Issues in the Diagnosis of Native American Culture-Bound Syndromes

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Abstract
This paper provides an introduction to the concept of culture-bound syndromes and the application of this concept to Native Americans. Culture-bound syndromes are patterns of abnormal behavior that are only found in specific cultures or sub-cultures. Counselors and others who work with Native American clients should understand the controversy over culture-bound syndromes and the ways that Native American clients may express psychological distress in culturally-specific ways. A list of Native American culture-bound syndromes is presented, and suggestions are made regarding their diagnosis in Native clients.
While some mental disorders and syndromes are thought to be universal, others are only found in specific cultures or sub-cultures (Lilienfeld & Arkowitz, 2009). Native Americans, like all human beings, are subject to experiencing psychological distress. There is good evidence that several forms of psychopathology existed among indigenous peoples in North America prior to European colonization (Waldram, 2004). Indigenous peoples experienced many challenges in daily life and were not immune to conditions such as anxiety, depression and suicide. Negative feelings, maladaptive responses to stress, and disorders with a large biological component (such as schizophrenia) have been found in every culture studied (Stevenson, 2010). Indigenous people in North America experience mental disorders common to all human beings, but they may also experience mental disorders that are only found in their own tribal cultures or sub-cultures.

The DSM-IV-TR (American Psychiatric Association, 2000) included an appendix with a glossary of “culture-bound syndromes,” defined as “recurrent, locality-specific patterns of aberrant behavior and troubling experience;” they “are localized, folk diagnostic categories” (p. 898). These culture-bound syndromes may or may not correspond to DSM-IV-TR mental disorders. They have also been called “ethnic neuroses,” “culture-reactive syndromes,” and “folk diagnoses” (Hughes, Simons, & Wintrob, 1997). Some culture-bound syndromes have been found to occur only in Native Americans.

The concept of culture-bound syndromes is controversial. Are there mental disorders or syndromes that only exist in one or a few cultures, or are those syndromes simply local cultural variations of forms of psychopathology that are universal?
Proponents of universalism believe that all human beings have basically the same underlying psychological mechanisms that are common to various forms of psychopathology across cultures. On the other hand, cultural relativists argue that all forms of psychopathology are linked to the cultural meanings in particular contexts (Stevenson, 2010). Hughes (1998) suggested that the DSM-IV-TR’s assumptions about the ontologic status of the culture-bound syndromes are unacceptably ambiguous. Since culture should be considered in every diagnosis, the claim that some syndromes are unique or specific to a particular culture may be unnecessary. Another criticism is that when culture-bound syndromes are separated from other mental disorders they become a museum of exotic, static entities, rather than simply culture-specific expressions of the same underlying psychopathology (Hughes, 1998).

The idea that some mental disorders are present in all cultures does not preclude the possibility that some disorders may exist only in certain cultures. For example, some Inuit seal hunters in Greenland experience a condition called kayak angst (which is considered a culture-bound syndrome) characterized by feelings of panic while out on the ocean. But from the point of view of Western psychiatry the condition could also be seen as panic disorder with agoraphobia (Lilienfeld & Arkowitz, 2009). So kayak angst could be seen either as a disorder specific to the seal hunters, or it could be seen as a unique cultural expression of panic disorder. It is likely that while general forms of psychopathology such as depression and anxiety are universal, the ways that these syndromes are expressed are determined by cultural values, norms, and traditions. Experts agree that culture can shape both the experience and the expression of mental disorders in significant ways (Simons & Hughes, 1985). If culture influences the
expression of all disorders, then in a sense all mental disorders are culture-bound. If that is true, then there is no need to have a separate category of culture-bound syndromes in our diagnostic systems.

The American Psychiatric Association, which sponsors the development of the diagnostic manuals used by counselors, psychologists, psychiatrists, and other mental health specialists, takes the position that psychopathology is universal, but specific cultures exhibit psychopathology in culturally specific ways. The culture-bound syndromes are considered different enough from general forms of psychopathology that they should have their own labels. Psychopathology is universal, but cultures vary in how it is expressed (Simons, 2001). Both the DSM-IV-TR and the DSM-5 contain lists of culture-bound syndromes, suggesting that they are real syndromes, but they are not coded and are not included in the main part of the manual, which gives them a secondary status. Since they are not coded the treatment of these conditions is not typically reimbursable by third-party payers. This practical consideration could affect how often culture-bound syndromes are diagnosed by counselors, psychologists, and psychiatrists.

**Native American Culture-Bound Syndromes**

The DSM-IV-TR appendix (American Psychiatric Association, 2000) refers specifically to Native Americans as experiencing ghost sickness (among many tribes), *pibloktroq* (among the artic and subarctic Inuit), and *iich’ aa* (a pattern of behavior similar to amok, among the Navajo). A fourth syndrome, *susto* (fright), also called soul loss, is described as a folk illness affecting people in many cultures, presumably including Native Americans. The placement of these conditions in an appendix indicates that although these syndromes can be diagnosed, they are not mental disorders in the same
sense as the mental disorders in the main part of the manual. The DSM-IV-TR also has a reference to Navajo “frenzy” witchcraft as a condition that may have symptoms that meet diagnostic criteria for Dissociative Fugue (p. 524). The condition is characterized by the sudden onset of a high level of activity (such as running), a trancelike state, and potentially dangerous behavior (American Psychiatric Association, 2000). However, the disorder Dissociative Fugue was omitted from the DSM-5, which was published in 2013, and there is no mention of Navajo “frenzy” witchcraft in DSM-5.

The glossary of culture-bound syndromes in the appendix of the DSM-IV-TR was not intended to include all such syndromes. Rather, it “lists some of the best-studied culture-bound syndromes and idioms of distress that may be encountered in clinical practice” (American Psychiatric Association, 2000, p. 899). The DSM-5 includes a similar glossary of conditions called “cultural concepts of distress” (p. 833) rather than culture-bound syndromes. No explanation for the change in terminology was provided, but it suggests that these conditions should be seen as heavily influenced by culture, but not necessarily bound or limited to one specific culture. The change in terminology may have been prompted by the controversy over culture-bound syndromes in the literature since DSM-IV-TR was published. Three syndromes included in the DSM-IV-TR glossary were omitted in the DSM-5 glossary (ghost sickness, pibloktoq, and iich’ aa, a condition listed under the heading “amok”). Susto was retained in the DSM-5 glossary. The only mention of Native Americans in the DSM-5 glossary is the statement that they may experience a condition similar to Kufungisisa (“thinking too much”) (p. 835).

Table 1 presents a list of the cultural syndromes which are included in the DSM-IV-TR and the DSM-5. These are considered some of the most well-established Native
American culture-bound syndromes, but the list is not comprehensive. Some of these syndromes are thought to occur in individuals from many tribes (such as ghost sickness and soul loss) while others have only been found in specific tribes. Table 2 presents several additional Native American culture-bound syndromes that are described in the literature.

Table 1

Native American Cultural Syndromes Included in the DSM-IV-TR and the DSM-5

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>ghost sickness</td>
<td>DSM-IV-TR, p. 900</td>
</tr>
<tr>
<td><em>pibloktoq</em> (arctic hysteria) (Inuit)</td>
<td>DSM-IV-TR, p. 901</td>
</tr>
<tr>
<td>soul loss (similar to <em>susto</em>)</td>
<td>DSM-5, p. 836 and DSM-IV-TR, p. 903</td>
</tr>
<tr>
<td><em>iich’ aa</em> (moth madness) (Navajo)</td>
<td>DSM-IV-TR, p. 899</td>
</tr>
<tr>
<td>“frenzy” witchcraft (Navajo)</td>
<td>DSM-IV-TR, p. 524</td>
</tr>
<tr>
<td>fatigue from thinking too much</td>
<td>DSM-5, p. 835 and DSM-IV-TR, p. 900</td>
</tr>
</tbody>
</table>
Table 2

Additional Native American Cultural Syndromes Described in the Literature

<table>
<thead>
<tr>
<th>Syndrome/Condition</th>
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<tbody>
<tr>
<td><em>wacinko</em> syndrome (Oglala Sioux; Lakota Sioux)</td>
</tr>
<tr>
<td><em>windigo</em> (or windigo psychosis); also spelled wendigo; witiko, windiga, etc.</td>
</tr>
<tr>
<td>(Northern Algonkian; Cree, Ojibwa, Salteaux, and related groups)</td>
</tr>
<tr>
<td>crazy sickness or crazy violence (Navajo)</td>
</tr>
<tr>
<td>worry sickness; unhappiness; heartbreak; drunkenlike craziness; turning one’s face to the wall (Hopi)</td>
</tr>
<tr>
<td>heartbreak (Mohave)</td>
</tr>
<tr>
<td>kayak angst (Inuit)</td>
</tr>
<tr>
<td><em>hiwa: itck</em> (loss of appetite, sleeplessness, depressed behavior) (Mohave)</td>
</tr>
<tr>
<td><em>tawatl ye sni</em> (‘totally discouraged’) (Dakota Sioux)</td>
</tr>
</tbody>
</table>

**Conceptualization of Mental Illness**

A research study was conducted to investigate how Hopi Indians conceptualize mental illness. The study participants were asked “What are the sicknesses or things that can be wrong with people’s minds or spirits?” (Manson, Shore, & Bloom, 1985, p. 336). The participants responded with names for five tribal-specific disorders: worry sickness; unhappiness; heartbreak; drunkenlike craziness (with or without alcohol); and turning one’s face to the wall. No exact conceptual equivalent to “depression” was found among the Hopi, but the condition “heartbreak” was strongly associated with symptoms of depression, and was the most frequent condition among those Hopi people diagnosed
with major depressive disorder (Manson, Shore, & Bloom, 1985, p. 336-7). The five categories the Hopi use to think about mental illness do not fit well with DSM nosology, and it would be improper to try to force them into standard psychiatric categories (Trimble & Medicine, 1993).

Many so-called culture-bound syndromes are actually syndromes with local names but a shared, cross-cultural distribution (Hughes, 1998). Some researchers have argued that efforts to describe mental disorders as unique to specific cultures can easily lead to cultural stereotyping, which could contribute to stigmatization. Waldram (2004) has argued that the culture-bound syndromes *windigo* psychosis, *pibloktok*, and ghost sickness are actually constructions of scholars rather than actual mental disorders.

The story of the *windigo* provides a cautionary example showing how a literal interpretation of folklore can lead to false conclusions. Stories about the *windigo* were told by members of Algonkian communities in northern Canada (mostly Cree and Ojibwa). The *windigo* in Algonkian folklore was said to be a cannibal monster who roamed the forests and attacked passers-by. The folklore said that under certain circumstances a person could transform into a *windigo*. Some Western anthropologists took the folklore seriously and suggested that people could develop *windigo* psychosis and become cannibalistic. *Windigo* psychosis was proposed as a culture-bound psychiatric syndrome among the Algonkian. However, according to Waldram (2004) the *windigo* monster and *windigo* psychosis are both mythical concepts; no actual cases have ever been found or studied.

*Pibloktok*, or “Arctic hysteria,” is a condition that has been described as occurring among most Inuit populations. It has been used as a prime example of a culture-bound
syndrome, and it is listed as such in the DSM-IV-TR (American Psychiatric Association, 2000). The DSM-IV-TR describes *pibloktoq* as “an abrupt dissociative episode accompanied by extreme excitement . . . and frequently followed by convulsive seizures and coma” (p. 901). The individual tears off his or her clothes, runs around in the snow, and performs irrational or dangerous acts. However, few cases of *pibloktoq* have actually been reported; Vallee (1966) was only able to find one Inuit who had ever heard the word *pibloktoq*. Kirmayer, Fletcher, Corin, and Boothroyd (1997) were unable to find a single case of *pibloktoq* in their study of three Inuit communities. Like *windigo* psychosis, it may be that *pibloktoq* exists more as a construction of anthropologists and psychiatrists than as a reality (Dick, 1995).

The idea that spirits can cause illness is a common belief of indigenous peoples around the world. Traditionally, people in many different indigenous tribes have suffered from mental and emotional stress related to concerns about death, ghosts, and witchcraft (Stevenson, 2010). The culture-bound syndrome “ghost sickness” has been found in many Native American tribes. Navajo individuals who experience ghost sickness have the symptoms anxiety, fear, helplessness, delusions, and nightmares (Trimble, Manson, Dinges, & Medicine (1984). Fathauer (1951) wrote that Mohave people experiencing ghost sickness were unable to sleep, had nightmares, were afraid of darkness, and cried for long periods of time. Opler (1945) described the Apache peoples as having a terror of ghosts and of anything associated with death.

The DSM-IV-TR (American Psychiatric Association, 2000) described ghost sickness as “a preoccupation with death and the deceased (sometimes associated with witchcraft) frequently observed among members of many American Indian tribes” (p.
Symptoms can be quite various, including bad dreams, weakness, fear, anxiety, hallucinations, confusion, and feelings of futility. Based on their research among the Navajo, Kaplan and Johnson (1964) described ghost sickness as a mental disorder in which the individual thinks he or she has been possessed by a ghost, and as a result feels weak and sick and has troubling thoughts. Sometimes these symptoms were also thought to be attributable to witchcraft. While ghost sickness has been considered a bona fide mental disorder (Kaplan & Johnson, 1964), little research has been done to determine how it might fit into Western psychiatric nosologies (Waldram, 2004). In the literature, descriptions of “typical” cases of ghost sickness in Navaho individuals were based on very small sample sizes (e.g., 12 people) and their symptoms were so varied that it is questionable whether they all had the same disorder.

The research on ghost sickness is very limited, and it may well be that several different syndromes have been called ghost sickness, even though the symptom profiles differ. Some of the people in the cases of ghost sickness described in the literature do not even refer to death, ghosts or witchcraft. Given the ambiguity of defining ghost sickness, and the lack of good research on its actual occurrence, the statement in the DSM-IV-TR that it is “frequently observed among members of many American Indian tribes” (American Psychiatric Association, 2000, p. 900) is difficult to support. The controversy over whether the conditions windigo psychosis, pibloktoq, and ghost sickness exist illustrates the difficulty of studying mental disorders in different cultures. People in different cultures have their own culture-specific ways of thinking and talking about mental health and mental illness, and their concepts are difficult to compare cross-culturally.
Conceptualization of Depression

Depression is an example of a form of psychopathology that is generally considered universal; some people in all cultures experience depression (Stevenson, 2010). But depression is a Western psychiatric concept, and some of the diagnostic criteria used to define and diagnose depression in European Americans do not apply to people in other cultures. A depressed mood (feeling sad, empty, hopeless) is typical of depression according to the DSM-5, but in many non-Western cultures the main complaints of people who are diagnosed with depression are conditions such as fatigue, headaches, insomnia, stomach upset, and loss of appetite. Most depressed people around the world do not report having a sad mood; for them, their physical experiences are more salient. In other cultures people often experience depression as a feeling of emptiness or a sense of “soul loss” (Ericksen & Kress, 2004, p. 68).

Studies of indigenous peoples have provided many examples of conditions that seem similar to what is called depression in the DSM-5. Devereux (1940) described a traditional condition called “heartbreak” among the Mohave which sometimes led to suicide. Lewis (1975) described “wacinko syndrome” among the Oglala Sioux as a form of depression with the symptoms of anger, withdrawal, despondency, and occasional suicidal ideation. Ojibwa elders in northern Ontario described depression as a condition that had existed for hundreds of years, and the Flathead of Montana experienced periods of depression characterized by intense loneliness and feelings of worthlessness (Waldram, 2004).

While the Navajo do not have a single word or term for “depression,” there are words to denote a person who is worried, sad, or distraught, and a Navajo dictionary
defines depression as meaning either “lonely and sick” or “something not right that is giving you a problem” (Storck, Csordas, & Strauss, 2000, p. 589). The Navajo seem to understand depression as consisting of the symptoms of pain, depressed affect, and a reaction to a negative event or setback.

**Prevalence of Native American Culture-Bound Syndromes**

The prevalence today of culture-bound syndromes among Native Americans is unknown. No systematic studies attempting to determine their frequency in contemporary times can be found in the literature. Trimble et al. (1984) cautioned that these disorders may not exist in contemporary Native Americans. Anthropologists and psychiatrists who studied indigenous peoples in the twentieth century encountered individuals who were suffering from various symptoms which were attributed to various causes. As described above, the researchers proposed new diagnostic labels for these syndromes, such as *windigo* psychosis, *pibloktoq*, and ghost sickness, but the detailed research to establish the validity of these conditions and their symptom profiles was never conducted. It is possible that these conditions existed in the past but no longer. Indigenous informants in the early part of the twentieth century reported that *windigo* sickness was already rare (Saindon, 1933). Contemporary psychiatry continues to assume that Native Americans can experience these culture-bound syndromes and disorders, and perhaps they can. But good research to document their existence is lacking.

Thomason (2011) included questions on the diagnosis of culture-bound syndromes as part of a national survey of mental health counselors who work mainly with Native American clients. The majority of the respondents (71%) said they had never
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diagnosed a Native American client with a culture-bound syndrome, and it was a rare occurrence for those who had. Some respondents said they avoid diagnosing culture-bound syndromes because they do not have diagnostic codes and their treatment is not reimbursed by third-party payers. A slight majority of the respondents (57%) said that the list of culture-bound syndromes in the DSM should be expanded, and only 10% said it should be eliminated (the rest were not sure or had no opinion). This suggests that most of the survey respondents think that Native American culture-bound syndromes do exist, and they should be included in our diagnostic nosologies. The DSM-IV-TR glossary described 25 culture-bound syndromes, of which four are found in Native Americans. Rather than expanding the list of the syndromes, the DSM-5 described a total of only nine syndromes, two of which are found in Native Americans.

**Implications for Counselors**

Counselors and psychologists should be familiar with the various culture-bound syndromes that may affect Native Americans, but they should be cautious about diagnosing them. It is important that counselors and clinicians establish good rapport with Native clients before talking about their emotional functioning. During the intake interview it is essential to elicit the client’s complaints regarding both physical and psychological functioning, since for some conditions such as depression some clients express their depression as physical rather than psychological symptoms.

Counselors should consider whether their Native clients’ symptoms suggest the presence of a culture-bound syndrome. These syndromes should be diagnosed when they are clearly present, but mental disorders in the DSM-5 that also apply to the client should also be diagnosed. This is particularly important in settings where reimbursement for the
treatment of culture-bound syndromes is not available. For traditional Native American clients with certain culture-bound syndromes (such as ghost sickness) it is probably best to refer them to a tribal healer, because counselors are not trained to treat such conditions. Clients who have common psychological symptoms such as anxiety and depression (even in the context of a culture-bound syndrome) may be able to be treated by culturally sensitive counselors and psychotherapists if the client is interested in and motivated for such treatment.

Much more research is needed to study the prevalence of culture-bound syndromes in Native Americans. Evidence-based guidelines for culturally appropriate treatment of the syndromes are also needed. Counselor education programs should address the mental health needs of Native Americans and provide training in the diagnosis and treatment of culture-bound syndromes. This information could be included in courses on multicultural counseling.

**Conclusions**

Culture-bound syndromes among Native Americans probably do exist, but they are probably rare. Their inclusion in DSM-IV-TR and DSM-5 is justified, but the statements in the manuals that say they are common or frequently encountered in contemporary Native Americans is not supported by any data. Their listing in the DSMs implies that the culture-bound disorders are valid disorders with symptoms that can be used to diagnose them reliably. The DSMs do not mention the debate over whether these specific syndromes actually exist. Those that do exist were rare in the past and are even more rare today (Waldram, 2004).
Counselors who work with Native American clients should understand the debate over the existence of culture-bound syndromes, and they should be able to list and describe the most common Native American culture-bound syndromes. Counselors and clinicians should be cautious about diagnosing these syndromes and should provide culturally appropriate counseling for Native Americans who have them, or refer such clients to indigenous healers.
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