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Cross-Cultural Psychiatry: A Myth or Reality

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SINCE THE WORK of Benedict[1] on cultural relativity in relation to human behavior, other anthropologists,[2,3] sociologists,[4] psychologists,[5-8] and psychiatrists[9-11] have in various forms supported her hypothesis. The effect of the hypothesis on psychiatry is far-reaching. While Scheff[4] considered mental illness as a label for social offenders (labelling theory), Szasz[9] thought of mental illness as a myth. Laing,[10] on the other hand, considered schizophrenia not as an illness but as a voyage of inner exploration, while Dabrowski[11] talked of schizophrenia as a breakthrough but not as a breakdown. The viewpoints expressed by these authors suggest heterogeneity in the symptom presentation of "mental illness" across the various cultures. In favor of cultural relativity are some allegedly culture-bound syndromes, such as the "Latah syndrome" characterized by imitation of the reactions such as echopraxia and echolalia,[12] "Windigo psychosis," which is a state of excitement,[13] "Frenzied anxiety,"[14] and the "Running wild" of Feugian tribes.[15] Also, in favor of cultural relativity is the low incidence of severe depressive symtomatologies in the non-Western cultures.[14,16-18] In a series of 558 patients, Carothers claimed to have detected no case of depression.[14]

In variance with cultural relativity are the findings of Murphy,[19] an anthropologist who carried out field work in two non-Western cultures (Siberian Eskimos living on an island in the Bering Strait and the Yoruba living in Nigeria). In the studies, she employed ethnographic methods involving participant observation, interviewing key people, daily recording of events, comments, and observations. It was essentially studying the individual and his views of his society. She found that in the two cultures, there was a distinction between the mind and the body. Both cultures recognized mental illness as an affliction of the mind. "Muthkavihak" in Eskimo and "Were" in Yoruba mean madness. The reported behavioral patterns of a "Muthkavihak" man and a "Were" man were similar. Murphy reported that the concept of insanity in

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both cultures was similar to those of the Western culture. Edgerton,[20] who worked with four tribal societies in East Africa, gave a similar report. He found close similarity in the symptoms of schizoprenia between the African society and Western Europeans. This viewpoint has also been supported by several other reports.[21-24] The distribution of psychodiagnostic categories of 569 outpatient psychiatric cases in the University College Hospital, Ibadan, Nigeria[25] shows that all the Western types of mental disorders are represented (Table 1). The culture-bound syndromes previously described can be regarded as excitement states that will probably fragment into different diagnostic entities (organic or functional psychoses) when the acute phase subsides. At times, language difficulties of the foreigners describing the disease, coupled with the preconceived notion of culture-bound syndromes, result in the diagnosis of new syndromes that could aptly be described as acute psychosis until further observations help in placing the patient in the existing classificatory category.

FUNCTIONAL PSYCHOPATHOLOGY

The processes underlying these "atypical" psychiatric symptoms in the non-Western cultures are invariably similar to those of the Western cultures. The major difference lies in the contents of the symptomatology of the syndromes in the various cultures. For example, the paranoid schizophrenic in the Western culture may have delusions related to electronic bugging, while the Nigerian paranoid schizophrenic with no formal education will have delusions of supernatural powers. On the contrary, an educated Nigerian who is well exposed to the Western culture describes his delusions in a similar way to those of his Western counterparts. It, therefore, seems that it is the mode of describing symptoms in psychiatric disorders that is culturally and environmentally

Table 1. Distribution of Psychodiagnostic Categories

Diagnosis	Number of Cases	Percentage of Total New Outpatients
Psychoneuroses		
Anxiety reaction	96	17
Depressive reaction	58	10
Hysteria	5	1
Unspecified psychoneurosis	129	23
Psychoses		
Affective	22	4
Schizophrenia	77	14
Paranoid reaction	1	1
Others (nonspecific)	33	6
Personality Disorder	4	1
Organic Syndromes		
Brain damage	3	1
Epilepsy	42	7
Mental deficiency	6	1
Unspecified others	18	3
*Miscellaneous	75	13

*The miscellaneous includes patients with physical disorders wrongly referred to the psychiatric clinic and those with insufficient data to classify.

influenced. This viewpoint is supported by various cross-cultural studies[19,21-24] and the International Pilot Study on Schizophrenia.[26]

Also, the notion that in the non-Western cultures, severe depressive symtomatologies are very rare, seems unproven. In an extensive crosscultural study of depression, Murphy et al., found that depressive mood, dejection, diurnal mood change, insomnia with early morning wakening, and a decrease of interest in social environment were almost universal. In an outpatient population study, Odejide[27] reported that 4% of the cases presented with affective disorders. Also, in Ghana, Adomakoh found that 12.4% of his psychiatric inpatient population had manic-depressive illness. In two consecutive studies of the psychodiagnostic categories at the University College Hospital, Ibadan, Nigeria,[25,28] and in a review of admissions to the Aro Village Community-oriented center, Abeokuta, Nigeria,[29] it was possible to demonstrate that the various types of psychodiagnostic entities encountered in the Western cultures are adequately represented. The cultural tolerance of the nondisruptive psychiatric symptoms of the unipolar depressives, the spontaneous remission of biologic depressives and the hospital admission policies might explain some of the differences reported. As a result of the limited psychiatric inpatient facilities at the University College Hospital, Ibadan, Nigeria, schizophrenics who are disorderly and disruptive have a better chance of being hospitalized than a moderately depressed patient.

NEUROSES

Much of the controversy had been essentially on the psychotics, with very little emphasis on the neurotics. In the two psychiatric outpatient studies from the University College Hospital, Ibadan, the neurotics were adequately represented.[25,28] In both studies, the neurotics were more than 50% of the population. Odejide et al. reported that the neurotics usually visited other medical specialists for physical (somatic) complaints and referral to the psychiatrists was usually as a last resort. Among the neurotics, the two studies identified a group of unspecified psychoneuroses. These were the patients with coexisting symptoms of anxiety and depression. The usual difficulty is to identify which of the disease processes is primary. The authors found that the psychiatrists dealing with this core group of patients often tried using anxiolytics, and at other antidepressants while some of the patients were on combination of anxiolytics and antidepressants without significant symptom relief. These were the subtype of patients reported to have better improvement with the traditional (native) psychotherapy.[21,30] Odejide et al. blamed the failure of treatment mainly on the reliance on chemotherapy. They suggested that supportive or superficial forms of individual psychotherapy as adjuncts to chemotherapy might be more helpful to the patients. The present ratio of psychiatrists to patients in Nigeria (0.5/million population) makes this recommendation possible for only a few patients.

DRUG ABUSE

Another area of psychiatric diagnosis that demonstrates the universality of psychiatric disorders is the area of drug abuse. As in the Western world, abuse

of drugs has been widely reported in Nigeria, a non-Western culture.[31-43] The drugs identified by the authors as being commonly abused are Indian Hemp (cannabis), stimulants such as dexamphatamine and its derivatives, alcohol, Mandrax (methaqualone 250 mgm and diphenylhydramine 25 mgm), Proplus (contains caffeine), Reactivan (fencamfamin and vitamins B_1, B_6, and C), Ritalin (methylphenidate), and Soneryl (butobarbitone). The use of stimulants and hallucinogens were reported to be limited to the medical and paramedical professions and the abuse of hypnosedatives was blamed on the overprescribing habits of doctors.

As in the Western culture, the etiological factors in the drug abuse subculture were reported to vary widely.[38,40] Some of their findings were: (1) consequences of unhappy and poor background culminating in defective personality development; (2) the pressure to succeed in academic work; (3) influence of the significant others (peer groups, parents, etc.); (4) easy accessibility of drugs, as well as ineffective control of the purchase and sale of addictive drugs, and (5) primary psychiatric illnesses, especially the psychoneurotics.

In a Unesco meeting on the problems connected with the use of drugs in six African countries (Lome, Togo, September 13 and 17, 1976), the final report essentially supported the findings on drug abuse as reported by studies from Nigeria.

CHILD PSYCHIATRY

As in the area of drug abuse, child psychiatric illnesses are found in Nigeria just as in any of the Western cultures. In a review of child psychiatric disorders in Ibadan, Nigeria, Olatawura and Odejide[44] found the various subtypes of disorders reported in the non-Western cultures. However, brain damage from febrile convulsions, arising especially from malaria in infancy, was the most prevalent illness reported. Educational difficulty and delinquent acts were found to be common causes of child psychiatric referrals.

TREATMENT

Apart from the crosscultural similarity in the subtypes of psychiatric disorders and their symptom presentations, the line of management of psychiatric disorders in Nigeria is essentially similar (Table 2). Nigerian psychiatrists use chlorpromazine, thioridazine, trifluoperazine, fluphenazine decanoate, and haloperidol in the treatment of schizophrenia; imipramine, amitriptyline, trimipramine, chlorimipramine, and nortriptyline in the treatment of depression; chlordiazapoxide and diazepam in the treatment of neurosis; and nitrazepam, butobarbitone, and secobarbital in the treatment of early insomnia.[45] A review of psychotropic and antiparkinsonian drug use in a Nigerian University Teaching Hospital[46] supports the above finding. Similar psychotropic drugs are used in the Western culture.[47] The view that there is no difference in the types of psychotropic drugs in use between the Western and non-Western cultures is further substantiated by the reports of participants of World Health Organization—National Institute of Mental Health (WHO/NIMH) Workshop held in December, 1978 in the United States.

Table 2. Commonly Used Drugs in Nigeria for Certain Diagnoses

Diagnosis	Commonly Used Drugs
Schizophrenia	Chlorpromazine
	Thioridazine
	Trifluoperazine
	Haloperidol
	Fluphenazine Decanoate
Mania	Chlorpromazine
	Haloperidol
Depression	Imipramine
	Amitriptyline
	Trimipramine
	Nortriptyline
	Chlorimipramine
Neurosis	Chlordiazepoxide
	Diazepam
Early insomnia	Butabarbital
	Secobarbital
	Nitrazepam

However, psychiatrists in Nigeria have not been practicing psychoanalysis. The psychotherapeutic techniques commonly in use are supportive and superficial types: marital and family therapies as adjuncts to chemotherapy for the neurotics, and group therapies for psychiatric patients in the hospitals. The reasons for not practicing the orthodox psychotherapy (psychoanalysis) might be two-fold. The psychiatrists are very few in number and their workload might not permit the use of such a time-consuming method of treatment. Secondly, they might have the notion that it needs to be modified to be acceptable by the patients as a form of treatment. This second point supports Prince's opinion[21] that psychotherapeutic techniques fit with the cultures in which they have developed and cannot cross cultural boundaries so successfully as can physical therapies.

CONCLUSION

From the various reports cited on the universality of psychiatric disorders and their symptoms across cultures, the stable prevalence rate (0.3 percent) of schizophrenia over time and across space, and the similarities in the prescription practices of psychotropic drugs across cultures, it seems appropriate to conclude that crosscultural psychiatry is real. There is little evidence in support of the theory of cultural relativity (violations of the social norms of particular groups) in the diagnosis of psychiatric disorders.

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