

Introduction to Culture-Bound Syndromes

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In the glossary of our book *The Culture-Bound Syndromes*, Charles C. Hughes, Ph.D., listed almost 200 folk illnesses that have, at one time or another, been considered culture-bound syndromes (Simons and Hughes, 1986). Many have wonderfully exotic and evocative names: *Arctic hysteria*, *amok*, *brain fag*, *windigo*. Some of the more common syndromes are described in the [Table](#). These diagnostic entities, both individually and collectively, have been the subject of a large and contentious body of literature. Are they best explained within the conceptual framework of Western psychiatry, or are they best explained anthropologically as manifestations of structural and functional elements operating in the societies in which they are found?

Table		
Common Culture-Bound Syndromes		
Syndrome	Region/Population Affected	Description
Amok	Malaysia	Dissociative episode characterized by a period of brooding followed by an outburst of violent, aggressive or homicidal behavior.
Arctic Hysteria	Alaska Natives	Abrupt dissociative episode accompanied by extreme excitement and frequently followed by convulsive seizures and coma.
Ataque de Nervios	Latin America	Symptoms include uncontrollable shouting, attacks of crying, trembling, heat in the chest rising to the head, and verbal or physical aggression.
Brain Fag	West Africa	Symptoms include difficulties in concentrating, remembering and thinking.
Koro	Malaysia	Sudden and intense anxiety that the penis will recede into the body and possibly cause death.
Mal de Ojo (Evil Eye)	Spain and Latin America	A common idiom to describe disease, misfortune and social disruption.
Windigo	Native Americans Central and N. E. Canada	Morbid state of anxiety with fears of becoming a cannibal.

Source: Data from Glossary of Culture-Bound Syndromes (2001). Available at: <http://webster.ucsd.edu/~hall/cbs_glos.html>. Accessed Oct. 1.

In the introductory comments to the glossary, Hughes pointed out that it is impossible to produce a definitive list of this group of diagnostic entities (Simons and Hughes, 1986). It is unclear exactly what sort of things should be included. How about reports of possession and trance states, which often had local names? Should descriptively similar patterns of behavior or experience from different cultures be lumped together or split apart? What can reasonably be called an illness, and what is better considered a set of customary beliefs and practices of an entirely different order? Hughes concluded that the term *culture-bound syndrome* "still has currency but little discriminable [i.e., operationally definable] content" (Simons and Hughes, 1986).

In theory, culture-bound syndromes are those folk illnesses in which alterations of behavior and experience figure prominently. In actuality, however, many are not syndromes at all. Instead, they are local ways of explaining any of a wide assortment of misfortunes.

In certain parts of the Philippines, for example, when a person becomes ill in a number of very different ways (fever, stomachache, shouting during sleep, incessant crying, various skin ailments), it may be said that the individual is suffering from *lanti*. This is a way of saying that the presumed etiology of all of these complaints is having been shocked or startled some time before. There is no discrete *lanti* syndrome with either a specific experience of altered reality or any specific altered behavior. Instead, the illness label is used as an explanation for a variety of troubles. *Saladera*, from the Peruvian Amazon, is also a way of explaining any of a host of misfortunes such as a persistent run of bad luck. In addition to suffering misfortunes of many kinds, patients with *saladera* may exhibit signs of great anxiety, but this is because they believe that they have been bewitched.

People with bipolar disorder, major depression, schizophrenia or intellectual handicap may also be considered to be suffering from a locally prevalent culture-bound syndrome. This can be the case even when the majority of people classified locally as suffering from that particular diagnostic entity do not suffer from an illness meeting any *DSM-IV* diagnosis.

However, some culture-bound syndromes are indeed syndromes. *Latah*, described from Malaysia and Indonesia, is a good example (Simons, 1996, 1983). Although everyone can be startled, in all populations some people startle more readily and strongly than others. In Malaysia and Indonesia, these people are repetitively startled by others until they become extremely flustered whenever they are startled. In the highly flustered state that follows being startled, these people may say things that are normally considered obscene or irreverent, imitate the actions of others around them ([Photograph](#)), and obey commands that are forcefully directed at them. These hyperstartling people are called *latahs*, and this condition of being *latah* is a well-defined role in Malay and Indonesian society with its own set of rules and understandings.

This same physiology has been elaborated in a variety of societies that are unrelated either historically or culturally. Among the Ainu in Japan, the syndrome is called *imu*, and in a French-Canadian population in Maine it is called *jumping*. Thus, these syndromes are similar, but not identical, from society to society. This, of course, is true of the diagnostic entities described in *DSM-IV* as well. Like hyperstartling, sleep paralysis (a feeling of paralysis when either just falling asleep or waking up, sometimes accompanied by visual or audio hallucinations) has been elaborated into a culture-bound syndrome in a number of unrelated geographic locations. It is known as *uqamairineq* among the Yupik Eskimos and as *old hag* in parts of Newfoundland, Canada.

An article in *The Atlantic Monthly* (Elliott, 2000) on apotemnophilia (compulsion to amputate one's healthy limbs) discussed two books on dissociative disorders by Ian Hacking, Ph.D. The article contained a wonderfully succinct restatement of Hacking's main thesis, applicable to a great many human conditions, including culture-bound syndromes:

Unlike objects, people are conscious of the way they are classified, and they alter their behavior and self-conceptions in response to their classification.

That is, in a cultural setting in which there is a particular folk illness, both the experience and the behaviors of the ill person will be shaped by that patient's understanding of that illness. Hacking considers multiple personality disorder (dissociative identity disorder) to be a prime example of just such a condition, and his argument is well worth considering (Elliott, 2000). His observation is especially apt with regard to the culture-bound syndromes.

Since many of the culture-bound syndromes are not really syndromes, another term is needed to signify what we are talking about. Furthermore, not only are many of these conditions not syndromes, but some are not

bound to a single culture. Alert readers will have noted the awkward phrase "diagnostic entities," which has been used in this article for lack of a better alternative.

There have been many suggestions of more descriptive terms, some of which include *atypical psychoses* (Manschreck and Petri, 1978), but these entities are not usually psychoses; *syndromes not seen in Western culture* (Favazza, 1985), but this is a definition by exclusion and ignores conditions such as jumping and old hag that do occur in the West; *culture-related specific syndromes* (Tseng, 2001), but what syndromes aren't culturally related and specific?

To date, no one has come up with a really good name for this group of conditions. Thus the name culture-bound syndrome persists simply for lack of a better term.

Because the culture-bound syndromes are so varied, there can be no single type of diagnostic or therapeutic approach. For some patients, even the idea of therapy seems ill-considered. In some cases, their behaviors are eccentricities that do not need treatment, and, for some people, a therapeutic approach that has nothing to do with any medical system may be most helpful and least disruptive.

When dealing with a patient from another culture who presents with an assortment of symptoms that seem unfamiliar, it is always useful to find out what they and other concerned individuals believe is going on. What prior efforts for help or cure have been tried? What were the results? What have culture-relevant authorities advised and concluded? Since there is no one-to-one correspondence between culture-bound syndromes and *DSM* diagnoses, what is the *DSM* diagnosis, if any, for this particular patient? Particularly with regard to issues of compliance, a therapeutic approach that includes both culture-specific and Western biomedical ways of understanding the world is likely to be most successful.

However, study of the culture-bound syndromes can teach an important lesson. In considering the situation of a suffering human being, especially if the goal is to ameliorate that suffering, it is necessary to consider not only the physiology, but also culturally significant beliefs and practices and the patient's social situation in puzzling out whether to intervene and, if so, how. In my experience, sometimes the best therapy is a shamanistic healing ceremony, sometimes it is an antidepressant or antipsychotic, and sometimes it is an antibiotic. Since people presenting with an indigenous diagnosis of a culture-bound syndrome may in fact be suffering from tuberculosis, schizophrenia, intrafamilial oppression and so on, the best therapy is that which deals with the problematic factor in the specific case. Often, just as in Western psychiatry, a combination of several approaches makes the most sense.

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