

## ‘Universality of Mental Illness’ Revisited: Assumptions, Artefacts and New Directions

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The universality of mental illness is a concept which implies the existence, across a wide range of cultures, of categories of mental illness with similar presentations or comparable rates, or both. Clinical experience leaves no doubt about the universality of mental illness as a broad group of phenomena which are part of universal human experience, just as there is no question about the universal experience of infectious disease or malignancy. However, this does not imply the universality of specific categories of mental illness as defined by ICD-10 or DSM-III-R (World Health Organization, 1992; American Psychiatric Association, 1987). The concept of universality is unique to psychiatry; it has imposed restrictions on cross-cultural psychiatry which have limited the latter’s scope and affected the validity of its findings.

### Why determine universality?

One answer to this question lies in the assumptions held by psychiatric epidemiologists, and psychiatrists in general, that “the implication of this finding [of universality] is that the cause or causes of narrowly defined schizophrenia must be common to a variety of cultures” (Wolff *et al*, 1990) and that “if a psychiatric disorder is found to have the same manifestation in two different cultural settings, then it must be either the production of genes that are common to man . . . or else the consequence of environmental features which are shared by the two cultures” (Leff, 1988). In these statements universality (i.e. “the same manifestation”) is assumed to have aetiological significance. If environmental and cultural factors are assumed to be widely variable, the finding of universality may be taken as implicit evidence of a biological aetiology for an illness. On the other hand, if one allowed several biological aetiologies, then universality would require external factors to be identical, and to be of prime importance in the aetiology of the disease in question. Furthermore, since “. . . the search for relevant causal factors . . . is often undertaken without a coherent theoretical framework, epidemiological data can help to build this framework and establish its validity” (Tansella *et al*, 1992). The search for

universality seems driven in part by the belief that, once it is determined, a biological aetiology can be assumed, and this aetiological assumption can then be used to confirm the validity of modern diagnostic categories.

There are problems with this approach, regardless of whether the term ‘manifestations’ refers to psychopathology or frequency. First, if a certain set of symptoms or signs were defined as characteristic of a particular category of mental illness, and the same set was encountered in different cultures, then this could be taken as evidence of universality. However, in somatic medicine one would search for a common *pathology* in different populations as evidence of universality; conditions with similar presentations can have very different aetiologies, and vice versa. The problem of distinguishing between illness and disease (Helman, 1981) is relevant here. In the absence of independent validating criteria for our diagnoses, psychiatric categories might be best classed as illnesses, or even ‘folk’ categories of Euro-American thought. The finding of common phenomenology may simply mean that the particular research interview has successfully identified similar phenomena in different cultures (Kleinman, 1987) and, while these findings may validate the existence of similar syndromes, they have little aetiological significance by themselves. Moreover, the phenomena detected by current diagnostic systems are expressions of pathology and not the pathology itself; it is still a matter of some debate which manifestations relate to which syndromes. On the other hand, ‘manifestations’ could refer to the frequency of an illness. Thus, if a syndrome had a similar prevalence in different settings, this might be taken to have aetiological significance. However, in order to make causal inferences from epidemiological data, one has to study the relationship between proposed causal factors and the illness. One would need to show that the syndrome was consistently related to a particular hypothesised factor, or factors, in different cultures and assess the strength of the association, the temporal nature of the relationship and so on (Rothman, 1986) before making any causal inference.

Despite these problems with the aetiological implications of universality, it has influenced the design and interpretation of many cross-cultural studies. For example, the finding that the prevalence of schizophrenia may be much higher among British persons of Caribbean origin sparked much debate on racist attitudes, cultural biases, and misdiagnoses (Fernando, 1991) not least because, as schizophrenia was a 'biological' illness, most psychiatrists expected equal prevalence rates. Contrast this with the finding that sickle-cell anaemia was particularly common among West Africans in the UK; in this case, independent data on aetiology and distribution patterns led to an understanding of the different prevalence rates.

#### Who defines universality?

The predominant paradigm in psychiatry today is that developed in Europe and North America over the past century or so. Models of mental illness have been built up over decades, and as the search for definitive pathologies continues, complex systems of classification have been developed and new interview schedules designed to test these classifications in large multi-centre field trials. This experimental model has been chosen even though many of the categories are imprecise and some workers have even questioned the usefulness of categorising common mental illness (Goldberg & Huxley, 1992). Those who design such studies take great efforts to collaborate with colleagues worldwide. However, if one considers the composition of the team that finalised the ICD-10, the sole international classification (WHO, 1992), it hardly appears to fairly represent different cultures. Of the 47 eminent psychiatrists who contributed the initial draft, only 2 are from Africa, and none of the 14 field trial centres has been in sub-Saharan Africa. The results are perhaps not surprising; categories such as nymphomania and multiple personality disorder are classified under individual codes (Excessive sexual drive [F52.7] and Multiple personality disorder [F44.81] respectively), while conditions such as the brain fag syndrome, which has been described for over 30 years in Africa (Anumonye, 1985), are not classified at all. This is in contrast to the classification of somatic illnesses; to take one example, the Kyasanur Forest Disease, a viral illness encountered in isolated forests in southern India, has an independent category in the ICD-10.

This dominant model has reduced illnesses encountered in other cultures which do not resemble Western categories to 'culture-bound' or 'masked' representations of 'real' illness. For example, despite

finding that "none of the patients complained of subjective symptoms of either apprehension or fearfulness in the case of anxiety, or sadness, guilt or nihilism in the case of depression" and that even "direct inquiry about these feeling states also failed to elicit positive responses", Ndeti & Muhangi (1979) report that anxiety and depression were the commonest diagnoses in their sample of patients in a rural clinic in Kenya. The unstated assumption is that there is some common 'pathology' shared by depression in Western settings and that taken to be 'depression' in Kenya even in the absence of any archetypal mood change. Similarly, Gillis *et al* (1982) report from South Africa that "there are undoubtedly differences in the manner by which they [the experiential events of psychiatric disturbance] are expressed or described, and in the syndromes and compound diagnostic entities, but *these are ascribable to cultural factors*" (our emphasis). The diagnoses (defined by the PSE) are assumed to be valid, and any variations (apparently numerous) dismissed as being due to cultural factors, without any evidence being presented to support this view (Swartz, 1987).

#### Future directions

Attempts to determine universality to date have established one fact: that mental disorder is identifiable in all cultures. The universality of any specific ICD-10 or DSM-III-R category has not been proven beyond doubt. If proven, it would be astonishing—for mental illnesses could vary within regions and peoples in a single geographical area, such as schizophrenia in the UK, and yet seem to be 'universal' at an international level. Further, this would be a finding unique in medicine since no known illness occurs with identical presentation and frequency throughout the world. Given that mental illnesses are virtually always multi-factorial in aetiology, the balance of biological, genetic, cultural and environmental factors would have to be remarkably similar to generate similar rates. Indeed, the frequently stated universality of schizophrenia may be an artefact created by three factors: the use of predefined criteria resulting in a category fallacy (Kleinman, 1987); the selective use of epidemiological data (Torrey, 1987); and methodological flaws of the multi-national studies on the epidemiology of schizophrenia (Leff, 1988).

#### Multi-national v. regional studies

The emphasis of cross-cultural research should shift from multi-national to regional studies. The

methodologies and aims of multi-national studies have been problematic for many reasons. First, there has been an extreme reliance on standardisation. Premature construction of uniform standards of diagnosis and classification do not necessarily facilitate the study or understanding of mental disorder. Indeed, such an approach may stifle or discourage new insights and ideas, especially from those with differing cultural backgrounds to the designers of the systems. Second, developing nations tend to be stereotyped, and the variations in the nature of mental illness in each country are minimised by assuming psychiatrists to be the only "experts". Up to 70% of the rural population of Botswana consult a traditional healer in a year; psychosomatic symptoms account for nearly 40% of cases (Staugard, 1985). In Zimbabwe, up to 80% of the rural population consult traditional healers (Mutambirwa, 1989) who not only recognise that they have a special skill in the treatment of mental illness (Fanuel, 1992) but are also recognised by the formal medical sector as playing a significant role in primary mental health care (Chikara & Manley, 1991). The few psychiatrists who work in Zimbabwe and Botswana are primarily concerned with hospital based care of severely disturbed patients. Third, it is unclear whether the findings of such studies are understood and accepted by 'non-psychiatric' communities in different cultures. Finally, there seems to be little attempt to link the findings of multi-national studies to health policies or the delivery of mental health services in developing countries.

#### A need for regional classifications

In the absence of validating pathological criteria, the process of determining the nature and prevalence of mental disorders in different cultures needs to begin with the identification of particular illness categories as described by communities in those different cultures. Clusters of similar patients should be observed longitudinally to determine course, treatment response and outcome. This will necessitate the development of locally-validated instruments, sometimes *de novo*. Once such a regional classification is developed, categories could then be compared with those identified elsewhere. Such studies should include health workers such as nurses and traditional healers. While generating such culturally valid psychiatric categories may seem a daunting task, such research has been accomplished successfully (Beiser *et al*, 1972; Kleinman, 1980) and is likely to be less complex and costly than multi-national studies. Non-governmental organisations in Zimbabwe are funding extensive research into

maternal and child health and AIDS to determine locally relevant data on prevalence and practice; mental health rarely appears among their "areas of interest". The Mental Health Division of the WHO, and others working in international research, should take the lead in conducting local or regional studies in selected areas to complement multinational ones. Such regions should be encouraged to define their own priorities and methodologies within an enabling and supporting international framework, while local clinicians and researchers develop classifications and instruments for regional use.

Mental disorder occurs in all cultural settings and psychiatric treatments appear effective in all racial groups. However, if 'mental health for all' is to be a meaningful slogan, knowledge gained from cross-cultural psychiatric research must be valid and be made accessible, comprehensible and useful to all health professionals and to the communities in which they work. For this, cross-cultural research needs to begin in the community it is supposed to serve, and be guided by its needs and priorities.

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