

# Culture-Bound (or Culturally Salient?): The Role of Culture in Disorder

Irene López and Avril Ho  
*Kenyon College, USA*

An established body of research has documented the role of culture in mental disorders and notes that culture not only shapes the experiences and symptomatology of disorders, but is a key factor in the organization and clustering of symptoms. As a result, disorders across cultures can be composed of an array of symptoms that do not easily or directly correspond to the disorders listed in the North American nomenclature of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). To account for such difficulties, the DSM-IV-R has a glossary titled “culture-bound syndromes” that lists 25 of the most frequently studied experiences (see Table 1). These experiences are defined as recurrent patterns of abnormal behaviors and distressing experiences that are “bound” to particular populations or regions, which may or may not be associated with specific DSM diagnoses (American Psychiatric Association, 2000).

However, the term *culture-bound*, which was first coined by Yap (1969) to give focused attention to those experiences previously described as “peculiar,” “exotic,” or “unclassifiable,” is problematic because it assumes that Western classifications of mental illnesses are universal, absolute, and culture free. Instead, culture affects the formulation and manifestation of all disorders – not just those the DSM considers culture-bound. Thus, deviant, dysfunctional, dangerous, and distressing (typical hallmarks used to define abnormality) are all conditional qualities that are

linked to prevailing social and cultural mores and practices. For example, although the negative effects of pedophilia are well documented in Western culture, in other societies anthropological literature has noted the prevalence of adult–child sexual relationships which are devoid of negative consequences and, in fact, necessary for the fulfillment of social roles (e.g., Herdt, 1999). Conversely, while dissociation and trance states are prevalent in other cultures, dissociative identity disorder is not. Culture, therefore, is not bound to any particular type of disorder but instead defines the boundaries of all disorders.

Additionally, particular disorders may no longer be bound or exclusive to specific groups or areas. For example, *koro*, originally documented in Asia (with Malay and Chinese populations, and later Indian samples) has subsequently been documented across the globe, from New Zealand to Africa, and even the Western world (Garlipp, 2008). Although the meaning associated with these behaviors is qualitatively different in different contexts, the rise of globalization and global migration has enabled the unprecedented ability to export, as well as change, symptoms. Furthermore, as cultures change and emerge, new forms of distress will not only constantly appear, but older forms of distress will either evolve or disappear altogether, (such as the condition of *imu* among the Ainu) resulting in subsequent changes in manifestation and prevalence rates. Paradoxically, although the inclusion of the culture-bound disorders was an attempt to try to include culture as an important element in the formulation of distress, its appearance at the end of the DSM marginalized the role of culture.

Given the difficulties associated with the term culture-bound, it is more apt to think of experiences as being culturally salient or relevant, rather than culturally specific or bound. Understanding the cultural salience of

distress allows for examination of how culturally relevant factors explain the occurrence, meaning, exacerbation, or alleviation of distress, while also acknowledging that such occurrences can manifest in different settings, among various populations. Understood in this fashion the culture-bound syndromes are a group of heterogeneous experiences that convey distress in ways that are most salient, meaningful, and understood by the communities in which they occur.

### Conceptualization

Discussion of the culture-bound syndromes is useful because it focuses our attention on how culture can shape distress. Although these experiences have typically been conceptualized based on the types of symptoms expressed, Tseng (2006) provided a broader conceptualization based on the function of culture. In particular, culture may shape abnormality by having a pathogenic effect (wherein culture influences the development or etiology of a disorder), a psychoselective effect (whereby culture affects the types of coping styles used to alleviate stress), a psychoplastic effect (wherein cultures affect the clinical manifestations of distress), a pathoelaborating effect (in which a culture may particularize mental conditions into a specific nature), a psychofacilitating effect (wherein a culture may increase the prevalence and incidence rate of a disorder) and/or a psychoreactive effect (in which a culture can shape the traditional responses to a clinical condition). In other words, culture affects the types of symptoms displayed and expressed, how they cluster together, how individuals label their experiences, and which symptoms become naturalized. Additionally, many so-called culture-bound syndromes occur disproportionately among the poor and least educated, indicating that they are a socialized way of expressing distress among the most disenfranchised. Two of the most studied idioms, *koro* and *ataques de nervios*, provide excellent examples of how culture and social status shape distress.

*Koro* is defined as an episode of sudden and intense anxiety that the penis, or the vulva and the nipples, will recede into the body and possibly cause death (American Psychiatric Association, 2000). *Koro* may exist in two types, epidemic and isolated, and comprises three main features: perceptual; cognitive; and emotional (Buckle, Chuah, Fones, & Wong, 2007). An afflicted individual has the perception that a protruding sexual organ is shrinking into the body and the belief that the retraction will cause death, and as a result experiences fear and panic. Episodes are usually short, ranging from half an hour to days, and because of its time frame and symptomatology this experience can map onto a host of DSM disorders, such as hypochondriasis, depersonalization, body dysmorphic disorder, and schizophrenia.

*Koro* is also typically considered a culture-bound syndrome because it is found mainly in South and East Asia, in countries such as Malaysia, China, Singapore, India, and Thailand. *Koro* is most likely to occur as an epidemic, with outbreaks that may start and end quickly, and may affect hundreds of individuals at the same time. Sufferers often have little education and are typically of lower socioeconomic status. However, *koro* has occurred in other places, indicating that it is not bound to these areas. Instead, isolated cases have been found in Western countries like the United States, Canada, and Britain, with a substantial number of these cases occurring in migrant communities (Garlipp, 2008), indicating that global migration and the stressors associated with this practice may have some psychofacilitating effect and explain some of the syndrome's current expansion.

*Koro* has been observed after a variety of sexually related experiences, including sexual arousal, masturbation, coitus, or urination. Yet, it may also emerge in response to cannabis or amphetamine use, although culturally pathogenic causes, such as exposure to cold baths or cold winds, have also been documented among Chinese individuals (Yap, 1969). The multiple etiologies of *koro* suggest

**Table 1** Culture-Bound Syndromes

<i>Name</i>	<i>Definition(s)</i>	<i>Geographical localization/ Sub-group populations</i>	<i>Prevalence rates</i>
amok	Dissociative episode – period of brooding followed by outburst of violent, aggressive, or homicidal behavior.	Asia/Asians Found in various places: groups: New Guinea, Papua New Guinea, Malaysia, Laos, Thailand, Philippines	
dhat	Severe anxiety and hypochondriacal concerns associated with the discharge of semen, whitish discoloration of the urine, and feelings of weakness and exhaustion.	India, Pakistan. Similar to jiryana (Indian), sukra prameha (Sri Lanka), and shen-k'uei (China).	Seen by some as most common CBS in India (e.g., 77% in outpatient dept) <sup>1</sup>
hwa-byung, wool-hwa-byung	“Anger syndrome” including symptoms of insomnia, fatigue, panic, fear of impending death, anorexia, aches and pains, palpitations.	Koreans	4.2–11.9% of women of Korean heritage <sup>2</sup>
koro	Episode of sudden and intense anxiety that the penis (or vulva/nipples) will recede into the body and possibly cause death. Cases may be isolated or occur in an epidemic.	Chinese, Malaysian and Indian populations in South and East Asia; occasionally in West	2% in India <sup>3</sup>
latah	Hypersensitivity to sudden shock or startle, often with echopraxia, echolalia, dissociative or trancelike behavior.	Originally believed to be only Malaysia and Indonesia, but has been found among other groups	
qi-gong psychotic reaction or qi-gong deviation	Acute, time-limited episode characterized by dissociative, paranoid, or other psychotic or non-psychotic symptoms, after participation in “qi-gong”, a Chinese health-enhancing practice.	Chinese	
shenjing shuairuo or “neurasthenia”	Involves physical and mental fatigue, dizziness, headaches, pains, concentration difficulties, sleep disturbances, and memory loss, sexual dysfunction, irritability, excitability, gastrointestinal problems.	Chinese	1.3–14% in China <sup>4</sup>
shen-k'uei	Marked anxiety or panic symptoms with accompanying somatic complaints for which no physical cause can be demonstrated. Attributed to excessive semen loss from frequent intercourse, masturbation, nocturnal emissions, etc.	Chinese	
shin-byung	Syndrome with initial anxiety and somatic symptoms (general weakness, fear, insomnia, anorexia, etc), followed by dissociation and possession by ancestral spirits.	Korean	

**Table 1** (Cont'd)

<i>Name</i>	<i>Definition(s)</i>	<i>Geographical localization/ Sub-group populations</i>	<i>Prevalence rates</i>
taijin kyofusho	Resembles Social Phobia. Intense fear that one's body, its parts or its functions, displeas, embarrass, or are offensive to others in appearance, odor, facial expressions, or movements.	Japanese	6.8% in Japan <sup>5</sup>
boufée delirante	Sudden outburst of agitated and aggressive behavior, marked confusion, psychomotor excitement. May include hallucinations or paranoid ideation.	Africa/Africans West Africa and Haiti	
brain fag	Symptoms include difficulties in concentrating, thinking, and remembering, as well as somatic symptoms such as pain, pressure, tightness of the head and neck, and the blurring of vision.	West African students	6–53.8% in Nigeria student populations <sup>6</sup>
zar	Experience of spirits possessing an individual. Dissociative episodes that include shouting, laughing, singing, weeping, etc. Not considered as illnesses in the relevant cultures.	Ethiopia, Somalia, Egypt, Sudan, Iran, and other North African and Middle Eastern societies	
ataque de nervios	Symptoms include uncontrollable shouting, acts of crying, trembling, seizure or fainting-like episodes, similar to panic attacks. Precipitated by stressful event related to family.	Latin America/Latinos Predominantly Latinos from Caribbean and Latin American	15% in Puerto Rica <sup>7</sup> ; in United States, 15% of Puerto Ricans, 9.6% of Mexicans, 9% of Cubans, 7% of Other Latinos <sup>8</sup> . 3–4% among Puerto Rican children <sup>9</sup>
bilis and colera	Symptoms include acute nervous tension, headache, trembling, screaming. Precipitated by anger or rage.	Latinos	
locura	Severe form of chronic psychosis. Symptoms include incoherence, agitation, hallucinations, unpredictability, and possible violence. Attributed to an inherited vulnerability or multiple life difficulties.	Latinos in the United States and Latin America	
mal de ojo	“Evil eye.” A “strong” stare or contact with a “strong” force, combined with envy, directed at attractive or vulnerable people may result in mal de ojo. Symptoms include fitful sleep, crying without apparent reason, diarrhea, vomiting, and fever.	Mediterranean populations	97% in Guatemala, 90% in Texas, 69% in Mexico, and 48% in Connecticut. <sup>10</sup>
nervios	Broad syndrome that ranges from cases free of mental disorder to presentations resembling Adjustment, Anxiety, Psychotic, Depressive Disorders, among others. Common symptoms include headaches, tingling sensations, easy tearfulness, and sleep difficulties.	Latinos in the United States and Latin America	15.5% in Mexico <sup>11</sup>

**Table 1** (Cont'd)

<i>Name</i>	<i>Definition(s)</i>	<i>Geographical localization/ Sub-group populations</i>	<i>Prevalence rates</i>
susto – “fright” or “soul loss”	Precipitated by frightening event, that causes the soul to leave the body. Symptoms include appetite disturbances, sleep disturbances, sadness, and lack of motivation. May include somatic symptoms like headaches, diarrhea, muscle aches, etc.	Latinos in the United States; Mexico, Central America and South America	37% in Guatemala, 58% in Mexico, 59% in South Texas <sup>12</sup>
falling-out or blacking out	Sudden collapse preceded by feelings of dizziness, eyes are usually open but person “cannot see.” Person is conscious (hearing) of what is happening but is powerless to move.	Within the United States/ European Southern United States and Caribbean groups	
ghost sickness	A preoccupation with death and the deceased. Symptoms include bad dreams, weakness, feelings of danger, fear, hallucinations, feelings of futility, a sense of suffocation.	American Indians	
rootwork	Symptoms include generalized anxiety, gastrointestinal complaints, and fear of being poisoned or killed. Set of cultural interpretations that link illness with “roots,” “spells,” and “hexes” and witchcraft/sorcery.	African American and White populations in southern United States; Caribbean	
sangue dormido or “sleeping blood”	Symptoms include pain, numbness, tremors, paralysis, convulsions, stroke, blindness, heart attack, infection, and miscarriage.	Portuguese populations in Cape Verde, and their immigrants in the United States.	
spell	Trance state in which individuals “communicate” with deceased relatives or spirits. Associated with brief durations of personality change. Not considered as illnesses in the relevant cultures but may be misinterpreted as psychotic episodes.	African American and White populations in the southern United States.	
Pibloktoq (“Arctic Hysteria”)	Abrupt dissociative episode – extreme excitement involving tearing off clothing, performing irrational acts, fleeing from protective shelters, and shouting obscenities, for up to 30 minutes, frequently followed by convulsive seizures and coma lasting up to 12 hours.	Other Arctic and subarctic Eskimo populations	

*Sources:* <sup>1</sup>Ranganathan & Bhattacharya (2007); <sup>2</sup>Lin et al. (1992); Park, et al. (2001); Min, Namkoong, & Lee (1990);

<sup>3</sup>Bhatia, Jhanjee, & Kumar (2011); <sup>4</sup>Cooper & Sartorius (1996); Zhang, Shen, & Li (1998); <sup>5</sup>Ono et al. (2001); <sup>6</sup>Ola,

Morakinyo, & Adewuyi (2009); Fatoye & Morakinyo (2003); Morakinyo & Peltzer (2002); Fatoye (2004); <sup>7</sup>Guarnaccia,

Canino, Rubio-Stipec, & Bravo (1993); <sup>8</sup>Guarnaccia et al. (2010); <sup>9</sup>López et al. (2009); <sup>10</sup>Weller & Baer (2001); <sup>11</sup>de Snyder,

Diaz-Perez, & Ojeda (2000); <sup>12</sup>Weller et al. (2002).

that sociodemographic, cultural, and medical factors involved in each individual case must be considered in its treatment. More importantly, the cultural meanings associated with supposed genitalia retraction must be examined systematically.

Similarly to *koro*, *ataques de nervios* (hereafter *ataques*), are intense episodes of emotional distress throughout the body. However, unlike with *koro*, the body is not the cause for the distress experienced in *ataques*. Instead the pathogenic causes of *ataques* are different, and they may be provoked by disruptions in familial bonds, such as a conflict or a death in the family. *Ataques* may also be expressed through a variety of symptoms, although all symptoms follow a well known pathoelaborative pattern of trembling, crying, convulsions, and screaming. The typical *ataque* sufferer is female and of lower socioeconomic status.

Like *koro*, *ataques* have often been considered a culture-bound syndrome because they have been documented most extensively among one ethnic group – notably Puerto Ricans. However, although it was once even known pejoratively as the “Puerto Rican Syndrome,” it has been noted among other Caribbean Latinos, such as Dominicans and Cubans, as well as other Latinos, such as Mexicans and Guatemalans. Yet, as with *koro*, its appearance among migrant communities has occurred in places of great transition. For example, despite similar rates of *ataques* among island and mainland Puerto Rican children, recent epidemiological data indicate that *ataques* are associated with worse outcomes among mainland children, such as more stressful life events and more exposure to violence (López et al., 2009). Additionally, as with *koro*, *ataques* may map onto a number of disorders, although they are often co-morbid with an array of anxiety disorders (López et al., 2009). In fact, in a recent study, Puerto Rican children with *ataques* were approximately three times more likely to be diagnosed with any anxiety disorder, even after controlling for several sociodemographic covariates and psychosocial stressors (López et al. 2009).

Furthermore, *ataques* have been associated with an array of somatic concerns (López et al., 2011). The emphasis on the bodily experience of *ataques* is particularly salient for Puerto Ricans because past epidemiological studies have consistently indicated that they report higher rates of somatic symptoms in comparison to Whites and other Latinos, such as Mexican Americans, even after controlling for a host of sociodemographic factors. Treatment, therefore, must consider the role of culturally embodied and interpersonal factors such as sensitivity to somatic distress, anxiety sensitivity, and the influence of social status in those afflicted, and offer interventions that address these experiences.

## Conclusion

Both *koro* and *ataques* are culturally sanctioned ways of experiencing distress that are not bound or exclusive to particular groups or areas – although they do occur at greater rates among some groups than others. When they occur at higher rates among specific groups, they are often psychoplastic and psychoelective. However, even when they occur in other locations, they still most often occur among migrant communities undergoing acculturative stress, indicating that these forms of distress are still culturally salient or relevant for these new groups of sufferers. The key, therefore, in trying to understand these experiences, is to simultaneously assess their meaning and to ascertain how their meanings are intimately related to their context but not bound, exclusive, or specific to one group or area. In sum, given that there are currently seven billion people in the world, it is unlikely that there are only 25 localized categories that do not correspond neatly to the current diagnostic system of the DSM. Instead, culture underscores all behavior, not just the “culture-bound disorders.”

**SEE ALSO:** Abnormality/Psychopathology; Indigenous Healing Systems; Indigenous Psychology

## References

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (Revised 4th ed.). Washington, DC: Author.
- Bhatia, M., Jhanjee, A., & Kumar, P. (2011). Culture bound syndromes: A cross-sectional study from India. *European Psychiatry*, *26*, 448. doi: 10.1016/S0924-9338(11)72155-1
- Buckle, C., Chuah, Y. M. L., Fones, C. S. L., & Wong, A. H. C. (2007). A conceptual history of *koro*. *Transcultural Psychiatry*, *44*, 27–43.
- Cooper, J. E., & Sartorius, N. (1996). Results: The prevalence of mental disorders. In J. E. Cooper, N. Sartorius, & G. London (Eds.), *Mental disorders in China* (pp 44–73). London, UK: Gaskell.
- de Snyder, V. N. S., Diaz-Perez, M. d. J., & Ojeda, V. D. (2000). The prevalence of *nervios* and associated symptomatology among inhabitants of Mexican rural communities. *Culture, Medicine and Psychiatry*, *24*, 453–470.
- Fatoye, F. O. (2004). Brain fog syndrome among Nigerian undergraduates: Present status and association with personality and psychosocial factors. *Ifè Psychologia*, *12*(1), 74–85. doi: 10.4314/ifep.v12i1.23509
- Fatoye, F. O., & Morakinyo, O. (2003). Study difficulty and the ‘Brain Fog’ syndrome in south western Nigeria. *Journal of Psychology in Africa*, *13*, 70–80.
- Garlipp, P. (2008). *Koro* – a culture-bound phenomenon: Intercultural psychiatric implications. *German Journal of Psychiatry*, *11*, 21–28.
- Guarnaccia, P. J., Canino, G., Rubio-Stipec, M., & Bravo, M. (1993). The prevalence of *ataques de nervios* in the Puerto Rico disaster study: The role of culture in psychiatric epidemiology. *The Journal of Nervous and Mental Disease*, *181*, 157–165. doi: 10.1097/00005053-199303000-00003
- Guarnaccia, P. J., Lewis-Fernandez, R., Martinez Pincay, I., Shrout, P., Guo, J., Torres, M., ... Alegria, M. (2010). *Ataque de nervios* as a marker of social and psychiatric vulnerability: Results for the NCLASS. *International Journal of Social Psychiatry*, *56*, 298–309. doi: 10.1177/0020764008101636
- Herd, G. (1999). *Sambia sexual culture*. Chicago, IL: University of Chicago Press.
- Lin, K. M., Lau, J. K., Yamamoto, J., Zheng, Y. P., Kim, H. S., & Cho, K. H. (1992). Hwa-byung: A community study of Korean Americans. *Journal of Nervous and Mental Disease*, *180*, 386–391.
- López, I., Ramirez, R., Guarnaccia, P., Canino, G., & Bird, H. (2011). *Ataques de nervios* and somatic complaints among island and mainland Puerto Rican children. *CNS Neuroscience & Therapeutics*, *17*, 158–166. doi: 10.1111/j.1755-5949.2010.00137.x
- López, I., Rivera, F., Ramirez, R., Guarnaccia, P., Canino, G., & Bird, H. (2009). *Ataques de nervios* and their psychiatric correlates in Puerto Rican children from two different contexts. *Journal of Nervous and Mental Diseases*, *197*, 923–929. doi: 10.1097/NMD.0b013e3181c2997d
- Min, S. K., Namkoong, K., & Lee, H. Y. (1990). An epidemiological study on *hwa-byung*. *Journal of Korean Neuropsychiatry Association*, *29*, 867–873.
- Morakinyo, O., & Peltzer, K. (2002). Brain fog symptoms in apprentices in Nigeria. *Psychopathology*, *35*, 362–366. doi: 10.1159/000068594
- Ola, B. A., Morakinyo, O., & Adewuya, A. O. (2009). Brain fog syndrome – a myth or a reality. *African Journal of Psychiatry*, *12*, 135–143.
- Ono, Y., Yoshimura, K., Yamauchi, K., Asai, M., Young, J., Fujuhara, S., & Kitamura, T. (2001). *Taijin Kyofusho* in a Japanese community population. *Transcultural Psychiatry*, *38*, 506–514. doi: 10.1177/136346150103800408
- Park, Y., Kim, H. S., Kang, H., & Kim, J. (2001). A survey of *hwa-byung* in middle-age Korean women. *Journal of Transcultural Nursing*, *12*(2), 115–122. doi: 10.1177/104365960101200205
- Ranganathan, S., & Bhattacharya, T. (2007). Culture-bound syndromes: A problematic category. *Psychological Studies*, *52*, 153–157. Retrieved from <http://www.springer.com/psychology/journal/12646>
- Tseng, W. S. (2006). From peculiar psychiatric disorders through culture-bound syndromes to culture-related specific syndromes. *Transcultural Psychiatry*, *43*, 554–576. doi: 10.1177/1363461506070781
- Weller, S. C., & Baer, R. D. (2001). Intra- and intercultural variation in the definition of five illnesses: AIDS, diabetes, the common cold, *empacho*, and *mal de ojo*. *Cross-Cultural Research*, *35*, 201–226. doi: 10.1177/106939710103500206

- Weller, S. C., Baer, R. D., de Alba Garcia, J. G., Glazer, M., Trotter, R., Pachter, L., & Klein, R. E. (2002). Regional variation in Latino descriptions of *susto*. *Culture, Medicine and Psychiatry*, 26, 449–472.
- Yap, P. M. (1969). The culture-bound reactive syndromes. In W. Caudill & T.-Y. Lin (Eds.), *Mental health research in Asia and the Pacific* (pp. 33–53). Honolulu, HI: East-West Center.
- Zhang, W., Shen, Y., & Li, S. (1998). Epidemiological investigation on mental disorders in seven areas of China. *Chinese Journal of Psychiatry*, 31, 69–71.