Dear Dr Bolton:

We have read with interest the paper published in the November 2016 issue by Mingoia and Sharma titled “Management of Brujeria, a Culture-Bound Syndrome.” We would like to highlight 2 main ideas that, in our opinion, merit additional mention. First, Brujeria, the culture-bound syndrome described by Mingoia and Sharma, is only one example of a diverse group of conditions presenting within the context of a specific culture. Second is the vital role of the interpreter, who brought the notion of culture to his or her job, broadening the understanding of the concepts of health and disease.

Since 1962, the term “culture-bound syndrome” has been commonly used, with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) describing 25 culture-bound syndromes as of 2000. However, in 2013, the DSM was updated and the concept of culture-bound syndrome was revised to “cultural concepts of distress.” Of note, the DSM was primarily developed for its use in the United States, as some DSM “disorders” are unlikely to fit in other countries with different sociocultural, political, and economic environments.

Culture-bound syndromes are considered to be illnesses limited to specific areas, societies, or cultures. In population health, health beliefs and culture are important determinants, often influencing outcomes in health care. For this reason, we agree with the authors regarding the need for clinicians to be aware of these conditions. We also suggest that this subject be included in medical school curriculums.

Several additional and frequently seen culture-bound syndromes in the United States include Amok, a disorder characterized by sudden homicidal rages and most often seen in Malaysian men; Brain Fag, which causes depression and demotivation among West Africans; anorexia nervosa, an eating disorder that causes people primarily in Western cultures to be obsessed with their weight and what they eat; Koro, an anxiety disorder where Asian men come to fear that their penis is disappearing; Devaki Syndrome, which causes depression and anxiety in Hindu women with previous fetal loss resulting from spontaneous abortions; and semen loss anxiety, an anxiety disorder reported in men in various parts of the world following loss of semen from nocturnal emissions or masturbation, affecting the idea of masculinity. Brujeria should be viewed in a similar light to these syndromes.

Brujeria and any associated symptoms depend on cultural beliefs. Since culture has an important influence on the expression of psychopathology, we believe that Brujeria is not a nosologic entity by itself. For example, in 2014, an unusual outbreak of neurologic symptoms was reported in the city of Carmen de Bolivar following the country-wide human papillomavirus immunization strategy implemented by the Colombian government. Approximately 300 young women in Carmen de Bolivar received the vaccine. From these women, 200 developed the unreported side effects of fainting spells and pseudocrisis. The local people believed this reaction to be a massive spell, and the Colombian government was forced to cancel the immunization program, even though this event was an isolated one. This situation is a classic example of mass psychogenic illness within a cultural context, despite Brujeria not being a particularly common cultural belief in Colombia.

Finally, one important aspect to be considered in clinical practice is a patient’s level of education. Depending on patients’ education, they may use different words to describe their symptoms, diseases, and even body parts, which could present a challenge for both the physician and interpreter. The same way clinicians should receive additional training in cultural awareness, interpreters may also benefit from similar instruction. The ability
to understand medical terminology and speak the patient’s language is important. However, being familiar with the patient’s culture and possible associated beliefs could provide the interpreter with unique insight and additional avenues of communication.

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References