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culture-bound syndrome

In [medicine](#) and [medical anthropology](#), a **culture-specific syndrome** or **culture-bound syndrome** is a combination of psychiatric and somatic [symptoms](#) that are considered to be a recognizable disease only within a specific society or [culture](#). There are no objective biochemical or structural alterations of [body organs](#) or functions, and the disease is not recognized in other cultures. While a substantial portion of mental disorders, in the way they are manifested and experienced, are at least partially conditioned by the culture in which they are found, some disorders are more culture-specific than others. The term culture-bound syndrome was included in the fourth version of the *Diagnostic and Statistical Manual of Mental disorders* (American Psychiatric Association, 1994) which also includes a list of the most common culture-bound conditions (DSM-IV: Appendix I). American [psychiatrist](#) and [medical anthropologist](#) [Arthur Kleinman](#) has contributed much to the understanding of these syndromes.

The identification of culture-specific syndromes

A culture-specific syndrome is characterized by:

1. categorization as a [disease](#) in the culture (i.e., not a voluntary behaviour or false claim);
2. widespread familiarity in the culture;
3. complete lack of familiarity of the condition to people in other cultures;
4. no objectively demonstrable biochemical or tissue abnormalities (symptoms);
5. the condition usually is recognized and treated by the [folk medicine](#) of the culture.

Some culture-specific syndromes involve somatic symptoms (pain or disturbed function of a body part), while others are purely behavioral. Some culture-bound syndromes appear with similar features in several cultures, but with locally-specific traits, such as [penis panics](#).

A culture-specific syndrome is not the same as a geographically localized disease with specific, identifiable, causal tissue abnormalities, such as [kuru](#) or [sleeping sickness](#), or genetic conditions limited to certain populations. It is possible that a condition originally assumed to be a culture-bound behavioral syndrome is found to have a biological cause; from a medical perspective it would then be redefined into another [nosological](#) category.

Western medical perspectives

An interesting aspect of culture-specific syndromes is the extent to which they are "real". Characterizing them as "imaginary" is as inaccurate as characterizing them as "[malingering](#)", but there is no clear way to understand them from a Western scientific perspective. Culture-specific syndromes shed light on how our [mind](#) decides that symptoms are connected and how a society defines a known "disease."

The American Psychiatric Association states that: "The term culture-bound syndrome denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be 'illnesses', or at least afflictions, and most have local names. Although presentations conforming to the major DSM-IV categories can be found throughout the world, the particular symptoms, course, and social response are very often influenced by local cultural factors. In contrast, culture-bound syndromes are 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" (American Psychiatric Association, 1994:844).

Medical care of the condition is challenging and illustrates a truly fundamental but rarely discussed aspect of the physician-patient relationship: the need to negotiate a [diagnosis](#) that fits the way of looking at the body and its diseases of both parties. The [physician](#) may

1. share the way the patient sees the disorder, and offer the folk medicine treatment;
2. recognize it as a culture-bound syndrome, but pretend to share the patient's perspectives and offer the folk medicine treatment or a new improvised treatment;
3. recognize it as a culture-bound syndrome but try to educate the patient into seeing the condition as the physician sees it.

The problem with choice 1 is that a physician who prides himself on his knowledge of [disease](#) likes to think he knows the difference between culture-specific disorders and "organic" diseases. While choice 2 may be the quickest and most comfortable choice, the physician must deliberately deceive the patient. Currently in [Western culture](#) this is considered one of the most [unethical](#) things a physician can do, whereas in other times and cultures deception with benevolent intent has been an accepted tool of treatment. Choice 3 is the most difficult and time-consuming to do without leaving the patient disappointed, insulted, or lacking confidence in the physician, and may leave both physician and patient haunted by doubts ("maybe the condition *is* real" or "maybe this doctor doesn't know what she/he is talking about").

The term culture-bound syndrome has, in many ways, been a controversial topic since it has reflected the different opinions of anthropologists and psychiatrists. Anthropologists have a tendency to emphasize the relativistic and culture-specific dimensions of the syndromes, while physicians tend to emphasize the universal and neuropsychological dimensions (Prince, 2000; Jilek, 2001). Guarnaccia & Rogler (1999) have argued in favor of investigating culture-bound syndromes on their own terms, and believe that the syndromes have enough cultural integrity to be treated as independent objects of research.

Selected list of syndromes

- General
 - [genital retraction syndrome](#) (GRS)
 - arctic hysteria
 - [dromomania](#)
 - [dhat syndrome](#)
 - [kundalini syndrome](#)
- Western societies
 - [neurasthenia](#)
 - [idiopathic postprandial syndrome](#)
 - [anorexia nervosa](#)
 - [bulimia nervosa](#)

- anorexia mirabilis (religious-associated anorexia)
- [abduction phenomenon](#)
- multiple chemical sensitivity syndrome
- [Gulf War syndrome](#)
- [morgellons](#)
- [Latin American](#) cultures:
 - mal de pelea
 - [susto](#)
- Indonesia-Malaysia/Southeast Asia
 - [amok](#)
 - [latah](#)
 - koro - [Genital retraction syndrome](#)
- East Asia
 - Shook yang or suoyang (Chinese cultures) - [Genital retraction syndrome](#)
 - shenkui, "semen loss" syndrome (Chinese)
 - qi-gong psychotic reaction
 - shenjing shuairuo (Chinese cultures)
 - [Hwa-Byung](#) (Korea)
 - [taijin kyofusho](#) (Japan)
 - [hikikomori](#) (Japan)
 - [Fan death](#) (Korea)
- South Asia
 - [Suudu](#) ([Tamil culture](#))
 - Sami ([Tamil culture](#))
 - dhat, semen-loss syndrome
- Polynesia
 - cafard, similar to [amok](#)
- United States (exclusively)
 - [rootwork](#), witchcraft attacks
- Africa
 - [brain fog](#), mental fatigue

Selected list of somatoform disorders

- [Jerusalem syndrome](#)
- [Medical student syndrome](#)
- [Somatization disorder](#)
- [Stendhal syndrome](#)

References

- American Psychiatric Association (1994) *Diagnostic And Statistical Manual Of Mental Disorders*, Fourth Edition. Washington, DC: American Psychiatric Association
- Guarnaccia, Peter J. & Rogler, Lloyd H. (1999) *Research on Culture-Bound Syndromes: New Directions*. American Journal of Psychiatry 156:1322-1327, September
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- Prince, Raymond H. (2000) *In Review. Transcultural Psychiatry: Personal Experiences and Canadian Perspectives*. Canadian Journal of Psychiatry, 45: 431-437

External links

- [Culture-Bound Syndromes](#)
- [Psychiatric Times - Introduction to Culture-Bound Syndromes](#)
- [Skeptical Inquirer - Culture-bound syndromes as fakery](#)

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