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Are culture-bound syndromes as real as universally-occurring disorders?

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A R T I C L E I N F O

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A B S T R A C T

This paper asks what it means to say that a disorder is a "real" disorder and then considers whether culture-bound syndromes are real disorders. Following J.L. Austin I note that when we ask whether some supposed culture-bound syndrome is a real disorder we should start by specifying what possible alternatives we have in mind. We might be asking whether the reported behaviours genuinely occur, that is, whether the culture-bound syndrome is a genuine phenomenon as opposed to a myth. We might be wondering whether the condition should rightly be considered a disorder, as opposed to some sort of non-disorder condition (for example, a non-disorder form of deviance, or a potentially valuable condition). We might want to know whether the culture-bound syndrome is really a distinct disorder, in the sense that scientific classification systems should include it as a separate category, or whether it is just a variant of a universally occurring disorder. I argue that some specific difficulties can arise with determining whether a culture-bound syndrome is a real disorder in each of these three senses. However, the frequent assumption that real disorders will necessarily occur universally, and that those that occur only in certain environments are suspicious is not generally justified.

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1. Preface

While some disorders have afflicted people throughout history and in all cultures, others only seem to occur in highly specific social contexts. It is tempting to think that disorders that occur universally are somehow more "real" than those which only occur in particular cultures. Though this claim is seldom explicitly formulated it lurks behind certain popular forms of reasoning. Consider the debates that occur when the reality of some contested condition is under discussion. Those who claim that the condition is a genuine disorder often seek to support their claim by showing that the condition can be seen to have occurred throughout history or in all places. For example, in his paper 'Samuel Pepys and post-traumatic stress disorder' (Daly, 1983), published in the *British Journal of Psychiatry*, R.J. Daly defends the validity of Post-Traumatic Stress Disorder (PTSD) by arguing that Pepys' diary entry shows that his contemporaries suffered from PTSD after witnessing the Great Fire of London. Similarly, the proponents of Multiple Personality Disorder (MPD) have dredged through history looking for cases of multiples (Goff & Simms, 1993).

The reverse reasoning also occurs and those who are convinced that some disorder is real frequently assume that this implies that it will be found amongst all human populations. Thus, therapists who are convinced of the reality of PTSD have rushed to offer therapy when disasters afflict non-Western cultures, based on the assumption that in so far as PTSD is a genuine disorder it will be found everywhere (Watters, 2010). When presented with populations that have faced disaster and yet do not manifest anticipated symptoms, these therapists have concluded that cultural norms have inhibited the expression of distress that *must* really be there.

In this paper I seek to unpack and assess the notion that real disorders must occur universally and that those that occur only at certain times and in certain places should be viewed with suspicion. I start by considering what it might mean for something to be a "real disorder". I then go on to consider whether it is true that culture-bound syndromes are less real than universally occurring disorders. The possible links between reality and universality that I will unpack and assess have generally been left tacit, but are nonetheless possible to discern and analyse. I hope to make a convincing case that the tacit beliefs that I uncover have played a key

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role in reasoning relating to disorders, and that subjecting them to philosophical analysis is useful, as making such tacit beliefs explicit enables us to clarify them, assess them and, where appropriate, reject them.

2. What counts as a "real disorder"?

Debates as to whether some particular condition is a "real disorder" are commonplace among both health care professionals and lay people. Even when talk of "real disorders" is avoided, cognate concepts such as "valid disorders" or "genuine disorders" may be invoked instead. However, despite the centrality of the notion, philosophers generally shy away from speaking of the "real".

J.L. Austin's *Sense and Sensibilia* (1962) constitutes an exception and provides the classic source for thinking about what it means to describe something as "real". Austin reminds us that asking whether something is real only makes sense when we have some specific alternative in mind. As he puts it:

> ... a definite sense attaches to the assertion that something is real, a real such-and-such, only in the light of a specific way in which it might be, or might have been, not real ... (p. 70)

Thus we can ask "Is this real cream?", where the alternative is that it is made from vegetable fat rather than milk. "Is this a real Monet?", meaning "Did Monet actually paint this picture?" Or, "Is that a real ghost?", where the alternatives would be that it's someone wearing a sheet, or I've mistaken a shadow, or something of that sort.

Following Austin's lead, we can flesh out the question "Are culture-bound syndromes real disorders?" by specifying what alternatives we might have in mind. There are a number of possibilities:

- Do the behaviours that are said to characterise a culture-bound syndrome really occur? That is, is the culture-bound syndrome a genuine phenomenon as opposed to a myth?
- Is the culture-bound syndrome really a disorder as opposed to a non-disorder state (for example, a non-disorder form of deviance, or a potentially valuable condition)?
- Is the culture-bound syndrome really a distinct disorder, in the sense that scientific classification systems should include it as a separate category, or is it just a variant of a universally occurring disorder?

The remainder of the paper considers each possibility in turn.

3. Genuine phenomenon or myth?

The most straightforward way in which a culture-bound syndrome may fail to be a real disorder is if the behaviours that are said to characterise it do not actually occur. By definition, culture-bound syndromes are only found in certain cultures. This means that those who would observe cases must travel far and wide, and will frequently have to depend on interpreters. Even then, observing cases first-hand may prove to be impossible and as a consequence those who describe culture-bound syndromes may resort to relying on reports that are second or even third hand. To make things still worse, many culture-bound syndromes are distinctly "exotic" in character. Stories of penis-shrinking anxieties, of sudden homicidal rages, and of cannibalism can be expected to be told and retold, and embellished with each retelling. In such a context, distinguishing reliable reports from travellers' tales becomes difficult.

"Windigo psychosis" may be an example whereby tales and fact have become confused. Windigo psychosis has been included in many lists of culture-bound syndromes and is said to be a psychotic state characterised by an obsessional craving for human flesh that occurs among the Northern Algonkian peoples. However, in his 1982 paper, Lou Marano analyses the case reports that are found in the literature and finds that none provide first-hand accounts of psychotic cannibalism. Though the Northern Algonkian peoples tell stories of Windigo as part of their folklore, and have frequently faced starvation and thus fear cannibalism, there is little evidence of psychotic cannibalism—as opposed to famine-induced cannibalism—occurring. Marano concludes that 'the windigo phenomenon is more of an example of mass suggestibility amongst anthropologists than among Northern Algonkians' (Marano, 1982, p. 388).

The fact that culturally specific phenomena are generally harder to observe than universally occurring phenomena gives us the first reason why we might doubt the reality of some culture-bound syndromes. The simplest way in which a putative culture-bound syndrome may fail to be a real disorder is if the behaviours that are said to characterise it don't actually occur. This sort of case is included here for completeness, but is discussed only briefly because there is little of philosophical interest to say about such cases. Such "fake" disorders can be guarded against by common-sense means—here, the diligent checking of sources provides the remedy.

4. A disorder or a non-disorder state?

Let us suppose that the behaviours that are said to characterise a culture-bound syndrome genuinely occur. Still the condition may fail to be a real *disorder*. Real disorders can be confused with various lookalikes. At the boundaries of disorder lie the following types of non-disorder states: (1) behaviours that may be undesirable but that are under voluntary control—arguably, excessive drinking, shoplifting and rioting provide examples—these are forms of non-disorder deviance; (2) unpleasant but normal biological and psychological states, such as menstruation and justified sadness; (3) conditions that are unusual but valuable, such as being an especially fast runner, or not having body odour—these are not disorders but are simply manifestations of human diversity.

Difficulties with determining whether a condition is a disorder or another type of condition can arise with both universally occurring disorders and culture-bound syndromes. As an example of a controversial and yet universally occurring condition, consider alcoholism. Alcoholism occurs amongst all cultures with access to alcohol, but whether it should be considered a disorder or a vice is still debatable. However, although difficulties in determining whether a universally occurring condition should be considered a disorder can occur, specific doubts can arise in the case of culture-bound disorders. First, one may have special reason to suspect that, in the case of a putative culture-bound disorder, interested parties have mislabelled a non-disorder state. Second, determining whether a condition is a disorder or non-disorder state can be particularly difficult cross-culturally. I discuss each worry in turn in the subsections that follow.

4.1. Mislabelling cases

In certain circumstances, incentives arise for a non-disorder condition to be mislabelled as a disorder, and where a putative disorder is recognised only in certain cultures we may have reason to be particularly suspicious that this has occurred. Incentives arise for non-disorder states to be labelled disorders because people with disorders are treated differently from the healthy. Suffering from a disorder can entitle a person to various benefits, function as an excuse, and also make it the case that a person is seen as an appropriate focus of medical attention. Thus, both the "suffering" individuals themselves and those who gain from treating

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