

General Psychology (PSY150) This course provides an overview of the scientific study of human behavior. Topics include history, methodology, biopsychology, sensation, perception, learning, motivation, cognition, abnormal behavior, personality theory, social psychology, and other relevant topics. Upon completion, students should be able to demonstrate a basic knowledge of the science of psychology.

Global Learning Outcomes:

1. Describe the challenge of defining mental health, psychological disorders, and treatment methods in various countries.
2. Identify the impact of socio-cultural perceptions on individuals with psychological disorders.

“Normal” or “Abnormal”?: by Steve Turner
Students will discover through representative portrayal and group collaboration the impact of socio-cultural perceptions on individuals with psychological disorders.
Objective:
The purpose of this activity is to get students to understand the perception in various cultures of what is <i>normal</i> behavior and what is <i>abnormal</i> behavior. Students will encounter various scenarios that depict psychological disorders within a specific culture. Students will determine which behaviors are culturally acceptable and compare with perceptions (and/or diagnoses) in the United States. It is expected that students will have had an initial exposure to the <i>Psychological Disorders</i> (or similarly titled) chapter of a General Psychology textbook. Prior discussion of what constitutes <i>normal</i> and <i>abnormal</i> is a “plus”.
Time:
45 minutes
Materials:
<ol style="list-style-type: none"> 1. Case Studies (Word document attached) of behavior deemed <i>abnormal</i> according to DSM-5 and a named culture (Asian, African, Middle Eastern, Latin American, indigenous) where behavior is deemed <i>normal</i> 2. Paper/pencil for teams 3. Global maps (this example is interactive by country, http://geology.com/world/world-map.shtml) 4. Cultural Concepts in DSM 5 (.pdf attached) 5. Stop watch/time-keeping device
Procedure:
It is expected that students will have had an initial exposure to the <i>Psychological Disorders</i> (or similarly titled) chapter of a General Psychology textbook. Prior discussion of what constitutes <i>normal</i> and <i>abnormal</i> is a “plus”.
<ol style="list-style-type: none"> 1. The instructor will divide the class into five teams and provide each team with a different Case Study (attached .pdf). <i>Up to six teams can be accommodated with</i>

Case Studies; total time based on five teams. Additional teams (for larger classes) can be formed by duplicating the Case Study assignments.

2. Each team will create a fictional client/patient that presents symptoms of either a DSM-type mental illness/disorder or a culture-bound syndrome/culturally-relevant behavior. A “bio” for the fictional client/patient will be compiled in a substantive paragraph that includes a history, symptoms, and major concerns of the diagnosis/behavior *but do not identify disorder by name*. (15 min)
 - a. Each team will appoint a Representative to send to a neighboring team and present the fictional client’s/patient’s “bio”.
 - b. Representatives will move to neighboring teams in *clockwise* fashion
3. Upon hearing the “bio” of the fictional client/patient, teams will take into account earlier class lecture/readings on the concept of *abnormal* as well as basic symptoms of major DSM-diagnosed disorders. Each team will ask, “Is this *normal*?” or, “Is this *abnormal*?” based on 1) DSM-type disorders, and then 2) within the culture of the fictional client/patient.
4. After the “assessment” of the fictional client/patient is complete, the Representative will clarify any missed symptoms, causes, “clues”, as well as add any culturally relevant information (tradition, history, how that culture views mental illness, etc.).
 - a. A world map should be accessed by the team to locate the country-of-origin of the fictional client/patient
 - b. A world map can be projected onto a classroom screen (if computer/projector equipment is available) or paper copies of maps can be distributed (1 per team).
 - c. Another option is to allow students to access an online map with their “smart” phones. (The example listed in the activity overview is a link to an interactive map where students can “drill down” to each country by clicking on the specific location.)
5. Rotate Representatives every 5 minutes (20-25 min, based on number of teams).

After the final rotation, the Instructor should debrief the class on the team discoveries and insights. The Instructor should highlight the *socio-cultural* perspective and the need to consider *culture* in which behaviors are learned/exhibited. (The attached .pdf "*Cultural Concepts in DSM 5*" can be a resource.) (5-10 min, based on number of teams)

In addition to the recommended Assessment (compare/contrast paragraph as homework or test essay question), the Instructor can collect "bio" paragraphs from each Representative or diagnoses/discussion from teams for credit.

Assessment:

Students will write a compare/contrast paragraph (graded homework assignment or test essay question) to demonstrate their understanding of the impact of socio-cultural perceptions on mental health issues.

Additional Resources:

- Articles (citations included in Case Studies)



Cultural Concepts in DSM-5



In an effort to improve diagnosis and care to people of all backgrounds, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) incorporates a greater cultural sensitivity throughout the manual. Rather than a simple list of culture-bound syndromes, DSM-5 updates criteria to reflect cross-cultural variations in presentations, gives more detailed and structured information about cultural concepts of distress, and includes a clinical interview tool to facilitate comprehensive, person-centered assessments.

The Impact of Cultural Differences

Different cultures and communities exhibit or explain symptoms in various ways. Because of this, it is important for clinicians to be aware of relevant contextual information stemming from a patient's culture, race, ethnicity, religion or geographical origin. For example, uncontrollable crying and headaches are symptoms of panic attacks in some cultures, while difficulty breathing may be the primary symptom in other cultures. Understanding such distinctions will help clinicians more accurately diagnose problems as well as more effectively treat them.

Cultural Considerations in Clinical Practice

Throughout the DSM-5 development process, the Work Groups made a concerted effort to modify culturally determined criteria so they would be more equivalent across different cultures. In Section II, specific diagnostic criteria were changed to better apply across diverse cultures. For example, the criteria for social anxiety disorder now include the fear of "offending others" to reflect the Japanese concept in which avoiding harm to others is emphasized rather than harm to oneself.

The new manual also addresses cultural concepts of distress, which detail ways in which different cultures describe symptoms. In the Appendix, they are described through cultural syndromes, idioms of distress, and explanations. These concepts assist clinicians in recognizing how people in different cultures think and talk about psychological problems.

Finally, the cultural formulation interview guide will help clinicians to assess cultural factors influencing patients' perspectives of their symptoms and treatment options. It includes questions about patients' background in terms of their culture, race, ethnicity, religion or geographical origin. The interview provides an opportunity for individuals to define their distress in their own words and then relate this to how others, who may not share their culture, see their problems. This gives the clinician a more comprehensive foundation on which to base both diagnosis and care.

DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American Psychiatric Association (APA) will publish DSM-5 in 2013, culminating a 14-year revision process. For more information, go to www.DSM5.org.

APA is a national medical specialty society whose more than 36,000 physician members specialize in the diagnosis, treatment, prevention and research of mental illnesses, including substance use disorders. Visit the APA at www.psychiatry.org. For more information, please contact Eve Herold at 703-907-8640 or press@psych.org.

CASE STUDIES FOR “NORMAL”/“ABNORMAL” ACTIVITY

Each team will create a fictional client/patient that presents symptoms of either a DSM-type mental illness/disorder or a culture-bound syndrome/culturally-relevant behavior. That client/patient’s “bio” will be compiled in a substantive paragraph that includes a history, symptoms, and major concerns of the diagnosis/behavior/behavior.

Each team will appoint an “expert” to rotate to a neighboring team and present the fictional client/patient.

Neighboring teams will take into account earlier class lecture/readings on definition of ‘abnormal’ as well as basic symptoms of major DSM-diagnosed disorders. Each team will ask, “Is this ‘normal’?” or, “Is this ‘abnormal’?” based on 1) DSM-type disorders, and then 2) the culture of the client/patient.

After an “assessment” is completed, the “expert” will clarify any missed symptoms, causes, “clues”, as well as add any culturally relevant information (tradition, history, view of mental illness, etc.).

World map (interactive by country): <http://geology.com/world/world-map.shtml>

EAST ASIA

- HISTORY
 - 68- year old Korean immigrant, female, living in the Pacific Northwest
 - Moved to USA eight years ago to be closer to adult children and their families
 - 11-year history of physical abuse by husband
 - Husband recently committed suicide
- SYMPTOMS
 - Suppressed anger, hate, animosity toward now-deceased husband and some family members
 - Extended periods of depressed mood, loss of interest in being with family, grandchildren
 - Loss of appetite, sleep disturbances
 - No suicidal ideation/attempts
 - Despite above symptomology, appears resilient; self-diagnosed as “depressed”
- POSSIBLE “DIAGNOSIS”
 - Major depression; bipolar; other mood disorder
- MISCELLANEOUS
 - Client/patient self-diagnoses as culture-bound syndrome *Hwa-Byung*. Seen in situations where woman’s son or spouse has died
 - Different than *depression* in lack of suicidal ideation/attempts
 - Most first generation Korean-Americans born in Korea and reflect traditional values, culture. Stigma in Korea toward those with mental illness, those who seek help, women who seek help (“deviants”)

- “Case study” based on: Myunghan, C., & Hye-A, Y. (2011). Identifying and treating the culture-bound syndrome of Hwa-Byung among older Korean immigrant women: Recommendations for practitioners. *Journal of the American Academy of Nurse Practitioners*, 23(5), 226-232.

LATIN AMERICA & CARIBBEAN (1)

- HISTORY
 - 26-year old female living in Puerto Rico
 - Psychotic episode post-partum after birth of first child 10 years ago
 - At that time, was married to an older husband, a frequent user of illegal drugs
 - Improved somewhat over next 12 months; when asked why, “It was the spiritist that helped me.”
 - Now 2 years later, involved with another man and symptoms returned
- SYMPTOMS
 - “very disturbed” (mother’s report)
 - Delusions
 - Visual hallucinations
 - Illogical thinking
 - Aggressive behavior, violent
- POSSIBLE “DIAGNOSIS”
 - Schizophrenia; dissociative identity disorder
- MISCELLANEOUS
 - *Spiritism* is a popular religion in Latin America
 - Spirit healers are often helpful in relieving psychotic symptoms/conditions that mimic schizophrenia and (in the accompanying study) were cooperative in treatments with mental health professionals. However, the use of antipsychotics was not approved by the spirit healers.
 - What would be considered as hallucinations/delusions are sometimes labeled “true visions” in that they differ by containing facts (later corroborated) previously unknown to the individual. These experiences are often given high value in the culture.
 - In Brazil, cause based on “obsession by molesting spirits” is not as accepted as in Puerto Rico
- “Case study” based on: Moreira-Almeida, A., & Koss-Chioino, J. (2009). Recognition and treatment of psychotic symptoms: Spiritists compared to mental health professionals in puerto rico and brazil. *Psychiatry*, 72(3), 268-83. Retrieved from <http://ezproxy.gtcc.edu:2048/login?url=http://search.proquest.com/docview/220655075?accountid=11099>

LATIN AMERICA & CARIBBEAN (2)

- HISTORY

- 17-year old female living in the southern, Quechua-speaking, Peru; highlands village of 362 inhabitants
- Previously very attached to family, rituals, traditions, important societal events (such as meals, festivities)
- Previously strong appetite, “could eat all day”
- SYMPTOMS
 - Deliberate withdrawal from family; argumentative; (Mother: “She’s changed so much, it’s like she’s a different person.”)
 - Occasional aggression; insulting
 - Wanders the mountain roads at mealtime; (Mother: “She walks and walks as if she didn’t have a home where she could eat.”)
 - Picks up and eats animals killed by the occasional vehicle on roadway
 - Malnourished
 - Delusions
 - Auditory hallucinations
- POSSIBLE “DIAGNOSIS”
 - Schizophrenia; other psychosis; dissociate identity disorder
- MISCELLANEOUS
 - Food and communal eating is a primary societal expectation/behavior. Issues are seen in relation to a disruption to the individual’s connection with the culture, not the presentation of mental illness symptomology.
 - Parent comment from study: “Before she had appetite, she wanted to eat all day. She loved meat. Now we bring her meat, she doesn’t even look at it. She’s like another; her body, her behavior. She doesn’t eat with us—when we eat together, she looks far away.”
 - In identifying condition of mentally ill, their symptoms are always in the context of food/commensality. Obvious psychotic behaviors are secondary to the culture’s “fellowship of the table”.
 - Said another parent of one who exhibited psychotic symptoms and would disappear for days: “It’d be better if he dies, and then we’d bury him. And that way he couldn’t live like this, eating or not eating...he wanders.”
- “Case study” based on: Orr, D. M., & R. (2013). "Now he walks and walks, as if he didn't have a home where he could eat": Food, healing, and hunger in quechua narratives of madness. *Culture, Medicine and Psychiatry*, 37(4), 694-710.

MIDDLE EAST/NORTH AFRICA

- HISTORY
 - 57-year old male living in Taiz, Yemen

- Married for 30 years, father of five children
- Previously outgoing, optimistic, deeply religious; upper SES
- Positive childhood experience with many interests, skills, and talents
- SYMPTOMS
 - Agitated behavior following work-related issues
 - Withdrawn; forgetful; lack of energy
 - Nightmares; sleep disturbances; awakens screaming; feels like something in his dreams is sitting on his chest and he can't breathe/chokes him
 - Frequently worries over small matters
 - Frequent jerking movements after times spent reading sacred texts
 - Exhibited recent (albeit infrequent) violent behavior toward wife
 - Increased morbid fears
- POSSIBLE "DIAGNOSIS"
 - Generalized anxiety disorder; panic attack; other anxiety disorder; dissociate identity disorder
- MISCELLANEOUS
 - *Jinn (spirit) possession*; especially seen in individuals in Arabic cultures; those deeply religious
 - Sometimes seen as a postnatal illness exhibited by sadness, anxiety
- "Case study" based on: Dein, S. & Illaiee, A.S. Jinn and mental health: looking at jinn possession in modern psychiatric practice. *The Psychiatrist* (2013), **37(9)**, 290-293.

SOUTHEAST ASIA

- HISTORY
 - 47-year old female now living in Phnom Penh, Cambodia
 - Grew up in rural village in mid-1970s during Khmer Rouge regime
- SYMPTOMS
 - Nightmares of deceased husband ("He came to me as a shadow, because he is a ghost now."); heightened concern over his spiritual status
 - Involuntary, intrusive memories
 - Sleep disturbance
 - Hypervigilance
 - Problems with focus, concentration
- POSSIBLE "DIAGNOSIS"
 - PTSD; other anxiety disorder
- MISCELLANEOUS
 - Cambodians who survived "The Killing Fields" of Khmer Rouge continue to suffer from that catastrophic event. A sense of survival was threatened (and persists),
 - Dreams of deceased parents, spouses, acquaintances who were killed by Khmer Rouge are common and seen in Cambodia to be a natural part of grief.

- Cambodians (and other similarly impacted SE Asians) place strong hopes in the rituals and practices of Buddhism in efforts to cope and de-stress. A “restoration of moral order” is an attractive component of that religion.
- “Case study” based on: Agger, I (2015) Calming the mind: Healing after mass atrocity in Cambodia. *Transcultural Psychiatry* Published online before print February 4, 2015, doi: 10.1177/1363461514568336 Retrieved from: <http://tps.sagepub.com/content/early/2015/02/04/1363461514568336.full>

SUB-SAHARAN AFRICA

- HISTORY
 - 23-year old male, formerly of Nimba County, Liberia
 - Survivor of Liberian Second Civil War (1999-2003)
- SYMPTOMS
 - “Survivor’s guilt”
 - Hyperalertness
 - Recurring dreams of walking along the primary road leaving his village when soldiers open fire on his family/friends
 - “I feel numb to whatever’s happening around me.”
 - Can’t watch current media coverage of ISIS conflict in Middle East
- POSSIBLE “DIAGNOSIS”
 - PTSD; other anxiety disorder
- MISCELLANEOUS
 - High percentage of inhabitants of rural villages witnessed murder of friends/family in First (~1990) and Second (1999-2003) Civil Wars
 - Villages flattened and burned with regularity, dozens killed by “marauding soldiers”
- “Case study” based on: Galea, Sandro, M.D., DrP.H., Rockers, P. C., M.P.H., Saydee, G., PhD., Macauley, Rose, M.D., M.P.H., Varpilah, S. T., & Kruk, Margaret E, M.D., M.P.H. (2010). Persistent psychopathology in the wake of civil war: Long-term posttraumatic stress disorder in nimba county, liberia. *American Journal of Public Health, 100*(9), 1745-51. Retrieved from <http://ezproxy.gtcc.edu:2048/login?url=http://search.proquest.com/docview/747120347?accountid=11099>

Possible questions/approaches by neighboring teams, when client/patient “presents”:

- As a US/Western-based mental healthcare worker, is this ‘normal’ or ‘abnormal’ (ie, is it acceptable behavior in society or is it a mental illness, in line with DSM-type diagnosis)? Why? (What explanation/diagnosis could be given for the presenting symptoms?)
- As a healthcare worker from the country/region of origin of the individual, is this ‘normal’ or ‘abnormal’? Why? (What explanation/diagnosis could be given for the presenting symptoms?)

Additional comments, discussion from DSM-5 consideration of *culture* in diagnosis.

- In reference to *spirit possession*, the DSM-5 states it is, “not a disorder if it is ‘a normal part of a broadly accepted cultural or religious practice’” as quoted in Saville-Smith, R. (2013) *Releasing the Spirits—The implication of cultural accommodation in DSM 5*. Retrieved from: [http://www.academia.edu/3126064/Releasing_the_Spirits -
_The_implications_of_cultural_accommodation_in_DSM5](http://www.academia.edu/3126064/Releasing_the_Spirits_-_The_implications_of_cultural_accommodation_in_DSM5) (This is an interesting read/discussion-starter to further conversation on “normal/abnormal” and the DSM-5 updates.)
- See attached .pdf on “Cultural Concepts in DSM-5”