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Cultural Aspects of Depressive Experience and Disorders

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The Importance of Cultural Considerations in Depressive Experience and Disorder

Within the last decade, depressive experience and disorder has emerged as one of the world's major health and social problems (e.g., Bebbington, 1993; Desjarlais, Eisenberg, Good, & Kleinman, 1995). This can be attributed to a spectrum of biological (e.g., longevity, chronic diseases, toxin exposure, malnutrition, medications), psychological (e.g., identity confusion and conflict, loss of meaning, learned helplessness, powerlessness) and sociocultural and environmental (e.g., role confusion and conflict, uprooting due to war and natural disasters, urbanization, rapid social change, cultural disintegration and collapse, and racism and sexism) factors associated with the etiology, exacerbation, and maintenance of depressive experience and disorder. As a result of the increased worldwide risk and burden of depressive experience and disorders (Murray & Lopez, 1996), it is essential researchers and professionals improve their understanding of the complex cultural knowledge, issues, and concerns related to this problem.

Cultural variations in the nature and meaning of depressive experience and disorder have critical implications for assessment, diagnosis/classification, and treatment because cultural variations imply cultural relativism regarding with regard to such critical variables as epistemology, personhood, self, body, health and disorder, normality, and the spectrum of social and interactive behaviors (e.g., Fabrega, 1989, 1992; Kleinman & Good, 1986;; Marsella & Yamada, 2001; Kirmayer, 2001; Marsella, Kaplan, & Suarez, 2002). In brief, to the extent cultures differ in their constructions of reality, their meaning systems, and their socialization patterns, differences will emerge in psychopathology, including depressive experience and disorder.

A major problem facing clinicians and researchers is the semantic confusion surrounding the term "depression." "Depression" denotes a mood, a symptom, and various syndromes of disorder and disease, and simultaneously connotes a broad spectrum of affective experiences and social consequences. In many instances, the three terms -- mood, symptom, and syndrome -- are discussed apart from the many different life contexts in which they are shaped, experienced, communicated, and responded to by others. That is to say, they are decontextualized. This is a serious problem because decontextualization permits the researcher/clinician to assign their ethnocentric meanings and interpretations to the problems independent of the context in which they emerge and are sustained. There may be little consideration for situation stressors as well as normative personality configurations that may differ from those of the researcher/clinician.

The Concept of Depressive Experience and Disorder

Western Historical Perspectives

Depressive experience and disorder have long been a source of concern in Western cultural traditions. "Depression," according to Jackson (1986), is derived from the Latin word "deprimere" meaning "to press down." With the passage of time, "depression" gained increasing currency in English, French, and German medical treatises. Initially, it was used

as a subset of "melancholy," then as a synonym, and later as a replacement for the term. Hippocrates (330-399 BCE) 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 AD, 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) (see Jackson, 1986, pp. 65-70).

"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. It is noteworthy, that "melancholy" has re-emerged in DSM IV as a major sub-type of depression characterized by symptoms associated with the previous concept of "endogenous depression" (e.g., APA, 1994; Jackson, 1986).

The continuous presence of the terms "melancholy" and "depression" through the past centuries of Western European and North American history -- indeed its literal dominance of psychiatric thought and practice -- suggests a massive and widespread cultural pre-occupation with the topic. This is especially true because of Judao-Christian religious concerns with guilt, sin, sloth, despair, and worthlessness. But, the longevity and pervasiveness of this pre-occupation has not necessarily increased our understanding of the topic, especially with regard to its etiology, assessment, and treatment. Theories and classification systems abound today, as do a multiplicity of approaches to measurement and diagnosis/classification (e.g., APA, 1994), but controversy and debate continue as professionals and researchers seek to disentangle the complex web of biological, psychological, and social determinants, and the historical overlays that have shaped our understanding.

Problems in Psychiatric Diagnosis and Classification

Within Western psychiatry, biological and psychological perspectives have dominated thinking, and little attention has been directed to ethnocultural variations in depressive experience and disorder, and the significance these variations could have for rethinking

current views. Clearly, ethnocultural variations in depressive experience and disorder demand that Western psychiatry and psychology -- now exported throughout the world as universally applicable and relevant -- revise many of their assumptions and practices. In a strong statement, Thakker and Ward (1998) noted that the implicit assumption of universality of DSM-IV primary syndromes limits its utility and validity. Kirmayer (1998), the editor-in-chief of the journal, *Transcultural Psychiatry*, devoted an entire issue to the transcultural problems of DSM-IV. Kirmayer 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 DSM-IV (1994) modestly states:

Culture can influence the experience and communication of symptoms of depression. Underdiagnosis or misdiagnosis can be reduced by being alert to ethnic and cultural specificity in the presenting complaints of a Major Depression Episode. For example, in some cultures, depression may be experienced largely in somatic terms rather than with sadness or guilt. Complaints of nerves and headaches (in Latino and Mediterranean cultures), of weakness, tiredness, or imbalance (in Chinese and Asian cultures), of problems of the "heart" (in Middle Eastern cultures), or of being "heartbroken" (among the Hopi) may express depressive experiences (1994, 324).

It is also notable that DSM-IV TR provides a lengthy list culture-bound disorders (e.g., *latah*, *koro*, *susto*) and it does note that that these should be considered. But, it stops short of providing specific diagnostic procedures for assessing culture-bound disorders, and for warning diagnosticians of the risks of using DSM-IV categories for non-Western patients.

It is the current opinion of many clinicians and scholars that this is precisely what is demanded. Cross-cultural research in anthropology, psychiatry, psychology and other professionals and disciplines has been uniform in its conclusion that there are substantial variations in depressive experience and disorder (e.g., Kleinman & Good, 1986; Manson & Kleinman, 1998; Marsella, 1993; Marsella, Kaplan, & Suarez, 2002). Continued efforts to disregard or dismiss this fact can only result in problems for both patients and practitioners. Different historical and cultural traditions frame depressive experience and disorders within different contexts, thereby promoting and/or limiting particular symptoms,

and shaping different understandings and meanings. Marsella (1998A) points out that Western mental health professionals and scientists have been guided by two assumptions:

1. problems reside in individual brains and minds, and thus, individual brains and minds should be locus of treatment and prevention;
2. the world in which we live can be understood objectively through the use of quantitative and empirical data. .

Both of these assumptions stand in direct opposition to the post-modernist views that currently characterize and inform the study of culture and mental health relationships. These views emphasize the importance of the sociocultural context of psychological problems (i.e., powerlessness, poverty, underprivileging marginalization, inequality) in understanding the etiology and expression of psychopathology, and in understanding its assessment, diagnosis and treatment. These views also neglect or marginalize qualitative research and commentary because it is considered inexact. Of course, there is often little criticism of the many limitations and biases of empirical/quantitative research even when there are scores of problems that limit its findings (e.g., sample size, sample bias, low statistical power, inappropriate statistics, invalid and non-equivalent instruments). In brief, problems of depressive experience and disorder must be understood within the cultural context that socializes, interprets, and responds to them. This requires that we proceed from different values, perspectives, and practices, especially those that emphasize context, ecology, and qualitative and naturalistic methods (e.g., Carr, Marsella & Purcell, 2002).

Culture and Depressive Experience and Disorder

The Concept of Culture

The author will define culture as shared learned meanings and behaviors that are transmitted within social activity contexts for purposes of promoting individual and societal adjustment, growth, and development. Culture has both external (i.e., artifacts, roles, activity contexts, institutions) and internal (i.e., values, beliefs, attitudes, activity contexts, patterns of consciousness, personality styles, epistemology) representations. The shared meanings and behaviors are subject to continuous change and modification in response to changing internal and external circumstances.

This definition acknowledges that the meanings and behaviors shaped by culture, in both its external and internal representations, are dynamic and subject to continuous modification and change. While the impulse is generally toward adaptation and adjustment, it should be noted that cultures can frequently become pathogenic (e.g., Leighton, 1959; Edgerton, 1992) because of the values and cultural constructions of reality they impart. Culture is the lens or template we use in constructing, defining, and interpreting reality. This definition suggests that people from different cultural contexts and traditions will define and experience reality in very different ways. Thus, even mental

disorders must vary across cultures because they cannot be separated from cultural experience. Marsella (1982) stated:

We cannot separate our experience of an event from our sensory and linguistic mediation of it. If these differ, so must the experience differ across cultures. If we define who we are in different ways (i.e., self as object), if we process reality in different ways (i.e., self as process), if we define the very nature of what is real, and what is acceptable, and even what is right and wrong, how can we then expect similarities in something as complex as madness (1982, p. 363).

Ethnocultural Identity

Ethnocultural identity refers to the extent to which an individual endorses and manifests the cultural traditions and practices of a particular group. Clearly, what is important is not a person's ethnicity, but rather, the extent to which they actually are identified with and practice the lifestyle of that group. In groups undergoing acculturation, there can be considerable variation in the extent of ethnocultural identity with a particular cultural tradition. Thus, it is important to determine both a person's ethnicity and their degree of identification with their ethnocultural heritage. While some individuals may be bicultural, others may be fully acculturated, and still others may maintain a traditional identification. Ethnocultural identity has emerged as one of the most popular new areas of inquiry in cross-cultural research. It is the "new" independent variable in cross-cultural research, replacing the simple comparison of different ethnic groups. Today, ethnocultural identity is being assessed by a variety of methods including the measurement of similarities in attitudes, values, and behaviors of different groups (e.g., Yamada, Marsella, & Yamada, 1998) as well as the extent of acculturation (e.g., Paniagua, 1994; Ramirez, 1999, see p. 171). In studying cultural aspects of mental disorder, it is important that patients be evaluated for their degree of ethnocultural identification and acculturation.

Literature Review Articles on Culture and Depressive Experience and Disorder

By the 1980s, a sizeable number of literature reviews on cross-cultural studies of depression had been published (e.g., Marsella, 1980; Marsella, Kaplan, & Suarez, 2002; Marsella, Sartorius, Jablensky, & Fenton, 1986; Prince, 1968; Pfeiffer, 1968; Singer, 1975; Weiss & Kleinman, 1988). These reviews culminated in the most important book on the topic, Kleinman and Good's (1986) *Culture and Depression*. This edited volume provided a spectrum of theoretical and empirical chapters that uniformly suggested the cultural decontextualization of depression had resulted in inaccurate clinical and research conclusions. These early publications reached the following conclusions:

1. There is no universal conceptualization of depressive disorders;
2. The experience, meaning, expression of depressive experience varies as a function of the cultural context in which it occurs;

3. Somatic signs, symptoms, and complaints often dominate the presentation of depressive experiences in non-Western cultural contexts;
4. Guilt, self-deprecation, suicidal ideation and gestures, and existential complaints vary across cultures and especially tend to be rarer within non-Western cultures;
5. Standard personality correlates of depression in Western societies (e.g., low self-esteem) may not be present across cultures;
6. There is a need to study idioms of distress specific to across cultures.

In the last decade, a number of other review papers have been published sustaining the conclusions of the Kleinman and Good (1986) volume and the previous literature reviews (e.g., Bebbington, 1993; Jenkins, Kleinman, & Good, 1990; *Journal of Clinical Psychiatry Supplement #13*; Manson, 1995). These reviews, both recent and past, provide a summary and overview of the extensive literature on cultural aspects of depressive experience and disorder, and the interested reader should consult them for details about studies and conclusions. It is now clear, however, that cultural variations exist in all of the following areas: meaning, perceived causes, onset patterns, epidemiology, symptom expression, course and outcome. These variations have important implications for understanding clinical activities including conceptualization, assessment, and therapy.

How Does Culture Influence Depressive Experience and Disorder

Some Cultural Determinants

Culture can influence depressive experience and disorder via a number of different cultural mechanisms and forces. These mechanisms and forces are listed in Table 1 as part of a brief self-evaluation that professionals and researchers can conduct regarding the extent of their patient's or subject's participation in cultural traditions or life styles that vary from those assumed in conventional western psychiatry and psychology. Table 1 is not an measure of ethnic identity, but rather a quick way for appraising cultural factors that can influence depressive experience and disorder.

One of the major cultural influences of depressive experience and disorder is the concept of personhood or selfhood held by a particular cultural tradition. Marsella (1980; 1985) noted that cultures that tend to socialize unindividuated self structures (i.e., sociocentric, collectivistic) in combination with strong metaphorical languages and imagistic mediations of reality promote "subjective" (context-based) epistemological orientations that encourage people to remain attached and bonded to others. This mitigates the isolation, loneliness, narcissism, and perceived helpless associated with depressive experience and disorder in Western cultural traditions. Other researchers support the sociocentric personhood concept and its relationship to mental disorders (e.g., Kleinman & Good, 1986; Koenig, 1997; Manson, 1995; Shweder, 1991).

The relationship of depressive disorders and experience to culture is further mediated by a number of personality factors. For example, in the West, because of the

Table 1
A Checklist of Some of Cultural Determinants of Depressive Experience and Disorder

How much does your patient/client identify with ethnocultural traditions, life styles, behavior patterns, and world views in which there are cultural variations in the following:

Very Much (4)	Somewhat (3)	A Little (2)	Not At All (1)	Don't Know (0)	
_____					1. Cultural variations in the concepts of personhood, selfhood, and self-structure;
_____					2. Cultural variations in concepts regarding the nature and causes of abnormality and normality, health, and well being, and social deviancy and conventionality;
_____					3. Cultural variations in concepts and practices regarding attitudes toward illness and disease;
_____					4. Cultural variations in concepts and practices regarding breeding patterns and high-risk genetic lineages;
_____					5. Cultural variations in concepts regarding pre-natal care, birth practices, and post-natal care, especially in such areas as nutrition and disease exposure;
_____					6. Cultural variations in concepts and practices regarding socialization, especially regarding the importance of family, community, and religious institutions;
_____					7. Cultural variations 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 variations in stressors such as responses to sociotechnical change, sociocultural disintegration, family disintegration, migration, economic development, industrialization, and urbanization;
_____					9. Culturally-related variations patterns of deviance and dysfunction including participation in alternative economies and social structures;
_____					10. Cultural variations in stressors related to the clarity, conflicts, deprivations, denigrations, and discrepancies associated with particular needs, roles, values, statuses, and identities;
_____					11. Cultural variations in stressors related to sociopolitical factors such as racism, sexism, and ageism and the accompanying marginalization, segmentalization, and underprivileging;
_____					12. Cultural variations resources and coping patterns including institutional supports, social networks, social supports, and religious beliefs and practices.

Notes. If your evaluation earns more than 24 points, use of conventional Western psychiatry and psychology can result in potential errors and risks. If you assign numerous "don't know" ratings, it would be appropriate for you to conduct additional interviews and assessments prior to developing and initiating a therapeutic program. These figures have not been validated in studies but represent useful clinical guidelines that have developed out of the authors clinical and research experiences with ethnocultural minority and non-Western patients.

value of individual autonomy and responsibility, the concept of personal control is closely related to depressive disorders and experience including powerlessness, helplessness, and detachment. Yet, among many Asian cultures (e.g., Chinese, Japanese, Korean, Indian), research (e.g., Sastry & Ross, 1998) has suggested that loss of personal control does not have the same aversive consequences because of the Asian emphasis on selfless subordination to family and the tendency to value non-personal control.

In one of the classic statements on personhood in non-Western cultures, Geertz (1973), an American cultural anthropologist, wrote:

The Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgment, and action, organized into a distinctive whole and set contrastively -- both against other such wholes and against social and natural background -- is however incorrigible it may seem to us, a rather peculiar idea within the context of the world's cultures (Geertz, 1973, p. 34).

Marsella (1980; 1985) noted that depressive experience and disorder in non-western cultures are often expressed without the associated existential problems found in the West because the non-western collective or sociocentric identity encourages the construction and experience of the disorder in somatic or interpersonal domains. The result is that complaints of personal meaninglessness, worthlessness, helplessness, guilt, and suicidal thoughts are reduced or absent. But, within Western cultures, the long historical pre-occupation with "acedia" and "melancholia" frames depressive experience and disorders within personal responsibility for "sin" and sin's related behaviors sloth, self-indulgence, suicide, worthlessness, guilt, and despair. Thus, for so much of Western history, depressive experience and disorder have been associated with individual will power and strength of character. Depressive experience and disorder has been framed within a "moral" context. The phrases are well known: "It's up to you!" "You have got to pull yourself out of it." "It is your choice." Western cultural thinking managed to turn dysfunctions of multiple origins and expressions into a battleground within the individual between "good" and "evil." Personal responsibility for depressive experience and disorder became the norm, and guilt, worthlessness, and failure became hallmarks of immoral character associated with depressive experience and disorder -- it was a deficit, a lack, an inadequacy, a fault in personal determination. Furnham & Malik (1994) provide an interesting discussion of cultural variations in beliefs about depression in which they point out the cultural variations in ideas about etiology, expression, and consequence.

Culture-Bound Disorders

Yet another approach for understanding cultural influences on depressive experience and disorders involves the concept of culture-bound disorders. Culture bound disorders represent a major area of concern and debate in the study of culture and mental health because their existence raises questions about the cultural foundations on which Western

psychiatry is based. The 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 (APA, DSM-IV, 1994, p. 844).

But, if culture bound syndromes are limited to specific societies or culture areas, who defines what are the criteria for mental illness - American or European psychiatrists? Is it not possible that Western disorders also constitute culture bound syndromes since they are found primarily in Western cultures? Consider the current views on "anorexia" and "bulimia." Marsella (2000), noted that there are many questions that are still being debated regarding culture bound disorders including:

1. Should these disorders be considered variants of disorders considered to be "universal" by Western scientists and professionals (e.g., Is *susto* [soul loss] merely a variant of depression?)?
2. Are all disorders "culture-bound" disorders since no disorder can escape cultural encoding, shaping, and presentation (e.g., schizophrenia, depression, anxiety disorders)? In the case of depressive experience and disorder, a number of culture bound disorders (e.g., APA, 1994) have been reported to be associated with "depressive" functioning including brain fag (West Africa), *dhat* (Indian subcontinent), *shenjing shairuo* (Chinese), *susto* (Latino-Hispanic), *tawatl ye sni* (Sioux Indian).

The universal human capacity for sadness, grief, and remorse does not mean that depression, as a psychiatric construct, is universal. In the West, depression and melancholia have been considered a dysfunction for more than 2000 years. This historical and cultural embeddedness brings with it a set of meanings and implications for both the patient and the societal response to them. Today, many different kinds and patterns of depression are used (e.g., despair, helplessness, major depression, melancholia, atypical, agitated, dysthymic). These constructions of depression reflect not only medical knowledge, but also ideas about religion, social relationships, morality, related emotions such as aggression/hostility and anxiety/fear, and responses to life activity contexts (e.g., marriage, child rearing, work, stress situations). And, of course, they also reflect Western notions about the essential nature and purpose of the person.

When depressive experience and disorder is considered within a historical and cultural framework, the potential for cultural variations in meaning and consequence become more apparent. The following set of questions may be useful:

1. What is the range of expressions for depressive experience and disorder?
2. What functions does having depressive experience disorder serve?
3. In what social situations does depressive experience and disorder occur?

4. What is the social response to depressive experience and disorders?
5. What is the range of causes of depressive experience and disorders
6. What is the range of treatments for depressive experience and disorder?

Cultural Considerations in the Etiology of Depressive Experience and Disorder

Conventional psychiatry and psychology often proceeds from assumptions that depressive experience arise from dysfunctions or disorders in biological (e.g., genetics, neurotransmitter deficits, anatomical disorders [e.g., thyroid deficiency, adrenal dysfunction], medical illnesses, and medication side effects) and/or psychological (e.g., poor self esteem, faulty cognitions, personality styles) . Yet to treat these problems without consideration of the problems that cultural roles, institutions, and social structures may play in generating and sustaining them cannot truly solve the problem. In brief, by confining attention to biological and psychological variables, there is a failure to acknowledge the interaction and interdependencies of different strata or levels of variables. While neurotransmitter deficits in serotonin or norepinephrine may be dysfunctional, a full understanding of the etiology of depressive experience and disorder requires attention be given to ascending levels of variables at the microsocial (e.g., family, community, workplace), macrosocial (e.g., social change, class structure, poverty, war). Neurochemistry responds to both genetic and microsocial/macrosocial variables. This is a standard systems perspective (e.g., Marsella, 1998B).

Mental health professionals cannot be content to treat pained and disordered psyches with medications and therapies, they must respond to the social and cultural milieu that the biology of the synapses and psyches come to represent, including the problems of rapid sociotechnical change, racism, poverty, inequality, and acculturation. It is out of these milieus that spring hopelessness, helplessness, marginalization, fear, anger, and powerlessness. Thus, biological and psychological variables are shaped and constructed within the larger cultural context of the macrosocial world via internal cognitive and affective representations. The world in which we live can be a source of comfort or of madness (eg., Edgerton, 1992; Marsella & Yamada, 2001; Sloan, 1996; Wilbur, 1998).

Within the larger context of contemporary life, cultures around the world are being faced with critical challenges that are linked to depressive experience and disorder including the following:

- a) Socio-Environmental (e.g., crowding, pollution, noise, slums, unemployment, poverty, crime, homelessness, violence, industrialization, community decay);
- b) Psychosocial (e.g., racism, sexism, inequality, cultural disintegration, social drift, social stress, social change);
- c) Psychological and Spiritual (e.g., hopelessness, helplessness, powerlessness, alienation, anomie, fear, anxiety, isolation, loneliness, rootlessness, low quality of life, marginalization);
- d) Biopsychological (e.g., malnutrition, toxins, immune reactions, stress-related collapse with its attendant changes in neurotransmitters and hormones).

In brief, depressive experience and disorder cannot be treated solely as dysfunctions of individuals. Their roots, precipitating circumstances, exacerbating, and maintaining conditions reside at multiple levels, and these too must be addressed if the problem is to be understood and solved. For example, is the worldwide increase in depressive experience and disorder related to the upheavals of social change including the collapse of traditional cultures and the subsequent alienation and powerlessness and confusion that this brings? Lastly, even as we look at etiological factors, we must consider the presence of cultural resources and protective factors that exist via the presence of mourning rituals, nutritional patterns, religious rituals, family strengths, and related coping or support systems.

Cultural Considerations Factors in Assessment of Depressive Experience and Disorder

Assessment of depressive experience and disorder has been conducted with self-report (e.g., Beck Depression Scale, Zung Depression Scale), interviewer rating scales (e.g., Hamilton Rating Scale, SCIDS, WHO Rating Scale), and in more recent decades, non-clinical family, attitude, and social cognition scales (see Marsella, Hirschfeld, & Katz, 1987, for a summary and review). While these scales have been used as standards for depressive experience across ethnic and cultural groups, their validity remains in question. These self-report and interviewer rating scales are based on symptom criteria that is geared to Western culture patients. As a result, use with non-Western cultures patients can result in faulty diagnoses because they do not sample culturally relevant symptoms and idioms of distress (e.g., Bertschy, Viel, & Ahyi, 1992; Ebert & Martus, 1994; Ebigno, 1982; Fugita & Crittenden, 1990; Griffith & Baker, 1993; Hamdi, Amin, & Abou-Saleh, 1997; Takeuchi, Kuo, Kim, & Leaf, 1989; Thornicroft & Sartorius, 1993; Zheng & Lin, 1991). These problems are associated with linguistic, conceptual, scale, and normative equivalence (e.g., Marsella, Dubanoski, Hamada, & Morse, 2000). Equivalence refers to the "comparability" of the scale. Quite simply, is it equivalent, is it the same?

Constructs like depressive experience and disorder that are developed and used in Western psychiatry and psychology do not have the same connotative meanings in non-Western cultures. Thus, before beginning comparative studies, it is necessary to use ethnosemantic procedures (e.g., Marsella, 1987) to identify similarity in meanings and behavior patterns. These procedures provide a foundation for testing and/or establishing cultural equivalence. Ethnosemantic procedures involve

1. eliciting the universe of terms in a particular domain (e.g., the emotions),
2. ordering the terms according to various dimensions (e.g., good-bad, strong-weak),
3. assessing their meaning through word association and antecedent-consequence methods, and
4. mapping their behavioral or action components through observation or behavior intention scales.

The result is an "emic" perspective of the construct one chooses to study or at least a better understanding of the biases associated with using construct.

Since many depression studies are based on self-report replies, there is a risk of bias because of cultural variations in response style and perceived demand characteristics of the instruments. While definitive research on cultural variations is still needed, there are studies indicating some cultural groups have difficulty with five and seven point Likert scale items and tend to endorse the middle positions (e.g., Marin, Gamba, & Marin, 1992; Watkins & Cheung, 1995). Marsella, Dubanoski, Hamada, and Morse (2000) stated:

The simple fact of the matter is that asking self-report questions is a complex task. This is made even more complex when psychologists move across cultural boundaries to ask questions of people whose perceptions of the task and whose motivations to participate differ from those on whom the scale was constructed. These perceptual and motivational differences include

1. desire to conform socially,
2. fear of possible persecution,
3. concern for giving the "right" answer rather than an accurate answer,
4. desire to please authorities,
5. limited self awareness and insights,
6. confusion with the perceived meaning and implication of terms and words used in the questions, and
7. variations in the construction of personhood and personality (Marsella et al. , 2000).

Assessment of depressive experience and disorder across cultures must consider the following factors:

1. appropriate items and questions, including the use of idioms of distress;
2. opportunities to index frequency, severity, and duration of symptoms since groups vary in their reporting within certain modes;
3. establishment of culturally relevant baselines in symptom parameters;
4. sensitivity to the mode and context of of response (i.e., self-report, interview, translator present),
5. awareness of normal behavior patterns;
6. symptom scales should be normalized and factor analyzed for specific cultural groups.

Dana (1993) and Paniagua (1994) provide some of the most thorough and detailed discussions of the risks associated with culturally biased measuring instruments. In addition to listing risks and preferred procedures for assessment, Paniagua (1994) provides a self-evaluation instrument for clinicians to assess their possible biases and prejudices. It is clear that the measurement of depressive experience is a complex task. Crossing cultural boundaries introduces yet new problems in validity and reliability

because of variations in the nature, meaning, and consequences of signs and symptoms, and the variations in measurement procedures and approaches.

A Concluding Thought

In a challenge to Western psychology's ethnocentric and biased global hegemony, Marsella (1998) proposed the development of a new psychology for the 21st century: global-community psychology. This psychology repositions Western psychology as one of many psychologies throughout the world rather than the only psychology. Marsella pointed out that the dominance of Western psychology was less a matter of its accuracy than a matter of social, economic, and political power. Psychologists throughout the world are increasingly resisting the imposition of Western psychology. For example, Misra (1996) an Asian Indian psychologist, writes:

The current Western thinking of the science of psychology in its prototypical form, despite being local and indigenous, assumes a global relevance and is treated as a universal mode of generating knowledge. Its dominant voice subscribes to a decontextualized vision with an extraordinary emphasis on individualism, mechanism, and objectivity. This peculiarly Western mode of thinking is fabricated, projected, and institutionalized through representation technologies and scientific rituals and transported on a large scale to the non-Western societies under political-economic domination. As a result, Western psychology tends to maintain an independent stance at cost of ignoring other substantive possibilities from disparate cultural traditions. Mapping reality through Western constructs has offered a pseudounderstanding of the people of alien cultures and has had debilitating effects in terms of misconstruing the special realities of other people and exoticizing or disregarding psychologies that are non-Western. Consequently, when people from other cultures are exposed to Western psychology, they find their identities placed in question and their conceptual repertoires rendered obsolete (p. 497-498).

This is the reality of our contemporary world. The empowerment of non-Western psychologies will bring with it a new and more critical response to widespread and indiscriminate use of Western psychology. The new psychology will need to be more responsive to the multitude of forces present in our world. The new psychology will need to be multisectoral, multidisciplinary, and multicultural. It will need to understand and accept the problems of ethnocentricity and the importance of cultural determinants of human behavior.

Contemporary mental health professionals and researchers now acknowledge, accept, and seek to understand and use cultural factors in their studies of depressive experience and disorder. They understand the importance of preserving diversity, rather than destroying it through the adoption and use of culturally inappropriate and biased clinical practices. They understand that the world is culturally pluralistic and that accuracy requires an understanding of phenomena within its unique cultural context. None of this means that we must ignore or disregard all previous knowledge generated on depressive experience and disorder in the West, but rather that we must be aware of its possible limitations, and the especially the potential consequences of its use and application. If we,

as professionals and researchers value diversity and all that it means for creating opportunity and choice for human beings everywhere, then we cannot ignore cultural variation.

This thought was eloquently stated by Octavio Paz (1967), the Nobel Prize winning Mexican poet and essayist, when he wrote:

What sets worlds in motion is the interplay of differences, their attractions and repulsions. Life is plurality, death is uniformity. By suppressing differences and peculiarities, by eliminating different civilizations and cultures, progress weakens life and favors death. The ideal of a single civilization for everyone, implicit in the cult of progress and technique, impoverishes and mutilates us. Every view of the world that becomes extinct, every culture that disappears, diminishes a possibility of life (The Labyrinth of Solitude, 1967).

When we ignore cultural factors in understanding, assessing, and treating depressive experience and disorder, we are contributing to the homogenization of world cultures and we are reducing the very cultural pluralism on which human survival depends.

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Appendix

Some Guidelines for Assessing and Treating Depressive Experience and Disorder in the Cross-Cultural Clinical Encounter

1. Formal Training: Clinicians should seek formal training in cross-cultural studies of psychology, psychopathology, and psychotherapy. These courses are now available at most universities and they should be required given the cultural pluralism of our society and the world.
2. Cultural Fluency: Clinicians should strive to develop language and cultural fluency and competence for those groups with whom much of their professional work occurs. If possible, this should include to travel to locations in which these groups live.
3. Culturological Interview: Clinicians should conduct a culturological interview (much as they conduct a psychiatric and a psychological interview) that can provide

information regarding the patient's ethnocultural identity, cultural construction of reality, cultural explanatory models, culture-related stressors and coping methods.

4. **Cultural Participation:** Clinicians should work with the patient, family, and cultural consultants to develop a clinical assessment and treatment program that is valid for the patient. To be valid, this program must actively consider cultural variables much as clinicians now consider gender, age, gender preference, and other forms of social identity.
5. **Cultural Equivalency in Assessment:** Clinicians should be aware of the cultural limitations of clinical assessment methods for their patient because of non-equivalence in language, concepts, norms, and scaling methods. They should strive to use assessment methods that are responsive to these problems. This may require increased use of qualitative methods such as narrative assessment and therapy. Qualitative methods, because they explicitly acknowledge clinician and patient realities, should be used more often in clinical settings.
6. **Cultural Formulations of Diagnosis:** Clinicians should limit use of DSM-IV diagnostic categories because of their biases and rely increasingly on diagnostic formulations that describe problem (i.e., symptom, disability) frequency and severity within identifiable settings and situations. In addition, the formulation should seek and formalize the differences between clinician, family, and patient constructions.
7. **Cultural Collaboration and Options:** Clinicians should evolve treatment intervention programs in collaboration with their clients. They should present explanations of their decisions and seek approval. Whenever possible, they should present therapeutic options including the use of alternative and complementary methods.
8. **Cultural Experts:** Clinicians should work with experts familiar with the cultural context of their patient's life style and disorder. These experts can provide services as referral agents, consultants, co-therapists, or therapists.
9. **Cultural Awareness of History and Life Context:** Clinicians should be fully aware of the history and life circumstances of their patients with regard to possible impacts of ethnic and racial minority status on the causes and expression of their disorders. This information can be part of the culturological interview. The critical consideration here is that the clinician come to understand that the etiology and treatment of the problem may reside in factors external to the individual patient in such areas as poverty, injustice, inequity, cultural dislocation and abuse, marginalization, racism, and a host of other societal factors. Indeed, the clinician may need to work as both an individual and a social change agent. Cultural Issues in Depression 15