

Original Research Article

Regional Variations in Psychopathology, Culture Bound Syndromes and Disorders of Uncertain Nosology

Celestine O. Mume

Department of Mental Health, Faculty of Clinical Sciences, Obafemi Awolowo University, Ile – Ife, Osun State, Nigeria

ABSTRACT

In this paper the author advances an opinion that different factors including the culture of an individual influence psychopathological manifestations. It is argued that we know relatively very little about the clinical conditions we deal with. Somatoform disorders and other conditions with prominent somatic symptoms are largely yet to be understood in Psychiatry.

Since culture affects the expression of symptoms of many disorders, it may not be appropriate to regard some disorders as culture-bound and others as otherwise. In the light of the above the nosological status of Culture-Bound Syndromes is considered unsettled.

Keywords: Culture – Bound Syndromes; nosology; psychopathology; diagnostic challenges; Somatoform disorders; treatment outcome; psychiatry

INTRODUCTION

In psychiatry expression of symptoms of many disorders is usually a function of many variables. Some of the factors that determine the expression of the symptoms are those that are common to all humans as members of the same species. All humans have the same or similar sensory modalities; thus features such as hallucinations are more or less universal. For a similar reason in cognitive faculties, delusions are also universal depending on the diagnostic entities under consideration.

However the contents of the hallucinations and delusions are influenced by the culture of the individuals. Many psychotic patients express hallucinations and delusions with predominantly religious contents. The religious contents are usually consistent with the individual's faith. It is not uncommon for the patient to express some kind of experiences with the avatars of

their respective religions. This is true also in their dreams. As a matter of fact, even within a particular religion, the expression of psychotic symptoms by patients varies with the respective denominations to which they belong. Further still, the expression of psychotic symptoms may depend on factors that are particular to the individual, such as their wishes, personality, educational status, employment status and nature of job (if employed), marital status and other socio-demographic variables. If this were not the case, how would two psychotic patients with the same diagnosis have differences in the contents of their hallucinations (auditory, visual, etc) and delusions (grandiose, persecutory etc)? As we continue with the trend of our argument, we note that some disorders are commoner in certain parts of the world than in other areas. Parts of the world that have relatively young populations are likely to have lower

prevalence of dementia in Alzheimer's disease – other conditions being equal – compared to those regions that have largely high percentage of their populations as elderly. There are also gender differences in the prevalence of certain disorders. Naturally some disorders are rare in some regions of the world; this is not specific to psychiatry. Thus among other factors, culture is a major consideration in psychopathology. The expression of symptoms of many psychiatric disorders is among others, a function of the culture of the individuals.

Somatoform Disorders

According to the World Health Organization ⁽¹⁾ the main features of somatoform disorders include repeated presentation of physical symptoms and persistent requests for medical investigations in spite of repeated negative findings and reassurances by doctors that there are no physical bases for the symptoms. It is further stated that even when physical disorders are present, these do not explain the nature and severity of the symptoms or the preoccupation of the patient. One type of somatoform disorder is somatization disorder. The main features of this disorder according to WHO are multiple, recurrent and frequently changing physical symptoms which have usually been present for several years before the patient is referred to a psychiatrist. A minimum duration of two years is required for diagnosis. WHO went ahead to add that "Marked depression and anxiety and are frequently present and may justify specific treatment."

Somatization disorder is said to be the most valid and reliable somatoform disorder, ⁽²⁾ but it has been argued that the validity of somatization disorder is debatable. ⁽³⁾ This would suggest that somatoform disorders in general may possess more uncertainty as a group of disorders. Multiple Somatic complaints are said to be particularly common among African Psychiatric Patients. ⁽⁴⁻⁹⁾ In a recent

study, most patients who presented with multiple somatic complaints were diagnosed to be suffering from anxiety and depressive disorders, ⁽¹⁰⁾ using the ICD-10 criteria.

Culture Bound Syndromes

There are some psychopathological manifestations that are rare in certain cultures and common in others. To these manifestations have been given the appellation of Culture- Bound Syndromes, suggesting that they occur exclusively in those areas where they are seen or known. Amok, koro and brain fag syndromes are a few examples. There is a probability that these are manifestations of known psychopathological states which exist in other places, only modified by the culture of where the patients are.

This paper is not based on an empirical study. The author has also avoided the review of a large body of literature because that would not affect what I have to say on this topic. The reader is encouraged to go through the simple statements and points as they have been stated before arriving at a conclusion as to whether they amount to conjectures or not.

There are cultural influences on the expression of the symptoms of many psychiatric disorders, including the well – known disorders of schizophrenia and mood disorders. This should simply remind us that biology alone cannot account for the etiology and manifestations of psychiatric disorders. The mind functions in such a way that any new experience we have at any point in time has some degree of association with an old experience or something previously known to us. This applies also in psychopathological states. The so called abnormal, unusual and irrational speeches of patients are strongly associated with their previous experiences and knowledge. Those previous experiences and knowledge are usually the products of their culture. This is why there are usually cultural elements and dimensions to psychopathological manifestations. Viewed from this perspective, many psychiatric syndromes

would qualify as culture-bound syndromes. It would then appear inappropriate to regard a group of disorders as culture bound and regard others as universal since as said earlier there is a cultural dimension in the expression of many psychological syndromes.

One cannot but agree with Sartorius (11) that classification is a way of seeing the world at a particular point in time. There will always be a need to review any system of classification.

Diagnostic and Therapeutic Challenges

Classification is a very rigorous and rigid venture. This explains why from time to time we see disease conditions which fail to meet the criteria for any of the known diagnostic entities. The fact is that disorders do not operate to meet human expectations; and they have no objectives.

The other issue is that when we classify disorders, we do so based on what we know about them; but there are many things we do not know about the disease conditions. Thus in many cases we have little information about the diagnostic entities we deal with. For some of these cases, the information we have about their etiology is only at the level of a hypothesis. Sometimes we know little about their symptoms; the disorder may exhibit different symptoms in different individuals and may therefore be seen as different diagnostic entities in these subjects. Two different disorders may have similarities in their symptoms and may then be seen as one diagnostic entity.

In terms of therapy we know that drugs are not approved for use on the basis of a 100% efficacy; neither are they approved because they have no side effects. Quite importantly too, the prevailing situations during drug trials are often different from the prevailing situations after the drugs have been approved for use. During drug trials there are usually exclusion criteria; for instance people with comorbid clinical conditions may be excluded. Subjects outside a certain age

range may also be excluded. Again patients tend to receive special attention during trials. For instance efforts are made to see that the patients comply with medications. In simple terms subjects undergoing drug trials receive attention of physical and psychological nature that may not be available to patients after the drugs have been approved for use.

Our understanding of psychopathological states may differ and our treatment/management may also be different depending on the setting in which we deal with the disorders and all these contribute to differences in outcome – even in individuals that have the same diagnoses.

In conclusion I would like to state that we know only very little about the disorders we deal with, and the nosological status of a number of them such as Culture – Bound Syndromes and Somatoform disorders remains unsettled.

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