CHAPTER 2

Mental Illness in a Multicultural Context

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How does culture affect the expression and prevalence of mental illness? This question reflects a critical tension in scientific investigations of mental health and illness that is revealed in the history of the development of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM provides a description of different "accepted" mental disorders and the clinical criteria for assessing each. Since the American Psychiatric Association (APA) first published the DSM in 1952, it has become widely used by clinicians, psychiatric researchers, and social scientists for different purposes. As a foundation, DSM assumes that mental disorders are discrete biomedical entities that are explained by biomedical processes. It is often implicitly assumed that psychiatric symptoms or syndromes are universally distributed and uniformly manifested. This assumption is unwarranted, because groups vary in how they define such constructs as "distress," "normality," and "abnormality." These variations affect definitions of mental health and mental illness, expressions of psychopathology, and coping mechanisms (White & Marsella, 1982).

The changes from DSM-I to the latest version, DSM-IV, mirror some of the social and institutional changes that have taken place in the United States over this 45 year period

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(Rogler, 1997; see Chapter 26). As DSM-IV was being developed, social scientists and policy makers pressured the manual developers to consider cultural factors in the assessment of mental disorders. As a result, DSM-IV includes an appendix of culture-bound syndromes and statements about "specific cultural features" within each disorder section. Although the concession to include cultural factors in DSM was seen by some as a marked improvement, it did leave the DSM with a somewhat shaky foundation. Social and cultural explanations may not be consistent with the psychiatric tendency to focus on standardized discrete classifications of mental disorders (Aneshensel,1992; Kleinman, 1988).

The debate about the role and significance of culture and mental illness is not new, nor is it recent. This chapter begins with a review of the historical basis for the debate, examines the sources for the current interest in these issues, and provides a summary of the theoretical perspectives that guide empirical research on the role that culture plays in expressing, reporting, and responding to mental illness. The chapter concludes by advocating the integration of structural and cultural perspectives with conventional methodologies when investigating psychological distress and more serious forms of mental illness in ethnic minority communities.

HISTORICAL CONTEXT

Cultural relativists contend that explanations of mental illness cannot be separated from the individual's social and cultural context. In contrast, the universalists argue that a biological similarity and unity among people supersedes culture. Both perspectives agree that culture plays a role in the perception of mental illness. However, conceptual and theoretical disagreements continue unresolved regarding the impact of culture on the etiology, experience, expression, responses, and outcome of mental illness.

Each perspective comes with a voluminous body of theoretical and empirical research that supports its respective explanation of mental illness. Inherent in each explanation is a set of beliefs that frames research questions and methodology, guides diagnosis, and implies prevention and treatment techniques and strategies. Changing definitions and explanations of mental illness provide evidence for a cultural and social constructionist perspective. At the same time, a biomedical perspective maintains that historical evidence supports the argument that mental illness is a universal phenomenon that has consistently occurred throughout history and continues to afflict humankind. From this perspective, changing definitions and explanations are viewed merely as differences in interpretation based on available knowledge for any given period in time (see Chapter 4).

The Cultural Perspective

Cultural theories have disputed psychiatry's biological reductionism (Fabrega, 1995). During the 1950's, social construction theorists questioned the validity of a medical model and argued that mental illness was socially and politically constructed (Szasz, 1960). Biomedical explanations of mental illness as a disease similar to physical diseases were contested (Foucault, 1957). Although anatomical and physiological links were made for physical diseases, none could be made for the majority of identified mental disorders. Cultural theorists argued that our perceptions and responses to mental illness are shaped through social interactions, which are themselves formed by the cultural and sociopolitical context of

society. Concepts of mental illness are not fixed, but are specific to a culture at a given time in its history (Foucault, 1965; Szasz, 1961).

A Euro-Mediterranean orientation of madness was dominant from the Medieval to Renaissance periods. Individuals who manifested patterns of symptoms outside the normal boundaries of behavior were labeled as mad. Dominant religious beliefs and symbols were reflected in definitions and explanations of madness, which was perceived as a conflict between the external supernatural forces of good and evil. Intervention was generally apathetic, and the afflicted were ostracized, left to wander, or were imprisoned. The perception and response to mentally ill persons began to change parallel to a restructuring of the economic system from a peasant economy to a capitalist one. Perceptions of the mad as victims of supernatural conflicts shifted to one of individual moral corruption and sinfulness. By the sixteenth century, persons believed to be mentally ill were institutionalized in hospitals originally established for lepers. These institutions played an important socioeconomic function of protecting the status quo by ensuring that a cheap source of labor was readily available and by tempering uprisings by the unemployed and homeless (Foucault, 1965).

Perceptions of mental illness during the American Colonial period also incorporated religious ideology (Manning & Zucker, 1976). The concept of mental illness did not exist prior to the nineteenth century, and affected individuals were referred to as "distracted." Emotional distress was expressed through religious idioms that reflected the dominant religious ideology and generally consisted of a blending of medical and religious treatment. As the United States began a transition from an agricultural to an industrial economy, the perceptions of mental illness caused by supernatural forces shifted to individual moral blame. Overindulgence, idleness, and masturbation were the prominent explanations given for behavior patterns perceived as insane. A biological basis for insanity also emerged during this historical period. The chronically afflicted were thought to have had an incurable hereditary disposition to insanity. Thus, two perceptions of mental illness existed: Individuals either caused their own insanity or inherited a predisposition for developing it. Asylums established to treat the chronically insane were largely occupied by the poor and homeless, who rarely were discharged. The affluent were treated in private sanitariums and had a more successful treatment outcome than those placed in asylums. Differences in social class influenced perceptions of insanity, its course, treatment, and outcome (Manning & Zucker, 1976).

With a predominant orientation that mental illness was a myth and nonexistent, early social constructionist theories were viewed as "antipsychiatry" and were ineffective in redirecting psychiatry's momentum toward a biological explanation of mental illness (Fabrega, 1995). With their roots in social construction, sociological theories such as social labeling and symbolic interaction also fell from prominence as primary explanations of mental illness. Although these theories did not dispute a biomedical explanation of mental illness, they redirected the focus of attention from the individual to society by conceptualizing mental illness as a product of societal response (see Chapter 4). Anthropological research made significant contributions toward a cultural understanding of mental illness and was a prominent leader in the cultural relativity movement beginning in the midtwentieth century. Anthropology has generally tended to focus and rely on cross cultural studies of mental disorders with populations in preindustrial, non-western, "exotic" cultures. Although this research significantly contributed to the clarification and development of concepts and theory in cross-cultural research on mental illness, it was seldom applied or tested in the same manner with racial and ethnic minorities who were considered culturally different in modern, mainstream Western societies such as the United States.

The Biomedical Perspective

The historical evolution of psychiatry's perception of mental illness as a universal phenomena began during the early twentieth century as it moved toward a scientific medical model of mental illness (Jimenez, 1988). The twentieth century ushered in the concept of psychiatry as an official branch of the medical sciences. Although moral and ethical issues were still believed to be related to the causes of mental illness, psychiatry, wanting to share in the medical knowledge and developments of the twentieth century, began to move purposely toward "scientific" explanations of mental illness (Pilgrim & Rogers, 1993). It was also assumed that an alignment with the medical sciences would bring recognized legitimization to a somewhat nebulous profession. Thus, psychiatrists began to use scientific idioms such as diagnosis, treatment, and outcome to categorize mental illness according to a medical model. The focus shifted, then, from the individual to a disease. The discovery of encephalitis, epilepsy, and paresis with its origin in syphilitic infection provided convincing evidence that mental and physical disorders were linked (Grob, 1983). Eventually, biological explanations of mental illness have found acceptance in the general public's attitudes and beliefs through popular media and literature, along with the popularized use of some medications (e.g., Prozac) that have become common household words.

Although social science research continues to advance a greater understanding of the cultural and social origins of distress, psychiatric research continues to strengthen its biomedical perspective of mental illness. Hereditary predisposition is the current theme that dominates perceptions and treatment interventions of mental illness (Fabrega, 1987; Kleinman, 1988). As psychiatry becomes more entrenched in medical explanations and as the biological orientation of mental illness is strengthened, the role of structural and cultural factors becomes increasingly minimized.

ETHNIC AND RACIAL MINORITIES IN THE UNITED STATES

The United States is becoming increasingly diverse as we move into the twenty-first century. Currently, ethnic and racial minority groups comprise 31% of children and 23% of the entire population (Hollman, 1993). By the year 2025, nearly one-third of all adults and one-half of all children will be from ethnic minorities (Lewit & Baker, 1994). In the past decade alone, the majority of people in some major urban cities, such as Los Angeles and New York, are from ethnic minority groups. Thus, the racial makeup of the United States. is changing dramatically, while our understanding of ethnic minority mental health and illness has not significantly increased since the 1980s. A critical component of these changes is attributed to immigration from non-European geographical areas such as Mexico, Asia, Cuba, and Haiti. The rate of immigration parallels that at the turn of the century, when large numbers of Europeans entered the United States. Although still the largest of the racial and ethnic minority groups in the United States., African Americans are projected to be the second largest group next to Latinos by the year 2025 (Lewit & Baker, 1994). Immigrants from other countries will increasing alter the composition of ethnic and racial minority groups in the United States.

As the United States undergoes continued demographic changes, there is renewed interest in studying cultural factors in the distribution of mental illness within ethnic minority communities. When examining prevalence rates of specific disorders, we find great variation in both cross-national studies and among ethnic groups in the United States. For

example, a wide range has been observed in lifetime prevalence rates for major depression across different countries: Taiwan; 1.5%, Edmonton, Canada, 9.6%; Savigny, France, 16.4%; United States, 17.1%; Christchurch, New Zealand, 11.6%; Korea, 2.9% (Weissman et al., 1996; Kessler et al., 1994).

Rates of Minority Mental Illness

In attempting to understand the impact of cultural factors on mental illness, a common research strategy has been to describe the distribution of mental illness across different racial and ethnic categories. In the early part of this century, data based on hospital and clinic admissions and treatment were used to draw conclusions about the prevalence and type of mental disorders found in ethnic and racial minority communities. Using a treated-case-method approach, late nineteenth- and early twentieth-century research consistently reported a high prevalence rate of schizophrenia among African Americans (Bell & Mehta, 1980). Reportedly low rates of depression were explained as African Americans lacking the psychic makeup to experience sadness and depression (Bevis, 1921). Conversely, other research suggests that repeated misdiagnosis of African Americans led to higher rates of schizophrenia and lower rates of affective disorders (Bell & Mehta, 1980; Jones & Gray, 1986; Simon, 1973; Spitzer, Endicott, & Robins, 1978).

Although African Americans were reported to have high rates of mental illness, Asian Americans were described as a relatively problem-free population (Kimmich, 1960; Kitano 1962; Sue & McKinney, 1975; Yamamoto, James, & Palley, 1968). Findings from these studies supported a belief that Asian Americans had lower rates of mental disorders than most other groups in the United States, including Euro-Americans.

The rates of mental illness for nonwhite Hispanic groups vary widely, and it is often unclear if these rates of mental illness are similar to or different from other groups (Martinez, 1993). Data are mixed and sometimes contradictory on nonwhite Hispanic rates of mental illness (Vega & Miranda, 1985). Research has indicated lower, similar, and higher rates of overall and specific disorders (Jaco, 1960; Malzberg & Lee, 1956; Vega & Miranda, 1985).

Treatment data, however, have been criticized for not adequately reporting true prevalence rates. For example, researchers have repeatedly demonstrated the underutilization of mental health services by some ethnic minority group members, whereas others have questioned the validity of clinical diagnosis (Jones & Gray, 1986, Rogler, Malgady, & Rodriquez, 1989; Sue & Morishima, 1982).

African Americans. By the middle of the twentieth century, survey research became a more prominent means of documenting the level of treated and untreated cases of mental illness in communities. A shift from treated populations to community surveys brought with it contradictions of earlier assumptions and understanding of ethnic and racial minorities. For example, unlike the wide discrepancies found in treatment data between African Americans and whites, community surveys demonstrate only modest or no differences in diagnostic disorders (Adebimpe, 1994).

Unlike rates under treatment data, Epidemiologic Catchment Area study (ECA) data showed no differences in the rates of schizophrenia between whites and African Americans after controlling for age, sex, socioeconomic status, and marital status (Adebimpe 1994). Adebimpe suggests that the disparity in findings found between community and treated samples can be attributed to an interaction between racism, sociodemographic, and experi-

ential differences between whites and African Americans that necessarily affect treatment. For example, racial stereotypes and assumptions about African Americans have resulted in this history of receiving more severe diagnoses misdiagnosis, and differential treatment than whites (Adebimpe, 1994). The ECA study also found that African Americans had higher 6-month prevalence rates of cognitive impairment, drug abuse, panic attacks, and phobia (Griffith and Baker, 1993, p.152). Griffith and Baker caution that significantly higher cognitive impairment may be related to substance abuse, anxiety disorders, panic attacks, and other medical problems. Although the ECA offers new information about the prevalence and types of mental disorders experienced by African Americans, Williams (1986) warns that the ECA sampling methodology significantly undersampled middle- and upper-income African Americans, seriously limiting the extent to which the study's findings can be generalized.

Within-group variability has been generally neglected in epidemiological research with African Americans. Although stereotypes have led to an assumption that the majority of African Americans are poor and disadvantaged, about 10% are found in the upper classes and approximately 40% are middle class (Sue & Sue, 1990). Differences between Euro-American and African American rates of psychiatric illness are typically attributed to race. In a review of community surveys on African American mental disorders, Williams (1986) concluded that most findings of racial differences can be accounted for by socioeconomic variables. However, the fact remains that African Americans are overrepresented in lower socioeconomic levels, and, as such, may be more vulnerable to stressors linked to psychological distress. In an analysis of 21 cross-national studies, including the United States, Dohrenwend et al. (1980) concluded that the severest psychopathology is twice as common in lower socioeconomic classes.

ASIAN AMERICANS. Asian Americans were not specifically recruited for inclusion in the ECA study. However, the notion that Asian Americans are generally well adjusted and problem free has been challenged by other research (Sue & Sue, 1974). Low utilization rates are not necessarily indicative of low prevalence rates, but may be a reflection of cultural factors, such as a stigma associated with perceptions of mental illness, the presence of family support, cultural incompatibility of Western forms of treatment, and differential meanings associated with mental illness. Uba (1994) conducted an extensive review of the research literature on Asian American emotional distress and concluded that Asian Americans have a rate of mental illness higher or equal to Euro-American rates. In addition, variations in rates and types of mental disorders vary across the numerous subgroups that comprise the Asian American category. For example, Southeast Asians have higher rates of posttraumatic stress syndromes than other Asian American groups, whereas Filipino Americans reportedly have higher rates of depression than most other Asian groups (Kuo, 1984) and the general population (Tompar-Tiu & Sustento-Seneriches, 1994).

NATIONAL COMORBIDITY STUDY AND ETHNIC AND RACIAL MINORITIES

A decade after the ECA study, the National Comorbidity Survey (NCS), another large-scale psychiatric epidemiological survey was launched (see Chapter 7). It was the first time that a structured interview schedule, the Composite International Diagnostic Interview (CIDI; World Health Organization 1990) was used on noninstitutionalized random sample of the

national population. The CIDI is based on DSM-III-R nosology because revisions to what would become DSM-IV were still in progress at the time. Spanning 17 months of lay interviews across the 48 contiguous states, the NCS looked at the comorbidity of substance disorders and nonsubstance psychiatric disorders (Kessler et al., 1994).

Kessler et al. (1994) reported a 48% lifetime prevalence of one or more psychiatric disorders (i.e., affective, anxiety, substance use, and other disorders) (see Chapter 7). Meanwhile, nearly 30% had at least one disorder within the past 12 months. Major depressive episode (17.1%), alcohol dependence (14.1%), social phobia (13.3%), and simple phobia (11.3%) had the highest lifetime prevalence rates. Of those with a history of mental disorder (48%), more than half (56%) had two or more DSM-III-R disorders. Overall, NCS findings were similar to those reported from the ECA study, although the NCS rates are generally higher in the absolute.

However, notable differences emerged between the two studies in relation to race. Controlling for age, income, and education, Kessler divided race into four categories—"white," "black," "Hispanic" and "other"—and found that blacks were 50% less likely than whites to have had any kind of disorder within their lifetime or within the past year. Hispanics, on the other hand, showed no significant differences in lifetime or 12-month prevalence of any disorder compared to non-Hispanic whites. Neither the ECA nor NCS studies actively focused on Asian Americans.

Mexican Americans

Until recently, the ECA project was considered one of the most sophisticated and comprehensive in epidemiological research on Mexican American mental illness. Findings showed that Mexican Americans and non-Hispanic whites in Los Angeles were very similar across selected mental disorders, whereas whites had higher rates of drug abuse/dependency (Karno et al., 1987). Research has been mixed about the role of immigrant status on psychological distress and mental illness. Some studies have reported a greater vulnerability toward mental distress by immigrants than nonimmigrants, whereas others have concluded the opposite (Burnam, Hough, Karno, Escobar, & Telles, 1987; Rogler, Cortes, & Malgady 1991; Warhiet, Vega, Auth, & Meinhardt, 1985).

The ECA data suggest that structural and cultural factors play a powerful role in shaping rates of mental illness. Burnam et al. (1987) examined the relationship of acculturation, mental disorder, and immigrant status. Mexican Americans who were native born and highly acculturated had the highest lifetime prevalence rates across five disorders: major depression, dysthymia, phobia and alcohol and drug abuse/dependence. Immigrant Mexican Americans had lower prevalence of major depression and drug abuse/dependency than nonwhite Hispanics, whereas native Mexican Americans had higher prevalence than non-Hispanic whites of dysthymia, phobia, and alcohol abuse/dependency. The differential rate of mental distress between native born and immigrant groups has been attributed to structural and cultural factors, including an association between acculturation and a sense of status deprivation; selective immigration, with the disproportionate immigration of the most healthy individuals (Burnam et al., 1987); and, traditional cultural factors, such as strong family cohesiveness and support, and perceptions of mental illness (Shuval, 1982). Although these explanations point out important differences among Mexican Americans related to acculturation, they do little to advance an understanding of the cultural sources for these differences. In research with ethnic minorities, acculturation has been used to mea-

sured either the extent to which one has learned a new culture or the psychological changes experienced by the individual as a result of being in contact with other cultures and participating in the process of acculturation. Thus, the operationalization of acculturation as a social learning or psychological construct does not directly measure culturally related factors.

Explanations of Group Differences

Generally, there appear to be both similarities and differences across racial and ethnic categories. Differential rates between groups and within groups indicate a need to examine cultural and structural factors. When group differences are found, cultural explanations are often neglected in favor of explanations based on ethnic or racial differences, or factors related to cultural conflict. For example, differences in levels of acculturation have been used to explain greater immigrant vulnerability to psychological distress such as depression (Vega, Warheit, Auth, & Meinhardt, 1984), adjustment problems (Abe & Zane, 1990), and unhappiness (Padilla, Alvarez, & Lindholm, 1986). Conversely, recent data have indicated that immigrants have less psychological distress and mental disorders than their native-born cohorts. However, little is known about how the acculturation process creates psychological distress, nor is it clear whether acculturation protects individuals or makes them more vulnerable to mental disorders. Generally, level of acculturation does not communicate much information except to point out that people come from different cultures and describe the extent to which they hold on to traditional ways. Minimal information is revealed on the sources of cultural differences and how cultural content affects the etiology, expression, and treatment of mental disorders. Research on ethnic and racial minorities has tended to superimpose empirically untested cultural descriptions of a group onto findings in an attempt to understand and explain observed ethnic and racial differences in rates of mental disorders. For the most part, cultural factors are not directly examined but are inferred. Thus, we are left to speculate about the role of culture in mental disorders and how culture affects rates of mental illness for ethnic and racial minorities.

Figure 2.1 illustrates the two models of mental health research with ethnic and racial minorities discussed earlier. The conventional model examines how social factors directly affect mental health outcomes, unless the elaborated model allows for the integration of social, structural, and cultural factors. The conventional model is based on an assumption that one's place in society, such as membership in ethnic minority group, or as immigrant, is analogous with cultural factors such as beliefs, attitudes, and values, and as such can predict the expression, response, and prevalence of psychological distress and psychopathology. An empirical examination of the direct effect of cultural variables on mental health outcomes is oftentimes circumvented and replaced with conceptual descriptions of a group's culture. One problem with this approach is that we lose sight of the fact that cultural factors are only inferred and are not empirically based. The conventional model also assumes that all individuals within a particular category are similar based on their shared membership. For example, research has tended to focus on four general ethnic minority categories. However, each category is comprised of within group differences that may conceal more than they inform (Takeuchi, Uehara, & Maramba, 1997). The category Asian American encompasses numerous subgroups with distinct cultural, educational, historical, and socioeconomic differences. The elaborated model proposes to directly examine cultural factors and their impact on mental health outcome, while continuing to include social factors.

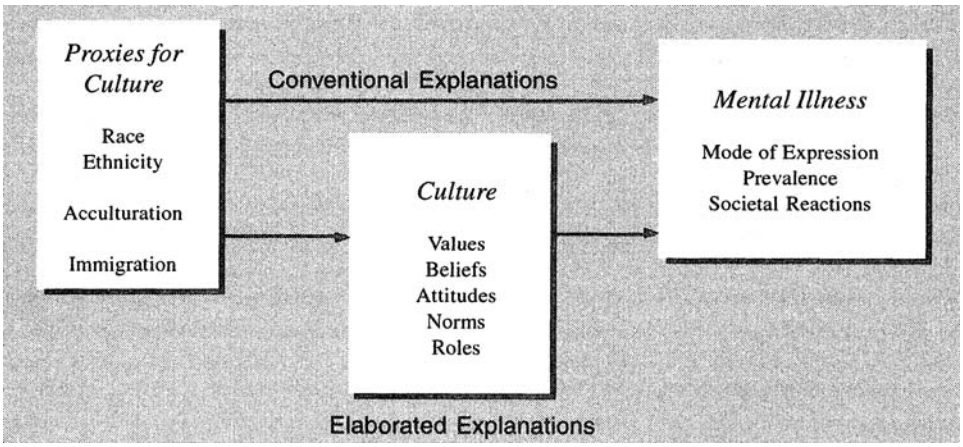

FIGURE 2.1. Conventional and Elaborated Explanations of Culture and Mental Illness

CULTURAL THEMES

Two major themes emerge from the literature examining ethnic and racial group differences in psychopathology: structural factors and cultural factors. Social structural factors can enhance or constrain the manner in which cultures express distress (Linsky, Bachman, & Straus 1995). Although a number of channels of expression for psychiatric distress may exist universally, whether a society is individualistic or collectivistic, for example, could pave specific pathways and affect the manifestation of symptoms. A study of the Hutterites in North America illustrates how structural factors influence the expression of mental illness. Alternately, cultural factors may also influence modes of expressing mental illness such that these modes are more acceptable in some groups than others. The preference of the Chinese for a clinical diagnosis of "neurasthenia" as opposed to depression, for example, illustrates how culture affects the manner in which individuals present psychological distress. The next two sections will briefly discuss the Hutterite and Chinese cultures to illustrate these two themes.

The Hutterites

The Hutterites are members of the Anabaptist sect that originated in Central Europe during the sixteenth century. Severe religious persecution in 1565 drove them out from Moravia (a geographic region in the former Czechoslovakia) and into other countries, including the Ukraine. A large number of Hutterites eventually migrated to the United States beginning in 1874, and in 1918 to Canada, where they have remained in religious communes. As a socially (and genetically) homogeneous group, the Hutterites provide an interesting insight into the effects of sociostructural factors on mental health.

An NIMH-funded study on the Hutterites conducted in the early 1950s by sociologist Joseph Eaton, in collaboration with psychiatrist Robert Weil, showed high rates of psychoses (Eaton & Weil, 1955). This finding was unexpected. After a thorough investigation, Eaton claimed that "the Hutterite way of life, despite the good mental health reputation of

its members, provides no immunity from severe psychiatric disorders" (p. 53). The sect ranked third among nine other groups (e.g., an urban district in Baltimore, an arctic village in Norway, Williamson County in Tennessee). But rather than interpret the results as indicative of the Hutterites' proneness to psychotic illness, Eaton was more inclined to propose that the high expectancy ratio was "a function of the thoroughness of the survey methods" (p. 76). Since methodology has often been a source of disagreement among researchers, it is indeed relevant to meaningful comparisons of diverse groups. However, the various rates presented by Eaton in his analyses, and results of more recent cross-national studies, highlight a more striking observation: Culture has a profound impact on the expression and interpretation of psychological distress, which manifests in the different rates that have been reported in the psychiatric epidemiological literature.

Eaton and Weil (1955) found a lifetime morbidity of 199 in a population of 8,542, or one case per 43 Hutterites. A breakdown of the diagnostic categories revealed that 74% of psychotic cases (n = 53), were of the manic-depressive kind. These 39 Hutterites showed psychotic symptomatology characterized by a depressed mood with "mental and motor retardation, perplexity, or agitation" (p. 100). Meanwhile, other categories were discovered to be much less prevalent than manic-depressive reaction. A recent reanalysis of Eaton's data by Torrey (1995) using DSM-III-R criteria showed strikingly low rates of schizophrenia (0.9 per 1,000) and bipolar disorder (0.6 per 1,000). Thirty-two (3.7 per 1,000) were rediagnosed with major depression.[1]

That depression among Hutterites is four times more prevalent than schizophrenia and six times more common than bipolar disorder brings some intriguing questions to the fore: What is it in the Hutterite way of life that contributes in the expression of psychological distress, specifically depression? How does a Hutterite view her or his depressive condition?

Hutterites reside in agricultural colonies called *Bruderhöfe*, and practice a highly conservative, Christian way of life. They are isolated from more modern communities surrounding their enclaves, decline involvement in political issues, and are strict pacifists. Crime is almost unheard of and transgressions against one another are highly discouraged. The collectivistic orientation of this society requires every individual, child or adult, to give up selfish motives for the good of the group. Thus, a theocratic system coupled with a heavy emphasis on collectivistic values work hand in hand in the formation of a Hutterite culture.

The Hutterites' religious orthodoxy influences this group's depressive symptomatology. Eaton and Weil (1955) observed that "the content of the delusions and the verbal production [seemed] to be greatly colored by their notion that their disorder [was] a spiritual or religious trial by God" (p. 101). The Hutterites referred to depression as *Anfechtung*, meaning "temptation by the devil" (p. 101). It was believed that *Anfechtung* befalls "good people" (p.102); hence, its victims did not need to feel stigmatized for having the disease. Despite the supportive atmosphere in the colonies, the depressives nevertheless experienced a loss of self-esteem and felt sinful. Eaton claimed that "the culture of a Hutterite village [was] conducive to the development of such sentiments" (pp. 105–106).

Psychoanalytical theories and research on anger and its relationship to mental health

[1] At the time of Eaton's study, individuals who have had an episode of depression of any state (mild, acute, or depressive stupor), may be diagnosed with manic-depressive psychosis without having a prior history of manic attacks. Conversely, it could also be used on individuals who have had manic attacks only. Torrey's (1995) reanalysis using DSM-III-R criteria reflects the breakdown of Eaton's single category into three separate diagnoses—schizophrenia, bipolar disorder, and major depression.

may provide some insight into the high prevalence of depression among the Hutterites. Abraham (1927) attributed depression to repressed violence, and Freud (1993) conceptualized it as anger turned inward. Modern theories of depression suggest a similar causal link (White, 1977). A number of empirical studies have indeed found a positive correlation between suppressed anger and depression (Biaggio & Godwin 1987; Moore & Paolillo 1984; Riley, Treiber, & Woods 1989; Clay, Anderson, & Dixon 1993).

Laden with guilt for experiencing a socially unacceptable emotion such as anger, a Hutterite who has been conditioned to control overt display of a basic human emotion has little choice but to internalize her or his aggression. In addition, Hutterites are socialized at an early age to find guilt within themselves instead of their brethren (Eaton & Weil, 1955, p. 86). Not surprisingly, Eaton found that among the manic-depressives in the sect, only a few expressed verbal threats, and there were no incidents involving physical injury. Thus, the Hutterites' constant suppression of aggressive impulses to maintain group harmony may have drastic repercussions on their mental health.

That depression was found to be a common reaction to the Hutterite way of life is a classic example of culture's profound influence on the ways individuals respond to their environment. Thus, the context in which mental disorders appear should be treated with equal gravity as their prevalence. This concept has been clearly elucidated by Bales (1946) in his attempt to identify the social structural factors that influence rates of alcoholism within society. He suggested that (1) levels of stress or "inner tensions"; (2) societal attitudes toward drinking (abstinence, ritualistic, "social drinking," utilitarian); and (3) the availability of means other than drinking to relieve stress work simultaneously and may have differential effects in any particular culture. In a recent study testing Bales's theory, Linsky et al. (1995) found that levels of societal stress and degree of permissiveness toward drinking were correlated with indicators of alcohol problems (death rate from cirrhosis and average consumption of alcohol) at the state level of analysis. These results support Bales's theory and further emphasize the importance of cultures and social structures in the expression of mental disorders.

The Chinese

Neurasthenia. Numerous studies on depression among the Chinese have verified the prominence of somatic complaints presented by depressive individuals (Cheung, Bernard, & Waldmann, 1981; Kleinman, 1977, 1980, 1982; Marsella, Kinzie, & Gordon, 1973; Tseng, 1975). Chinese depressive symptomatology is markedly different from the affective and dysphoric manifestations of the disorder that are more common in the West. Lin (1982) remarks that "one may even wonder if one is not looking at a distinctly different illness" (p. 240). Additionally, results of these studies reveal significantly lower prevalence rates of depression among the Chinese compared with Western populations. However, some researchers ascribe these findings to culturally biased diagnostic criteria being used inappropriately in these epidemiological studies (Kleinman, 1977; Lin, 1982; Zhang, 1995). Thus, Chinese depressives whose primary symptoms are somatic are systematically being undercounted as a result of using culturally irrelevant instruments. Kleinman (1977) refers to this error as "category fallacy," a major source of error in the interpretation of cross-cultural epidemiological studies.

Although major depressive disorder has been found to have low prevalence among the Chinese, researchers have reported high rates of "neurasthenia." Furthermore, the dis-

order also appears to be the most common clinical diagnosis in this population (Cheung, 1989; Ming-Yuan, 1989). A term introduced by American neurologist George Beard in 1869, neurasthenia's symptoms include physical and mental fatigue, memory loss, insomnia, palpitations, dizziness, hypochondriasis, depressed mood, phobias, and headache—to name but a few of the 70 some symptoms described by Beard (1880). From the late 1800s until the mid-1900s, neurasthenia became a popular diagnosis worldwide. It gradually lost its foothold in the psychiatric community when biological etiologies failed to explain the constellation of neurasthenic manifestations and its symptoms overlapped with newly developed categories (e.g., depressive, anxiety, and somatoform disorders). Despite the APA's decision to exclude neurasthenia in DSM-III (and in subsequent editions), it has remained an indispensable category in the Chinese psychiatric nosology. Instead of concurring with Kleinman's (1986) conclusion that neurasthenia is but "a culturally salient form of chronic somatization that acts as a final common pathway for several distinctive types of pathology, of which major depressive disorder is the principal disease" (p.165), some researchers maintain that neurasthenia should be kept a separate construct, not a subtype of depression (Ming-Yuan, 1989; Yan, 1989; Young, 1989). Young (1989) asserts that "the elimination of the category only indicates change of diagnostic concept without definite direction" (p. 138).

In addition to the narrowly defined depressive criteria that are built into research instruments, unique aspects of the Chinese culture may mask depression altogether, thereby favoring the diagnosis of neurasthenia. Language, absence of body–mind dualism, shame and loss of face, family privacy issues, and a somatopsychic orientation of traditional Chinese medicine are factors that have been repeatedly cited in the literature (Draguns, 1996; Lin, 1985). As a "nosological dilemma," Rin and Huang (1989) have found that the diagnosis of neurasthenia is preferred by patients because it does not carry the stigma that is often associated with mental disorders. Consequently, clinicians favor using neurasthenia to establish rapport with their clients and their family.

Neurasthenia is a culturally sanctioned disease category among the Chinese. Moreover, its status as a "heterogeneous disease" (Yan, 1989) clearly warrants further investigation. Thus, it may be premature to jettison this disorder given the repercussions it may have on future cross-cultural comparisons.

CONCLUSIONS

The effect of culture on the expression and prevalence of mental illness has been relatively ignored in epidemiological research. As discussed earlier, culture is typically addressed only indirectly with the proxies of ethnic and racial categories, immigration, and acculturation. This approach precludes a direct examination of cultural and structural explanations. Using ethnic and racial categories to imply cultural explanations tells us little about how culture shapes the perceptions, expression, and responses to mental illness. In the future, studies must begin to develop and include measures that function to directly assess the multiple facets of culture.

Figure 2.2 depicts a working illustration of the elaborated model that integrates social factors and directly examines the effect of cultural variables on mental health outcome.

For example, using the construct of individualism–collectivism, Triandis (1993) proposed that mental health and psychological well-being are associated with an individual's set of cultural values and beliefs. The construct of individualism–collectivism is defined as

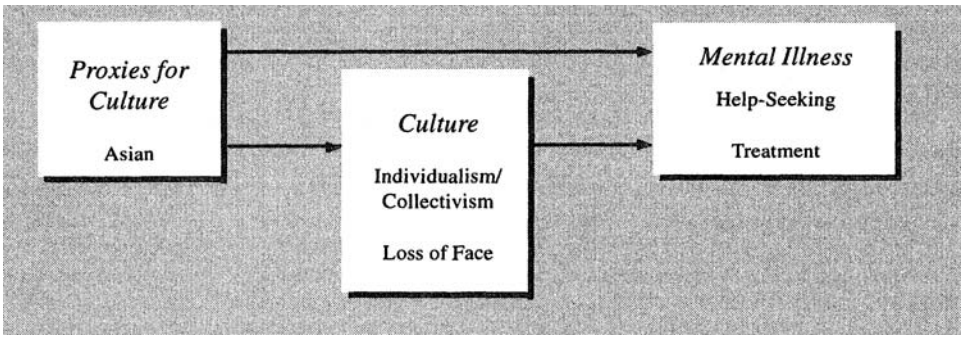

FIGURE 2.2. Cultural Explanation of Responses to Mental Illness among Asians

a cultural syndrome such as shared beliefs, attitudes, norms, roles, and values organized around a theme that is manifested in individual and group behavior. Individualism emphasizes autonomy, with personal goals taking precedence over group goals. Collectivism, in contrast, makes minimal distinction between personal and group goals. Collectivists will not generally perceive individual personal problems as sufficiently important reasons to seek professional help (Tracey, Leong, & Glidden, 1986). They tend to rely on collective forms of coping that make facing life's challenges more manageable (Kashima & Triandis, 1986). Collective coping may help to explain why some ethnic groups seemingly underutilize mental health services and instead, rely on family members to care for mentally ill relatives. The measure of individualism–collectivism goes beyond ethnic and racial categories to an in-depth examination of underlying cultural structures that affect perceptions, expression, and response to mental disorders.

Another example of a culturally specific construct is "loss of face." Defined within the context of an individual's strong identification with a specific collective, "loss of face" pertains to "a threat [to] or loss of one's social integrity" (Zane, 1993, p. 1). Extant literature on Asian culture has consistently alluded to or directly identified loss of face as an important construct in social dynamics. In examining various putative factors that prevent Asian Americans from seeking treatment for substance abuse, loss of face to the family and the ethnic community has been recognized as a significant cultural component (Ja & Aoki, 1993). As illustrated in Figure 2.2, cultural constructs should serve a key function when probing for unique explanations and causations in mental health research in areas such as modes of expression, social reactions, help-seeking behaviors, and the utilization of services.

In addition to a direct examination of the structural and cultural variables discussed earlier, the predictive ability of an elaborated model requires that outcome measures be culturally appropriate and relevant. Epidemiological research has tended to examine Western conceptualizations of mental disorders. Social and cultural explanations of mental disorders may not be consistent with the psychiatric tendency to focus on standardized, discrete classifications of mental disorders. Examining symptoms or clusters of symptoms based on Western conceptualizations of mental disorders or psychological distress may not be valid for use with ethnic and racial minorities (Rogler et al., 1989). The symptoms chosen as indicators of the various mental disorders may not represent the experiences of some groups. For example, exposure to stress can affect groups in different ways. Recent immigrants may respond to distress in ways that are similar to those found in their country

of origin. Statistical equivalence-of-scale measures between groups do not necessarily translate into conceptual equivalence (Vernon & Roberts, 1982). Measurement error may occur, because the symptoms that comprise diagnostic categories may be interpreted differently across different groups. It may prove useful to consider constructs that are common in other cultures (e.g., *susto* for Mexicans and neurasthenia for the Chinese), because variations in rates of mental illness may reflect differences in how an immigrant group perceives, experiences, and expresses psychological distress.

Rates of mental disorders may be affected by the types and number of outcomes used in epidemiological research. By expanding the spectrum of outcomes measured, we could gain a better understanding of the cultural and structural factors that account for variation in rates of mental illness. The recent ECA study left out the majority of DSM-III diagnostic categories, leaving us to speculate on possible alternative expressions of psychological distress. The inclusion of multiple outcomes may avoid biased over- or underreporting of mental disorders. Fabrega, Rubel, and Wallace (1967) reported Mexican American gender differences in the expression of internalized distress. Women tended to express their distress as depression and anxiety, whereas men used alcohol and aggressive behavior. Examining recent ECA data, Aneshensel, Rutter, and Lachenbruch (1991) demonstrated that gender differences in the expression of stress are disorder-specific and that there is no difference between men and women's vulnerability to stress. Stress exposure was related to depression for women and to substance use for men. If only depression had been measured, the findings would have led to an incorrect conclusion that women were more vulnerable to stress than men. The extension of this issue to race, ethnicity, and cultural groups is self-evident.

Rates of mental disorders may also be affected by a group's cultural perceptions, attitudes, and beliefs regarding mental illness through the methods of data collection. For example, loss of face may result in a response bias to Western concepts of psychological distress, resulting in the underreporting of mental disorders. Similarly, overreporting results biases findings when excessively compliant respondents answer questions regarding their mental health status (Rogler et al.,1989).

Since each group constitutes a unique set of social and cultural structures and beliefs, mental illness will be processed differently with concomitant variances in rates of psychopathology, treatments, and outcomes. Ethnocentric cultural assumptions about abnormal behavior and symptoms make it difficult to accurately assess true differences in mental disorders across groups or culturally influenced expressions of psychological distress (Good & Good, 1986). It may be more helpful to examine the level of functioning, such as daily routines that are related to definitions of normal and abnormal behavior, within a particular culture, along with assessing the individual's ability to fulfill culturally specific psychological, social and occupational role expectations (see Waxler 1974). Without fully rejecting a biological basis of mental illness, evaluating the individual's level of functioning incorporates the structural and cultural context of mental illness (Lemert 1951). It also redirects the focus of attention from the individual to society by viewing mental illness as the product of a process of societal interaction and reaction. This perspective represents a person-in-environment model that integrates biomedical, sociostructural, and cultural factors.

Epidemiological studies are especially vulnerable to problems of instrument validity and cultural biases in the reporting and understanding of mental illness among ethnic and racial minority groups. Current epidemiological studies, with a reliance on traditional methodologies, will do little to unravel the sources of variations in rates of mental disorders.

Until these issues are addressed, it is not clear if findings represent a biased or valid report of psychological distress and mental illness. Extant literature strongly suggests the prominent role of culture in the perception, experience, response, treatment, and outcome of mental illness. Along with a biomedical perspective, epidemiological research on mental disorders needs to include a person-in-environment perspective that more accurately represents the reality of ethnic and racial minorities. Because of the nature of their methods, researchers using large-scale epidemiological studies will have difficulties in fully understanding the cultural factors that help to explain the distribution of mental illness. If the intent is to understand reasons for ethnic differences in rates of mental illness or more systematically understand cultural factors, it may be prudent in the future to supplement large scale community surveys with more ethnographic investigations and/or in-depth interviews. By incorporating and integrating different approaches to the study of culture, we will have a more complete grasp of the cultural contexts that so profoundly shape and affect people's lives.

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