Psichiatria e Psicoterapia Culturale

Vol. VIII/n. 1/Giugno 2020

Versione Italiana di WCPRR curata e diretta dall'Istituto Igiene Mentale Transculturale

WCPRR

PRESENTATION AT THE 5TH WORLD CULTURAL PSYCHIATRY CONGRESS "ACHIEVING GLOBAL MENTAL HEALTH EQUITY: MAKING CULTURAL PSYCHIATRY COUNT", NEW YORK, 10-13 OCTOBER 2018

DELUSIONS AND CULTURES. PSYCHOPATHOLOGICAL AND CLINICAL NOTES ON CULTURAL DELUSIONS

Gian Giacomo Rovera[1]

ISSN: 2283-8961

Abstract

Background: *Culture and different cultural groups are not only of interest for the ethnological and anthropological studies, but also for the psychopathology, the clinical studies and the psychotherapy development. In this sense, cultural psychiatry pioneered the research on the relationship between psychiatric syndromes and different bio-psycho-political-religious-social environments. Since extreme beliefs might reach the definition of cultural delusions they are an important issue for cultural psychiatry and psychotherapy even if they have not yet become part of the classical psychopathological and clinical literature.* ***Aims***: *The presentation aims to define and discuss the theoretical and research framework of cultural-based delusional syndromes and cultural delusions.* ***Methods***: *The presentation briefly reviews 1) how the "system of culture" can shape individual psychopathology 2) issues about deviance and normality in psychiatry; furthermore*

[1]Honorary Professor of Psychiatry, Turin University, Department of Neurosciences. Honorary President of the International Society of Individual Psychology. Italian Institute of Transcultural Mental health, Founder. Mail to: ggrovera@hotmail.com

it proposes a way to integrate current nosography with old and new acquisitions of cultural psychiatry (specifically, the overcoming of cultural radical relativism, cultural-orientated clinical practice). Finally it proposes a synthesis of theoretical, descriptive and normative perspectives to understand cultural delusions.
Results*: Comprehension of cultural-based delusional syndromes and cultural delusions could help in understanding new western pathological phenomena and enhance therapeutic clinical practice. It offers a different and likely more comprehensive view of delusions, integrating the assumptions of modern nosography with the ones of cultural psychiatry.*
Discussion*: Further research on cultural delusions may offer a meaningful contribution to cultural psychiatry, widening therapeutic and research field and embracing multiple disciplines such as anthropology and philosophy. In this sense it could give new insights on new pathological beliefs of western culture.*

Key words:

Cultural delusions, psychopathology, anastomoses

I) Preamble

1) Cultural Psychiatry, especially with regard to the complex delusional psychopathology, concerns the patient's worldview, the characteristics of the symbolic scope and the inner experiences. Therefore, the way of being (*Dasein*) generates a particular type of practices and existential rules that can build psychotic precursors for the properly called cultural delusions.

After the epistemological fragmentation of the twentieth century, in the current era of biotechnology, neuroscience and information technology, the analysis of the multiethnic and multicultural post-modern condition (Coppo, 2003) has involved many scholars from different disciplines who sometimes pursue the “third way” of neo-humanism (Kandel, 2005) or dissolve into a liquid society (Bauman, 2010); or even lean towards Ethnoanalysis (Nathan, 1993), considering that a plurality focuses in a narrow sense on psychopathological disorders related to cultural-specific characteristics. Faced with this evolutionary process, the historical-scientific models of “Classical Psychiatry” are re-emerging, which seem to offer greater resources when

using the evolutionary psychopathological models (Lewis and Miller, 1990) that make it possible to contextualize the various cultures.

2) In fact, the developments of psychopathology represent the trunk on which culture-bound syndromes and also cultural delusions can be grafted. The latter are related to the various (biomedical, behavioural, psychodynamic, cognitive, socio-cultural, family) microparadigms and relate to the variations of customs, the Orientation of Values (Ponce, 1998), religious beliefs, the historical context, the various languages and lifestyles (Adler 1933). Also the configurations regarding normality and deviance (Sicialiani et al, 1981; Biondi, 1999), can change in relation to the factors of evolutionary adaptation, such as: the first affective bonds; Bowlby's attachment (1980); education, technological innovations, the socio-political-religious context. The result of individual and collective change goes hand in hand with institutional change, forging the cultural mind. Although there are niches of cultural conservation (myths, rites, beliefs) (Bartocci, 2016), and partial retrogressions of individual groups or individuals, in psychopathology and Cultural Psychiatry, beyond the traditional roots, there are "transformations" in the symptomatologies, which often underpin the underlying dynamics, creating anastomotic networks (Rovera, 2017), Riv. Online) that Prince (1970) calls "Integranal belief".

3) Culture is notoriously a powerful diagnostic and nosological factor in psychiatry. The key concept is to avoid a categorical error - i.e. attempting to classify entities or clinical behaviours that are intrinsic to certain cultures, societies or human groups into categories, models or diagnostic terms proposed by the dominant classifying systems (Csordas e Kleinman, 1996; Kleinman, 1987). A fundamental model to reach this objective has been to propose the cultural formulation for a correct approach to the patient's Cultural Identity, the explanation (*Erklären*) and the understanding of the symptoms (*Verstehen*), the functioning of the psycho-social environment, and to the overall evaluation of the cultural factors for a correct diagnosis and treatment (Fabrega, 1987, Fassino et al. 2007; Rovera, 2018).

4) The expression "Cultural Delusions" - i.e. beliefs that are indemonstrable, unverifiable, unchangeable despite the very poor adherence to (or even dissociation from) reality - is used to designate cultural structures encouraging the radicalisation of

extreme forms of detachment that can be followed by delusions in the strict sense, as described by the psychiatric clinic (Bartocci and Zupin, 2016).

Thanks to this psychopathological-clinical consideration, over the last few decades, Psychiatry and Cultural Psychotherapy have become one of the most interesting and controversial topics, especially in Western countries. In fact, the debate covers various disciplines such as anthropology, medicine, neuroscience, social sciences and even the philosophical disciplines and the "narration" of apocryphal beliefs (Bartocci, 2016).
The overall classification of cultural delusions underlines the interest of scholars in the problems and dilemmas related to psychopathology, nosography, clinical diagnosis and treatments. This defines the setting (which I will discuss later) within which the attitude and counter-attitude, transference and countertransference interact (Tseng, 2001), and the ethno-religious cultural identification (Michel, 1999; Rovera, 2009) that make the therapeutic alliance "culturally appropriate" (Rovera, 2014). Following this pathogenetic hypothesis, cultural delusions can fall within the criteria of classical nosography, overall assessment, differential diagnosis, prognosis and therapies. In other words, they constitute a building brick of Cultural Psychiatry (Kirmayer et al. 2013).

If anthropology (Bartocci and Zupin, 2016) has always been engaged in the study of the roots of magical thought, tribal superstitions, trance, religious sectarianism (Maniscalco and Pellizzari, 2016) or diabolical possessions (Rovera and others 1990; Bartocci, 1990), and cultural-bound healings (Jilek, 1982; Rovera, 2002) to be able to grasp the ambivalent influential power of numinous entities rooted in specific cultures, the disciplines related to Cultural Psychiatry have investigated the way in which each one of these phenomena is articulated in the visions of the world which, according to their structure, can be associated to the definition of similar-delusionary beliefs (Murphy 1967). They define not only spirituality, but also the collective ideational abnormalities, which have become an integral part of individual cultures and can be considered as precursors of cultural delusions (Frighi e Mazzetti 1993; Bartocci, 2016).

This is also because, as emerged from the studies of neuroscience, our brain is not a static and unchangeable organ, but it is deeply affected by environmental influences

and experiences. If beliefs are among the main determinants of the world-environment in which we live, some of its main axes are internalized at the psychic level and influence the structure of neural districts. The arrangement of the neuronal circuits thus constitutes a sort of preformed scheme, a lens through which the facts of life are interpreted. In other words, cultural elements play the role of a sort of tuning fork that can not only cause apperception to take on a delusional-like inclination, but also a “dissociation”, to the point of a delusional fracture.

II) Exemplification

1) Thanks are due to Dr. Micol Ascoli, Cultural Psychiatrist, who has been working for years as the Director of a Public Centre in London, for indicating and contributing to the drafting of the clinical case reported and discussed here. This example of cultural delusion shows some characteristic aspects, such as treatment, Integranal-Belief, apocryphal beliefs, difficulties of cultural integration of immigrant communities, etc..

2) Reference person: Micol Ascoli, Director of the Psychiatry Department of the Tower Hamlets Cultural Consultation Service, London UK.

Health care team: cultural mediators, nurses, psychiatrist.

Patient: R.S.; 24 year old female.

RS is a 24-year-old woman from Zimbabwe, from the Shona ethnic group, a university student. For decades she has been living in London with her immigrant parents, in a family context characterised by the traditional cultural and religious roots of her country of origin. She attends a Pentecostal Congregation, where some of her fellow countrymen are very active and have been collaborating with the African Pastor and Bishop for years.

● At the beginning of 2006, RS fell in love with a man who regularly used drugs and alcohol. The two young people decided to get married in June 2007.

RS, did not inform either the family or the religious community of her relationship with her boyfriend (a stranger to the community). After some vain efforts by RS to convert her partner to Pentecostal Worship, the relationship ended abruptly at the end of 2006. RS's subsequent attempts to reconnect with her ex-boyfriend failed. In April 2007, RS became rather secluded and silent. RS convened the group of elders and the Pastor to announce that miraculously God had spoken to her and told her to get ready, as she was to get married on 12th June. Upon the request of the elderly, RS denied that she had a boyfriend, but insisted on having to prepare for the wedding by order of God. During the weeks that followed, piling up debts for several thousand pounds, RS bought the rings and the wedding dress, arranged the wedding banquet, defined and reserved the place where the wedding was to be celebrated. She has also booked a limousine and three coaches to take the guests from the church, where the religious community was to meet, to the hotel where the festivities would then take place.

● The Pentecostal Community, including the Bishop, who came from Zimbabwe for his annual visit to the Congregation, was surprised that facing these "oddities" there had been no adequate psychiatric consultation for RS. This consideration was reported to the centre's specialist. Parents believed that their daughter was a victim of diabolical possession and believed that the best response to RS's behaviour was prayer, together with a willingness to help, understand and support her. Two psychiatric nurses who belonged to the same religious group as RS also told the girl that they had the impression that she was mentally ill. RS reacted by accusing them of having been inspired by the devil, because only the devil could have challenged what God himself had told her. RS's belief in the groom's presence (on the day scheduled for the wedding) was unshakable and not open to criticism, despite the fact that she had no real contact with her ex-boyfriend. At the beginning of June, the general anxiety of the Religious Community increased significantly. Two days before the wedding no one had received the invitation yet.

● On 12th June, the date of the wedding, nothing happened. No one showed up at the scheduled appointment in front of the church. RS spent the whole day in bed and did not leave the house. The following week, RS did not attend mass and no one asked for explanations.

In the months that followed, RS moved away from the community and from religion in general. As a result, her parents left the Pentecostal Congregation and joined another religious group.

● The two psychiatric nurses, who were also cultural mediators and RS's close friends, reported this additional information to the Director of the Psychiatric Department. The operators listed, on specific request, the criteria based on which the "miracles section" of the Congregation, which firmly believes that God speaks to the faithful, was able to consider RS's experiences and behaviour as pathological. In fact, in miracles God speaks to the faithful within the limits of reasonableness. In other words, God may well announce a wedding, but He certainly does not go into specific details (e.g. ordering invitations to be sent by SMS, indicating the number of participants, establishing the type and quantity of cars, etc.). A miracle is usually confirmed by similar and contemporaneous experiences by other members of the Community. God speaks to the faithful at the moment of the completion of a precise path of spiritual growth within the community. In the case of R.S., the miracle announced by the faithful must find a similar equivalent both in the Sacred Texts and in other Pentecostal Congregations.

III) Comments and Reflections

1) The patient R.S., her family and the Shona community she belongs to, are immersed in the context of diasporic Pentecostalism. The community, besides its religious tradition and its own doctrinal and ritual system, is also characterized by cultural and social traits: such as the country of origin, ethnicity, language and daily lifestyles. The peculiarity of the various cultural contexts lies also in the fact that the Pentecostal communities in Europe are largely due to immigration. In fact, individuals emigrate with their customs and traditions, as well as their beliefs and rituals (In Turin, these Churches now include fifteen communities, many of which have immigrated from Brazil, Africa and Romania).

Recent studies have analyzed the socio-cultural functions of these religious congregations. A first group of functions is represented by the search for a collective identity for the protection of the members of the community from the material and

psychological risks connected to the condition of foreigners. A second group of functions is related to maintaining and reproducing their own "socio-cultural constructors of knowledge". These Pentecostal Churches maintain the original memory (first skin) that is transformed into "epos"; the codification of customs as "religion" and "spirituality" (Fernando, 2004); the bonds of kinship as "lineage"; the common cultural heritage, beliefs, rituals, and language of the ethnical group (the mother tongue) are interwoven in this case with the English language and culture, as a second skin (Guzder, 2011). The set of "social frameworks of knowledge" point to Value Orientations (Ponce, 1998) gives meaning to individual and group existence. So that through the topicality of the ethnos experienced as a "root", the stratified aggregation of the individual aspects with the current reality of the new socio-cultural context takes place (Berzano, 1997, 2012).

2) In the clinical work with patients it is necessary to carry out both an overall diagnostic evaluation (assessment) (Kirmayer, 1994; Barron, 1998; Kirmayer et al., 2013), and an appropriate therapy. This way, the cultural characteristics and the apocryphal beliefs (Bartocci, 2016) emerge with psychopathological and clinical significance (migratory process, perception that the patient has of the country of the host culture, the spoken language). One of the peculiarities of the exemplifying case reported is due to the fact that it was the nurses (belonging to the same ethnic group and religion as the patient) who, as cultural mediators, took care of the subject and acted as intermediaries with psychiatry, as well as with the family and the religious community.

A Cultural Intervention brings out topics on cultural identity (Gudzer, 2011), on interindividuality, on the sense of belonging, on empathic involvement, on relational tactics (Mitchell, 2000) (particular "emic" communication), on existential semantics (general "etic" communication). The problem of the effectiveness of treatments (psychopharmacological, psychotherapeutic and rehabilitative treatments in an intercultural context) is a challenge to make therapies culturally appropriate.

2) It is also necessary to consider that some orientations, to diagnostically distinguish "what is normal from what is pathological" (see DSM IV-TR, 2000; DSM 5, 2013; PDM 2, 2017), refer to difficult and complex nosological models that are not univocal.

Many do not coincide with Culture-bound syndromes, with the criteria and treatments developed by the so-called Western Classical Psychiatry.

Some characteristics that can be referred to in this clinical example and extended by analogy to other psychiatric cases are useful for an overall assessment, for a therapy, and also for a catamnesis:

- The context of the Shona Pentecostal community, which immigrated to the large cosmopolitan city
- The existential failure suffered by the patient that was favourable to a “refuge in illness”, and the following cultural delusion, primary or secondary (deliroid) to a depression and a histrionic dissociation (Torre, 1981).
- Religious faith in Pentecostalism, as spirituality and in the emotional sacred: a mixture of beliefs, rites and values that produce meaning (miracles), shared by the socio-cultural community.
- The role of the nurses as cultural mediators (who belong to the patient’s ethnic group, language and religion).
- The difficulty of a correct therapy and catamnesis also because of the “disappearance” not only of the patient but also of the family, due to their transfer from one Shona community to another.

3) The theme of Cultural Delusions is part of the vast territory of Cultural Psychiatry and Psychotherapy (Daverio, 2015; Bartocci and Zupin, 2016; Rovera, 2018) proposed through approaches of clinical Psychopathology underpinned by a dynamic cultural basis.

The main currents refer to cultural delusions (Daverio, 2015), schizophrenic disorders (acute delusional states; other so-called secondary delusions, bipolar disorders and also histrionic dissociative disorders, etc.).

From the psychotherapeutic point of view (Rovera, 1974), the importance of cultural identification emerges (Michel, 1993), bearing in mind that mechanisms of cultural projection can be mobilized in the field of helping professions.

The therapeutic relationship is mediated by symbolic spheres that do not refer only to a traditional setting, but imply empathic involvement (in this case performed by the

psychiatric nurses/cultural mediators). This is expressed in terms of verbal and non-verbal language and also through cognitive supports and behavioural suggestions.

The previously mentioned perspectives allow psychotherapeutic interventions to modulate with greater awareness the attitude / counter-attitude (Rovera, 2015) (within which transferral and counter-transferral movements are rooted) and to immerse themselves in the fabric that culturally connects the structure of the personality with the social structure (Gerth and Mills, 1953).

The therapeutic process involves not only an explanation of the symptomatology, but also an understanding of the person and an awareness of the socio-cultural environment of the family and the community.

4) In an overall treatment, the context provided by the therapy group interacting with the group to which the patient belongs indicates the reference frameworks to be respected, so that the processes of change and therapy lead to an improvement of the clinical picture in this direction. It would be useful to create “substitutional therapeutic anastomoses”, putting complementary strategies in direct connection (Rovera, 2014, 2015): for example, with the involvement of the family, in order to encourage a negotiated therapeutic alliance.

IV. Critical considerations

1) This contribution addresses the topic of “cultural delusions” (Daverio, 2015; Bartocci, 2016; Bartocci and Zupin, 2016) through the general theme of “Cultures and delusions” (Rovera, 2017).

The focus has been on General and Clinical Psychopathology (Bleuler, 1911; Jaspers, 1913-1959; Kurt Schneider, 1946) of Delusions through Cultural Psychiatry. It is assumed that cultural delusions are integranal belief (Prince et al., 1987) or anastomoses (i. e. connection channels) (Rovera, 2017): between miracles, apocryphal beliefs, primary and deliroid delusions (Rossi Monti, 2006), disorders of consciousness and personality (Ey, 1956). This can lead to reflections on the cultural mind (Anolli, 2011).

2) Psychiatry, Psychopathology and Cultural Therapy (Lewis and Miller, 1990) highlight how society and culture are inseparable and in continuous development, and how helping professions are rooted in this evolution, also through culturally appropriate identification. Interventions must refer to a programme, to be shared by the multidisciplinary team in charge and by the patients, which includes the entire network of disciplines inherent to the project (Nathan, 1993; Rovera, 2017).

Since no paradigm solves all the problems it defines, a teaching can come from the relational cultural plurality when one considers delusions and also beliefs according to the criteria of classical psychopathology, entering also the cultural parameter [categorial, dimensional and dynamic-structural], both in the psychiatric diagnostic evaluation and in the typology of the interventions.

From these reflections we can trace the recognition of the plurality of cultures and their normative dimension (Rossi P., 1983), which can be correlated to a series of non-definitive responses, which come to the attention of psychopathologists, psychiatrists and cultural therapists.

Apart from the various “reductionisms” or “trialogues” between philosophers, psychoanalysts and neuroscientists (Northoff, 2011), there is the usefulness of a paradigmatic assumption and a theoretical/practical scheme. Comparing psychiatrists’ models can lead to a new awareness of the importance of psychopathology (Jaspers, 1913-1959). The path of Cultural Psychiatry introduces “progressive” changes in psychopathological models and clinical practices, combined with neuroscientific studies and the socio-cultural context (Lewis and Miller, 1990; DSM-IV R, 2000; DSM5, 2013).

Therefore, the epistemological verdict is not definitive without a perspective of historical-scientific research. In fact, in the current dispute between the various paradigms, it is necessary to remember that not all the problems that could have been “solved” by using a single model can be solved in the future with new schemes. For example: the psychodynamic method can be used within the cultural approach (Siciliani et al. 1981; Gabbard, 2014). When considering socio-cultural rules and dynamics, the structural elements of the two contexts are different. This is true for the countless “beliefs” which, although apocryphal (Bartocci, 2016), are part of a pre-

interpreted cultural universe (Rovera, 1984) and which cannot always be considered delusional (in the strict sense of the term).

3) With regard to the psychopathological/Cultural Delusions configuration, "psychopathological constellations" seem to emerge according to the different cultures and psychopathological languages. That is to say that even in the cultural dimension there may be so-called primary delusions (Rossi Monti, 2006) (with a cultural clinical typology), but there may also various be derived (or deliroid) delusions (for example from mood disorders or bouffées délíriantes, compatible with classical nosographies) (Kreapelin, 1904; Bleuer, 1911; Tanzi and Lugaro 1914; Weitbrecht, 1963; Torre, 1981; Pancheri, 1999). Such conjectures seem to be validated by clinical examples and psychopathological-clinical-cultural reflections (Kirmayer et al, 2008). In fact, in some cultures and communities, even in today's Western societies overflowing with neo-prophets, neo-shamans and neo-paganism (Daverio, 2015; Bartocci e Zupin 2016), it is difficult to draw pre-established boundaries between cultural delusions and apocryphal beliefs, even if not demonstrable, such as those rooted in historical religions (AA.VV., APA, 2004).

And this is where the psychopathological-clinical dilemma can be posed, as to whether it is a delusional cultural syndrome or whether it is a reactive cultural delusion such as Kretschmer's (1922) sensory delusion or fantastic pseudology or mythomania "versus" a delusional cultural syndrome. The anastomotic connections between consciousness and personality disorders derived from Henry Ey's organodynamics (1956), allow us to approach different psychopathological syndromes, even culture-bound ones, suggesting the conventional nosological typology through a particular interpretation of the "cultural delusional syndromes".

Also interconnections, which allow identification processes based on an internal imitative mirroring (Gallese, 2003), are activated when the subject tries to guess other people's thoughts, emotions and intentions. Therefore, intercultural investigations make it possible to activate, not only an appropriate cultural identification, as an excellent therapeutic function (Michel, 1999), but also authentic and continuous therapeutic alliances (Rovera, 2014).

4) The current research programs on network process interaction (Rovera, 2009) convey streams of study to nodal points, which subsequently open new paths of Cultural Psychiatry. On the one hand, these disciplinary anastomoses overcome liquid disintegration and, on the other, they differ from the unitary paradigm which is considered too reductionist and hierarchical. What has been and is supported by the APA (2002) and has been elaborated by the philosophy of science (Lanfredini, 1995) leaves aside the pretence of building a unitary science and aims at disciplinary interactions which, in their constant evolution, tend to develop converging research techniques and results of investigation areas: among natural sciences, psychological, social and cultural sciences.

This model of interaction also favours research on the role and impact of culture both in terms of cultural self (Kirmayer, 1994; Kirmayer et al., 2008), and at the psychopathological and clinical level, with particular regard to the Cultural Diagnostic Formulations (Barron, 1998; DSM 5, 2013; Gabbard, 2014) and the ways in which interventions are carried out. Among the nodes of functional interaction, the factors of empathy and therapeutic relationship must also be reinforced: interpreted both as theoretical schemes and as cultural instruments with appropriate connotations (Michel, 1999; Rovera, 2015; Wampold, 2015).

6) This leads us to reflect on the so-called "scientific psychology" of the so-called western civilized cultures, in relation to other cultural/natural psychologies (Nathan, 1993), as well as on the "developments of psychopathology" (Harkness and Super, 1990), variations in nosography, diagnoses (DSM 5, 2013; Gabbard, 2014) and treatments.

● The development of epistemological reflection, with particular reference to process interaction, seems to make it possible to raise questions both with respect to scientificity (Michel, 1999; Fassino, et al., 2007; Northoff, 2011¸ Wampoldt, 2015) and with respect to a clinical method aimed, through interindividual empathic involvement, to embrace as an instrument of knowledge of therapeutic work not only the cultural dimension, but also the style of attachment (Bowlby, 1980; Wallin, 2007; Bartocci and Zupin, 2016), the implicit memories, feelings, affections, the symbolic, the type of internal "language" and the one used in the interindividual exchange

(Mitchell, 2000); and also in relation to the melting pot of cultures that continues to evolve in relation to their mixing (partly due to migration phenomena).

The disciplinary reconfluence in a network of models (Rovera, 2004) leads to new reflections and conceptualizations on the explanatory schemes and also on the problem of the training of all "cultural aid workers", especially if we consider the multiple "healing strategies" and the various figures of cultural healers (for example, curanderos and shamans) (Rovera, 2002).

V) Final notes

1) These assumptions can favour the approach with Culture-bound Syndromes (DSM-IV TR, 2000, DSM-5, 2013), and therefore not only concerning the various glossaries, but also the psychopathological and clinical approaches, giving a greater awareness of cultural lifestyles (Shulman and Mosak, 2008).

Individuals who have had experiences of attachment and multiple cultural learning (e.g. children of migrants) (Anolli, 2011) are more vulnerable to cultural detachment (DSM-5, 2015; Gabbard, 2014) and delusions (Daverio, 2015; Bartocci, 2016; Bartocci and Zupin, 2016). This consideration indicates the possibility of using tools for cultural identification (Michel, 1999; Rovera, 2011) for an appropriate therapeutic style (Rovera, 2015).

The theoretical, clinical and educational challenges lie thus in addressing the complex subject of cultural delusions, which provide a useful contribution to Psychiatry and Cultural Psychotherapy, also through researchers and practitioners of helping professions (Tseng, 2001, Kirmayer et al., 2008).

Cultural Psychiatrists have become more familiar with the medicine of other cultures (Rovera, 2002) which explain the predispositions based on somatic typology, family genetic heritage, biochemical imbalances, and also spiritual influences, sin or karma (Ruesch, 1961). When patients are asked about their models of disease explanation (Kleinman, 1987) and about their conception of the causes and roots of their clinical

symptoms, horizons open up on their cultural world and on their most intimate fears, hopes, anxieties and emotions (AA.VV., APA, 2002).

The value of language in the clinical context consists in transmitting a message that expresses, mostly in the form of a socially accepted disorder, deeply felt individual or collective suffering. Clinicians who are aware of the importance of cultural factors can, by developing their skills, immerse themselves in the symbolic repertoire of the patients and help them to understand and manage the symptoms displayed.

3) A concern regarding the cultural dimensions (in the psychosocial sphere of the patient) derives from what are considered prejudices in the West (Jaspers, 1913-1959), in particular the clinical practices of privacy and confidentiality (AA.VV., APA, 2002) that in some cultures are almost impossible or may be unacceptable by medical ethics.

In the field of clinical research (Rovera et al., 2004), the ever more important culture cannot ignore the role in the study of procedures played by tests, psychotherapeutic approaches, diagnostic criteria and in the more recent field of disease management. By adapting the methodology to the cultural characteristics of the patients under examination, the research will reflect the renewed imprint on the truly effective intervention methods (AA.VV., APA, 2002, Bartocci, 2013).

As far as specific research areas are concerned, the use of the elements that build up the cultural formulation offers the possibility to design ad hoc measuring instruments (Lewis-Fernandez, 1996). And so, cultural variables: such as spirituality, radical violence, age and gender will increasingly be the subject of attention. This development is even more interesting if we consider the growing number of studies on the links between biology and culture, which will explain in more detail the many problems of mental disorders (AA.VV., APA, 2002; Bartocci, 2016).

4) Through the cultural dimension in diagnostic evaluation and complex treatments, the clinician expands the biopsychosocial approach (Fassino et al., 2007) to include conceptual and pragmatic subtleties ranging from ecology to spirituality. The cultural approach increases the ability to assess the clinical case by improving both the clinician's understanding and the patients' perception of their own suffering, to the point of considering Culture as a Therapeutic Factor (Rovera, 2018).

It should be stressed that current Cultural Psychiatry biological factors (in particular neurobiological factors) in human behaviour (AA.VV., APA, 2002). Current research is able to identify substrates of general emotions, which used to be considered fundamentally “subjective” phenomena. The basic tendency of biological research should be counterbalanced by the assumption that many human expressions are conditioned by genetic heritage, and that many other psychopathological syndromes can be placed in a medial area between the extremes of nature and culture. This is “Heisenberg’s niche”, postulated as a crucial element of Cultural Delusions, and also Kurt Schneider’s anthropological mystery (1965), and Jaspers’ concrete enigma (1912-1956), which are postulated as crucial elements of cultural delusions. In this regard, we are still far from having found definitive answers, which should stimulate future investigations, even with regard to syndromes concerning delusions and cultures.

Therefore, the study of cultural delusions is “work in progress” for those who wish to deepen the cultural values in the clinical field, through the cognitive and historical cornerstones, which make it possible to re-elaborate the anthropological foundations - both emics (typical of a culture) and etics (relevant to several cultures) (Tseng, 2001) - aimed at the theoretical-practical knowledge that relates to Cultural Psychiatry (Kirmayer, 2007).

REFERENCES

Adler, A. (1933). *Il senso della vita* (tr. it). Newton, Roma. [1997].

Anolli, L. (2006), *La mente multiculturale*, Laterza, Roma-Bari.

APA, AA.VV. (2002) *Psichiatria Culturale: un introduzione*, Raffaello Cortina, Milano, 2004.

Anolli, L. (2011). *La sfida della mente culturale*. Raffaello Cortina, Milano.

Bartocci, G. (2013) *Réflexions sul Spiritualité Religion et psychiatrie encyclopédie Mèdico-chilurgichale*, Psychiatrie 108 (1) (pp.1-9).

Bartocci, G. (2016). *Visioni Apocrife*. The Freak, Roma.

Bartocci, G., Zupin, D. (2016) *Tecniche di trascendenza, Deliri culturali e deterioramento dell'Io*. In *Deliri culturali* (Eds.). Maniscalco M.L. Pelizzari E. (Eds.). L'Harmattan Italia, Torino. (pp. 110-130).

Barron, J.W. (Ed.) (2005) *Dare un senso alla diagnosi,* Raffaello Cortina, Milano.

Bauman, Z. (2010) *Living on Borrowed Time*. (tr. it). *Vite che non possiamo permetterci*. Laterza, Roma-Bari.

Berzano, L. (Ed) (1997). *Forme del pluralismo religioso*. Il Segnalibro, Torino.

Berzano, L. (2012). Religione e immigrazione: le Chiese pentecostali. In: Roldan, V. (Ed) *Libera Chiesa in Libero Stato*, Firenze, Paglia (pp. 211-220).

Biondi, M. (1999). *Il concetto di norma in psicologia*. In: Pancheri P., Cassano G. (Eds). *Trattato italiano di Psichiatria*. Masson. Milano. I, 4: (pp. 105-134).

Bleuler, E. (1960), *Dementia Precox*, in *Lehrbuch der Psychiatrie*, 10 Ed., Springer, Berlin [1911].

Bowlby, J. (2000). *Attaccamento e perdita. Vol. 3: La perdita della madre*. 2° ed. Bollati Boringhieri. Torino. [1980].

Bhui, K., Warfa, N., Edinya, P. et. al. (2007), Cultural competence in mental health care: a review of model evalutations. *BMC Health Serv Res.* 7:15.

Castiglioni, M.E., Del Rio, G., Servida, A., Terranova-Cecchini, R. (Eds) (2018), *Culture che curano. Materiali e contributi per una Psicoterapia Transculturale,* ed. Borla, Roma.

Coppo, P. (2003). *Tra psiche e cultura*. Bollati Boringhieri, Torino.

Csordas, T.J., Kleiman, A. (1996) The Therapeutic process, in: Sargent, C., Johnson, T. (Eds.) *Medical Anthropology: Contemporary Theory and Method,* Greenwood Press, New York.

Daverio, A. (2015) To be delusional, but not alone: Psychopathology and Cultural perspective of "Folie à Deux", Mass Hysteria and Cultural Delusion, *4th World Cultural Psychiatry Congress, Global Challenges and Cultural Psychiatry,* Puerto Vallarta (Mexico) October 29, Nov 1.

Dein, S., Lewis, C.A., Loewenthal, K.M. (2011). Psychiatrists' views on the place of religion in psychiatry: An introduction to this special issue on *Mental Health, Religion and Culture,* 14(1), (pp. 1-8).

DSM IV-TR. (A.P.A) (2001) *Manuale diagnostico e statistico dei disturbi mentali*, (Tr. It.) Masson, Milano [2000].

APA (2014), DSM-5 *Manuale diagnostico e statistico dei disturbi mentali,* (Tr. It.) Raffaello Cortina, Milano, [2013].

Ey, H. (1956). *Études Psychiatriques. Structure des Psychoses Aigues et Destructuration de la Coscience*. Desclée de Brouwer. Paris. Vol. 1,3, 27: (pp. 751-759).

Fabrega, H. (1987). *Disease and social behavior; an interdisciplinary perspective*. The MIT Press. Cambridge.

Fassino, S. (2014). *Presentazione* in Northoff G. (2011). (Tr. It.) *Neuropsicoanalisi in pratica: Cervello, Sé e Oggetti*. Ananke. Torino.

Fassino, S., Abbate, G., Leombruni, P., (2007) *Manuale di Psichiatria Bio-Psico-Social,* C.S.T. Torino.

Fernando, S. (2004), Spiritual Psychology*, Open Mind*, pp.29-25.

Fonagy, P., Target, M. (2003), *Psicoterapia evolutiva: Le teorie Psicoanalitiche,* (tr. It.) Raffaello Cortina, Milano.

Frighi, L. (1971) La rappresentazione fantasmatica dell'emigrante malato. *Riv. Sper. Fren*. CXV. 4:532-540.

Frighi, L. (ed.) (1972) *Problemi di Igiene Mentale*. Il Pensiero Scientifico. Roma. (pp. 254-275).

Frighi, L., Mazzetti, M. (1993) Screening e psicodiagnosi in culture non occidentali: strumenti e problemi. *Riv. Speriment. Fren.* CXVII. 2. pp. 179-202.

Gabbard, C. (2014) *Psichiatria Psicodinamica.* (Tr. it.) Quindi Ed. DSM-5, Raffaello Cortina, Milano, 2005.

Gallese, V. (2003). La molteplice natura delle relazioni interpersonali. *Network.*1: (pp. 24- 27).

Gerth, H.C., Mills, W. (1969) *Carattere e struttura sociale*. (Tr.it.) UTET, Torino [1953].

Gone, J.P., Kirmayer, L.J. (2010) On the wisdom od considering culture and context in psycholathology. Millon T., Krueger, R.F., Simonsen, E. (Eds.) *Contemporary Directions in Psychopathology: Scientific Roundations of the DSM-V and ICD-11*. New York, Guilford Press (pp.72-96).

Guzder, J. (2011) Second Skins: Family Therapy Agendas of Migration , Identity and Cultural Change, *Focus Familien,* 3, (pp.160-179).

Harkness, S., Super, C.M. (1990) *Cultura e Psicopatologia*. In: Lewis, M., Miller, S.M. (Eds) *Handbook of Developmental Psychopathology*. Reenum Press. New York, 4: 41-52.

Inghilleri, P. (Ed.) (2009), *Psicologia culturale*, Raffaello Cortina, Milano.

Jaspers, K. (1964). *Psicopatologia generale* (Tr. It.). (VII ed.) Il Pensiero Scientifico. Roma [1914].

Jilek, M.D. (1982). Indian Healing. Shamanic ceremonialism in the Pacific Northwest Today. *Hancock House Publishers*. WA.

Kandel, E. (2007) *Psichiatria, Psicoanalisi e nuova biologia della mente.* (Tr. it.) Raffaello Cortina. Milano [2005].

Kirmayer, L.J. (1994) *Pacing the void: Social and cultural dimensions of dissociation*. In: Spiegel, D. (Ed.) *Dissociation: culture, mind and body*. Washington D.C. American Psychiatric Press: 91-122.

Kirmayer, L.J. (2007) Psychotherapy and the cultural concept of the person, *Transcultural Psychiatry*, 44(2): 232-257.

Kirmayer, L.J., Valiskakis, GG (Eds.) (2013) Healing Traditions: The mental Health of Aboriginal Peoples in Canada, Vancouver, *Cultural Psychiatry,* UBC Press, II, 13.

Kleinman, A. (1987). Anthropology and psychiatry; the role of culture in cross-cultural research on illness. *Br. J. Psychiatr.* 151: (pp. 447-454).

Kraepelin, E. (1929), Vergleichende Psychiatrie, Zentralblatt, Nervenheilken Psychiatrie, 27, (pp.433-443) *Handbuch der Psychiatric*, IX Ed., Barth, Leipriz [1904].

Kretschmer, E. (1922). *Medizinische Psychologie*. Thieme. Leipzig.

Lanfredini R. (1995). Filosofia della Scienza. In: Rossi, P. (Ed.) *Le Filosofie Speciali*. UTET. Torino. I: (pp. 69 -135).

Lewis-Fernandez, R. (1996), Cultural formulation of psychiatric diagnosis, *Culture, Medicine and Psychiatry,* 20(2), 133-144.

Lewis, M., Miller, S.M. (Eds) (1990). *Handbook of Developmental Psychopathology*. Plenum Press. New York. Cap 4 (pp. 41-52).

Maniscalco, M.L., Pelizzari, E. (ed.). (2016*). Introduzione a "Deliri culturali. Sette, fondamentalismi religiosi, pratiche sacrificali, genocidi".* L'Harmattan Italia, Torino.

Michel, L. (1999). Des stéréotipes culturals au transfert-controtransfert dans la relation psychothérapeutique interculturelle. *Psychotherapies*. 19. 4: 247-255.

Mitchell, S. (2000), *Il modello relazionale*, (Tr. it) Raffaello Cortina, Milano(2002).

Murphy, H.B.M. (1967). Cultural aspects of delusion. *Studium Generale*. 20 (11): 684-692.

Nathan, T. (1996). *Principi di etnopsicoanalisi*. (Tr. it.) Bollati Boringhieri, Torino. [1993].

Northoff, G. (2011). *Neuropsicoanalisi in pratica: Cervello, Sé e Oggetti*. (Tr.it.) Ananke. Torino. [2014].

Pancheri, P., Cassano, G. (Eds) (1999). *Trattato Italiano di Psichiatria*. (II Ed.) Masson. Milano.

PDM-2, (2018) Tr. It., *Manuale Diagnostico Psicodinamico: PDM-2*, (Eds) Raffaello Cortina Editore, Milano [2017].

Ponce, D.E. (1998). *Cultural epistemology and value orientation.* In: Opkaku, S.O. (Ed.) *Clinical Methods in Transcultural Psychiatry.* A.M. Psych. Press., Washington (pp. 69-87).

Porot, A. (Ed.) (1965) voce Délires (Généralités)*,* In: *Manuel Alphabétique de Psychiatrie: Clinique et thérapeutique,* (III Ed.), 108, Paris.

Prince, R. (1970). Delusions, dogma and mental health. *Transcultural Psychiatry Research Review*. 7: (pp. 58-62).

Prince, R., Tcheng-Laroche, F. (1987) Culture-bound Syndromes and international disease classifications. *Culture, Medicine and Psychiatry*. 11(1). 3-20.

Rossi, P. (1983) *Cultura e antropologia*. Einaudi, Torino.

Rossi Monti, M. (2006) *Delirio (Paranoia).* In: Barale, F. et al. (Eds) *Psiche: Dizionario di psicologia, psichiatria, psicoanalisi, neuroscienze.* Einaudi, Torino. V. I, (pp. 299-305).

Rovera, G.G. (1974) Psicoterapia e Cultura: prospettive su base Adleriana, in *Psicoterapia e Cultura,* Quaderni di Psicoterapia, Il Pensiero Scientifico, Roma, 7, (pp. 74-86).

Rovera, G.G. (Eds), (1984), L'approccio Transculturale in Psichiatria*, Atti del Convegno S.I.P.T.,* Sinchetto, Torino.

Rovera, G.G. (Ed) (1990) Demologia, Psichiatria e Transculturalismo, In: *L'autunno del Diavolo* (Eds) Bompiani, Milano, II (pp.287-513).

Rovera, G.G. (1992), *The Family in different Sub-Culture*, An. Ist. Sup. Sanità, 28, (pp.-227-232).

Rovera, G.G. (2002). *L'espressione del malessere fisico e psichico nelle diverse culture*. La Grafica, Torino.

Rovera, G.G. (2004a). Iatrogenia e Malpratica in Psicoterapia. *Riv. Psicol. Indiv*. 55. (pp. 7-50).

Rovera, G.G. (2004b). Il modello adleriano nelle relazioni d'aiuto. *Riv. Psicol. Indiv*. 56. (pp. 9-14).

Rovera, G.G. (2011). *La psicoterapia interculturale e transculturale*. Congresso Mondiale IAIP. Vienna. Abstract.

Rovera, G.G. (2014) Le alleanze terapeutiche. *Riv. Psicol. Indiv.* n. 76 (pp. 3- 30).

Rovera, G.G. (2015) Lo Stile Terapeutico. *Riv. Psicol. Indiv*. n.78 (pp. 19-85).

Rovera, G.G. (2018) Prefazione In Castiglioni, M.E. et al. (Eds) *Culture che curano,* Borla, Roma. 1978 (pp.7-12).

Rovera, G.G. (2018) *Psichiatria Culturale o Psicoterapia Transculturale?,* in Castigioni, M.E. et al., *Culture che curano,* Borla, Roma, 12, (pp.169-197).

Rovera, G.G., Cuminetti, C., Bogetto, F. (1978), Individual-Psicologia, Antropologia Culturale e Transculturalismo, estratto dalla *Rivista do Psicologia Individuale,* Ed. a cura della Società Italiana di Psicologia Individuale, anno 6, N. 9, pp. 27-38.

Rovera, G.G., Del Sedime, N., Fassino, S., Ponzani, N. (2004), *La ricerca in Psicologia Individuale,* CSE, Torino.

Rovera, G.G., Fassino, S., Ferrero, A., Gatti, A., Scarso, G. (1884), Il modello di rete in psichiatria: considerazioni preliminari, *Rassegna di Ipnosi,* Ed. Minerva Medica, (pp.1-9).

Rovera, G.G., Fassino, S., Scarso, G. (1986) The Therapeutic Rapport in transcultural Psychiatry, *Psichiatria e Psicoterapia Analitica,* V, 2, 267-280.

Ruesch, J. (1961), *Therapeutic Communication,* Norton, New York.

Schneider, K. (1983). *Psicopatologia clinica*. (Tr. it.) VII Ed. [1946] Città Nuova. Roma, [1965].

Seligman, R., Kirmayer, L.J. (2008) Dissociative experience and Cultural neuroscience: narrative, metaphor and Mechanism. *Culture, Medicine and Psychoatry,* 32(1) (pp.31-64).

Shaw, E. et. al. (Eds.), (1971) *The biopsychology of development*. Academic Press. New York.

Shulman, B. H., Mosak (2008), *Manuale per l'analisi dello stile di vita*, (tr. It.) FrancoAngeli, Milano [1990].

Shulman, B., Mosak., H.H. (2008) (Tr. It.) *Manuale per l'analisi dello stile di vita,* Angeli, Milano, [1995].

Siciliani, O., Muzi, P.C., Bianca, M. (Eds) (1981). *Normalità e devianza. Analisi epistemologiche e fondazionali in psicopatologia*. Angeli. Milano.

Tanzi, E., Lugaro, E. (I Ed. 1914/1916, II Ed. 1923). *Trattato delle malattie mentali*. Società editrice libraria. Milano. III Ed., I Vol: (pp. 84 e seg.), II Vol: (pp. 744 e seg.).

Torre, M. (1981). *Psichiatria*. UTET. Torino.

Tseng, W.S. (2001) *Manuale di Psichiatria Culturale,* Ed. (tr. it. Bartocci, G.), CIC, Roma, 2003.

Wallin, D.J. (2009). *Psicoterapia e teoria dell'attaccamento*. (Tr.it.) Il Mulino, Bologna. [2007].

Wampold, B.E. (2015). How important are the common factors in psychotherapy? An update. *World Psych*. 2015. 14: 270-277.

Weitbrecht, H. J. (1970). *Compendio di Psichiatria*. (Tr. It.), Piccin. Padova. [1963].