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# Perspectives of Psychopathology Across Cultures and Among Indigenous Societies

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The field of clinical psychology has been shaped primarily by European and American researchers (Daughtry, Keeley, Gonzales, & Peterson, 2016; Leong, Pickren, & Tang, 2012). To this day, it largely retains its Western views. However, substantial attempts to investigate cultural factors in clinical psychology have resulted in an emerging field called cultural-clinical psychology (Ryder, Ban, & Chentsova-Dutton, 2011). Psychopathology is thus viewed as a social and cultural construct which shapes how people across different cultures experience clinical disorders and psychological distress, how psychopathology is detected and understood, and how it is treated.

In this chapter I discuss the approaches that have been taken to understand the link between culture and psychopathology. I will also present an examination of the indigenous psychologies and issues associated with attempts to situate them within the current state of the field. Finally, I will discuss challenges and opportunities facing the field.

## Approaches to Cultural-Clinical Psychology

There are two broad approaches in the field of cultural-clinical psychology: universality and relativism (Canino & Alegría, 2008; Mena & Joseph, 2017).

### Universality

The universality (*etic*) perspective, which is closely aligned with the biomedical model of mental health, maintains that the same kinds of psychopathology can be

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found across cultures. Although it can present in different syndromal patterns across cultures, it can be explained by universal principles of human functioning because all humans are believed to share core personality traits and biology. For example, in a review of studies conducted in different countries, Bauermeister, Canino, Polanczyk, and Rohde (2010) reported that the results supported the cross-cultural validity of attention deficit hyperactivity disorder (ADHD) because the international data showed the disorder to have two underlying factors: inattention and combined hyperactivity and impulsivity. Bauer et al. (2011) examined patients from seven countries who had received a clinical diagnosis of schizophrenia and found different kinds of hallucinations across their samples. They posited that these differences could reflect cultural differences in perceptual and attentional processing, in addition to clinical factors such as age of the patient, age of onset, and the duration of the disorder.

Agüera et al. (2017) reported finding different psychopathological expressions in patients with anorexia nervosa from three countries. Patients from Spain and the United Kingdom presented with higher scores on body dissatisfaction, somatization, and overall psychopathology, while patients from China had lower scores on emotional difficulties (depression and anxiety). Bakker, van Dijk, Pramono, Sutarni, and Tijssen (2013) carried out an electromyographic study of 12 patients who exhibited symptoms consistent with *latah*. This syndrome is seen among the Malays in Indonesia and Malaysia, but not observed among other racial groups living in these countries (Geertz, 1968). Its characteristics are excessive startle responses that do not habituate over time and involuntary obedience to commands, echolalia, and echopraxia. The researchers concluded from their findings that the syndrome could be understood as a neuropsychiatric startle syndrome. In the preceding examples, the premise of these studies is that a particular diagnostic entity that is under investigation is real and presents either universally or as a variant across different societies.

When differences in prevalence rates of mental illness are found across societies, universalists maintain that the disparity might be explained by a number of factors. One of them relates to cultural differences in the *threshold at which* certain behaviors are perceived to be deviant or abnormal. For example, Mann et al. (1992) reported that Chinese and Indonesian clinicians gave higher ratings for hyperactive behaviors than Japanese and U.S. clinicians, even though all these clinicians were viewing the same videotape vignettes of four boys in individual and group activities. The researchers postulated that the results could be explained by different cultural expectations for what constitutes proper childhood behaviors. Another factor that has been cited to account for the variation in prevalence rates of psychopathology across countries is differences in recognition of disorders by both professionals and lay persons, which has a subsequent effect on referrals and contact with the mental health system. Other factors include the decision of afflicted individuals to seek help from traditional

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healers instead of Western medicine; somatic presentation of psychiatric distress which might lead to the problem being treated as a physical (not mental) disorder (Tsai, 2000); the diagnostic criteria used in the studies; degree of impairment of the samples; and source of the clinical information, such as the patient or reports from third parties (Polanczyk, de Lima, Horta, Biederman, & Rohde, 2007).

## Relativism

Those who adopt the relativism (*emic*) approach emphasize an understanding of native perspectives, knowledge, and skills. They also consider the role played by culture in human experience and explanation of psychopathology (Mena & Joseph, 2017). Some behaviors that would be deemed as unequivocally abnormal in Western psychiatry might be considered otherwise in other societies. Where Western clinicians might define hallucinations as false perceptions and a break from reality, some cultural groups might consider hallucinations as spiritual guidance or divine messages that hold some cultural meaning (Larøi et al., 2014). Christians are more likely to hallucinate about religious figures such as Jesus, Mother Mary, or the devil; rural Africans are more likely to hallucinate about ancestor worship. Data collected from 488 societies showed that ordinary ritual practices in 62% of these cultures involve hallucinations (Bourguignon, 1970), indicating the typicality of hallucination experiences in these societies.

Another interesting example is the annual Hindu religious festival of Thaipusam where devotees fall into a trance while their faces and bodies are pierced with hooks, needles, and skewers (Ward, 1984). This religious ritual is a means for the devotees to give penance, to honor a vow made to the Hindu god of war to overcome bad karma, or to gain spiritual enlightenment (Mellor et al., 2012). The author has personally witnessed Thaipusam in Malaysia several times and noticed no bleeding on the devotees during the piercing; after the ritual ceremony is over, the piercings are removed leaving few or no marks. The trance that the devotees fall into could well be considered a psychotic break from reality. However, it cannot be considered as a form of psychopathology because it was voluntarily induced for religious reasons and accepted by the Hindus as normal during the festival.

Cultures also vary in their attributions for mental disorders. Supernatural or spiritual causes are commonly believed among Haitians (Desrosiers & St. Fleurose, 2002), Thais (Burnard, Naiyapatana, & Lloyd, 2006), and Malays (Haque, 2008). The etiological agents may include spiritual possessions, black magic or curses, or punishment for neglecting the gods or religious values. Other cultures believe that improper flow of the vital life forces leads to illness. The life force is variously

referred to as the *kwan* in Thailand, the *qi* in China, the *ki* in Korea, and the *prana* in India (Tyson & Flaskerud, 2009).

Some cultures might express their distress through physical symptoms instead of psychological complaints. The physical manifestations of psychopathology can be broadly clustered into pain symptoms (e.g., headaches), gastro-intestinal symptoms (e.g., diarrhea), pseudo-neurological symptoms (e.g., muscle weakness), reproductive organ symptoms (e.g., burning sensations in sexual organs), and other physical syndromes (e.g., temporo-mandibular joint syndrome). These physical manifestations are expressed to varying degrees in the different societies (So, 2008). A few examples are *hwa-byung* in Korea, which is characterized by headaches, indigestion, cardiovascular symptoms, anxiety, and anger (Lee, Wachholtz, & Choi, 2014); *shenjing shuairuo* in China that presents as symptoms of aches and pains, memory loss, cognitive difficulties, sleep problems, and fatigue (Chang et al., 2005); and *brain fag* in Nigeria, identified by complaints of memory and concentration problems, unpleasant sensations in the head, and visual impairments (Uchendu, Chikezie, & Morakinyo, 2014). These syndromes are viewed as disorders that are specific to certain cultures and not commonly seen in the West.

More direct evidence for the influence of culture on symptom expression comes from a study by Rao, Young, and Raguram (2007). These researchers showed that South Indian psychiatric patients who had less familiarity with Western cultures tended to endorse more somatic symptoms, whereas those who were more Westernized tended to indicate a greater balance of both psychological and somatic symptoms. Another study examined the prevalence rates of psychiatric disorders among Vietnamese individuals living in the Mekong Delta region of Vietnam and Vietnamese living in Australia (Steel et al., 2009). When the Composite International Diagnostic Interview (CIDI) was used with these individuals, the prevalence rates for positive diagnosis was 1.8% among the Mekong Delta Vietnamese, and 6.1% for the Australian Vietnamese. However, when the researchers included another measure, the Phan Vietnamese Psychiatric Scale (PVPS), which captures cultural idioms (expressions) of distress in the Vietnamese society, the prevalence rates increased to 8.8% for the Mekong Delta Vietnamese and 11.7% for the Australian Vietnamese. Steel et al. attributed the increase to the PVPS somatization scale, providing support for the position that some cultures express their psychological distress through physical symptoms.

Mental health clinicians who adopt a universalistic approach adhere to evidence-based treatments, but examine ways of making the appropriate cultural adaptations to their interventions when working with non-Western clients. As well, the clinicians need to be culturally sensitive and competent in their practice. There has been much discussion and writing about cultural adaptations of mental health treatments and training of clinicians to ensure cultural competency (e.g., American Psychological Association, 2017; Cardemil, 2015; Huey, Tilley, Jones, & Smith, 2014; Kalibatseva & Leong, 2014).



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Universalists argue that cultural influences on symptom expression support their notion of an underlying disorder that is exhibited in its variant forms across culture. However, relativists interpret the same information to mean that the cultural variation in symptom presentation could reflect the existence of syndromes that are culture-specific or culture-bound. Culture-bound syndromes are a combination of somatic and psychological symptoms that are exhibited and recognized as an illness only within a specific culture or specific region of the world. A few examples of the culture-bound syndromes that appeared in the *DSM-IV-TR* (American Psychiatric Association, 2000) are *dhat* in India, an anxiety reaction to fear of semen loss from excessive masturbation (Grover et al., 2016); *amok*, or sudden and unexplained short-lived outbursts of violence in Malaysia (Haque, 2008); and *koro* in South Asia and China, which is characterized by intense anxiety that the genitalia or nipples will retract into the body (Crozier, 2011).

The concept of culture-specific or culture-bound syndromes has produced considerable controversy. Critics have complained that accepting the notion of culture-bound syndromes meant that other clinical conditions were universal and immune to the effects of culture, that the culture-bound syndromes excluded clinical conditions (such as anorexia nervosa) that were found primarily in the United States and Europe, and that there were insufficient data to conclude whether the syndromes were distinct clinical entities or culturally-influenced variants of formally recognized psychiatric disorders (Cardemil & Keefe, 2017).

The incorporation of cultural factors in psychopathology was strengthened in the *DSM-V* (American Psychiatric Association, 2013) through the inclusion of three cultural concepts of distress which convey information on how different cultures experience, understand, and express psychological distress or symptoms. *Cultural syndromes* describe constellations of symptoms that appear in specific cultural groups and are similar to *DSM-IV-TR* culture-bound syndromes. *Cultural idioms of distress* refer to the ways that a cultural group communicates or talks about psychological distress. Some societies might focus more on somatic symptoms and others on psychological or emotional symptoms. Instead of symptoms, some might use more metaphorical descriptions, such as the Punjabi "sinking heart" (Krause, 1989). Finally, *cultural explanations of distress* relate to causes of distress or symptoms that are recognized by the specific cultures. The *DSM-V* also provides a cultural formulation interview guide to aid clinicians in their assessment of cultural factors that influence their patients' experience, reporting, and explanation of symptoms. The changes from *DSM-IV-TR* to *DSM-V* point to the increasing influence that cultural relativism has on the field of clinical psychology. The *DSM-V* nevertheless remains a psychiatric manual based on Western views of psychopathology. Even so, it reflects a blend of cultural universality and relativism with the aim of increasing cultural sensitivity among clinicians in their work.

## Indigenous Psychologies

Much of the work on cultural-clinical psychology has focused on minority groups (e.g., African Americans, Asian Americans, Latinos) within the mainstream populations of a country or comparing nationalities across countries (e.g., Agüera et al., 2017; Ryder et al., 2008). Little attention has been paid to marginalized indigenous populations within countries. This is not to say that no studies have been carried out with indigenous peoples. On the contrary, there is extensive research on indigenous peoples around the world. However, this body of research tends to be largely ignored by mainstream cultural-clinical psychology.

Indigenous psychologies developed in reaction to Western psychology (Allwood & Berry, 2006). Unlike mainstream psychology, which focuses on intra-individual factors to explain illnesses, indigenous psychologies look to historical, social, political, and cultural factors to explain the health disparity between indigenous and non-indigenous populations where the former have higher rates of morbidity and mortality (Anderson, 2015; Anderson et al., 2006; King, Smith, & Gracey, 2009). There is much research to show that the mental health problems of indigenous peoples are the result of their colonization by Europeans; their forced assimilation led to the loss of their indigenous cultures, disintegration of family and kinship systems, intergenerational trauma, land dispossession, and sociopolitical oppression (e.g., Aho & Liu, 2010; Anderson et al., 2006; Bombay, Matheson, & Anisman, 2011; Czyzewski, 2011; King et al., 2009; Reading & Wien, 2009; Wesley-Esquimaux & Smolewski, 2004). Self-determination and a return to their cultural roots and identity are important to their healing and health (Chandler & Lalonde, 2008; Lavallee & Poole, 2009; McLennan & Khavarpour, 2004).

It is important for indigenous psychologies to be connected to the broader field of cultural-clinical psychology because arguably it is a purer form of cultural relativism. Indigenous ways of knowing are very different from Western ways of knowing. Consider that Western concepts of health and psychopathology typically revolve around the individual and illnesses. There also tends to be a separation between body and mind as shown in psychological theories that invoke biological or psychological underpinnings of clinical disorders. Even when the mind–body connection is acknowledged, the two are still being treated as separate aspects of the human totality. In contrast, indigenous ways of knowing tend to be holistic.

As an example, the First Nations in Canada see health as a balance among four equal and interconnected dimensions of a human: the emotional, the mental, the spiritual, and the physical (McCormick, 1996). Many of the First Nations are also guided by relational ethics that are commonly known as the seven grandfather teachings: wisdom, love, respect, bravery, honesty, humility, and truth (Verbos & Humphries, 2014). In New Zealand, the Māori concept of health and well-being is reflected in the *Te Whare Tapa Whā* model (Vaka, 2016) which is represented by a house (*whare*) that sits on the land (*whenua*) and supported by four poles: the



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spiritual dimension (*Te Taha Wairua*), the mental dimension (*Te Taha Hinengaro*), the physical dimension (*Te Taha Tinana*), and the family and social dimension (*Te Taha Whānau*). The four dimensions are interrelated and necessary for good health. The Maori values that are essential to well-being emphasize interconnectedness and behaviors such as sensitivity, respect, and humility that promote interpersonal harmony (Hiha, 2015).

Among the Inuit who live in the circumpolar regions, mental health is associated with pride in Inuit identity and having connection to the land through traditional activities such as hunting for food, sharing, and consuming traditional foods (Gray, Richer, & Harper, 2016; Kirmayer, Fletcher, & Watt, 2008). Inuit also live by traditional values of which there are four natural laws (*maligait*) that speak to respect for all living things, working for the common good, maintaining harmony, and planning and preparing for the future (McGregor, 2012). These four natural laws are augmented by eight communal principles (*Inuit Qaujimajatuqangit* or IQ): respecting and caring for others (*inuuqatigiitsiarniq*), fostering good spirits by being open, welcoming and inclusive (*tunnganarniq*), serving and providing for family and/or community (*pijitsirniq*), decision making through discussion and consensus (*aajiiqatigiinniq*), development of skills through observation, mentoring, practice, and effort (*pilimmaksarniq/pijariuqsarniq*), working together for a common cause (*piliriqatigiinniq/ikajuqtigiinniq*), being innovative and resourceful (*qanuqtuurniq*), and respect and care for the land, animals, and the environment (*avatittinnik kamatsiarniq*). IQ has been officially adopted by the Government of Nunavut as societal values that guide its work (see www.gov.nu.ca/information/inuit-societal-values).

As can be seen, indigenous societies focus largely on health and well-being, not illnesses as Western science tends to do. They place importance on cultural beliefs and values, such as achieving balance among all aspects of a person and maintaining strong connections between the individual and everything else that exists beyond, for example, family members, the community, deceased ancestors, the animals, the land, and the environment (Blackstock, 2008; Government of Canada, 2006). Research shows that culture revitalization (Barker, Goodman, & DeBeck, 2017) and enculturation which will allow the indigenous peoples to regain connection with their native cultures (Fleming & Ledogar, 2008) are important to mental health interventions with them.

The other critical element of indigenous mental health efforts is addressing the gross inequality in basic living standards and socioeconomic opportunities that they experience. For example, the social factors relating to the poor health status of Canadian Inuit are lack of resources to promote positive and healthy early childhood development, loss of culture and language, inadequate access to employment opportunities, high cost of living and few opportunities for income generation, inadequate housing, interpersonal violence and substance use, poor access to education, food insecurity, low access to health services, mental health issues, and environmental contaminants and climate change (Inuit Tapiriit Kanatami, 2014). It would seem that ensuring that the basic

survival needs of the individual are met before attending to their mental health needs not only seems prudent but also logical.

## Possible Reasons for the Disconnection

As previously mentioned, there is abundant research within the mainstream field of cultural-clinical psychology and indigenous psychologies. Yet, it is puzzling that there seems to be little connection between the two areas, given that they have a common objective to investigate the link between cultures and mental health. There are a few possible reasons for this segregation. Indigenous psychologies developed in reaction to mainstream psychology; the latter was seen as emphasizing defects within the individual without considering the social, cultural, political, and historical forces that affect indigenous peoples. Thus, mainstream psychology was deemed inadequate to address local problems (Allwood & Berry, 2006). Mainstream psychology seeks to generalize principles that were developed in Western cultures to other cultures across the world. Indigenous psychologies seek to understand psychology within local contexts because some factors influencing human behaviors are different in different cultural groups. This results in making indigenous psychologies more relevant and responsive to local problems.

Another factor that contributes to the segregation between mainstream psychology and indigenous psychologies has to do with the way research is conducted. Mainstream psychology often relies on empirical and quantitative research methods, whereas indigenous psychologies tend to use qualitative research strategies such as focus groups (e.g., Korhonen, 2006), interviews (e.g., Kral, Idlout, Minore, Dyck, & Kirmayer, 2011), and more recently, Photovoice (e.g., Mark & Boulton, 2017). The conversational style in qualitative research is more aligned with the indigenous acquisition and transmission of knowledge through oral means (Blackstock, 2008). It also allows for personal voices of individual participants to be heard and their subjective experiences to be understood.

Another important factor is that indigenous research tends to be participatory in nature. It involves the participants at all stages of the research, from identifying research questions that have potential to benefit participants and their community to interpreting the findings to ensure their cultural validity. In essence, it is research that is done *with* and *by* the participants, instead of *on* them, and the power that is normally accorded to the researcher is shared with the participants (Cornwall & Jewkes, 1995). Participatory research is more appropriate for use in indigenous psychologies because of the skepticism and mistrust that many indigenous peoples have toward Western researchers after years of being the subject of investigation and experiencing some culturally insensitive and inappropriate research practices (Cochran et al., 2008). Several indigenous groups are wary of accepting findings arising from Western-style research because of their history with colonialism



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Mainstream and indigenous psychologies use different journals and outlets for publishing their findings and appeal to different audiences. Mainstream psychological studies are usually carried out by Western-trained researchers and practitioners, their empirical findings are published in peer-reviewed journals, and their works are typically consumed by Western-trained researchers and practitioners. Indigenous psychological research is often conducted by qualitative researchers and indigenous community partners under the aegis of indigenous organizations or networks to address research questions that can help to address local problems or issues of interest to their cultural groups. Their findings are published in journals that have specific interest in indigenous psychology, and that are open to qualitative inquiries. Often, indigenous research is also available as research reports that can be openly downloaded from the websites of the organizations or networks involved in the research project. Research reports such as these are considered to be gray literature and not normally accessed by mainstream researchers who prefer peer-reviewed journals.

## Synergy Between Mainstream and Aboriginal Psychologies

The weak communication and connection between mainstream cultural-clinical psychology and indigenous psychologies are unfortunate. Enriquez (1992) noted that indigenous psychologies can help to identify overall patterns when research from different cultures is compared. This could be used to inform mainstream psychology about what might be universal in human functioning and inform universal treatment guidelines. Conversely, should investigations find that culture-specific agents cause certain kinds of culture-bound psychological suffering, then interventions would have to be culture-specific to be effective. Collaborative efforts could provide greater and more nuanced understanding of the complex relations between culture and biology/psychology in the development, expression, maintenance, treatment, and prevention of different kinds of psychopathology, as well as the promotion of well-being.

There are instances where research from both mainstream and indigenous psychologies can work very well together to address important social issues for indigenous populations. A good example is the recent National Inuit Suicide Prevention Strategy developed by the Inuit Tapiriit Kanatami (Eggertson, 2016; Inuit Tapiriit Kanatami, 2016). The Strategy identifies six priority areas for intervention, namely, creating social equity, creating cultural continuity, healthy childhood development from birth, increasing access to mental wellness services, addressing unresolved trauma and grief, and using Inuit knowledge to increase Inuit resilience and prevent suicides. Each priority area has its own objectives and action plans mapped out, and all the initiatives are Inuit-specific and led by Inuit. Both Inuit and Western

knowledge were harnessed to inform the comprehensive action plans which involve all sectors (e.g., political, educational, social services, medical, mental health, media, law enforcement, crisis responders, researchers, and Inuit individuals with traditional knowledge, among others) of the Inuit community. Some of the initiatives proposed in the action plans include training in Applied Suicide Intervention Skills Training and Mental Health First Aid (derived from Western knowledge); connecting youth with Inuit history, language, and culture (derived from Indigenous knowledge); and research on Inuit-specific best practices for Inuit suicide prevention (informed by both Western and Indigenous knowledge).

## Looking Forward

Culture is not static and is ever-evolving. Ease of transportation and advances in communication technology have resulted in greater contact between cultures and greater exchange of world views, values, and ideas. The face of psychopathology will very likely change with the blending of cultures. For instance, eating disorders have long been considered a primarily Western disorder because of their prevalence in the West (Hopton, 2011). However, the rate has been increasing in Asia and is believed to be related to greater exposure of these countries to Western cultures and the ideals of thinness (Lee, 2000; Lai, 2000; Tsai, 2000). Indigenous youth who leave their family and rural community to attend post-secondary educational institutions will come in greater contact with the mainstream society and might encounter cultural adjustment problems. Refugees who flee their war-torn countries will arrive in foreign countries where the local people might or might not be friendly to them. In addition to the trauma of having to leave their friends, families, and cultures behind, refugees face the enormous challenge of resettling in a new country often with no home, employment, or social network, beyond the initial assistance that is provided to them by their government or private sponsors.

Cultural-clinical psychologists are in a unique position to investigate the psychological consequences of the increasing contact between cultures in different contexts. There is an abundance of research on the psychological repercussions of individuals moving to a new society or culture either by choice or otherwise. However, the globalization that is occurring across the world also provides opportunities for researchers to examine the psychological health impact on local populations who are witnessing increasing numbers of people from other countries coming into their home country and changing the profile of their demographics. How do they react to the rapid cultural change occurring in their home country? What kinds of stress reactions will we see and in what forms will such reactions be expressed? The potential for cultural-clinical psychologists to make significant contributions to understanding and addressing some of the world's contemporary issues both within and outside of clinical settings is significant.



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