What is Abnormal?

In your opinion which of the following behaviors are abnormal?

1. Bathing only a few times a month.
2. Fearing constantly that the government is after you.
3. Washing thoroughly five or more times a day.
4. Screaming and crying in public situations.
5. Being very upset over the death of a relative for over 2 yrs, wearing dark clothes, and crying every time you talk about them.
6. An adult having consensual sexual relationships with teens.
7. Using visions & hallucinations to guide important decisions.
8. Using only one hand for one activity & one hand for the other.
9. Frequently urinating in the street.

The Cultural Relativism View

• Cultures differ in beliefs and attitudes about abnormal behavior, perhaps viewing it as normal part of life or as a religious or spiritual experience that should be experienced and accepted, not cured.
• Not possible to use Western classification schemes to understand culture-specific syndromes because because they are not functionally/semantically equivalent across cultures.
The Cross-Cultural View

- Three criteria:
  - Deviates from the statistical norm for a culture.
  - Maladaptive, impairs daily functions/life.
  - Distressing to the person.
Need all 3 criteria because each one alone is refutable.

Which Aspects of Mental Health Are Universal?
Arthur Kleinman (1996): Evidence for 4 global mental disorders:
- **Schizophrenia**: WHO 1970’s study identified a core of symptoms found in schizophrenics across cultures, including hallucinations, delusions of reference, inappropriate affect, social withdrawal, and unintelligible speech.
- **Major depression**: WHO’s 1983 study identified cross-culturally constant symptoms including loss of enjoyment, sleep, appetite, concentration.
- **Manic-depressive (bipolar) disorder**: Periods of depression followed by periods of euphoria, energy, restlessness
- **Certain anxiety disorders**: Ex. panic disorder, obsessive-compulsive disorder, and some phobias.

Which Aspects of Mental Health are Culture Specific?
Even for “universal” mental disorders, culture influences:
- **Prevalence of the disorder** Ex. schizophrenia occurs in higher rates in more economically advanced, industrialized, urbanized societies.
- **Way symptoms are manifested** Ex. Depressed individuals in individualistic cultures more likely to report loneliness, sadness, vs. more somatic symptoms in collectivist cultures.
- **Circumstances related to the onset of the disorder** Ex. family conflicts associated with the onset of depression in north India probably due to cultural emphasis on family responsibilities and expectations.
- **Prognosis for the illness** Ex. Recovery from schizophrenia in non-industrialized societies easier
DSM-IV and Cultural Factors in Psychological Disorders

DSM-IV finally addresses cultural factors related to the abnormal behavior through:

- Information on cultural variation in the clinical manifestations of disorders
- Guidelines for in-depth assessment of a patient’s cultural background
- An appendix listing 25 culture-bound syndromes.

Some Culture-Bound disorders

- **Amok**: Males in Philippines, Thailand, Malaysia. Period of anxious brooding & sleeplessness followed by rage & homicidal aggression, ending with exhaustion-amnesia. Attributed to loss of personal honor & spirit procession.
- **Witiko (Windigo)**: Native Indians in Canada. Feelings of possession of man-eating spirit, suicidal ideation to avoid acting on cannibalistic urges.
- **Ataques de nervios**: Latin America. Trembling, shouting, intense crying, dizziness-related to grief over family members or family conflict
- **Koro**: Southeast Asians. Fear of penis/nipples retracting

Culture-Bound disorders Cont’d

- **Zar**: Africa & Middle East. Belief in possession by spirits, engaging in involuntary movements & incomprehensible language
- **Premenstrual syndrome**: Modern societies.
- **Anorexia Nervosa**: Western countries.
- **False memory syndrome**: U.S.
- **Satanic Ritual Abuse**: U.S., complex hallucinatory experience, spirit possession, sexual relations with animals and murder of babies.
Possible Errors in Cross-Cultural Diagnosis

- Overpathologizing
- Underpathologizing
- Misdiagnosis: Ex.
  - European American male therapists more likely to rate Chinese American clients as depressed, Chinese male therapists more likely to rate White American clients as aggressive.
  - African Americans more likely to be diagnosed with schizophrenia, even if same symptoms as depression.

The Culturally Competent Clinician

- Familiar with cultural background of client
- Aware of own biases, stereotypes, prejudices
- Not quick to dismiss symptoms as culture-related
- Asks culturally sensitive/appropriate questions

Gender Differences in Diagnosis of Psychological Disorders

The DSM-IV provides information on prevalence rates for males and females for 101 of the 125 disorders it describes. Many disorders show large gender differences, with females at higher risk. Ex.:
- 2 to 2 ½ times greater incidence of depression among women.
- 95% of those suffering from eating disorders are women
Possible Explanations of Gender Differences

• **Biological Vulnerability:** Medical models assert that women more vulnerable to depression during periods of hormonal change (ex. menstruation, childbirth, menopause).
  – Too simplistic because not supported by historical trends & cultural/ethnic differences

Possible Explanations Cont’d

• **Sampling bias:** differential ability/willingness to acknowledge having a disorder/seek treatment. Why?
  – Differential societal reactions to symptoms in men vs. women: Ex. depression inconsistent with traditional masculine role.
  – An additional disorder may be present that affects the likelihood of seeking and receiving treatment (Ex. alcoholism, more often diagnosed in men, may mask depression).

Possible Explanations Cont’d

• **Gender Bias in Diagnosis:** Stereotypic beliefs can lead to different labels being attached to the same symptoms. Women and men may internalize these beliefs so that they themselves view their symptoms differently and seek treatment at differing rates.
  – Ex. Broverman, et. al. (1970) asked clinically trained professionals to give descriptions of a mature, healthy, socially competent adult “male,” “female,” or “a person.” Responses showed that descriptions of men fit the description of a “person” but descriptions of women did not, regardless of the gender of the professional. Thus the standards for a mentally healthy person were essentially the same as those for a man but not those for a woman.
Possible Explanations Cont’d

• The Negative Impact of Sexist Events: Living in a sexist society may contribute to women’s psychological distress. Ex. Klonoff & Landrine (1995) used the “The Schedule of Sexist Events” scale, which measures women’s experience with sex discrimination, and found:
  – 94% had to listen to sexist jokes at least once in their lives, 82% were sexually harassed, 77% were discriminated against by people in service jobs, 56% had been picked on, hit, shoved, or threatened with harm because they were women.
  – Never-married women, younger women, and women of color reported more incidents of sex discrimination
  – Number of discriminatory events reported related to depression, premenstrual discomfort, obsessive-compulsive, & somatic symptoms.
  – Sexist discrimination contributed more to women’s symptoms than other stressors (ex. family problems)