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Medical Anthropology (8) **"Transcultural psychiatry and indigenous psychology"**

based on Chapter 6 (pp.203-247), In: Winkelman M "Culture and Health: Applying Medical Anthropology", Jossey-Bass, 2009.

Culture and personality

"Characteristics as a person" <= interaction between biological capabilities and cultural/social environments
Anthropological view on "culture and personality" => "normal" personality, behaviors, illness of an individual are related with culture
(e.g.) East Asian virtue of modesty (hesitate to express self-esteem) causes low positive affect scores of CES-D in Japanese
Understanding and treating mental health maladies require such cultural perspective on normalcy
How does (collective) culture get imposed on individuals' personality development? => transcultural psychiatry: Cross-cultural studies on (1) the interaction of culture and biology in producing universals of human psychology and illness, (2) differences and similarities in psychology and mental illness in different groups, (3) cultural effects on psychological states and predispositions to specific mental illness, (4) ways in which mental illnesses are viewed and treated in different cultures

Personality: some conventional theories on personality cannot stand cross-culturally. "big five" theory was confirmed about its reliability across the world: 5 components of personality = extraversion, agreeableness, conscientiousness, neuroticism, openness; of which scores differ by country: Japan showed lowest conscientiousness and highest neuroticism scores[1].

Psychiatric conceptions of a person differ between Western and other culture. => Needs for indigenous psychology (culture-based view of the nature of personal psychology, identity and illness) ~ researches on songs, myths, ...
Psychological and medical anthropology address core questions about ethnicity, how culture relates to our personal and social identity, and the interactions among physiology, culture and social contexts in producing disorders.

Biomedical perspectives presume a universally valid system for classifying mental illness based on symptoms.
However, there are cross-cultural differences in the meaning of behaviors and their personal implications.
(e.g.) Possession（憑依）~ psychiatric condition vs normal cultural behavior (different by culture)
Psychological distress ~ ethnomedical syndrome "folk illness", culture-bound syndromes such as possession, witchcraft, evil eye
=> understanding these maladies from indigenous psychology may reveal culture-specific conceptions of personhood, self.

Cultural concepts of normalcy and abnormalcy

What is "normal" is related to one's personal and cultural circumstances: cultural definitions of what is acceptable behavior and tolerable deviation (usually implicit), behaviors appropriate for different roles (e.g. patient vs doctor), behaviors appropriate for different contexts (e.g. school vs hospital), influences on the significance of symptoms (e.g. when is a "late" menstrual period a concern?). "All cultures distinguish normal and abnormal behavior, but the specific criteria differ."

PNG people regard sudden illness as "normally" caused by witches , ghosts, and possessions, but it is "normally" judged as delusions and symptoms of psychiatric disorders in developed countries.
Following behaviors are "normal" in some cultures: seeing spirits (hallucinations) of one's deceased parents or children, living with your parents as an unmarried adult, beating up your sister's boyfriend, drinking cow blood and smearing your body with dung, burning down your mother's house after she dies.

When a person's behavior significantly departs from cultural norms (culturally defined "normal"), almost all cultures regard the one as mentally disturbed. However, culture distinguish ritual leaders from insane individuals (the difference is determined by the cultural norms). From the viewpoint of **social labeling theory of deviance**, cultural and social conditions to produce deviance by determining what is normal and what is unacceptable. Suicide is unacceptable in Japan now, it was "normal" to compensate for critical failure as "*harakiri*" by "*bushi*" (soldier class in *Edo*-era) in the past. Homosexuality is usually exposed to negative social labeling in Western culture, but homosexual behavior is part of normal (compulsory) development of all men in some ethnic group in PNG. From the viewpoint of **cultural relativism**, the concept of normal is controversial: Weak form of cultural relativism holds "what is normal is culturally defined and can be understood only in cultural context", stronger form indicates "what is experienced in each culture is so unique that valid cross-cultural comparison is impossible." => please evaluate your own cultural concept of normalcy.
Some personality disorders defined by DSM-IV are based on modern educated working or middle-class people. People socialized in premodern traditional societies may have religious beliefs or other behaviors viewed as symptoms of neurosis or psychosis in modern societies. (e.g. Neurotic fear of witchcraft). DSM-IV outlines for cultural formulation and glossary of culture-bound syndromes in appendix 1, but not enough.

Personality and self in indigenous psychology

Dynamic relationships among biology, psychology, culture, society => cultural illness and healing processes. Regularity and predictability of behavior among people derived from the effects of culture in patterning humans' behavioral capacities. Composing societies needs recognition of "others' intention" and "self". Socially structured aspects of individual identity derive from social position (status). **Indigenous psychology** appears as **"expressive culture"** (providing role models as gods or heroes, expressing feelings and communicating culturally important meanings, formulating and expressing social sentiment, expressing ideal social behavior and social structure, ...) or as **"religion"** (psychological dynamics and identity in ideals for individual behavior, rules for social behavior and a cosmology: expectation about the origin and nature of the world. Providing a social identity in a "sacred self" and ultimate values and justifications). **Self** refers to a number of social aspects of identity. A sense of status, a type of position within a social network, or the associated roles the responsibilities and behavioral expectations associated with that status or position.

1 Schmitt DP et al. (2007) The geographic distribution of big five personality traits: Patterns and profiles of human self-description across 56 nations. *J. Cross-Cultural Psychology*, 38(2): 173-212.

Possession in clinical and cross-cultural perspectives

Possession is the control of a person by spirits. It takes many different forms and interpretations. (e.g. Exorcist in the movie).
It relates with dissociative disorders (exemplified by symptoms such as glazed eyes, psychomotor activity, change in facial expression and voice quality, constricted attention, sleep disturbances, depressed mood, psychosomatic ailments, anxiety, panic attacks). In DSM-IV, dissociative disorders include dissociative amnesia, dissociative fugue status, and dissociative trance disorder. Biomedically possession is diagnosed as multiple personality disorder (or dissociative identity disorder). However, in some cultures, possession can be regarded as normal behavior (with several grades).

Biocultural approaches to indigenous psychology

Culture affects brain plasticity during development. **Brain develops adaptation** to (1) biologically primary needs and drives (linked to social or cultural values), emotions (shaped by culture), gender roles, life stages, (2) ethnic identity (beliefs regarding the inherent characteristics of people as social beings, concepts of persons and their inherent characteristics, the self in contrast to models of identity provided by out-group others; multidimensional and implicit, having wide variety), (3) psychocultural model (cultural-ecological systems approach for examining personality within the contexts of biological, environmental, social structural, ideological influences; it emphasizes 7 main influences = history, environment, maintenance system, childrearing environment, innate needs, learned behaviors, projective systems).
Cultural diversity in human development are seen in (1) age reckoning (Western norms see the child as being zero years old at birth, others consider the child to be one year old at birth, Chinese tradition adds another year of age at the Chinese New Year), (2) caregiving and neglect (Euro-American norms considered the mother to be the primary caregiver, others grandmothers, aunts or sisters => forced removal and foster placement and adoption of Native American children), (3) sleeping practices (with infants, ranging from "always direct contact" to "isolated in their own room and bed"), (4) infanticide and neglect (in culture with strong son-preference, medical tests to detect sex during pregnancy may be used to decide to abort female fetuses, or similar preference for male children may be linked with female infanticide, by neglecting them after birth; however, mothers just after birth are allowed to neglect babies when their relatives can take care of the newborn babies; Not only in the case of son-preference, the medical tests during pregnancy to detect congenital abnormalities [pay attention to normal/abnormal may be culturally defined] may lead to indued abortion), (5) circumcision and clitorectomy (USA's biomedical norms regarding male circumcision are based more in cultural tradition than empirical evidence, African's clitorectomy are not allowable in other cultures), (6) punishment and abuse (the border of punishment and abuse is vague, when the child did culturally "wrong" behavior, (7) puberty and adolescence (Mexico allows early marriage at age 14 years or younger after the puberty, which is not allowed in USA), (8) aging processes (aged people are respected in some traditional societies, but regarded as fragile, degraded, ... in some developed countries), (9) death (the termination of life support and do-not-resuscitate orders may be unacceptable or require culturally specific management)

Ethnomedical theories of illness

Early approaches distinguished primitive medicine, folk medicine and scientific medicine. Ethnomedicines rely on useful empirical knowledge for managing practical problems of illness and sickness (e.g., culture-bound syndromes like soul loss, magical fright [in Spanish, *susto*], and "nightmare deaths" ~ folk illness).

Cross-cultural ethnomedical syndromes

Natural disease causation (loss of balance, extraordinary emotions), supernatural causation (animistic causation, magical causation, impersonal supernatural punishment [~ mystical illnesses ~ "*bachi-ga-atatta*" in Japanese], fate, ominous sensations, contagion[="*kegare*" in Japanese]).

***** SELF-ASSESSMENT: culture and normalcy; assess below from "completely normal" to "highly deviant"

1. A son burns down the house in which his mother died.
2. A family kills their daughter because she lost her virginity before marriage.
3. A family has a party to celebrate the birth of a child to their unmarried daughter.
4. A person is condemned to death for providing a medicine (heroin) that makes people feel good.
5. A woman wears black for the rest of her life following her husband's death.
6. A woman drinks alcohol frequently after her divorce.
7. A thirty-year-old unmarried men lives with his parents.
8. A young woman stays up late night after night reading books.
9. A young woman stays up late night after night going to bars and parties.
10. A family hallucinates the presence of their son for months after his untimely death.
11. A family consults with an oracle to decide whether to invest in buying a farm.
12. A man behaves erratically and attributes his actions to the wishes of his deceased grandfather.

[In addition:] Do you know of cultural groups in which these behaviors are considered to be completely normal? or highly deviant?

<Debate of next week>

- In the current cultural normalcy in Japan, unhealthy behaviors such as heavy drinking, smoking and drug abuse are usually blamed as one's own lack of responsibility for health promotion. However, the true causes of such unhealthy behaviors may be sometimes socio-environmental condition such as social stress, lack of education, and drug-familiar social situation including large social disparity and thus it's difficult to quit such unhealthy behavior only by individual effort. To reduce such unhealthy behavior, which of those (individual and society) is better to start?
  - Individual side: Enforcing regulation with punishment or medical treatment should be prioritized.
  - Society side: Reducing socio-environmental causes of unhealthy behaviors should be prioritized.