CHAPTER 17

Cultural Factors Influence the Expression of Psychopathology

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Because we live in an increasingly multicultural world, many mental health professionals are faced with the challenge of assessing and treating individuals whose cultural contexts vary significantly from their own. Consider the following scenario: A young woman complains that she is suffering from attacks by angry spirits. She tells you that these spirits visit her at night (she can see vague outlines of the spirits and hear them whispering) and sit on top of her, rendering her immobile and helpless. Do you think that this woman's behavior is normal or abnormal? The answer to this question depends in part on the woman's cultural context. In mainstream American contexts, these symptoms are rare and often associated with schizophrenia. However, in Hmong contexts, these symptoms (referred to as the tsog tsuam, or evil spirit who smothers) are common and not associated with mental illness (Adler, 1991). Thus, the same behavior may be interpreted very differently depending on the cultural context in which it occurs. Therefore, in addition to functional impairment and subjective distress, mental health professionals must consider cultural norms and values when assessing and treating mental illness (see also Chapter 16).
DEFINING CULTURE

Before discussing how culture shapes the expression of mental illness, we must define "culture." We refer to Kroeber and Kluckhohn's (1952) widely cited definition of culture as:

Patterns, explicit and implicit, of and for behavior acquired and transmitted by symbols... including their embodiment in artifacts; the essential core of culture consists of traditional... ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, on the other, as conditional elements of future action.

This definition not only highlights the complex and dynamic nature of culture but also emphasizes the mutual constitution of culture and psychological processes. That is, culture shapes patterns of behavior and, in turn, is shaped by them (Adams & Markus, 2004). For example, cultural products such as child-rearing advice manuals can influence the choice of child-rearing practices adopted by parents. In turn, when writing the manuals, parenting experts respond to common child-rearing practices of their time (Hulbert, 2003).

Concepts related to 'culture' include 'ethnicity,' 'nationality,' and 'race.' Although these terms are often used interchangeably, they also differ in significant ways. Although the term 'culture' is typically used to describe systems of shared meanings, values, customs, and beliefs as well as social institutions and physical products (e.g., American versus Chinese culture) (Betancourt & Lopez, 1993; Kroeber & Kluckhohn, 1952), the term 'ethnicity' is used to characterize a discrete group of individuals 'in terms of common nationality, culture, and language' (e.g., Asian Americans or Hispanic Americans) (Betancourt & Lopez, 1993, p. 631). Furthermore, although 'ethnicity' is most often used when describing minority groups within a larger culture, the term 'nationality' is often used to differentiate among individuals within an ethnic group by their country of origin (e.g., Chinese Americans versus Japanese Americans). Finally, 'race' is often used to differentiate groups in terms of their physical characteristics such as skin color (e.g., White Americans and Black Americans) and has been typically used in the context of studying group differences in power, status, and opportunity (Betancourt & Lopez, 1993; Matsumoto, 2000). We use the term 'culture' because we are interested in the effects of practices, values, and perspectives (rather than common language, country of origin, or skin color) on psychopathology.

CULTURAL UNIVERSALISM VERSUS CULTURAL RELATIVISM

What is the role of culture in shaping mental illness? Does culture matter, and if so, which aspects of mental illness are shaped by cultural factors? Is the influence of culture on mental illness pathogenic (meaning that cultural factors cause the illness) or pathoplastic (meaning that cultural factors shape the symptoms of the illness)? To what extent do cultural and biological factors in mental illness interact with each other? Can diagnoses be compared across cultural contexts?

Before answering these questions, it is important to acknowledge the historical tension between cultural universalism and cultural relativism (see also Chapter 16 for a discussion). Although few, if any, scholars hold either perspective in its purest form, these perspectives reveal the critical issues and challenges that have confronted cross-cultural investigations of psychopathology. The cultural universalism perspective argues that the fundamental processes that underlie different forms of psychopathology are similar across cultures and that cultural variation in the expressions of these fundamental processes is minimal (Maslowski, Jansen van Rensburg, & Mthoko, 1998; Murphy, 1982). For example, in a classic article, Murphy (1976) provided evidence for cultural universality in the expression of mental illness. She investigated patterns of psychological and behavioral disturbances across two non-Western cultural contexts (Eskimo and Yoruba villages) and compared them to Western categories of mental illness. The content of particular symptoms was observed to be "colored by culture" (Murphy, 1976, p. 191). For example, Eskimo delusions were based on Eskimo cultural beliefs, whereas Yoruba delusions were based on Yoruba cultural beliefs. However, these differences in content were overshadowed by important similarities. Despite differences in cultural norms and in the availability of labels for aberrant behavior patterns, Murphy observed that markedly similar forms of mental illness (such as psychotic symptoms, anxiety, and antisocial behavior) existed in Western and non-Western contexts. These findings were interpreted as evidence of similarities in fundamental processes underlying mental illness (see Chapter 16).

These universalist claims received much criticism from anthropologists, cultural psychologists, and psychiatrists who asserted that psychological functioning is culturally constructed, or embedded in and shaped by cultural meaning systems (the "cultural relativism" approach) (Boas, 1948; Geertz, 1984; Markus & Kitayama, 1991; Shwedler, & Haidt, 2000). These researchers cautioned that uncritically imposing Western mental illness categories on individuals in non-Western cultural contexts might lead to a category fallacy, or an overidentification of universals and omission of cultural differences (Lewis-Hernandez, & Kleinman, 1994; Kleinman, 1977; Kleinman, 1988). For example, Kleinman (1988) criticized a "pathogenic/pathoplastic" model embedded in many cross-cultural studies of psychopathology. In this model, "biology is presumed to 'determine' the cause and structure of... mental disease, while cultural and social factors at most 'shape' or 'influence' the 'content' of disorder" (p. 24). He noted that this model is faulty because it does not account for the interaction and mutual influence of cultural and biological factors in mental illness (see Chapter 16). Not surprisingly, this
perspective has motivated research on the expression of psychopathology across diverse cultural contexts (Kleinman, 1986; Marsella 1980). For instance, Kleinman (1986) interviewed Chinese patients with a diagnosis of neurasthenia (a syndrome that is common in China, and that is characterized by chronic fatigue, weakness, and associated bodily and emotional complaints) in an effort to understand the relationship between neurasthenia and depression. A large percentage of Chinese neurasthenics met the criteria for a Western diagnosis of major depression. However, the chief complaints of the Chinese patients were somatic (or affecting the body, from the Greek “soma,” or body) rather than emotional (e.g., headaches and dizziness). Kleinman noted that in the Chinese cultural context, somatic complaints are sanctioned ways to elicit support and treatment without evoking the stigma of mental illness. However, neurasthenia was not just another form of Western depression. For instance, antidepressant medications did not alleviate the somatic complaints of the Chinese patients. Instead, their physical symptoms improved only when the patients were able to resolve interpersonal or occupational problems in their lives. Based on this evidence, Kleinman (1986) concluded that emotional distress is the product of an interaction between cultural, psychosocial, and biological factors.

As mentioned earlier, few scholars endorse either the universalist or the cultural relativist positions in their extreme forms, especially as increasing evidence suggests that mental illness is both universal and culturally shaped. In this chapter, we highlight the aspects of mental disorders that are known to be culturally shaped.

We begin with several examples of cultural variability in the prevalence rates of several common mental disorders and their expression. Each of these examples is based on evidence from studies using emic (based on indigenous concepts and instruments) or etic (based on Western concepts and instruments, adapted for use in a non-Western context) approaches. We then outline possible mechanisms by which cultural ideas and practices may shape mental illness. Finally, we discuss the implications of cultural differences in mental illness for clinical practice.

CULTURE AND THE EXPRESSION OF COMMON MENTAL DISORDERS

Major Depression

Major depression is a disorder that is common across cultures and is associated with significant global economic burden and disability (Murray & Lopez, 1997; Ormel et al., 1994). Using Western-based criteria for depressive symptoms, etic studies reveal significant cross-cultural differences in the prevalence rates of major depression, with Western and Latin American countries having higher rates of depression than Asian countries (Kawakami, Shimizu, Hara, Iwata, & Kitamura, 2004; Simon, Von Korff, Pecknold, Fullerton, & Ormel, 1993). Depression also has higher recurrence rates in Western and Latin American cultural contexts than in Asian cultural contexts (Simon, Goldberg, Von Korff, & Ustun, 2002). For example, 33–44% of patients in Western and Latin American cultural contexts experienced recurrence of their depressive symptoms after 1 year, compared to 9% of patients in Asian cultural contexts. Moreover, studies of immigrant groups living in Western cultures suggest that lifetime exposure to Western culture is associated with increased rates of depression. For example, American-born Mexican Americans have higher rates of depression than Mexican-born Mexican Americans and Mexicans living in Mexico (Vega et al., 1998; Vega, Sribney, Aguilar-Gaxiola, & Kolody, 2004). Moreover, individuals who moved to the United States as children show higher prevalence rates of psychiatric disorders than individuals who moved to the United States as teenagers and young adults. These differences cannot be explained by economic and educational disparities between individuals in these cultural contexts (Vega, Sribney, Aguilar-Gaxiola, & Kolody, 2004). Instead, the higher rates of depression among American-born Mexican Americans may in part be caused by the erosion of cultural factors (such as family stability and cohesiveness) that protect individuals from becoming depressed. Similarly, internalization of the North American “pursuit of happiness” and having minority status in North American culture may place American-born Mexican Americans at higher risk for depressive symptoms compared to their counterparts living in Mexico.

In addition to influencing the prevalence and recurrence rates of depression, cultural factors appear to shape the expression of depression. In many Western contexts, depression is characterized by “affective” or emotional complaints, such as sad mood or a sense of hopelessness (Manson, 1995). As stated earlier, in many Asian contexts, depression is characterized by somatic symptoms (e.g., Korean [Pang, 1995], Japanese [Waza, et al., 1999], and Punjabi cultures [Krause, 1989]). For example, ethnographic evidence suggests that a Punjabi indigenous disorder called the “sinking heart” is similar to depression in that it is often precipitated by social stress and characterized by emotional distress and worry (Krause, 1989). Unlike Western individuals with major depression, however, sinking heart sufferers complain primarily of somatic (e.g., a painful sensation in the head) rather than emotional (e.g., sadness and sense of hopelessness) symptoms. In contrast, in some cultural contexts, depressed individuals complain primarily of interpersonal distress rather than somatic and emotional symptoms. For example, in rural Ecuador, an illness named “pena” is a depressive illness that is characterized by...

1 It is possible that the differences between immigrants and Mexicans living in Mexico are due to a self-selection bias, such that individuals genetically predisposed to depression may be more likely to migrate away from their families. Future studies should assess whether this is the case.
a breakdown in social functioning and by appeals for social reciprocity (Tousignant & Maldonado, 1989).

Ethnographic evidence of cultural differences in the somatization of depression, however, has been recently challenged by findings from etic studies (see Kirmayer & Young, 1998, for review). For example, a study conducted by a World Health Organization research team (Simon et al., 1999) examined the links between somatic and psychological symptoms in 14 countries. The authors found that, contrary to the notion that patients in non-Western cultures somatize their psychological symptoms, the proportion of somatic symptoms to psychological symptoms did not differ across countries. Instead, across cultures, patients were more likely to initially report somatic symptoms when they used walk-in clinics and did not have an ongoing relationship with their physicians. These findings seem to indicate that both somatic and emotional symptoms are at the core of depression across cultural contexts and that patients tend to make initial somatic complaints to their physicians when they do not feel comfortable disclosing information about their emotional distress. It is important to note that findings of this study may be biased by its use of Western-based instruments to assess somatic complaints (see also Chapter 15 for a discussion of links between physical health and psychological adjustment).

In summary, ethnographic studies suggest that patients in non-Western cultural contexts are more likely to express their distress through somatic complaints than patients in Western cultural contexts, whereas epidemiological data uncover cultural similarities in somatization. To integrate these disparate findings, cross-cultural studies of somatization that combine emic and etic research approaches are sorely needed (see Guarnaccia & Rogler, 1999, for an example of such comprehensive research programs). Only by combining these research approaches can we uncover the extent of cultural similarities and differences in the somatization of distress.

Social Anxiety Disorder

In the DSM-IV, social anxiety disorder (social phobia) is characterized by “marked and persistent fear of social situations in which embarrassment may occur” (APA, 1994, p. 411). Etic studies find that the lifetime prevalence of this disorder varies significantly across cultural contexts, ranging from an average low of 0.4–0.6% in Asian countries (such as Korea and Taiwan) to an average high of 7–16% in Western countries (such as the United States, Canada, the Netherlands, and Norway). In rural Russia, the lifetime prevalence of social anxiety disorder is 53% (see Furmark, 2002 for a complete review). Studies using both emic and etic approaches also suggest that social anxiety is expressed differently across cultural contexts. For example, in Japan, Taijin Kyofusho (TKS) resembles social anxiety disorder in its incapacitating fear related to social situations. However, whereas individuals with social anxiety disorder in Western cultures fear that they may humiliate or embarrass themselves (e.g., “I am making a fool of myself”; APA, 1994), individuals with TKS in Japan are more concerned with the impact of their behavior on others (e.g., “I am bringing shame on my parents”). Specifically, they are afraid of offending or bringing shame on close others (Kleinke, Dinnel, Kleinke, Hiruma, & Harada, 1997).

Alcohol Abuse

Abuse of alcohol is another mental disorder that is associated with significant global burden (World Health Organization, n.d.). The World Health Organization reported that in 2000, consumption of alcohol varied considerably across cultures (World Health Organization, n.d.). Not surprisingly, alcohol consumption is higher in “wet” or “vinocultural” (wine-producing and wine-drinking) countries, in which social drinking is an essential part of gatherings and celebrations (e.g., France, Germany, Eastern European countries, and Thailand) and lower in “dry” countries in which social drinking is strongly discouraged (e.g., Egypt, Indonesia, and Iraq). For example, the lowest recorded annual consumption rate (0.02 liters of alcohol per capita) was recorded for the predominantly Muslim country of Mauritania, whereas the highest recorded rate (21 liters per capita) was recorded in the Republic of Moldova, a “wet” country.

Because the definition of “normal” drinking varies considerably across cultures, it is difficult to establish universal criteria for a ‘pathological’ levels of alcohol consumption (Bennett, Janca, Grant, & Sartorius, 1993; Gareje, Vazquez-Barquero, & Janca, 1996). For example, in Korea, disturbing others is commonly considered an indicator of excessive drinking, whereas in the United States, having physical symptoms, such as passing out or developing a yellow eye tint, is commonly considered an indicator of excessive drinking (Bennett, Janca, Grant, & Sartorius, 1993). Thus, reliance on standardized Western criteria for alcohol abuse or dependence may miss cases of problematic drinking in some cultural contexts.

Keeping this limitation in mind, let us consider evidence based on etic studies that have assessed the prevalence of alcohol-related disorders (alcohol abuse, dependence and harmful use) across cultural contexts (World Health Organization, 2004). These studies report considerable cultural variability in rates of alcohol-related disorders. This variability appears to be due at least in part to cultural strategies for regulating drinking, such as socialization of moderate drinking or religious proscriptions against drinking. For example, rates of alcohol-related mental health problems are lower in “wet” cultural contexts such as among Jewish Americans and Mediterranean Americans (Italian, Greek), as compared with other cultural groups in the United States (e.g., Irish Americans) (Calahan & Room, 1974; Glassner & Berg, 1980; Vaillant, 1983). These results suggest that in “wet” cultural contexts, high levels of alcohol...
use are integrated into social and religious practices and regulated by tradition, resulting in paradoxically low prevalence rates of alcoholism. Interestingly, the opposite approach of cultural proscription against the use of alcohol also lowers the prevalence of alcoholism. For example, Islam calls for complete abstinence from alcohol. Cultural contexts that are influenced by Islam show not only low alcohol consumption rates but also very low rates of alcohol abuse and dependence. Whereas the annual prevalence of alcohol dependence is 9.9% for Canada and 3% for Germany, it is only 0.2% for Egypt (World Health Organization, 2004).

Thus, different cultures can provide drastically different norms regarding the use of alcohol (e.g., incorporation of alcohol into social rituals or prescription against the use of alcohol) that lead to low levels of alcohol-related problems.

**POSSIBLE CULTURAL MECHANISMS**

Extant research has identified a number of potential cultural variables that can help us account for cultural differences in mental illness. In this section, we will focus on the impact of cultural models of mental health and beauty on the occurrence and expression of mental illness.

Across cultures, people differ in what emotions they would like to feel, what kinds of relationships they would like to have, and how they would like to look. People in different cultural contexts also vary in the extent that they perceive the emotional, social, and physical aspects of themselves to be interrelated. Because notions of mental health are inversely related to notions of mental illness, these cultural models have implications for the occurrence and expression of mental illness. By cultural models we mean shared assumptions that are widely held by individuals in a particular cultural context. These assumptions are typically reinforced by cultural products (e.g., advertisements, child-rearing manuals), institutions (e.g., educational settings), and practices (e.g., parenting practices; see Chapter 14) (see Holland & Quinn, 1987; Markus & Kitayama, 2003; Shore, 1996). These cultural models provide implicit and explicit guidance on desirable and undesirable feelings and behaviors.

**Cultural Models of Mental Health**

**Emotional Functioning.** One core aspect of healthy psychological functioning is emotional balance. Views of healthy emotional responses differ across cultural contexts. For example, in European American cultures, healthy emotional functioning is associated with open emotional responding (Bellah, Madsen, Sullivan, Swindler, & Tipton, 1985; Wierzbicka, 1992; 1999), whereas in Asian cultures, healthy emotional functioning is associated with emotional moderation and control (Bond, 1991). Recent studies also indicate that although most individuals want to feel positive, the nature of valued positive emotions differs across cultures (Tsai, Knutson, & Fung, 2006). For instance, high arousal positive emotions such as excitement and enthusiasm are more highly valued in European American than in Asian cultural contexts, whereas low arousal positive emotions such as calmness and serenity show the opposite pattern. These differences in valued positive emotions are consistent with cultural differences in the expression of emotions. A laboratory study in which European Americans and Asian Americans were asked to relive different emotional episodes or engage in emotional conversations with their romantic partners revealed that European Americans express positive emotions (e.g., smile) more often and more intensely than Asian Americans, despite there being no group differences in subjective reports of positive emotional experience or in levels of physiological responding (Tsai, Chentsova-Dutton, Freire-Bebeau, & Przymus, 2002; Tsai, Levenson, McCoy, in press). Intense smiles may be indicative of European American cultural norms of open emotional expression, particularly for high arousal positive emotions such as excitement. Thus, healthy emotional functioning varies for Asian Americans and European Americans in ways that are consistent with their ideal emotions.

Notions of abnormal emotional functioning also can be expected to vary in ways that are consistent with cultural models of emotional functioning. That is, emotional symptoms of psychopathology may represent deviations from culturally specific norms of emotional expression. As mentioned earlier, healthy functioning is associated with open expression of emotions in European American cultural contexts, and with emotional moderation in Asian cultural contexts. One study examined whether the impact of depression on emotional responding differs as a function of cultural norms regarding emotional expression (Chentsova-Dutton, Chu, Tsai, Rottenberg, Gross, & Gotlib, 2006). We predicted that depression may reduce attention to, or concern with, cultural norms of emotional responding, resulting in emotional responses that contradict these norms. That is, in European American cultural contexts, a depressed individual may fail to express his or her feelings. In contrast, in Asian cultural contexts, a depressed individual may fail to moderate his or her emotions. To test this hypothesis, we presented depressed and nondepressed European Americans and Asian Americans with a sad film. While watching the sad film, depressed European Americans reported less sadness and cried less than did nondepressed European Americans. This finding is consistent with evidence that depressed European Americans show dampened emotional responses to emotional imagery, slides, and films compared with nondepressed controls (Allen, Trinder, & Brennan, 1999; Berenbaum, 1992; Rottenberg, Kasch, Gross & Gotlib, 2002). Importantly, despite similar severity levels of depression, this pattern was reversed for Asian Americans. Depressed Asian Americans reported more sadness and cried more than did nondepressed Asian Americans. Therefore, depression was associated with diminished emotional responding to a sad film for
European Americans and with enhanced emotional responding for Asian Americans. Thus, within each cultural group, the depressed participants demonstrated the culturally inappropriate emotional response. These findings suggest that the impact of depression on emotional responding may be in part shaped by cultural models of healthy emotional functioning. Future studies need to examine whether these findings hold for patterns of emotional functioning in other forms of mental illness across cultural contexts.

**Interpersonal Functioning.** Another key aspect of normal functioning is the ability to engage in meaningful social relationships. Models of meaningful social relationships, however, vary significantly across cultures. Western industrialized cultures such as the United States, Australia, and Great Britain have been characterized as individualistic. In individualistic cultures, being able to maintain one’s autonomy and independence even in the context of close social relationships is valued (Triandis, 1994). Even young infants are expected to develop independent skills, such as being able to sleep through the night or play on their own. In contrast, non-Western cultural contexts, such as Latin American and Asian cultures, have been characterized as collectivist. In collectivist cultures, a state of mutual interdependence with close others is considered optimal, and priority is given to the goals of in-groups over one’s individual goals (Markus & Kitayama, 1991; Triandis, 1972; Triandis, 1994). According to these values, parental socialization aims to foster children’s interdependence with their family (Verweijken, Riksen-Walraven, & Van Lieshout, 1997). For example, infants and toddlers in Japanese families are more likely to regularly share a bed with their parents than infants and toddlers in U.S. families (Latz, Wolf, Lozoff, 1999). As a result, healthy psychological functioning may be more strongly associated with being able to achieve the goals of independence in individualist cultures, and interdependence in collectivist cultures. Thus, the expression of mental illness may emphasize individual concerns in individualist cultures and relational concerns in collectivist cultures (as illustrated earlier in our discussion of social anxiety disorder).

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1 It is important to note that there is considerable within-culture heterogeneity in individuals’ engagement with individualistic or collectivist models of self, goals, and pursuits. While all individuals are likely to be exposed to the dominant values and practices of their cultural context, they may respond in different ways. For example, Triandis, Chen, and Chan (1998) found that only 61–67% of individuals in Western cultures (the United States, Australia, The Netherlands, and Germany) reported individualistic tendencies, whereas only 40–56% of individuals in Asian cultures (Japan, Hong Kong, and Korea) reported collectivist tendencies. When we characterize cultural contexts, we describe dominant cultural norms and values without making an assumption that behavior of all individuals within the cultural context is uniformly shaped by the dominant norms and values.

Strong social ties also can provide protection against occurrence or exacerbation of mental illness. For example, low rates of major depression and social anxiety disorder in Asian cultures can be explained in part by cohesive social structures in these collectivist cultural contexts. Such built-in social networks offer a stable source of social support for its members and may allow them to manage stress more effectively (Chen, Copeland, & Wei, 1999). However, when an individual becomes mentally ill, tightly knit social networks also may increase stigma associated with mental illness. Thus, interpersonal factors can influence the course as well as the occurrence of mental health disorders.

For example, despite the strong evidence for a genetic predisposition to schizophrenia (Jablensky, 2000; Prescott & Gottesman, 1993; see also Chapter 10), aspects of family environment are associated with relapse in patients treated for this disorder (Kanter, Lamb, & Looper, 1987). Interestingly, different aspects of the family environment predict relapse rates of patients in individualistic and collectivist cultural contexts. Schizophrenic patients in individualistic European American cultural contexts who return to overly critical family environments are more likely to relapse than patients returning to less critical families (Burtzaff & Hooley, 1998; Lopez et al., 2004). In European American culture, achieving independence is viewed as an important goal. Critical comments from family members may undermine patients’ independence and create high levels of stress, ultimately contributing to a relapse. The goal of achieving independence is less important in collectivistic Mexican American culture, and critical comments from family members assert patients’ culturally appropriate dependence on family. As a result, family criticism does not predict relapse for Mexican American patients (Lopez et al., 2004).

What interpersonal factors are associated with relapse in collectivistic cultural contexts? Lopez and colleagues (2004) argued that family warmth (or expression of positive emotions and concern for the patient) serves as a critical indicator of healthy interdependence within a Mexican American family. Because achieving interdependence and harmony with one’s family is more salient in Mexican American than in European American cultural contexts, lack of family warmth predicts relapse for Mexican American, but not European American, patients with schizophrenia (Lopez et al., 2004). These studies illustrate that cultural models of healthy interpersonal functioning can shape the expression and course of psychopathology.

**Mind-Body-Social Context Relationships.** The views of what types of symptoms constitute mental illness are deeply embedded in our cultural
models of psychological functioning. Current definitions of mental disorders reflect Western biases of viewing mental illness as primarily characterizing individuals rather than families or communities, and as fundamentally different from physical illnesses (mind-body dualism; see Chapter 15) (Marsella & White, 1982; Manson, 1995). These ideas are not universally shared by other cultures. In many cultures, social, physical, and emotional aspects of functioning are not differentiated. As evident in our examples of major depression, social anxiety, and alcohol-related disorders, emotional distress can be expressed as physical or interpersonal distress in non-Western cultural contexts. For example, recall that depression is expressed primarily in somatic terms in Punjabi culture, and social anxiety disorder and alcohol abuse are defined by their social effects in Asian cultures. Moreover, the tendency to describe distress in emotional (rather than somatic or interpersonal) terms increases as individuals from non-Western cultural contexts acculturate to Western culture and pay increasingly more attention to their own emotions (Chen, Guarnaccia, & Chung, 2003).

The fusion of interpersonal, somatic, and emotional distress is common in non-Western cultural contexts. This fusion can become encoded in the local language, creating a culture-specific “language of affect” (Manson, 1995, p. 491) or the local idioms of distress. Emotional distress may be verbalized as physical or relational symptoms depending on the terms and metaphors available in a particular language and on the appropriate codes for expression and communication of emotions. For instance, in Polynesian Tongan, idiomatic expressions for distress emphasize kinship connections and collective coping (Parsons, 1984), and in Chinese, such somatic terms as “heart discomfort” serve as shared metaphors for affective states or emotions (Tung, 1994). These cultural differences are preserved even when English is used instead of native languages. Tsai, Simeonova, and Watanabe (2004) compared English word use among Chinese Americans and European Americans during discussion of emotional events. They found that Chinese Americans, particularly those who were less oriented to American culture, used more somatic and social words than did European Americans, even though they experienced similar levels of emotion.

**Cultural Models of Beauty**

Cultural models can foster the occurrence of some types of psychopathology (see Chapter 16). One notable example of this is the growing epidemic of eating disorders such as anorexia nervosa (characterized by refusal to maintain normal body weight) and bulimia nervosa (characterized by binge eating and using inappropriate methods such as purging or laxatives to prevent weight gain). These eating disorders appear to be associated with a cultural idealization of the thin body type for women (Miller & Pumariaga, 2001). Data show that cultural models of the ideal body weight as presented in the media and reinforced in specific social groups, such as sororities, contribute to the development of eating disorders (Crandall, 1988; Markey, 2004). Rapid cultural change and exposure to Western cultural ideals appear to be associated with increases in the incidence of disordered eating in non-Western cultural contexts (Miller & Pumariaga, 2001). For example, the introduction of Western television programming to the island of Fiji in 1995 was followed by a sharp rise in disordered eating behavior and unhealthy attitudes about eating among Fijian girls (Becker, Burwell, Herzog, Hamburg, & Gilman, 2002).

Interestingly, cultural ideals appear to shape some aspects and forms of eating disorders, but not others. For example, weight concerns and bulimic behavior appear to be limited to Western or Westernized cultural settings. These differences occur against a background of cultural similarities in the occurrence of self-starving behaviors (Keel & Klump, 2003). This pattern of disordered eating does not occur exclusively in Western or Westernized contexts. For example, some cases of anorexia nervosa have been reported for women from Pakistan, India, and the United Arab Emirates with no exposure to Western cultural influences. Prevalence rates of anorexia nervosa are also similar across cultures (see Keel & Klump, 2003, for a review; see also Chapter 16). Thus, Western cultural models of beauty combined with abundant food resources in most modern industrialized countries may foster culturally dependent forms of disordered eating (i.e., excessive concerns about one’s weight and the occurrence of binging and purging behaviors), whereas other factors, such as genetic predispositions or similar sociocultural pressures, may foster culturally universal forms of disordered eating (i.e., self-starvation).

We have argued that the individuals’ models of optimal psychological functioning and beauty are influenced by culture. These core cultural ideas regarding emotions, social relationships, the relationship between emotions and physical sensations, and desirable body size may shape the expression of mental illness in a particular cultural context. How do we translate these data to clinical settings and apply them to developing assessment and treatment techniques that can be used with diverse patient populations? Research on cultural models of mental health and mental illness can help clinical practitioners integrate their own conceptions of the patients’ symptoms with those of the patients and their cultural contexts.

**Implications for Clinical Practitioners**

In an increasingly diverse world, mental health workers are striving to effectively deliver services to individuals from different cultural contexts. Delivering mental health services to diverse populations can be challenging. For example, members of minority cultural groups (particularly Asian Americans and Hispanic Americans) in the United
States underutilize psychological services, are more likely to withdraw from treatment prematurely, and are more likely to exhibit poor treatment outcomes than European American patients (Cheung & Snowden, 1990; Sue, Zane, Young, 1994). In part, these results may be a result of Western biases inherent in assessment and psychotherapy (Hahn & Kleinman, 1983; Wohi, 1989). That is, assessment and psychotherapy typically target individuals rather than cultures, and focus on emotional or cognitive rather than somatic and interpersonal symptoms of distress. Steps can be taken by mental health workers to bridge the client’s and practitioner’s cultural worldviews.

Clinicians’ cultural biases. During clinical assessment and treatment, clinicians working with diverse populations may notice that their conceptions of mental illness are shaped by their own cultural values and assumptions. We need to recognize that thoughts, feelings, and behaviors of clinicians and their clients alike are culturally shaped. In some cases, clinicians’ values and assumptions may even come into conflict with the values and assumptions of their patients. In addition to cultural differences that are easily accepted and tolerated by outsiders, cultural models of optimal functioning also give rise to some controversial practices (such as female genital modifications in African cultures, arranged marriage in India, or plastic surgery in Western cultures). These practices can engender misunderstanding, discomfort, or even moral criticism from members of other cultures. There are no easy answers to discarding culturally impermissible behavior from culturally rooted and meaningful practices (Rice & O’Donohue, 2001; Shwedler, 2001). The highest standards of rigorous scientific evidence (including etic and emic approaches) should be used when evaluating normative cultural practices that engender moral criticism from members of other cultures (see also Chapter 2 for a discussion of other biases in clinical judgment).

Risk of misdiagnosis. Western diagnostic tools may pathologize behaviors that are considered functional in particular cultural contexts, or fail to detect maladaptive behaviors that are normative in Western cultures. For example, one study found that the General Health Questionnaire, a standardized instrument designed to screen for psychological disorders, requires different thresholds to detect mental illness in different cultural contexts (Goldberg, Oldehinkel, & Ormel, 1998).

In addition to standardized assessment tools, clinician’s judgments can also result in misdiagnosis. Clinicians’ expectations of open expression of positive emotions and positive self-evaluations may be culturally biased and should not be equated with mental health among individuals from other cultural contexts. As we discussed, healthy individuals from non-Western cultural contexts (particularly individuals from Asian cultures) may exhibit lower, but culturally normative, levels of positive emotions (Tsai et al., 2002), self-esteem (Heine & Lehman, 2003), optimism (Heine & Lehman, 1995), and satisfaction with life (Diener, Eiener, & Diener, 1995). Thus, healthy individuals from Asian cultures are at risk of being overdiagnosed with mental illness, particularly depression.

Clinicians need to be aware that baselines of healthy and adaptive functioning may differ across cultural contexts. As Dragns (1995) advocated, deviance from the norms of the majority culture should not be mistaken for psychological disturbance (see Chapter 4 for a discussion of norms).

Clinicians also need to be aware of underdiagnosing individuals from non-Western cultural contexts who express their distress in somatic terms, instead of psychological terms or both. Research suggests that around their first therapies, a presentation of mental illness in somatic terms is likely to occur when patients do not feel comfortable confiding to their physicians because they do not have an ongoing relationship with them (Simon et al., 1999). This pattern is probably caused by an enduring stigma regarding mental illness that is particularly salient in non-Western cultural contexts. Thus, it is crucially important to establish rapport with clients from diverse cultural backgrounds before taking their responses about emotional functioning at face value. During initial visits, clinicians need to pay close attention to complaints about physical ailments and interpersonal difficulties, because these complaints may serve as signals of mental illness.

Despite these issues, diagnoses of mental illness can be made across cultural contexts by carefully integrating local conceptions of mental illness (symptoms that constitute illness, boundaries between normality and illness, precipitating factors, treatment options, course and outcome expectations) with Western-based diagnostic criteria and knowledge. For example, a Western diagnosis of depression given to Asian patients should be complemented with thorough assessment of the patients’ interpersonal and somatic complaints and an exploration of the patients’ own conceptions of their illness. The DSM-IV proposed a useful and comprehensive strategy for cultural case formulation that focuses on identification of cultural factors related to explanatory models of the individual illness, psychosocial environment, relationship between the individual and the clinician, and the desired treatment (APA, 1994; see also Chapter 5). Unfortunately, empirical reports of the effectiveness of this approach are still limited to isolated case reports. More empirical studies examining the effects of this approach on patient treatment continuation, compliance, and effectiveness are clearly needed.

Assessment of cultural orientation. No clinician can be expected to become an expert in the cultural values and norms of all of his or her patients. Directly consulting patients about their culture is not always helpful, because they may not be explicitly aware of their own cultural norms and values. That is, culture can be “invisible, in large part, to its bearer” (Lutz, 1985, p. 65). In such cases, consulting cultural experts or literature on cultural norms and values can be useful and should be considered an essential part of psychological assessment when working with diverse populations.

One important caveat is that in gathering such information, a clinician needs to be aware of within-cultural heterogeneity in values and beliefs and be able to resist ethnic stereotyping based on group membership. Information about cultural values and beliefs should not be blindly
applied to every patient from a particular cultural context. Instead, a strategy for cultural case formulation needs to start with assessment of cultural identity of the individual (APA, 1994). Assessing the cultural orientation of the client can range from asking “How Chinese/Mexican/Polish are you?” to administering validated measures of cultural orientation, such as the General Ethnicity Questionnaire (Tsai, Ying, & Lee, 2000). Knowing the level of cultural identity would help the clinician determine whether cultural norms and values may apply to an individual patient from a particular cultural context. Taking such steps can ensure that principles of patient-centered care are implemented in each case.

Future Directions

An important question to consider in our discussion of cultural differences in the prevalence rates and expressions of mental illness is the role of genetic factors. It is possible that some populations may be more genetically predisposed to developing a particular type of mental illness than other populations. It is also possible that the underlying genetic vulnerability may be expressed differently in different cultural contexts. Indeed, behavioral genetics studies have shown that the contribution of genes to many mental disorders is substantial (see Cooper, 2001, for review; see also Chapter 10). It is important to note that the high heritability estimates obtained in behavioral genetics research may be determined by low levels of cultural variability in the primarily monocultural Western study samples. Future studies need to include samples of twins from a variety of cultural contexts or examine the occurrence and expression of mental illness among overseas adoptees living in Western cultural contexts to begin to distinguish genetic from cultural influences of the expression of psychopathology. In turn, studies of culture and psychopathology need to examine within-culture and across-time differences in the expression of mental disorders to establish that variability or changes in cultural values or norms are associated with corresponding changes in the prevalence and expression of mental illness within populations. More studies that take into account genetic and cultural factors and their interaction are sorely needed.

In summary, culture plays an important role in shaping mental illness (see also Chapter 16). Examples from emic and etic research illustrate that prevalence rates and symptom expression of common mental disorders vary across cultures. Cultural factors such as conceptions of healthy emotional and interpersonal functioning can account for these differences. Between-culture and within-culture differences in emotions, social relationships, cognition, and behavior deserve more attention in clinical diagnosis and treatment. In an increasingly multicultural world, it is critically important to consider how culture shapes the expression of psychopathology and to develop effective treatment strategies for individuals from diverse cultural contexts.


CHAPTER 18
The Great Ideas of Clinical Science Redux: Revisiting Our Intellectual Roots

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Why are the Great Ideas of Clinical Science useful? Why are they essential to the intellectual life of all clinical scientists?

We can glean some insight into these questions by revisiting our intellectual roots in the Boulder, or scientist-practitioner, model of clinical training, formulated in the late 1940s at a major conference in Boulder, Colorado. Over half a century later, it is all too easy to forget that David Shakow, the prime mover behind this model, urged programs to train aspiring clinical psychologists to be psychologists first and clinical psychologists second (see Shakow, 1969). That is, according to Shakow, clinical psychologists should first and foremost be intimately acquainted with the basic science of psychology, and they should apply this broad knowledge to every aspect of their clinical practice and research. Moreover, Shakow maintained that clinical psychology graduate programs should focus on teaching courses in general theoretical and research principles rather than in specialized methods, such as the MMPI or Rorschach Inkblot Test. Clinical psychologists, Shakow argued, should be critical thinkers, not technicians.

Shakow’s sage advice is often lost in the fast-paced modern era of hyper-specialization in academia. Mounting pressures on graduate students to publish papers in premier journals and accumulate large numbers of clinical hours, and on young academics to publish still more papers in premier journals and obtain large federal grants, mitigate against