It may well be that the dichotomy between “us” and “them” in regard to discussions of culture-bound syndromes has been too quickly drawn; between, that is, the non-western peoples, the “underdeveloped” peoples, the “primitives” (who have the “exotic” and the “culture-bound” syndromes) and the western world, the “developed world,” the “civilized” world.

—Hughes (1985, p. 11)

This chapter examines the relationship between culture-specific diagnoses and mood disorders. How researchers and clinicians refer to cultural syndromes related to mood disorders is a contentious issue. We open our chapter with a brief discussion of the history and controversies (as the quote from Hughes [1985] that opens this chapter indicates) surrounding these labels. We then discuss the relationship between a well-documented range of cultural categories of distress and mood disorders. A key point that we want to make early and often is that there is no one-to-one relationship between these cultural categories and psychiatric disorders as codified in either the American (DSM-IV [American Psychiatric Association, 1994]) or international (ICD-10 [World Health Organization, 1992]) diagnostic systems.

The relationship between cultural categories and psychiatric diagnoses needs much more careful investigation. We offer a program of such research based on our previous work (Guarnaccia & Rogler, 1999). Another key issue is that only a few of the many cultural forms of expressing distress have received sustained research attention integrating cultural and psychiatric research methods. We focus our review on those syndromes, particularly atques de nervios, neurasthenia, and susto, which have received the most intensive research and have been shown to be associated in some ways with depression and anxiety. We end the chapter with some suggestions for responding to culture-specific diagnoses in clinical settings and for the incorporation of these syndromes into future versions of the diagnostic manuals.
THE MEANING OF CULTURE-SPECIFIC DIAGNOSES

Cross-cultural mental health researchers have introduced a number of terms to refer to and describe culture-specific forms of expressing and diagnosing emotional distress. The problem of multiple labels itself is indicative of the problems associated with the identification of the phenomenon. The label of *culture-bound syndrome* emerged as an alternative to earlier characterizations of cultural expressions of distress in pejorative language. More recent writing has critically examined the appropriateness of the culture-bound syndrome label.

The term *culture-bound syndrome* was introduced by Yap (1969) almost 40 years ago to describe “forms of psychopathology produced by certain systems of implicit values, social structure and obviously shared beliefs indigenous to certain areas” (Yap, 1969, cited in Levine & Gaw, 1995:524). Several authors (Hughes, 1985; Levine & Gaw, 1995; Prince & Tcheng–Laroche, 1987; Simons, 1985) have reviewed the different names, often pejorative, that were used prior to Yap’s usage: *exotic psychoses, ethnic psychoses, psychogenic psychoses*, and *hysterical psychoses*. The general preference for Yap’s usage is the result of his efforts to avoid biases inherent in the earlier labels, which carried assumptions about the “irrational” behavioral and thought patterns of “exotic” people from non-Western cultures. The use of *culture-bound syndromes* was intended to be less judgmental and more descriptive.

Recent critiques have pointed out that the culture-bound syndrome label, which practically always refers to forms of distress among persons in societies other than the United States or Europe, is not devoid of troublesome assumptions. Trouble stems from the assumption that if the syndromes that are culture bound belong to “them,” those that are “culture-free” belong to “us” (Bartholomew, 2000; Hahn, 1995). The dichotomy, of course, is patently false. Culture suffuses all forms of psychological distress, the familiar as well as the unfamiliar (Mezzich, Kleinman, Fabrega, & Parron, 1999b; Rogler, 1997).

The relegation of the culture-bound syndromes to the next-to-last appendix of the *DSM-IV* (American Psychiatric Association, 1994) reinforces the notion that the glossary is in some sense a “museum of exotica” (Mezzich et al., 1999b); there, the syndromes are isolated from other parts of the manual (Lewis–Fernandez & Kleinman, 1995). Many of the descriptions of specific syndromes in the glossary do suggest links between the culture-bound syndrome and DSM disorders. The DSM-IV defines culture-bound syndrome as follows:

The term culture-bound syndrome denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be illnesses, or at least afflictions and most have local names. . . . culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned and troubling sets of experiences and observations. (American Psychiatric Association, 1994, p. 844)

The term *syndrome* fits the experiences designated by culture-bound syndromes. Their listing in the DSM-IV glossary makes it clear that each represents
a constellation of symptoms and experiences within a cultural group or cultural area. The syndromes have coherence within their respective cultural settings, where they are explained according to local understandings of illness.

The notion of a syndrome being bound by culture is more problematic. The attribution of “boundedness” emerged early in the history of the term in studies that focused on a particular cultural group in a particular community and found a behavior pattern that appeared unique. The behavior pattern had a specific popular label, but the pattern itself did not readily fit the experience of Western observers, whether they were missionaries, anthropologists, or clinicians (Bartholomew, 2000). The observers often believed that the communities in question had somehow been socially isolated and, therefore, saw patterns of distress as unique and locality bound. Considering the massive cultural diffusions that have occurred throughout human history, the concept of boundedness has rarely been tenable.

It would be more accurate to say that many of these syndromes have developed or spread within broad cultural areas and that they are labeled and elaborated in accord with cultural ideas and norms. Although syndromes may originate in particular cultural areas, they have spread widely with migrations and have been incorporated into indigenous concepts of illness, thus qualifying the concept of boundedness. In the contemporary global market of intensified cultural exchanges, exportable syndromes become detached from geographic areas. Their boundedness inheres not in specific locales, but among ethnic groups and in the sociocultural patterns of which they form a part, whether in their countries of origin or in new homes.

The term folk illness sometimes is used by anthropologists as an alternative designation that does not carry the conceptual baggage of the term culture-bound syndrome. Folk illnesses are meaningful because “their symptomatology expresses a patterned relationship to the society’s salient cultural values” (Hughes, Simons, & Wintrob, 1997, p. 998). One drawback to this label is that the descriptor folk connotes illness among the common people, or that sector of the population that is “untutored or unrefined” (Morris, 1981). Its usage repeats the early ethnocentrism of labels by referring to potentially devalued social statuses.

Idiom of distress (Nichter, 1981) has gained some popularity in anthropology. The use of the term idiom links the study of these categories to linguistic concerns that are central in anthropology. The term idiom also does not presuppose pathology. Similarly, the use of distress indicates that although the experience may be upsetting to the person and his or her social network, and may reflect suffering on the part of the ill person, the condition may not be viewed as a disorder within the social network and community.

Related concerns are reflected in another term, popular illness, which connotes a category of distress recognized in the community but not in professional nosology (Good & Good, 1982; Guarnaccia, 1993). This label recognizes some parallelisms between popular illnesses within the lay sector of the health care system and the biomedical nosology of the professional sector (Kleinman, 1980). Popular derives from the Latin words popularis (of the people) and populus (people). The term’s emphasis is the personal experience and understanding of distress from the perspective of the sufferer, which parallels the professional
understanding of the problem as disease (Hahn, 1995; Kleinman, 1980). Although the term popular illness has the advantage of this important parallelism, it has not entered professional discourse on this topic.

The editors of this book provided the term culture-specific diagnoses to highlight the parallel between these syndromes and psychiatric diagnoses. This term emphasizes the importance of studying these syndromes within their cultural context. There continues to be no clear consensus on what label to use. Usage cannot be centrally mandated. Because culture-bound syndrome was adopted for the title of the DSM-IV glossary, this term maintains a certain privileged status, although it is a contested privilege. It is contested both because of difficulties inherent in discussions of these experiences and in relating such phenomena to psychiatric diagnostic categories. Throughout this chapter, we will use several of these terms, depending on the context of the discussion.

A REVIEW OF KEY CULTURE-SPECIFIC DIAGNOSES
AND THEIR RELATIONSHIP TO MOOD DISORDERS

DSM and ICD categories do not easily subsume most culture-specific diagnoses, although studies of the relationship between culture-specific diagnoses and psychiatric diagnoses show that there are sometimes close associations between the two. There would not be a question of the relationship between culture-specific diagnoses and psychiatric diagnoses had previous attempts to subsume the cultural syndromes into standard psychiatric nomenclature been successful. The conditional statement in the DSM-IV that these syndromes “may or may not” be linked to a psychiatric diagnosis, makes clear that the relationship between the cultural syndromes and psychiatric disorders is complex and still needs considerable research. Our position is that DSM and ICD categories do not easily subsume most culture-specific diagnoses, although such syndromes are sometimes closely associated with psychiatric diagnoses in what may be termed a comorbid relationship.

In this section we review some of the major culture-specific diagnoses for which we have ample research information that addresses the issues of their relationship to mood disorders. All these syndromes are referenced in “Glossary of Culture-Bound Syndromes” in the DSM-IV (American Psychiatric Association, 1994, pp. 844–849). We begin each discussion of the cultural syndrome with its definition from the DSM-IV. We then briefly review the research literature on the syndrome, identifying its relationship to mood disorders. We include ataques de nervios (attacks of nerves), neurasthenia, and susto (fright). In addition, we discuss an innovative and important study by Manson and colleagues (1985) that examined the relationship between several Hopi forms of illness and the diagnoses of depression.

Ataque de Nervios (Attack of Nerves)

The DSM-IV glossary of culture-bound syndromes includes the following definition of ataque de nervios based on the research programs of Guarnaccia
An idiom of distress principally reported among Latinos from the Caribbean, but recognized among many Latin American and Latin Mediterranean groups. Commonly reported symptoms include uncontrollable shouting, attacks of crying, trembling, heat in the chest rising into the head, and verbal or physical aggression. Dissociative experiences, seizure-like or fainting episodes, and suicidal gestures are prominent in some attacks but absent in others. A general feature of an ataque de nervios is a sense of being out of control. Ataques de nervios frequently occur as a direct result of a stressful event relating to the family (e.g., news of a death of a close relative, a separation or divorce from a spouse, conflicts with a spouse or children, or witnessing an accident involving a family member). People may experience amnesia for what occurred during the ataque de nervios, but they otherwise return rapidly to their usual level of functioning. Although descriptions of some ataques de nervios most closely fit the DSM-IV description of panic attacks, the association of most ataques with a precipitating event and the frequent absence of the hallmark symptom of acute fear or apprehension distinguish them from panic disorder. Ataques de nervios span the range from normal expressions of distress not associated with having a mental disorder to symptom presentations associated with the diagnoses of anxiety, mood, dissociative, or somatoform disorders. (American Psychiatric Association, 1994, p. 845)

The research programs of Guarnaccia, Lewis–Fernandez, and colleagues (Guarnaccia et al., 1996, 2003; Lewis–Fernandez, 1998) have documented the cultural coherence and meanings of ataques de nervios as a cultural syndrome among Puerto Ricans and other Caribbean Latinos. Our work has identified loss of control of emotions, behaviors, and a social world out of control as the core experiences of ataques de nervios. This loss of control is a result of major dislocations in the family and other close social networks. We have also identified older women from lower socioeconomic status as being particularly likely to express their emotional distress through this idiom (Guarnaccia et al., 1993). Our work suggests a popular nosology based on various categories of nervios, several of which require more systematic research, as we have done for ataques de nervios (Guarnaccia et al., 2003).

At the same time, our work has clearly shown that people who experience ataques de nervios are more vulnerable to developing a psychiatric disorder, particular along the anxiety–depression spectrum (Guarnaccia et al., 1993; Lewis–Fernandez et al., 2002; Liebowitz, Salman, Jusino, Garfinkel, Street, Cardenas, Silvestre, Fyer, Carrasco, Davies, Guarnaccia, & Klein, 1994; Salman, Liebowitz, Guarnaccia, Jusino, Garfinkel, Street, et al., 1998). Although much speculation by psychiatrists focused on ataques being a culturally shaped version of a panic attack, Lewis–Fernandez and colleagues (2002) systematically demonstrated that most ataques did not meet the criteria for panic attacks and that they were associated with a range of disorders.
The association of ataqués de nervios with mood disorders was clearly established in the initial adult epidemiology study in Puerto Rico that examined ataque in relation to DSM disorders (Guarnaccia et al., 1993). In that study of 912 subjects selected to represent the island of Puerto Rico, 20% of those who reported an ataque also met criteria for major depressive disorder (using research interview criteria) compared with 2% of those who did not report an ataque (odds ratio (OR), 9.84). Similarly, 28% of those who reported an ataque met criteria for dysthymic disorder compared with 9% of those who did not report an ataque (OR, 3.63). Overall, 30% of those who reported an ataque de nervios met research criteria for any of the mood disorders assessed in the study, compared with 6% of those who did not report an ataque (OR, 6.18). Of those who met research criteria for any of the anxiety disorders, 40% were in the ataque group compared with 14% in the no ataque group (OR, 4.02). This epidemiological study revealed that there was a strong association with meeting research criteria for both mood and anxiety disorders among those who reported an ataque de nervios.

A subsequent study among Puerto Ricans and Dominicans in the Washington Heights neighborhood of Manhattan at the Hispanic Treatment Program of the New York State Psychiatric Institute provided clearer delineation of the relationship of different ataque features to psychiatric disorders (Salman et al., 1998). This study included 156 clinical subjects, of whom 109 reported an ataque de nervios. Of this group, 33 met criteria for an affective disorder (primarily major depressive episode; \( n = 26 \)) and 69 met criteria for an anxiety disorder (most frequently, panic disorder; \( n = 45 \)). The identification of ataque subtypes in this study aided in establishing its relationship to particular psychiatric disorders. Among those participants in the study whose ataqués de nervios were characterized by intense fearfulness and feelings of asphyxia and chest tightness, diagnoses of panic disorder were more common. Those whose ataqués were more dominated by the emotion of anger and aggressive behavior, such as breaking things, were more likely to meet criteria for co-occurring mood disorders. These studies provide an empirical basis for uncovering specific linkages between ataqués de nervios and psychiatric disorders within the structure of comorbid relationships.

More recent work has examined the comorbidity of ataqués de nervios with psychiatric disorder in Puerto Rican children (Guarnaccia, Martinez, Ramirez, & Canino, 2005). This research built on a large epidemiological study in Puerto Rico (Canino, Shrout, Rubio–Stipec, Bird, Bravo, Ramirez, et al., 2004) that examined representative samples of children in the community and in the mental health service system. The prevalence of ataque de nervios was 9% (\( n = 1897 \)) in the community sample and 26% (\( n = 767 \)) in the clinical sample. As in the adult study, children in Puerto Rico who reported an ataque de nervios were more likely to meet research diagnostic criteria for both mood and anxiety disorders. Children in the community who reported an ataque de nervios were almost eight times more likely to meet criteria for any mood disorder and five times more likely to meet criteria for any anxiety disorder than children who did not report an ataque. Similarly, in the clinical sample, children who reported an ataque were six times
more likely to meet criteria for any mood disorder and 3.5 times more likely to meet criteria for any anxiety disorder.

The combined findings of these studies support a strong relationship between ataque de nervios and both mood and anxiety disorders. These studies also suggest that different characteristics of ataque profiles are associated with the different psychiatric diagnoses. The overall research program on ataque de nervios provides a model for assessing the relationship between culture-specific diagnoses and psychiatric disorders (Guarnaccia & Rogler, 1999). The findings of strong relationships with both mood and anxiety disorders also lend support for the need for a mixed anxiety–depression diagnosis for multicultural populations.

Neurasthenia


In China, a condition characterized by physical and mental fatigue, dizziness, headaches, other pains, concentration difficulties, sleep disturbance, and memory loss. Other symptoms include gastrointestinal problems, sexual dysfunction, irritability, excitability, and various signs suggesting disturbance of the autonomic nervous system. In many cases, the symptoms would meet the criteria for a DSM-IV mood or anxiety disorder. This diagnosis is included in the Chinese Classification of Mental Disorders, Second Edition (CCMD-2). (American Psychiatric Association, 1994, p. 848)

The ICD-10 includes neurasthenia as one of the disorders in the main section of the manual, as opposed to in a glossary of culture-bound syndromes. It is incorporated in the section on neurotic, stress-related, and somatoform disorders under the category “other neurotic disorders (F48)” (http://www.who.int/classifications/apps/icd/icdonline/gf40.htm). Given the long association of neurasthenia with depression, it is somewhat surprising to see it categorized in the ICD-10 with primarily anxiety and somatoform disorders. The ICD-10 contains the following description of neurasthenia (F48.0):

Considerable cultural variations occur in the presentation of this disorder, and two main types occur, with substantial overlap. In one type, the main feature is a complaint of increased fatigue after mental effort, often associated with some decrease in occupational performance or coping efficiency in daily tasks. The mental fatiguability is typically described as an unpleasant intrusion of distracting associations or recollections, difficulty in concentrating, and generally inefficient thinking. In the other type, the emphasis is on feelings of bodily or physical weakness and exhaustion after only minimal effort, accompanied by a feeling of muscular aches and pains and inability to relax. In both types a variety of other unpleasant physical feelings are common, such as dizziness, tension headaches, and feelings of general instability. Worry about decreasing mental and bodily well-being, irritability, anhedonia, and varying minor degrees of both depression and anxiety are all common. Sleep is often disturbed in its initial and middle phases but
hypersomnia may also be prominent. (http://www.who.int/classifications/apps/icd/icd10online/gf40.htm, accessed 6/4/2007)

Several studies in China have found a strong comorbidity between neurasthenia and mood disorders, as well as somatization. Kleinman (1986) in his studies in both mainland China and Taiwan found considerable overlap between the diagnosis of neurasthenia and depressive disorders. In his study of 100 Chinese patients diagnosed with neurasthenia, 93 also had a depression diagnosis, with 87 meeting criteria for major depressive disorder. Sixty-nine of the patients were also diagnosed with an anxiety disorder and 25 with a somatoform disorder. In Taiwan, 22 of 51 patients with neurasthenia also met criteria for a major depressive disorder, which was the most common psychiatric diagnosis in this group of patients.

More recently, Chang and colleagues (2005) report on the relation between shenjing shuairuo and DSM-IV disorders in a Chinese primary care clinic. The study included 139 patients, most of rural Chinese origin, who presented with unexplained somatic complaints. These patients were assessed using the Structured Clinical Interview for Diagnosis (SCID), the Brief Symptom Inventory (BSI), and the Short Form 36 (SF-36) to assess functional impairment. Of the 49 patients who were diagnosed using the cultural definition of shenjing shuairuo, 26 met criteria for the ICD-10 diagnosis of neurasthenia, with a focus on symptoms of fatigue or weakness. Of those who met criteria for a DSM-IV diagnosis, all were in the somatoform disorders spectrum. Twenty-two did not meet criteria for a DSM-IV diagnosis. This study indicates an evolution of the use of shenjing shuairuo, neurasthenia, and depression in China so that these categories have become more differentiated. The study also found that those diagnosed with a primary mood disorder experienced more impairment than those with shenjing shuairuo. Chang and colleagues (2005) argue for seeing shenjing shuairuo as a somatocognitive–affective syndrome that remains culturally salient among laypersons in China and is not easily captured by either mood or somatoform disorders.

An epidemiological study of neurasthenia by Zheng and colleagues (1997) of Chinese Americans found similar distinctions between neurasthenia and DSM disorders. Using ICD-10 criteria for neurasthenia, they identified 112 (6.4%) subjects with neurasthenia out of a sample of 1747 Chinese Americans residing in Los Angeles. More than half \( n = 63, 56\% \) did not meet criteria for a DSM-III-R diagnosis. Compared with those with depression and anxiety diagnoses, they reported fewer psychological symptoms on the Symptom Checklist -90-Revised (SCL-90-R), but similar levels of somatization symptoms. Their conclusion is that neurasthenia is a distinct clinical condition with only partial comorbidity with DSM diagnoses.

Neurasthenia, like ataque de nervios discussed earlier, is a complex syndrome with only partial overlap with DSM psychiatric disorders. Although Kleinman’s (1982, 1986) earlier research identified a strong link between neurasthenia and depression in China, more recent research in China and among Chinese Americans has identified changing understandings of the syndrome and differing relationships between neurasthenia and psychiatric disorders. Given that many
people who report or meet criteria for neurasthenia do not meet criteria for any DSM disorder, neurasthenia is better understood as a distinct category for organizing the experience of distress among people of Chinese origin. If they do also meet criteria for a DSM disorder, it is as likely to be a somatoform disorder rather than a mood disorder. These findings further complicate the relationship between culture-specific diagnoses and mood disorders. They also raise questions about the clarity of the boundaries among mood, anxiety, and somatoform disorders.

**Susto—Fright or Soul Loss**

The following description of susto depends heavily on the ethnography of Rubel and colleagues (1984), as well as a study by Taub (1992). More recent work by Weller, Baer, and colleagues (2002, 2005) provides new insights into the relationship of susto to mental disorders.

A folk illness prevalent among some Latinos in the United States and among people in Mexico, Central America, and South America. Susto is also referred to as espanto, pasmo, trapa ida, perdida del alma, or chibih. Susto is an illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness. Individuals with susto also experience significant strains in key social roles. Symptoms may appear any time from days to years after the fright is experienced. It is believed that in extreme cases, susto may result in death. Typical symptoms include appetite disturbances, inadequate or excessive sleep, troubled sleep or dreams, feeling sadness, lack of motivation to do anything, and feelings of low self-worth or dirtiness. Somatic symptoms accompanying susto include muscle aches and pains, headache, stomachache, and diarrhea. Ritual healings are focused on calling the soul back to the body and cleansing the person to restore bodily and spiritual balance. Different experiences of susto may be related to major depressive disorder, posttraumatic stress disorder, and somatoform disorders. Similar etiological beliefs and symptom configurations are found in many parts of the world. (American Psychiatric Association, 1994, pp. 848–849)

Rubel and colleagues (1984) carried out a comprehensive study of susto, a Latin American folk illness associated with fright that has a long history of research. The researchers specifically rejected at the outset any hypotheses about the correlation between susto and biomedical categories, choosing to focus on understanding the local context and meaning of the illness before attempting to identify relationships with biomedically defined disorders (Rubel et al., 1984, p. 7). Based on their own previous work on susto, they hypothesized that the major cause of susto would be social stressors, particularly those resulting from an inability to carry out social roles. The authors used multiple methods to study those identified as suffering susto, including detailed ethnographic interviews with sufferers about their experience with and understanding of the illness, medical histories and examinations, psychiatric assessment using a symptom scale called the 22-Item Screening Score for Measuring Psychiatric Impairment, and a measure of social stress.

Their major findings were that people suffering susto experienced more feelings of inadequacy in social role performance, that they suffered more diseases...
and had higher rates of fatality from those diseases, and that they were no different from control subjects on the measure of psychiatric impairment. *Susto* was not associated, however, with any specific disease; *susto* sufferers appeared to be susceptible to a range of disorders and experienced a range of symptoms. They concluded: “Now it is inadequate and inappropriate to conceive of *susto* as a form of unique social behavior on the one hand, or as a purely biomedical phenomena on the other” (Rubel et al., 1984, p. 122). Their study indicates the importance of studying folk illnesses on their own terms, and of investigating them from a range of perspectives using both in-depth interviews and clinical methods.

More recent work on *susto* (Taub, 1992) has delineated different dimensions of the *susto* experience and its relationship to different psychiatric disorders. Using anthropological and epidemiological methods to study *chibih* (the Zapotec term for *susto* in Oaxaca), Taub investigated the relationship between *susto* and Western-defined psychology. She recruited a sample of 40 women and carried out in-depth anthropological interviews and psychiatric assessments (Diagnostic Interview Schedule [DIS], Center for Epidemiological Studies–Depression Scale [CES-D]). Ten of the women had current *chibih* and 18 reported *chibih* in the past. Women with current or past *chibih* were much more likely to meet the DIS depression criteria (72% of those with lifetime *chibih* vs. 24% of those without) and were more likely to have CES-D scores in the range of likely casesness (CES-D score, >16 points).

Taub (1992) also identified three types of *chibih* that had different relationships with psychiatric diagnoses. An interpersonal *susto* characterized by feelings of loss, abandonment, and not being loved by family, with accompanying symptoms of sadness, poor self image, and suicidal ideation, seemed to be closely related to major depression. When the *susto* resulted from a traumatic event that played a major role in shaping symptoms and in emotional processing of the experience, the diagnosis of posttraumatic stress disorder (PTSD) was more appropriate. *Susto* that was characterized by several somatic symptoms that recurred and were chronic, and for which the person sought health care from several practitioners, resembled one of the somatoform disorders.

Weller and colleagues (2002) have conducted systematic studies of *susto* in different Latino communities in the United States, Mexico, and Guatemala as part of a larger study of folk and biomedical illnesses. Their first work involved a comprehensive description of *susto* based on studies with Mexican Americans in Texas, Mexicans in Guadalajara, Mexico, and mestizos in Guatemala. Although they note some regional variations in *susto*, some of the core experiences include that the illness is caused by a fright, but not necessarily soul loss, and that core symptoms include agitation, crying, nervousness, trembling, fear of unfamiliar places, and sleep disturbances. *Susto* was also seen as a serious illness that could cause diabetes and lead to death.

In a subsequent study, Weller and colleagues (2005) examined the relationships among *susto*, *nervios*, and depression symptoms in an urban clinic in Mexico. They surveyed 200 adults in a public primary care clinic. Sixty-nine percent reported having experienced *susto* and 65%, *nervios*. Using the Zung depression scale (ranging from 20–80 points, with a higher score meaning more depressed)
to measure depression, they found that those who reported susto and nervios had higher rates of depressive symptoms than those who did not report these folk illnesses (42 points vs. 38 points, \( p < .04 \) for susto; 44 points vs. 34 points, \( p < .0001 \) for nervios). Those who reported both susto and nervios had higher depression scores. Nervios sufferers were more likely to be depressed than susto sufferers.

As with the previous syndromes we have discussed, susto has a complex relationship with psychiatric disorders as well as with medical conditions. Susto clearly indicates someone who is more vulnerable to distress and who has experienced more difficult life problems. Those with susto are more likely to suffer from psychological problems of varying types. Knowing the context of the fright and the social characteristics of the person may provide clues regarding whether the person is more likely to experience a mood, anxiety, or somatoform disorder.

**Hopi Illnesses Related to Mood Disorders**

Manson and colleagues (1985) developed the American Indian Depression Schedule (AIDS) specifically to assess concurrently Hopi illness categories and psychiatric diagnoses of depression, somatization, and alcohol-related behavior. The researchers first elicited Hopi illness categories that affected people’s minds or spirits from a sample of 36 subjects selected to represent gender, age, and geographic diversity within the Hopi reservation. They then identified the affective, cognitive, and behavioral experiences associated with these syndromes using standard question frames designed to elicit key information systematically about these illnesses. Using this information and modified versions of the relevant sections of the Diagnostic Interview Schedule, they constructed the American Indian Depression Schedule that was then used in an epidemiological study of matched clinical \( (n = 22) \) and community samples \( (n = 32) \) of Hopis.

Manson and colleagues (1985) were able to examine the relationship among the Hopi illness categories and psychiatric disorders. One of the most important findings of this study was that although the key depression symptom of prolonged sadness correlated with one of the Hopi illnesses, other Hopi illnesses shared the somatic and psychosocial experiences of depression without this mood symptom criterion. Although there was overlap among the Hopi illnesses and several of the symptoms of depression, there was no one-to-one mapping between any of the Hopi illnesses and depression as a disorder. In addition, the prevalence of the Hopi illness categories indicated the importance of assessing these categories in addition to the most frequent mood disorders to gain a fuller understanding of the mental health of the Hopi. This study clearly demonstrated the importance of including culture-specific diagnoses in cross-cultural psychiatric research to improve the validity of such studies.

**Summary**

Without a more systematic and wide-ranging program of research on a broader range of culture-specific diagnoses, current approaches that only focus on classificatory exercises with culture-specific diagnoses do not, from our viewpoint,
further our understanding of these syndromes. The strategy of trying to find the right classificatory scheme by basing it on similarity between one or two symptoms of the culture-specific diagnosis and of the psychiatric disorder is limited. It is particularly problematic when researchers privilege the DSM categories as the main organizing structure of relevance to culture-specific diagnoses. This approach is not likely to produce new insights into these syndromes on their own terms or in relation to psychiatric diagnosis. To resolve the cognitive dissonance created by the complex relationship between the culture-specific diagnoses and psychiatric disorders, cross-cultural mental health researchers need to carry out intensive research that illuminates these syndromes, rather than simply attempting to subsume them into psychiatric categories and obliterating them (Guarnaccia & Rogler, 1999; Hughes, 1985; Kleinman, 1978).

This section has provided some insights into the potential for understanding the relationship between culture-specific diagnoses and mood disorders, as well as other mental health problems. We examined research that focuses in depth on the relationship between a small number of cultural syndromes and mood disorders; however, there is still considerable work to do. The next section proposes a framework for research (Guarnaccia & Rogler, 1999) that would bring the study of culture-specific diagnoses into the mainstream of mental health research.

**RESEARCH PROGRAM ON THE RELATIONSHIP BETWEEN CULTURE-SPECIFIC DIAGNOSES AND MOOD DISORDERS**

Whether or not there are “new” psychiatric illnesses to be found in folk cultures or nonmetropolitan populations is a question that first requires semantic resolution. Undoubtedly there are in certain cultures clinical manifestations quite unlike those described in standard psychiatric textbooks, which historically are based on the experiences of Western psychiatrists. In this sense, illnesses presenting so strangely may be regarded as “new.” However, each of the same textbooks also espouses a system of disease classification that by its own logic is meant to be final and exhaustive. From this point of view, no more new illnesses are to be discovered, and any strange clinical condition can only be a variation of something already recognized and described. Two problems then arise: Firstly, how much do we know about the culture-bound syndromes for us to be able to fit them into standard classification; and secondly, whether such a standard and exhaustive classification in fact exists. (Yap, 1974, p. 86)

Yap (1969, 1974) challenged the field to learn more about the culture-bound syndromes so that their relationship to psychiatric disorders could be resolved, yet there is still far to go. This next section proposes a research program on culture-specific diagnoses that is faithful to the holistic nature of these syndromes, while at the same time applying the most current research approaches from a number of fields. This research effort comprises a series of key questions that need to be answered for understanding culture-specific diagnoses on their own terms and in relationship to psychiatric disorders. The questions are organized into the following four broad dimensions:
1. Nature of the phenomenon
2. Location in the social context
3. Relationship to psychiatric disorder
4. Social/psychiatric history of the syndrome

We provide a general approach to addressing each of these areas (these questions were originally proposed and discussed in Guarnaccia and Rogler [1999]). At the end of this review we propose a new fifth question on outcomes.

**First Question: Nature of the Phenomenon**

How do we characterize the syndrome within its cultural context? What are the defining features of the phenomenon? One way to begin studying a culture-specific diagnosis is to refer to the research literature in anthropology and psychiatry. The DSM-IV glossary of culture-bound syndromes has descriptions of 25 syndromes that cultural experts identified as particularly relevant to psychiatry. When a society’s illness categories are not known by the researcher, a common elicitation technique is to do open-ended interviewing with key informants to identify the ways things can go wrong with people’s minds, emotions, or spirits (this was the approach used by Manson and colleagues [1985]).

The salience of a culture-bound syndrome, the quickness and extent of its recognition within a cultural group, is more difficult to establish. Appearance in the literature provides some evidence of a category’s salience, but this is not a foolproof standard. Clinical and epidemiological studies can provide a basis for documenting the salience of culture-bound syndromes. For example, the salience of ataque de nervios to Puerto Rican mental health was actively debated until a question on ataques was incorporated into an epidemiological study of adult mental health in Puerto Rico (Guarnaccia et al., 1993). In that community study in Puerto Rico, 145 of the 912 (16%) people interviewed reported having had at least one ataque de nervios. The large proportion of respondents who recognized the syndrome during the interview and who admitted to the experience in their lifetime attested to the salience of ataques de nervios to Puerto Ricans’ mental health.

After the salience is documented, the subjective experiences associated with the syndrome—that is, the syndrome’s phenomenology—needs examination. Investigations should focus on what it feels like to experience the syndrome: the physical sensations, emotions, and thoughts of the person while experiencing the syndrome. The questions in Kleinman’s explanatory model (Kleinman, 1980, p. 106) can be very useful in developing prototypical descriptions of the syndrome, including information about the range in variation of that experience. They are intended to provide a starting point for assessment.

A fuller phenomenological portrait can be developed most effectively with representative samples of individuals who have experienced a culture-bound syndrome. Developing a complete picture of the syndromal experience is important, because a key feature in defining culture-specific diagnoses is eliciting the full symptom profile of the experience, not just a few predominant symptoms. A careful symptomatic description of the experience serves to distinguish it from
other syndromes. Interviews about the phenomenology of the syndrome should allow for the systematic elicitation of symptoms using both open-ended questions and symptom checklists.

Second Question: Location in the Social Context

Who are the people who report this syndrome and what is their location in the social structure? What are the situational factors that provoke these syndromes? Fully characterizing the culture-specific diagnosis involves identifying the social characteristics and social position of people who suffer from the syndrome. Social structural factors determine who is most at risk for experiencing illness and disorder. Contextual factors influence when the syndrome is likely to occur and the social situations that provoke them. For example, *susto* is a syndrome that is defined by being provoked by a frightening experience. In many cases, the social context is central to diagnosing the syndrome.

Third Question: Relationship to Psychiatric Disorder

How is the cultural syndrome empirically related to psychiatric disorder? With the kinds of knowledge already identified in previous questions about a culture-specific diagnosis, researchers can then address the relationship between the syndrome and the psychiatric disorder. We call this the comorbidity question on the assumption that studying the syndrome’s patterned relationship to psychiatric diagnoses is a more fruitful approach than attempting prematurely to subsume it into the official diagnostic categories. Systematic research, such as that described in the previous section, has identified strong correlations between culture-specific diagnoses and criteria for psychiatric disorder, but there is rarely a one-to-one relationship. Hughes and colleagues (1997) state this point eloquently:

> The phenomena of the culture-bound syndromes do not constitute discrete, bounded entities that can be directly translated into conventional Western categories. Rather, when examined at a primary level, they interpenetrate established diagnostic entities with symptoms that flood across numerous parts of the DSM nosological structure. (pp. 996–997)

Culture-specific diagnoses are often comorbid with a range of psychiatric disorders, as most psychiatric disorders are with each other (Kessler, McGonagle, Zhao, et al., 1994). Answers to the comorbidity question bring research on culture-specific diagnoses into the mainstream of psychiatric research.

Differences in the symptomatic, emotional, and contextual aspects of cultural syndromes, in turn, may signal different comorbid relationships, or lack of relationships, with psychiatric diagnoses. For mood disorders, one is clearly looking to see whether sadness is a key dimension of the cultural syndrome. However, as previously indicated in the review of syndromes, the cultural syndromes are more likely to share somatic symptoms with mood disorders than the primary symptom of sadness. At the same time, loss events, which have been shown to be key correlates of depression (Brown & Harris, 1978), are prominent experiences that
provoking several of the syndromes that we reviewed. Thus, it is critical to understand how the syndrome fits within the life course of the person to identify fully the link with mood disorders.

Fourth Question: Social/Psychiatric History of the Syndrome

When the syndrome and psychiatric disorders are comorbid, what is the sequence of onset? How does the life history of the sufferer, particularly the experience of traumatic events, affect the sequence? The fourth question elaborates concerns raised in the third question, but emphasizes integrating the history of cultural syndromes with the history of psychiatric disorder. These experiences do not exist outside the life course of the person, and understanding them in that context provides additional insights into the relationship among the syndromes and disorders that cannot be understood in isolation. Knowing whether there has been a recent death of a loved one or a loss of a key social relationship, or whether the person is close by or in the country of origin (in the case of immigrants), is a key aspect of making an appropriate cultural and psychiatric diagnosis. To help interpret the current episode as normative distress or the sign of current or developing disorder, it would help to know whether there have been several episodes of the cultural syndrome or of other psychiatric problems in the person’s life history.

The need for this type of integrative program has been recognized for 30 years, but has yet to be fully realized. As Kleinman (1978) pointed out in an early editorial,

> not only do cross-cultural psychiatry and psychology need to regularly assess and assimilate relevant anthropological approaches, but anthropology needs to do the same for developments in psychiatry and psychology...the great gap in concepts, methods, style of doing research, orientation to practical therapeutic concerns, and findings that separates these three disciplines will not narrow significantly until each discipline becomes at least as interested in assembling an integrated picture of a complex, plural reality as it is in further isolating a much simpler account of a single dimension. (p. 208)

After this more phenomenological and epidemiological program has provided detailed understanding of the cultural syndrome, a key issue becomes how to intervene to aid the person in distress. Effective alleviation of suffering is both a key research and clinical concern. Important questions revolve around what treatments are offered. One question is, if the culture-specific diagnosis is effectively treated, does the person also experience relief of the mood disorder? Given the effectiveness of both psychotherapeutic and pharmacological treatments for mood disorders, if the mood disorder is resolved, does the culture-specific diagnosis resolve as well? Given the different conceptualizations of these types of disorders, with depression being seen as more psychobiological in psychiatry and cultural syndromes as more social–contextual in anthropology, one would not necessarily expect such neat resolution of the problem if only some dimensions are addressed. A research program focused on treatment and
outcomes for culture-specific and psychiatric diagnoses would begin to address these questions, as well as relieve human suffering.

TOOLS FOR WORKING WITH CULTURE-SPECIFIC DIAGNOSES IN CLINICAL SETTINGS

Medical anthropology and cultural psychiatry have developed tools and perspectives that are useful in assessing culture-specific diagnoses in clinical work and in negotiating between culture-specific diagnoses and psychiatric diagnoses. One such model includes the explanatory model questions developed by Kleinman (1980). Another more recent model is the DSM-IV Outline for Cultural Formulation, which was developed for and included in DSM-IV by the National Institute of Mental Health (NIMH) Culture and Diagnosis Work Group (Mezzich et al., 1999b) and elaborated on by the Group for the Advancement of Psychiatry (GAP) Committee on Cultural Psychiatry (Group for the Advancement of Psychiatry, 2002). These frameworks are designed to help clinicians inquire about and better understand the cultural dimensions of their patients’ presentations of their mental health problems.

The explanatory model questions were proposed by Kleinman (1980, p. 106) as a tool to aid clinicians in interviewing their patients about the cultural understandings of their illnesses. This deceptively simple set of eight questions provides a framework for a brief clinical interview that can identify the presence and meaning of a culture-specific diagnosis. In particular, the first five questions are useful in this regard and include the following: What do you call your problem? What do you think has caused your problem? Why do you think it started when it did? What does your sickness do to you? How severe is the sickness? These queries could easily fit into an intake or initial interview when a patient is first seen by a provider, and can help guide the clinician in determining the best assessment techniques and course of treatment for the patient.

For a particularly accessible and informative example of the use of these questions to elucidate a culture-specific diagnosis, we refer the reader to Anne Fadiman’s *The Spirit Catches You and You Fall Down* (1997, p. 260–261). This book concerns a young Hmong girl with *quag da peg*, which are the Hmong words for the title of the book, and which is sometimes equivalent to the medical diagnosis of epilepsy. After detailing the miscommunications, misunderstandings, and conflicts between the family and their medical providers, Fadiman uses the explanatory model questions to highlight her understanding of spirit possession and soul loss for the Hmong family she has come to know. She realizes that had the doctors been able to ask these questions and understand the answers with the use of a skilled interpreter, they would have had a much better understanding of the family’s perspective on their daughter’s illness. More research-oriented examples related to depression can be found in Kleinman’s *Social Origins of Distress and Disease* (1986) and *The Illness Narratives* (1988).

A more specific set of questions concerning the relationship between culture-specific diagnoses and psychiatric diagnoses grew out of the work of the NIMH...
Culture and Diagnosis Group (Mezzich et al., 1999b). This group provided wide-ranging cultural input to the development of DSM-IV. Two particular features of this input appear in Appendix I, “Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes” (American Psychiatric Association, 1994, pp. 843–849). The “Outline for Cultural Formulation” was included in abbreviated form in the DSM-IV with no examples, and its juxtaposition to “Glossary of Culture-Bound Syndromes” led to the misleading impression that the formulation was only for those presenting with cultural syndromes (Lewis–Fernandez & Kleinman, 1995; Mezzich, Kirmayer, Kleinman, Fabrega, Parron, Good, et al., 1999a). For the purposes of this chapter, this linking is useful to clinicians, because our point is that clinicians need guidance on how to inquire about and understand culture-specific presentations of mental illness. However, we concur with those cited earlier that the cultural formulation is relevant to all clinical encounters.

The key area of the cultural formulation in this regard is the section on cultural explanations of the individual’s illness (American Psychiatric Association, 1994, pp. 843–844). The major elements of inquiry include the predominant idioms of distress through which symptoms are communicated, the meaning and perceived severity of the individual’s symptoms in relation to the norms of the cultural reference group, local illness categories used by the individual’s family and community to identify the condition, the perceived causes or explanatory models that the individual and reference group use to explain the illness, and past and current experiences with popular and professional sources of care. Again, these areas can serve as a support for clinicians who seek to understand better their patients’ perspectives on the symptoms, expressions, and difficulties they present.

There are several resources to which clinicians can turn for further guidance and examples using this formulation technique. The cultural formulation has been elaborated by the GAP Committee on Cultural Psychiatry in their publication Cultural Assessment in Clinical Psychiatry (Group for the Advancement of Psychiatry, 2002). Illustrative cases using the cultural formulation and discussing the implications of cultural understanding of mental health problems have been available in select issues of Culture, Medicine and Psychiatry starting in the mid 1990s (for example, see Lewis–Fernandez, 1996). Although there is no magic to these questions or to the process of eliciting answers to them from patients who have different cultural understandings of their illness from their provider, they provide a framework to aid the clinician in getting started.

After the information is elicited, the next key step is for the clinician to lead a negotiation process whereby the clinician and patient come to understand each others’ perspectives on the mental health problem and come to agreement on how to proceed. Kleinman describes this approach in The Illness Narratives (1988, pp. 227–251). The process that Kleinman develops is first for the provider to elicit and understand the patient’s explanatory model, and then to make clear the provider’s explanatory model. The process then focuses on developing a treatment plan based on negotiation between the patient and provider models. This approach has been further elaborated in a variety of models developed for
cultural competence training for physicians to aid them in this negotiation process (Like, 2005). The effects on quality of depression care from these approaches to assessing cultural understandings of culture-specific diagnoses and psychiatrist–patient negotiation are pressing areas for research.

TOWARD DSM-V: SOME MODEST PROPOSALS CONCERNING THE RELATIONSHIP OF CULTURE-SPECIFIC DIAGNOSES AND MOOD DISORDERS

We conclude this chapter with some suggestions for incorporating issues raised by our review of culture-specific diagnoses for inclusion in the mood disorders section of DSM-V. Our first recommendation is that the DSM-V should incorporate a mixed anxiety–depression diagnosis. This diagnosis already exists in ICD-10, code F41.2 (World Health Organization, 1999; see also http://www.who.int/classification/apps/icd/icd10online/gf40.htm): “This category should be used when symptoms of anxiety and depression are both present, but neither is clearly predominant, and neither type of symptom is present to the extent that justifies a diagnosis if considered separately.” Further criteria include that the symptoms taken together should result in disability. The patient may first report physical symptoms, such as fatigue or pain, but (with further diagnostic assessment) depressed mood and anxiety are often present. This description fits with the presentation of cultural syndromes presented in the previous section of this chapter.

DSM-IV includes a mixed anxiety–depression diagnosis in “Appendix B: Criteria Sets and Axes Provided for Further Study.” The inclusion of this category grew out of the recommendations of the DSM-IV field trial (Zinbarg, Barlow, Liebowitz, Street, Broadhead, Katon, Roy–Byrne, Lepine, Teherani, Richards, Brantley, & Kraemer, 1994). The description of the disorder from the DSM-IV (American Psychiatric Association, 1994, p. 723) parallels the ICD-10 description, with some important differences. The DSM-IV description emphasizes the presence of depressed mood for at least a month, whereas the ICD-10 recognizes the presence of both depression and anxiety, and notes that the primary presentation may be somatic. The DSM-IV description is as follows:

The essential feature [of mixed anxiety–depression disorder] is a persistent or recurrent dysphoric mood for at least one month. The dysphoric mood is accompanied by additional symptoms that also must persist for at least one month and include at least four of the following: concentration or memory difficulties, sleep disturbance, fatigue or low energy, irritability, worry, being easily moved to tears, hypervigilance, anticipating the worst, hopelessness or pessimism about the future, and low self-esteem or feelings of worthlessness. The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. (American Psychiatric Association, 1994, p. 723)

The overview also notes that the disorder is particularly common in primary care settings, which is the basis of this description, and that the disorder is also common in outpatient community mental health settings (Barlow & Campbell,
Support for inclusion of this diagnosis comes from both the prevalence of mixed anxiety–depression symptoms associated with culture-specific diagnoses and the prevalence of these presentations in primary health and mental health care settings where most people seek mental health care, particularly multicultural patients. The requirement for the presence of one month of dysphoric mood as the essential symptom seems unwarranted given the mixed nature of the diagnosis and that many primary-care patients, particularly those who are recent immigrants, present distress through primarily somatic idioms recognized in the description of the disorder.

A second recommendation is to refine and expand the discussion of the outline for cultural formulation. The outline should be moved to the introductory section of the DSM-V, where it can be discussed in relation to the multiaxial system of diagnosis. This was always the intent of the NIMH Culture and Diagnosis Group—that the cultural formulation be seen as an adjunct to a complete multiaxial diagnosis. The discussion of the cultural formulation should be expanded using materials from the GAP publication on cultural assessment (Group for the Advancement of Psychiatry, 2002). A series of case examples of cultural formulations should be included as part of the supplementary materials developed to enhance the use of DSM-V. These could be drawn from the GAP publication, from the case series in Culture, Medicine and Psychiatry, and from other sources.

The glossary of culture-bound syndromes needs to be updated in two ways for DSM-V. Syndromes that are already present in the DSM-IV glossary need updating with more recent research, such as that presented in this chapter. In addition, more intensive research on a broader range of culture-specific diagnoses needs to be commissioned as part of the DSM-V field trials and other research endeavors. We have provided a framework for such a research effort. For example, ataques de nervios and neurasthenia were included in the recent NIMH-funded national Latino and Asian American mental health study (Alegria, Takeuchi, Canino, Duan, Shrout, Meng, et al., 2004a; Alegria, Vila, Woo, Canino, Takeuchi, Vera, et al., 2004b). Although it may still be appropriate to include these syndromes in an appendix to DSM-V, there should be a greater effort to link the syndromes to specific disorder chapters, such as those we have provided to mood disorders. As the research on other culture-specific diagnoses develops that allows for fuller characterization of those diagnoses as well as an assessment of their relationship to psychiatric diagnoses, this information should be incorporated into DSM-V and other official psychiatric diagnostic systems.

Given the growing cultural diversity of the United States in general, and the increasing attention to cultural competence in mental health care, one facet of improving care for multicultural populations is improving our understanding of the culture-specific diagnoses on their own, and in relationship to psychiatric diagnoses. Given the prevalence of depression and other mood disorders in clinical settings and community surveys, and the significant disability attributable to depressive disorders, better understanding of the relationship between culture-specific diagnoses and mood disorders is a research, clinical, and public health imperative.
REFERENCES


