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ISSUE: 2021 / NO. 01 / ISSN 2773-5818(ONLINE)

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Singapore | January 2021

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Executive Summary

The movement for global mental health (MGMH) has been initiated to improve mental health care services in countries where such services are scarce. However, one of the criticisms of the MGMH is its' overemphasis on Western mental health approaches that may not be generalized to other cultures, particularly those in developing and non-Western countries. This article aims to examine the importance of recognizing local idioms of distress, and integrating indigenous healing systems into mental health care by using Asia as a case example.

Suggested citation: Lee, B.O. (2021, January). *Idioms of Distress and Indigenous Healing System in Asia*. Relate Insights 2021/01. Relate Mental Health Malaysia. https://relate.com.my/idioms-of-distress-and-indigenous-healing-system-in-asia/

Cultural Syndrome and Idiom of Distress

The MGMH aims to "close the treatment gap for people living with mental disorders worldwide. The Movement focuses on those populations where the gaps are the largest: among people living in low- and middle-income (LAMI) countries (p. 88).[1] Treatment gap refers to the difference between the number of people diagnosed with *mental disorders* and the number of people receiving *mental health care*.[2] However, this notion of treatment gap can be further interpreted that a *specific* form of mental health care (together with its nosology) is not adequately available and accessible in LAMI countries. This form of mental health care is primarily embedded in the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013) or the International Classification of Disease.[4] Before asking the question about how to make this form of mental health care more available and accessible, it is germane to ask whether it is epistemologically relevant to the local community, and whether Asian people have their own ways to explain their distress.

Culture shapes the meaning, experience, expression and coping of distress [5-7] including those conditions listed in DSM. DSM-5 [3] acknowledges that

> all forms of distress are locally shaped, including the DSM disorders… many DSM diagnoses can be understood as operationalized prototypes that started out as *cultural syndromes*, and became widely accepted as a result of their clinical and research utility. Across groups there remain culturally patterned differences in symptoms, ways of talking about distress, and locally perceived causes, which are in turn

associated with coping strategies and patterns of help seeking." (p. 758; emphasis added).

Cultural syndromes are "clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts and that are recognized locally as coherent patterns of experience" [3] (American Psychiatric Association, 2013, p. 758). As such, the DSM nosology, which has been primarily developed in Euro-American cultures, is a collection of cultural syndromes that may or may not be applicable to Asians. Nonetheless, this does not mean DSM disorders are completely irrelevant, as cultural syndromes are not necessarily unique to a particular local culture due to globalization, intercultural influences, cultural dynamic, and shared experiences (e.g., somatization, dissociation). This is one of the reasons for DSM-5 to replace "culture-bound syndrome" with "cultural syndromes". However, it is still important to apply the DSM diagnoses across cultures with caution.

Although DSM disorders can be perceived as cultural syndromes, most of them are not organized as syndromes with distinctive symptoms, courses, etiologies or responses to treatment.[8] Many DSM disorders, for example, are not discrete and may have common latent structures. [9-11] DSM disorders tend to be dimensional, situating on a continuum between normality and abnormality as symptoms (e.g., depression, anxiety, hallucinations) are

commonly present in both clinical and non-clinical populations.[12] This dimensional and dynamic approach to emotional distress may be better captured by the concept of idiom of distress than cultural syndrome. The term "idiom", which does not presuppose pathology, can be used to denote everyday life concerns or more clinically significant afflictions.[8,13] People verbally and non-verbally communicate their distress through idioms as a part of their lived experiences.

Asian culture is rich in such idioms. *Latah*, which is found in Indonesia, Malaysia and Singapore, is characterized by exaggerated and uncontrollable startled response, altered states of consciousness, echolalia, and obeying other people's commands.[14] These behaviors usually occur in unpleasant social situations. Japanese people may develop *taijin kyofusho* (対人恐怖症), stemming from the fear of offending and embarrassing others. Common presenting narratives include the anxieties of blushing, maintaining eye contact, having deformed body, and having foul bodily odor.[15] *Latah* and *taijin kyofusho* may reflect an interdependent view of self [16] and a heightened sense of sensitivity to interpersonal relationships in Asian people. As a result, they may become more prone to socially-related distress.[17]

In Korea, people may present *hwabyung* (火病 or fire-illness) with symptoms such as chest pain, suffocating feelings, anger and fatigue.[18] Among the

Chinese people, they may present *shenjing shuairuo* (神經衰弱 or weakness of the nervous system) marked by weakness, fatigue, worry and insomnia.[19] *Hwabyung* and *Shenjing shuairuo* cannot be understood in a sociocultural vacuum. They are embedded in the traditional Chinese medical system that does not differentiate among mind, body and the environment.[20] As such, in contrast to the DSM diagnoses of somatic symptom and related disorders, these idioms of distress may make more sense to Asian people subscribing to traditional health beliefs.

The concept of idiom of distress accentuates the importance of contextualizing emotional distress. The recent trends in promoting technical paradigms in psychiatry, such as medicalization, have sidelined beliefs, meanings and values involved in personal experiences of life predicaments.[21] Local idioms such as *latah* or *shenjing shuairuo*, rather than "social anxiety" or "major depressive disorder", may be more meaningful to some Asian people. Using words and phrases that local people can comprehend will facilitate a strong therapeutic relationship. Therefore, it is relevant to incorporate local conceptualizations of emotional distress in mental health care instead of simply imposing DSM diagnoses on Asian people.

Incorporation of local idioms of distress is not the same as using local languages to replace DSM diagnoses for the sake of communication or de-

stigmatization. For example, *jungshinbunyeolbyung* (精神分裂病), schizophrenia in Korean, means mind-splitting disorder. Korean psychiatrists have changed it to *johyeonbyung* (調絃病) or "attunement disorder", likened to a string instrument that goes out of tune.[22] The new name is supposed to be less stigmatized. Similarly, in Taiwan, schizophrenia is now called "the disorder of thought disturbances" without having the connotation of mind-splitting.[23]

Although these efforts point to the importance of understanding emotional distress in a cultural context, they are not the same as identifying concepts and ideas that are already existing in Asian cultures. Idioms of distress capture local experiences that may be overlooked in the DSM nosology. They are not the same entities as DSM diagnoses in different names. *Latah* is not completely the same as social anxiety or neither is *shenjing shuairuo* completely the same as major depressive disorder even though they share similar symptoms. Symptoms of *latah* include a combination of anxiety, fear, dissociations and somatic symptoms. Somatic symptoms are also commonly presented in *taijin kyofusho*, *hwabyung*, and *shenjing shuairuo*. In contrast, somatic symptoms are separately listed in categories such as "Somatic Symptom and Related Disorders" or "Sleep-Wake Disorders" in DSM. The differences between some Asian idioms of distress and the DSM nosology may reflect the cultural variations in viewing the mind-body relationship and symptom interpretations.

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If "DSM disorders started out as cultural syndromes and became widely accepted as a result of their clinical and research utility (p. 758)"[3] the same can be attained for these idioms of distress in Asian societies. However, with the sociopolitical power of biomedicine and psychiatry, the Western form of mental health care has dominated the social discourse of normality and abnormality in Asian societies where local idioms are relegated as "cultural beliefs" whereas the DSM and ICD nosology is considered "objective" or "scientific".

Indigenous Healing Systems

As mentioned earlier, the notion of treatment gap simply means the unavailability and inaccessibility of the Western form of mental health care based on the DSM or ICD nosology. It ignores the local resources that are already available for people to draw on to cope with life aversities. These local resources or indigenous healing systems are the cultural strengths and resilience of ethnocultural groups.[20,24] They can be potentially integrated into the total health care systems in Asia to culturally sensitize mental health care, including psychotherapy. There are many indigenous healing practices in Asia,[20] for example, traditional medicines including Ayurvedic, Islamic and traditional Chinese medicines.[25] Despite a large body of research on their relevance to mental health, it is important to recognize that these traditional medicines do not strictly separate among mind, body and a larger social and cosmological context. In other words, mental health should

be addressed and promoted in relation to physical health and in a larger social context. This is in shape contrast to the biological reductionism and Cartesian dualism in Western mental health practices.

There has been a movement of indigenous psychology in Asia since the 1970s,[20] including the development of indigenous psychotherapies. For example, the Korean *Onmeum* counseling (온마음상담), and the Japanese *Morita* (森田療法) and *Naikan* (內觀療法) therapies, which are embedded in Buddhist philosophy. There are also the Chinese Taoist Cognitive Psychotherapy and the Korean Tao Psychotherapy, which are both rooted in Taoist philosophy.

All these indigen ous healing practices reflect the Asian notion of self in which the self is inseparable from a larger whole comprising not only other people but also divine forces, nonhuman agencies, physical environments and the cosmic order.[26-27] The aim is not to regulate unique inner attributes or biochemical imbalance, as in the case of Western mental health treatments, but to guide individuals to live in harmony with other beings and the environment.[27] Of course, given the diversities in Asian cultures, not all Asian people (e.g., Christians or Muslims) are receptive to their own Asian indigenous healing practices.

Conclusion and Implication

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Since there are already local conceptualizations of distress and healing practices, the MGMH can tap these recourses and collaborate with indigenous healers to narrow the treatment gap. Western nosology and mental health care certainly have their therapeutic values. However, an emphasis on local resources, meanings and diversities will make mental health care more culturally sensitive, relevant and pragmatic.

There are a few ways to make mental health care more culturally sensitive in Asia. First, a course on culture and mental health should be included in the curricula for training mental health professionals such as psychologists, counselors, social workers, nurses and psychiatrists. At the end of this course, they are expected to be competent in self-awareness (becoming aware of their own cultural values, worldviews and biases), cultural knowledge (becoming aware of their clients' or patients' worldviews), and skills (abilities in implementing culturally sensitive interventions).[28] These professionals will then provide direct clinical services or consultations to other professionals in the health care sectors.

Second, as mentioned earlier, if "DSM disorders started out as cultural syndromes and became widely accepted as a result of their clinical and research utility" (p. 758),[3] the same can be attained for idioms of distress in Asian societies. Tertiary institutions and government organizations should set up research grants to study local idioms of distress and their relevance

to mental health care. Clinical trials may be conducted to examine the efficacy of cultural formulations and interventions that are based on local idioms of distress or indigenous healing practices.

Finally, indigenous healing systems can be systematically integrated into the total health care systems to encourage collaborations between mental health professionals and indigenous healers.[24] Asian mental health professionals may learn from a hospital in America where a Hmong shaman is allowed to perform ritual ceremonies in patients' rooms).[29] This form of creative integration between Western and Eastern approaches reflects an open-minded and inclusive policy recognizing the value of diversity and pragmatism.

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