Transcultural Psychiatry
http://tps.sagepub.com

From Peculiar Psychiatric Disorders through Culture-bound Syndromes to Culture-related Specific Syndromes

Wen-Shing Tseng

TRANSCULT PSYCHIATRY 2006; 43; 554
DOI: 10.1177/1363461506070781

The online version of this article can be found at:
http://tps.sagepub.com/cgi/content/abstract/43/4/554

Published by:
SAGE Publications
http://www.sagepublications.com

transcultural psychiatry

December 2006

ARTICLE

From Peculiar Psychiatric Disorders through Culture-bound Syndromes to Culture-related Specific Syndromes

WEN-SHING TSENG
University of Hawaii School of Medicine

Abstract This article reviews the historical evolution and progress of nosological concepts from exotic psychiatric disorders and culture-bound syndromes to culture-related specific syndromes. Approaches to classification and subgrouping these disorders are disccused and an argument offered for finding a place for culturally unique syndromes in the existing classification system. The characteristics of various syndromes are elaborated and suggestions are made for future research. Finally, emphasis is given to the need to be concerned with the impact of culture on every psychiatric disorder, not only culture-specific syndromes, to promote culturally competent care for every patient.

Key words culture-bound syndromes • diagnostic classification • history of psychiatry • nosology

Culture-bound syndromes are mental conditions or psychiatric syndromes whose occurrence or manifestation are closely related to cultural factors and which thus warrant understanding and management from a cultural perspective. Approaches to culture-related specific syndromes have gone though several stages, reflecting the history of cultural psychiatry. The phenomena were initially called 'peculiar

Vol 43(4): 554–576 DOI: 10.1177/1363461506070781 www.sagepublications.com

psychiatric disorders' (Yap, 1951), and later 'culture-bound syndromes' (Yap, 1967). Suggestions have been made to rename them 'culture-related specific psychiatric conditions' (Tseng & McDermott, 1981) and, recently, 'culture-related specific syndromes' (Tseng, 2001), to indicate more accurately the meaning of the issues addressed. This article will examine how this terminology has evolved, and how cultural psychiatry has gone through various stages of development in association with the study of culture-related specific syndromes.

Peculiar, Atypical, or Exotic Psychiatric Disorders: 1890 to 1970

Around the turn of the 20th century, during a period of colonization by western societies, western missionaries, physicians, and others visited faraway countries, where they encountered behaviors and unique psychiatric conditions that they had never experienced in their homelands, and labeled them 'peculiar' phenomena. Most of these conditions were known to the local people by folk names, such as *latah*, *amok*, and *koro*. According to available literature, W. Gilmore Ellis (1893, 1897), the British medical superintendent of the Government Asylum in Singapore, reported the phenomenon of *amok* observed among the Malays, and several years later described *latah* as a mental malady of the Malays, both in the *Journal of Mental Science*. Ellis speculated that certain cases of *latah* might be cases of *petit mal* epilepsy. About 10 years later, William Fletcher (1908), the district surgeon of the General Hospital of Kuala Lumpur, elaborated on *latah* and its relation to crime in the *Lancet*. He reflected that there were legal aspects involved when injury to others occurred during a (dissociated) *latah* attack. The phenomenon of mimic psychosis, similar to *latah*, and called *mali-mali* by the local people, was observed in the Philippines and reported by Musgrave and Sison (1910) a few years later.

Brill (1913) reported on *pibloktoq* (also known as Arctic hysteria), observed among the Inuit during Peary's visits to Greenland. Two decades later, Rev. John M. Cooper (1933), based on information gathered from local people in his field mission, reported in *The Anthropological Journal of Primitive Man* the peculiar form of mental disturbance called '*witiko* psychosis,' that he claimed 'typically' existed among the Cree, members of the Algonquian Indians living in northern Canada. The next year, van Wulfften Palthe (1934) reported on *koro* in a European journal. A couple of years later, Winiarz and Wielawski (1936) reported on *imu* as a psychoneurosis among Ainu in Japan in the *Psychoanalytic Review*. Uchimura, Akimoto, and Ishibash had, in 1938, already described this phenomenon in Japanese literature, commenting on the *imu* syndrome in the Ainu race in the *American Journal of Psychiatry*. Later on Still (1940)

made remarks in the *Indian Medical Gazette* on the etiology and symptoms of the *dhat* syndrome observed among young (male) Indian men. In 1948, Gillin elaborated on magical fright in the *Journal of Psychiatry*; in 1957, Cannon reported on 'voodoo' death in *Psychosomatic Medicine*; in 1959, Fernández-Marian mentioned a Puerto Rican syndrome known later as *ataques de nervios*; in 1960, Canadian cultural psychiatrist, Raymond Prince, after his field experience in Nigeria, Africa, reported on the 'brain fag' syndrome observed among Nigerian students; in 1962, T. A. Lambo, a native psychiatrist from Africa, after studying in Europe and returning to his home country, described and named the phenomenon of malignant anxiety in Africa; in 1964, Rubel presented the phenomenon of *susto* observed among Hispanic Americans; and, in 1966, a Chinese cultural psychiatrist, Hsien Rin, described a case of *frigophobia* (excessive fear of catching cold) observed in Taiwan.

Thus, from 1890 to 1970, more than a dozen distinct mental phenomena or behavioral disorders among non European people were reported one after another in various medical journals. It is worth mentioning that it was not only clinicians who reported on these syndromes, but, particularly in the earlier stages, writers in the nonmedical literature, as well.

These folk illnesses were referred to as a group of mental illnesses 'peculiar to certain cultures' by Yap (1951), a pioneer in the field of cultural psychiatry from Hong Kong. However, the terms 'exotic,' 'rare,' 'uncommon,' 'extraordinary,' or 'unclassifiable' mental disorders continued to be used by western psychiatrists (Arieti & Meth, 1959; Friedmann & Faguet, 1982; Meth, 1974). Psychiatric classifications were originally based on Anglo-Saxon patient populations in Europe and North America and any clinical pictures that were manifested by patient populations outside of those 'main' groups, that were not classifiable according to the western classification system, were seen as unusual or atypical. This shows that psychiatric classifications were the result of westerners' ethnocentric views of psychopathology: Anything beyond their commonly observed phenomena was considered peculiar or exotic. Nevertheless, the discovery of various, peculiar mental disorders inspired the realization among psychiatrists that cultural factors had an impact on psychopathology, and, consequently, stimulated the development of cultural psychiatry. In other words, the recognition of the existence of so called peculiar, atypical, or exotic psychiatric disorders served as the foundation for the emerging field of 'cross-cultural psychopathology.'

Culture-bound Syndromes: 1970 to 1980

Yap (1962) reviewed the literature on some of the 'peculiar' disorders from the perspective of comparative psychiatry and suggested the term

'atypical, culture-bound, psychogenic psychosis.' Later on he offered the term 'culture-bound, reactive syndrome' to cover the various psychopathologies or atypical syndromes that seem to be bound to certain cultures and to occur as a result of psychological reactions. The following year, he omitted the word 'reactive' and revised the term to 'culture-bound syndrome' (Yap, 1967). Since then, this term has been used by psychiatrists to refer to psychiatric syndromes that are closely related to culture or 'bound' to a particular cultural group or setting, such as *amok* among Malay people, *koro* among the Southern Chinese, and *dhat* syndrome among people in India.

Many clinicians around the world continued to report culture-bound syndromes labelling them with folk names or invented terms, such as 'anthrophobia' in Japan (Kasahara, 1974), 'cargo cult' in Papua New Guinea (Burton-Bradley, 1975), *phi pob* (spirit possession) in Thailand (Suwanlert, 1976), *malgri* (territorial anxiety) among aboriginals in Australia (Cawte, 1976), *hwabyung* (anger syndrome) among Koreans (Lee, 1977), *susto* (loss of soul associated with fright) (Rubel, 1964), and *ataques de nervios* (nervous attack, previously described as 'Puerto Rican syndrome' by Fernández-Marian, 1959) (Guarnaccia, Rubio-Stipec, & Canino, 1989) among Hispanic people.

Some authors have overused the term culture-bound syndrome, describing conditions that may not meet the definition in a strict sense. Scholars have reported hundreds of psychiatric conditions in the past as folk illnesses (Simons & Hughes, 1985). However, folk labels for mental disorders do not necessarily imply that the disorders are culture-related syndromes, in the sense that they are identifiable clusters of symptoms that are closely related to cultural factors.

Attempts to Subgroup Culture-bound Syndromes

Several different systems have been proposed by different scholars to organize and categorize the various culture-related syndromes, including subgrouping by cardinal symptoms, taxons, and relationship to culture.

Subgrouping by cardinal symptoms was suggested by Yap (1967). Based on the cardinal symptoms of prototypical case, he suggested subgroups of primary fear reactions (including malignant anxiety, latah, psychogenic or magical death); morbid rage reaction (amok); specific culture-imposed nosophobia (koro); and trance dissociation (windigo psychosis).

In 1985, American cultural psychiatrist, Ronald C. Simons, and his anthropologist colleague, Charles C. Hughes, suggested categorizing culture-related syndromes by 'taxon,' that is, a group defined by a common factor. Based on this approach, they suggested: The startle-matching taxon (including *latah, imu*); the sleep-paralysis taxon; the genital-retraction

taxon (*koro*); the sudden-mass-assault taxon (*amok*); the running taxon (*pibloktoq*, *grisi siknis*, Arctic hysteria); the fright-illness taxon (*susto*); and the cannibal-compulsion taxon (*windigo* psychosis).

Earlier Tseng and McDermott (1981) had proposed subgrouping the syndromes according to how they might be affected by cultural factors. Following this, Tseng (2001) divided specific syndromes into several groups: Culture-related beliefs as causes for the occurrence (such as *koro* or *dhat* syndromes), culture-patterned specific stress-coping reactions (such as *amok* or family suicide), culture-shaped variations of psychopathology (such as *taijinkuofusho* or brain fag syndrome), culturally elaborated unique behavior reactions (such as *latah*), culture-provoked frequent occurrences of pathological conditions (such as mass hysteria or substance abuse), and cultural interpretations and reactions to certain mental conditions (such as *hwabyung* or *susto*). This subgrouping is based on the different ways that culture impacts psychopathology. It is a more meaningful approach for addressing and understanding the disorders from a cultural perspective.

Finding a Place in the Existing Classification System

Associated with the increased awareness of the impact of culture on psychiatric classifications, there is controversy regarding how to deal with culture-related specific syndromes from a 'formal' diagnostic point of view (Hughes, 1996, 1998). Some clinicians feel strongly that various known culture-bound syndromes (such as *koro* or *hwabyung*) should be officially recognized and included in the classification system of the American Psychiatric Association (APA), which is widely used outside the United States.

However, it needs to be pointed out that the present DSM-IV (APA, 1994) classification system is based on the descriptive approach – categorizing psychiatric disorders by certain sets of behavioral manifestions and symptomatology. If clinicians attempt to fit culture-related specific syndromes into the categories of the existing classification system (Gaw, 2001), or to create new categories of disorders, those syndromes will be classified as NOS (not otherwise specified) or, at best, as 'variations' of presently recognized disorders. Many culture-related syndromes are illness defined or manifested by multiple or heterogenous clinical psychiatric conditions that are difficult to fit under a single diagnostic entity and forcing the culture-related specific syndromes into the descriptive-oriented classification system risks losing the unique meaning of the syndromes, from a cultural perspective (Guarnaccia, 1993; Pfeiffer, 1982). As pointed out by Hughes (1998), once cultural considerations are accepted as part of all diagnostic categories in the classification system, it

will no longer be necessary to group specific, culturally determined behavior patterns into the disjunctive category of 'culture-bound syndromes' in the DSM-IV. In other words, it is more important to emphasize the need for the proper cultural consideration of *every* disorder, rather than being concerned only with finding room for *specific* syndromes in the current classification system.

Furthermore, it needs to be emphasized that many culture-related specific syndromes are relatively rare, even in the cultures in which they occur. This is particularly true of the syndromes that occur through pathogenic effects of culture, such as *koro*, frigophobia, or *voodoo* death. Therefore, adding such rarely observed mental conditions into the present classification system would not be very useful from a practical point of view. Psychiatric classification should be aimed at clinical utility for the majority of psychiatric disorders.

From a diagnostic point of view, it is necessary to be careful in labeling 'peculiar behavior' as a 'disorder' simply because it is unfamiliar. A good example is provided by the phenomenon of *latah*. Behavioral scientists (mainly with anthropological backgrounds) favor the view that *latah* is a social behavior and not a 'disorder' from an etic point of view, even though some psychiatrists have considered it a psychopathological condition and offered various clinical diagnoses, such as hysterical dissociation or even hysterical psychosis.

Many behavioral scientists and clinicians who do not have sufficient psychiatric knowledge or direct clinical observation of actual cases, and simply rely on others' reports, have tried to construct classification schemes, unifying different culture-related syndromes. However, it is necessary to have culturally oriented psychiatric knowledge and experience in order to grasp the nature of culture-related disorders in an appropriate and meaningful way. This is the core of contemporary transcultural psychiatry as it has evolved from its early stages of cross-cultural psychopathology.

Culture-related Specific Syndromes: 1980 to the Present

From Culture Bound to Culture Related

When the term 'culture-bound' syndromes was initially suggested by Yap (1967), based on the descriptive approach of 'comparative psychiatry,' he thought that each syndrome was *bound* to a particular culture or ethnic group. However, careful study and review of available literature have revealed that in some cases similar syndromes can be found in many cultures, without being *bound* to one particular cultural unit.

Consider the example of *amok* attacks (mass, indiscriminate homicidal acts). American anthropologist, Philip L. Newman (1964), indicated that

running amuck had been reported in New Guinea, with 'wild-man' behavior noticed in a highland community there. A few years later, a British cultural psychiatrist, B. G. Burton-Bradley (1968), who had worked all his life in Papua New Guinea, made a similar report. After that, through his fieldwork in South Asia, American cultural psychiatrist Joseph Westermeyer (1972, 1973) reported *amok* behavior in Laos. The following year, he reviewed the literature and pointed out that, in addition to occurring among Malays, as originally described, *amok* occurred in many other areas, as well, including Laos, Thailand, and the Philippines, and addressed the issue of the epidemicity of *amok* violence. It is worth mentioning that terrifying examples of *amok* behavior have recently and frequently occurred on school campuses and in workplaces in the United States.

Cultural psychiatrists (mostly of Chinese ethnic background) originally considered *koro* (or *suoyang* in Chinese, literally meaning shrinking of yang-organ) to be a culture-bound disorder of only the Chinese (Gwee, 1963, 1968; Rin, 1965; Yap, 1965). In fact, most of the past literature concerning *koro* was related to Chinese ethnic groups (Gwee, 1963; Kobler, 1948; Rin, 1965; Tsai, 1982; Yap, 1965). Most Chinese investigators have taken the view that this particular disorder is related to the Chinese cultural concepts of yin and yang, and the folk belief in the ill effects of *suoyang* (penis shrinking). Gwee (1963), Tan (1981), and Yap (1965) speculated further that the occurrence of *koro* among people in South Asian countries, such as Malaysia and Indonesia, was the result of Chinese migrants. However, this cultural diffusion view is doubted now, since *koro* epidemics have been reported in Thailand and India, involving masses of entirely non Chinese victims.

The *dhat* syndrome was originally reported as a culture-bound syndrome observed in India (Still, 1940). However, according to Bhatia and Malik (1991), the syndrome is also widespread in Nepal, Sri Lanka (where it is referred to as *prameha* disease), Bangladesh, and Pakistan. In Taiwan, Wen (1995) considers *shenkui* ('kidney deficiency,' or insufficient vitality due to the excessive loss of semen), prevalent among young Taiwanese men, as the counterpart of the *dhat* syndrome observed among the Chinese.

The most striking example is *latah*, which was described as an unusual mental phenomenon commonly observed among people in Malaysia (Ellis, 1897). However, a similar behavior, referred to as *imu* (literally, possessed), was reported by Japanese psychiatrist Uchimura (1956; Uchimura et al., 1938) among the Ainu, an aboriginal minority ethnic group inhabiting the northern Japanese island of Hokkaido, an entirely different cultural group from the Malays.

Taijinkyofusho (literally, interpersonal-relations phobia, translated incorrectly into English as 'anthropophobia', which implies a fear of

human beings) was, for many years, considered by Japanese psychiatrists to be a culture-bound disorder related to Japanese culture, and found only among Japanese people. However, this view was challenged when Korean psychiatrist, Si-Hyung Lee (1987), reported that the disorder was prevalent in Korea, as well. Later, Cui (1996, personal communication), a psychiatrist from mainland China who specialized in Morita therapy, noted that she had seen the disorder frequently. Based on this information, it can now be said that *taijinkyofusho* is not a psychiatric condition 'bound' to Japanese culture. It is a psychiatric problem that can be observed in various societies in Asia which share certain cultural traits. In Japan, Korea, and China, there is a cultural emphasis on proper social etiquette and an overconcern about interpersonal relations with intermediately surrounding persons. Furthermore, there is a common pattern of overprotecting children in the early stages of child development, without proper socialization with others. Consequently, when children become adolescents or young adults, they find it difficult to deal with delicate social relations (including heterosexual ones), the core of developing the kind of social phobia observed in Asian societies.

Thus, the term 'culture-bound' does not seem to apply to most of the classic examples, and the term 'culture-related specific psychiatric conditions' should be used instead (Tseng & McDermott, 1981). The shorter terms, 'culture-related specific syndromes' (Tseng, 2001) and 'culture-related syndromes' (Jilek, 2000) have also been proposed. It would be more accurate to describe a syndrome that is closely related to certain cultural traits or cultural features rather than bound specifically to any one cultural system or culture unit. Accordingly, the definition has been modified to 'a collection of signs and symptoms that is restricted to a limited number of cultures, primarily by reason of certain of their psychosocial features' (Prince & Tcheng-Laroche, 1987, p. 3). This reflects the replacement of description-oriented 'comparative psychiatry' by contemporary 'transcultural psychiatry' or 'cultural psychiatry,' which views culture itself as undergoing constant change and examines its dynamic impact on human behavior and psychopathology.

Evolution or Vicissitude of Observed Syndromes through Time

Culture-related specific syndromes are not static and permanently bound to a culture, and recognized syndromes evolve or fade away as the cultural traits or circumstances that contribute to specific syndromes are modified in association with changes in the society. This section reviews evidence of such changes for *amok*, brain fag, *koro*, family suicide, *taijinkuofusho*, *latah* and *imu*, and western culture-related syndromes. Although no objective epidemiological studies have been carried on the actual prevalence of

most of the disorders concerned, it appears that, with the passing of time and with cultural changes occurring within the society, many culture-related specific syndromes recognized in the past are either changing in nature or diminishing in occurrence.

Evolution of Amok over Centuries

The Chinese-Malay cultural psychiatrist, Jin-Inn Teoh (1972), raised the issue of the changing psychopathology of *amok*. After reviewing the early literature, he pointed out that *amok* was originally the war cry of Malay pirates; plunder was their object and their actions were socially allowed and regarded as honorable. Later, however, because of the high frequency of *amok*, legislation was passed in 1893 by the British colonial government ruling that all *amok* subjects should be apprehended and tried in court. From that date onward, the rate of *amok* behavior dropped markedly. Teoh pointed out that, in Malaysia, as a result of negative sanctions by society since then, the clinical picture of *amok* has evolved from a deliberate, conscious, frenzied, socially tolerated attack to an unconsciously motivated psychiatric disorder.

Murphy (1973) also did an extensive historical review of *amok* in Malaysian society and supported Teoh's view that the *amok* syndrome showed a historical evolution over a 400-year period. During the 16th and 18th centuries, the person who ran *amok* initiated his actions consciously and deliberately, often as acts of political terrorism, attacking only identified 'enemy subjects' and avoiding injury to his relatives and friends. No signs of mental illness were noted before or after the *amok* attack, and society often saw the individual as an invincible hero, and approved of his acts. However, during the first half of the 19th century, the nature of the behavior seemed to change. An *amok* episode became sudden and unpremeditated, and the mass killings occurred in a dissociated state, with subsequent amnesia. Since the latter half of the 19th century, the frequency of *amok* has declined; *amok* runners have much more frequently had a history of long-term psychosis, and *amok* has become a manifestation of psychoses rather than the act of a normal individual or the result of a dissociative reaction. A cultural psychiatrist working in Malaysia, Eng-Seong Tan (1965), had the opportunity to clinically examine four survivors who committed 'running amok,' and diagnosed them as schizophrenic.

Elaboration of Brain Fag Syndrome over Time

Brain fag was originally described by Raymond Prince (1960) who, based on his clinical fieldwork in Nigeria, identified the syndrome as a very common, minor psychiatric disorder. The patients were mostly students in secondary school or university, or teachers or government clerks who

were studying in their spare time to raise their educational levels. The patients generally attributed their illnesses to fatigue of the brain due to excessive mental work. Prince noted that, in Nigeria, education was often a family affair, in which one of the brighter children was supported financially by family members, and the educated member, in turn, was expected to be responsible for the other family members when the need arose. This family aspect of education burdened the student with the responsibility of maintaining the family's prestige. Thus, his or her academic success or failure was associated with great stress.

Two decades later, a psychiatrist from Nigeria, R. O. Jegede (1983), observed that the disorder was not necessarily confined to students, and that excessive studying for examinations was just one of several possible precipitating factors. Further, Jegede reported that patients who were sophisticated enough to explain their symptoms in more psychologically oriented terms were less likely to complain of the somatic symptoms associated with brain fag. He suggested that brain fag syndrome did not constitute a single disease entity, as the patients were, in a way, suffering from anxiety neurosis or depressive neurosis.

Twenty-five years after he first described this disorder among the Yoruba, Ibo, and other ethnic groups in southern Nigeria, Prince (1990) indicated that it was subsequently observed in Uganda, Liberia, the Ivory Coast, and Malawi. Based on this, Prince confirmed that brain fag syndrome was a widespread and prevalent stress disorder among students in sub-Saharan Africa.

Fading of Koro Epidemics?

According to available literature, *koro* epidemics occurred outside of China in Singapore in 1967, Thailand in 1976, and in India in 1982, and no further episodes have been noted since then. Local records indicate endemic occurrences of *koro* on Hainan Island and Leizhou Peninsula in Guangdong, China, as early as the late 1800s. However, starting in the middle of the last century, there were a series of epidemic episodes in 1948, 1955, 1966, and 1974, with almost a decade between them, whenever there was social tension or impending disaster. These outbursts were followed by the last episode in 1984 to 1985 (Tseng et al., 1988). In the almost two decades since then, no further episodes of the epidemic have occurred. A mental health campaign was conducted immediately after the last episode. Also, during the past two decades, as part of a trend observed in southern China, there has been a remarkable improvement in local economic conditions, associated with a better quality of life. This social change might have contributed to the fading of the episodic occurrences of *koro* that were observed frequently in the previous half century.

The Decline of Family Suicide and Taijinkuofusho in Japan

Family suicide (joint child homicide and parent suicide) was originally described as a common phenomenon in Japan, with almost 100 cases reported in newspapers annually (Takahashi, Hirasawa, Koyama, & Senzaki, 1998). It was interpreted as closely related to Japanese culture, particularly to the concepts of family, the status of orphans, and the utilization of death as a way to cope with difficulties encountered in life (Tseng, 2001). This stress-coping method is based on the Japanese belief that the intense shame that follows from a public disgrace can be relieved by ending one's life. This is coupled with the conviction that children, if left as orphans, would be mistreated by others (non-blood-related care takers). Therefore, it would be better for them to die with their parents, resulting in family suicide. However, associated with recent cultural changes in Japan, the occurrence of this culture-related family homicide–suicide phenomenon is declining (Takahashi, personal communication, 2003).

Taijinkuofusho, originally described by Japanese psychiatrists as a 'classic' (culture-bound) neurosis has been gradually becoming less prevalent. Instead, borderline personality disorder is encountered clinically more often now, indicating that commonly observed psychopathology is changing in association with sociocultural changes occurring in Japan (Nishizono, 2005).

The Fate of Latah and Imu

Latah, originally reported as a common phenomenon among young women in Malaysia, is becoming less prevalent, particularly in urban areas, and is now only found among old ladies who have known of the phenomenon since they were young (Woon, 1980). Similarly, according to Japanese psychiatrists presently working in Hokkaido, Daiguji and Shichida (1998), the *latah*-like phenomenon of *imu* among the Ainu is rarely observed today.

Culture-related Syndromes in Western Societies

Culture-related specific syndromes, by definition, can exist in any society. However, most culture-related specific syndromes (such as *koro*, *amok*, or *dhat* syndromes) have been reported from nonwestern societies. This is because they were considered 'peculiar' phenomena observed in areas previously colonized by western people, or because syndromes observed in eastern societies simply did not fit the classification system developed for Euro American populations. In recent years, there is increased recognition by cultural psychiatrists of syndromes in western cultures that are heavily culture related, including: Anorexia nervosa (Littlewood & Lipsedge, 1986; Palazzoli, 1985; Prince, 1985, 1996; Swartz, 1985), obesity (Ritenbaugh, 1982), drug-induced dissociative states, multiple personality,

and even premenstrual syndrome (Johnson, 1987). Since these conditions are already recognized in the existing western nosological system as 'ordinary' disorders, they are, in a sense, not viewed as 'specific' syndromes. However, they can be viewed as 'culture-related' psychiatric conditions that are influenced by various aspects of western culture.

It deserves mention that, during the early part of the last century in western societies, it was fashionable for women to faint whenever they heard shocking news or encountered stressful situations, and then be rescued by the people around them. However, this 'peculiar' habitual behavior (from a nonwestern perspective) has almost disappeared in contemporary western societies. This decline in fainting spells may be due to changes in women's dress (women no longer tightly bind their waists), as some scholars speculate, or to changes in the image and status of women. Women today are stronger and more independent, and reject the image of women as vulnerable creatures who faint easily. This clearly illustrates that culture-related behavior can be modified by cultural changes.

Discussion

Culture-related specific syndromes are defined here as psychiatric syndromes that are closely and significantly related to certain cultural features in their formation or manifestation of psychopathology. The clinical manifestations tend to be different from those of psychiatric disorders that fit within existing psychiatric classifications. These syndromes tend to be observed more frequently in certain cultural areas that share common cultural traits or features than in others. Whether they are prevalent or infrequent in those areas is not as much an issue in determining whether special clinical attention is warranted as the importance of cultural factors in their formation and the significance of local people's reactions to them.

Cultural influences on psychiatric syndromes can occur in at least six distinct ways (Tseng, 2001): (1) pathogenic effect (cultural influence on the formation of a disorder); (2) psychoselective effect (culture selecting certain coping patterns to deal with stress); (3) psychoplastic effect (culture modifying the clinical manifestation); (4) pathoelaborating effect (culture elaborating mental conditions into a unique nature); (5) psychofacilitating effect (culture promoting the frequency of occurrence); or (6) psychoreactive effect (culture shaping folk responses to the clinical condition). If the cultural effect is merely a psychoreactive one, there will be an argument as to whether or not it will meet the criteria for a culture-related specific syndrome, because, in addition to there often being no specific or unique pathological condition involved, the cultural impact is secondary in nature, merely interpreting and labeling the phenomenon.

Cultural factors impact every kind of psychopathology to some extent – whether or not it is predominantly psychological or biological in nature (or a minor or major psychiatric disorder). However, unless the cultural impact is very significant and deserves special attention, there is no point in identifying and labeling any pathology as a 'culture-related specific syndrome.'

Symptom or Syndrome?

There is a need to distinguish clearly between symptom and syndrome to avoid confusion in discussions of culture-related syndromes. A symptom is a component of a clinical condition that is presented as a complaint or noticed by the clinician; a syndrome is a total clinical condition composed of a unique set of symptoms manifesting as a distinctive clinical entity. This distinction is necessary to elaborate on culture-related specific syndromes; for example, there is a need to distinguish among *koro*-like symptoms, a *koro* syndrome, and a *koro* epidemic (Tseng et al., 1988). Berrios and Morley (1984) reviewed literature that described *koro*-like symptoms in a total of 15 non Chinese subjects. They pointed out that, among the cases reported, all suffered from many psychiatric conditions: Affective disorders, nonaffective psychoses (schizophrenia), anxiety disorders, as well as drug abuse and organic brain disorders. They referred to the cases as having '*koro*-like symptoms,' which is not exactly the same as the '*koro* syndrome' presented by Chinese patients. Ede (1976) explained that the Chinese *koro* cases from South Asia usually present in a 'typical' fashion, including three cardinal manifestations: A feeling of the penis shrinking into the abdomen, severe anxiety, and the belief in ultimate death if the penis should disappear into the abdomen. He pointed out that non Asian patients usually manifest *koro*-like symptoms, but not the 'typical' *koro* syndrome. Even sporadically occurring *koro* cases may be different from an epidemic case. As a syndrome, in a sporadic case, the patient will manifest a clinical picture, more or less, of anxiety or hypochondriasis; in epidemic cases, it is usually characterized as an acute panic condition, which promotes an emotional atmosphere of fear to surrounding people, with a contagious effect.

Folk Label or Discrete Disorder?

It is useful to distinguish between culture-induced and culture-modified disorders versus culturally interpreted and/or labeled disorders. *Hwa-byung*, *susto*, and *ataques de nervios* fall into the latter category, as merely interpreted or labeled by culture, even though they are presently regarded and accepted by some cultural psychiatrists as culture-related specific syndromes.

Hwa-byung in Korean literally means 'fire (*hwa*) sickness (*byung*).' Based on a traditional Chinese medical concept that is still prevalent in Korea – that an imbalance among the five elements within the body (metal, wood, water, fire and earth) may cause physical disorders – lay people in Korea use the folk term 'fire sickness' to describe certain illness conditions. Many women, based on their culturally prescribed role status, encounter numerous stresses in the family, accumulating 'resentment' (*han*, in Korean), and may complain that they suffer from *hwa-byung*. It seems that it is more accurate to understand *hwa-byung* as a 'cultural interpretation' of suffering (through pathoreactive effects) than a culture-related syndrome. Cultural factors may indirectly contribute to the occurrence of particular psychological problems that are encountered by Korean women, but they do not contribute to the formation of particular psychiatric syndromes (pathogenically) with unique or specific manifestations (pathoplastically).

Susto is a Spanish word that literally means 'fright.' The term is widely used by people in Latin America to refer to the loss of soul (Rubel, 1964, Rubel, O'Nell, & Collado, 1985). This condition is based on the folk belief that every individual possesses a soul but, through certain experiences, such as being frightened or startled, a person's soul may depart from the body. As a result, the person will manifest certain morbid mental conditions and illness behavior. The remedy for such a condition is to recapture the soul through certain rituals. The concept of loss of soul as a cause for (mental) sickness is widespread, and terms similar, or equivalent, to *susto* are found across many different cultural groups, such as *el miedo* (fright) in Bolivia (Hollweg, 1997), *lanti* in the Philippines (Hart, 1985), and *mogo laya* in Papua New Guinea (Frankel, 1985). It should be pointed out that, although the cause is uniformly attributed to spiritual-psychological reasons relating mostly to a frightening experience or misfortune, from a clinical point of view, the manifested symptoms are quite heterogeneous, without a commonly shared syndrome (Gillin, 1948). Therefore, strictly speaking, *susto* is not a culture-related 'specific syndrome' derived from psychogenic or psychoplastic effects. It is culture related only in the sense that the morbid condition is 'interpreted' after the fact according to folk concepts of 'etiology,' and certain ways of regaining the lost soul, such as rituals, are offered.

The Need for Clinical Observation and Psychiatric Examination

It is very important to reexamine the sources of knowledge for each culture-related specific syndrome. For example, *witiko* psychosis refers to a person developing the delusion of transforming into a cannibalistic

monster and craving human flesh under the threat of starvation in severely cold weather. Although the cannibalistic belief-related behavior among the Cree living in the northern part of Canada was reported sporadically in various literatures as early as the 17th century, it was J. E. Saindon, an oblate missionary who worked among the Cree of the western James Bay area in Canada in the early part of the 20th century, who published his description in 1928 (Teicher, 1960). Saindon reported the case of a woman who did not wish to see anyone outside her immediate family, because strangers looked like wild animals to her and she experienced urges to kill them in self-defense. Saindon identified the phenomenon of fearing becoming *windigo* (a wild animal) as a 'sickness.' Later, another missionary, Rev. J. M. Cooper (1933), used the (psychiatric) term '*witiko* psychosis' in the anthropological journal *Primitive Man*. Both of these published accounts were based on second-hand information provided by nonclinical observers. Nevertheless, pioneer cultural psychiatrists (Kiev, 1972; Yap, 1951) dealt with the reports as though they were well-defined clinical entities with the diagnostic term *witiko* psychosis. Some scholars even elaborated theoretical explanations for cannibalistic beliefs and behaviors (Fogelson, 1965), and interpreted such 'mental disorders' in the context of the culture and personality (Parker, 1960). Marano (1982) pointed out that, although aspects of the *windigo* belief complex were part of Cree folklore and may have been 'components in some individuals' psychological dysfunction' (p. 411), there probably never was any *windigo* psychosis in the sense that cannibalism or murder was committed to satisfy an obsessional craving for human flesh. He argued that *windigo* psychosis as a behavioral syndrome was an artifact of research conducted without sufficient knowledge of indigenous experience.

There are other examples of the danger of elaborating theoretical models of syndromes without actual clinical experience with a case. The earlier writings by Yap (1965) concerning *koro* make it sound as if it were a clinical condition with a 'dissociated' or 'depersonalized' state, but direct observation of a clinical case makes it clear that there is no involvement of an altered state of consciousness. The disorder is better described as an anxiety or hypochondriacal state in sporadic cases, or panic in epidemic cases.

Without the opportunity to examine *frigophobia* cases directly (reported from Taiwan by Rin, 1966), based solely on information from other scholars, Kiev (1972) regarded the syndrome as classic obsessive-compulsive neurosis. However, a clinician who actually observed and clinically cared for patients with the disorder would have noticed that most cases were precipitated by a loss, manifested clinically with a mixture of depression, anxiety, hypochondriasis, and, often, an underlying personality disorder, either dependent or narcissistic in nature (Chang, Rin, & Chen,

1975; Chiou, Liu, Chen, & Yng, 1994; Tseng & Hsu, 1969/70), and were not related to obsessive-compulsive disorder at all.

These examples make it clear that it is necessary to carefully study each identified culture-related specific syndrome. Obviously, there is a risk of great misunderstanding in attempts to identify and explain culture-related specific disorders based exclusively on secondary information in literature, without psychiatric examination of actual cases.

Clinical Understanding versus Social Interpretation

As pointed out by Canadian cultural psychiatrists, Jilek and Jilek-Aall (1985), and echoed by Bartholomew (1994), in evaluations of culture-related specific syndromes, we have to look beyond individual psychodynamics and culture-specific personal traits to the total geopolitical, socioeconomic, and ideological circumstances of the society in which the phenomena occur. This will give us a more meaningful understanding of the metamorphosis of culture-related syndromes – how individuals respond to culture-related stress with culture-conditioned reactions within a particular sociocultural climate.

However, it needs to be pointed out that there is a risk in interpreting culture-related specific syndromes solely from the perspective of social or behavioral sciences, without adequate clinical knowledge and needed psychiatric insight. It is natural and necessary to utilize social and behavioral science knowledge, including sociology and anthropology, to elaborate on and interpret culture-related specific syndromes. After all, by definition, they are considered culture-related clinical conditions. However, interpretations made simply on the basis of social aspects, ignoring clinical perspectives, also may suffer from bias.

For instance, to regard the *latah* phenomenon merely as a 'faked' condition or a 'deception' of people in a community (Bartholomew, 1994, 1995) shows a lack of clinical knowledge and insight and a dynamic understanding of human behavior. Interpreting culture-related specific syndromes, not as clinical conditions, but simply as manifestations of 'social disorders,' also indicates an excessively social orientation and approach that ignores clinical understanding.

Suggestions for Further Research

Looking back, it is encouraging that some scholars have made efforts to carry out comprehensive studies of culture-related specific phenomena or syndromes (Simons & Hughes, 1985). The intensive study and theoretical elaboration regarding *latah* phenomena is one such achievement (Simons, 1996). However, the majority of the work carried out in the past

regarding culture-related syndromes has been in the nature of demographic surveys and clinical descriptions of phenomena (Chiu, Tong, & Schmidt, 1972; Guarnaccia, Canino, Rubio-Stipec, & Bravo, 1993; Lee, 1987; Lin et al., 1992). There is a need for studies that focus on the cultural dimensions and the impact of culture on such syndromes.

Intensive studies of individual cases are needed in order to understand the psychological and social dynamics of the disorders. We should not focus merely on clinical manifestations at a descriptive level, but carry out intensive clinical evaluations of individual cases from a cultural perspective. Following a dynamic approach, it would be desirable to understand comprehensively the individual's personal history, including family background, psychological development, stresses encountered, and coping patterns. Any cultural belief that might be related to the problems encountered or coping mechanism used needs elaboration, so that possible cultural attributes can be revealed. As Guarnaccia and Rogler (1999) have emphasized, instead of concentrating merely on clinical descriptions or diagnostic issues – such as how to subsume the syndromes into psychiatric categories – future research needs to focus on the cultural nature of the phenomena.

Few studies have used well-designed questionnaire surveys of subjects to test hypotheses about the specific ways in which culture may contribute to a particular disorder. The time is ripe for clinicians to move one step further and carry out more comprehensive culture-focused clinical studies, including comparative studies of different groups to solicit and verify cultural variables that contribute to the occurrence of culture-related specific syndromes among certain groups of people.

Because cases of culture-related syndromes are rare, from the standpoint of research, it is relatively difficult to design and conduct a survey, unless it occurs as an epidemic or at least in an endemic way. However, it is possible to survey nonpatient groups in communities where a specific syndrome tends to occur, and to compare their responses with individuals in communities where the syndromes seldom occur, examining their views, understandings, and attitudes toward the disorder.

For example, even though there has been speculation that *koro* is closely related to the Chinese concepts of *yin* and *yang* and to folk beliefs of *suoyang*, sporadic cases are reported more frequently among Southern Chinese than Northern Chinese, and *koro* epidemics are observed only among Southern Chinese in the Guangdong area. In order to understand this geographic distribution, a questionnaire was designed and administered to Chinese in Guagndong, Taiwan, and Harbin (Tseng et al., 1992). This revealed that all the Chinese people surveyed in the three geographic areas shared knowledge about *suoyang* (*koro*) phenomenon but, from an affective perspective, only the Chinese in the Guangdong area viewed the

disorder as dangerous. This helps us understand that it is not what people know about a syndrome cognitively, but how greatly they are affected by their beliefs emotionally that contributes to the occurrence of a disorder in epidemic proportions in certain areas.

Similar methods may be applied to study other specific syndromes, with appropriately selected groups of people in prevalent and nonprevalent areas, to analyze the actual contribution of cultural factors to those specific syndromes. It is hoped that, by doing so, we may accumulate more information on how culture impacts on specific syndromes and how best to respond to the pathology when it occurs.

Conclusion

The study of culture-related specific syndromes has helped us to understand the multiple ways in which culture influences psychopathology (Tseng, 2001). It is easier to see the impact of culture on specific syndromes that are strongly related to culture. However, it needs to be recognized that culture-related syndromes are merely the tip of the iceberg. Beneath them are all the ordinary psychiatric disorders that are affected by culture as well, in different ways and to varying degrees (Tseng, 2001). This the true spirit of contemporary 'cultural psychiatry,' focuses not on foreign or exotic cultures, but on our own culture and 'ordinary' disorders.

Historically, the study of culture-related specific syndromes prompted the development of transcultural psychiatry, and, later, cultural psychiatry, as subfields of general psychiatry. However, clinically, instead of being overly concerned with how to discover and label more culture-related specific syndromes and debating how to categorize them diagnostically, we need to move ahead and concentrate on the understanding of the cultural implications of all forms of psychopathology and examine approaches to culture-relevant treatment, that is, providing culturally competent care for all patients. This is a practical need that exists in contemporary societies, which are becoming increasingly multiethnic and polycultural.

In the past several decades, we have witnessed a new trend, in which cultural psychiatry strives for the provision of culturally competent clinical service for diversified populations. The focus is not merely on providing culturally relevant care for certain ethnic groups or minorities, but, most importantly, addressing the needs of different age groups in specific clinical settings (Tseng & Streltzer, 2004). It is time to move from merely studying the cultural aspects of psychopathology (fascinated by peculiar or exotic syndromes) to the provision of culturally competent care for all people of diverse cultures, in order to fulfill the contemporary mission of cultural psychiatry.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental di*sorders (4th ed.). Washington, DC: Author.

Arieti, S., & Meth, J. M. (1959). Rare, unclassifiable, collective, exotic syndromes. In S. Arieti (Ed.), *American handbook of psychiatry*, Vol. I (pp. 546–563). New York: Basic Books.

Bartholomew, R. E. (1994). Disease, disorder, or deception? Latah as habit in a Malay extended family. *Journal of Nervous and Mental Diseases*, *182*(6), 331–338.

Bartholomew, R. E. (1995). Culture-bound syndromes as fakery. *Skeptical Inquirer*, November/December, 36–41.

Berrios, G. E., & Morley, S. J. (1984). Koro-like symptom in a non-Chinese subject. *British Journal of Psychiatry*, *145*, 331–334.

Bhatia, M. S., & Malik, S. C. (1991). Dhat syndrome: A useful diagnostic entity in Indian culture. *British Journal of Psychiatry*, *159*, 691–695.

Brill, A. A. (1913). *Pibloktoq* or hysteria among Peary's Eskimos. *Journal of Nervous and Mental Disease*, *40*, 514–520.

Burton-Bradley, B. G. (1968). The *amok* syndrome in Papua and New Guinea. *Medical Journal of Australia*, *1*, 252–256.

Burton-Bradley, B. G (1975). *Stone age crisis: A psychiatric appraisal*. Nashville, TN: Vanderbilt University Press.

Cannon, W. B. (1957). 'Voodoo' death. *Psychosomatic Medicine*, *19*, 182–190.

Cawte, J. E. (1976). *Malgri*: A culture-bound syndrome. In W. P. Lebra (Ed.), *Culture-bound syndromes, ethnopsychiatry, and alternate therapies* (pp. 22–31). Honolulu, HI: University Press of Hawaii.

Chang, Y. H., Rin, H., & Chen, C. C. (1975). Frigophobia: A report of five cases. *Bulletin of Chinese Society of Neurology and Psychiatry*, *1*(2), 9–13 (in Chinese).

Chiou, N. M., Liu, C. Y., Chen, C. C., & Yng, Y. Y. (1994). Frigophobia: Report of two cases. *Chinese Psychiatry*, *8*(4), 297–302 (in Chniese).

Chiu, T. L., Tong, J. E., & Schmidt, K. E. (1972). A clinical and survey study of latah in Sarawak, Malaysia. *Psychological Medicine*, *2*, 155–165.

Cooper, J. M. (1933). The Cree Witiko psychosis. *Primitive Man*, *6*, 20–24.

Daiguji, M., & Shichida, H. (1998, October). *Imu phenomena observed among the Ainu people in northern Japan: Past and present*. Paper presented at The Second Pan Asia-Pacific Mental Health Conference, Beijing.

Ede, A. (1976). Koro in an Anglo-Saxon Canadian. *Canadian Psychiatric Association Journal*, *21*, 389–392.

Ellis, W. G. (1893). The *amok* of the Malays. *Journal of Mental Science*, *39*, 325–338.

Ellis, W. G. (1897). Latah: A mental malady of the Malays. *Journal of Mental Sciences*, *43*, 33–40.

Fernández-Marian, R. (1959). The Puerto Rican syndrome: Its dynamic and cultural determinants. *Psychiatry*, *24*, 79–82.

Fletcher, W. (1908). Latah and crime. *Lancet*, *2*, 254–255.

Fogelson, R. D. (1965). Psychological theories of windigo 'psychosis' and preliminary application of a models approach. In M. E. Spiro (Ed.), *Context and meaning in cultural anthropology*. New York: The Free Press.

Frankel, S. (1985). *Mogo laya*, a New Guinea fright illness. In R. C. Simons & C. C. Hughes (Eds.), *The culture-bound syndromes* (pp. 399–404). Dordrecht: D. Reidel.

Friedmann, C. T., & Faguet, R. A. (Eds.). (1982). *Extraordinary disorders of human behavior*. New York: Plenum Press.

Gaw, A. (2001). *Concise guide to cross-cultural psychiatry*. Washington, DC: American Psychiatric Publishing.

Gillin, J. (1948). Magical fright. *Psychiatry*, *11*, 387–400.

Guarnaccia, P. J. (1993). *Ataques de nervios* in Puerto Rico: Culture-bound syndrome or popular illness? *Medical Anthropology*, *15*, 157–170.

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. *Journal of Nervous and Mental Disease*, *181*(3), 157–165.

Guarnaccia, P. J., & Rogler, L. H. (1999). Research on culture-bound syndromes: New directions. *American Journal of Psychiatry*, *156*(9), 1322–1327.

Guarnaccia, P. J., Rubio-Stipec, M., & Canino, G. J. (1989). *Ataques de nervios* in the Puerto Rican Diagnostic Interview Schedule: The impact of cultural categories on psychiatric epidemiology. *Culture, Medicine, and Psychiatry*, *13*, 275–295.

Gwee, A. L. (1963). Koro: A cultural disease. *Singapore Medical Journal*, *4*, 119–122.

Gwee, A. L. (1968). Koro: Its origin and nature as a disease entity. *Singapore Medical Journal*, *9*, 3–6.

Hart, D. V. (1985). *Lanti*, illness by fright among Bisayan Filipino. In R. C. Simons & C. C. Hughes (Eds.), *The culture-bound syndromes* (pp. 371–397). Dordrecht: D. Reidel.

Hollweg, M. G. (1997). Main culture bound syndromes in Bolivia. *Curare*, *20*(1), 23–28.

Hughes, C. C. (1996). The culture-bound syndromes and psychiatric diagnosis. In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 289–305). Washington, DC: American Psychiatric Press.

Hughes, C. C. (1998). The glossary of 'culture-bound syndromes' in DSM-IV: A critique. *Transcultural Psychiatry*, *35*(3), 413–421.

Jegede, R. O. (1983). Psychiatric illness in African students: 'Brain fag' syndrome revisited. *Canadian Journal of Psychiatry*, *28*, 188–192.

Jilek, W. G. (2000). Culture related syndromes. In M. G. Gelder, J. J. López-Ibor, & N. Andreasen (Eds.), *New Oxford textbook of psychiatry*. New York: Oxford University Press.

Jilek, W. G., & Jilek-Aall, L. (1985). The metamorphosis of 'culture-bound' syndromes. *Social Science of Medicine*, *21*(2), 205–210.

Johnson, T. M. (1987). Premenstrual syndrome as a western culture-specific disorder. *Culture, Medicine, and Psychiatry*, *11*(3), 337–356.

Kasahara, Y. (1974). Fear of eye-to-eye confrontation among neurotic patients in Japan. In T. S. Lebra & P. L. Lebra (Eds.), *Japanese culture and behavior* (pp. 379–387). Honolulu, HI: University Press of Hawaii.

Kiev, A. (1972). *Transcultural psychiatry*. New York: The Free Press.

Kobler, F. (1948). Description of an acute castration fear, based on superstition. *Psychoanalytic Review*, *35*, 285–289.

Lambo, T. A. (1962). Malignant anxiety: A syndrome associated with criminal conduct in Africans. *Journal of Mental Science*, *108*, 256–264.

Lee, S. H. (1977). A study on the '*hwabyung*' (anger syndrome). *Journal of the Korean General Hospital*, *1*, 63–69.

Lee, S. H. (1987). Social phobia in Korea. *Social phobia in Japan and Korea: Proceedings of the First Cultural Psychiatry Symposium between Japan and Korea*. Seoul: The East Asian Academy of Cultural Psychiatry.

Lin, K. M., Lau, J. K. C., Yamamoto, J., Zheng, Y. P., Kim, H. S., Cho, K. H., & Nakasaki, G. (1992). Haw-byung: A community study of Korean Americans. *Journal of Nervous and Mental Disease*, *180*(6), 386–391.

Littlewood, R., & Lipsedge, M. (1986). The 'culture-bound syndromes' of the dominant culture: Culture, psychopathology and biomedicine. In J. L. Cox (Ed.), *Transcultural psychiatry* (pp. 253–273). London: Croom Helm.

Marano L. (1982). Windigo psychosis: The anatomy of an emic-etic confusion. In R. C. Simons & C. C. Hughes (Eds.), *The culture-bound syndromes* (pp. 411–448). Chicago: University of Chicago Press.

Meth, J. M. (1974). Exotic psychiatric syndromes. In S. Arieti & E. B. Brody (Eds.), *American Handbook of Psychiatry, Vol. III, Adult Clinical Psychiatry*. New York: Basic Books.

Murphy, H. B. M. (1973). History and evolution of syndromes: The striking case of *latah* and *amok*. In M. Hammer, K. Salzinger, & S. Sutton (Eds.), *Psychopathology*. New York: Wiley.

Musgrave, W. E., & Sison, A. G. (1910). *Mali-mali*, a mimic psychosis in the Philippine Islands: A plenary report. *Philippine Journal of Science*, *5*, 335–339.

Newman, P. L. (1964). 'Wild man' behavior in a New Guinea highlands community. *American Anthropologist*, *66*, 1–9.

Nishizono, M. (2005). Culture, psychopathology, and psychotherapy: Changes observed in Japan. In W. S. Tseng, S. C. Chang., & M. Nishizono (Eds.), *Asian culture and psychotherapy: Implications for East and West* (pp. 40–54). Honolulu, HI: University of Hawaii Press.

Palazzoli, M. S. (1985). Anorexia nervosa: A syndrome of the affluent society. *Transcultural Psychiatric Research Review*, *22*(3), 199–205.

Parker, S. (1960). The *witiko* psychosis in the context of Ojibwa personality and culture. *American Anthropologist*, *62*, 603–623.

Pfeiffer, W. M. (1982). Culture-bound syndromes. In I. Al-Issa (Ed.), *Culture and psychopathology* (pp. 201–218). Baltimore, MD: University Park Press.

Prince, R. H. (1960). The 'brain fag' syndrome in Nigerian students. *Journal of Mental Science*, *104*, 559–570.

Prince, R. H. (1985). The concept of culture-bound syndromes: Anorexia nervosa and brain fag. *Social Science and Medicine*, *21*, 197–203.

Prince, R. H. (1990). The brain-fag syndrome. In K. Pelzer & P. O. Ebigbo (Eds.), *A textbook of clinical psychiatry in Africa* (pp. 276–287). Enugu: Chuka.

Prince, R. H. (1996). Cultural comments on eating disorders. In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric*

diagnosis: A DSM-IV perspective (pp. 187–189). Washington, DC: American Psychiatric Press.
Prince, R. H., & Tcheng-Laroche, F. (1987). Culture-bound syndromes and international disease classifications. *Culture, Medicine and Psychiatry*, *11*, 3–19.
Rin, H. (1965). A study of the aetiology of *koro* in respect to the Chinese concept of illness. *International Journal of Social Psychiatry*, *11*, 7–13.
Rin, H. (1966). Two forms of vital deficiency syndrome among Chinese male mental patients. *Transcultural Psychiatric Research Review*, *III*(1), 19–21.
Ritenbaugh, C. (1982). Obesity as a culture-bound syndrome. *Culture, Medicine and Psychiatry*, *6*(4), 347–361.
Rubel, A. J. (1964). The epidemiology of a folk illness: *Susto* in Hispanic America. *Ethology*, *3*, 268–283.
Rubel, A. J., O'Nell, C. W., & Collado, R. (1985). The folk illness called *susto*. In R. C. Simons & C. C. Hughes (Eds.), *The culture-bound syndromes* (pp. 333–350). Dordrecht: D. Reidel.
Simons, R. C. (1996). *Boo! Culture, experience, and the startle reflex*. New York: Oxford University Press.
Simons, R. C., & Hughes, C. C. (1985). *The culture-bound syndromes: Folk illnesses of psychiatric and anthropological interest.* Dordrecht: D. Reidel.
Still, R. M. (1940). Remarks on the aetiology and symptoms of *young-dah-hte*, with a report on four cases and their medical-legal significance. *Indian Medical Gazette*, *75*, 88–91.
Suwanlert, S. (1976). *Phii pob*: Spirit possession in rural Thailand. In W. P. Lebra (Ed.), *Culture-bound syndromes, ethnopsychiatry, and alternate therapies* (pp. 68–87). Honolulu, HI: University Press of Hawaii.
Swartz, L. (1985). Anorexia nervosa as a culture bound syndrome. *Transcultural Psychiatric Research Review*, *22*(3), 205–207.
Takahashi, Y., Hirasawa, H., Koyama, K., & Senzaki, K. (1998). Suicide in Japan: Present state and future directions for prevention. *Transcultural Psychiatry*, *35*(2), 271–290.
Tan, E. S. (1965). *Amok*: A diagnostic consideration. *Proceedings of the Second Malaysian Congress of Medicine*, 22–25.
Tan, E. S. (1981). Culture-bound syndromes among overseas Chinese. In A. Kleinman & T. Y. Lin (Eds.), *Normal and abnormal behavior in Chinese culture* (pp. 371–386). Dordrecht: D. Reidel.
Teicher, M. I. (1960). Windigo psychosis: A study of a relationship between belief and behavior among the Indians of Northeastern Canada. *Proceedings of the 1960 Annual Spring Meeting of the American Ethnological Society* .
Teoh, J. I. (1972). The changing psychopathology of *amok*. *Psychiatry*, *35*, 345–351.
Tsai, J. B. (1982). *Suoyang* disorder: Five cases report. *Zhunguo Senjing Jjingsenbin Zazhi*, *4*, 206 [in Chinese].
Tseng, W. S. (2001). *Handbook of cultural psychiatry*. San Diego, CA: Academic Press.
Tseng, W. S., & Hsu, J. (1969/70). Chinese culture, personality formation and mental illness. *International Journal of Social Psychiatry*, *16*(1), 5–14.
Tseng, W. S., & McDermott, J. F., Jr. (1981). *Culture, mind and therapy: An introduction to cultural psychiatry.* New York: Brunner/Mazel.

Tseng, W. S., Mo, K. M., Hsu, J., Li, L. S., Chen, G. Q., Ou, L. W., & Zheng, H. B. (1992). *Koro* epidemics in Guandong, China: A questionnaire survey. *Journal of Nervous and Mental Disease*, *180*(2), 117–123.

Tseng, W. S., Mo, K. M., Hsu, J., Li, L. S., Ou, L. W., Chen, G. Q., & Jiang, D. W. (1988). A sociocultural study of *koro* epidemics in Guandong, China. *American Journal of Psychiatry*, *145*(12), 1538–1543.

Tseng, W. S., & Streltzer, J. (Eds.). (2004). *Cultural competence in clinical psychiatry*. Arlington, VA: American Psychiatry Publishing.

Uchimura, V. Y. (1956). Imu, eine psychoracktive Erscheinung der ainu-Frauen [*Imu*, a psychoactive phenomenon of *ainu* women]. *Der Nervenarzt*, *12*, 535–540.

Uchimura, V. Y., Akimoto, & Ishibash (1938). The syndrome of *imu* in the Ainu race. *American Journal of Psychiatry*, *94*, 1467–1469 (Comment).

van Wulfften Palthe, P. M. (1934). Koro: Een eigenaardig angstneurose. *Geneeskundia Tijdschrift voor Nederlandach-Indie*, *74*, 1713–1720.

Wen, J. K. (1995). Sexual beliefs and problems in contemporary Taiwan. In T. Y. Lin, W. S. Tseng, & E. K. Yeh (Eds.), *Chinese societies and mental health* (pp. 219–230). Hong Kong: Oxford University Press.

Westermeyer, J. (1972). A comparison of *amok* and other homicide in Laos. *American Journal of Psychiatry*, *129*(6), 703–709.

Westermeyer, J. (1973). On the epidemicy of *amok* violence. *Archives of General Psychiatry*, *28*, 873–876.

Winiarz, W., & Wielawski, J. (1936). *Imu*: A psychoneurosis occurring among Ainus. *Psychoanalytic Review*, *23*, 181–186.

Yap, P. M. (1951). Mental diseases peculiar to certain cultures: A survey of comparative psychiatry. *Journal of Mental Science*, *97*, 313–327.

Yap, P. M. (1962). Words and things in comparative psychiatry, with special reference to the exotic psychoses. *Acta Psyciatrica Scandinavica*, *38*, 163–169.

Yap, P. M. (1965). *Koro*: A culture-bound depersonalization syndrome. *British Journal of Psychiatry*, *111*, 43–50.

Yap, P. M. (1967). Classification of the culture-bound reactive syndromes. *Australia and New Zealand Journal of Psychiatry*, *1*, 172–179.

Wen-Shing Tseng, MD, is Professor of Psychiatry at the University of Hawaii School of Medicine and Guest Professor at the Institute of Mental Health, Peking University. He has authored or edited numerous books related to the subject of cultural psychiatry and/or culture and mental health, such as *Handbook of Cultural Psychiatry* (Academic Press, 2001), *Clinician's Guide to Cultural Psychiatry* (Academic Press, 2003), *Cultural Competence in Clinical Psychiatry* (American Psychiatric Publishing, 2004), *Cultural Competence in Forensic Mental Health* (Bruner-Routledge, 2004), and *Asian Culture and Psychotherapy: Implication for East and West* (University of Hawaii Press, 2005). He served two terms as Chair of the Transcultural Psychiatric Section of the World Psychiatric Association, and is the Founding President of the World Association of Cultural Psychiatry. *Address*: Department of Psychiatry, University of Hawaii School of Medicine, 1356 Lusitana Street, Honolulu, HI 96813–2421, USA. [E-mail: TsengW@dop.hawaii.edu]