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CHAPTER 3

# Culture and Mental Illness: Social Context and Explanatory Models

**Laurence J. Kirmayer**
*Professor & Director, Division of Social & Transcultural Psychiatry, McGill University, Culture & Mental Health Research Unit, Sir Mortimer B Davis–Jewish General Hospital, Montreal, Quebec, Canada*
**Dinesh Bhugra**
*Professor of Social & Cultural Psychiatry, Institute of Psychiatry, London, UK; President, Royal College of Psychiatrists, UK*

## 3.1 INTRODUCTION

There is wide recognition that cultural models influence how individuals interpret the signs and symptoms of illness, including psychiatric disorders. The processes of interpreting and ascribing meaning to one's bodily sensations, thoughts, feelings and behaviour are mediated by cognitive models and social interactions with others, which in turn reflect cultural knowledge and practices. Social scientists have distinguished between the biomedical concept of *disease*, the patient's subjective experience of *illness*, and the social meanings of *sickness*, each of which may be based on different explanatory models [1, 2]. However, pathophysiology, individual psychology and social responses interact. The cultural mediation of illness meaning, therefore, not only shapes the social manifestations of distress through symptom reports and help-seeking, but also influences the underlying psychophysiological processes that contribute to psychopathology and illness experience. In this chapter, we provide some examples of how social context and explanatory models influence common psychiatric conditions, including somatization, dissociation, mood, and anxiety disorders, as well as psychotic experience. Our aim is to demonstrate the important role played by explanations in the mechanisms of psychopathology as well as in clinical illness behaviour. Explanatory models are therefore an important target of research, clinical assessment, and intervention.

*Psychiatric Diagnosis: Challenges and Prospects* Edited by I.M. Salloum and J.E. Mezzich

## 3.2 UNDERSTANDING AND ELICITING EXPLANATORY MODELS

The notion of explanatory models was introduced by Kleinman and colleagues [3], building on work on schemas in cognitive psychology and medical anthropological studies of illness experience. Kleinman's view of explanatory models emphasized the parallels with clinicians' biomedical models of disease, which typically include specific names or labels located within a diagnostic system notions of causation, theories of underlying mechanisms, expectations for outcome or prognosis, and recommended or appropriate treatment. Kleinman and colleagues [3] devised a simple set of questions to elicit patients' explanatory models (Table 3.1). In an effort to draw clinical attention to what was at stake for patients, they included the question: 'What do you fear most about the illness?'. The explanatory model approach has stimulated a substantial body of research in medical anthropology and, along with a parallel body of work in health psychology on symptom and illness schemas and attributions, has influenced clinical training and practice.

Various other interviews and self-report questionnaires have been devised to elicit explanatory models and symptom or illness schemas. Eisenbruch [4] developed the Mental Distress Explanatory Model Questionnaire (MDEMQ), which asks respondents to rate the potential causes of mental illness on a list of 45 causes drawn from the earlier classification of theories of illness causation by Murdock and colleagues [5]. Subsequent work has also confirmed Murdock's broad distinction between natural and supernatural causes as two clusters that are differentially associated with mental disorder, with both common and severe mental disorders often attributed to spiritual or supernatural agents or influences [6]. A simple checklist can elicit some aspects of patients' explanatory models for common mental disorders, including causal attributions to social or spiritual causes that correlate with treatment preferences [7].

Following closely on Kleinman's work, Weiss developed the Explanatory Model Interview Catalogue (EMIC), a research method for systematically eliciting EMs and quantitatively scoring for specific content [8, 9]. Sections of the EMIC are adapted for specific research contexts and questions to address: (i) patterns of distress; (ii) perceived causes; (iii) help-seeking behaviour and treatment; (iv) general illness beliefs; and (v) disease-specific queries. The EMIC has proved useful for research (e.g. [10–12]) but is too long and cumbersome for use in large-scale surveys or clinical practice [13]. The Short Explanatory Model Interview (SEMI) [14]), developed for use in epidemiological studies, includes five sections, with open-ended questions assessing: (i) the patient's personal sociocultural background; (ii) the nature of the presenting problem (reason for consultation,

**Table 3.1** Explanatory model interview (Kleinman *et al.* 1978).

| |
|---|
| (1) What do you call your problem? |
| (2) What causes your problem? |
| (3) Why do you think it started when it did? |
| (4) How does it work? |
| (5) What is going on in your body? |
| (6) What kind of treatment do you think would be best for this problem? |
| (7) How has this problem affected your life? |
| (8) What frightens or concerns you most about this problem or treatment? |

Adapted from [3].

causes, consequences, severity); (iii) help-seeking behaviour; (iv) interaction with the clinician; and (v) attitudes toward mental health and illness, elicited by brief vignettes. The SEMI has been used to study explanatory models among patients and community health workers in a variety of settings [15].

There has been much interest, in the field of health psychology, on the role of explanatory models in illness experience, symptom regulation, and coping with chronic illness [16]. The Illness Perception Questionnaire (IPQ) [17], based on Leventhal's self-regulation model of illness cognition [18], assesses five dimensions of illness models: identity (symptoms, nature of condition), causal component (cause/causes), time-line component (perception of the duration of problem), consequences component (severity and impact on functioning), and cure component (extent to which problem is amenable to cure). The IPQ has been applied mainly to the study of physical illness but recent studies have applied it to psychiatric disorders [19], including depression [20] and schizophrenia [21, 22]. A revised version, the IPQ-R, improves the psychometric properties of the subscales and demonstrated that the cognitive and emotional aspects of illness representations can be distinguished [23]. There is also a brief, nine-item version that taps the basic attitudinal dimensions and elicits causal attributions but does not explore specific content or meaning [24]. To date, there has been little cross-cultural application of these measures.

## 3.3 CULTURE, CONTEXT AND EXPLANATION

Despite its utility, the notion of explanatory models is based on a problematic theory of knowledge and action. Young characterized the emphasis on explanatory models as the 'rational man' approach to subjectivity, with its assumption that patients have explicit 'logical' models to account for their illness [25]. Drawing from his ethnographic research on illness explanations, Young argued that many people do not have coherent models of the type sought for with the EM questions, but rather have a complex array of fragmentary explanations borrowing from multiple sources, including salient individual or cultural prototypes, and sequences of events or actions that are habitual or sedimented in institutional practices and procedures. These different knowledge structures are used to construct illness narratives using both logical arguments and the cognitive devices of metaphor and metonym (Table 3.2) [26].

**Table 3.2** Types of knowledge structure underlying illness narratives.

| | Chain complexes | Prototypes | Explanatory models |
|---|---|---|---|
| Structure | metonymical | analogical | schematic |
| Production system | contiguity | images and metaphors | propositional logic |
| Representation | events | prototypes | causal sequences, mechanisms |
| Mode of elicitation | 'What happened around the time you developed your symptoms?' | 'Have you ever had anything like this before?' 'Do you know anyone/Have you heard of anyone who had something similar?' | 'What caused your symptoms?' |

Adapted from [67].

In fact, many patients do not have well worked out explanations for their illness, particularly when it is acute. Over time, individuals develop coherent illness narratives, but these are not all based on explanatory models. Some knowledge of illness is procedural, involving learned dispositions to respond, automatically expressed skills, and habits that the individual may not be able to articulate or describe. These underlying models can be discerned by observing the individual's behaviour and social interactions, and by analyzing the structure of their illness narratives. In addition, much illness behaviour is governed by interactional processes with implicit rules that are distributed among participants so that the individual's behaviour can be understood not in terms of their own cognitive models but as an outcome of interactions with others.

The McGill Illness Narrative Interview (MINI), based on Young's earlier work, is an open-ended, semi-structured interview designed to elicit chain complexes, prototypes and explanatory models [27]. The models elicited are not simply individual representations but are embedded in an illness narrative that is *situated*, responding to the nature of the interlocutor and unfolding over the course of the interview.

Research with the MINI and with other ethnographic methods confirms that many individuals have multiple models that they use to answer different questions [28, 29, 30]. Different models may be accessed or elicited in different social contexts or particular moments in a clinical interview, depending on the patient's perception of the physician's expectations. This diversity of models extends to the patients' family and entourage, whose members may have different models; in some instances, the model of a relative or significant other may be more important than that of the patient for determining illness behaviour and outcome, especially in cultural settings where identity is sociocentric or kinship based [31].

Illness models may be tentative at first, and become stabilized and consolidated over time. Models can be contested by others and re-entrenched in response to challenges. Patients, also, may hold several inconsistent or contradictory models, without being troubled by the contradiction. The availability of multiple explanations creates additional possibilities for meaning and contributes to what Good has called a 'subjunctive' stance [32], in which the meaning and implications of symptoms and illness are deliberately kept open to allow for positive outcomes. The need for consistency varies across cultures [33] and is particularly important in some overarching systems, like biomedicine or religious doctrines, which insist that individuals work to reconcile contradictions and reject incompatible explanations. Faced with the ambiguity of many clinical conditions, demands for diagnostic certainty, closure and consistency — on the part of either clinician or patient — may increase the possibility of conflict in the clinical encounter [34].

In sum, explanatory models are not fixed, static products of cognitive schemas or representations, but fluid, dynamic and changeable strategies for making sense of affliction. At any given moment, the explanatory models offered by (or elicited from) patients will reflect their efforts to understand their predicament, deal with their own fears and concerns, communicate their needs to the clinician, and position themselves in the clinical relationship and in larger institutional and social contexts in which every explanation has specific consequences. The observation that illness narratives, and the explanatory models they contain, depend on social context means that the information provided by brief questionnaires or structured interviews must be understood in terms of this more dynamic, interactional view of illness meaning and experience.



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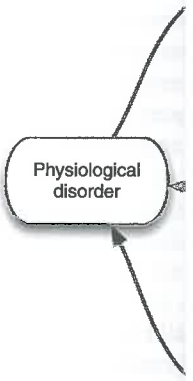


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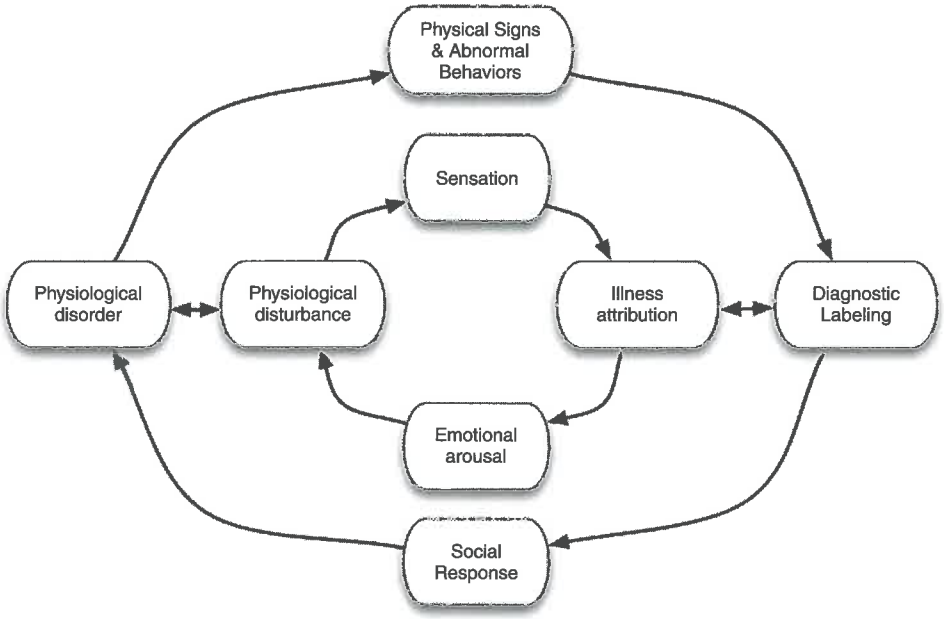
## 3.4 HOW REASONS BECOME CAUSES: EXPLANATIONS AND LOOPING EFFECTS

The ways that people interpret and respond to sensations, symptoms and behaviours can feed back into the physiological and psychological processes that give rise to sensations, symptoms and behaviours in the first place [35]. This sets the stage for cycles of symptom amplification that may intensify and maintain symptoms so that they reach thresholds of severity and chronicity. These amplifying loops can extend into the social world so that symptoms and behaviours lead to specific social responses, which in turn influence the symptoms and behaviours (Figure 3.1). A particular set of 'looping effects' acts to stabilize our categories of experience so that psychiatric diagnostic categories, which are tentative constructs, become socially reified and enacted by patients [36, 37]. In this way, psychiatric theory becomes self-confirming. In this section, we present some brief examples of how culturally mediated explanations and social contextual factors shape the causes, course and outcome of psychiatric disorders.




The inner loop represents the cognitive-emotional amplification of distress. The outer loop represents the social amplification of deviant behaviour. Other loops may cross these levels with circuits linking cognitive-emotional processes to social interaction. Culture influences every step in these cycles, but has particularly well studied effects at the levels of illness attributions (based on cultural models) and diagnostic labeling (based on systems of healing).

**Figure 3.1** How reasons become causes: a typology of looping effects.

### 3.4.1 Somatoform Disorders

Research on illness behaviour has demonstrated how cognitive schemas, emotional states and social responses to bodily experience shape the experience and expression of distress. Ordinary physical sensations may be viewed as symptoms of illness and prompt worry and help-seeking. Symptoms of an illness may be misinterpreted as ordinary sensations, and minimized or ignored, leading to delayed help-seeking or rejection of treatment. Even when sensations are recognized as unusual they may be interpreted in markedly different ways.

Many patients in primary care present with medically unexplained symptoms [29]. While most patients acknowledge psychosocial factors as contributors to their distress, some adamantly deny any causal connection [10]. In current nosology, these patterns of illness behaviour are classified as somatoform disorders, implying a specific form of psychopathology. Many common somatic symptoms reflect cultural idioms of distress used to express a wide range of personal concerns [38]. People in many parts of the world employ *sociosomatic* theories that link adverse life circumstances to physical and emotional illness. The pattern of symptom attribution or mode of explanation influences clinical presentations [39, 40]. However, patients' disclosure of the emotional and social dimensions of their predicament depends on their views of what is appropriate to express to others within the family, in the community or in health care settings. Social and emotional dimensions of distress may be suppressed or hidden because of the potential for social stigmatization, while somatic symptoms and illness may be more acceptable to express [28, 41]. The category of somatoform disorders — which implies psychological causation that is evident to the clinician but denied by the patient — thus, reflects both the persistent mind-body dualism of biomedicine, patients' patterns of symptom attribution, and the clinician's difficulty in accessing the social meanings of the patient's suffering [34, 42, 43]. A contextual view would argue for dissolving the somatoform disorders as a discrete category in favour of attention to the ways in which social context, cognitive and emotional processes shape the individual's response to bodily distress. In place of discrete disorders, we might have a typology of psychological, interpersonal and social looping effects that contribute to amplifying somatic distress [35].

### 3.4.2 Dissociative Disorders

Dissociative disorders have also been viewed as a distinct form of psychopathology reflecting a lack of normal integration of experience. However, around the world, dissociative experiences are extremely common and usually do not indicate pathology [44]. Trance and possession commonly occur as part of religious and healing cults and practices, where such behaviour is prescribed and follows cultural scripts [45]. In such contexts, dissociation may communicate a message about one's distress, lack of control and lack of culpability by showing that the person is somehow controlled by or speaking for an 'other' [46]. In many cultures, this other is a god, spirit, or ancestor; in Western societies, the 'other' tends to be understood as a fragment of one's own personal history or imagination. Dissociation may be evidence of psychopathology when it falls outside the range of locally accepted behaviour, but this judgment requires careful consideration of multiple social contexts, including the setting where the behaviour first emerged, the demand characteristics of the clinical situation, and the larger cultural meanings given to dissociative behaviours.



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Dissociation involves interpreting or attributing behaviours that are normally self-directed to agencies external to the self. The monological self assumed by Western folk psychology does not provide a place for the multiplicity of identity and multiple centres of agency that characterize human behaviour [47]. As a result, dissociation tends to be viewed as a maladaptive psychological coping mechanism or defence, rather than as socially scripted behaviour for managing fractures of identity, contradictions and social entrapment. A contextual view would put as much emphasis on the contexts in which dissociation occurs as on any psychological mechanism [48]. The observation that rates of dissociation are changing in response to increased industrialization and urbanization reflects this sensitivity to social context and needs to be explored further in cross-cultural studies.

### 3.4.3 Depressive and Anxiety Disorders

While major depression and anxiety disorders can be identified around the world, their symptoms, clinical presentation, and expected treatment vary substantially [39, 49, 50]. The development of individuals' self-representations and self-esteem are shaped by cultural norms and values and this may contribute to their vulnerability or resistance to depression [51]. Notions of guilt and shame also vary across religions and cultures, altering the cognitive schemas and specific symptoms associated with depressed mood [49, 52]. In many cultures, the psychological symptoms of depression are not recognized as a health problem but explained in sociomoral or spiritual terms [53].

Differences in the interpretation and causal explanation of events can also contribute to the processes that exacerbate depression and anxiety. The cognitive theories of depression and anxiety emphasize the role of specific attributions of behaviour and experience in creating vicious circles. A general self-enhancing attributional bias may help individuals maintain self-esteem [54]. However, the meaning of these attributions depends on cultural concepts of the person. For example, in individualistic cultures, attributing failures to one's self and success to others can precipitate or exacerbate depression, while in more sociocentric cultures such self-blame may be evidence of one's social responsibility [51].

Our understanding of the nature of depression and anxiety, and their effective treatment, is strongly influenced by the economic context of psychiatric practice [55]. Recent work has shown how the DSM criteria for depression have served to pathologize responses that can be understood as ordinary grief, sadness or demoralization [56, 57].

In some instances, a specific cultural model may be central to the development of a disorder. A growing body of work shows how the vicious circles of excessive self-awareness and expectations of catastrophe that drive panic disorder and other anxiety disorders (including the forms of health anxiety labelled 'hypochondriasis') may be mediated by culture-specific understandings of physical sensations that occur either as normal events or as a consequence of physiological dysregulation [58]. Clinical interventions targeting these specific attributions in ways that are culturally consonant can be effective [59].

### 3.4.4 Psychotic Disorders

Both the causes and the course of psychotic illness are influenced by social and cultural context. Psychotic experiences are deeply perplexing and prompt a search for meaning that

often results in invoking spiritual or other extra-ordinary explanations [60, 61]. The explanations that patients consider may be tentative and shift over time [62]. Explanations also vary across cultural groups [63]. Explanations that centre on brain dysfunction, while consonant with biomedical theory, may result in loss of self-esteem and social stigmatization that contribute to chronicity [64]. Religious and other cultural systems of meaning may allow the person to imbue psychotic experience with positive meaning, maintain social integration and, hence, contribute to better outcome. Although impaired insight is often viewed as intrinsic to psychotic disorders, it can also be understood in interpersonal or interactional terms as the failure of the patient to agree with the clinician's account [65]. The success or failure of the negotiation of meaning depends on the quality of the clinician-patient relationship — which may, of course, be influenced by a host of social and psychological factors, including the nature of the patient's psychopathology, but also the larger social contexts from which illness receives meaning.

## 3.5 CONCLUSION: CULTURE, CONTEXT AND MEANING IN PSYCHIATRIC NOSOLOGY

The recognition that both patients and clinicians have explanatory models is an important preliminary to successful clinical assessment, treatment negotiation and intervention. However, there remains a tendency to view patients' models as simply misguided or ill informed, so that the clinician's task is to replace these inaccurate models with the medically correct label and explanation. From this point of view, patients' explanatory models are important mainly as potential barriers to clinical communication and adherence to treatment. This view ignores the crucial function of explanations as ways of interpreting the social and moral meaning of affliction. It also ignores the cognitive and social effects of explanations, which not only govern illness behaviour but which can contribute directly to psychopathology, constituting social or psychological problems in their own right, and also provide strategies for coping, adaptation and recovery. Explanatory models, then, are not merely *post hoc* attempts to explain or rationalize illness experience but are themselves constitutive of psychiatric disorders and of the psychological and social response to psychopathology. Research on explanatory models suggests that cultural meanings may participate directly in psychological or social loops or vicious circles that lead to specific forms of psychopathology. Psychiatric nosology can incorporate this insight by developing a typology of looping effects relevant to specific types of disorder [35]. These looping effects may contribute to many types of disorders and so might be placed on a separate diagnostic axis reflecting the clinical assessment of illness cognition and behaviour.

The cultural formulation in DSM-V provides an outline of some of the basic information needed to understand diagnosis in social and cultural context [66]. The cultural formulation canvases four broad domains: (i) identity; (ii) illness meanings; (iii) social functioning, stresses and supports; and (iv) the relationship with the clinician. Of course, the domains of cultural influence and experience tapped by the cultural formulation are not independent. Anthropological studies make it clear that explanatory models interact with identity, family and social functioning, and the clinician-patient relationship. Illness explanations may reflect the individual's cognitive representations but they may also be distributed among family members and others in their lifeworld or larger social contexts. In addition to explicit explanatory models, illness meanings may be based on situated experiences and personal or



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Explanations, then, are not simply cognitive schemas or representations that can be accessed with a few direct questions, but acts of positioning, strategies for meaning-making, and ways of creating possibilities for recovery. Clinical assessment and treatment, therefore, must track the evolving meanings of distress throughout the clinical encounter, from diagnostic assessment to treatment negotiation and follow-up over the course of the illness. In this way, cultural models and explanations can become guides to diagnosis, a basis for empathic understanding, and resources for effective intervention.

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## 4.1 INTRODU

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## 4.2 THE RISE

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