Culture and Symptomatology. Summary*

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Basic Principles:

(1) Adaptation is a sociological concept. Psychopathology is a psychological concept. A psychologically normal person may be maladjusted in a pathological society, in which a suitably abnormal person may be well adjusted.

(2) Sociological and psychological explanations of behaviour stand in a complementarity relationship to each other; the two explanations can neither be commingled nor given simultaneously.

(3) Situations requiring recourse to the complementarity principle are not limited to quantum physics. An eminent theoretical physicist and epistemologist, Prof. Dr. Pascual Jorden (Hamburg), has shown that the first to observe and to describe a phenomenon involving complementatity was Josef Breuer and the first to formulate this principle (though without using the term "complementarity") was Sigmund Freud[3].

Definitions:

(1) Ethnic disorders: symptoms and syndromes are furnished by the culture, to fit culture-specific stresses; these are related to what Linton[4] calls: "patterns of misconduct".

(2) Type disorders are determined by the structure of society (e.g., Gemeinschaft vs. Gesellschaft, etc.)

(3) Idiosyncratic disorders are developed when neither ethnic nor type disorders fit the subject's personal and atypical conflicts.

Vicissitudes of Cultural Materials in Psychological Disorders:

(1) Neurosis: cultural material is recognized as being of external origin but is "transposed"—e.g., from one stage of the psychosexual development to another.

(2) Regression, fixation: cultural material, though recognized as of external origin, is handled in a regressive, anachronistic, infantile manner.

(3) Psychopathic character disorders: cultural material is recognized as of external origin, but the patient, who does not feel committed to it, is skilled in exploiting the cultural loyalties of others for his own ends.

(4) Psychosis: Awareness of the external origin of cultural material is generally lacking; it is treated as though it were of internal origin. Yet, "deculturalized" cultural material plays a major role in psychosis.[5]

Diagnostic Pitfalls:

(1) The culturally unsophisticated diagnostician may mistake a belief for a delusion.

(2) The culturally half-sophisticated diagnostician may mistake a delusion for a (cultural) belief.

(3) A caveat: A cultural belief, correctly reported as such by the patient, may be delusional if it is also "experienced" (erlebt).

Communication:

(1) A recent immigrant, who does not speak adequately the language of the host culture, may use what he believes to be a "universal" language: that

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of the body. But he speaks that "universal" language with the "accent" of his own culture: his physical complaints are specific (localized), but their meaning is that which such complaints have in his own culture, and are therefore not understood by his therapist.

(2) At that point the patient begins to replace specific complaints with generalized ones: "everything" aches, functions badly. French physicians call this "koulchite" (Arabic: koulchi = all, everything).[1]

(3) After the immigrant learns the language of the host culture, he often ceases to somatize and begins to report his real (psychological, social) problems.

A (seemingly) good adaptation may be symptomatic, if:

(1) It satisfies concrete wishes but frustrates the affective expectations associated with these wishes.

(2) Its personal meaning (which usually has cultural roots) is not the meaning the host culture assigns to that adaptive behaviour; this often leads to puzzling conflicts in seemingly normal interactions with members of the host culture.

(3) The adaptation actually implements the pre-existing neurotic, etc., needs of the immigrant.

(4) The adaptation is such that it permits neurotic, etc., members of the host culture to induce the "adjusted" immigrant to act out the abnormal (sexual, aggressive, etc.) needs of his hosts.

The ethnic personality is very resistant to acculturation, even in psychological disorders.

(1) In mild disorders, where both the conflict and its manifestations fit the immigrant's culture, the ethnic personality is hardly impaired at all.

(2) In disorders of medium severity the core-conflict may fit the ethnic personality, though its symptomatic façade is borrowed from the host culture. (E.g., a hysterical core may be overlaid by a schizophrenic façade.) The impairment of the ethnic personality is moderate.

(3) In severe disorders the ethnic personality is much impaired, for both the conflict and its manifestations (symptoms) become linked with the host culture. Disorders tend to become chronic.

Migration, like life in a rapidly changing environment, impairs foresight. The expected rewards for the postponement of gratifications fail to materialize. This impairs the capacity to sublimate, without which both society and culture perish.[2]

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