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CHAPTER 33

Culture and Psychopathology

Foundations, Issues, and Directions

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Shall we write about the things
not to be spoken of?
Shall we divulge the things
not to be divulged?
Shall we pronounce the things
not to be pronounced?
—JULIAN THE APOSTATE (332–363 C.E.)
Hymn to the Mother of the Gods

After decades of relative neglect and marginalization within psychiatry, the study of the relationship between culture and psychopathology has emerged as topic of considerable interest and influence. In 1994, under pressure from ethnic minority and international psychiatric professionals, the American Psychiatric Association included new sections in the fourth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) under the titles "Glossary of Culture-Bound Syndromes" and "Outline for the Cultural Formulation of Case." Though these sections appeared at the very ends of the book (pp. 843–849), they nevertheless signaled a new era in psychiatry, in which cultural factors would now be given increased attention in our understanding of the etiology, expression, assessment, diagnosis, and

treatment of psychopathology. Of particular note is the warning statement inserted at the beginning of DSM-IV and DSM-IV-TR (American Psychiatric Association, 1994, p. xxiv; 2000, p. xxxiv). This statement, perhaps more than any other in psychiatry, encourages clinicians and researchers to be sensitive to cultural variations or risk serious mistakes: "A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture."

The fact that this increased responsivity to cultural variables occurred in a time when biological and other reductionistic views of psychopathology dominated professional training, clinical applications, and research adds to the significance of what occurred and emphasizes the important influence of "political" forces in our work. The mental health professions would now be asked to consider "cultural" variables in their case construction, their training curricula, and their research efforts. Even with this, a gap remains between the fields of psychiatry and psychology. This chapter provides an overview of the study of culture and psychopathology, with special emphasis on its historical development, basic assumptions, theoretical and empirical findings, and related issues.

FORCES FOR CHANGE

The forces that led to these changes are numerous and deserve to be mentioned, because they reveal how our scientific and professional knowledge and practice are often determined not by "science" but by the particular people, theoretical orientations, and ideologies that hold the power and that come to dominate a field (e.g., biological reductionism). Clearly, although there was considerable evidence of cultural and ethnic bias and abuses in psychiatric practice, cultural considerations were ignored, and pressures for change ultimately required a "political" response in which ethnic minority and international voices called for significant changes in DSM-IV (e.g., Chakraborty, 1991; Mezzich, Kleinman, Fabrega, & Parron, 1996; Rogler, 1996).

The changes were facilitated by a number of events and forces that converged between 1980 and the present:

1. Increasing numbers of ethnic minority and international psychiatrists and social scientists gave increased power to their voices. Sometimes motivated by anger, resentment, and the problem of irrelevance, these voices raised questions about the universal applicability of Western concepts of illness and health.
2. Research was seen as inadequate, because it was often limited to Western samples; when research on ethnic/minority and non-Western patients did occur, it was conducted from a Western viewpoint and knowledge base.
3. Increases occurred in political and social awareness of the pathological consequences of racism, sexism, imperialism, colonialism, and other "isms" that produce powerlessness, marginalization, and underprivileging among sizable population sectors.
4. There emerged a new awareness of the multiple and interactive determinants of psychopathology (e.g., biological, psychological, cultural, sociological, spiritual, environmental).
5. Proliferation of scientific and professional communication networks and outlets promoted interest in the topic across the world through professional societies (e.g., International Association of Cross-Cultural Psychology, World Federation for Mental Health, World Psychiatric Association), journals (e.g., *Transcultural Psychiatry*, *Culture, Medicine and Psychiatry*, *Hispanic Journal of Behavioral Sciences*, *Cultural Diversity and Ethnic Minority Psychology*).
6. Development of cooperative international studies of psychiatric disorders by the World Health Organization (e.g., International Pilot Study of Schizophrenia; Determinants of Outcomes of Severe Mental Disorders) not only revealed cultural variations in disorder but also trained a growing number of non-Western psychiatric professionals capable and willing to critique contemporary psychiatry. Within psychology, the pioneering work of Juris Draguns (1973, 1980, 1990; Draguns & Tanaka-Matusmo, 2003) provided systematic coverage of major issues, conceptual models, and therapeutic considerations.

HISTORICAL CONSIDERATIONS

Concern for the sociocultural determinants of psychopathology can be traced to the 18th and 19th centuries, when philosophers (e.g., Jean Jacques Rousseau, Karl Marx), and physicians (e.g., Freud, Kraepelin) raised questions about the contributions of culture to the etiology, expression, and treatment of mental disorders. Emil Kraeplein (1904), the father of our contemporary diagnostic system, suggested that cultural variables need to be considered in understanding mental disorder, and he suggested that a new specialty area be created—*Vergleichende Psychiatrie*, or comparative psychiatry. Kraepelin wrote:

> The characteristics of a people should find expression in the frequency as well as the shaping of the manifestations of mental illness in general; so that comparative psychiatry shall make it possible to gain valuable insights into the psyche of nations and shall in turn also be able to contribute to the understanding of pathological psychic processes. (1904, p. 434)

In the years that followed, a score of terms emerged as culture and psychopathology were studied in different disciplines: transcultural psychiatry, cross-cultural psychiatry, comparative psychiatry, ethnopsychiatry, cultural psychiatry, psychiatric anthropology, and even the "new" transcultural psychiatry. A detailed review of these terms and of the history of the field from its beginnings to the 1980s can be found in Marsella (1993).

RESISTANCE TO WESTERN VIEWS

Initially, many of the critiques were commentaries designed to raise consciousness about the ethnocentric biases inherent in Western psychiatry. For example, Chakraborty (1991), an Asian Indian psychiatrist, wrote:

> Even where studies were sensitive, and the aim was to show relative differences caused by culture, the ideas and tools were still derived from a circumscribed area of European thought. This difficulty still continues and, despite modifications, mainstream psychiatry remains rooted in Kraepelin's classic 19th century classification, the essence of which is the description of the two major "mental diseases" seen in mental hospitals in his time—schizophrenia and manic depression. Research is constrained by this view of psychiatry. A central pattern of (Western) disorders is identified and taken as the standard by which other (local) patterns are seen as minor variations. Such a construct implies some inadequacy on the part of those patients who fail to reach "standard." Though few people would agree with such statements, there is evidence of biased, value-based, and often racist undercurrents in psychiatry. . . . Psychiatrists in the developing world . . . have accepted a diagnostic framework developed by Western medicine, but which does not seem to take into account the diversity of behavioral patterns they encounter. (p. 1204)

Kirmayer (1998), Editor-in-Chief of the journal *Transcultural Psychiatry*, captured the dilemma facing those supporting the "new" transcultural psychiatry and those holding traditional psychiatric medical perspectives, when he wrote:

> While cultural psychiatry aims to understand problems in context, diagnosis is essentializing: referring to decontextualized entities whose characteristics can be studied independently of the particulars of a person's life and social circumstances. The entities of the DSM implicitly situate human problems within the brain or the psychology of the individual, while many human problems brought to psychiatrists are located in patterns of interaction in families, communities, or wider social spheres. Ultimately, whatever the extent to which we can universalize the categories of the DSM by choosing suitable level of abstraction, diagnosis remains a social practice that must be studied, critiqued, and clarified by cultural analysis. (1998, p. 342)

THE CLINICAL AND RESEARCH LITERATURE

However, critical commentaries soon yielded to a widespread, implicit understanding that cultural factors are critical in shaping the onset, expression, course, and outcome of psychopathology. It was simply a case of a gathering mass of evidence combined with a new consciousness of the power of culture in shaping both normal and abnormal behavior. No single event nor publication turned the tide in favor of increased attention to cultural variables. However, certain publications are considered by many to have had a profound influence on the field. For example, within psychology, the

publication of the *Handbook of Cross-Cultural Psychology: Vol. VI. Psychopathology* (Triandis & Draguns, 1981) did much to articulate the relationship between culture and various forms of psychopathology, such as depression, schizophrenia, and disorders of everyday life. In anthropology, a series of publications from the University of Hawaii/National Institute of Mental Health (NIMH) Culture and Mental Health Program (e.g., Caudill & Lin, 1969; Lebra, 1972) served to raise clinical and scientific consciousness about cultural variations in psychopathology. In psychiatry the pioneering work by Alexander Leighton and his colleagues (1959; Leighton et al., 1963) laid the sociocultural foundations of psychopathology. By the 1970s and 1980s, publications by Kleinman (1980) and Marsella and White (1982; Marsella & Higginbotham, 1984) offered theoretical foundations for understanding the role of sociocultural factors in psychopathology. In 1992, the American Psychological Association (1992) published guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations in which the need for familiarity with the patient's background was advocated.

Of particular importance in strengthening interest in culture and psychopathology was the seminal volume *Culture and Depression* (Kleinman & Good, 1985), which applied the ideas of the new "transcultural psychiatry" to the topic of depression. This volume emphasized the importance of "context," asserting that depressive experience and disorder could be understood apart from the cultural context in which it was embedded. Indeed, it was noted that depressive experience and disorder might not have the same meaning or implications across cultural boundaries, or the same expressions or etiologies. The widespread impact of this volume was provided by a collection of substantive chapters written by experienced clinicians and academics.

Within the last decade, [illegible] a number of books have offered overviews of the culture and psychopathology field (e.g., Castillo, 1996; Cuellar & Paniagua, 2000; Mezzich & Fabrega, 2001), and topics such diagnosis/classification (e.g., Mezzich et al., 1996; Paniagua, 2001) and specific disorders such as posttraumatic stress disorder (PTSD; Marsella, Friedman, Gerrity, & Scurfield, 1996). It is notable that a topical specialization in ethnocultural variations in responsivity to medications has also emerged, under the rubric of "ethnopsychopharmacology," in the work of Keh Ming Lin (e.g., Lin, Smith, & Ortiz, 2001). A number of books have also appeared that address cultural variations in psychopathology among specific ethnic and racial populations including minorities (e.g., Bernal, Trimble, Burlew, & Leong, 2003; Littlewood & Lipsedge, 1997), Native Americans (O'Nell, 1998), Chinese (e.g., Lin, Tseng, & Yeh, 1999; Phoon & Macindoe, 2003), and Hispanics/Latinos (e.g., Becerra, Karno, & Escobar, 1982; Carrillo & Lopez, 2001; Telles & Karno, 1994).

Yet another important event in shaping the study of culture and psychopathology came via the U.S. Department of Health and Human Services (DHHS; 2001) in its published report *Mental Health: Culture, Race, and Ethnicity*. In this report, the DHHS reached specific conclusions about the role of culture and forcefully stated, "Culture counts!" The report detailed disparities in the provision of psychiatric services to racial/ethnic minorities in the United States and called for renewed efforts to address these problems:

> The main message of this supplement is that "culture counts." The cultures that patients come from shape their mental health and affect the types of mental health services they use. Likewise, the cultures of clinician and the service system affect diagnosis, treatment, and the organization and financing of services. Cultural and social influences are not the only influences on mental health and service delivery, but they have been historically underestimated—*and they do count.* Cultural differences must be accounted for to ensure that minorities, like all Americans, receive mental health care tailored to their needs. (p. 14)

In brief, after years of limited attention, the study of culture and psychopathology has now assumed a prominent position within the professional and scientific efforts of psychiatry and the social sciences. The result is that our understanding of psychopathology will never be the same!

THE CONCEPT OF CULTURE AND ITS IMPORTANCE FOR PSYCHOPATHOLOGY

Defining Culture

If we are to understand the relationship of culture to psychopathology, it is critical that we

first understand the concept of culture. Definitions of culture are numerous and varied. More than a half-century ago, Kluckhohn and Kroeber (1952) had already summarized more than 125 definitions. For our purposes, we use the following definition:

> Culture is shared, learned behavior and meanings that are socially transferred in various life-activity settings. Cultures can be (1) *transitory* (i.e., situational, for even a few minutes) or (2) *enduring* (e.g., ethnocultural lifestyles), and in all instances are (3) *dynamic* (i.e., constantly subject to change and modification). Cultures are represented (4) *internally* (i.e., values, beliefs, attitudes, images, symbols, orientations, epistemologies, consciousness levels, perceptions, expectations, personhood) and (5) *externally* (i.e., artifacts, roles, institutions, social structures). Cultures (6) *shape and construct our realities* (i.e., they contribute to our worldviews, perceptions, orientations) and, with this, frame many critical concepts (e.g., normality–abnormality, morality, aesthetics).

The virtue of this definition is that it captures the dynamic complexity of cultural experience and the fact that culture, while represented externally in artifacts, roles, and institutions, also is represented internally in the human psyche, in many forms that ultimately shape both normal and abnormal behavior (e.g., values, beliefs, epistemologies). The influence of cultural factors on psychopathology is now well accepted. That this should be the case is not surprising. The rates, etiology, diagnosis, and expression or manifestation of psychopathology are all culturally constructed and contextualized. Variations in stresses, coping resources, definitions of health and illness, and a score of cultural variables, such as language, dietary preferences, morality codes, and definitions of personhood, all converge to shape psychopathology.

Our views of reality are culturally constructed (Marsella, 1999)! Our worldviews—our cultural templates for negotiating reality—emerge from our inborn human effort after meaning, an effort that reflexively provokes us to describe, understand, predict, and control the world about us through the ordering of stimuli into complex belief and meaning systems that can guide behavior. The brain not only responds to stimuli, it also organizes, connects, and symbolizes them, and, in this process, generates patterns of explicit and implicit meanings and purposes that promote survival, growth, and development. This process occurs through socialization and often leads us to accept the idea that our "constructed" realities are in fact realities. The "relativity" of the process and product is ignored in favor of the "certainty" provided by the assumption that our way of life is correct, righteous, and indisputable (e.g., ethnocentricity).

Sometimes, an entire cultural milieu may be pathogenic. For example, Edgerton (1992) coined the term "sick societies" to describe cultures in which ways of life have become destructive their members. Consider the possibility that certain cultures may become pathogenic by virtue of their collapse and disintegration, with dire consequences for members (e.g., an inner-city slum area in which drugs, violence, disorders abound; a national culture that advocates war, violence, hate, and destruction as a means of defining its identity).

Ethnocentricity

Our "realities" are culturally constructed (Marsella, 1999), and because of this, it is easy for us to be ethnocentric in our assumptions and practices regarding psychopathology. "Ethnocentricity" refers to a tendency or inclination to perceive reality from the vantage point of our own cultural experience. Thus, we "center" or anchor our perceptions within a "biased" viewpoint, much as the term "egocentric" describes the tendency to see things only from our limited, individual perspective. The simple fact is that we are often unaware of and/or insensitive to alternative culturally constructed realities can lead to misguided intentions and behaviors. When ethnocentricity is combined with the power to control knowledge and opinion, the results are dangerous, because we are blinded to the possibilities of differences in our construction and experience of reality.

We must recognize that current knowledge about psychopathology as reflected in the widespread use of DSM-IV-TR (American Psychiatric Association, 2000) is based on assumptions about the nature of health and disease that are embedded within Western culture. The "power" assigned to Western psychiatry because of Western economic, political, and military dominance does not mean that Western psychiatry is "accurate"; rather, it is merely dominant. The position of dominance can lead to many problems, because people from differ-

ent ethnocultural groups are assessed, diagnosed, and treated according to the dominant viewpoint. Furthermore, even the research conducted is often framed with the dominant culture's assumptions and preferences for research design, data analysis, and data interpretation.

Ethnic Identity

As patients enter the Western psychiatric system as either ethnic/racial minorities or as patients within their own culture, but one dominated by a Western psychiatric system (e.g., Mexican patients in Mexico treated according to North American psychiatric approaches), the issue of ethnic identity becomes an essential consideration. The patient may belong to a particular ethnic/racial minority culture or be a resident in a mainstream culture but not be "identified" with that culture (e.g., Horvath, 1997; Yamada, 1998). Merely because the patient has a foreign last name and appearance (e.g., Japanese) does not mean he or she is not highly "Westernized" via acculturation processes (e.g., Chun, Organista, & Marin, 2002). The extent to which people are identified with a particular ethnic group, and engage in the attitudes, beliefs, and behaviors of that ethnic group, refers to their "ethnic identity" (Marsella & Kameoka, 1989). There are numerous ways to assess "ethnic identity" (see Dana, 1998; Ponterotto, Gretchen, & Chauhan, 2001; Yamada, Marsella, & Atuel, 2002). Some professionals have approached this topic from the viewpoint of "acculturation," or the extent to which a person may be embedded in a cultural context (e.g., Chun et al., 2002). It is noteworthy that DSM-IV-TR calls for an assessment of this variable in making a diagnosis as the first step in a cultural interview (American Psychiatric Association, 2000, p. 897).

CULTURAL INFLUENCES ON PSYCHOPATHOLOGY

The study of culture and psychopathology raises a number of basic questions that literally define the field:

- What is the role of cultural variables in the etiology of psychopathology?
- Are all mental disorders culture bound?
- What are the cultural variations in the rates and distribution of psychopathology? What are some of the methodological considerations in conducting epidemiological research across cultures?
- What are the cultural variations in the classification and diagnosis of psychopathology (e.g., Mezzich et al., 1996; Paniagua, 2001)?
- What are the cultural variations in the phenomenological experience, manifestation, course and outcome of psychopathology?
- What are the cultural variations in standards of normality and abnormality?
- What psychometric factors must be considered in the assessment of psychopathology across cultures (e.g., Marsella, 2000b; Marsella & Leong, 1995)?

Space does not permit a detailed discussion of all these questions, but the first three questions are of sufficient importance to warrant discussion in this chapter.

Culture and the Etiology of Mental Disorders

Biological and Cultural Interaction

The role of cultural factors in the etiology of mental disorders is complex and varies as a function of the particular disorder and its plasticity. To the extent that a mental disorder may have a strong biological penetrance (e.g., certain forms of depressive disorders), the disorder will evidence great homogeneity across cultures because of biological similarity, and the influence may be minimal. However, to the extent that a mental disorder is influenced and shaped by learning and other contextual factors, thus having much more behavioral plasticity, acquired cultural factors may play a critical role. Expressions of a disorder may be more "homogenous" as a function of biological penetrance; yet even when the biological penetrance is extensive (e.g., Alzheimer's disease), it is still possible to see cultural variation. Figure 33.1 displays this thinking. Clearly, normal behavior is subject to the greatest cultural influence. But, even when there are severe neurological intrusions, culture still impacts the meaning, experience, and expression of disorder (Fabrega, 1995).

Cultural Factors in the Etiology of Mental Disorders

Cultural factors have been demonstrated to influence and shape mental disorders through a number of factors (Leighton & Murphy, 1961; Marsella, 1982, 1987, 2000a):

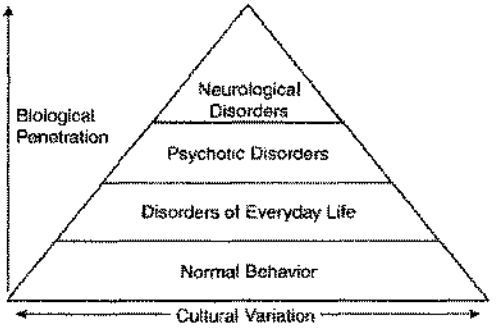

FIGURE 33.1. Cultural variations in mental disorders as a function of biological penetration and behavioral plasticity.

- Culture determines the types and parameters of physical and psychosocial stressors.
- Culture determines the types and parameters of coping mechanisms and resources used to mediate stressors.
- Culture determines basic personality patterns, including, but not limited to, self-structure, self-concept, and needs/motivational systems.
- Culture determines the language system of an individual, and it is language that assists us in the perception, classification, and organization of responses to reality.
- Culture determines the standards of normality, deviance, and health of an individual and society. It influences health ideology and attitudes, as well as treatment orientations and practices.
- Culture determines classification patterns for various disorders and diseases. In this respect, all mental disorders are culture-specific, and not simply those designated by Western professionals as exotic disorders.
- Culture determines the patterns of experience and expression of psychopathology, including factors such as onset, manifestation, course, and outcome.

Models of Cultural Etiology in Psychopathology

Among the conceptual approaches that have been advanced to explain cultural factors in the etiology of mental disorders, cultural disintegration and collapse has been advanced as a major hypothesis. This view was advocated quite early by Alexander Leighton (1959) in his classic work, *My Name is Legion*. Subsequent writings have elaborated on his contributions and suggested that general systems theory can be used to link stressors at the socioenvironmental level with the etiology of mental disorders at the individual level. Figure 33.2 displays these relationships (e.g., Marsella, Austin, & Grant, 2005).

Potential pathways between specific variables such as cultural collapse and disintegration, in which a culture's lack of coherence and integration eventually influences the mental health and well-being of members via intervening levels, are displayed in Figure 33.2. This is an important conceptual framework, because throughout the world today, as traditional cultures are faced with Westernization and other forms of rapid social change, members are left without a strong sense of ethnic identity and

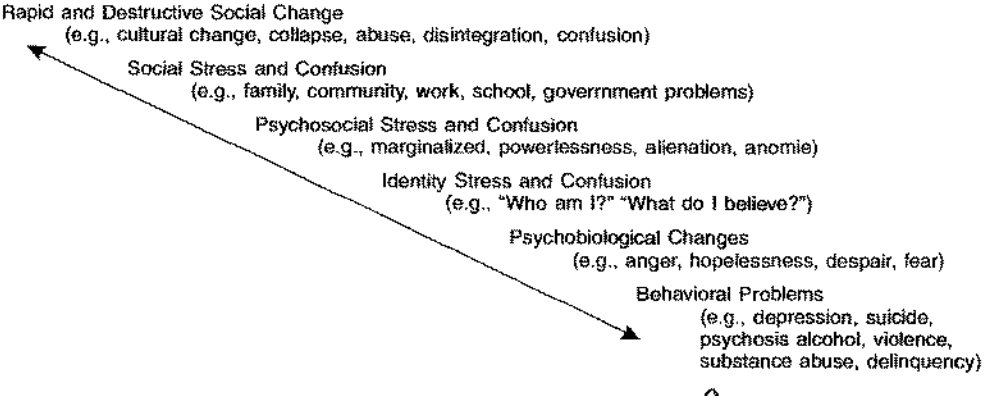

FIGURE 33.2. Sociocultural pathways to distress, deviancy, and disorder.

continuity with their past, which results in conflict, confusion, and despair (e.g., Marsella et al., 2005).

Specific Sociocultural Variables Associated with Psychopathology

Numerous sociocultural variables have been posited as sources of psychopathology, including acculturation, urbanization, migration, and poverty. These variables have been primarily concerned with the etiology of psychopathology rather than its manifestations and/or courses and outcomes. All of these variables exercise their effects via stressors and stress variables. But each is unique in the specific stressors it embodies, and in the variations in the stress response that occurs. For example, acculturation and poverty stressors are both capable of eliciting stress states that can attain pathogenic levels. But each is unique in their stressor and stress-state parameters because of individual and cultural differences in coping resources. Nevertheless, they remain critical determinants of psychopathology that are rooted within cultural contexts (Marsella & Scheuer, 1993).

Acculturation

Acculturation refers to both the content and the process by which an individual from one ethnocultural group begins to assimilate and accommodate to the cultural traditions and ways of life of another—often contrasting—group. Acculturation can be a major source of stress, and as such is frequently considered a cause of maladaptation and maladjustment (Berry, 1997; Chun et al., 2002; Schmitz, 2003; Ward, 1997). The topic itself has been the subject of considerable debate and argument, especially with regard to its nature and measurement (Rudmin, 2003). Of special interest has been the yet unresolved issue of whether acculturation stress is associated with the onset of psychopathology, or whether it has little or no impact on the latter. For our purposes, we point out that the evidence is equivocal: Both sides have offered data to support their point of view.

Three things are needed at this point: (1) valid and reliable instruments for its assessment, (2) valid and reliable instruments for the assessment of psychopathology in the target groups, and (3) a clear description and understanding of the acculturative stresses involved, and a conceptual linkage to a broad spectrum of psychopathology and to adaptive patterns. In other words, for some people, the interaction between acculturation stresses and traditional ways of life are clearly disruptive and can lead to psychopathology. However, others manage acculturation in such a way that they may have multiple cultural identities, completely assimilate into the new lifestyle, or even reject both.

Thus, the question becomes which individuals are most subject to psychopathology—those who maintain a traditional identity, those who embrace multiple identities, those who assimilate, or those for whom none of these apply? Furthermore, because of measurement problems, we must consider the possibility of the discrepancy among behaviors, attitudes, and a psychological sense of who one is or chooses to be. Conclusions are still being debated.

Urbanization and Psychopathology

Urbanization and urban life have long been proposed to be sources of psychopathology because of the multiple stressors imposed on urban residents (e.g., Marsella, 1998; Caracci & Mezzich, 2001) including stressors from overstimulation involved in crowding, noise–air–visual pollution, crime and violence, homelessness, poverty, and transportation. Clearly, rural life has its own share of stressors and rural dwellers should not be thought of as being immune to psychopathology. Because most of the world will soon be living in urban settings, the risks associated with urban life must be considered. Urban life is demanding, and the difficulties may exceed the abilities of individuals and groups to cope with the pressures.

Marsella (1998), in his review of the urbanization studies in the mental health literature, claimed that urban life stressors are numerous and varied (i.e., environmental, economic, sociological, psychosocial, and psychological) and as such are connected to a broad spectrum of psychopathological responses that often do not fit the standard psychiatric nomenclature (including misery, demoralization, apathy, indifference, alienation, trauma, distress and distrust, suspicion, dissatisfaction) but are nevertheless states of serious discomfort and maladjustment. Many social deviancies (i.e., substance abuse, alcoholism, divorce, crime, gambling) also emerge within the urban life

context. That these may also occur in nonurban settings does not exclude them from the pressures of urban life. Yet, even as we point this out, it is clear that urban life has many positive outcomes, including opportunities for new lifestyles, education, access to health care, and so forth. As was the case for acculturation, this topic is ripe for additional study.

Migration/Immigration

Migration/immigration has long been considered a major influence upon the onset of psychopathology (e.g., Marsella & Ring, 2003; Schmitz, 2003). Researchers have speculated about the possibility that migrants may actually be selected for particular forms of disorder or social deviancy, and this is reflected in the actual choice to migrate. Yet others have argued that the very best and strongest stock often migrates, and that the stress of the migration process and of acculturation is the source of psychopathology. The answer remains in debate. Certainly, if the pressures of migration and acculturation exceed the resources available for coping, then maladaptation and maladjustment may occur.

Culture shock, a syndrome of symptoms that includes paranoia, anxiety, somatic complaints, and a valorization of the home culture, is often found in sojourners and migrants during the early months of contact. Denial of opportunity and denigration of the migrant's self-esteem and sense of worth are also sources of discontent and distress. In our contemporary world, in which migration is now emerging as a major force for cultural contact, problems of acceptance are numerous. Ethnic and racial ghettos often develop as migrants are compelled to work for low wages and to live on the margins of acceptability and respect. This topic is in need of more research, because migration from East to West and from South to North brings millions of people from non-Western cultures to the Western world. Migrants seek hope and opportunity, but often find rejection and despair that lead to a breeding ground for anger, paranoia, and depression.

Poverty

Since the classic work on social class and mental illness by Hollingshead and Redlich (1958), it has long been accepted that lower social class individuals are at increased risk of mental illness. A recent meta-analysis of the literature (Lorant et al., 2003) supports the original conclusions. Low levels of education rather than low income per se has often been considered a key factor in these class differences. However, in a recent report on poverty and common mental disorders in developing countries, Patel and Kleinman (2003) concluded that factors such as the experience of insecurity and hopelessness, rapid social change, and risks of violence and poor physical health may better explain the vulnerability of the poor to common mental disorders. *Poverty and Psychology*, a recent volume edited by Carr and Sloan (2004), provides a detailed examination and analysis of the poverty experience, replete with its assaults on psychological and social well-being. In it, Moreira (2004) offers a specific review of the impact of poverty on mental health, including a discussion of the consequences of hegemonic globalization, marginalization, deprivation of power, trauma, low self-esteem, and nihilism. It seems clear that poverty imposes stresses of enormous proportion and frequency that exact a harsh toll on physical, mental, and spiritual health and well-being.

Culture-Specific (Culture-Bound) Disorders

The decision to list a series of "culture-bound" disorders in DSM-IV (American Psychiatric Association, 1994) called attention to a critical issue facing psychiatry and the study of psychopathology: Numerous previous publications had raised serious questions about these disorders and their implications for psychiatry (e.g., Simons & Hughes, 1985). DSM-IV (American Psychiatric Association, 1994) states the following about culture-bound disorders:

> Culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations. There is seldom a one-to-one equivalence of any culture-bound syndrome with a DSM diagnostic entity. (844)

But are mental disorders universal or are they a function of the cultural context in which they occur? For some, this controversy has been attenuated by the answer that both are possible. Nevertheless, the recognition that cultural factors may shape the rates and expres-

sions of mental disorders represented a critical conceptual issue. Identifying a group of disorders with "non-Western" and "exotic" (some of these culture-bound disorders used to be called the "exotic" disorders, a testimony to our ethnocentric biases) names raised the issue of whether any disorder can escape cultural influence. And if this is the case, then is it not logical to assume that all disorders, including schizophrenia, depression, anxiety disorders, and so forth, are "culture bound." The question must be asked: Is DSM-IV-TR, with its hundreds of disorders, a culturally biased work and as such, might it actually have destructive consequences when misapplied to cultures in which it is not applicable? Table 33.1 lists some "culture-bound" disorders.

Marsella (2000b, p. 407), listed a series of questions regarding culture-bound disorders:

1. Should culture-bound disorders be considered neurotic, psychotic, or personality disorders?
2. Should these disorders be considered variants of disorders considered to be "universal" by Western scientists and professionals (e.g., *susto* [soul loss] as merely a variant of depression)?
3. Are these disorders variations of common "hysteria," "anxiety," "depression," or "psychotic" processes that arise in response to severe tension, stress, and/or fear, and present with specific culture content and expression?
4. Are there taxonomically different kinds of culture-bound syndromes (i.e., anxiety syndromes, depression syndromes, violence/anger syndromes, startle syndromes, dissociation syndromes)?

TABLE 33.1. Examples of Culture-Bound Disorders

Name	Definition and Cultural and Geographical Location
Amok	Sudden outburst of explosive and assaultive violence preceded by period of social withdrawal and apathy (Southeast Asia, Philippines).
Ataque de nervios	Uncontrollable shouting and/or crying. Verbal and physical aggression. Heat in chest rising to head. Feeling of losing control. Occasional amnesia for experience (Caribbean Latinos and South American Latinos).
Hwa-Byung	Acute panic, fear of death, fatigue, anorexia, dyspnea, palpitations, lump in upper stomach (Korea).
Latah	Startle reaction followed by echolalia and echopraxia, and sometimes coprolalia and altered consciousness (Malaysia and Indonesia).
Koro (shook yong)	Intense fear following perception that one's genitalia (men/women) or breasts (women) are withdrawing into one's body. Shame may also be present if perception is associated in time with immoral sexual activity (Chinese populations in Hong Kong and Southeast Asia).
Phii pob	Believes one is possessed by a spirit. Numbness of limbs, shouting, weeping, confused speech, shyness (Thailand).
Pissu	Burning sensations in stomach, coldness in body, hallucinations, dissociation (Ceylon).
Suchi-bai	Excessive concerns for cleanliness (changes street clothes, washes money, hops while walking to avoid dirt, washes furniture, remains immersed in holy river (Bengal, India—especially Hindu widows).
Susto (espanto)	Strong sense of fear that one has lost his or her soul. Accompanied by anorexia, weight loss, skin pallor, fatigue, lethargy, extensive thirst, untidiness, tachycardia, and withdrawal (Latinos in South and Central America, Mexico, and Latino migrants to North America).
Taijin kyofusho	Intense fear of interpersonal relations. Belief that parts of body give off offensive odors or displease others (Japan).
Tawatl ye sni	Total discouragement. Preoccupation with death, ghosts, spirits. Excessive drinking, suicide thoughts and attempts (Sioux Indians).
Uquamairineq	Hypnotic states, disturbed sleep, sleep paralysis, dissociative episodes and occasional hallucinations (Native Alaskans: Inuit, Yuit).

Note. From Marsella (2000b, p. 408). Copyright 2000 by the American Psychological Association. Reprinted by permission.

5. Do some culture-bound disorders have biological origins (e.g., *pibloktoq*—screaming and running naked in the Artic snow—has been considered to result from calcium and potassium deficiencies because of dietary restrictions; *amok* has been considered to result from febrile disorders and neurological damage)?
6. Are all disorders "culture-bound" disorders given that no disorder can escape cultural encoding, shaping, and presentation (e.g., schizophrenia, depression, anxiety disorders)?

The last question continues to arouse controversy. If the answer is "yes," then the implications for Western psychiatry are truly profound, for it indicates an inherent bias in its assumptions and practices from diagnosis to treatment. In so many ways, the culture-bound disorders issue confronts Western psychiatry with its most significant challenge.

Diagnosis and Classification

The American Psychiatric Association's (2000) DSM-IV-TR provides clear-cut guidelines for diagnosing and classifying mental disorders when cultural boundaries are a concern. DSM-IV (American Psychiatric Association, 1994, pp. 843–844) guidelines suggest five major areas be addressed:

1. *Cultural identity of the individual* (e.g., ethnocultural identity, language abilities and preferences).
2. *Cultural explanations of the individual's illness* (e.g., idioms of distress, meaning and perceived severity, any local illness categories used, perceived causes or explanatory models, current preferences for care).
3. *Cultural factors related to psychosocial environment and levels of functioning* (e.g., interpretations of social stressors, available social supports, levels of functioning and disability).
4. *Cultural elements of the relationship between the individual and the clinician* (e.g., note differences in culture and status of patient and clinician, and possible problems these differences may present, including problems regarding perceived normality, symptom expression, communication).
5. *Overall cultural assessment for diagnosis and care* (e.g., how the cultural formulation impacts diagnosis and care).

These guidelines articulate and anticipate many of the problems that one must face when seeking to diagnose and classify an individual within a cross-cultural context. The risks of error are obvious. Without understanding a person's cultural identity and experience, errors in diagnosis may lead to destructive treatments. It is necessary to have a firm understanding of the standards of normality and abnormality for that person and his or her culture and, especially, particular models of health and illness (see Alarcon, Bell, et al., 2002; Canino, Canino, & Arroyo, 1997; Mezzich et al., 1996; Mezzich & Fabrega, 2001; Paniagua, 2001; Rogler, 1997).

It is also important to note that virtually every ethnocultural group has its own diagnostic and classification system for psychopathology and social deviancies. These systems often address disorders that appear to be "similar" to Western disorders, such as PTSD (e.g., Fox, 2003). Yet we are once again faced with the challenge of "decontextualizing" a disorder when we assume that it is similar. In Hispanic culture, is *ataques de nervious* simply an anxiety disorder, or is *susto* simply a depressive disorder? In Japanese culture, is *shinkeishitsusho* simply a variant of neurasthenia, a popular 19th-century Western diagnostic category (Ohnuki-Tierney, 1984)? For example, consider the case of Samoans, who speak of four major categories of mental illness (see Clement, 1982):

1. *Ma'i o le mafaufau* (physical brain abnormalities)
2. *Ma'i aitu* (spirit possession)
3. *Ma'i valea* (strange, severe, and stupid, improper behavior)
4. Excess emotion:
   - *Ma'i ita*—anger, rage
   - *Ma'i manatu*—sadness, grief
   - *Ma'i popole*—worry

Do the apparent similarities or approximations indicate that the disorder has the same etiology, onset, expression, course, and outcome as disorders in the Western world? The answer in our opinion is "no!" The overt appearance of a disorder does not mean that the causes, experience, or pattern are the same. How can we separate a disorder from the very psyche in which

it is construed and the very social context in which people respond to it?

The separation of mind and body introduces a dramatic difference in the conceptualization of psychopathology, especially with regard to its etiology and expressions. For example, in her excellent discussion of Japanese concepts and categories of mental illness, Ohnuki-Tierney (1984) wrote:

> When the Japanese postulate that *ki* (mind, spirit) is responsible for illness, they really do not mean psychogenesis. When they say *yamai wa ki kara* (illness from one's mind), they refer to physical illnesses resulting from worries and other psychological propensities that have a negative effect on the body. When they use the lable *ki no yamai*, they refer to a mild negative psychological state, such as a mild case of hypochondria. In both expressions, *ki* (mind, spirit) refers to a psychological state in the simple sense of the word. It does not refer to either "psychological problems" or "psychodynamics" as these terms are used in the United States. (p. 75)

Epidemiology of Mental Disorders

One of the most obvious questions [illegible] about mental illness is whether there are cultural and international variations in the rates and distribution of mental illness. But because of the complexities involved in obtaining data to inform this question, any answers must be very tentative and subject to careful scrutiny. Even case identification, which seems like such a straightforward activity, can be filled with problems depending upon the source of the data, the measurement criteria, and the biases of the researcher. As we have pointed out, numerous issues are involved in the assessment and diagnosis of mental illness across cultures. These issues make valid data collection a difficult task. Marsella (1979) and Marsella, Sartorious, Jablensky, and Fenton (1985) listed criteria that must be met before data can be compared. They stated that the comparative epidemiological studies must do the following:

1. Use relevant ethnographic and anthropological data in designing an epidemiological study, especially in determining what constitutes a symptom or category or a case.
2. Develop glossaries of terms and definitions for symptoms and categories.
3. Derive symptom patterns and clusters using multivariate techniques rather than relying on simple a priori clinical categories.
4. Use similar/comparable case identification and validation methods.
5. Use culturally appropriate measurement methods that include a broad range of indigenous symptoms and signs that can be reliably assessed.
6. Establish frequency, severity, and duration baselines for indigenous and medical symptoms for normal and pathological populations.

These steps do not guarantee accuracy, but they do call attention to the complexities involved in conducting comparative epidemiological studies of mental illness. Failure to consider them can lead to destructive consequences for cultures under study, because they may either overestimate or underestimate actual rates leading to faulty policy decisions and misleading stereotypes.

The World Health Organization (2004) initiated a survey of the prevalence, severity, and treatment of DSM-IV mental disorders in six less developed countries and eight developed countries using door-to-door surveys of 60,463 community adults in the Americas, Europe, the Middle East, Africa, and Asia. Psychiatric assessments were conducted using the WHO world Mental Health Composite International Diagnostic Interview (WMH-CIDI), a fully structured, lay-administered psychiatric diagnostic interview. Results revealed that the prevalence of having a disorder during the previous year varied widely, from low rates of 4.3% in Shanghai, China, and 4.6% in Nigeria, to the highest rate of a 26.4% in the United States. Higher rates of anxiety were found in the United States, France, and Lebanon, and lower rates of anxiety were found Shanghai, Beijing, and Nigeria. The study also reported that 35.5–50.3% of serious cases in developed countries and 76.3–85.4% in less developed countries received no treatment in the 12 months prior to the interviews.

The profound variations in rates of disorder across developed and less developed countries raise interesting questions about the reasons for the results. Although it is possible that these rates accurately reflect differences because of a number of reasons related to stress levels, coping resources, and even genetic variations, the risk of bias in content and process of the actual interviews cannot and should not be ignored. For example, the content of the interview is clearly Western (e.g., anxiety, mood) and does

not include indigenous examples of disorders. It is possible that different results might emerge if disorders were keyed to specific locations and the study examined rates of Western disorders and indigenous disorders in the less developed countries. Comparison data must meet stringent criteria for case recognition and inclusion, or one group may be seen as pathological and another as salutogenic, when the opposite may be true. The criteria listed previously for valid epidemiological studies must be considered.

Weiss (2001) proposes a culturally sensitive model of illness representations for epidemiological studies and Weiss, Cohen, and Eisenberg (2001) offer an integrative framework for cross-cultural epidemiological studies that captures both the complexity and critical consequences of epidemiological studies. In a similar vein, Alarcon et al. (2002) wrote:

> A crucial feature of the cultural epidemiologic context in relation to diagnosis is who decides on the values and priorities that transform findings into authoritative evidence. The cultural representation of mental illness requires a categorical identification but also a narrative account and a full assessment of the social context in which illness occurs. (p. 234)

CULTURE AND VARIOUS FORMS OF SERIOUS PSYCHOPATHOLOGY

Schizophrenia across Cultures

Among all the forms of mental disorder, schizophrenia has been considered to be the least influenced by cultural factors. Yet this assumption is highly questionable given the fact that there are considerable variations in the rates of schizophrenic disorders and considerable differences in its experience, course, and outcome (e.g., Jablensky et al., 1992; Marsella, Suarez, et al., 2002; Jenkins, 1998; Barrio et al., 2003; Jenkins & Barrett, 2004). The assumption is that because schizophrenia is considered to have a neurological (chemical and/or structural) basis, cultural variations should be minimal. But research indicates that that the very conceptualization of schizophrenia in the West may be a major source of impediment to understanding and curing it. Indeed, despite the fact that schizophrenia research in the West has advanced different sites of pathology, different etiologies, different expressions, and different treatment responsivities, we continue to use the term, thus inviting confusion for both the public and professionals.

Research has shown that the expression of psychotic symptoms can be embedded in the patient's sociocultural context reflecting strongly held values and beliefs (Suhail & Cochrane, 2002). For instance, in the U.S. triethnic study of psychotic symptoms assessed with a structured interview, African Americans were more likely to report higher hallucinatory behavior and suspicion scores than were European Americans, whereas European Americans exhibited more severity than African Americans in the excitement symptom score, and Latinos reported higher rates of somatic concern than both European Americans and African Americans (Barrio et al., 2003). In another triethnic study, which included a community outpatient sample, that European Americans had a more symptomatic profile than did African Americans and Latinos when assessed with standardized assessment tools (Bae, Brekke, Bola, 2004; Brekke & Barrio, 1997). One potential explanation is that content experienced as culturally syntonic may be less likely to be reported as a distressing psychiatric complaint by certain ethnic/minority patients (Guarnaccia et al., 1993).

Distinguishing between culturally appropriate and pathological content of symptoms to ensure that best practices are followed is facilitated by careful consideration of the manifestation and expression of distress (American Psychiatric Association, 1994; Gaines, 1995). Table 33.2 lists some of the sociocultural determinants of "schizophrenia" that have been advanced in the research literature, and Table 33.3 summarizes some of the many reasons why the course and outcome of schizophrenia varies across cultures (for reviews of the empirical literature, see also Jablensky et al., 1992; Marsella, Suarez, et al., 2002).

Kelly (2005) has called attention to the growing interest in the role of social, cultural, economic, and political factors in influencing clinical and outcome aspects of schizophrenic disorders:

> Despite clear evidence of a substantial biological basis to schizophrenia, there is also evidence that social, economic and political factors have considerable relevance to the clinical features, treatment and outcome of the illness. Individuals from lower socio-economic groups have an earlier age at first presentation and longer durations of untreated illness, both of which are associated with poor out-

TABLE 33.2. Some Sociocultural Determinants of Schizophrenia

1. Cultural concepts of personhood and the related implications of this for individuated versus unindividuated definitions of selfhood and reality.
2. Cultural concepts regarding the nature and causes of abnormality, discomfort, disorder, deviance, and disease, and those regarding the nature and cause of normality, health, and well-being.
3. Cultural concepts and practices regarding health, and medical care and prevention; attitudes toward illness and disease.
4. Cultural concepts and practices regarding breeding patterns and lineages.
5. Cultural concepts regarding prenatal care, birth practices, and postnatal care, especially in areas such as nutrition and disease exposure.
6. Cultural concepts and practices regarding socialization, especially family, community, and religious institutions, structures, and processes.
7. Cultural concepts and practices regarding medical and health care, especially with regard to the number and types of healers, doctors, sick-role statuses, etc.
8. Cultural stressors such as rates of sociotechnical change, sociocultural disintegration, family disintegration, migration, economic development, industrialization, and urbanization.
9. Culturally related patterns of deviance and dysfunction including trauma (PTSD), substance abuse, violence and crime, social isolation, alienation/anomie, and the creation of pathological and deviant subcultures.
10. Cultural stressors related to the clarity, conflicts, deprivations, denigrations, and discrepancies associated with particular needs, roles, values, statuses, and identities.
11. Cultural stressors related to sociopolitical factors such as racism, sexism, and ageism and the accompanying marginalization, segmentalization, and underprivileging.
12. Cultural resources and coping patterns, including institutional supports, social networks, social supports, and religious beliefs and practices.
13. Cultural exposure to various risk conditions, such as communicable diseases (e.g., viruses), toxins, dietary practices, population density, poverty, and homelessness.

TABLE 33.3. Potential Reasons for More Negative Course and Outcome of Schizophrenia (Psychotic Disorders) in Developed Countries

1. Schizophrenia is considered to be a biological disease that is relatively immutable to life circumstances.
2. Causes of schizophrenia are considered to be within the individual. Personal control and responsibility are assumed.
3. High social rejection and stigma attached to schizophrenia.
4. Individual burdens are demanding, because family resources are not often present.
5. Patient is often hospitalized and isolated from family and community. Custodial care, in disguised forms, is present.
6. Financial incentive to continue the sick role (i.e., disability payments, insurance payments) are numerous and easily available.
7. Stressors are numerous and supports are minimal.
8. Competency levels required for normal functioning are very high and very demanding upon social and intellectual skills and abilities (e.g., bank accounts, tax forms, housing, automobile maintenance, literacy skills).
9. Religious systems and spiritual concerns are often inadequate.
10. Comorbidities are numerous and complex (e.g., substance abuse, alcohol, trauma).
11. Treatments are primarily medical and invasive, with compounding iatrogenic effects (e.g., tardive dyskinesia).
12. Insensitivities to class and cultural differences between patient and professional abound with resulting communication problems.

Note. The inverse of these conditions is considered to be present in developing countries, accounting for their positive outcomes.

come. Individuals with schizophrenia are over-represented in the homeless population. Migration is associated with increased rates of mental illness, including schizophrenia, and this relationship appears to be mediated by psycho-social factors, including difficulties establishing social capital in smaller migrant groups. Individuals with schizophrenia are substantially over-represented amongst prison populations, and imprisonment increases the disability and stigma associated with mental illness, and impedes long-term recovery. The adverse effects of these social, economic and societal factors, along with the social stigma of mental illness, constitute a form of "structural violence" which impairs access to psychiatric and social services and amplifies the effects of schizophrenia in the lives of sufferers. As a result of these over-arching social and economic factors, many individuals with schizophrenia are systematically excluded from full participation in civic and social life, and are constrained to live lives that are shaped by stigma, isolation, homelessness and denial of rights. There are urgent needs for the development of enhanced aetiological models of schizophrenia, which elucidate the interactions between genetic risk and social environment, and can better inform bio-psycho-social approaches to treatment. (p. 721)

It is clear that in spite of extensive research, biological models of schizophrenic disorders continue to be inadequate in accounting for the many and varied patterns of symptomatology, course, outcome, and responsivity to treatment. The complexity of this spectrum of disorders appears to require a biopsychosocial approach in which cultural factors are considered to be a critical determinant of these clinical parameters.

Culture and Depressive Experience and Disorder

Another popular area of inquiry has been the relationship between culture and depressive experience and disorder. This topic has been the subject of extensive theoretical and clinical publications (e.g., Kleinman & Good, 1985; Marsella, Kaplan, & Suarez, 2002; Andrade et al., 2003). Marsella, Kaplan, et al. (2002) note that depression has long been a major topic of concern in Western medical history:

> Depressive experience and disorder have long been a source of concern in Western cultural traditions. Hippocrates (330–399 B.C.E.) included melancholia within his tripartite classification of disorders (i.e., mania, melancholia, phrenitis). He considered its cause to be a function of excessive black bile. Stanley Jackson (1986), in his scholarly book on the topic, *Melancholy and Depression: From Hippocratic Times to the Present*, points out that the term "melancholy" was first used in ancient Greece to describe a disorder characterized by fear, nervous conduct, and sorrow. By the fourth century A.D., the Christian Church had begun to shape the concept of melancholy with its use of the term *acedia* to designate a cluster of feelings and behaviors associated with "dejection" (Jackson, 1986). The condition was often associated with religious fervor among monks and others that practiced isolation and self-denial. It came to mean sluggishness, lassitude, torpor, and non-caring, as well as those emotions associated with *tristitia* (i.e., sadness) and *desperatio* (i.e., despair). . . . "Melancholy" was used extensively in Europe until the 17th century when the term "depression" began to acquire currency. The promotion of "melancholy" as a major mood disorder, dysfunction, and problematic characterological orientation was assisted by the publication of Robert Burton's tome, *The Anatomy of Melancholia*, published in 1652. This book gained immediate and widespread popularity and remained a vital source of clinical insight and acumen on mood problems for subsequent centuries because of its encyclopedic coverage of the topic. (p. 50)

Emerging social conditions now suggest that depressive disorders are becoming the world's foremost psychiatric problem because of global challenges such as war, natural disasters, racism, poverty, cultural collapse, aging populations, urbanization, and rapid social and technological changes. The burdens from these challenges often exceed individual and social resources necessary for mediation (Marsella, Kaplan, et al., 2002). Some writers, such as Murray and Lopez (1996), contend that within a few decades, depression may be the greatest cause of disability worldwide. Under these circumstances, it is clear that we must make every effort to grasp the nature and consequences of this disorder(s). And it also clear that we must consider cultural contributions to depressive experience and disorder.

Marsella (1985, 1987) notes that the Western experience with depressive disorders may be a function of Western preoccupation with guilt, individualism, self-structure, self-control, personal responsibility, and an "abstract" language structure that creates distance between the person and his or her experience through language and self. In contrast, the Eastern experience of depression tends to reflect the integrated conception of mind and body as one and

is portrayed through somatic symptoms rather than feelings of sadness (Marsella, Kinzie, & Gordon, 1973; Kleinman, 2004; Kleinman & Good, 1985).

In a fascinating study in Australia, Gattuso, Fullagar, and Young (2005) examined the construction of depression promoted in popular women's magazines (e.g., celebrity stories, advice columns, resource links) and contrasted this with governmental health materials promoting a "depression" literacy. They found that the latter privileges biomedical and psychological expertise and help-seeking behavior, whereas the former emphasizes self-management and biological expertise. The authors also contend the government materials do not emphasize gender differences and fail to discuss social inequities. What is so important about this study is its recognition of the critical role that communication media may play in favoring certain constructions over others and in shaping views that may or may not be held among populations—an example of cultural influences.

The very way we come to know the world about us (i.e., epistemology) becomes a mediator of depressive experience and disorder. Here, the possibility that cultural variations in the very nature of definition and construction the self (also personhood) mediates depressive experience and disorder become apparent. This viewpoint emphasizes the role of the subjective experience for psychopathology, because at this level the experiential meanings of both health and disorder become apparent (e.g., Jenkins, 1998; Jenkins & Barrett, 2004). In addition to Jenkins and Barrett (2004), many other writers acknowledge cultural variations in self, subjectivity, and emotion, and the implications this may have for behavior (e.g., Csordas, 1994; Kanagawa, Cross, & Markus, 2001; Kitayama, Markus, Matsumoto, & Norasakkunkit, 1997; Marsella, 1985; Nathan, Marsella, & Horvath, 1999).

Yet another variable that must be considered is social class and all that this implies for different racial and ethnic minorities. A recent meta-analytic review of social class by Lorant et al. (2004) concluded that depression is inversely related to social class (i.e., the lower the class, the higher the rate of depression). This is not unexpected because it highlights how certain social conditions such as poverty, racism, powerlessness, and marginalization can contribute to the onset of despair, hopelessness, and helplessness (Marsella, 1997). Marsella stated:

> Mental health is not only about biology and psychology, but also about education, economics, social structure, religion, and politics. There can be no mental health where there is *powerlessness*, because powerlessness breeds despair; there can be no mental health where there is *poverty*, because poverty breeds hopelessness; there can be no mental health where there is *inequality*, because inequality breeds anger and resentment; there can be no mental health where there is *racism*, because racism breeds low self-esteem and self denigration; and lastly, there can be no mental health where there is *cultural disintegration* and destruction, because cultural disintegration and destruction breed confusion and conflict. (Marsella, 1997, quoted in Marsella & Yamada, 2000, p. 10)

These words embody the complex challenges we face as mental health scientists and professionals. In a world in which medications have become commonplace, we must not forget the structural problems that contribute to depressive experience and disorder.

The stigma of depression can also be a cultural barrier to diagnosis and treatment in many cultures (e.g., Docherty, 1997). Despite an awareness of the urgent need for culturally sensitive interventions to address depressive disorders, relatively little research has been conducted. An NIMH-sponsored workgroup established to develop recommendations to improve access to preventive and treatment options for depression (Hollon et al., 2002) recommended increasing the involvement of minority researchers and developing user-friendly and nontraditional delivery methods to increase access of racial/ethnic minority groups to evidence-based interventions. A similar workgroup considered strategies that use social marketing research to increase access to services to ethnic and minority populations with affective disorders (Bruce, Smith, Miranda, Hoagwood, & Wells, 2002). Wells, Miranda, Bruce, Alegria, and Wallerstein (2004) also reported on an approach directed toward increasing access to mental health service interventions in diverse communities. There remains a need for special attention to disparities in access to treatments among vulnerable populations, such the youth (Richardson, DiGiuseppe, Garrison, & Christakis, 2003), older adults (Crystal, Sambamoorthi, Walkup, & Akincigil, 2003), and refugees and displaced victims of war and natural disaster (Carballo et al., 2004).

Culture, Alcoholism, and Substance Abuse

In a review of the literature on cultural aspects of alcoholism and substance abuse, Marsella (2004) noted that although the use and abuse of alcohol and various substances are quite old (e.g., mead or fermented honey may date back to 4000 B.C.E.; opium and hallucinogen use may date back to 1000 B.C.E.), misuse of both alcohol and substances has become a serious source of societal problems (e.g., Heath, 1995; Helzer & Canino, 1992; Staussner, 2001). The multiple cultural factors in alcohol and substance use include rituals (e.g., peyote cults), health and medications, religious experiences, social lubricants, occupational and group membership functions (e.g., military, police, factory workers), sensation seeking, commerce, and pleasurable states.

Cultural factors in the use and abuse of alcohol and various substances often assume location contexts that serve to reinforce and value them. For example, consider the fact that college fraternities now constitute one of the highest risk subcultures for the promotion of alcoholism and substance abuse. Other high-risk subcultures include the military, the entertainment industry, and the ubiquitous cocktail hour. These cultural activity settings often promote excesses in alcohol and substance use. American popular culture may also be considered a source for alcoholism and substance abuse, through its use of mass advertising, lobbying, and information groups supported by industries; corporations that produce alcohol and tobacco; positive portrayal of substance and alcohol use through celebrity and entertainment media; the promotion of subcultures that endorse social deviancies (e.g., violent rap music cultures, bars/pubs); and the promotion of positive images of substance abuse and alcohol use (e.g., the Marlboro Man, Joe Camel, beer drinkers as macho men and sensual women, sexual images).

In addition, high-stress situations, such as being homeless, have been associated with increased rates of substance use (VanGeest & Johnson, 1997). Although immigrants as a group experience numerous daily stressors, they have been shown to misuse substances to a much lesser degree than do native-born citizens (Johnson, VanGeest, & Cho, 2002). As immigrants acculturate and adapt to the "American" lifestyle, their use and misuse of substances rises (Johnson et al., 2002; O'Hare & Van Tran, 1998). This rise in substance abuse was noted whether degree of acculturation was measured in terms of learning to speak English or length of residence (Gfroerer & Tan, 2003). Despite evidence of the negative ramifications of American popular cultural investigating the characteristics of immigrants rather than studying the components of the American way of life that may be contributing to substance abuse has remained the focus of the literature.

The complex ecology of American popular culture that supports and maintains alcoholism and substance abuse is displayed in Figure 33.3, which points out that popular cultures, much like ethnocultural groups, can also influence psychopathology in the form of various personal and social deviancies. A WHO (2004) study comparing prevalence rates of substance abuse during the previous year across 14 coun-

Ethos	Subculture	Location	Rewards
Self-Indulgence	Celebrity	Home	Addiction
Hedonism	Advertising	School/College	Pleasure
Immediacy	Parents	Parties/Proms	Escape, Drop Out
Conformity	Rock Culture	Clubs	Dulling
Macho	Teen Culture	Parks	Liberation
Sexualism	Military	Bashes	Social Acceptance
Grow-Up Quick	Drop Out	Private Rooms	Altered Conscious
Risk Behaviors	Fraternities	Concerts	Punish Parents
Competition	Sororities	Bars	Status

FIGURE 33.3. The complex ecology of alcoholism and substance abuse: Interactions/reciprocity of cultural ethos, subcultures, locations, and rewards.

tries found the Ukraine to have highest rates (6.4%) and Italy, Spain, and France to have the lowest rates (0.1–0.7%). However, we need to consider instrument and procedural bias need before we accept these results.

Based on the research and clinical literature on cultural considerations in alcoholism and substance abuse (e.g., Marsella, 2004), a number of conclusions can be reached:

- The causes and functions of alcohol and substance use and abuse vary according to culture, society, and historical period (e.g., ritual, nutrition, pleasure, economic scale).
- As alcohol and substance use and abuse become a problem (i.e., medical health, safety, economic loss) in a given setting, laws and other social restrictions and guidelines emerge to control and limit problems (e.g., prohibition, labeling a person a "drunk").
- Substantial cultural, local, and national variations characterize the patterns of use and endorsement of alcohol and substances.
- The particular kinds of alcoholic beverage and substances that emerge in a given setting and time are a function of available substances (e.g., mushrooms, rice, wheat), technology (e.g., distillation), and particular aversions and/or preferences.
- The definition and meaning of "abuse" can vary according to "legal," "medical," "moral," and/or "normative" perspectives and across cultures and settings.
- Understanding alcoholism and substance abuse may require new conceptual models that consider the complex ecology of the substance, location, people present, functions, and antecedents–consequences of use and abuse.
- As cultures and societies grow, complex laws of supply and demand emerge that may have international implications (e.g., external suppliers of cocaine) as new sources and substances become available.
- Certain types of substances may come into being for one purpose but end up serving others for which they were not intended (e.g., opium, morphine, heroin).
- Cultures often have political, economic, and social forces that encourage the use of alcohol and substances in spite of their known dangers (e.g., alcohol industry, tobacco industry). These forces, driven by profit, can shape public views of alcoholic beverages and substance abuse.
- Changes in alcohol and substance use and abuse, patterns and consequences occur so rapidly that research is often dated.

CONCLUSIONS AND SUMMARY

After many years of being ignored and marginalized, both mental health professionals and researchers have come to accept the important role of cultural factors in the etiology, expression, manifestation, distribution, course, and outcome of all forms of psychopathology and social deviancy. This acceptance is now codified in DSM-IV-TR (American Psychiatric Association, 2000) in the form of both warnings to clinicians to consider cultural variables and a diagnostic heuristic (pp. 897–903) and list of culture-bound disorders. To a large extent, this acknowledgment has led to a widespread concern about among practitioners and scientists alike about teaching and practicing cultural competence.

The facts were clear! Cultural factors had for too long been ignored at the expense of the patient's welfare and an accurate, valid portrayal and understanding of psychopathology. As the research progressed, it became clear that psychopathology, like normal behavior, evidenced considerable variations. The etiology of disorders was seem to be linked to a broad spectrum of sociocultural conditions, including cultural disintegration and collapse, poverty, crowding, rapid social change, acculturation, and a host of other forces that increased stress levels in the face of inadequate personal and collective resources. It also became clear that mental health could not be achieved apart from the sociopolitical context of life, in which forces such as racism, sexism, and political oppression fostered marginalization, powerlessness, and lack of privilege. Individuals and groups compelled to live on the margins of society would inevitably be faced with stress levels that would lead to distress, dysfunction, deviancy, and disorder.

Rates and expressions of psychopathology were also demonstrated to vary across ethnocultural boundaries; comparative studies used matched diagnoses, matched samples, international surveys, and factor-analytic research strategies. What emerged for depressive disorders was a variation in the expression that included limited guilt, existential despair, and low self-esteem, all of which were hallmarks of the disorder in the Western World. Even in the

schizophrenic disorders, long considered to be universal disorders tied to genetic and biological substrates, ethnocultural and national variations emerged in rates, patterns, course, and outcome. For ethnic minorities in the United States, and for the entire international community, the consideration of cultural factors introduced a new hope that eradication of diagnostic inaccuracies and [redacted] erroneous treatments would lead to improvements in the accessibility, availability, and acceptability of care and service provision.

Today the study of culture and psychopathology has emerged as a popular area of inquiry, with its own journals and books, conferences, and professional and scientific leaders. To a large extent, many of the latter are ethnic minority or international figures, and this is good, for it ensures that issues ignored for so long now inspire a new level of awareness and a new response. The fact of the matter is that the study of culture and psychopathology has revealed how our clinical knowledge and practices are often shaped not by science but by social and political forces that advance particular views based on their ethnocentric or gender biases. We are not free of this risk, but now that we are much more aware of it, we are capable of responding with corrective and preventive measures.

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