

Defining Mental Illness:
Collectivist versus Individualist Approaches

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Psychology 303

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March 29, 2003

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Defining mental illness is a difficult task. Often, it seems the diagnosis reflects more about the observer than the person being observed. This task of defining mental illness is exacerbated by diverse cultural and biological factors inherent in human experience. No clinician is without bias and within each person exists a unique set of perceptions, experiences, predispositions, and objectives. Each person has unique ways of coping with, or not coping with, cultural expectations and norms. Perhaps in the cases of dysfunction (such as neurosis, psychosis, schizophrenia, personality disorders, depression), the individual's symptoms are more reflections of the limitations and hypocrisies of the dominant culture than they are signs of personal deficiency.

While investigating the cultural role in the definition and treatment of mental illness, it was clear several paradigms exist to explain health issues. In our culture the two predominant paradigms rely on the biomedical and behavioral sciences (Romanucci-Ross, 1983, p. viii). Using these two viewpoints, all diseases, whether physical or psychological, can be explained by toxins, microbes, physiological abnormalities, or by inadequate living conditions. Are these approaches inadequate, though, in defining and treating abnormal behavior? Most indigenous cultures include the belief in spiritual entities that influence and cause both physical illness and abnormal behavior. While rejected by our more modern approaches, these alternate paradigms carry their own validity and cogence when viewed in their proper cultural context.

What difficulties beleaguer attempts to classify, diagnose, and treat mental illness?

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), a mental disorder is defined by an individual's level of distress, disability, and increased risk of harming themselves or others. In addition, this pattern or syndrome must not be an acceptable and sanctioned response to an environmental or circumstantial event. The behavior must be perceived as a biological, behavioral, or psychological dysfunction of the individual, in which the conflict with societal norms arises as symptomology of the dysfunction.

The DSM-IV admits, however, its limitations in defining mental disorders, both in acknowledging the mind/body dualism and in cultural contexts. The authors of the DSM-IV are aware of the difficulty in isolating the "mental" out of the "physical" realm. As stated in the text, "there is much physical in mental disorders and much mental in physical disorders" (American Psychiatric Association, 2002. P. xxxii). Truly, our modern medicine and psychiatry does not adequately address the profound duality of human experience.

The DSM-IV has also broadened its understanding of cultural and ethnic considerations. Unlike the DSM-III, this text attempts to incorporate cultural deviations in what is perceived as normal behaviors, beliefs, and experiences. This is essential information for therapists and other mental health professionals to avoid misconstruing behavior which is permissible or encouraged in certain cultural contexts. These revised guidelines allow for a more perceptive and effective approach to understanding and assisting clients.

The DSM-IV also provides new information on some culture-bound syndromes that are common in other societies, such as latah, amok, and antaque denervios. While this information allows for a more comprehensive, informed, and sensitive approach to cross-cultural conditions, difficulties remain in applying these criteria across cultural settings. Wide variations in concepts of the self, coping mechanisms, and styles of communication, when combined with cultural and ethnic influences, create a daunting challenge for health care professionals.

Several questions arose after reading through various texts and articles on transcultural psychiatry, treatment styles, and attitudes toward mental illness. It was evident that different cultures not only view and respond to mental illness in distinctive ways, but the cultures themselves are greatly responsible for the manifestation of new disorders and to what extent treatment is effective. To what degree do cultural norms create and exacerbate mental illness? Similarly, are those individuals who demonstrate abnormal behavior truly maladaptive, or are they mirroring dysfunctional aspects of their society and culture? More questions came to mind as I read indigenous accounts of mental illness. Are the mentally ill – those with schizophrenia, delusions, depression – out of touch with reality? Is it possible they have a heightened sensitivity and thus experience alternate, yet equally valid, realities?

One of my closest friends was diagnosed years ago with paranoid schizophrenia. After years of substance abuse, homelessness, unemployment, and brutal rejection by society, she found herself in a 12-step program in Northern California. One of the elder members, a woman with many years experience working with addicts and the mentally ill, took her under her wing. Not unlike a native healer working with an apprentice, the

older woman guided her through the recovery process with both the physical addiction and the mental illness. The twelve steps, ritual, prayer, and group support were utilized. While recovery was slow, my friend began to understand and connect to her thinking patterns, behavioral habits, and vulnerabilities. Through the combination of conventional and unconventional healing techniques, she began to utilize her sensitivities and find new ways to tolerate and function in this culture.

Unlike earlier bouts with institutionalization, counseling, and drug therapy, she encountered a woman and a small community that could accept and respect her experiences and would allow her 'deviant' views of reality to be heard. Through this more loving, involved, and community based relationship, she found ways in which to monitor her own responses and impulses, relate to others constructively, and to appreciate and utilize her differences. Today, she has a home, is raising young children, and is active in her community. While her views remain "eccentric" to our Western standards, her pathology was healed and her views of reality are just as legitimate as any other person's in relation to our cultural tenets and paradoxes.

The manifestation of certain mental disorders and the resultant treatments vary by culture. In the United States and most of Europe, mental illness is viewed as a "fundamental attribution error" (Al-Issa, 2000, p 318), or as a deficit in the individual's internal predispositions and attributes. Western societies are individualistic by nature, emphasizing nuclear family structure, competition, pride, and autonomy.

My friend, during her many years of homelessness, substance abuse, schizophrenic episodes, depression, and despair, was classified by society as an outcast. She was blamed for her symptoms and received inadequate attention and care for years. She, too,

believed the deficits were within herself. Only after she was brought into a therapeutic, non-threatening group setting was she able to explore her responses to a society that was greatly unsupportive and ill in its own right. Through this healing process, she was able to reevaluate her previous experiences and find a place of productivity within a smaller community.

Individualist societies, such as our own, are more prone to personality disorders, substance abuse, schizophrenia, and clinical depression than are non-western cultures. The individualist structure presents many problems for the individual and for society, placing greater responsibility on the individual for frailties that are actually symptomatic of a troubled culture. Why, in societies where freedom of expression, material wellbeing, and progressive thinking, are so many people suffering from psychopathologies?

Many factors contribute to this situation, all of which stem from an individualist structure of thought and social expectations. Extended families are not common in Western societies, having been fractured into nuclear groups. Small children are at least partly raised in daycare situations, while parents work away from the home. The elderly are greatly abandoned and have lost their generative role in family structure and the community. Consumerism, with its insatiable push for more material belongings and the attached status, is the insidious underpinning of our media. Education and programs which enhance and solidify community identity are losing governmental funding. Our culture praises self-reliance and survival in a world where the stress level is high and the recognition of interconnectedness is deplorably low. It is no surprise that individuals

with psychological vulnerabilities (arising from both genetics and environment) would be more sensitive to the demands of our culture and would respond with behaviors we classify as mental illness.

Non-western cultures, such as in the Middle East, India, China, Japan, and with Native Americans, are traditionally collectivist in structure. These societies emphasize interdependence rather than independence and are supported by extended family, the tribe, and the community at large (Al-Issa, 2000, p.318). Unlike the Western view that behavior is a reflection of personal traits and abilities, the collectivist orientation views the individual in relation to social roles, obligations, and situational restrictions. Responsibility for individual members is assumed by extended family and the community. The individual is not as frequently ostracized or left to deal with the symptoms of mental illness alone.

Unlike the individual-centered therapy of Western culture that emphasizes modern techniques, pharmaceutical medications, self-disclosure, and personal empowerment, Islamic approaches to mental illness often include the entire family. Islamic society also takes into consideration cultural roles and responsibilities and values such religious tenets as patience, humility, sacrifice, and acceptance. Therapy is not a confrontation with the family or the culture, rather it attempts to resolve the patient's problems within the context of the culture. Psychotherapeutic practices are the product of social and cultural realities, necessarily varying between Arab-Muslim countries and Western cultures.

Muslims are a people who are still transitioning from nomadic or agricultural communities to urban industrialized societies. Many Arab medical practitioners and psychiatrists are aware of how changing lifestyles have resulted in the emergence and rise

of particular types of mental illness. As individuals disconnect from traditional communities, psychoses, suicide rates, depression, anxiety disorders, and schizophrenia are more prevalent today than in earlier times.

One account from Abul-Khassib, a small traditional Muslim town in southern Iraq, illustrated that prior to “Western schooling, there used to be eccentric old fools who functioned as entertainers, poets, and religious healers, but there was not a single case of schizophrenia” (Al-Issa, 2000, p. 329). Once Western schools were introduced into traditional society, however, serious cases of schizophrenia emerged in the community. Some of these schizophrenics were closely related to the “wise fools” . It is possible that these people inherited the vulnerability for schizophrenia and that in a modernized society, where stresses were more abundant and community support and acceptance were reduced, eccentricity would develop into illness?

Recognizing and treating mental illness is difficult within cross-cultural settings. The most successful observation and diagnosis is made by an “insider” rather than by an “outsider” who would impose Western diagnostic measurements on the subjects.

One study which attempted to view the treatment of mental illness in an unobtrusive and sensitive manner was conducted in the village of Valayuthamalayampudor, in the foothills of Palau, India. Between June and August 2000, a group of Indian and Western psychologists studied the effectiveness of religious healing at the site of the Muthusamy temple. Of the thirty one people who sought help and stayed at the temple, twenty three were diagnosed with paranoid schizophrenia, six with delusional disorders, and two with bipolar disorder (Raguram, 2002). The people were brought to the temple by their families. They stayed for many weeks, free of charge. A family member remained with

them, caring for their personal needs. While many similar temples restrained the mentally ill if they seemed to pose a danger to themselves or others, the temple of Muthusamy used no restraints. The ill were encouraged to pray with the group for a brief period of time each morning and assist in the upkeep of the temple and the grounds during the day. There was no imposed or formal ritual or healing ceremony, yet, after three months, twenty two of the people had noticeably improved and three had recovered completely.

This study had substantial scientific validity, in that the psychologists involved employed objective research techniques, conducted in-depth research on the ethnographic history of the temple, and became familiar with the community's ideas about the origin of the temple and the process of healing that occurs there (Raguram, 2002). Unlike the outsider using Western criteria to measure and evaluate phenomena, these researchers attempted to acclimate themselves with the culture and acknowledge its impact on the illness and the healing experience. This research not only recognized the healing qualities of a supportive and non-threatening environment, it exemplified an improved objective approach to the cross-cultural study of psychopathology.

While some communities in other countries have maintained connection to their collectivist traditions, indigenous peoples of the Americas have suffered greatly due to their loss of earlier cultural identities and social structures. Native Americans surpass other ethnic groups in the United States and Canada in the occurrence of mental illness. Why are our native peoples so susceptible to such mental ailments as depression, anxiety disorders, and schizophrenia?

There is some understanding within the medical health field that there are “limits of psychiatric nomenclature and conceptual frameworks for revealing Native constructions of mental health and mental illness” (Manson, 2000). While psychopathologies can manifest similarly across cultural divides, they can also arise differently. Unlike Western experience, the Native American acknowledges more than just the mind/body duality; the connection to the spiritual dimension plays an enormous factor in their cultural context.

As the collectivist structure of Native American societies was destroyed along with their traditional way of life, the resultant transition to Western culture left a physical, psychological, and spiritual void in their ability to cope with the demands of survival. Individualist values are not compatible with native traditions. The loss of collective identity and well-being, along with the brutal discrimination most native peoples experienced by the dominant European culture, contributed to their profound struggles with poverty, unemployment, substance abuse, single parent households, domestic violence, and mental illness. Faced with incredible stresses and constrictions, these previously resilient and successful peoples were decimated by the Western culture.

Prior to the arrival of Europeans, Native populations had few incidences of profound mental illness or dysfunction. While mental illness was not an anomaly in the Americas, it was not as rampant and disabling as in our modern times. As in Middle Eastern, Indian, and other traditional societies, there was adequate community support and intervention, and the reality of interconnectedness minimized and buffered many psychopathologies.

Western culture continues to fail the Native population in many ways, including their mental health needs. Most Native Americans receive assistance only when in in-patient

facilities or while incarcerated. Other options are greatly unavailable due to lack of funding, program biases, and organizational barriers (Manson, 2000). Likewise, the Native American population, due to economic and cultural orientations, fail to use mental health programs for such reasons as lack of transportation, geographic distance, lack of child care, and through issues of stigma, problem recognition, and doubts about cultural competence. Faced with profound poverty, lack of education, unemployment, and severance from their cultural traditions, Native Americans suffer from the highest percentage of mental illnesses than any other ethnic group.

One psychopathology, schizophrenia, was rarely seen in traditional Native populations. Interestingly, this phenomena is perceived by Western culture as a debilitating, problematic, and serious mental illness. Indigenous groups, however, identified the beginning stages of this phenomena as an indication of enhanced spiritual connection. This raises the issue of multiple realities. Unlike our Western experience, Native Americans rarely ostracized, rejected, or pathologized the symptoms of schizophrenia. Rather, the traditional healers and shamans often welcomed these individuals as apprentices, interpreting the hallucinations and hypersensitivity as possible strengths and tools to be used for the benefit of the community.

According to Winkleman's cross-cultural study that focused on 47 societies' magico-religious practitioners (Krippner, 2002), these healers claimed to interact with non-ordinary dimensions of human existence. This interaction involved special knowledge of spiritual entities, spiritual powers of plants and animals, and how to channel this interaction into a healing or preventative conclusion.

Shamans begin training in a number of ways, depending on their community. While some shamans inherit the role, beginning training at birth, most are chosen later in life because of physical signs (birthmarks, deformities), behaviors (hallucinations, intuition, trances), or experiences that seemed to call them to shamanism. Many of the traits exhibited and employed by shamans parallel delusional and schizophrenic symptoms. Traditional Native cultures, however, do not reject the experiences of their more “eccentric” members. Due to their awareness and acceptance of spiritual elements in the human psyche, their concept of reality allows for and validates the experiences of the shaman. Unlike the Western culture, where the future shaman might end up homeless, unemployed, and filled with despair (or in earlier times, burned at the stake or institutionalized), Native peoples supported, trained, and respected individuals who perceived other realities.

As seen in our experience with European-American culture, the individualist social structure has not only placed tremendous stress and alienation on its members, it has pathologized symptoms that have certain validity and credence when viewed in other cultural contexts. While it is not difficult to distinguish between behaviors that are congruent with social tenets and those that are dangerous or contrary to cultural norms, it remains difficult to define mental illness. Even with the most pronounced cases of personality disorders, schizophrenia, and mood disorders, the pathology always reflects some element of disease that is in the culture itself.

My experiences and reading support the conclusion that each individual is in constant relationship with their culture. When the culture provides support, connection to the

community, spiritual values, and a sense of purpose in the group, mental illnesses are less pronounced and less debilitating. As in the cases of the Iraqi “eccentric old fools” and Native American shamans, what is perceived by Western standards as mental illness is viewed by indigenous cultures as vital sensitivities and strengths. The concept and classification of mental illness is essential for modern psychiatry and healing practices, yet it seems our modern culture manufactures a great deal of our psychopathology. Perhaps the study of collectivist values and traditions would benefit our troubled culture, encouraging communities to reconnect, reducing the need to be always self-reliant, and encouraging some tolerance of and support for those who experience a reality beyond our normal senses.

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