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978 Chapter 21 Transcultural psychiatry A brief history of transcultural psychiatry The joint publication by the Departments of Psychiatry and Anthropology at McGill University, Canada of Transcultural Research in Mental Health Problems in 1956 marked a new movement in psychiatry at a time when a number of prominent psychiatrists working in the UK and Canada had developed similar and complementary theories about the origin of mental disorder based on their experiences during World War II. Eric Wittkower, of German-Jewish and British descent, emigrated from Germany to the UK prior to the war. His experience of migration and subsequent alienation in both Germany and the UK made him interested in the effect of culture on mental disorder. While serving in the British Army, he studied the impact of stress, particularly related to personality type. 'JR' Rees, a military psych iatrist at the Tavistock, believed conflict to be a key aetiological factor in mental disorder, evidenced by 'battle neurosis' in frontline troops in World War II. In Canada, Ewan Cameron observed that societal stress from the widespread effects of war resulted in mental distress in susceptible individ uals. All three psychiatrists were heavily influenced by Freud and used his psychodynamic approach as framework to underpin their theories. If con flict could cause a mental disorder, is this the factor that underpins all mental illness? And could addressing these conflicts result in a universal cure? So psychiatry became both a medical and a social science, hoping to address post-World War II problems: mass migration, rapid socio-economic change, and tension between neighbouring nations. In the early twentieth century, there were two dominant theories of 'cul ture'—defined as 'the temperament, ideas, and beliefs of peoples'. Darwin's theories had been extended to 'cultural Darwinism', which deemed culture to be universal, with the development stage varying globally and the dom inant western culture being the 'most advanced'. The anthropologist Frank Boas disagreed and took a more relativist view. He believed culture varied due to the range of experiences and environments to which cultural groups were exposed. A logical extension of the Boasian theory postulated that if personality and behaviours were affected by culture, could culture cause mental illness? Using the Freudian theory, culture may lead to intrapsychic conflict, altering thought and behaviour through primitive defence mech anisms, with resulting psychological disturbance or mental illness. Since the focus of anthropology and

psychiatry seemed increasingly aligned, it was felt that an alliance could be mutually beneficial. After the personal and societal trauma of war, a mood of collaboration to heal societies' wounds prevailed, prompting Wittkower to move to Canada to join Cameron—transcultural psychiatry was born. From the start, tensions existed. Some believed mental illness was uni versal, with culture only impacting on presentation. To others, this was a thoughtless over-simplification. Maybe psychiatry and anthropology were not so similar? Psychiatry viewed culture as a potential cause of mental illness that could be diagnosed and treated in a relatively short time frame of months to years, whereas anthropology viewed culture as nurturing of individuals over much longer time frames. The advent of effective medica tions to treat mental illness and the subsequent decline in Freud's theory

A brief history of transcultural psychiatry caused a seismic shift in psychiatric thinking. Neo-Kraeplinism and the med ical model became the popular paradigm. New diagnostic classification sys tems (ICD-9 in 1975 and DSM-III in 1980) became atheoretical and were developed to facilitate research on these new medications. Psychiatry was divided, with the rise of the anti-psychiatry movement, with which anthropology was aligned. Anthropologists deemed psychiatry 'too hasty', dismissing local illness categories and preferring DSM criteria without acknowledging that DSM was culturally derived, based on studies in western cultures. This resulted in 'culture-bound syndromes' (E Culture- bound syndromes?, p. 988), viewed by some as culturally influenced variants of universal disorders and by others as culturally specific behaviours with varying underlying causative factors (which could include mental illness). Illnesses such as CFS and anorexia nervosa were suggested as Western culture-bound syndromes. A dividing line grew between the increasingly dominant biological psychiatrists and the cultural/anthropological psychiat rists and anthropologists. In the midst of this came the American Civil Rights Movement and a new focus on race/racism in psychiatry. How had years of oppression and disadvantage impacted on the psyche of the African-American population? The mainstream view that it had impacted negatively was used to justify ongoing segregation and oppression. African-American psychiatrists (Griers and Cobbs) asserted a generally positive adaptation had occurred, strength ening the personality. At the same time, the anti-colonization movement was spreading through Asia and Africa. Post-colonial practitioners rejected the universal application of Western psychiatric principles, particularly if applied in the manner of ongoing colonial dominance. The writings of 'transcultural psychiatry experts' were criticized as maintaining colonialist and racist attitudes. In the UK, with i migration from former colonies, transcultural psych iatry became the domain of practitioners from minority ethnic groups or those working with ethnic minorities. It included anthropologists and psy chiatrists who took a firm anti-racism position, advocating for equality of mental health, irrespective of race, gender, or culture. It produced evidence demonstrating that racism existed within psychiatry. People from ethnic mi norities were more likely to be diagnosed with mental illness (especially schizophrenia) and to be admitted involuntarily to more restrictive secure units. They were less able to access beneficial treatment due to language barriers and lack of cultural understanding. Transcultural psychiatrists ad vocated for the commission of specialist units with 'culturally competent' practitioners and the development of culturally appropriate assessment tools. By 2005, the movement had come full circle—the broad categories or forms of mental disorder (psychotic disorder, affective disorder) re garded as universal; experiences and culture of the individual influencing the content of the presentation; consideration of both being necessary for meaningful diagnostic formulation and development of an appropriate treatment plan. Further reading Bains F (2005) Race, culture and psychiatry: a history of transcultural psychiatry. Hist

Psychiatry 16:139–54.

980 Chapter 21 Transcultural psychiatry Recent developments in global mental health The Global Burden of Disease (GBD) Study 1990 was undertaken by the Harvard School of Public Health, with funding from the World Bank, to evaluate the attribution of disease and injury from leading medical causes, exposures, and risk factors, to aid with control and prevention. This intro duced a new metric in standardizing the measurement of health outcomes to allow comparison across disorders and populations and reflect not just mortality, but also mortality and disability in combination. Disability- adjusted life years (DALYs) were calculated, combining years of expected life lost (YLL) plus years of life lived with a disability, weighted for the im pact of the disability on those years. The results of this study, published in 1992, were surprising. It provided clear epidemiological data on mental neurological substance misuse disorders (MNS) from all world regions, and they accounted for a higher proportion of burden of disease than expected. Previous studies using mortality outcomes had significantly underestimated the impact of MNS due to misclassification of deaths related to mental disorder to the underlying physical cause and the fact suicide was not al ways recorded due to uncertainty or being re-categorized as injury. Now that disability was included, the picture had changed. Unipolar depression was among the ten leading causes of disability worldwide, more in high- income countries, but also in low-income countries, matching cardiovas cular disease. Subsequently, the WHO World Health Report in 20011 focused on mental health. Mental Health: New Understanding, New Hope highlighted the need to address mental disorders and their human, social, and economic impact. It measured the gap between those requiring care and those re ceiving effective evidence-based healthcare, both in high- and low-income settings. The shortfall was shocking: 75% in high-income countries and up to 95% in low-income countries. The WHO conceptualized a framework with ten recommendations for action: treatment in primary care; availability of psychotropic medication; care in the community; education of the public to address stigma and discrimination; user and carer involvement; national mental health policies, plans, and legislation; human resources; multi-sector approach (social care, welfare, legal, education); monitoring systems for mental health and mental health outcomes; and research. However, lack of resources and leadership from the WHO meant the report had little impact. International development organizations and funders of research consistently ignored the increasing evidence on the burden and impact of mental disorders. In 2007, the Lancet Mental Health Group published the polemical Series on Global Mental Health—ten papers on the areas in the WHO World Report which highlighted the parlous current situation, cited the existing body of high-quality evidence to address the unmet need, and stated the 1 Lovell AM (2014) The World Health Organization and the contested beginnings of psychiatric epidemiology as an international discipline: one rope, many strands. Int J Epidemiol 43(Suppl 1):i6–18.

Recent developments in global mental health requirements for future action. The papers were written collaboratively by researchers and advocates from the international research world, based in institutions in both high- and low-income countries. The series ended with a call for urgent action by governments, development organizations, funding bodies, and researchers: ‘ . . . for political leadership and priority setting, for increasing financial support, for decentralising mental health services, for integrating mental health into primary care, for increasing health workers trained in mental health, and for strengthening public health perspectives in mental health . . . (with) a clear set of indicators to measure progress at country level.’ In 2008, the WHO launched the Mental Health Gap Action Programme (mhGAP)—‘Scaling up care for mental neurological and substance

misuse disorders', with the core objectives being: 'To reinforce the commitment of governments, international organizations, and other stakeholders to in crease the allocation of financial and human resources for care of MNS disorders. To achieve much higher coverage with key interventions in the countries with low and lower middle incomes that have a large proportion of the global burden of MNS disorders.' In 2010, the mhGAP treatment guide for assessment and management of MNS in non-specialist health settings was published. This was developed by a consortium of experts in the field and provided an evidence-based guide for primary care workers to start to address the unmet need. It was de signed to be contextualized for local use and has accompanying skills-based training material to develop capacity in non-specialist healthcare workers. To track progress over the proceeding 4yrs since the first global mental health (GMH) series, The Lancet published the second series on GMH in 2011. The results were encouraging; however, there were still significant challenges faced by the GMH community, researchers, clinicians, policy de velopers, and most importantly the service users, with poverty and human rights abuses remaining the norm, rather than the exception. Results from the GBD Study 2010 were published in 2015 and showed a further increase of 38% in the proportion of disability attributed to MNS. The reduction in under 5-yr mortality was the main reason attributed. This led to an epidemiological transition in population age structure of the popu lations studied, with a greater proportion of the population surviving to the age range when the majority of MNS develop. On 25 September 2015, the 194 countries of the United Nations General Assembly adopted the 2030 Development Agenda titled Transforming Our World: The 2030 Agenda for Sustainable Development. This agenda outlined 17 Sustainable Development Goals (SDGs) to replace the Millennium Development Goals. The SDGs include mental health in goal number 3: 'ensuring healthy lives and promoting well-being for all at all ages', with a reduction in suicide rate as a proposed outcome indicator. This is a signifi cant advance, raising the profile of mental health on the international health agenda, and attributable directly to the significant efforts of the GMH com munity in the last 25yrs.

982 Chapter 21 Transcultural psychiatry Cultural formulation in DSM-IV and DSM-5 DSM-IV, published in 1990, included the first section to address cultural influence on the presentation of mental disorders. This was the outline for cultural formulation (OCF), which was derived through literature review by the National Institute of Mental Health (NIMH) to 'identify cultural and contextual factors relevant to diagnosis and management . . . to supple ment the multiaxial diagnostic assessment and to address difficulties that may be encountered in applying DSM-IV criteria in a multicultural environ ment.'2 The purpose of this was to produce a more holistic and tailored management plan. While it was generally agreed that the OCF was a valuable addition to DSM-IV, there were problems with its clinical implementation due to little formal training being offered and a lack of implementation instructions, leading to confusion over whether it was a separate assessment from the diagnostic interview or it ought to be integrated into the standard interview through specific questions. There was even uncertainty about what service settings (inpatient or outpatient) and with which types of patients were ap propriate for it to be used. As a result, the DSM-5 Cultural Issues Subgroup met in 2010 and 2011 and devised a standard, manualized Cultural Formulation Interview (CFI) for use at the start of any diagnostic evaluation. The CFI was tested in 2011 and 2012 in an international field trial, examining its feasibility, acceptability, and clinical utility among clinicians and patients. There were 11 collaborating sites in the USA, Canada, India, Peru, Kenya, and the Netherlands. On the basis of these results, the CFI was revised into the final version, which was published in DSM-5 in 2013. DSM-5 Cultural

Formulation Interview The interview comes in a service user and an informant version. It designed to supplement formal psychiatric assessment to enhance clinical under standing and decision; it is not a diagnostic tool. Additional use of a cultural facilitator ± translator should be available, if required. It consists of 16 items, covering four broad concepts:3 1. Cultural definition of the problem • Why are you here? What do you think the problem is? • How would others in your community describe this problem? • What worries you most about what is happening? 2. Cultural perception of cause, context, and support Cause • What is the cause of the problem? Why is it happening? • What would others in your community think was causing the problem? 2 Aggarwal NK, Glass A, Tirado A, et al. (2014) The development of the DSM-5 Cultural Formulation Interview-Fidelity Instrument (CFI-FI): a pilot study. J Health Care Poor Underserved 25:1397–417. 3 American Psychiatric Association (2013) Cultural formulation. In: Diagnostic and Statistical Manual of Mental Disorders, 5th edn, pp. 749–59. Washington, DC: American Psychiatric Association.

Cultural formulation in DSM-IV and DSM-5 Stressors and support • Are there kinds of support that make your problem better? • Are there kinds of stresses that make your problem worse? Context—role of cultural identity • What are the most important aspects to you of your background/ culture/identity? • Do any aspects of this have an impact on your problem? • Identify whether there are other aspects of their background/culture/ identity that are causing concerns/difficulties. 3. Cultural factors affecting self-coping and past help seeking • What have you done on your own to cope with the problem? • In the past, what kinds of treatment, help, advice, or healing have you sought? Was this helpful or not? • Has anything prevented you from getting the help you need? Family commitments, stigma, lack of services? 4. Cultural factors affecting current help seeking • What do you think would be most helpful for you? • Have others in your community made suggestions about what would be helpful? • Sometimes misunderstandings occur between doctors and patients because they are from different backgrounds. Have you been worried about this? How can we make sure we provide the care you need?

984 Chapter 21 Transcultural psychiatry Cultural context and the presentation of psychiatric disorders Schizophrenia Some apparently psychotic experiences may be normal when viewed within a cultural context. This applies to delusions (e.g. belief in magic, spirits, or demons) and hallucinations (e.g. seeing ‘auras’, the appearance of divine entities, hearing God’s voice). Other evidence of apparent psych osis (e.g. disorganized speech) may actually reflect local variations in lan guage syntax or a lack of fluency in the language used by the interviewer. Differences in non-verbal communication (e.g. eye contact, facial expres sion, body language) may also be misinterpreted. In the UK and USA, schizophrenia is more readily diagnosed in certain cultural groups (e.g. Afro-Caribbeans). This may reflect actual higher rates of psychotic dis order in first- and second-generation migrants, with meta-analyses finding a tripling of rates of psychotic disorders in this population.4 Some symp toms of schizophrenia (e.g. catatonia) are more common in non-Western countries, and even between Western countries, the diagnosis of brief psychoses (e.g. bouffée déliriante) varies. The view that schizophrenia is more acute and has a better long-term outcome in developing countries has been challenged, with systematic reviews of the evidence finding out come measures were inconsistently applied and lack of access to care as sociated with worse outcomes. Subjects in earlier studies were recruited from academic institutions and may not truly represent the general popu lation of the included country.5 Depression Cultural expressions of depressive symptoms vary across popula tions. In some cultures, there is greater emphasis on somatic terms, e.g. ‘nerves’ or ‘headaches’ (Mediterranean cultures); ‘problems of the

heart’ (Middle East); ‘imbalance’, ‘weakness’, or ‘tiredness’ (China and Asia). This often makes use of Western diagnostic classifications diffi cult, as symptoms may cross diagnostic boundaries (e.g. mood, anxiety, somatoform disorders). Equally difficult may be the interpretation of culturally normal explanations for symptom causation—which may ap pear delusional (e.g. spirit possession) or associated with somatic symp toms (E Somatization disorder, p. 985)—that need to be distinguished from actual hallucinations. Anxiety and stress-related disorders OCD—religious and cultural beliefs strongly influence the content of obses sions and nature of compulsions. It may be difficult to assess the significance of ritualistic behaviours, which could be consistent with usual religious prac tice, unless the clinician has a knowledge of local customs. 4 Cantor-Graae E, Selten JP (2005) Schizophrenia and migration: a meta-analysis and review. Am J Psychiatry 162:12–24. 5 Cohen A, Patel V, et al. (2008) Questioning an axiom: better prognosis for schizophrenia in the developing world? Schizophrenia Bulletin 34:229–44.

985 THE PRESENTATION OF PSYCHIATRIC DISORDERS PTSD—immigrants may have emigrated to escape military conflict or par ticularly harsh regimes. They may have had experience of significant traumatic events but may be unwilling (or unable) to discuss them because of language problems or fears of being sent back. Somatization disorder Common types of somatic symptoms vary across cultures (and genders within cultures). These reflect the principal concerns of a population (or individual), e.g. worms/insects in the scalp/under the skin in South East Asia and Africa; concern about semen loss in India (see Dhat in E Examples of the most common cultural concepts of distress, p. 990) and China (see Shenk-k’ui in E Examples of the most common cultural concepts of distress, p. 990). Conversion and dissociative disorders More common in rural populations and isolated societies; may be culturally normal. Certain religious rituals involve alteration in consciousness (including trance states), beliefs in spirit possession, and varieties of socially sanctioned behaviours that could be viewed as conversion or dissociative disorders (e.g. spell or zar in E Box 21.1 Subtypes of culture-bound syndromes, p. 989). Similiarly, ‘running’ subtypes of culture-bound syndromes have symptoms that would meet criteria for dissociative fugue (E Dissociative (conversion) dis orders, p. 868). Anorexia nervosa Considered more prevalent in some Western societies where food is in abundance and cultural influences promote thinness as the ideal body shape. Immigrants may assimilate this ideal or may present with primary symptoms other than a disturbed body image and fear of weight gain (e.g. stomach pains, lack of enjoyment of food). Evidence from non-Western cultures suggests that food restriction does exist as a disorder, but with fasting viewed as a positive behaviour within a religious context. Alcohol and substance misuse Cultural factors heavily influence the availability, patterns of use, and attitudes about, and even the physiological or behavioural effects of, alcohol and other substances. Alcohol—social, family, and religious attitudes towards the use of alcohol may all influence patterns of use and the likelihood of developing alcohol- related problems. Low levels of education, unemployment, and low social status are all associated with i misuse of alcohol. In some populations (e.g. Japanese and Chinese), up to 50% may have a deficiency of aldehyde de hydrogenase (complete absence in 10%), with low rates of alcohol prob lems in these populations because the physiological effects of consuming alcohol may be extremely unpleasant (e.g. flushing and palpitations due to accumulation of acetylaldehyde). Russia, after the collapse of the USSR, experienced a reduction in life expectancy from all-cause mortality in men aged between 25 and 54yrs in 1990s, due to acute and chronic effects of

986 Chapter 21 Transcultural psychiatry prolonged and extreme binge drinking of non-regulated alcohol/alcohol proxies.6 Other substances—use of hallucinogens and other drugs may be culturally acceptable when part of religious rituals (e.g. peyote in the Native American Church, cannabis in Rastafarianism). Equally, secular movements, typified by the hippie movements of the 1960s and 1970s, or more recently the ‘dance culture’ provide a context in which psychedelic experiences (e.g. induced by LSD or MDMA) may be experienced without any adverse social sanctions. 6 Leon DA, Saburova L, Tomkins S, et al. (2007) Hazardous alcohol drinking and premature mor tality in Russia: a population based case-control study. Lancet 369:2001–9.

987 THE PRESENTATION OF PSYCHIATRIC DISORDERS

988 Chapter 21 Transcultural psychiatry Culture-bound syndromes? Culture-bound or culture-specific syndromes comprise a wide range of dis orders occurring in particular localities or ethnic groups, which are geo graphically isolated and culturally diverse. The term was first coined by Yap in his 1951 paper Mental diseases peculiar to certain cultures: a survey of comparative psychiatry.7 The main focus of this paper was ‘amok’, a condi tion first described in the eighteenth century by Captain Cook on witnessing individuals behaving in a frenzied and violent fashion, without apparent cause, with indiscriminate killing of individuals or animals, first in the Malay islands and then throughout South East Asia. Local mythology attributed this apparently involuntary behaviour to an individual being possessed by ‘hantu belian’ (the evil tiger spirit), and it was tolerated by the communities in which the behaviour occurred. Yap delineated the phenomenology of amok—a preceding period of brooding, low mood, or personal loss; sub sequent extreme, apparently motiveless violent attacks, with the individual either being killed during the process or collapsing in exhaustion and having amnesia for the event. This underlying pathogenesis was suggested to be a psychotic depression or dissociative disorder. Subsequent critique of this paper in particular and the concept of ‘culture- bound syndromes’ in general suggested that for a syndrome to be truly culture-bound, it should only be found in a discrete society; however, by the twentieth century, this type of behaviour had been described in many other countries. When researchers attempted to categorize culture-bound syndromes according to primary phenomenology, a number of subtypes appeared to emerge (see Box 21.1). Many commentators questioned whether it was possible to understand and conceptualize culture-bound syndromes within the sphere of diagnosable mental disorders. This re flected concerns—that continue to the present day—about the dominating impact of western classification systems and the medical model resulting in an undervaluing of local wisdom and an understanding of role of these be haviours within a society being lost. DSM-5 (2013) attempts to address this issue by acknowledging that ‘all forms of distress are locally shaped, including DSM diagnoses’ and by modi fying culturally determined criteria to make them more equivalent across different cultures, e.g. including the fear of ‘offending others’ in the criteria for social anxiety to reflect the Japanese concept in which avoiding harm to others is emphasized, rather than harm to oneself. DSM-5 considers the term ‘culture-bound syndrome’ to be insufficient to encompass the broad range of both presentations and variation in severity. Similarly, ‘idioms of distress’, ‘popular category of distress’, ‘cultural syndrome’, and ‘explanatory model’ are also regarded as inadequate. The agreed term ‘cultural concept of distress’ (CCD) attempts to bring together these concepts without implying cultural exclusivity. GMH research has now started to apply epidemiological methodology more systematically to the available evidence. For example, a multinational 7 Yap PM (1951) Mental diseases peculiar to certain cultures: a survey of comparative psychiatry. J Ment Sci

97:313–27.

Culture-bound syndromes? group of researchers, led by Duke Global Health Institute has compared CCDs with diagnostic criteria and epidemiological/aetiological determin ants of psychiatric disorders through a literature review and meta-analysis that included 45 studies of sufficient quality, comprising 18,782 unique par ticipants.8 The most common CCDs were identified (E Examples of the most common cultural concepts of distress, p. 990), and there were asso ciations between CCD and mental disorder, with an increase in odds of 7.5 of having depression, five times the odds of having GAD, and ten times the odds of having PTSD. While the authors acknowledged that CCDs are not inherently unamenable to epidemiological study, the poor quality of the evi dence base has impeded conceptual advancement and service application. It is hoped that through the use of culturally contextual rating scales [e.g. the Systematic Assessment of Quality in Observational Research (SAQOR) adapted for use in cultural psychiatric epidemiology (SAQOR-CPE)], CCD research could lead to enhanced detection of mental health problems by identifying vulnerable populations (i.e. CCD may be regarded as prodromal or as a vulnerability marker), reduced cultural biases in diagnostic criteria, and i cultural salience of interventions—both service delivery and effective treatment. As we move further into the twenty-first century, we are moving away from ever increasingly long lists of unvalidated culture-bound syndromes to wards a more culturally sensitive, global conceptualization of mental health problems that is person-centered.9 Box 21.1 ‘Subtypes’ of culture-bound syndromes • Startle reaction, e.g. latah, amurakh, irkunii, ikota, olan miryachit, menkeiti, bah-tschi, bah-tsi, baah-ji, imu, mali-mali, silok. • Genital retraction, e.g. koro, kattao, suo yang, jinjinia bemar, rok-joo. • Sudden assault, e.g. amok, cafard/cathard, mal de pelea, fighting sickness, juramentado, Puerto Rican syndrome, iich ‘aa, going postal. • Running, e.g. pibloktoq/arctic hysteria, grisi siknis. • Semen loss, e.g. dhat, jiryan, sukra prameha, shenkui. • Food restriction, e.g. anorexia nervosa, bulimia nervosa, anorexia mirabilis/holy anorexia. • Spirit possession, e.g. bebainan, spell, zar. • Obsession with the deceased, e.g. ghost sickness, hsieh-ping, shin-byung. • Exhaustion, e.g. neuraesthenia, CFS/ME, brain fag/brain fog, shenjian shuairuo, nervios. • Suppressed rage, e.g. hwa-byung/wool-hwa-bung, bilis, colera. 8 Kohrt BA, Rasmussen A, Kaiser BN, et al. (2014) Cultural concepts of distress and psychiatric disorders: literature review and research recommendations for global mental health epidemiology. Int J Epidemiol 43:365–406. 9 For this reason, we have abandoned the glossary of culture-bound syndromes in this fourth edition of the handbook. Lists can still be found easily on Wikipedia for die-hard fans of psychiatric trivia. However, a good clinician should always familiarize themselves with local idioms of disease when working with individuals from a culture with which they are unfamiliar.

990 Chapter 21 Transcultural psychiatry Examples of the most common cultural concepts of distress Nervios-related conditions In the Americas, nervios (‘nerves’)-related con ditions among Latino populations are the most commonly described CCD. Nervios is described as starting with a persistent idea that ‘is stuck to one’s mind’ (‘idea pegada a la mente’) and that comes to preoccupy the individual affected. Feelings of humiliation may lead to slow deterioration of the mind, nerves, and spirit, and sufferers are worried that this may even cause death if adequate help is not received in time. The spectrum of nervios begins with socially acceptable nervousness—‘ser una persona nerviosa’ (being a ner vous person). ‘Padecer de los nervios’ (suffering from nerves) is more serious. ‘Ataques de nervios’ (attacks of nerves) are more severe and characterized by social stressors triggering the loss of behavioural control, with dissoci ation, violent acts towards oneself

or others, anger, and somatic distress. Severe cases can progress to ‘loco’ (madness). ‘Ataques de nervios’ share similarities with symptoms of panic attacks and panic disorder. However, the centrality of interpersonal disputes in triggering episodes, the marked dissociative features, and the evident relief experienced by some individuals after an attack distinguish them from panic attacks. These nervios-related conditions are associated with MUS, including neurological complaints, physical health problems, and functional impairment, independent of their association with psychiatric disorders. Dhat Dhat syndrome has been studied in South Asia, including India, rural areas of Nepal, Sri Lanka, and Bangladesh and is rooted in Ayurvedic tradi tions about bodily production of semen as representing an end-product of energy-demanding metabolism. Dhat is recognized by a whitish discharge in the urine assumed to be semen. This ‘loss of semen’ is associated with somatic symptoms (weakness, exhaustion), severe anxiety, hypochon driasis, and sexual dysfunction. Although STIs may be a source of such white discharge, dhat sufferers do not appear to have a greater frequency of STIs. Traditional remedies consist of herbal tonics to restore semen/ humoral balance. Similar syndromes include jiryan (India), sukra prameha (Sri Lanka), shenkui/shenk-k’ui (China), and Western ideas of weakness, physical illness, and mental illness being related to the loss of semen (or attributed to masturbation). Koro Malay: ‘to shrink’ or referring to a ‘tortoise’ (a popular word for penis). A form of ‘genital retraction syndrome’—the fear or delusion that the genitals are retracting into the abdomen and that death will occur once this has happened. Prodromal depersonalization usually occurs, and elab orate measures may be taken to prevent the penis from retracting (e.g. grasping of the genitals, splints or other devices, herbal remedies, or fel latio). Occurs predominantly in young, single ♂ in Asia and the Middle East, with epidemics described in the Malay Archipelago, Thailand, China, India, Singapore, and Israel. Sporadic cases have been reported in Africa, Europe, and North America. The ♀ equivalent (fear or delusion that the labia or nipples are retracting) occurs rarely, and most reported cases have been during epidemics. Cases have been associated with other psychiatric

 disorders, including phobic anxiety disorders, depression, schizophrenia, and depersonalization syndromes. Other names for this syndrome in clude: suk-yeong/suo yang (Chinese: ‘shrunken penis’), kattao (Indian: ‘cut off’), jinjinia bemar (Assam), and rok-joo (Thailand). Brain fag Described particularly in Western African students and charac terized by distress from ‘thinking too much’, reduced concentration, poor memory, blurred vision, and head/neck pain (often described as tightness, pressure, heat, or burning). Symptoms closely resemble anxiety, depressive, or somatoform disorders. There are similarities with the Nigerian cultural concept of distress—ode ori (‘hunter in the head’), in which the brain under the anterior fontanelle is affected [this area is thought to be where the iye (‘senses’) control mental functions through okun (‘strings’) that project throughout the body and provide direct links between the brain, eyes, ears, and heart]. Kufungisisa (‘thinking too much’) is regarded as both a cause and a consequence of other physical and psychological problems in Zimbabwe, with symptoms including pain and feelings of physical pressure on the heart. Khyal attacks and ‘wind’-related illnesses The substance qi (or chi, chi’i, khı, khii, rlung, khyal) is associated with wind flow and wind balance. Wind- related illnesses are commonly described in East Asian populations, including Tibetans, Cambodians, Vietnamese, Chinese, and Mongolians. Examples in clude Shenjing shuairuo (Chinese), studied by Kleinman in the 1970s and 1980s and associated with weakness, fatigue, and social distress (thought to be mediated by an alteration in qi), and Yadargaa (Mongolian)—a form of nervous fatigue (attributed to alteration in khii flow and balance). In the Vietnamese CCD, ‘hit by wind’ describes shifts in ambient temperature, es pecially gusts of cold air, causing physical complaints, traumatic memories, thinking too much, epilepsy,

and stroke. In China, the cold is thought to worsen nerve weakness, and among Cambodians, the wind-like substance khyal is thought to precipitate attacks associated with palpitations, asphyxia, and dizziness. Hwa-byung Heat and fire are important elements in East Asian ethnopsychology. Hwa-byung (‘fire illness due to chronic accumulated anger’) in Korea occurs when haan (a mixture of sorrow, regret, hatred, revenge, and perseverance) builds up to create a pushing sensation in the chest, resulting in the inability to appropriately control one’s anger, as well as other physical symptoms, e.g. tiredness, muscular aches and pains, breath lessness, palpitations, insomnia, dysphoria, panic, loss of appetite, and GI problems (indigestion, anorexia). Hwa-byung affects middle-aged women in Korea who have experienced years of interpersonal conflict, typically in the context of an abusive marital relationship. Similar CCDs include bilis and colera (Latin America), in which physical or mental illness is explained as due to extreme emotion (anger) that upsets the humours (described in terms of hot and cold).