REVISTAPORTUGUESADE PSIQUIATRIA ESAÚDEMENTAL
2020; 6(3): 118-130; https://doi.org/10.51338/rppsm.2020.v6.i3.139

ARTIGO DE REVISÃO NARRATIVA/REVIEW ARTICLE

Culture-Bound Syndromes and Cultural Concepts of Distress in Psychiatry
Síndromes Psiquiátricos Ligados à Cultura e Conceitos Culturais de Sofrimento em Psiquiatria

TOMÁS TEODORO[*1,2,] PEDRO AFONSO[3]

1. Department of Psychiatry, Centro Hospitalar Psiquiátrico de Lisboa, Lisbon, Portugal
2. CHRC – Comprehensive Health Research Centre, NOVA Medical School – Faculdade de Ciências Médicas, Universidade Nova de Lisboa, Lisbon, Portugal
3. Department of Medical Psychology and Psychiatry, Faculdade de Medicina, Universidade de Lisboa, Lisbon, Portugal

Abstract

Culture-bound syndromes (CBS) and cultural concepts of distress include syndromes or disease manifestations whose occurrence is related to particular cultural contexts. The term CBS is controversial, because ultimately all psychiatric and medical conditions are associated with culture. They constitute different points of view on mental health based on alternative explanatory models of mental distress. These idioms of distress have experienced a growing interest in Western countries either by an increase in the number of cases or the influence that transcultural psychiatry has come to conquer. This review describes clinical, epidemiological and contextual characteristics of most commonly reported CBS and briefly discusses the relationship between culture and psychiatric disorders. Modern societies are increasingly multi-ethnic and multicultural and thus, discussion of these concepts remains relevant, aiming to integrate CBS in current classification systems or establishing criteria that best define them as legitimate nosological entities.

Resumo

Síndromes psiquiátricos ligados à cultura (SLC) e conceitos culturais de sofrimento incluem síndromes ou manifestações de doença cuja ocorrência se relaciona com contextos culturais particulares. O termo SLC é controverso porque todas as perturbações psiquiátricas ou condições médicas em geral estão por definição associadas ao contexto cultural. Constituem diferentes pontos de vista relativamente à saúde mental baseados em diferentes modelos explicativos da vivência de sofrimento mental. Estes idiomas de sofrimento têm vindo a ter um crescente interesse nos países ocidentais, quer pelo aumento do número de casos reportados, quer pela influência que a psiquiatria transcultural tem vindo a conquistar. Este artigo de revisão pretende descrever a apresentação clínica, aspetos epidemiológicos e características particulares dos SLC mais frequentemente descritos bem como refletir sobre a influência de aspetos culturais nas perturbações psiquiátricas. Em sociedades modernas multiétnicas e multiculturais a discussão sobre estes conceitos permanece, procurando integrar os SLC nos sistemas de classificação atuais ou estabelecer critérios que melhor os definam como potenciais entidades nosológicas próprias.

Keywords: Anxiety Disorders; Culture; Ethnopsychology; Mental Disorders; Psychological Distress

Palavras-chave: Angústia Psicológica; Cultura; Distúrbios de Ansiedade; Etnopsicologia; Perturbações Mentais; Stress Psicológico

Recebido/Received: 2020-07-10
Aceite/Accepted: 2020-08-29
Publicado / Published: 2020-11-27

*Autor Correspondente/Corresponding Author: Tomás Teodoro | tomasteodoro@chpl.min-saude.pt | ORCID: 0000-0002--4603-3946 | Department of Psychiatry, Centro Hospitalar Psiquiátrico de Lisboa, Avenida do Brasil 53, 1749-002 Lisbon, Portugal, Telephone: +351 21 791 7000, Fax: +351 21 795 2989

INTRODUCTION

The influence of culture in the presentation of mental illness first came to light at the end of 19th century and early 20th century with Emil Kraepelin coining the term *Vergleichende Psychiatrie/*Comparative Psychiatry, that would later become Transcultural Psychiatry (TP).[1,2] In 1903, while in Indonesia, Kraepelin acknowledged several differences between native and German patients. For instance, he noticed that certain prevalent conditions in German patients (e.g. alcohol-related disorders) were non-existent in the native population, while other disorders (e.g. *dementia praecox*) were equally prevalent in both groups despite the remarkably different presentation (e.g. lower prevalence of catatonia and auditive hallucinations).[1,3] Over the years, following Kraepelin's studies, other psychiatrists working in non-western countries (Burton-Bradley in Papua New Guinea and John Cawte in Australia) and non-western psychiatrists (Shoma Morita, Yap Pow Meng and Thomas Lambo) contributed to an increase in the attention devoted to the field of comparative psychiatry.[1,4,5]

In 1955, TP became an independent discipline with the creation of the Section of Transcultural Studies at McGill University by Eric Wittkower and Jacob Fried.[1] The focus of this field of study primarily concerns the pathoplastic effect of culture on mental illness.[6] Following this landmark, the first journals entirely dedicated to TP were created, such as "Transcultural Psychiatry" and "*Psychopathologie Africaine*". Another important landmark was the creation of a committee dedicated to TP by the American Psychiatric Association (APA) in 1964. The term "culture-bound syndromes" (CBS) was first used in 1966 by Meng, referring to the influence of sociocultural context in the mental illness presentation in specific cultures.[3,7] CBS are syndromes whose occurrence and presentation is directly related to cultural factors, requiring a comprehensive cultural approach and management.[6]

For several years CBS were considered rare and a somewhat exotic medical curiosity exclusive of more primitive societies, uniquely related to local beliefs.[8] Thus, their main interest resided in their bizarre nature from a western standpoint.[9] Often, they were named with local terms and were not considered of a pathological nature in the cultural context in which they arose.[2] When cases started being reported in Europe and North America, psychiatrists developed a growing interest as evidenced by the number of papers and books published on the subject.

Culture in current classification systems

In the last decades, the interest in cultural syndromes in mainstream psychiatry became clear with the inclusion of CBS in the 4th Edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). In DSM-IV, CBS were defined as "recurrent, locality-specific patterns of aberrant behaviour and troubling experience (...) generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations".[10] However, to this day they have not been officially categorized in the main section of DSM, being present as an appendix of the manual, where 25 cases of CBS are described. The current edition of DSM (DSM-5) presents three major changes tentatively aiming at a wider integration and recognition of anthropology and cultural variation in the clinical presentation.[11] A model of cultural formulation as an update of DSM-IV concepts and the semi-structured interview Cultural Formulation Interview (CFI) were introduced.[11] The term CBS was replaced by "cultural concepts of distress" (CCD) defined as "ways that cultural groups experience, understand, and communicate suffering, behavioural problems, or troubling thoughts and emotions". CCD include cultural syndromes, cultural idioms of distress and cultural explanations and perceived causes.[11] "Glossary of Cultural Concepts of Distress" is a new appendix where instead of the previous 25 descriptions are now listed only nine syndromes. *Amok, Latah* and *Pibloktoq* have been removed and are now considered dissociative disorders; new additions include *Khyâl cap, Kufungisisa, Maladi moun, Nervios* and *Shenjing suairuo*; Brain Fag is recategorized as related to *Kufungisisa* and *Shenjing suairuo*; *Hwa-byung* is mentioned as being related to *Dhat* and Obsessive-Compulsive Disorder.[11] World Health Organization's 10th International Classification of Disease (ICD-10), published in 1993, does not include the term CBS. However, some syndromes such as *Latah, Koro* and *Dhat* are mentioned in the "Other specified neurotic disorders" section.[12]

CULTURE-BOUND SYNDROMES AND CULTURAL CONCEPTS OF DISTRESS

Amok is etymologically related to the Malayan "*meng--âmuk*" which means "to make a furious and desperate charge".[13] First described in Malaysia it was later reported in other countries such as Papua New Guinea, Lao, Philippines, Thailand, Indonesia, Polynesia ("*cafard*","*cathard*"), Puerto Rico ("*mal de pelea*") and in the USA.[6,10,13,14] Reported only in males it consists of episodes of undirected aggressiveness towards others or objects, with persecutory delusions and automatic movements.[10,15] Episodes are preceded by a prodrome of a vague sense of worry and are followed by a full return to premorbid state with amnesia and physical exhaustion.[14-16]

Ataque de nervios is a Hispanic term, meaning "attack of nerves" describing this syndrome first described in Puerto Rico ("Puerto Rican syndrome"), although it was also reported in other countries.[17-19] The prevalence is higher in females, who compromise about 80% of cases.[14] A comparative study analysing the presence of the syndrome in African Americans, Caucasians and Hispanics revealed the prevalence to be identical.[20] Episodes are usually triggered by stressful family-related events (e.g. death, conflicts).[17] Presentation includes features of anxiety, dissociative and conversion disorders. An intense emotional reaction occurs with symptoms of anxiety, anger and sometimes severe behavioural disturbances (e.g. screaming, crying, shaking uncontrollably) with physical and verbal violence. Also commonly described is a feeling of heat in the chest rising into the head. Dissociative and conversive

symptoms (depersonalization, amnesia, nonepileptic seizures, fainting) are often prominent.[11,17,21] Another central feature is the subjective sensation of loss of control during the episodes.[17] Full recovery occurs with frequent amnesia for the acute episode.[18]

Brain fag was described in Nigerian students in 1960, who themselves coined this term. Later reports emerged from other African countries, Brazil, Argentina, India and China.[22,23] It originates from the belief that the symptoms are caused by brain damage induced by excessive studying.[22,23] More frequent in male university students it consists of cognitive impairment, sleep disturbances and several somatic complaints (e.g. burning sensations in the head and neck, blurred vision).[23,24] The rate of diagnosis has declined and nowadays its diagnosis is infrequent in Nigeria.[25] Currently it is considered as part of another CCD known as *Kunfugisisa*. Even though the symptoms are related to intellectual activities, there have been reports of cases where they become permanent.[24,26]

Dhat is a word derived from sanskrit referring to semen, considered a vital and an integral part of the body indispensable for health according to Ayurvedic medicine principles.[11,27] Originally from India it has been described in other geographical areas (*Jiryan* in Southeast Asia, *Prameha* in Sri Lanka, *Shen-k'uei* in China).[28] It provides a cultural explanation for perceived somatic and mental symptoms (e.g. fatigue, weakness, anorexia, weight loss, impotence, depressed mood) which are attributed to inappropriate semen loss (masturbation, nocturnal ejaculation, urine).[14,29-31] Despite the wide range of possible symptoms attributed to *dhat*, cardinal features include severe anxiety and distress. In fact, this clinical presentation is also known as semen-loss or semen-leaking anxiety disorder. Studies show that it affects most frequently young single males, although a variant in females with vaginal discharge has been described.[11,29]

Maladi moun loosely means "humanly caused illness" in Haitian. It is part of a classification of diseases provided in Haitian culture that includes other categories such as *maladi bondye* (natural origins), *maladi peyi* (common short-term diseases) and *maladi iwa/satan* (diseases of supernatural origins).[32] This term refers to an etiological cultural model of disease classification that serves as an explanation for several medical and psychiatric disorders or symptoms. According to this, certain disease states would be caused by others who would magically send diseases to their enemies due to interpersonal envy or greed. Similar explanatory models exist in other cultures such as the Spanish and Portuguese *mal de ojo/mau olhado* or the Italian *mal'occhiu* (meaning "evil eye").[11,32]

Nervios means "nerves" and constitutes a widely reported idiom of distress in Latin America that has also been described in other groups (*Nevra* in Greeks and *Nierbi* in Sicilians). *Nervios* consists of a general state of increased vulnerability to develop a maladaptive response to adverse life events. It is a broad concept whose boundaries are difficult to define, encompassing complaints of emotional suffering, somatic disturbances and marked functional disability. Symptoms include physical pain, dizziness and vertigo, cognitive disturbances, tremor, anxiety and irritability. As described above, it is an unspecific syndrome and patients under such label may range from individuals without a psychiatric disorder to individuals diagnosed with depression, anxiety, dissociative and even psychotic spectrum disorders.[11]

Khyâl cap meaning "inner air or wind attacks" was originally described in Cambodians.[11] At its core is the ethnophysiological explanation that there is a rise of a wind-like substance that is carried along with blood within the human body. This is believed to be the basis for a variety of somatic symptoms that would result in asphyxia, cardiac arrest, visual and auditive disturbances and, ultimately death. Similar clinical presentations in other cultures include *Pen Lom* in Laos, *Srog rlunggi nad* in Tibet and *Yata* in Sri Lanka. Common symptoms overlap with those described in several anxiety and stress-related disorders, including in panic attacks and post-traumatic stress disorder. Although these episodes may occur without precipitant factors, there are potential triggers such as worrisome thoughts, orthostasis and several environmental stimuli with negative cognitive associations. Self-treatment with folk "wind-removal" techniques is prevalent.[33] Recently, studies on Cambodian refugees have proposed that an adaptation of cognitive-behavioral interventions may be effective to treat these symptoms.[34]

Koro is a Malayan word meaning "turtle head", also known as penis-shrinking anxiety.[35,36] First described in Southeast Asia (south of China, Singapore, India, Thailand) but later reported in Europe and USA.[35-37] It usually results from the belief that the penis is shrinking and that it will disappear inside the abdomen, resulting in death.[38] Episodes are of acute onset, short duration and manifest themselves as extreme anxiety and distress. In some cases, individuals try to avoid the presumed penile retraction with specific maneuvers.[39] Rarely, other body parts (nose, ears, nipples) are implicated, including in the few cases reported in females.[14] Common comorbidities include organic brain disease (epilepsy, tumors), psychiatric disorders (depression, schizophrenia, panic attacks) or substance-use disorders.[40]

Kufungisisa means "thinking too much or thinking a lot" in Shona, from Zimbabwe.[11] It is a common idiom of distress representing an explanation to several somatic and mental symptoms (anxiety, irritability, depression, negative ruminations and pain). It is usually indicative of interpersonal or social problems. This idiom of distress is one of the most prevalent in the world. It has been described in other regions, mainly in African and Asian countries, but also in Australia (*kulini-kulini*), Haiti (*kalkile twòp*), Nicaragua (*pensando mucho*) and in refugees and emigrants in North America and Europe.[11,41]

Hwa-byung is a Korean expression meaning "fire sickness" or "anger disease".[42,43] First described in South Korea there are also some literature reports from the United Kingdom and USA.[44] More common in females with a male to female ratio of approximately 1:3.[44] This idiom of distress occurs in relation to interpersonal conflicts and adverse life events with suppression of emotional reactions.[14,42] Conceptualized as an accumulation of anger, its onset is

usually insidious and consists of several affective, cognitive, somatic and behavioral symptoms (anxiety, irritability, insomnia, heating sensations and cognitive distortions with pessimism).[43] It is presumed that the dynamics behind its emergence is related to the role of women in Korean society. At its core is a chronic buildup of resentment from women subjected to adverse life events without external emotional manifestations of frustration in order to avoid disturbance of family stability.[45]

Latah is a Malayan term meaning "nervous" or "unstable".[46] Although initially described in Malaysia it also occurred in India, China, Burma (*yaun*), Thailand (*bah--tsche*), Phillipines (*mali-mali*), Russia (*myriachit*) and Japan (*imu*).[14,47] Prevalence is higher in middle-aged females in rural areas.[14] Episodes are often an acute reaction to external stimuli (noises, gestures, touches, words), although there are some chronic reactions without clear triggers.[3,14] Individuals experience an altered state of conscience for minutes to hours, presenting with echolalia, echopraxia, coprolalia and motor automatisms.[3,14] Usually there is amnesia for the episode. Today it is considered a dissociative experience also known as startle-induced dissociative reaction.[14]

Pibloktoq is an eskimo term for a clinical situation known as "artic/polar hysteria", described in the artic region and Siberia.[14,48] Occurring predominantly in females it consists of acute episodes of extreme psychomotor agitation and impairment of conscientiousness, usually without any identified precipitating factor. Episodes last up to 30 minutes with the individual demonstrating behavioral changes and motor abnormalities such as getting undressed or tearing off clothing, breaking objects, nonepileptic seizures and other bizarre behavior. In typical cases full remission to premorbid state with amnesia for the episode is expected.[14,48]

Shenjing shuairuo is a mandarin chinese expression meaning "weakness of the nervous system/neurasthenia".[11] Prevalent in China, its ancient origins are related to traditional principles of Chinese medicine having to do with dysregulation and imbalances of vital essences (*qi*, the vital energy) due to various stressors. Modern perspectives of this syndrome include five symptom clusters: weakness, emotions, excitement, pain and sleep disturbances.[49] It is included in the Chinese Classification of Mental Disorders and, interestingly around 45% of patients do not meet criteria for any DSM disorder.[11] Similar syndromes include *Ashaktapanna* in India and *Shinkei-suijaku* in Japan. Other CBS and DSM diagnosis may also be included in this hypothetical spectrum (brain fag, burnout and chronic fatigue syndrome).[11]

Susto is a spanish word meaning "fright/scare" referring to a cultural explanation for distress described for decades in Latin America. It is believed that a frightening experience may cause the soul to leave the body.[50,51] It is also known as *espanto*, *pasmo*, *el miedo* (Bolivia), *lanti* (Phillipines), *mogo laya* (Papua New Guinea) and *tripa ida*, *perdida del alma* or *chibih.*[11,14] The frightening event might involve natural phenomena, another person, an animal or a particular situation. Different triggers and differential manifestations allow the distinction of several subtypes.[11] Prevalence is higher in females.[50] It is not a true clinical syndrome but rather an explanation for a wide diversity of somatic complaints (e.g. muscle pain, dizziness, headaches, diarrhea) and psychiatric symptoms (e.g. low mood, abulia, sleep disturbances). In severe cases there may be a belief that there is a possibility of death.[10] Treatments provided include traditional rituals intending to restore the soul to the body.[10]

Taijin Kyofy-sho is a Japanese term meaning "fear of interpersonal relationships/anthropophobia".[14,52,53] It is included in the Japanese mental disease classification system.[10] It usually develops in adolescence and is more common in males.[54] Individuals express concerns related to "an intense fear that his or her body, its parts, or its functions displease, embarrass, or are offensive to other people in appearance, odor, facial expressions, or movements".[10] Social withdrawal and isolation usually develop. Four main subtypes are described: *sekimen-kyofu* (fear of blushing), *shubo--kyofu* (fear of body dysmorphia), *jiko-shu-kyofu* (fear of unpleasant bodily odor) and *jiko-shisen-kyofu* (fear of eye contact).[53,54]

CULTURE AND WESTERN PSYCHIATRY

Western psychiatrists' reports describing CBS and diverse cultural idioms of distress have led to an increased interest on the influence of cultural factors on psychiatric disorders and their presentation. Over the years, due to migratory phenomena, some of these clinical presentations have been reported in western countries, deepening the interest of the scientific community on this subject.[6]

A culturally minded understanding of psychopathology in individuals from non-western backgrounds has brought to the foreground the discussion on the limits of what psychiatry considers normal *versus* pathological behavior. Indeed, certain behaviors may be normal within a certain sociocultural background, but the exact same behavior being considered abnormal in different cultural contexts.[55] An example would be trance and possession syndromes that in certain countries are considered normal experiences while from another point of view they would probably be considered as a dissociative or conversion disorder.[56] An important point is that there is no cultural gold-standard that should be viewed as a reference against which one can evaluate whether a certain behavioral feature is normal or of a pathological nature.[56]

TP presents itself as a discipline that proposes to develop an understanding of the psychological features of distress from the perspective of the reality of the presenting individual, which may be radically different from the perspective of the clinician responsible for the clinical assessment. A transcultural approach would therefore contribute to a reduction of a potential ethnocentric cultural bias. This field focus on an important dichotomic debate within psychiatry as a whole: the universality *versus* the cultural specificity of psychiatric disorders.[2]

A subjective phenomenological psychopathological approach is necessary for a proper and comprehensive

assessment of CBS and different idioms of distress. The individual subject emerges from a field observation and their description is only valid for the context in which it is described. Anthropologists describe this approach of reality as an "emic approach" *versus* the "etic approach" adopted by traditional western psychiatric practice in which universally predefined criteria are applied and "forcibly" searched for in the field.[57]

There is a general consensus regarding the marked influence of culture on psychopathology and although the introduction of CBS in DSM-IV served as a boost to increase research, its impact on clinical practice was not as significant.[2,58] Also, the addition of CBS as an appendix underlines the little importance that mainstream psychiatry has given to these clinical situations. This is in line with anthropologic observations that consider these syndromes as exclusive phenomena of certain social groups.[58]

The rarity of CBS is one of the possible factors explaining their undervaluation. Their low prevalence even in the cultures where originally described makes it questionable to classify them as independent nosological entities, when classification systems should have clinical utility for most psychiatric diseases.[6] On the other hand, it is important to stress the dynamic nature of culture. Culture is not a static entity, being constantly influenced and changing over time in such a way that many CBS may no longer be specific of a particular culture and their prevalence might also decrease as a result of such changes.[59]

A major contribution regarding the classification of these syndromes came through Tseng who proposed a division of CBS based on the predominant effect culture exerts on psychopathology[14,60]:(1) Pathogenic: culture has a causal influence on the emergence of the syndrome (*Koro*, *Dhat*); (2) Pathoselective: culture selects coping patterns as reactions to stressful situations (*Amok*); (3) Pathoplastic: culture-shaped variations of psychopathology in disorders included in current diagnostic systems (*Taijin Kyofu-sho*, Brain Fag, *Pibloktoq*); (4) Pathoelaborative*:* culture models and reinforces certain types of manifestation (*Latah*); (5) Pathofacilitating: culture strongly promotes the frequency of the occurrence (massive hysteria, substance abuse); (6) Pathoreactive: culture models the interpretation of several symptoms and clinical conditions (*ataque de nervios*, *hwa-byung*, *susto*).

CONTROVERSIES AND CRITICISMS

Classification systems have been subject to criticism by transcultural psychiatrists. The ethnocentrism of western psychiatry is at the core of such critics with so-called dominant cultures evaluating reality through its own cultural experience, necessarily belittling other points of view. A widely referenced example of cultural ethnocentrism in western psychiatry is the case of anorexia nervosa. Although this disease was initially limited to western countries, it was never considered a CBS and added directly as an independent diagnosis in current classification systems. Although it is true that over time reports of anorexia nervosa emerged from several different countries with distinct cultural backgrounds, the same is also true for other CBS. This is understandable if one considers movements of globalization, westernization and acculturation of societies today.[55]

It is therefore important to make a critical analysis of the conditions under which CBS and cultural concepts of distress have been described, seeking with this clarification to assume a consistent position regarding their classification in standard diagnostic manuals. The possibility that some of the syndromes described above may be equivalent to some of the psychiatric diseases already described has arisen, with the difference that they may have incorporated specific cultural aspects into their clinical expression. Thus, a CBS and cultural concepts of distress correspondence with DSM-IV-TR and DSM-5 diagnostic categories has been proposed (Table 1).

Table 1. Selection of culture-bound syndromes and related DSM-5 diagnosis

Syndromes	**Diagnostic Categories (DSM-5)**
Ataque de nervios	Panic attack Dissociative disorder Intermittent explosive disorder Other anxiety, trauma and stressor-related disorder
Dhat	Mood disorders (major depressive disorder, dysthymia) Generalized anxiety disorder Somatic symptom disorder Illness anxiety disorder
Khyâl cap	Anxiety disorders (panic, generalized anxiety disorder, agoraphobia) Post-traumatic stress disorder Illness anxiety disorder
Kufungisisa	Mood disorders (major depressive disorder, dysthymia) Generalized anxiety disorder Post-traumatic stress disorder Obsessive-compulsive disorder
Maladi moun	Delusional disorder, persecutory type Schizophrenia with paranoid features
Nervios	Mood disorders (major depressive disorder, dysthymia) Anxiety disorders (generalized anxiety disorder, social anxiety disorder) Dissociative disorder Somatic symptom disorder
Shenjing Shuairuo	Mood disorders (major depressive disorder, dysthymia) Anxiety disorders (generalized anxiety disorder, social anxiety disorder, specific phobia) Post-traumatic stress disorder Somatic symptom disorder
Susto	Major depressive disorder Post-traumatic stress disorder Somatic symptom disorders
Taijin kyofusho	Social anxiety disorder Body dysmorphic disorder Obsessive compulsive-disorder (including olfactory reference syndrome) Delusional disorder

APA, 2013[11]; Table originally adapted from Balhara, 2011[55]

DSM-5, despite the claim to cultural progress, has kept its western ethnocentrism by maintaining the main text for western countries, and an appendix to the rest of the world. The creation of the CFI mirrors the relevance given to anthropology, allowing a cultural and ethnic evaluation of the patient. However, this semi-structured interview and its theoretical conceptualization are poorly integrated and there is a lack of cultural criteria in many of the diagnoses in DSM-5 itself. The fact that a listing of these syndromes and idioms of distress is still included as an appendix of the manual is not consistent with its initial goal of truly being a more integrative and culturally minded document. The integration of CBS in diagnostic manuals remains a controversial subject matter. Some authors support the need to consider some CBS as distinct diagnostic categories in mainstream diagnostic manuals (*koro*, *hwabyung*), while others advocate the elimination of some of these syndromes (voodoo death, *dhat*).[6,61,62]

The term CBS itself is subject to criticism. Alternative terms such as "Specific Psychiatric Conditions" and "Culturally Interpreted Symptoms" have been proposed.[6,63] CBS is also associated with a certain stigma regarding certain authors' colonial heritage. More than a semantic discussion this is an important issue because it represents the distorted underlying ethnocentrism of western psychiatry.[8]

DIAGNOSTIC VALIDITY OF CULTURE-BOUND SYNDROMES: THE CASE OF AMOK

The diagnostic validity of many CBS cases has been subject to criticism. One such example is the validity of *Amok* as a diagnosis. Murphy (1973) conducted a paradigmatic retrospective study analyzing data up until the 19th century. He found that many of the episodes were, in fact, premeditated, aimed at enemies and in some cases authentic terrorist attacks of a political nature.[64] No signs of mental illness were detected in individuals before and after the attacks. At that time, the Malaysian society had a tolerant attitude regarding these situations going as far as considering some of these individuals as true national heroes. In 1893 after the British colonization, there was legislation passed that considered the attacks perpetrated by these individuals as crimes, forcing their perpetrators to be tried as criminals with the number of cases decreasing dramatically.[60] Tan & Carr (1977) performed clinical evaluations of several cases of *amok* and diagnosed many of the individuals with schizophrenia, invalidating the original diagnosis, since there was a psychiatric disorder apparently explaining the abnormal behavior.[65] This reinforced the need for CBS cases to be assessed by a psychiatrist, avoiding their validation only through cultural references, often reported by sociologists or anthropologists. This aspect is of great importance since we can be faced with a certain culturally elaborate behavior and not a true clinical disorder.

RESEARCH CHALLENGES IN TRANSCULTURAL PSYCHIATRY

Researching CBS is challenging mainly due to methodological difficulties in obtaining valid scientific data. Another difficulty in the approach to CBS is the lack of rigorous epidemiological data and the fact that most cases referenced in the literature are case reports or studies with small samples. The rarity of some reports impairs the execution of large epidemiological studies excluding the situations in which these syndromes occur in an epidemic fashion. A comparative analysis is hampered by the fact that very similar clinical pictures are often named differently around the world.[24] There are few studies that, using validated structured questionnaires, allow an accurate evaluation of the ways in which a given cultural context can contribute to a specific psychiatric illness.

CONCLUSION

Migratory phenomena have transformed societies in multiethnic and multicultural dynamic entities. Contemporary psychiatrists need to be culture-sensitive with psychiatric assessment focusing not only on medical and biographical details but also on cultural context. The discipline of TP can play a pivotal role by allowing a wider framework for the understanding of psychopathology variants in different cultural backgrounds. Terms such as CBS spark controversy due to the fact that all disease presentations are associated with culture. Despite the controversial nomenclature, the concepts beneath these terms are still relevant and remain in open discussion. Further studies are in order to allow for a deeper phenomenological understanding of these syndromes, their diagnostic validity, and their relevance in our current and future classification systems.

ACKNOWLEDGMENTS

Authors would like to acknowledge Sérgio Saraiva and Zita Gameiro for their previous contributions in earlier drafts of this work.

Responsabilidades Éticas

Conflitos de Interesse: Os autores declaram não possuir conflitos de interesse.
Suporte Financeiro: O presente trabalho não foi suportado por nenhum subsidio o bolsa ou bolsa.
Proveniência e Revisão por Pares: Não comissionado; revisão externa por pares.

Ethical Disclosures

Conflicts of interest: The authors have no conflicts of interest to declare.
Financial Support: This work has not received any contribution grant or scholarship.
Provenance and Peer Review: Not commissioned; externally peer reviewed.

References

1. Prince RH, Okpaku SO, Merkel L. Transcultural Psychiatry: A Note on Origins and Definitions. In: Okpaku SO, editor. Clinical Methods in Transcultural Psychiatry. Washington: American Psychiatric Press; 1998: p 3.
2. Vikash R, Chaudhury S, Sukumaran S, Singh AR, Giri DK, Srivastava K, et al. Transcultural Psychiatry. Ind Psychiatry J. 2008;17:4-20.
3. Prince RH. Transcultural psychiatry: personal experiences and Canadian perspectives. Can J Psychiatry. 2000;45:431-7. doi: 10.1177/070674370004500502.
4. Prince RH. Pioneers in Transcultural Psychiatry: Sir Burton Garth Burton-Bradley (1914-1994). Transcult Psychiatry. 1994;31: 429-35. doi: 10.1177/136346159403100413.
5. Prince RH. Pioneers of Transcultural Psychiatry: John Cawte. Transcult Psychiatry. 1999;36: 347-57. doi: 10.1177/136346159903600301.
6. Tseng WS. From Peculiar Psychiatric Disorders through Culture-bound Syndromes to Culture-related Specific Syndromes. Transcult Psychiatry. 2006; 43:554-76. doi: 10.1177/1363461506070781.
7. Yap PM, Lau MP, Stokes AB. Comparative Psychiatry: A Theoretical Framework. Toronto: University of Toronto Press; 1974: p74.
8. Bhugra D, Sumathipala A, Siribaddana S. Culture--bound syndromes: a re-evaluation. In: Bhugra D, Shui K, editors. Textbook of Cultural Psychiatry. New York: Cambridge University Press; 2007: p141.
9. Kirmayer LJ. Cultural psychiatry in historical perspective. In: Bhugra D, Shui K, editors. Textbook of Cultural Psychiatry. New York: Cambridge University Press; 2007: p 3.
10. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed. Arlington: American Psychiatric Publishing; 2000.
11. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington: American Psychiatric Publishing; 2013.
12. Paniagua FA. ICD-10 Versus DSM-5 on Cultural Issues. SAGE Open. 2018;8. doi: 10.1177/2158244018756165.
13. Saint Martin ML. Running Amok. A Modern Perspective on a Culture-Bound Syndrome. Prim Care Companion J Clin Psychiatry. 1999;1:66-70. doi: 10.4088/pcc.v01n0302.
14. Tseng WS. Culture-related specific psychiatric syndromes. In: Gelder MJ, Andreasen NC, López-Ibor Jr. JJ, Geddes JR, editors. New Oxford Textbook of Psychiatry. New York: Oxford University Press; 2009. p.979-85.
15. Yap PM. Mental diseases peculiar to certain cultures: a survey of comparative psychiatry. J Ment Sci. 1951;97:313-27. doi: 10.1192/bjp.97.407.313
16. Imai H, Ogawa Y, Okumiya K, Matsubayashi K. Amok: a mirror of time and people. A historical review of literature. Hist Psychiatry. 2019;30:38-57. doi: 10.1177/0957154X18803499
17. Guarnaccia PJ, Rivera M, Franco F, Neighbors C. The experiences of ataques de nervios: towards an anthropology of emotions in Puerto Rico. Cult Med Psychiatry. 1996;20:343-67. doi: 10.1007/BF00113824
18. Guarnaccia PJ, Canino G, Rubio-Stipec M, Bravo M. The prevalence of ataques de nervios in the Puerto Rico disaster study. The role of culture in psychiatric epidemiology. J Nerv Ment Dis. 1993;181:157-65. doi: 10.1097/00005053-199303000-00003
19. Lizardi D, Oquendo MA, Graver R. Clinical pitfalls in the diagnosis of ataque de nervios: a case study. Transcult Psychiatry. 2009;46:463-86. doi: 10.1177/1363461509343090
20. Keough ME, Timpano KR, Schmidt NB. Ataques de nervios: culturally bound and distinct from panic attacks? Depress Anxiety. 2009;26:16-21. doi: 10.1002/da.20498.
21. Escobar JI. Transcultural aspects of dissociative and somatoform disorders. Psychiatr Clin North Am. 1995;18:555-69.
22. Prince R. The “brain fag” syndrome in Nigerian students. J Ment Sci. 1960;106:559-70. doi: 10.1192/bjp.106.443.559.
23. Ola BA, Morakinyo O, Adequya AO. Brain Fag Syndrome - a myth or a reality. Afr J Psychiatry. 2009;12:135-43. doi: 10.4314/ajpsy.v12i2.43731.
24. Morakinyo O, Peltzer K. ‘Brain fag’ symptoms in apprentices in Nigeria. Psychopathology. 2002;35:362--6. doi: 10.1159/000068594.
25. Ayonrinde OA, Obuaya C, Adeyemi SO. Brain fag syndrome: a cultural-bound syndrome that may be approaching extinction. BJPsych Bull. 2015; 39:156-61. doi: 10.1192/pb.bp.114.049049.
26. Morakinyo O. The brain-fag syndrome in Nigeria: cognitive deficits in an illness associated with study. Br J Psychiatry. 1985;146:209-10. doi: 10.1192/bjp.146.2.209.
27. Shumathipala A, Siribaddana SH, Bhugra D. Culture--bound syndromes: the story of dhat syndrome. Br J Psychiatry. 2004;184:200-9. doi: 10.1192/bjp.184.3.200.
28. Mehta V, Abishek D , Balachandran C. Dhat syndrome: a reappraisal. Indian J Dermatol. 2009;54:89--90. doi: 10.4103/0019-5154.49002.
29. Udina M, Foulon H, Valdés M, Bhattacharyya S, Martín-Santos R. Dhat syndrome: a systematic review. Psychosomatics. 2013; 54:212-8. doi:10.1016/j.psym.2012.09.003.
30. Bhatia MS, Malik SC. Dhat syndrome: a useful diagnostic entity in Indian culture. Br J Psychiatry. 1991; 159:691-5. doi:10.1192/bjp.159.5.691.
31. Prakash S, Sharan P, Sood M. A qualitative study on psychopathology of dhat syndrome in men: implications for classification of disorders. Asian J Psychiatr. 2018; 35:79-88. doi: 10.1016/j.ajp.2018.05.007.
32. Culture et and Mental Health in Haiti: A Literature Review. Geneva: WHO/PAHO; 2010.
33. Hofman SG, Hinton DE. Cross-cultural aspects of anxiety disorders. Curr Psychiatry Rep. 2014. 16:450. doi: 10.1007/s11920-014-0450-3

34. Hinton DE, Otto MW. Symptom Presentation and Symptom Meaning Among Traumatized Cambodian Refugees: Relevance to a Somatically Focused Cognitive-Behavior Therapy. Cogn Behav Pract. 2006; 13:249-60. doi: 10.1016/j.cbpra.2006.04.006.
35. Sachdev PS. Koro epidemic in north-east India. Aust N Z J Psychiatry. 1985;19:433-8. doi: 10.1080/00048678509158852.
36. Earleywne M. Cannabis-induced Koro in Americans. Addiction. 2001;96:1663-6. doi: 10.1046/j.1360-0443.2001.9611166312.x.
37. Crozier I. Making up koro: multiplicity, psychiatry, culture, and penis-shrinking anxieties. J Hist Med Allied Sci. 2012;67:36-70. doi: 10.1093/jhmas/jrr008.
38. Mattelaer JJ, Jilek W. Koro--the psychological disappearance of the penis. J Sex Med. 2007;4:1509-15. doi: 10.1111/j.1743-6109.2007.00586.x.
39. Berrios GE, Morley SJ. Koro-like symptom in a non--Chinese subject. Br J Psychiatry. 1984;145:331-4. doi: 10.1192/bjp.145.3.331.
40. Stip E, Bergeron T, Lavigueur C, Fabian JL, Ait Bentaleb L. Le syndrome de Koro. Annales medico--psychologiques. 2007;165: 147-53. doi:10.1016/j.amp.2005.04.015.
41. Kaiser BN, Haroz EE, Kohrt BA, Bolton PA, Bass JK, Hinton DE. "Thinking too much": A Systematic review of a common idiom of distress. Soc Sci Med. 2015; 147: 170–83. doi: 10.1016/j.socscimed.2015.10.044
42. Min SK, Suh SY. The anger syndrome hwa-byung and its comorbidity. J Affect Disord. 2010;124:211-4. doi: 10.1016/j.jad.2009.10.011
43. Min SK. Clinical correlates of hwa-byung and a proposal for a new anger disorder. Psychiatry Investig. 2008;5:125-41. doi: 10.4306/pi.2008.5.3.125
44. Lin KM, Lau JK, Yamamoto J, Zheng YP, Kim HS, Cho KH, et al. Hwa-byung. A community study of Korean Americans. J Nerv Ment Dis. 1992;180:386-91.
45. Min SWK. Hwabyung: a culture-related chronic anger syndrome of Korea. The First World Congress of Cultural Psychiatry Proceeding. 2006; S-III-23.
46. Gimlette JD. Remarks on the Etiology, Symptoms, and Treatment of Latah, with a Report of Two Cases. Br Med J. 1897;2:455-7. doi: 10.1136/bmj.2.1912.455-a.
47. Bartholomew RE. Disease, disorder, or deception? Latah as habit in a Malay extended family. J Nerv Ment Dis. 1994;182:331-8; discussion 339-41. doi: 10.1097/00005053-199406000-00004.
48. Landy D. Pibloktoq (hysteria) and Inuit nutrition: possible implication of hypervitaminosis A. Soc Sci Med. 1985;21:173-85.doi:10.1016/0277-9536(85)90087-5.
49. Lee S. Diagnosis postponed: shenjing shuairuo and the transformation of psychiatry in post-mao China. Cult Med Psychiatry. 1999;23:349-80. doi: 10.1023/a:1005586301895.
50. Weller SC, Baer RD, de Alba Garcia JG, Glazer M, Trotter R, Patcher L et al. Regional variation in Latino descriptions of susto. Cult Med Psychiatry. 2002;26:449-72. doi: 10.1023/a:1021743405946.
51. Durà-Vilà G, Hodes M. Cross-cultural study of idioms of distress among Spanish nationals and Hispanic American migrants: susto, nervios and ataque de nervios. Soc Psychiatry Psychiatr Epidemiol. 2012;47:1627-37. doi: 10.1007/s00127-011-0468-3.
52. Maeda F, Nathan JH. Understanding taijin kyofusho through its treatment, Morita therapy. J Psychosom Res. 1999;46:525-30. doi: 10.1016/s0022-3999(98)00113-5.
53. Suzuki K, Takei N, Kawai M, Minabe Y, Mori N. Is taijin kyofusho a culture-bound syndrome? Am J Psychiatry. 2003;160:1358. doi: 10.1176/appi.ajp.160.7.1358.
54. Iwata Y, Suzuki K, Takei N, Toulopoulou T, Tsuchiya KJ, Matsumoto K, et al. Jiko-shisen-kyofu (fear of one's own glance), but not taijin-kyofusho (fear of interpersonal relations), is an east Asian culture-related specific syndrome. Aust N Z J Psychiatry. 2011;45:148--52. doi: 10.3109/00048674.2010.534068.
55. Balhara YO. Culture-bound Syndrome: Has it Found its Right Niche? Indian J Psychol Med. 2011;33:210--5. doi: 10.4103/0253-7176.92055.
56. Flaskerud JD. What do we need to know about the culture-bound syndromes? Issues Ment Health Nurs. 2009;30:406-7. doi: 10.1080/01612840902812947.
57. Mateus MDML. Culture-bound syndromes. Psychiatry online Brazil. . 1998 [Cited 2020 Jun]. Available from: http://www.polbr.med.br/ano98/sinboun.php
58. Spiro ME. Cultural Determinism, Cultural Relativism and the Comparative Study of Psychopathology. Ethos. 2001;29:218-34. doi:10.1525/eth.2001.29.2.218
59. 59. Sam DL. Acculturation: conceptual background and core components. In: Sam DL, Berry JW, editors. The Cambridge Handbook of Acculturation Psychology. Cambridge: University Press; 2006. p11.
60. Tseng WS, editor. Handbook of cultural psychiatry. San Diego: Academic Press; 2001.
61. Blease C. Scientific progress and the prospects for culture-bound syndromes. Stud Hist Philos Biol Biomed Sci. 2010;41:333-9. doi: 10.1016/j.shpsc.2010.10.013
62. Sushrut J. Dhat syndrome: a re-evaluation. Psychiatry. 2004;3:14-6.
63. Low SM. Culturally interpreted symptoms or culture-bound syndromes: a cross-cultural review of nerves. Soc Sci Med. 1985;21:187-96. doi:10.1383/psyt.3.8.14.43399
64. Murphy HM. History and the Evolution of Syndromes; The Striking Case of Latah and Amok. In: Hammer M, Salzinger K, Sutton S, editors. Psychopathology. Contributions from the Social, Behavioral, and Biological Sciences. New York: John Wiley & Sons; 1973.
65. Tan EK, Carr JE. Psychiatric sequelae of Amok. Cult Med Psychiatry. 1977;1:59-67. doi: 10.1007/BF00114810