance caused by the spirit attack
Zar	Ethiopia, Somalia, Egypt, Sudan, Iran	Spirit possession leads to shouting, laughing, hiting head against wall or weeping found especially among women

Culture-related Syndromes Characterised by Sexuality

In relation to sexuality, two types of culture-related syndromes are found and these include loss of semen along with urine and retraction of genital organs such as breast or nipples among women and penis among men. The culture-related syndromes related to sexuality were deeply rooted in socio-cultural factors such as social stress as in case of *dhat* syndrome and lack

of sex information to explain their physical development as in case of *koro.* The culture-related syndromes characterised by sexuality are discussed as:

(a) Loss of semen: *Dhat* syndrome found in Indian sub-continent is the most common example. A number of scholars have studied *dhat* syndrome as a culture-related syndromes (Bhatia and Malik, 1991; Singh, 1985; Chadda, 1995; Sumathipala et al., 2004). It is recognised by fatigue (Mumford, 1996; Ranjith and Mohan, 2006), depressed mood (Mumford, 1996) along with the semen loss (Ranjith and Mohan, 2006). Under social stress, persons predisposed to amplification of somatic symptoms and health anxiety may focus attention on physiological changes such as turbidity of urine and tiredness, and misattribute them to the loss of semen beliefs (Ranjith and Mohan, 2006). The patients suffering from this syndrome believe that there is a loss of semen along with the urine.

(b) Retraction of genital organs: *Koro* is the most common example. It is commonly reported from the Chinese populations and other non-Chinese populations include Indian, Indonesian and that of Thailand**.** It is commonly referred to as *suo-yang* in China, *jinjinia bemar* in India and *rok-joo* in Thailand. This is a unique example of depersonalisation syndrome whose form and content, and indeed occurrence and distribution are determined by a combination of social and cultural factors acting on predisposed person. The depersonalisation is seen as a dissociative mechanism affecting the integrity of body-image (Yap, 1965). The life patterns and attitudes toward supernatural beings and the commonly shared folk belief of evil-induced genital retraction were grounds for the panic (Tseng et al., 1988). Education, age and marital status are considered as individual risk factors. *Koro* has mainly been reported among the males but it has also been reported in females in terms of retraction of nipples (Kovacs and Osvath, 1998). It has been described to be caused by female fox spirits in China, mass poisoning in Singapore and Thailand, and by sorcery in Africa (Mattelaer and Jilek, 2007). Relatives and neighbours of the same sex often help to rescue the organ in question, especially in applying anchoring devices. Others may also believe a person has *Koro* and attempt to rescue their organ without their consent (Cheng, 1997). *Koro* in China is best described as a social sickness supported by cultural myths which tend to affect young people who are deprived of proper sex information to explain their physical development. The importance of psychosocial dynamic in *Koro* is reflected in the epidemic occurrences of this illness in Chinese culture. These occurrences may not reflect physiological retraction but rather, a panic reaction based in the fear of such retraction and its

personal consequences. The detailed list of culture-related syndromes related to sexuality is given in Table 4.

Table 4 Culture-related syndromes characterised by sexuality

Syndrome	Region/Populations affected	Description
Ascetic syndrome	Indian sub-continent	Psycho-social withdrawal, sexual abstinence and practices of religious austerities
Dhat syndrome	Indian sub-continent	Loss of semen
Jhin jhina	India	Possession by evil spirit in form of tingling and numbness of body leading to death. Bizarre and seemingly involuntary contractions and spasms
Juju	West Africa	Genital shrinkage
Koro	China, India, Indonesia and Thailand	Psychiatric, non-psychotic syndrome involving an acute, panic-like anxiety about the penis receding into the abdomen
Prameha disease	Sri Lanka	Loss of semen
Shen-k'uei syndrome	Taiwan	Kidney deficiency, insufficient vitality due to the excessive loss of semen

Discussion

Culture-related syndromes are mental conditions or psychiatric syndromes whose occurrence or manifestation are closely related to cultural factors and thus, warrant understanding and management from a cultural perspective. These were initially viewed in standard biological or psychiatric diagnostic schemes as not being real but the inclusion of glossary on culture-related syndromes in DSM-IV emphasised the understanding of culture in context of psychiatric illnesses. The present paper provides a comprehensive list of various culture-related syndromes and also attempts to broadly classify them. As a medical anthropologist, the aim of author was to enlist the various culture-related syndromes along with their areas of occurrence and descriptions, and also to point the various socio-cultural factors that explain these syndromes.

It is also clear from the review that some of the illnesses are culture-specific while others are spread over a number of cultures such as *dhat* syndrome of Indian sub-continent and *koro* of China, India and Thailand. For example, *dhat* syndrome was originally reported as culture-related syndrome from India but later it was found that it is found in other areas such as Nepal, Sri Lanka where it is referred as *prameha* disease and in Taiwan, it is referred as *Shen-k'uei*. Similarly, *koro* is reported from both the Chinese and non-Chinese populations. It is described using different names such as *suo-yang* (China), *jinjinia bemar* (India) and *rok-joo* (Thailand).

Furthermore, from a diagnostic point of view, it is necessary to be careful in labelling 'peculiar behaviour' as a 'disorder' simply because it is unfamiliar. The medical anthropologists favour that the certain culture-specific syndromes such as *latah* may be a social behaviour and not a 'disorder'. Thus, the understanding of various psychiatric disorders in their socio-cultural context provides the deeper understanding of their causes and treatment. Along with the understanding of these syndromes, the healers and healing practices used to cure these syndromes are also important for medical anthropologists, transcultural psychiatrists and the psychiatrists treating these patients for a deeper understanding and management of these syndromes. Thus, as medical anthropologists and transcultural psychiatrists, we need to look beyond individual psychodynamics and culture-specific personal traits and to take a holistic view of total geopolitical, socioeconomic, and ideological circumstances of a society in which the phenomena occurs.

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