Culture and Mental Illness

Importance of culture:

- To see variety of mental illness and mental illness treatment
- To examine ethnomedicine
- Important re: biological theories
- Western medicine (biomedicine) locates disease within the individual, separates healer from patient/Ethnomedicine concentrates on groups/healer close to patient
- Division between Western/non-Western, modern/traditional, individualistic collectivist/sociocentric

Horwitz - universal and variation

Waxier
Reports cultural variation in mental illness prognosis v IPSS

One explanation - simple societies simply have higher tolerance for deviance
Simple societies not so simple - caste obligations
Her work is in Sri Lanka
Guiding principle is that society molds patient to fit their conceptions of what mental illness is

Traditional; societies: believe mental illness minor; short-lived and can be treated
In accord with Labeling: theory: society 'creates' chronic patient; biomedicine: m.i. same all over

Response - sanctions - also shape course of disease Symptomatic person frightened and bewildered - very suggestible - looks for clues as to what is going on - models behavior on exp and imp messages (supported by Asch)
Different societies, different messages

SL. - disease thought to be externally caused; therefore can be cured West - belief is that illness is centered on the self permanent - cure not possible sanctions are negative and stigmatizing, alienating (with hospitalization) Not just one role - mad, bad, impaired Why do trad, societies have higher cure rates than modern Functions of deviance: helps in integration and in boundary maintenance (lineage resp. for offense)
Deviance incurs obligations (child repaying parent)
Sanctions major integrating force - lack of formal institutions
Basic unit family (Sri Lanka) individual (West) LowEE
Substantial evidence that recovery rates are higher in Nigeria, and India, then Denmark (Actually, general difference)
  Does not explain why early cure beliefs in collectivist not individualistic
  Not everybody or everything gets labeled
What would be depression in the West isn't given much attention in SL
Labeling contingent - social power no guarantee
  Sex - women doing the same thing as men are called crazy, but not the men (deviant deviance)
  Laughing, pacing, singing not evidence of mania in adol - considered normal - but would
  be consider symptomatic in middle-aged housewife (context) Social conditions, (outside of village, already had treatment contact) foster labeling
Availability of alternate roles soothsayer M.I.
culturally specific, so are contingency rules
Secondary deviance more likely in West Basic
unit the family Pt. integrated Don't implicate the self
Trad: external causes, modern, individualistic causes
Treatment involves groups meeting with groups - family, extended kin, village
West - treat individual (but family systems) Family goes to clinic can have dx without patient Illness is an opportunity m.i. not stigmatized (but T.B. is)
Obligations between pt. and family, family with other families (siblings not so keen)
  Travel - wide-ranging obligations
  West - illness intensely private
  Illness sometimes provoked by changes such as marriage
  (Lreelawai-the - ritual involving other family) Tikri Banda - married someone outside the group - suicide attempt sent wife back

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<thead>
<tr>
<th>Traditional/Collectivist</th>
<th>Industrialized/Individualistic</th>
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<tr>
<td>External causes</td>
<td>Cause within indivual; implicates self</td>
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<td>Can be cured</td>
<td>Can't be cured</td>
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<td>Patient integrated into society</td>
<td>Patient separated from society</td>
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<td>M.I. public knowledge; outside groups involved; deep family involvement</td>
<td>Illness very private; fear of stigma; patient sometimes extruded by family</td>
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Multiple healers | One healer
Scheper-Hughes Reasons for looking at culture Behavior first apparent in community Treatment more decentralized Psychiatric expertise less valued Non-Medical treatment techniques Looks at cultural influences on ind., fam and community

Part of larger study of 55 chronics Range of data-gathering techniques (P.O. phone survey Location: South Boston Archetypal Irish-Catholic community Scattered throughout South Boston Other ethnic groups more segregated Community felt to be under siege (busing) By WASP liberalism (forcing integration) and Jewish radicals (forcing mh treatment facilities; NIMBY) Jobs shrinking Boston State - "bounty hunters Feared institution Police, c.j. system, clergy Boston State extremely stigmatizing Patients come from Boston State; in day treatment Most Catholic, Irish, other ethnicities Deinstitutionalization - 3,000 to 300 rest inc community Range of dxes; schiz by far the most common Wretched home lies, extreme poverty, family violence alcoholism, abandonment and abuse - but not more so than nonhosp community resident

Recognition and Labeling Extreme denial - by everyone (in line with Scheff) (Physical symptoms, too) First florid symptoms - overlooked for months and years Mary - got more and more eccentric, bizarre behavior - became concerned when she was on roof waiting for Aer Lingus Robert - only became concerned when telephone cord used to reach "contacts" Eileen - mother denied illness; Eileen said she couldn't because no idiom available Ability to deny partly a function of family dynamics Everybody gets great deal of personal space High regard for privacy Great story tellers, but not about their own feelings Subjects often not open to discussion - Didn't know about mutilation; bloody rags men striation, couldn't talk about that Ignore ex-patients on the street (good for ex-patients)
CMHC opposed because community didn't have any mental illness
Ignored "the dreaming"

Madness, Culture an Ethnic Stereotypes

Patients used stereotypes
Staff permitted it (within limits)
Irish dominant
Religious holidays triggers
Patients very fearful of leaving South Boston on trips - "neighborhood psychosis" (typical of neighborhood too)
Irish personality: reserve, secretiveness, religiosity, intense guilt; double-talk anxiety provoking situations away

Irish reluctant to talk about family secrets
Most suicides young, quiet, single Irish males (propriety - delayed suicide)
In day hospital - Irish behaved decorously - irritated when others didn't

Much less upset by cognitive abnormality than behavioral
Religious content - cancer of the brain from masturbation, bad thought caused all her orifices to close, pursued by Hound of Heaven and ran away from six children

Ties completely severed - the "cut-off"
Effectively ceased to exist - family would have no contact - couldn't use public facilities
Means reliance on residences and
Nobody knew about RC and GO at day hospital

Community life more isolated for Irish - 8/11 Lithuanian lived with relatives

Suicide common - in respectable ways

Italian patient - went to funeral of father- felt she was expected to

Cultural Diversity and MH Treatment and MH Systems in Cross-Cultural Context
much different from Waxier and Scheper-Hughes - How?
- Review articles
- Biomedical model simply accepted

Cultural Diversity - different meaning of culture Race/ethnic composition changing - 35% in 2025 Immigration very important Different from
1890-1920 - old immigrants closer to receiving population
Early 1900s - A-As overrepresented on mental hospitals
  Can't draw many conclusions - "Treated prevalence" Ethnic minorities seek help less than whites, belong to groups with limited access to mental health services (homeless, HIV/AIDS) Limited health insurance coverage

High dropout rates while in treatment (whites?)
but - great deal of variation in utilization rates
Language and ethnic match predicts longer stay in treatment, better outcomes (Weissman and Teitelbaum)
Cross-cultural perspective on mental illness undercuts biological models

Stress may be higher in ethnic groups

Look at societal functions of mh services Use Political Economy Perspective
  Means we look at mh services as an element in social welfare; social welfare a major element in market society
  Social control perspective - mh services can cause smoother running of the market by preserving o and conformity, create secondary labor market Most important function is containment Can be looked at from viewpoint of controllers or controlled First perspective: success at containing disruptive or dangerous - ability to "change" patients - make them less dangerous
  Second perspective - complementary - can the system enable participants in the market system Compensatory - mh system operates to redistribute resources more effectively

MH Systems in X-Cultural Context
Lefley known for work in family
Work in biology
Stress
Culture-bound syndromes (windigo, arctic hysteria (pibloktoq)
IPSS findings explained by: lower stress, higher social support, externalizing cause; greater opportunity for work roles, extended kinship networks
EE - high and low
Family education
Ethnicity, Minority and Refugee status
Italian experiment - mental patients "freed" in 1978- very different results in North and South - thought to be due service availability
Advocacy and Self-help
Principles
International distribution