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# Culture & Schizophrenia: How the Manifestation of Schizophrenia Symptoms in Hue Reflects Vietnamese Culture

Rebecca Gaines  
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# **CULTURE & SCHIZOPHRENIA: HOW THE MANIFESTATION OF SCHIZOPHRENIA SYMPTOMS IN HUE REFLECTS VIETNAMESE CULTURE**



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## **ABSTRACT**

Although schizophrenia has the same essential cognitive basis in all people, the content of the hallucinations and delusions of patients varies significantly across the world.

Schizophrenia is a culture-bound illness, which means that a difference in culture can influence how it manifests. Western societies tend to view schizophrenia symptoms as a medical issue, while Eastern societies treat it as a spiritual or supernatural phenomenon. Vietnam has many specific cultural factors rooted in collectivism and Confucian and Buddhism traditions that make sufferers of schizophrenia present drastically different symptoms than patients from Western societies. The role of family, ancestor veneration, traditional healing, and stigma all have a paramount role in Vietnamese culture. The present study found that those hallmarks of Vietnamese society contribute considerably to how hallucinations and delusions manifest in Vietnamese patients. Patients here are likely to believe an ancestor is haunting them for a family's past shame, or will have a visual hallucination of the Buddha. The strong family unit and the stigma of psychiatry in Vietnam also wield a powerful influence over the content of the patients' delusions and hallucinations.

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## INTRODUCTION

Mental illness is the “last frontier” of the medical field. Of all the medical sciences, it is the least researched, the least financed, and ultimately, the least understood. It is nestled between psychology, a social science, and psychiatry, a hard science. Unlike other chronic disorders that afflict people physically, mental illness and its effects are not always observable. If someone is diagnosed with cancer, nobody doubts the patient’s pain or needs. With mental illness, however, there is a multitude of explanations that attempt to understand the abnormal behavior a person exhibits. For each person, there is a unique combination of biology, genetics, and the environment that somehow mesh together to produce a psychological disorder. The scientific community knows relatively little about the production of mental illnesses compared to other diseases, and this lack of knowledge invites alternate explanations across the world. This creates a fear and stigma of mental illness, which prevents people from getting the help they need.

As a psychology major, I am fascinated by how we perceive and treat mental illness. I have always pursued my studies grounded in the understanding that something neurological is at the epicenter of all mental disorders. When I meet someone or read about someone who exhibits symptoms of a mental illness, my first few thoughts are wondering what in their brain made them more susceptible, and what trigger in the environment pushed these symptoms to the forefront. I had assumed that since cognitively everybody is relatively the same, how the symptoms manifest must be the same as well. It was only once I came to Vietnam that some of these assumptions began to be challenged.

For my ISP, I knew that I wanted to study something related to mental health in a smaller urban area. Having spent half of the program in Ho Chi Minh City, I wanted to explore a new type of landscape that would still be able to provide me with the resources necessary to conduct psychological research. My academic director, Co Thanh, suggested the central city of Hue: it

was a small city with a fascinating background as Vietnam's former imperial capital, and it had a renowned medical college that would help me to conduct research. This was important, because my initial research on mental health in Vietnam showed me there was a dearth of services for psychiatric needs, and clinical psychology is only starting to be recognized as a legitimate field. The school, Hue University of Medicine and Pharmacy (UMP), is associated with the International Collaborative Centre for Community Health Research (ICCCHR). I met with a team of researchers, professors, and students from the UMP, who informed me the main focus of psychiatry in Vietnam was on schizophrenia and epilepsy. As epilepsy is a neurological disorder than a psychiatric one, I chose to focus my project on schizophrenia. I wanted to explore a side of schizophrenia that could only be researched in Vietnam, something that would incorporate the culture I'd just spent learning three months about.

With these guidelines, I began reading cross-cultural studies on schizophrenia, and was blown away to learn how culture-bound the disorder is. Study after study showed a wide variation in how schizophrenia manifests in different cultures. I had already known that typical delusions of schizophrenic patients included thinking a microchip was controlling them, or that the CIA was after them. It had never occurred to me how Westernized those views were. I saw my time in Hue as an opportunity to explore a whole new side of schizophrenia from an Eastern cultural standpoint, from a Vietnamese point of view. I began to wonder what aspects of Vietnamese culture permeated so deeply into the collective psyche of the people that it would manifest through schizophrenic symptoms. Thus, my research questions were formulated around exploring that perspective:

- I. What are the common themes of hallucinations and delusions from Vietnamese schizophrenic patients?

II. How do these manifestations reflect Vietnamese culture?

Armed with those questions, a translator and my own sense of curiosity, I set out to find how people with schizophrenia in Hue understand their own condition in the broader context of the unique Vietnamese culture.



## **LITERATURE REVIEW**

### **EASTERN-WESTERN MENTAL HEALTH DIFFERENCES**

Scores of research papers have been dedicated to studying the underlying differences between how Western and Eastern societies exhibit, understand, and treat mental health. Scientists usually look to sociocentricity to explain many of these differences. Sociocentricity refers to the spectrum of collectivism to individualism present in a particular culture's values (Banerjee 2012). Western cultures tend to be more individualistic, whereas Eastern cultures to be more collectivist. Collectivist societies are more concerned with sharing goods (both material and nonmaterial), place an emphasis on the family as the basic unit, and encouraging good self-presentation which would lead to better social acceptability. People are more intricately involved in each other's lives, so a significant emphasis is placed on contribution and belonging to a group. This downplays the role of the individual, because it is understood that "one's own outcome correspond to the outcome of others" (Banerjee 2012). Individualism, on the other hand, emphasizes a singular person's achievement and rewards competition rather than collaboration. Personal benefit takes importance over collective gain. There are many character traits that are exhibited more commonly among either Eastern and Western cultures, traits that often link back to foundational cultural values. Stoicism, for example, is a well-documented characteristic among Asian cultures. They tend to be reluctant to discuss emotional problems with strangers, and instead focus on physical issues (Versola-Russo 2006). This could be detrimental in terms of psychiatric help, which often deals with issues that are more emotional rather than somatic.

### **EXPLANATION OF SCHIZOPHRENIA**

As a disorder that has been documented in almost every country across the world, *schizophrenia* is an interesting case to examine how distinct cultures can produce wildly different manifestations of the same illness. The most commonly quoted statistic is that schizophrenia affects approximately 0.7% of the world's population, although that number varies between and within countries (Banerjee 2012). The typical on-set of schizophrenia begins for men in their mid to early twenties, and for women, late twenties. It is rarely diagnosed in children or adults older than 45 (Mayo Clinic). Schizophrenia is characterized by delusions, hallucinations, disorganized speech and behavior. Delusions and hallucinations are known as the “positive” symptoms of schizophrenia; the negative symptoms refer to a severe decrease in emotional expressiveness, leading the patient to withdraw socially and exhibit no motivation. For a patient to be officially diagnosed with schizophrenia according to the Diagnostic and Statistical Manual, at least two symptoms need to be present for six months and active for one month (DSM-5). These core symptoms are seen in all patients, but the manifestations of the symptoms tend to be quite different across cultures.

## **STUDYING SCHIZOPHRENIA ACROSS THE WORLD**

The earliest cross-cultural studies on schizophrenia symptoms focused more intensely on delusions rather than hallucinations. This is likely the case because delusions are easier to measure and evaluate than hallucinations. These studies, which were conducted by Murphy et al. in the 1960s, collected data by sending questionnaires to psychiatric centers across the globe. The questionnaires asked about the psychotic symptoms present in the patients at each local center. The results of these early studies showed a strong link between culture and type of hallucinations. In North Africa and the Near East, visual and tactile hallucinations were the most common. In Europe, auditory hallucinations appeared more frequently (Murphy et al. 1963 via

Bauer et al. 2010). This early research was confirmed with a new study that evaluated over 1,080 patients with schizophrenia from Australia, Poland, Lithuania, Georgia, Pakistan, Nigeria, and Ghana. In the overall sample, auditory hallucinations were the most prevalent, affecting 74.8% of participants, followed by visual hallucinations at 39.1% of participants. The visual hallucinations were highest in the West African countries. This result falls in line with previous literature that has found visual hallucinations to be the highest in traditional cultures (Bauer et al. 2010). Prevalence of symptoms varied across countries as well, “suggesting that cultural effects may not necessarily be delineated by geopolitical boundaries” (Myers 2011).

Once it was understood that the type of symptoms varied across culture, scientists began to examine if the specific content of each symptom would differ as well. Abnormal behaviors and thought expressions have a wide spectrum along which people consider them a problem. Western societies tend to attribute hallucinations and delusions to a mental illness that needs to immediately be cured. They look toward biological, chemical, and genetic explanations as to why these strange phenomena are occurring, and try to fix them with heavy medications and isolating hospitalizations. In Eastern societies, on the other hand, behavioral deviance and illness are usually explained through spiritual or supernatural reasons. For instance, mental illness in a traditional society could “be attributed to fate, possession by evil spirits, a curse, punishment from the dead... malevolence and misfortune placed for misdeeds that angered his/her ancestors... or that an individual is attacked by spirits, ancestors, or Gods” (Nguyen 2012).

The influence of culture is so powerful that the immediate environment one is in can strongly affect the type of hallucinations that patients are having. Suhail and Cochrane (2002) conducted a study that compared 3 groups of patients to better understand how the current environment can influence the content of schizophrenia symptoms. Their groups were: 1) Pakistani patients living in Pakistan, 2) Pakistani immigrants living in Great Britain, and 3) white

British patients living in Great Britain. The patients currently living in Pakistan had more visual hallucinations than the other two groups, and they attributed those hallucinations to spirits or ghosts. They also had many fewer auditory hallucinations than the British Pakistani or white British groups. There was a much larger difference between the British Pakistani and Pakistanis living in Pakistan than between the British Pakistani and white British participants. This clearly demonstrates how the immediate environment has a substantially stronger influence on the manifestation of hallucinations and delusions than the culture of origin.

### **CROSS-CULTURAL NEUROPSYCHOLOGICAL PROCESSING DIFFERENCES**

The effects of culture on schizophrenia run so deep that scientists have found neuropsychological differences between cultures that can explain symptom variation. Nisbett and Miyamoto (2005) believe that “different emphases in visual and attentional processing could be the source of differentiation in hallucination types” between cultures. The researchers examined several studies that had participants examine relationships in a variety of environments. They concluded that Asians “tend to engage in context-dependent and holistic perceptual processes,” while Westerners “tend to engage in context-independent and analytic perceptual processes.” Essentially, Asians focus on patterns rather than the details, and pay attention to everything in their field of vision in a certain scene. By attending more to the relationships between objects (rather than the objects themselves, as Westerners are more likely to do), they can remember the scene better and notice changes in it more easily.

There are even differences in the eye movements of Eastern and Western subjects: Asians made more saccades (rapid eye blinks) in general, and especially when looking at the background of a scene, compared to Westerners (Nisbett and Miyamoto 2005). This indicates that they were paying more attention to the whole scene and especially more attention to the

background. The researchers believe these differences are due to the significant cultural variances, notably how Asians have more collectivist cultures and Westerners have more individualist cultures. Since Asians have a more interconnected social world “with many role prescriptions,” they need to pay more attention to the relationships and context. This is quite evident in Vietnamese culture with the complex pronoun system, where your relationship to a person can drastically alter how you refer to them and a mistake in that is a grave social mishap. These neuropsychological differences between societies further highlight how the sociocentricity of a culture can have a significant effect on a person’s psychological state, which influences their mental health status.

## **DEFINING MENTAL ILLNESS IN VIETNAM**

Treating hallucinations and delusions as solely a sign of mental illness is a very Westernized point of view. Many Eastern cultures attribute what Westerners think as signs of schizophrenia to something more spiritual or supernatural. In Vietnam specifically, the term mental illness is translated to *benh tam than*, which is usually approximated with madness or a severe psychiatric disorder. Following collectivist beliefs, this madness is measured by how its potential to harm those involved with the patient, rather than the self-harm induced by having a mental illness. Additionally, psychiatrists are referred to as *bac si tam than*, or “doctors who treat madness.” The extremity of both words has created an intensely negative stereotype surrounding the “wild, unpredictable and dangerous” sufferers of mental illness and those who are “obliged” to the ridiculous task of treating them. Colloquially, people use the terms *dien* and *khung*, which respectively translate to “crazy” and “nuts.” The use of terms associated with mental illness in casual conversation, while also common in Western cultures, creates an atmosphere of fear and

apprehension in Vietnam. The terminology used to understand mental illness creates a stigma surrounding both patients and doctors who are involved in the psychiatric field (Nguyen 2003).

## **VIETNAMESE CULTURAL FACTORS AFFECTING MENTAL ILLNESS**

Nguyen (2003) studied the cultural and social attitudes towards illness in Ho Chi Minh City. Like other Eastern cultures, Confucianism and Buddhism have significantly influenced traditional Vietnamese belief systems. This has created a society where “the importance of the family cannot be understated.” As the most essential piece that holds Vietnam society together, the family’s needs take precedence over the individual. Each person does not have individual misfortune – it is linked with the good (or bad) luck of his or her entire extended family, including actions that may have been taken in a previous life. If a person has a mental illness, they may be paying for the sins of their ancestors and their problems “represent repatriation for personal, familiar, or ancestral transgressions” (Nguyen et al 2005). Therefore, when a patient’s mental illness produces embarrassing behavior, “the moral implications of his affliction are regarded as marks of shame for his family, extended family, and ancestors” (Nguyen 2003).

While families are a powerful force that exacerbates the stigma felt by their relatives with schizophrenia, the close connections created within collectivist societies may also act as a protective factor. Instead of accepting that their relative has a mental illness, the family will come up with alternate explanations to understand the deviant behavior. In China, families will use the term *xiang tai duo*, meaning "excessive thinking," when a family member hallucinates. Families in southern India also use this as an explanation for schizophrenic symptoms (Myers 2011). In Vietnam, families will attribute symptoms to natural causes rather than psychiatric ones, such as trauma, being lovesick, or studying too much (Nguyen 2003).

When a family member presents signs of a mental illness, the family generally follows a hierarchy to solve the problem. When seeking help, the first option is usually to resolve the issue within the family. When a patient becomes out of control, the family will turn to traditional medicine for treatment (Nguyen et al 2005). Fortune-tellers and monks have a long history in Vietnamese culture of helping the needy, and it is much more acceptable for a family to be seen asking for traditional healing than going to a psychiatric hospital. Traditional healing is also more available to families, since there are “over 10,000 traditional healers in Vietnam, compared to merely 600 psychiatrists” (Nguyen 2003). They are significantly cheaper than going to a psychiatric hospital, and usually more locally accessible due to their high prevalence. Going to see a psychiatrist is usually a last-resort option.

## **CURRENT STATE OF PSYCHAITRY IN VIETNAM**

The Vietnamese government developed and implemented a national mental plan in 2000. This plan created a legislative and policy framework for organizing services and resources for mental health issues. The essential components of the plan included developing community mental health services, involving families and patients in patient decisions, advocacy and promotion, human rights protections, financing, equity of access to services for all groups of people, and a monitoring system to keep everything in check (WHO-AIMS report). The services consist of providing free psychotropic medication to all qualified patients and training for health staff. The strengths of the system indicate the Vietnam is working hard toward creating comprehensive coverage for its mentally ill citizens. All users under the system are covered by human rights legislation and efforts are being made to promote equity of access. The mental health sector works in conjunction with other related public sectors such as health, criminal justice, and education to ensure that everyone is receiving proper treatment. Mental health

providers are directly involved with the staff providing direct care, so there is a clear connection from providers to patients.

However, the problems with the system are far more prominent than its successes. The World Health Organization reports that the main faults of the program are that the network of mental health facilities is not finished and that the services are skewed heavily towards providing resources in the mental hospitals rather than at community health centers. Although training is provided, it is very limited and not always competent for primary care staff. Additionally, the information system that links mental health centers does not work well. In terms of human resources, there are relatively few psychiatrists compared to the number of non-psychiatric doctors and nurses in Vietnam. There are only a few hundred psychiatrists in the entire country, whereas medical doctors range close to 1000 and nurses reach about 1,700 in number. Other mental health areas, such as paraprofessional counselors and health assistants, have about 650 workers. As of 2004, there were no licensed psychiatrists working in outpatient clinics, although that estimate has increased in the time since then. The low rate of psychiatrists in the country means that there are .06 psychiatrists per every bed in a mental health facility (WHO-AIMS report).

The reasoning behind the lack of properly trained psychiatrists goes back to a deeper cultural problem with the psychiatry field as a whole. There is a stigma for doctors who train in psychiatry as opposed to other fields, and it frequently falls to the bottom percentage of the graduating class in medical school. The fear of mental illness is still very prevalent in Vietnam, which contributes to the hesitancy of medicine students to follow a psychiatric path. Those with the lowest grades can either go work in rural areas and train further there with very limited resources, or they can continue with their education as specialized psychiatrists. Some psychiatrists won't even tell their own families what their specialty because the field is



considered shameful. Hence, there is a huge dearth of psychiatrists in Vietnam, which means there are many patients who are not receiving proper care. Since many of the doctors who do enter psychiatry are were not at the top of their class, the quality of doctors is not necessarily as good as in other medical fields (Nguyen 2003).

## **METHODOLOGY**

In-depth interviews were conducted with eight Vietnamese people: four patients, one family member, three psychiatrists, and one community health leader to explore the different types of hallucinations and delusions they or people they knew had experienced. The qualitative method was determined to be the most appropriate method to get a rich and thorough understanding of how the content of schizophrenia symptoms reflect Vietnamese culture. Since some of the questions, especially for the patients, were quite personal, a one-one-one (or two-on-one, with a translator) interview was considered to be the best way to get as much information from the participant as possible while maintaining their privacy.

## **SETTING & RECRUITMENT**

Dr. Dung Ho and Thang Binh arranged interviews for me with several psychiatrists that worked for Hue University of Medicine and Pharmacy and the affiliated hospital. The qualifications for the psychiatrists were that they had significant experience working with schizophrenic patients in Hue. They also sought patients with a diagnosis of schizophrenia, preferably ones who had experienced hallucinations and delusions. Due to the small number of patients currently residing in the affiliated psychiatric hospital, a patient with negative schizophrenia symptoms was also included. The three psychiatrists and two patients were interviewed on the grounds of the psychiatric hospital. The other two patients are inpatients at the provincial hospital in Hue, and they were interviewed there. The community health leader was interviewed at her community health station in Hue.

## **PARTICIPANTS**

The three psychiatrists were Dr. Cat, the head of the psychiatry department at Hue University of Medicine and Pharmacy, Dr. Luong, the head of the psychiatry department in the Hue hospital affiliated with the university, and Dr. Hang, a psychiatrist who has been working at the university for 16 years. The community health leader was Lien Nguyen, who has been at her station for several months. The family member was the sister of a patient. The patients' identities are being kept anonymous to protect their right to privacy and confidentiality. All four patients interviewed were male and in their 30s or 40s. One was from Hue City and three were from villages outside of the city. Three patients were ethnic Vietnamese and one patient was a member of the ethnic minority group C• Tu.

## **PROCEDURE**

The interviews were scheduled over the course of two weeks, from 5 May to 16 May. Dr. Cat and Dr. Hang were interviewed in English, and all other participants were interviewed in Vietnamese with the help of a translator. The translators were either members of the psychiatry department or preventative medicine students at the University of Medicine and Pharmacy. The psychiatrists' interviews and two of the patients' interviews took place at the Department of Psychiatry at the hospital. The interview with the sister of a patient took place simultaneously with the patient at the hospital. The other two patients were admitted to the provincial hospital of Hue, so their interviews took place on site there. Chi Lien's interview took place at the community health station in Hue. Participants (except for the psychiatrists) were compensated 50,000 VND for their participation in the study.

## **DATA COLLECTION**

I created an interview guide with open-ended questions and prompts that varied for each sub-group of participants. There were three similar sets of questions for patients, relatives of patients, and professionals. The format of the interviews was semi-structured, so I could ask follow up questions that were not listed directly on the guide. I wrote the guide in English, and the translators prepared a Vietnamese version. The guide was emailed to the professionals ahead of time to give them an opportunity to prepare their answers. The guide listed my research goals, research questions, and specific questions for each sub-group of participants. Major topics covered in the interview protocols relate to the schizophrenia symptoms experienced by the patients or patients of the professionals, the treatment undertaken by the patients (ie, if they sought traditional medicine before coming to the hospital), family attitudes and practices towards mental illness, and stigma experienced. The full interview guide is provided in Appendix 1. On average, the interviews lasted 30-60 minutes and were not tape-recorded. I typed all the responses as the participant or translator was speaking.

## RESULTS

| Patient | Hallucinations           | Delusions                | Persecution              | Possession               | Other<br>(grandeur, etc) |
|---------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| A       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          | <input type="checkbox"/> |
| B       |                          | <input type="checkbox"/> |                          |                          |                          |
| C       |                          | <input type="checkbox"/> | <input type="checkbox"/> |                          | <input type="checkbox"/> |
| D       |                          | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| E       |                          | <input type="checkbox"/> |                          | <input type="checkbox"/> |                          |
| F       |                          | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| G       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |

Figure 1: Types of delusions & hallucinations experienced by patients

### DELUSIONS

Delusions are more common among schizophrenia patients than hallucinations. The most common delusions amongst participants were delusions of persecution, which is when a person has “false and irrational beliefs that they are being cheated, harassed, poisoned or conspired against... [and] that they, or a member of the family or someone close to them, are the focus of this persecution” (National Institute of Mental Health). Patient A was scared that somebody from his family would kill him, so he tried to run away. He also began thinking that the military would come and get him to kill him. He believed that the military was trying to kill everyone, and especially targeting the children by giving them toxin injections through a vaccination program. He would shout for help in his home, yelling, “People are being killed!” and “Save the women!” while running all over the house. The patient thought the media and houses around him are videotaping him with lots of cameras. To remedy this, he closed all of the doors and windows and hid inside. He additionally believed that a judge and court would fine and imprison him for crimes he had never committed. He knew he was not guilty of anything illegal, but was still scared that he would be caught and falsely accused. Patient D also believed that people (such as his parents, neighbors, and brother) want to rob him and this caused him to feel very out of control, which lead to dangerous circumstances for him and his family. Patient G was returning

from a visit to the central highlands back when he suffered a persecutory delusion. He thought that a group of terrorists were following him and the group asked him to confess to crimes or else be executed and they will kill his family.

Patient F was a member of a minority group and thought his friends wanted to take over his assets, such as his wife, house, and other precious things. Dr. Luong said that the delusions suffered by members of ethnic minorities tend to be persecutory delusions. They occur especially when they are far from their own community, and become afraid of something. The psychiatric community in Vietnam used to refer to this as “railway syndrome,” named after the “Paris syndrome” suffered by Japanese people who visit Paris for the first time and experience bouts of psychosis. The railway syndrome is characterized by people from ethnic minority groups who travel a long way from home and feel fear, anxiety and exhaustion. Essentially, it is an extreme culture shock that results in acute psychosis. If this acute psychosis lasts for more than month and satisfies other criteria, it is diagnosed as schizophrenia. The delusions of ethnic minorities are not as diverse as the delusions of ethnic Vietnamese.

The delusion of possession was another common theme experienced by the participants. Dr. Luong often sees patients from rural areas with lower education levels suffering from delusions of possession. These patients believe that a spirit haunts their mind and control their body and they hear the voice of their ancestor. The spirits ask them to do something extraordinary, like heal the illnesses of other people through superstitious measures such as massaging affected organs to cure disease. The families of these patients do not think their relative has a mental disorder, rather, they too believe that a spirit haunts the person from another world. They believe that people from the other world interfere and take action on Vietnamese patients. In terms of participants, Patient E wore a bracelet that belonged to her grandmother, and she believes that the spirits of her dead grandparents are controlling her through the bracelet.

These spirits told her that her parents are not good, and so she punched her mother and father.

Dr. Hang says that visiting fortune-tellers may enhance the delusions of possession, because they often tell the patient there is someone who died and is now following the patient.

Patients suffered from other types of delusions as well, such as Patient A believing that the media and houses around him are videotaping him with lots of cameras. To remedy this, he closed all of the doors and windows and hid inside. He additionally believed that a judge and court would fine and imprison him for crimes he had never committed. He knew he was not guilty of anything illegal, but was still scared that he would be caught and falsely accused.

Patient C became paranoid that he would lose his job, that he would get into an accident, or that he would not be able to find his wife. Dr. Luong also spoke of patients who have delusions of grandeur, where you “have character like Ho Chi Minh” and can take care of people.

## **HALLUCINATIONS**

Although visual hallucinations have been found to be more frequent in traditional cultures according to past research, Dr. Hang believes that auditory hallucinations are more common in Vietnam. The content of the auditory hallucinations for her patients usually consist of hearing a voice in their head from their everyday life, such as a relative or neighbor, telling them to do something. She gave the example of a patient who thought that someone told him to climb to the roof of his house, which he did, and then his family had to climb on the house to get him down. Patient A experienced auditory hallucinations where rough noises were making an “ooo” sound in his ear. When a patient has visual hallucinations, which are less common than their auditory counterparts, they may see Buddha or a dead relative, according to Dr. Hang. For ethnic minorities, who do not necessarily follow Buddhism, their hallucinations are more related to mountain gods than Buddha. Patient A hallucinated that soldiers were lying on the ground

outside of his house, doing inspections with telescopes. Patient G saw a group of terrorists that he thought were coming to kill him and his family.



## DISCUSSION

There are several themes that are prevalent across the stories of patients I interviewed or heard directly about from their psychiatrists. While I have broken the themes down and explained them individually, it must be noted that they are not in fact disparate entities: the extreme importance placed on family has its roots in Buddhism, which also encourages the practices of ancestor veneration and traditional healing. Ancestor veneration illuminates the strong family ties and also perpetuates them. These themes are complex, interrelated concepts and work together to have a strong effect on the manifestations of schizophrenia symptoms of Vietnamese patients.

| Patient | Ancestor/<br>Spirit haunting | Became<br>violent to<br>protect<br>self/family | Physical<br>illness      | Pursued<br>alternative<br>treatment |
|---------|------------------------------|--|--------------------------|-------------------------------------|
| A       | <input type="checkbox"/>     |  | <input type="checkbox"/> | <input type="checkbox"/>            |
| B       |                              |  | <input type="checkbox"/> | <input type="checkbox"/>            |
| C       |                              | <input type="checkbox"/>                       | <input type="checkbox"/> |                                     |
| D       |                              | <input type="checkbox"/>                       |                          | <input type="checkbox"/>            |
| E       | <input type="checkbox"/>     |  |                          |                                     |
| F       |                              | <input type="checkbox"/>                       |                          |                                     |
| G       |                              | <input type="checkbox"/>                       |                          |                                     |

Figure 2: Vietnamese cultural themes present in patients' symptoms

## FAMILY

Since the family unit is at the heart of Vietnamese society, it plays a key part in how the contents of schizophrenic symptoms manifest. There is a common understanding that the family is more important than the individual, and thus many patients exhibit symptoms that cause them to go to extreme lengths to protect their families. Under the guise that they are protecting their families from potential danger, they often act violently. After Patient D had returned from a visit to the psychiatric hospital, his child was hit by a motorbike one day and needed to go to the

hospital. The motorbike driver only gave the very poor family a meager sum to cover the medical costs, and the patient's disordered thoughts returned. He took a knife and went to the driver's house and attacked him. People came and grabbed him off of the driver, and brought him back to the psychiatric hospital for the third time. He feels ashamed and mad because he cannot live with his family while in the hospital. Patient F, who had delusions that his friends wanted to steal his assets, decided the best way to avoid losing his family was to kill them and then commit suicide. He used a shovel to try and hit them, but the wife took the older children and ran away. When they returned, they found that the three-month-old baby had been killed with a strong blow to his head. The patient then tried to throw his dead baby in a spring nearby. He did not have a chance for a suicide attempt before the police caught him. When Patient G thought that terrorists were after his family, he attempted suicide by stabbing himself in the stomach, *seppuku*-style, in hopes that the terrorists would leave his family alone.

## **SPIRITUAL HAUNTING**

Being haunted by spirits is a common explanation to understand why a patient is experiencing hallucinations and delusions. Spirits coming back plays a large part in ancestor veneration, a practice that nearly all Buddhist Vietnamese families participate in. Every house and storefront will have a small alter with sacrificial altars to offer to their dead relatives. Even if a family does not consider themselves to be "religious," they will venerate their ancestors as a sign of respect towards them. Patient E experienced this when she felt her dead grandparents were controlling her through a bracelet that used to belong to her grandmother. After camping in the mountains and chopping down trees, Patient A was told that the mountain gods haunted him for disturbing the peace of the area. Since spirituality is already so involved in the lives of most Vietnamese, it makes sense that when a patient has a delusion of being controlled, it will come to

them in an already familiar form. When a person does not understand what is happening to them, if something clearly abnormal is occurring, they look for an explanation that within the realm of what they do know. If a patient is feeling possessed or controlled, they will assume it is a dead relative coming back to haunt them, because scores of legends exist on the idea that ancestors want to correct their progenies for wrongdoings.

## **TRADITIONAL HEALING**

Consequently, families of the patients often bring them to pagodas and try traditional healing for a long time before they go to the hospital. Most of the patients with schizophrenia that Dr. Luong has seen had some alternative treatment before coming to the hospital. These spiritual healers “always told patients that they are haunted by the devil or demons” and they gave them some herbal medicine or acupuncture to heal. The fortune-teller will often tell the patient there is someone who died and is now following the patient. The advice given by fortune-tellers can actually exacerbate the symptoms of patients. By legitimizing the presence of spirits instead of recognizing the hallucinations and delusions as a psychiatric problem, it reinforces their presence and they continue to haunt the patients. The family must create some symbolic material for the person who died, such as a car, motorbike, or clothing, and then burn them. Burning effigies is a common practice, usually done during death anniversaries, to send the spirit of a relative who is haunting the patient back to another world and leave the still-living members of the family alone. However, Dr. Cat says this method is as effective as to “going to a bank and burning money to make a deposit.” Alternative treatment can only go for so long before the families recognize the symptoms are worsening rather than being alleviated, and only then do they seek psychiatric or medical help.

## **STIGMA**

The strong stigma of mental illness in Vietnam, as demonstrated by the linguistic associations with psychiatric terms, creates a powerful desire to avoid admitting a problem at any cost. Stigma prevents patients from seeking help at an appropriate time, which exacerbates their symptoms for a longer period. There is a long tradition of remaining silent on these issues, because Asians in general “have a hard time verbalizing problems,” especially ones that are as sensitive as schizophrenia symptoms, according to Dr. Cat. One way that patients work around discussing their psychiatric problems is by instead seeking treatment for somatic issues. Several of the participants complained of headaches, backaches, and insomnia. Patient B said the reason he was admitted to the hospital was for the physical side effects of medication; however, nothing in his medical records mentioned medication issues as his reason for admittance. It is much more likely that his lack of feeling emotions for seven years landed him in the psychiatric ward. Since physical illness is readily accepted in Vietnam and there is no stigma attached to getting treatment for something like a neck ache, patients may unconsciously develop psychosomatic symptoms that can be used as a method to get them in the hospital. These physical problems can also be signs of imminent psychiatric ills: Patient A had attended a funeral where his relatives made fun of him and offended him. A few days after the funeral, he began to suffer an ear inflammation, and then began having auditory hallucinations. The jokes from the relatives may have triggered the patient’s underlying paranoia from his schizophrenia, which could then have caused his subsequent ear problems and hallucinations.

## **CONCLUSION**

My research goals focused on understanding the specific facets of Vietnamese culture that influenced how symptoms of schizophrenia patients manifested in Hue. I wanted to get patients’ personal stories as well as psychiatrists’ experiences with patients to create a well-

rounded perspective of the cultural influence on symptomatology. Through a thematic examination of hallucinations and delusions, I was able to tap into a relatively misunderstood field in Vietnam and hopefully bring new light to a stigmatized illness. By creating awareness of the state of schizophrenia in Vietnam, I wanted to enlighten both Vietnamese and foreigners about how mental illness is understood and treated here. Although there is a strong reluctance to discuss such intensely personal issues such as mental health in Vietnam, I hope that my research will encourage people to start the conversation.

## **LIMITATIONS**

The major limitation was the small sample size of my participants. I was only able to interview four participants by myself, and received stories about three patients from interviews with their psychiatrists. Stories about seven patients is not sufficient to create a clear understanding of trends and themes across Vietnam, especially considering I only worked in Hue. I was not able to interview the family members or doctors of most patients, and therefore I only got a one-sided view of the patient's symptoms. This issue, combined with possible translation errors, made it difficult sometimes to get a straight answer out of a patient. If a patient did not properly respond to my question, I did not know if the translator misunderstood or misinterpreted the question, or if the patient had disordered thoughts (a common symptom of schizophrenia) and did not coherently answer my question. Sometimes, the answers that patients gave did not match their medical records, so it was hard to know what the truth really was.

## **RECOMMENDATIONS FOR FUTURE STUDY**

I believe that creating a larger pool of participants will increase the significance of the study. By examining more and different symptoms, explicit trends can come through and more stories will be told. Additionally, I think it is important to note the different sub-cultures in

Vietnam, and explore how these various groups may have a whole separate set of trends. For example, I think it would be important to look into the difference between ethnic Vietnamese and ethnic minorities. My research touched on the “railway syndrome” that affects ethnic minorities in Vietnam, and I think that is a substantial reason to not lump them in with having the same culture as the Kinh people. The regional differences should also be explored to see if traditional beliefs hold more weight in the northern, central, or southern regions. Lastly, getting the full story about a patient’s symptoms is important to truly understand their situation. By cross-referencing information from the patient, their family, and their doctor, we can sufficiently understand the extent of the symptoms that the patient is experiencing.

### WORKS CITED

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Banerjee, A. (2012). Cross-Cultural Variance of Schizophrenia in Symptoms, Diagnosis and Treatment. *Georgetown University Journal of Health Sciences*, 6(2). Retrieved from <https://blogs.commonsgorgetown.edu/journal-of-health-sciences/issues-2/vol-6-no-2-july-2012/cross-cultural-variance-of-schizophrenia-in-symptoms-diagnosis-and-treatment/>.
- Bauer, S. M., et al. (2011). Culture and the prevalence of hallucinations in schizophrenia. *Comprehensive Psychiatry*, 52, 319–325.
- Mayo Clinic Staff. *Schizophrenia*. Retrieved from <http://www.mayoclinic.org/diseases->

conditions/schizophrenia/basics/definition/con-20021077.

Myers, N.L. Update: Schizophrenia across Cultures. *Current Psychiatry Reports*, 13(4). doi:10.1007/s11920-011-0208-0.

Nguyen, A. (2003). Cultural and Social Attitudes Towards Mental Illness in Ho Chi Minh City, Vietnam. *Stanford University Research Journal*. Retrieved from [http://www.stanford.edu/group/journal/cgi-bin/wordpress/wp-content/uploads/2012/09/Nguyen\\_SocSci\\_2003.pdf](http://www.stanford.edu/group/journal/cgi-bin/wordpress/wp-content/uploads/2012/09/Nguyen_SocSci_2003.pdf).

Nguyen, C.X. and Anderson, L. (2005). Vietnamese Americans' attitudes toward seeking mental health services: Relation to cultural variables. *Journal of Community Psychiatry*, 33(2). DOI: 10.1002/jcop.20039.

Nguyen, H. T., Yamada, A. M., & Dinh, T. Q. (2012). Religious leaders' assessment and attribution of the causes of mental illness: an in-depth exploration of Vietnamese American Buddhist leaders. *Mental Health, Religion & Culture*, 15(5), 511-527.

Nisbett, R. and Miyamoto, Y. (2005). The influence of culture: holistic versus analytic perception. *TRENDS in Cognitive Science*, 9(10). Retrieved from <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.87.43&rep=rep1&type=pdf>.

Suhail, K. and Cochrane, R. (2002). Effect of culture and environment on the phenomenology of delusions and hallucinations. *International Journal of Psychiatry*, 48(2). Retrieved from <http://isp.sagepub.com/content/48/2/126.short>.

Versola-Russo, J. M. (2005). Cultural and Demographic Factors of Schizophrenia. *International Journal of Psychosocial Rehabilitation*, 10(2).

World Health Organization. (2005). World Health Organization assessment instrument for mental health systems-WHO-AIMS version 2.2. Retrieved from [http://www.who.int/mental\\_health/evidence/who\\_aims\\_report\\_viet\\_nam.pdf](http://www.who.int/mental_health/evidence/who_aims_report_viet_nam.pdf).

## APPENDIX 1

### Interview Guide

#### Goals of Research:

1. To explore the influence of culture on mental illness by specifically looking at schizophrenia
  - a. Cultural values such as: collectivism, strong family ties, Buddhism/Confucianism
2. To gain a thorough understanding of the hallucinations and delusions of patients with schizophrenia
3. Role of Vietnamese cultural elements in hallucinations/delusions
4. To understand why these specific cultural aspects are so pervasive in hallucinations and delusions

#### Research Questions:

1. What are the common themes of hallucinations and delusions from Vietnamese schizophrenic patients?
2. How do these manifestations reflect Vietnamese culture?

Type of Interview: Semi-structured interview with open-ended questions

**Topic guide for PATIENTS:**

1. What are the symptoms that you've experienced?
2. Could you describe in detail some of your symptoms? Try to give as full a description as possible
3. When did they begin? How frequent were they until you decided to seek help?
4. What type of treatment did you choose?
5. What is your family situation like?
  - a. Do you live with your family?
  - b. Is your family more traditional or modern – how do they approach traditional values such as filial piety?
  - c. Do they help to take care of you?
  - d. Are they open about or ashamed of your disorder?
  - e. Is your family religious? Do you also practice a religion?
6. Is there a history of mental illness in the family?

**Topic guide for PSYCHIATRISTS:**

1. How do you evaluate a patient who comes in with possible symptoms of schizophrenia?
2. What are the typical symptoms that you see in Hue?
3. Could you give some specific examples of patients you've worked with in terms of their hallucinations and delusions?
4. Do you see any themes across their hallucinations/delusions?
5. Do you think that the types of hallucinations/delusions of your patients relate back to Vietnamese culture (ie, a reliance of traditional medicine or strong belief in spirituality?)?
6. How do you think a patient's family affects their symptoms or treatment? Do you see a difference in terms of families who provide more care at home or families who use hospital treatment more?

**Topic guide for FAMILY MEMBERS OF PATIENTS:**

1. What were the symptoms that your family member had that alerted you that something was not right?
  - a. Please explain in detail the hallucinations and delusions that your family member experienced
2. What did you think the symptoms were caused by?
3. How did you first want to treat them? (ie, traditional or modern medicine?)
4. Why did you choose that particular treatment?
5. Did anything change after the first treatment?
  - a. Did they take medications, herbal supplements, etc
6. Do you feel that there is a stigma or shame surrounding mental illness in Vietnam?
  - a. Are you open about your family member's disorder? Why/why not?
7. Does your family take full care of your relative, or do you frequently see doctors?
  - a. Who administers your relative's medication, if they take it?
8. Is there a history of mental illness in the family?



**Topic Guide for COMMUNITY HEALTH LEADER**

1. How do you see stigma of mental illness in VN?
2. What do you do to combat this stigma?
3. When people think of someone who is "mentally ill," what image comes to mind? (What does a "stereotypical" mentally ill person look like to you?)
4. What do you do when someone comes into the center who is mentally ill?
5. Do you give the families support as well as the patients?
6. Do you have people with schizophrenia at the clinic?
7. Do they come here before or after going to see a psychiatrist?
8. What type of symptoms do they have?
9. Do you see their symptoms relating back to Vietnamese culture?