Culture, Community, and Schizophrenia

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INTRODUCTION AND OVERVIEW

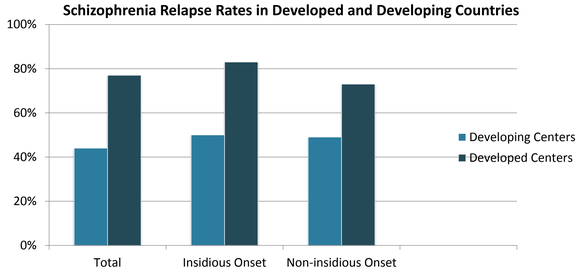
In the context of western psychology, schizophrenia is commonly spoken of by mental health professionals and laypeople alike with little to no emphasis on cultural factors. Rather, schizophrenia in the west has been generally conceived of as a medical, culture-free, neurobiologically-based mental illness that is immune to the particularities of sociality, history, religion/spirituality, and indigeneity (all factors that are instrumental to the richness and dynamism of culture). In this poster, we explore the phenomenon of culture as it pertains to the perceived etiology and persistence or remission of symptoms related to schizophrenia in developed (western) and developing (nonwestern) countries. Social perceptions of and interactions with persons with schizophrenia as evident through culturally sensitive lens will be of special interest in our discussion in terms of expressed emotion (EE) and its impact on symptom levels. Examining a psychological phenomenon in a manner that is empirical, universal, and devoid of any social particularity is only half the story.

In reviewing the literature with this sentiment in mind, we are implicitly calling for a glimpse into schizophrenia that honors and encompasses a more complete view of human experience; one that is sociological and not only biological/medical. To this end, we deem the inclusion of culture as a method of conceptualizing schizophrenia as an inclusion that is both essential and hopefully efficacious with regard to the understanding and treatment of schizophrenia. In this poster, our aim is to: (a) assess why persons with schizophrenia fare better in nonwestern cultures and (b) explore what sorts of cultural roles religion might play in positively enhancing treatment approaches to schizophrenia.

Question

What cultural factors might play a role in persons with schizophrenia faring more poorly in western cultures than in nonwestern ones?

Schizophrenia Relapse Rates in Developed and Developing Countries



Craig, Siegel, Hooper, & Sartorius (1997) re-analyzed the data from the original WHO study with improved statistical method to study 1056 individuals with schizophrenia over the course of two years in both developing and developed countries. Data collected in Aarhus, Agra, Cali, Chandigarh, Dublin, Honolulu, Ibadan, Moscow, Nagasaki, Nottingham, Prague, and Rochester.

CULTURAL DIFFERENCES

- In the U.S., there is a history of separating the mentally ill from the society at large. Since 1754 when President Franklin petitioned for "lunatics" to be kept in hospitals because they were "terrors to their neighbors," there has lingered a general apprehensiveness toward mentally afflicted individuals (Myers, 2010). In fact, 61% of U.S. Americans reported that they felt people with schizophrenia posed a danger to others, even though they do not (Myers, 2010). This may be contrasted significantly with other studies that demonstrate nonwestern countries' tendencies to keep people with schizophrenia integrated into societal living, rather than segregated. Jenkins' and Barrett's (2004) observation that persons with schizophrenia in nonwestern countries are much more likely to be married than their counterparts in the west. The social exclusion experienced by persons with schizophrenia in the west is certain to elevate stress levels and, so too, worsen mental health.

CULTURAL DIFFERENCES

- One of the most popular interpretations of the WHO study (lower relapse rate among individuals with schizophrenia in developing countries than in developed countries) was cultural differences in EE (Luhrmann, 2007; Watters, 2010). EE was first coined by George Brown in 1960s, and it has been an area of interest in its association with schizophrenia prognosis in many studies. "Expressed emotion, which is assessed through an interview with a key family member (parent, spouse, etc.), is a measure of how much criticism, hostility, or emotional over involvement the relative expresses when speaking about a family member with psychopathology. Although it is measured in an individual, it is thought to reflect disturbances in the organization, emotional climate, and transactional patterns of the entire family system." (Hooley, 2007, p. 331)

High EE Relatives in Comparison With Low EE Relatives

- Internal locus of control
- Over involvement behaviors
- Hostile
- Critical
- More readily to disagree with patients
- Display lower level of accepting behavior

(Hooley, 2007)

- Although EE has shown to be a significant predictor of schizophrenia relapse rate, the validity of EE as a predictor varies across cultures, which suggests culture may moderate the relationship between EE and relapse rate (Hooley, 2007). Bhugra and McKenzie (2003) suggested family and cultural factors contribute to intermediary factors which these intermediary factor will in turn influence level of EE, and EE affects patient's prognosis.
- Higher EE is more likely to be found in western societies. "For Whites, the perception that personality attributes are to be blamed for patient symptoms is likely related to core Anglo American cultural values which place a primary emphasis on factors such as independence, autonomy, responsibility, and goal achievement" (Jenkins & Karno, 1992). When schizophrenic persons' "personality attributes" are seen through the lens of such values, the likelihood of their experiencing higher EE is bound to increase. A culture that stresses personal will power and individual volition will also be a culture that is more critical of socially inappropriate behavior, thus contributing to higher EE and lower remission.
- Researchers have theorized that high levels of experienced stress and confusion on the part of patients with schizophrenia may make them more susceptible to both the emergence and persistence of symptoms (Kymalainen & Weisman de Mamani, 2008). Cultural mores that stress individual success and productivity may engender experienced stress and confusion for those persons with schizophrenia who are unable to respond according to the standards laid out by their societies. Industrialized western cultures are more prone to stress and are likely to create poorer social milieus for persons with schizophrenia.
- The afflicted person's self-awareness as pertaining to knowledge of the details of their condition is also a culture-specific phenomenon. Saravanan, David, Bhugra, Prince, and Jacob (2005) commented on the importance of measuring this sort of personal insight on the part of the schizophrenic person against the knowledge standards of the local culture. The authors insisted that measuring a person's view of reality (insight) against the social norms is essential for assessing an individual's mental health. That is, schizophrenic symptoms must not be seen in a way that is universal, but particular to the culture in question (Saravanan et al., 2005). This, according to the researchers, is the most humane method for assessing psychosis because it measures afflicted persons' levels of insight only from within their respective contexts. Though the authors make what appears to be a keen observation, it nevertheless contains implicit features of a western mindset. After all, the notion of self-reflection, personal insight, and introspection (even if with respect to one's own mental health) is in itself a culture-based value (more characteristic of western cultures) that assumes the potential for individualistic notions of the self. Correlating this form of insight with quality of mental health is a maneuver that may inadvertently marginalize persons with schizophrenia in westernized cultures, rendering them worse off symptomatically.

RELIGION, CULTURE, AND SCHIZOPHRENIA

McGruder (2004) pointed out that biological positivism and disease-oriented medical approaches to diagnosis and treatment of schizophrenia may prove to be counter-therapeutic for persons with illness because they situate the problem entirely inside the individual afflicted and cast aside the potential social dynamics involved. In other words, certain cultural conceptions may be less conducive than others to health and wholeness of individuals with schizophrenia. This, if true, carries implications for the methods used in treating schizophrenia since the positivist approach toward conceptualizing schizophrenia is one that is likely to render high traces of EE. A positivist, medically-oriented approach may pinpoint "the problem" as something objectively deficient within the person with illness. As a result, attitudes of judgment, marginalization, pity, anger, and frustration toward the person with schizophrenia may arise on the parts of members of society. This may be connected closely with higher EE. Religious and/or cultural environments that allow for or promote mystery and inclusiveness (rather than positivism and exclusiveness) may be more suitable for the psychological well-being of persons with schizophrenia.

The Mennonite Experience

During WWII conscientious objectors to the war were given the option of Civilian Public Service by serving in forestry, mental hospitals, etc. During these years some 1500 Mennonites served as attendants in asylums that warehoused the mentally ill. Neufeld (1983) reports that the simple care of the patients resulted in profound changes. Mennonite Mental Health Services (MMHS) was created to respond to the needs of the marginalized mentally ill and from 1947 onwards Mennonites established seven community oriented mental health centers across the country, including Kings View, Oaklawn, Prairie View, Philhaven and Brooklane. The original vision was to create a community for the mentally ill that reflected the Mennonite conviction that the church as a healing community could also serve as a context for the care of the mentally ill. Following the example of the Gheel community which stressed live-in care for mentally ill persons rather than centralized hospitals (Neufeld, 1983), patients in some centers lived in homes in the community, the facilities were not locked, and distinctions between patients and staff were minimized. The focus was to be on treatment rather than custodial care. Staff were recruited who shared this vision and many worked voluntarily as service assignments. No data is available on the effectiveness of this experiment. A 1987 reports states: "The mental health centers focused increasingly on professionalism and the contribution science offered in the field of prevention and treatment of mental illness. Principles and motivation of the church coupled with a high level of professionalism soon won recognition and approval of accrediting agencies, professional associations, and federal, state, and local agencies who provided grants and contracts to those centers which applied" (Fast & Jost, 1987).

RELIGION, CULTURE, AND SCHIZOPHRENIA

A Muslim Approach

McGruder (2004) found that families in Zanzibar with a member with schizophrenia had low EE and had adopted a normative local conflict resolution style which was marked by low confrontation and indirectness, and would avoid bringing shame to patients. The family endorsed traditional beliefs that the patient was possessed by the spirit of a deceased ancestor and magical forces. This perceived etiology led to positive effects on the patient's recovery because it was not assumed to be a permanent condition. The application of traditional beliefs to the patient's bizarre behaviors allowed the family to adopt an understanding and forgiving approach to the patient. They did not impose judgment on the patient's delusions, nor did they push for normal behavior. An absence of emotional over involvement and a low level of hostility toward the patient were observed. The patient did daily chores at home which were within her ability and she was accepted by her family for her contribution at home. Because others in the society also held traditional beliefs, the mentally ill family member received social support from both the family and the society. One participant was calmed by socially acceptable spiritual interventions, such as drinking a mix of herbs and having the Koran read over her bath water prior to its use (McGruder, 2004). McGruder observed: "There was a clear congruence between Swahili cultural values regarding conflict resolution and expression of emotion, Islamic beliefs, expectation of adversity in life and the low expressed emotion of family environments" (McGruder, 2004, p. 315). That is, culture and religion combined to inform interpersonal relations between members of the community, including the mentally afflicted person. The Qu'ran states that Muslims are people who during ease and hardship, in the cause of Allah, "restrain anger and [who] pardon the people, and Allah loves the doers of good" (Qur'an 3:134). The family members of the participants in McGruder's Zanzibar study, as faithful Muslims, lived in accordance with this religious teaching, thus creating lower levels of EE in their cultural context.

CONCLUSION

We conclude that while biological factors are a most important factor in understanding schizophrenia, culture does influence schizophrenia in particular ways. Negative expressed emotion toward persons with schizophrenia varies with the level of individualism in cultures such that in some contexts the patient is less integrated into the social milieu. The Muslim study and the Mennonite experience suggest that religions may model greater social inclusion of persons with schizophrenia. More experiments with communal and religiously sensitive approaches to treatment are encouraged.

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