PERGAMON

Behaviour Research and Therapy 41 (2003) 755–776

BEHAVIOUR RESEARCH AND THERAPY

www.elsevier.com/locate/brat

Assessment of psychopathology across and within cultures: issues and findings

Juris G. Draguns [a,*], Junko Tanaka-Matsumi [b]

[a] *Department of Psychology, The Pennsylvania State University, 410 Moore Building, University Park, PA 16802, USA*

[b] *Department of Psychology, Kwansei Gakuin University, 1-155 Ichibancho, Uegahara, Nishinomiya-City, 662-8501 Japan*

Accepted 30 November 2001

Abstract

Research based information on the impact of culture on psychopathology is reviewed, with particular reference to depression, somatization, schizophrenia, anxiety, and dissociation. A number of worldwide constants in the incidence and mode of expression of psychological disorders are identified, especially in relation to schizophrenia and depression. The scope of variation of psychopathological manifestations across cultures is impressive. Two tasks for future investigations involve the determination of the generic relationship between psychological disturbance and culture and the specification of links between cultural characteristics and psychopathology. To this end, hypotheses are advanced pertaining to the cultural dimensions investigated by Hofstede and their possible reflection in psychiatric symptomatology. It is concluded that the interrelationship of culture and psychopathology should be studied in context and that observer, institution, and community variables should be investigated together with the person's experience of distress and disability.

Keywords: Psychopathology; Culture; Symptoms; Cross-cultural; Adaptation

1. Introduction

Over the last two decades, culture's interplay with human behavior and experience has moved from periphery toward the center among the concerns of contemporary psychology. Psychopath-

* Corresponding author. Tel.: +1-(814)-863-1735; fax: +1-(814)-863-7002.
E-mail address: jgd1@psu.edu (J.G. Draguns).

0005-7967/03/$ - see front matter
doi:10.1016/S0005-7967(02)00190-0

ology has not been exempt from this trend. Against this background, we shall endeavor to provide a concentrated survey of the current state of conceptualization and knowledge in this area of inquiry. Cultural influences will be examined in their dual manifestations, across regions and boundaries around the world and within the ethnoculturally diverse milieus of many contemporary nation states. Accumulated findings will be reviewed, unsolved problems identified, and recommendations for future research and clinical practice formulated. To this end, we embark upon a consideration of the contrasting perspectives that have served as points of departure for the investigation of culture and abnormal behavior.

1.1. Culturalist and universalist orientations and their prospective integration

Herskovits (1949) equated culture with the part of the environment that was created by human beings. Marsella (1988, pp. 8–9) provided a more elaborate, psychologically oriented, description of the attributes of culture as follows:

> Shared learned behavior which is transmitted from one generation to another for purposes of individual and societal growth, adjustment, and adaptation: culture is represented externally as artifacts, roles, and institutions, and it is represented internally as values, beliefs, attitudes, epistemology, consciousness, and biological functioning.

This conception overlaps with that of subjective culture as formulated by Triandis (1972).

How culture impinges upon and penetrates manifestations of psychological disturbance has been studied from two contrasting points of view. Universalists have focused upon differences in degree and number in preexisting, presumably worldwide, dimensions and categories. Relativists have been impressed with the scope of cultural variation and with the interpenetration of culture and psychopathology. Consequently, they have emphasized the uniqueness of phenomena within any given culture and the need to study them on their own terms.

Emil Kraepelin (1904) is usually considered the originator of the universalistic comparison of psychological entities. Specifically, he initiated the observation of the manifestations and incidence of depression in Java. Moreoever, in a remarkably perceptive and prescient statement he anticipated the major tasks and issues of cross-cultural or comparative study of psychopathology:

> If the characteristics of a people are manifested in its religion and its customs, in its intellectual artistic achievements, in its political acts and its historical development, then they will also find expression in the frequency and clinical formation of its mental disorders, especially those that emerge from internal conditions. Just as the knowledge of morbid psychic phenomena has opened up for us deep insights into the working of our psychic life, so we may also hope that the psychiatric characteristics of a people can further our understanding of its entire psychic character. In this sense comparative psychiatry may be destined to one day become an important auxiliary science to comparative ethnopsychology (Ṽölkerpsychologie), (as quoted by Jilek, 1995, p. 231).

A more outspoken, radically relativistic, point of view upon psychopathology has been propounded by Benedict (1934); Devereux (1961); Nathan (1994); and Nathan and Hounkpatin

(1998), among others. These researchers prefer to observe psychological disorders within their respective cultural context and tend to eschew or de-emphasize comparative investigations, especially those of isolated aspects of psychopathology torn out of the matrix of their occurrence. They warn against purportedly universal explanations and are reluctant to impose imported external frameworks.

The universalistic and relativistic positions show overlap with the etic and emic orientations, which focus upon the origins of the concepts to be investigated. The emic point of view capitalizes upon notions and labels derived from the experience within a culture. Etically oriented theoreticians and researchers concentrate their efforts upon the purportedly universal rubrics and continua of experience. Thus, the study of the consequences of parental rejection around the world (Rohner, 1986) is an eminently etic undertaking while the description of the uniquely Japanese pattern of lifelong dependence or amae (Doi, 1973) exemplifies an emic inquiry. An etic orientation, however, can also be applied to disentangling relationships within a culture. In Japan, for example, Kurabayashi (2001) has explored the culturally characteristic interplay of work related stress, depression, and suicide—three variables that tend toward universality. Culture-bound or emic disorders are typically studied at their respective cultural sites and are rarely subjected to quantification. However, in Southern China Tseng, Mo, Hsu, Li, Ou, Chen and Jiang (1988) conducted an epidemiological study during an outbreak of koro, an anxiety syndrome over imaginary penis shrinkage. This project was followed up by the collection of biographical and psychometric data, couched entirely in etic terms (Tseng, Mo, Hsu, Li, Chen, Ou, & Zheng, 1992). These admittedly atypical and innovative studies illustrate the potential of combining emic concepts with an etic modus operandi. Switching from one perspective to the other is not only possible but salutary and enriching. Integrative sources on psychopathology across cultures (e.g., Pfeiffer, 1994; Tseng, 2001) blend and incorporate information from these seemingly opposed, but actually complementary, outlooks. In an ongoing project in France and at four Francophone sites in the Indian Ocean: Madagascar, Mauritius, Comorro Islands, and Reunion, Roelandt (2001) is simultaneously pursuing universalistic and relativistic objectives by investigating the cultural conceptions of depression, mental illness, and madness and by recording the prevalence of mental disorder. In Table 1, the characteristics of the emic and etic approaches are schematically presented and then integrated within a more comprehensive framework in both gathering data on cultural groups and in the assessment of individuals.

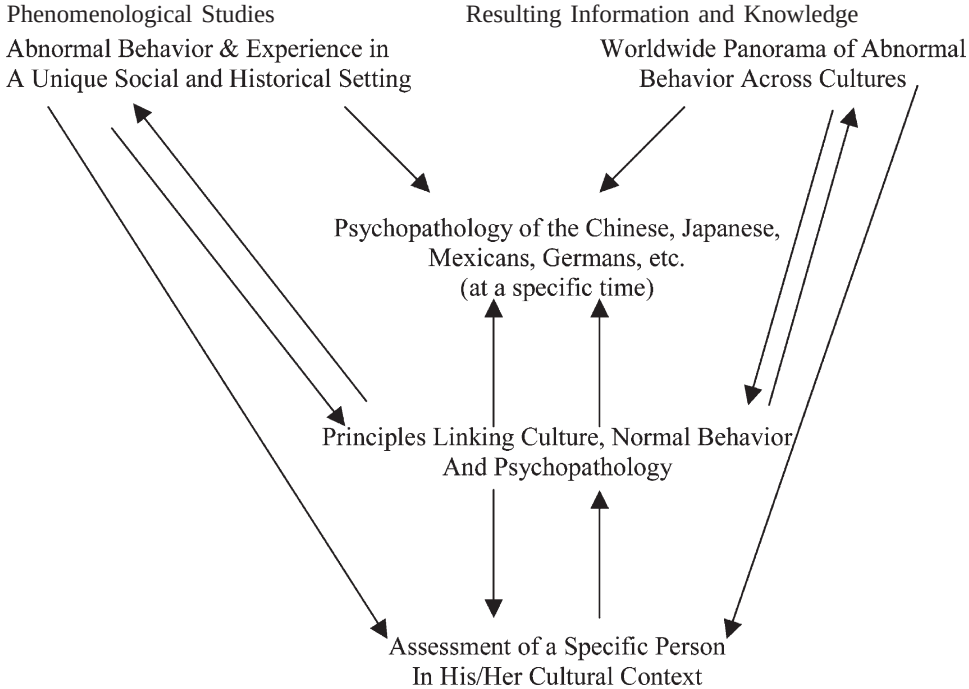
2. Psychiatric diagnoses in a global perspective: etic positions, emic critiques, and integrative reformulations

2.1. US–UK diagnostic project

Although observations on psychopathology in various parts of the world had been gradually accumulating beginning with Kraepelin's (1904) seminal account, and even some systematic data had been collected, the US–UK Diagnostic Project (Cooper et al., 1972) can be considered as a harbinger of modern cross-cultural research on psychopathology. In the three phases of this investigation, Cooper et al. first confirmed the previously reported striking disparity in the distribution of psychiatric diagnoses in London and New York. Specifically, schizophrenia was found to be

Table 1
Culture research and assessment in psychopathology: Options and integration

	Orientations
Emic:	Etic:
Idiographic	Nomothetic
Uniqueness and Sensitivity	Objectivity and Comparability
	Objective
Description	Comparison
	Types of Studies
Anthropological Descriptions	Multicultural Comparisons, e.g. WHO Studies
Indigenous Concepts and Explanations	Epidemiological Research
Culture-Bound Syndromes	Archival Studies
Native Healers	Bicultural Comparisons
Relationships Within Culture	Traditional Transcultural
Case Studies Within a Cultural Framework	Studies of Incidence and Expression of Schizophrenia, Depression, etc.
Phenomenological Studies	Resulting Information and Knowledge



much more frequently diagnosed in New York than in London. Conversely, initial diagnoses of depression were a lot more prevalent for patients in London than in New York. In the second phase of the study, Cooper et al. discovered that these diagnostic differences disappeared when patients were diagnosed on the basis of World Health Organization's (WHO) standardized diagnostic system (ICD-8). In the final phase of the project, American and British psychiatrists were found to apply different diagnostic criteria to videotaped interviews of psychiatric patients some of whom were British and some American. Cross-national agreement was substantial for typical, 'textbook' cases. In the more frequent instances where mixed symptom pictures were presented,

Americans opted for schizophrenia and Britons, for affective disorder. These results conformed to the then emerging model (Draguns, 1973) which recognized that not only patients, but mental health professionals and community as well as institutional settings, may contribute to differences across cultures. Westermeyer (1987) proposed that a complex socio-cultural process was involved in identifying, describing, labeling, and intervening in cases of behavioral or mental deviance. Kleinman, 1978, 1991) advocated a shift from an exclusive preoccupation with the patient's symptoms and syndromes to a more comprehensive view of the context in which the disturbance occurred. Such contexts include the family, the community, and the institution with their norms and values (Tanaka-Matsumi & Higginbotham, 1996; Tanaka-Matsumi, Seiden, & Lam, 1996). These developments sparked two divergent, etic and emic, trends. From the etic perspective, validation of cross-culturally usable diagnostic scales was powerfully stimulated. At the same time, from the emic point of view, the uniqueness of each culture was increasingly recognized and the futility of cross-cultural comparisons conceded. By now, standardized diagnostic instruments exist for every major psychiatric disorder (Sartorius & Janca, 1996). The advent of these measures has brought new problems with it. In particular, culturally distinctive factors have often gone unnoticed and culturally relevant hypotheses have not been formulated or tested (Betancourt & López, 1993; Canino, Lewis-Fernandez, & Bravo, 1997). From a contextual perspective, Kleinman (1977, p.4) pointed out that the traditional diagnostic categories are embedded in of the culturally bound Euro-American psychiatric conceptualization and practice. The cross-cultural applicability of the current American diagnostic system (DSM-IV) remains to be tested (Thakker & Ward, 1998). Draguns (1980) identified three complicating factors in specifying which features of psychopathology were universal and which were particular to distinct cultures: (1) the application of the Kraepelinian diagnostic categories throughout the world; (2) the construction of psychiatric institutions in various regions imitating their Western prototypes, and (3) the imitation, to an as yet unknown degree, of Western symptoms in cultures undergoing modernization. In an attempt to divest themselves of the obtrusive features of the Western categories and the framework within which they are embedded, proponents of the more relativistic "new transcultural psychiatry" (e.g., Kleinman & Good, 1985a) have concentrated their research efforts on cultural interpretations of depression, cultural idioms of distress, and contextual descriptions of culture-bound disorders.

2.2. Assessment within and across cultures: the observer's contribution

Regardless of the diagnostician's or interviewer's orientation, the process of gathering information about another individual involves a transaction during which personal information is communicated through a variety of channels. Such communication is greatly complicated when it occurs across cultural barriers and screens. In an early report, Cheetham and Griffiths (1981) documented a high proportion of diagnostic errors that occurred in interviewing African and Indian patients in South Africa, traceable to the misinterpretation of their presenting symptoms. Thus, affect was judged to be inappropriate on the basis of cultural misunderstandings and culturally shared and sanctioned beliefs were deemed diagnostically significant. Among the Amish in Pennsylvania, American psychiatrists were found to exhibit a predilection for diagnosing schizophrenia (Egeland, Hostetter, & Eshleman, 1983). Upon the institution of uniform and objective diagnostic procedure, most of these diagnoses were changed to bipolar mood disorder. These

findings should alert diagnosticians to two dangers. The first of these involves equating deviance with disturbance (American Psychiatric Association, 1994; Draguns, 1990). The second danger is more complex and subtle. Draguns (1973, 1990, 1996) and Tanaka-Matsumi (1992) have proposed an inverse relationship between cultural or social distance and empathy. The more a person's cultural background is unfamiliar and baffling, the more difficult it is to experience empathically. In the absence of personal contact and factual information, stereotypes tend to be invoked. As a result, quantitative differences tend to be converted into qualitative distinctions, overlap between groups is disregarded, and the complexities of trait distribution within a group are overlooked. Thus, stereotypes stand in the way of recognizing a person's individuality and of being able to share his or her perspective and affect. As Ridley (1989) has cautioned, stereotyping is not limited to prejudiced individuals. López (1989) concluded that errors in assessment stem more typically from selective information processing than from prejudicial and rejecting attitudes. Therefore, such errors should be more readily amenable to modification through cognitive techniques. In López's view, biases toward underdiagnosing or overdiagnosing a disorder in a cultural group may reflect diagnosticians' implicit baselines for psychopathological entities in various populations. Moreover, as Adebimpe (1981) suggested, such baselines may be influenced by the clinicians' normative judgments. Standardized project diagnoses counteract such errors and increase precision. However, as Kleinman (1988) has indicated, such procedures tend not to do justice to diagnostically atypical cases, which may be especially revealing and indicative from the cultural point of view.

2.3. Innovations and advances in epidemiological research

Epidemiology is a branch of medicine that studies the distribution of diseases in designated populations and/or specified territories. Progress in epidemiological research on mental disorders has been greatly facilitated by the standardization of diagnostic and other assessment procedures. As a result, epidemiological information has been gathered on the incidence and prevalence of psychopathological categories within the major ethnic components of the United States population. Epidemiological data have also been collected and compared across nations.

The Epidemiological Catchment Area Study (ECA), conducted at five urban centers in the United States, relied upon the Diagnostic Interview Schedule for case identification (Escobar, Karno, Burnam, Hough, & Golding, 1988; Robins & Regier, 1991). In Los Angeles, there was only a small number of diagnostic differences across ethnocultural lines. Among Mexican Americans, prevalence for most diagnostic categories was lower by comparison with the US born segment of the population (Escobar, Karno, Burnam, Hough & Golding, 1988). These differences shrank or disappeared when Mexican Americans who were born in the United States were compared with "Anglos" (Robins & Regier, 1991). These findings highlight the complex and interactive nature of epidemiological differences, the extent of overlap between the ethnocultural groups compared, and the vulnerabilities of specific segments of the American population defined on the basis of gender, age, and ethnicity. They also suggest the variability of such differences across settings and time. Thus, the complex pattern of the findings obtained in ECA is not identical with the array of results from the more recent National Comorbidity Survey (Kessler et al., 1994). If epidemiological research has not yet brought forth definitive results pertaining to ethnic differences in the major components of psychopathology, it has called into question premature and

hasty assertions about such findings. Thus, Neal and Turner (1991) found that the conclusions about the allegedly elevated levels of anxiety disorders among African Americans were unwarranted. Again, a more promising undertaking is to look for pertinent findings in specific portions of the African American population which may be susceptible to certain anxiety related symptoms or syndromes (cf. Draguns, 2000). In Taiwan, Rin and Lin (1962) conducted a comparison of prevalence of various mental disorders among the majority Chinese and the minority Taiwan aboriginals. Differences emerged, with organic psychoses, epilepsy and alcoholism being higher among the aborigines and schizophrenia and neuroses, among the Chinese. These discrepancies, however, were traced to economic conditions rather than to intrinsic cultural characteristics.

Until recently, the comparison of epidemiological data on psychopathology across nations appeared utopian. With the advent of standardized instruments and procedures, this objective is beginning to be realized. This advance is exemplified by Hwu and Comptom (1994) who compared the results of major epidemiological surveys completed in mainland United States, Puerto Rico, Canada, Korea, Taiwan, and New Zealand. They found lower lifetime prevalence rates for most disorders in Taiwan and Korea than in Canada, Puerto Rico, and New Zealand. An even more ambitious task was undertaken by Weissman et al. (1996) who investigated the rates of various depressive disorders in ten nations. Rates of bipolar mood disorder were much less variable across nations, and insomnia and lack of appetite were found to be prominent and prevalent symptoms of depression at all research sites. There were also ample differences in rates of depression some of which Weissman et al. found puzzling, such as major discrepancies between seemingly similar urban centers in the United States and Canada and between Korea and Taiwan while major depression was virtually unaffected by such prolonged and intense stresses as the civil war in Lebanon. These findings suggest the magnitude of the as yet unmet challenges in comparative epidemiological research, even with validated and appropriate interview schedules. While epidemiological investigations beyond national borders constitute a methodological breakthrough, obtaining interpretable, definitive, and stable data from such studies remains an ambitious objective.

3. Specific mental disorders: the accumulated findings

3.1. Depression

Depression occurs in widely different cultural contexts, yet is exceedingly difficult to reduce to its fundamental and presumably culturally invariant features. This state of affairs has hampered cross-cultural investigation; thorny conceptual and definitional issues have not been resolved (Fabrega, 1974; Marsella, 1980). Marsella (1980) concluded that no universal conception of depression exists but added that “even among those cultures not having conceptually equivalent terms, it is sometimes possible to find variants of depressive disorders similar to those found in Western cultures.” (p. 274). In numerous languages, there is no adequate dictionary equivalent for depression (Marsella, 1980). Even if there is a term for depression, a high proportion of the population may be unfamiliar with it, as is the case in Madagascar (Roelandt, 2001). Moreover, cultures have been found to be different in the connotative meaning evoked by depression-related experiences and the labels for them (Tanaka-Matsumi & Marsella, 1976).

Criteria of depression have also shifted with the changes in the historical and political context. Thus, during the colonial era in Africa, reports abounded of the rarity of depressive manifestations south of the Sahara. Prince (1968) addressed the issue of the changes in the picture of depressive manifestations and syndromes upon the advent of independence and traced the substantial increase in reported depression to the increased prestige assigned to depressive experiences, the inclusion of indirect and masked depressive symptoms, the shift from the institutional to community settings of observations, and the actual increase of incidence due to westernization. Going beyond Prince's cautious conclusions, it would appear that the broadening of conceptions of depression and extending the search for cases outside of closed milieus are the most plausible factors in the short run; the effect of prestige and modernization is worth investigating over a longer period of time.

Both national and international research on the epidemiology of depression has been stymied by the difficulty of establishing stable and general diagnostic criteria (Marsella, Sartorius, Jablensky & Fenton, 1985). Thus, the differences in lifetime prevalence rates between Seoul, Korea and Christchurch, New Zealand, appear dramatic, even with the standardized Diagnostic Interview Schedule (Hwu & Comptom, 1994). However, they are paralleled by such discrepancies within the same country, such as those between the ECA study (Robins & Regier, 1991) and the National Comorbodity Survey (Kessler et al., 1994) in the United States.

WHO (1983) sponsored a prototypically etic study on the symptomatology of depression in Canada, Iran, Japan, and Switzerland by means of the Schedule for Standardized Assessment of Depressive Disorders. More than 76% of depressed patients reported a common pattern of depressive symptoms that included sadness, absence of joy or pleasure, lowered pleasure, reduced concentration, lack of energy, and a sense of inadequacy. Suicidal ideation was acknowledged in 59% of cases.

Beyond these widely shared components of depressive experience, sense of guilt has emerged as a source of cultural variation. Reports from Africa (Sow, 1980), India (Rao, 1973), Indonesia (Pfeiffer, 1994), Japan (Kimura, l995), and China (Yap, 1971) converge in suggesting that guilt feelings are less prominently featured among the subjective symptoms of depression. Moreover, when guilt is experienced it is conceptualized and communicated differently than in Europe or America. Murphy (1978) traced the prominence of guilt feelings in depression to the advent of individualism during the Renaissance, Reformation, and Enlightenment. In Japan, guilt feelings are more likely to be triggered by having violated personal obligations than by having transgressed against abstract and absolute principles (Kimura, 1995). Among African people, spontaneous reports of guilt are rare as a result of attributions of exogenous persecution (Sow, 1980).

In addition to etic comparisons of depression in incidence or symptomatology, search for emic conceptions of depression has been pursued. Manson, Shore and Bloom (1985) developed the American Indian Depression Scale on the basis of indigenous words and concepts used to describe depression. In this manner, five Hopi illness categories were identified that were labeled respectively as worry sickness, unhappiness, heartbroken, drunken-like craziness, and disappointment. Unhappiness was closely related to dysphoric mood in DSM while being heartbroken encompassed the core syndrome of depression exemplified by loss of sleep, motor retardation, fatigue, decline of interest in sexuality, and various aspects of self-rejection.

According to Abe (1996, 2001), who compared depressed patients in Japan and Spain, catastrophic delusions overshadow delusions of guilt among Japanese depressives. The premorbid personality of depressive patients shows similarity to the *typus homo melancholicus*, identified

by Tellenbach (1976) in Germany. In Japan, as well as in Germany, depression prone individuals tend to be scrupulous, orderly, thrifty, and hardworking. In Japan, this personality constellation is imbued by Confucian values which emphasize maintenance of sameness, preservation of group harmony, and an equilibrium between the person and society.

Räder, Krampen, and Sultan (1990) found that external locus of control was more prevalent among depressed patients in Egypt than in Germany. Moreover, these findings paralleled differences between normal Germans and Egyptians. This finding was extended in a triple comparison of Afghan, Egyptian, and German patients. It is worth noting that Afghan and Egyptian responses were similar and stood in contrast to the German findings (Shakoor, 1992).

In Sweden Perris (1988) has reopened the issue of the recall of childhood rejection and deprivation as an antecedent of depression in adulthood. In a series of multinational studies, he has been able to demonstrate the cross-cultural robustness of the relationship between depression and current recollections of lack of parental warmth. Less clear is the pattern of any cross-cultural differentiation in this respect, and the link between familial and more broadly cultural context and susceptibility to depression remains a promising subject for future investigation.

3.2. Somatization in depression and in other disorders

Bodily distress in the form of general malaise, sometimes equated with neurasthenia, shows a great deal of overlap with the experience of various depressive states. This is also true of the more specific states of somatic dysfunction and discomfort limited to or focused upon an organ or a system. Moreover, pain and distress may function as avenues of communicating and experiencing dysphoria in various cultures, and there may be cultural differences in the prominence accorded to somatization.

Kleinman (1982) and Kleinman and Kleinman (1985) investigated neurasthenia or *shenjing shuaiuro* in Hunan, China. With the Chinese language version of the Schedule of Affective Disorders and Schizophrenia, Kleinman found that 87 out of 100 patients met the DSM-III criteria for major depression and six more exhibited other depressive disorders. On specific inquiry, Chinese neurasthenic patients acknowledged dysphoric mood, anhedonia, trouble concentrating, hopelessness, and low self esteem. However, more recent findings (e.g., Zhang, 1989; Lee & Wong, 1995) point to a mixture of anxiety related and depressive symptoms in *shenjing shuaiuro* and hold open the possibility of a shift toward a more psychological construal of this syndrome in younger and more urbanized samples. Moreover, the disparity between the somatic symptoms reported spontaneously and the expressions of psychological distress elicited on inquiry opens the possibility of distortion by means of imported scales and externally imposed criteria. Traditionally, in China psychological symptoms were not regarded as problems that would justify seeking help from health professionals (Cheung, 1989). Indeed, a culturally sanctioned code for couching specific psychological experiences in organ related terms survives to this day (Ots, 1990).

Seiden (1999) presented both Chinese and European–American clinicians with videotaped interviews of four Chinese immigrant patients with neurasthenic complaints in the United States. There was consensus on the symptoms presented and the interventions indicated. However, cultural differences appeared in the relative importance assigned to somatic experiences versus cognitive problems.

In addition to China, prominence of somatic complaints has been reported in Japan, India, Latin

America, and Africa (Kirmayer, 1984). Indeed, their relative neglect by clinicians in North America and Western Europe may itself be a cultural phenomenon as is the Cartesian dichotomization of soma and psyche. Around the world and across epochs, fusion of bodily and mental experience is a lot more prevalent (Draguns, 1975). The challenge is to incorporate this recognition into a comprehensive system of worldwide assessment of psychopathology.

3.3. Schizophrenia

The most ambitious project of investigating schizophrenia across nations was initiated by the WHO. In the initial phase of this continuing research program, patients experiencing their first episode of schizophrenia in nine countries were interviewed, observed, and diagnosed by means of a standardized Present Status Examination (WHO, 1973). A pattern of core symptoms presented by the great majority of schizophrenic patients at all centers was ascertained, consisting of lack of insight, flat affect, delusional mood, ideas of reference, perplexity, auditory hallucinations, and experience of control (see also Tseng, 2001). Two years later, WHO (1980) conducted a follow-up study on the course and outcome of schizophrenia. Most positive symptoms such as hallucinations had disappeared. However, negative symptoms exemplified by lack of insight and flatness of affect persisted in a substantial proportion of cases. Somewhat surprisingly, prognosis was more favorable in the three developing countries (Colombia, Nigeria, and India) than in developed countries (United States, Great Britain, and Denmark). Also unexpectedly, high educational level was associated with chronicity in developing countries. On a more general plane, Jablensky and Sartorius (1988) summarized the results of the WHO research as follows: "(I) Syndromes of schizophrenia occur in all cultures and geographical areas investigated; (II) their rate of incidence is very similar in the different populations; (III) the course and prognosis of schizophrenia is extremely variable, but outcome is significantly better in the developing countries (p. 65)."

In the most recent and ambitious phase of the WHO series of investigation, Jablensky et al., 1992) set out to compare the true prevalence of schizophrenia across cultures at 12 centers in ten countries. All persons who sought their first contact with a helping agency within the catchment area of a participating center were identified. They were then screened for schizophrenic symptoms. There were no major differences between individual centers, and the incidence rates in developing and developed countries were comparable. Acute onset of schizophrenia was more frequently encountered in the developing countries.

This case finding procedure was also employed to investigate the impact of stressful events within two to three weeks prior to the onset of schizophrenia. Day et al. (1987) reported similarity in the mean number of stressful events among six of the nine participating centers. Two centers in India and one in Nigeria reported lower rates of such events. It is not clear whether these findings reflect a true difference or whether the experience of stress at these locations was not adequately represented among the measures of this study.

The results of the WHO research provide impressive corroboration of similarities of rates of schizophrenia across cultures. At the same time, some differences have also been identified. In pursuit of such variations, Murphy (1982) identified faulty information processing as a potential risk factor in developing schizophrenia. Murphy's formulation is akin to the double bind hypothesis by Bateson, Jackson, Haley and Wheatland (1956). It is, however, extended beyond messages from the mother to the child. Rather, the community (and, by extension, the culture) is regarded

as the putative source of unclear, complex, and contradictory messages, which are difficult to ignore or to disregard. Work on these intriguing possibilities, however, does not appear to be pursued by any current investigators.

The WHO finding of a better prognosis in developing countries is somewhat counterintuitive, and it has not gone unchallenged. Cohen (1992) has offered an alternative explanation on the basis of availability of hospital contact rather than the actual course of schizophrenia. Waxler-Morrison (1992), however, has challenged this reinterpretation and has corroborated positive outcomes in a five-year study of hospitalized schizophrenics in Sri Lanka. Kurihara, Kato and Yagi (2000) compared prognosis of schizophrenic patients in Japan and Bali. Consistent with the WHO finding, five-year prognosis was better for patients in Bali in terms of length of hospital stay, social participation, and percent of follow-up patients on drug treatment. A significantly higher proportion of Bali patients were married, lived with extended families, and were less educated than Japanese patients. Jablensky and Sartorius (1988) asserted that the culturally relativistic position that schizophrenia is labeled and identified differently across cultures has received little support from the findings of the WHO series of studies.

If culture impinges upon the experience of schizophrenia, it may do so in a subtle manner. A promising area of research is focused upon expressed emotion (EE). This variable has been demonstrated to have a prognostic significance in Great Britain and North America (Leff & Vaughn, 1986) Specifically, emotional, negatively toned communications toward the patient by the members of his or her family increase the likelihood of relapse. Across cultures, however, the proportion of EE communications is highly variable, and its rate in India is found to be about half of what it is in Britain (Wig et al., 1987). Could this be one of the reasons why the prognosis for schizophrenia is better in India than in the United Kingdom?

Hallucinations are a prominent symptom of schizophrenia in many cultures. Al-Issa, 1977, 1995) has demonstrated that cultural concepts of reality are related to the attitudes toward hallucination and their thresholds of acceptability. Moreover, hallucinations trigger different social responses across cultures. The choice of sense modality, visual or auditory, is in part determined by culture. Whether a hallucinatory experience is construed as supernatural or pathological is again influenced by the prevailing cultural beliefs. Cultures do not simply differ in the frequency of hallucinations. As any other symptom, they occur in a context. Therefore, it is important to identify the antecedent and consequent events and to describe the setting in which hallucinations have occurred. Like any other behavior, hallucinations become a symptom when they are so labeled.

Cross-cultural research has also been extended to varieties of delusions. In particular, Stompe (2001) summarized research conducted over more than a century by saying that “religious delusions are most frequent in Catholic societies followed by Protestant and Islamic ones” (p. 17) while in Buddhist countries they are exceedingly rare. A recent comparison of religious delusions in Austria and in Pakistan sheds more light on this issue. In line with the above rank ordering of religious content of delusions, Austrians exceeded the Pakistanis in the frequency of religious delusions. Secular delusions, however, were also found to be more frequent in Austria than in Pakistan. Among Austrian patients negative delusions centered upon the patient’s person were invariably associated with a sense of transgression and an attendant feeling of guilt in an absolute ontological sense (Stompe & Strobl, 2000). These findings illustrate how the prevailing values and beliefs shape the content of delusions rather than cause them or trigger their appearance.

3.4. Anxiety disorders

In their review of anxiety in culture, Good and Kleinman (1985) concluded that anxiety disorders are present in all human societies, but that they differ in phenomenology, modes of expression, communication, and societal structuring. In light of this recognition, it is somewhat paradoxical that anxiety related phenomena across cultures have been studied less intensively and extensively than depression or schizophrenia. Perhaps the ready availability of depressives and schizophrenics in institutional settings has something to do with it. Patients with anxiety disorders, on the other hand, tend to be ambulatory and more difficult to track down.

In Hwu and Compton's (1994) comparison of epidemiological surveys in six countries, lifetime prevalence rates of specific anxiety disorders based on DIS differed markedly both across diagnostic categories and cultures. These findings are indicative of differences in thresholds for anxiety related experiences and manifestations. On the basis of reviewing mostly anthropological evidence, Pfeiffer (1994) concluded that traditional small-scale cultures are not immune to anxiety, and that they tend to be expressed in the form of intense avoidance reactions and panic states.

In one of the few studies that included both normal and clinical samples, Tseng, Asai, Jieqiu, Wibulwasd, Suryiani et al. (1990) investigated anxiety related symptomatology at five Asian sites, in Thailand, Bali (Indonesia), Taiwan, Mainland China, and Japan. In conformity with earlier predictions (Draguns, 1973, 1980), profiles of the patients in the five locations deviated from the baseline toward a magnification of symptoms observed among normals. Moreover, Tseng et al. found the greatest degree similarity between the Chinese participants on the mainland and Taiwan, presumably reflective of their shared cultural heritage.

Diagnosticians' practices also potentially contribute to the reported cross-cultural differences in anxiety related symptoms, as demonstrated by the comparisons of psychiatrists in Beijing, Tokyo, and Honolulu (Tseng, Xu, Ebata, Hsu, & Cui, 1986; Tseng, Asai, Kitanishi, McLaughlin, & Kyomen, 1992). In particular, disagreements revolved around neurasthenia versus adjustment disorder, and were particularly marked in the culturally shaped syndromes of social phobia in the United States and anthropophobia or *taijin kyofusho* in Japan. These findings were obtained on the basis of identical videotapes, with the diagnosticians abiding by their usual clinical practices. Presumably, discrepancies would have been reduced if a standardized international diagnostic system were employed.

Many of the intensively studied culture bound syndromes (CBS) represent the culturally structured anxiety syndromes, as prominently exemplified by *taijin kyofusho* in Japan (Russell, 1989; Tanaka-Matsumi, 1979), a similar anthropophobic disorder in China (Zhang, 1995), *koro* throughout Southeast Asia (Tseng et al. (1992), and *ataque de nervios* in Latin America (Guaranaccia, Rivera, Franco, & Neighbors, 1996). In addition to clinical, case-based description of CBS, recent studies have investigated the epidemiology of koro (Jilek, 1986; Tseng et al., 1988), have provided test based information about the patients of this disorder (Tseng, Mo et al., 1992), and have compared anthropophobic Chinese with their neurasthenic and normal counterparts in symptomatology, social relationships, and attitudes (Zhang, Yu, Draguns, Zhang, & Tang, 2000; Zhang, Yu, Tang, & Draguns, 2001). Tseng (2001) has proposed a comprehensive classification of these syndromes into culture-related beliefs, culture-patterned reactions for coping with stress, culturally shaped variations of psychopathology, culturally elaborated behavioral reactions, culturally provoked frequent occurrence of pathological conditions; and cultural interpretations of specific men-

tal conditions. Of the above examples, koro is based on a culturally shaped belief, and *taijin kyofusho*, anthropophobia, and *ataques de nervios* represent culturally shaped variants of psychopathology.

The Expanatory Model Interview Catalogue (EMIC) has been developed by Weiss et al. (1992) as an alternative to standardized assessment for identifying culture specific idioms of distress. It was applied by Guaranaccia et al. (1996) to investigate *ataque de nervios* in Puerto Rico in its social context and subjective experiences. Guarnaccia et al. found that it was the second most prevalent psychiatric disorder in Puerto Rico, barely behind generalized anxiety disorder.

3.5. Dissociative disorders and phenomena

CBS greatly overlap with dissociative conditions, "characterized by a loss of integration of faculties or functions that are normally integrated in consciousness." (Castillo, 1998, p. 223). An example of dissociative disorder is provided by an intermittent trance-like state marked by episodes of extreme restlessness, thrashing about of arms and legs, attempts at self-injurious behavior, inability to recognize members of one's family, and emitting animal calls, e,g., dog's bark. These behaviors were observed in rural Tipura in India (Chowdhury, Nath, & Chakraborty, 1993).

Dissociative manifestations are very much shaped by culture and are subject to imitation and epidemic spread. Cultural factors also determine the meaning that is attributed to these phenomena, and spiritual, magical, biological, or interpersonal causes may be assigned to them. Culture also affects the threshold beyond which dissociative manifestations may be regarded as symptoms of a psychological disorder (Pakaslahti, 2001). As all of the above factors tend to vary simultaneously, it has been difficult to initiate comparative research and the available documentation typically remains in the form of descriptive accounts (cf., Tseng, 2001).

Recently, however, the Dissociation Questionnaire has been developed by Vanderlinden, Van-Dyck, Vanderdeycken, Vertommen and Verkes (1993) in The Netherlands. It has been applied across several countries in Europe to investigate two plausible antecedents of dissociation: (1) the experience of abuse in childhood; and (2) the experience of totalitarian rule together with the subsequent split between public and private discourse (Sebre, 2000). Qualitative findings have provided preliminary support for the above relationships (Sebre, 2000). In the process, a paradox has been discovered in the form of relatively high rates of self-reported dissociative phenomena, for example among the general population in Latvia, while psychiatric diagnoses of dissociative disorders in the same country remain extremely rare and those of multiple personality are virtually absent (Sebre, 2000).

4. From psychopathology across cultures to culture in psychopathology

Our survey has demonstrated that the impact of culture upon psychopathology is considerable. It remains, however, to be ascertained what kinds of features or dimensions of culture are implicated in generating the distinctive manifestations of disturbance of a given time and place. This question can be posed emically and etically. Within an emic framework, symptoms have been traced to culturally shared preoccupations and themes (e.g., Kimura, 1995). Within an etic orien-

tation, antecedents, especially in the form of characteristic values and shared attitudes, are worth exploring in relation to psychopathological manifestations across cultures.

A set of four major dimensions of national cultures were identified by Hofstede (2001) on the basis of a worldwide multivariate investigation of work-related values, as follows: (1) individualism-collectivism, which pertains to the degree to which the person experiences himself or herself as an autonomous self-contained human being, as opposed to feeling inextricably integrated into the family or the community; (2) power distance, which is based on the acceptance and tolerance of inequality in status and income; (3) masculinity–femininity, which refers to the degree of differentiation of gender roles and to the emphasis on success and achievement vs interpersonal relationships and sympathy; and (4) uncertainty avoidance, defined on the basis of the degree of discomfort experienced in unstructured or unclear situations. To these four factorially derived dimensions, Hofstede (2001) added the axis of Confucian Dynamism, rooted in values dominant in China and developed by means of a very different methodology (Chinese Culture Connection, 1987; Hofstede & Bond, 1988). This construct emphasizes individual striving, social stability, and hierarchical or vertical human relationships. In Hofstede's (2001) recent reformulation, its gist boils down to long-term orientation in relation to values, goals, and rewards. The above five dimensions were extended beyond their original industrial organizational context to the school setting (Hofstede, 1986), the psychotherapy enterprise (Draguns, 1995, 1997), and the experience of subjective well-being (Arrindell et al., 1997). Expectations appear to be justified that Hofstede's continua are also relevant to psychopathology.

The self has evolved into a key construct in cultural psychology (Markus & Kitayama, 1991; Triandis, 1989). In particular, the contrast between self experience in individualistic and collectivistic cultures has been highlighted. An individualistic self is described as being clearly delineated, highly differentiated, and constant across situations and time. A collectivistic self is construed to be malleable across situations and to lack a sharp boundary between the person and other people. Rather, such a self is defined by the individual's distinctive relationships with significant other persons. Draguns (1985, 1987) has articulated the hypothetical attributes of the self to the other four cultural dimensions. In schematic form, this information is contained in Table 2.

High power distance is expected to promote the development of an encapsulated self, dependent for its worth on indices of status and prestige, while low power distance would foster a more permeable self, more closely linked to friendship and popularity. Masculinity is hypothesized to foster the development of a pragmatic self, crucially dependent on productivity, efficiency, and achievement while a feminine self is expected to value care, altruism, relationship, and feelings. Uncertainty avoidance would put a premium on consistency and articulation of self-experience at the high end of the continuum; at the low end, an intuitive self would be valued, and unverbalized aspects of self experience would be tolerated. Finally, Confucian dynamism or long-term orientation would emphasize self-control and self-restraint; its Western contrast would thrive on self-assertion and self-actualization.

These formulations are easily extended to symptomatology, which is also described in Table 2. In individualistic cultures, psychopathology is expected to be characterized by guilt, alienation, and loneliness; distress and frustration in collectivistic cultures would be focused upon unrewarding personal relationships, social rejection, and shame. Power distance may be associated with a sense of inadequacy and failure for not meeting conventional standards of success. Masculinity may breed a sense of guilt and self-blame while femininity would be associated with anxiety-

Table 2
Hofstede's five dimensions in relation to self and symptoms

Individualism–Collectivism		
Individualism		**Collectivism**
Self:	Autonomous	Contextual
	Private, differentiated	Public, less differentiated, "fuzzy boundaries" between self and others
	Constant, slow to change	Malleable, adaptable to situations
Symptoms and Issues:	Guilt	Shame
	Loneliness	Rejection
	Alienation	Social conflict and disharmony
	Grandiosity	Social phobia and self-consciousness
	Narcissism	
Power distance		
	Low	**High**
Self:	Permeable	Encapsulated
	Relationships important	Status and wealth important
Symptoms and Issues:	Internal conflict	Sense of failure
	Personal uncertainty & confusion	Self-blame
Femininity/masculinity		
	Femininity	**Masculinity**
Self:	Altruistic	Pragmatic
	Care-oriented	Performance-oriented
	Sensitive	Efficient
Symptoms and Issues:	Anxiety	Guilt
	Feeling misunderstood	Skill & performance deficits
	Unsatisfied dependent needs	Inadequate sense of control and compentence
Uncertainty avoidance		
	High	**Low**
Self:	Articulate, consistent	Partially verbalized, somewhat inconsistent
	Rational	Intuitive
Symptoms and Issues:	Well delineated, specific	More amorphous, hard to verbalize
	Intellectualization of distress and discomfort	Spontaneous expression
	Constricted feelings	Emotional liability
	Tension anxiety	Confusion, helplessness
Dynamism (orientation)		
	Western (Short-term)	**Confucian (Long-term)**
Self:	Self-expression	Self-control
	Self-assertion	Self-effacement
	Self-actualization	Self-subordination
Symptoms and Issues:	Psychological discomfort	Bodily distress
	Insensitivity to others	Overaccommodation to others
	Elaborate construals of own actions and behaviors, often faulty	Limited self-understanding and insight
	Impulsivity under stress	Passivity under stress

related and dependent symptoms. Uncertainty avoidance may be linked to highly articulate and well delineated symptoms. Long-term orientation would direct attention to bodily discomfort and distress and would be associated with few psychological symptoms and with their minimal elaboration. It would also favor excesses of self-control and self-abnegation, in contrast to short-term orientation which would promote symptoms associated with grandiosity and narcissim. It should be emphasized that all of the proposed relationships are inferential and conjectural at this point. If corroborated by systematic research, they would open the possibilities of adjusting techniques of intervention to culturally dominant values and expectations.

5. Conclusions

1. This review documents substantial advances in research on psychopathology and culture achieved over the recent three decades. Both etic and emic approaches have been operationalized and refined. The bulk of this information has been gathered in the course of cross-cultural comparisons. Time is ripe for a partial shift toward a more emic orientation in conceptualization and data gathering. Eventually, we expect convergence and integration of these two approaches as etic research is informed by greater cultural sensitivity and emic studies become more objective, quantified, and rigorous (Tanaka-Matsumi, 2001; Tanaka-Matsumi & Draguns, 1997).
2. Cultural research on psychopathology starts with the development of scales and other instruments of assessment. It culminates with their application across and within cultures. The past several decades have seen a major spurt in the standardization, validation, and utilization of such measures. These tools are proving their usefulness in the assessment of help seeking individuals in their respective cultural milieus, as a prelude to more flexible, sensitive, and effective intervention.
3. In epidemiological research, the development of standardized procedures has led to comparisons of data across cultures. In smaller scale cross-cultural studies, both normal and psychopathological samples have been included in a few pioneering investigations. This development has enabled researchers to put to the test two general hypotheses about the nature of the relationship of abnormal behavior and culture. Thus, Marsella's (1988) expectation that cultural variability decreases as psychological disturbance becomes more severe was tentatively confirmed in a comparison in Sweden and Nicaragua of normal, borderline, and schizophrenic individuals (Sundbom, Jacobsson, Kullgren, & Penayo, 1998). Draguns (1973, 1980) anticipated exaggeration of cultural differences in psychopathology; this notion has received support in one study (Tseng et al., 1990) while two investigations (Räder et al., 1990; Radford, 1989) have yielded ambiguous results.
4. A substantial amount of findings has accumulated on the universal features of psychopathology, especially in relation to schizophrenia and depression. These results invariably coexist with substantial differences in symptomatology and other features across cultures. In line with Marsella's (1988) hypothesis, such differences appear to be more pronounced as the disorders become less disabling.
5. An open question pertains to the extent and nature of the links between psychopathology and cultural characteristics. Predictions have been advanced about the psychopathological reflections of Hofstede's (2001) cultural dimensions, but they remain to be systematically tested.

6. Guilt and somatization have emerged as two prominent sources of variation across cultures. Both of these variables, and many others, interact in a complex and shifting fashion with a variety of social, contextual, and psychopathological variables which have not yet been completely disentangled.
7. Culturally characteristic features of abnormal behavior are invariably expressed in the course of an encounter between the patient and the observer(s) in a specified culturally distinctive context. Yet, in most of the research reviewed, "culture of diagnosticians has been forgotten and cultural context has received minimal research attention." (Tanaka-Matsumi, 1999, p. 24). The challenge remains to recognize the importance of the observer and the milieu and to incorporate these variables into future studies.
8. It is often overlooked that the impact of culture upon psychological disturbance is recorded at a specific point in both space and time. With the fast pace of social transformation and increasing globalization, many of the findings recorded here may become obsolete. Abrupt and unanticipated social change, such as the collapse of the Soviet regime in Russia, is likely to enhance some symptoms and reduce others (cf. Korolenko & Dmitriyeva, 1999). The task of culturally oriented investigators is to follow and document the trends that such events may both shape and provoke, especially in relation to distress and disability.
9. The bulk of empirically ascertained knowledge in this area pertains to the effects of culture upon the manner in which psychological disorder is experienced, expressed, and communicated. As yet, very little is known about any cultural causation of psychopathology, which remains an important if elusive field of investigation (Jilek, 1982; Tseng, 2001).
10. It should be emphasized that the findings we have reviewed pertain to trends rather than types. Invariably, there is overlap between cultures. Moreover, cultural characteristics described in this article stand in a complex relationship to individual differences with culture. For example, there are many individualists in cultures deemed collectivistic, and vice versa. Taking note of cultural features, we strongly caution against converting them into stereotypes.

References

Abe, Y. (1996). Spain to Nipon ni okeru utsubyou no hikakubunka seishim igakuteki kenkyu: utsubyousha no byouzen seikaku o chuushinni (A transcultural psychiatric study of depression in Spain and Japan: Focusing on the premorbid personality of depression). *Nipponn Shakai Seishinn Igakkai Zasshi*, *5*, 63–79 (in Japanese).

Abe, Y. (2001). Algunos razgos de pacientes depresivos en Japon. (Some characteristics of depressive patients in Japan) Paper at Andorra 2001 Transcultural Psychiatry Section Symposium, Andorra la Vella (in Spanish).

Adebimpe, V. R. (1981). Overview: White norms and psychiatric diagnoses of black patients. *American Journal of Psychiatry*, *138*, 279–285.

Al-Issa, I. (1977). Social and cultural aspects of hallucinations. *Psychological Bulletin*, *84*, 167–176.

Al-Issa, I. (1995). The illusion of reality or the reality of illusion. Hallucinations and culture. *British Journal of Psychiatry*, *166*, 368–373.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Arrindell, W. A., Hatzichristou, C., Wensink, J., Rosenberg, E., van Twillert, B., Stedema, J., & Meijer, D. (1997). Dimensions of national culture as predictors of cross-national differences in subjective well-being. *Personality and Individual Differences*, *23*, 37–53.

Bateson, G., Jackson, D. D., Haley, J., & Wheatland, J. (1956). Toward a theory of schizophrenia. *Behavioral Science*, *1*, 251–264.

Benedict, R. (1934). Culture and the abnormal. *Journal of Genetic Psychology*, *10*, 59–82.
Betancourt, H., & López, S. R. (1993). The study of culture, ethnicity and race in American psychology. *American Psychologist*, *48*, 629–637.
Canino, G., Lewis-Fernandez, R., & Bravo, M. (1997). Methodological challenges in cross-cultural mental health research. *Transcultural Psychiatry*, *34*, 163–184.
Castillo, R. J. (1998). *Meanings of madness*. Pacific Grove, CA: Brooks/Cole.
Cheetham, R. W. S., & Griffiths, J. A. (1981). Errors in the diagnosis of schizophrenia in Black and Indian patients. *South African Medical Journal*, *59*, 71–75.
Cheung, F. M. C. (1989). The indigenization of neurasthenia in Hong Kong. *Culture, Medicine and Psychiatry*, *13*, 227–241.
Chinese Culture Connection (1987). Chinese values and the search for culture-free dimensions of culture. *Journal of Cross-Cultural Psychology*, *18*, 143–164.
Chowdhury, A. N., Nath, A. K., & Chakraborty, J. (1993). An atypical hysteria epidemic in Tripura, India. *Transcultural Psychiatric Research Review*, *30*, 143–151.
Cohen, A. (1992). Prognosis for schizophrenia in the Third World: A reevaluation of cross-cultural research. *Culture, Medicine and Psychiatry*, *16*, 53–75.
Cooper, J. E., Kendell, R. E., Gurland, B. J., Sharpe, L., Copeland, J. R. M., & Simon, R. (1972). *Psychiatric diagnosis in New York and London*. London: Oxford University Press.
Day, R., Nielsen, J. A., Korten, A., Ernberg, G., Dube, K. C., Gebhart, J., Jablensky, A., Leon, C., Marsella, A. J., Olatawura, M., Sartorius, N., Stromgren, E., Takahashi, R., Wig, N., & Wynne, L. C. (1987). Stressful life events preceding the acute onset of schizophrenia: A cross-national study from the World Health Organization. *Culture, Medicine and Psychiatry*, *11*, 123–205.
Devereux, G. (1961). *Mohave ethnopsychiatry and suicide: the psychiatric knowledge and the psychic disturbances of an Indian tribe*. Washington, DC: Smithsonian Institution, Bureau of American Ethnology, No. 1975.
Doi, T. L. (1973). *Anatomy of dependence*. Tokyo: Kodansha (translated by J. Beiser).
Draguns, J. G. (1973). Comparisons of psychopathology across cultures: Issues, findings, directions. *Journal of Cross-Cultural Psychology*, *4*, 9–47.
Draguns, J. G. (1975). Resocialization into culture: The complexities of taking a worldwide view of psychotherapy. In R. W. Brislin, S. Bochner, & W. J. Lonner (Eds.), *Cross-cultural perspectives on learning* (pp. 273–289). Beverly Hills, CA: Sage Publications.
Draguns, J. G. (1990). Normal and abnormal behavior in cross-cultural perspective: Specifying the nature of their relationship. In J. J. Berman (Ed.), *Nebraska Symposium on Motivation, 1989: Cross-cultural perspectives*, 37. Lincoln, NE: University of Nebraska Press.
Draguns, J. G. (1995). Cultural influences upon psychopathology: Clinical and practical implications. *Journal of Social Distress and the Homeless*, *4*(2), 79–103.
Draguns, J. G. (1996). Multicultural and cross-cultural assessment of psychological disorder: Dilemmas and decisions. In G. R. Sodowsky, & J. Impara (Eds.), (pp. 37–84). *Multicultural assessment in counseling and psychology (Buros-Nebraska Symposim on Measurement and Testing*, 9. Lincoln, NE: Buros Institute of Mental Measurements.
Draguns, J. G. (1997). Abnormal behavior patterns across cultures: Implications for counseling and psychotherapy. *International Journal of Intercultural Relations8*, *21*, 213–248.
Draguns, J. G. (2000). Psychopathology and ethnicity. In J. F. Aponte, & J. Wohl (Eds.), *Psychological intervention and cultural diversity* (pp. 40–58). Boston, MA: Allyn & Bacon.
Egeland, J. A., Hostetter, A. M., & Eshleman, S. K. (1983). Amish Study: 3. The impact of cultural factors on diagnosis of bipolar illness. *American Journal of Psychiatry*, *140*, 67–71.
Escobar, J., Karno, M., Burnam, A., Hough, R. L., & Golding, J. (1988). Distribution of major mental disorders in a US metropolis. *Acta Psychiatrica Scandinavica Suppl*, *344*, 45–54.
Fabrega, H. (1974). Problems implicit in the cultural and social study of depression. *Psychosomatic Medicine*, *36*, 377–398.
Good, B., & Kleinman, A. (1985). Culture and anxiety: Cross-cultural evidence for the patterning of anxiety disorders. In A. H. Tuma, & J. D. Maser (Eds.), *Anxiety and anxiety disorders* (pp. 297–324). Hillsdale, NJ: Lawrence Erlbaum.
Guaranaccia, P. J., Rivera, M., Franco, F., & Neighbors, C. (1996). The experiences of ataques de nervios: Towards an anthropology of emotions in Puerto Rico. *Culture, Medicine and Psychiatry*, *10*, 343–367.

Herskovits, M. (1949). *Man and his works*. New York: Knopf.
Hofstede, G. (1986). Cultural differences in teaching and learning. *International Journal of Intercultural Relations, 10*, 301–320.
Hofstede, G. (2001). *Culture's consequences: Comparing values, institutions and organisations across nations* (2nd ed.). Thousand Oaks, CA: Sage.
Hofstede, G., & Bond, M. H. (1988). The Confucius connection: From cultural roots to economic growth. *Organizational Dynamics, 16*(4), 4–21.
Hwu, H. G., & Comptom, W. M. (1994). Comparison of major epidemiological surveys using the diagnostic interview schedule. *International Review of Psychiatry, 6*, 309–327.
Jablensky, A., & Sartorius, N. (1988). Is schizophrenia universal? *Acta Psychiatrica Scandinavica, 78*, 65–70.
Jablensky, A., Sartorius, N., Ernberg, G., Anker, M., Korten, A., Cooper, J. E., Day, R., Bertelsen, A. (1992). *Schizophrenia: Manifestations, incidence, and course in different cultures: A World Health Organization Ten Country Study*. Psychological Medicine Monograph Supplement 20. Cambridge: Cambridge University Press.
Jilek, W. G. (1982). Culture—'pathoplastic' or 'pathogenic'? A key question of comparative psychiatry. *Curare, 5*, 57–68.
Jilek, W. G. (1986). Epidemic of 'genital shrinking' (koro): Historical review and report of a recent outbreak in South China. *Curare, 9*, 269–282.
Jilek, W. G. (1995). Emil Kraepelin and comparative sociocultural psychiatry. *European Archives of Psychiatry and Clinical Neuroscience, 245*, 231–238.
Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., Wittchen, H. U., & Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry, 51*, 8–19.
Kimura, B. (1995). *Zwischen Mensch und Mensch (Between one human being and another)*. Darmstadt, Germany: Akademische Verlaganstalt (translated by H. Weinhendl).
Kirmayer, L. J. (1984). Culture, affect, and somatization: Parts 1 and 2. *Transcultural Psychiatric Research Review, 21*, 159–262 & 237–262.
Kleinman, A. (1977). Depression, somatization, and the 'New Cross-Cultural Psychiatry'. *Social Science and Medicine, 11*, 3–9.
Kleinman, A. (1978). Clinical relevance of anthropological and cross-cultural research: Concepts and strategies. *American Journal of Psychiatry, 135*, 427–431.
Kleinman, A. (1982). Neurasthenia and depression: A study of somatization and culture in China. *Culture, Medicine, and Psychiatry, 6*, 117–189.
Kleinman, A. (1988). *Rethinking psychiatry: From cultural category to personal experience*. New York: Free Press.
Kleinman, A., & Kleinman, J. (1985). Somatization: The interconnections in Chinese society among culture, depressive experiences, and the meaning of pain. In A. Kleinman, & B. Good (Eds.), *Culture and depression* (pp. 429–490). Berkeley, CA: University of California Press.
Korolenko, C. P., & Dmitriyeva, N. (1999). *Sotsiodinamicheskaya psikhiatriya (Sociodynamic psychiatry)*. Novosibirsk. Russia: Novosibirsk State Pedagogical University Press (in Russian).
Kraepelin, E. (1904). Vergleichende Psychiatrie (Comparative psychiatry). *Zentralblatt für Nervenheilkunde und Psychiatrie, 27*, 433–437 (in German).
Kurabayashi, L. (2001). 'Karo-Jisatsu'—Suicide from overwork in Japan. Paper at Andorra 2001 Transcultural Psychiatry Symposium, Andorra la Vella.
Kurihara, T., Kato, M., & Yago, G. (2000). Bali tou ni okeru seishinbunretsubyo no yogo: yogo ni eikyousuru shakaitekina inshi ni tsuite (Outcome of schizophrenia in Bali: Socio-cultural factors associated with outcome). *Seishisn Ryouhou, 26*, 451–460 (in Japanese).
Lee, S., & Wong, K. C. (1995). Rethinking neurasthenia: The illness concepts of shenjing shuairuo among Chinese undergraduates in Hong Kong. *Culture, Medicine and Psychiatry, 19*, 91–111.
Leff, J., & Vaughn, C. (1986). *Expressed emotion in families: Its significance for mental illness*. New York: London.
López, S. R. (1989). Patient variable biases in clinical judgment: Conceptual overview and methodological considerations. *Psychological Bulletin, 106*, 184–204.
Manson, S. M., Shore, J. G., & Bloom, J. D. (1985). The depressive experience in American Indian communities: A

challenge for psychiatric theory and diagnosis. In A. Kleinman, & B. Good (Eds.), *Culture and depression* (pp. 331–368). Berkeley, CA: University of California Press.

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review, 98*(2), 224–253.

Marsella, A. J. (1980). Depressive experience and disorder across cultures. In H. C. Triandis, & J. G. Draguns (Eds.), (pp. 233–262). *Handbook of cross culturual psychology: Psychopathology*, 6. Boston, MA: Allyn and Bacon.

Marsella, J. A. (1988). Cross-cultural research on severe mental disorders. Issues and findings. *Acta Psychiatrica Scandinavica Suppl, 344*, 7–22.

Marsella, A. J., Sartorius, N., Jablensky, A., & Fenton, F. (1985). Cross-cultural studies of depressive disorders: An overview. In A. Kleinman, & B. Good (Eds.), *Studies in the anthropology and cross-cultural psychiatry of affect and disorders* (pp. 299–324). Berkeley, CA: University of California Press.

Murphy, H. B. M. (1978). The advent of guilt feelings as a common depressive symptom: A historical comparison on two continents. *Psychiatry, 41*, 229–242.

Murphy, H. B. M. (1982). Culture and schizophrenia. In I. Al-Issa (Ed.), *Culture and psychopathology* (pp. 221–250). Baltimore, MD: University Park Press.

Nathan, T. (1994). *L'influence qui quérit (The healing influence)*. Paris: Odile Jacob (in French).

Nathan, T., & Hounkpatin, L. (1998). *La guérison Yoruba (Yoruba healing)*. Paris: Odile Jacob (in French).

Neal, A. M., & Turner, S. M. (1991). Anxiety disorders research with African Americans: Current status. *Psychological Bulletin, 109*, 400–410.

Ots, T. (1990). The angry liver, the anxious heart, and the melancholy spleen. The phenomenology of perceptions in Chinese culture. *Culture, Medicine, and Psychiatry, 14*, 21–58.

Pakaslahti, A. (2001). Dissociative disorder and possession: A cross-cultural comparison. Paper at Andorra 2001 Transcultural Studies Section, Andorra la Vella.

Perris, C. (1988). A theoretical framework for linking the experience of dysfunctional parental rearing attitudes with manifest psychopathology. *Acta Psychiatrica Scandinavica Suppl, 244*, 93–109.

Pfeiffer, W. (1994). *Transkulturelle Psychiatrie: Ergebnisse und Probleme* [*Transcultural psychiatry: Findings and problems*] (2nd ed.). Stuttgart: Thieme.

Prince, R. H. (1968). The changing picture of depressive syndromes in Africa: Is it fact or diagnostic fashion? *Canadian Journal of African Studies, 1*, 177–192.

Radford, M.H.B. (1989). *Culture, depression, and decision- making behaviour: A study with Japanese and Australian clinical and non-clinical populations*. Unpublished Doctoral Dissertation, Flinders University of South Australia.

Rao, A. V. (1973). Depressive illness and guilt in Indian cultures. *Indian Journal of Psychiatry, 23*, 213–221.

Ridley, C. R. (1989). Racism in counseling as an adversive behavioral process. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (3rd ed.) (pp. 55–77). Honolulu, HI: University of Hawaii Press.

Rin, H., & Lin, T. Y. (1962). Mental illness among Formosan Aborigines as compared with Chinese in Taiwan. *Journal of Mental Science, 108*, 123–146.

Robins, L.N., & Regier, D.A. (Eds.). (1991). *Psychiatric disorders in America: the Epidemiologic Catchment Area Study*. New York: The Free Press.

Roelandt, J.-L. (2001). Echanges internationaux: Culture et santé mentale (International exchanges: Culture and mental health). Paper at Andorra 2001 Transcultural Psychiatry Section Symposium, Andorra la Vella.

Rohner, R. (1986). *The warmth dimension*. Newbury Park, CA: Sage.

Russell, J. G. (1989). Anxiety disorders in Japan: A review of the Japanese literature on Shinkeishitsu and Taijin Kyofusho. *Culture, Medicine, and Psychiatry, 13*, 391–403.

Sartorius, N., & Janca, A. (1996). Psychiatric assessment instruments developed by the World Health Organization. *Social Psychiatry and Psychiatric Epidemiology, 31*, 55–69.

Sebre, S. (2000). Dissociation, hostility, resentment, and intolerance in relation to familial and political abuse. *Journal of Baltic Psychology, 1*, 27–45.

Seiden, D.Y. (1999). *Cross-cultural behavioral case formulation with Chinese neurasthenia patients*. Unpublished doctoral dissertation, Hofstra University, Hempstead, NY.

Shakoor, M.A. (1992). *Kontollüberzeugungen Depressiver im transkulturellen Vergleich. Eine Studie uber kognitive Orientierungen depressiver afghanischer, ägyptischer und deutscher Patienten. (Control beliefs of depressives in a*

transcultural comparison. A study of cognitive orientations of depressed Afghan, Egyptian, and German patients). Unpublished Doctoral Dissertation in medicine, Georg August University of Gőttingen, Germany.

Sow, I. (1980). *Anthropological structures of madness in Black Africa*. New York: International Universities Press.

Stompe, T. (2001). Religious delusions among schizophrenia. *Newsletter Transcultural Psychiatry Section World Psychiatric Association*, *19*(1), 16–19.

Stompe, T., & Strobl, R. (2000). Negative Wahnidentitäten in schizophrenen Psychosen (Negative delusional identities in schizophrenia psychoses). *Fortschritte der Neurologie und Psychiatrie*, *68*, 169–175 (in German).

Sundbom, E., Jacobsson, L., Kullgren, G., & Penayo, U. (1998). Personality and defenses: A cross-cultural study of psychiatric patients and healthy individuals in Nicaragua and Sweden. *Psychological Reports*, *83*, 1331–1347.

Tanaka-Matsumi, J. (1979). Taijin Kyofusho, Diagnostic and cultural issues in Japanese psychiatry. *Culture, Medicine and Psychiatry*, *3*, 231–245.

Tanaka-Matsumi, J. (1992). Cultural and social factors in depression. Unpublished paper.

Tanaka-Matsumi, J. (1999). What happened to comparisons of mental health diagnosis across cultures? *Cross-Cultural Psychology Bulletin*, *33*(3 & 4), 22–26.

Tanaka-Matsumi, J. (2001). Abnormal psychology and culture. In D. Matsumoto (Ed.), *The handbook of culture and psychology* (pp. 265–286). New York: Oxford University Press.

Tanaka-Matsumi, J., & Draguns, J. G. (1997). Culture and psychopathology. In J. Berry, M. H. Segall, & C. Kâgitçibasi (Eds.), *Handbook of cross-cultural psychology 3: Social psychology* (2nd ed.) (pp. 449–491). Boston, MA: Allyn and Bacon.

Tanaka-Matsumi, J., & Higginbotham, N. H. (1996). Behavioral approaches to cross-cultural counseling. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (4th ed.) (pp. 236–292). Newbury Park, CA: Sage.

Tanaka-Matsumi, J., & Marsella, A. J. (1976). Cross-cultural variations in the phenomenological experience of depression: I. Word association studies. *Journal of Cross-Cultural Psychology*, *7*, 379–396.

Tanaka-Matsumi, J., Seiden, D. Y., & Lam, K. (1996). Culturally-Informed Functional Assessment (CIFA) Interview: Cross-cultural behavioral practice. *Cognitive and Behavioral Practice*, *2*, 215–233.

Tellenbach, H. (1976). *Melancholie (Melancholia)*. Heidelberg: Springer.

Thakker, J., & Ward, T. (1998). Culture and classification: The cross-cultural application of the DSM-IV. *Clinical Psychology Review*, *18*, 501–529.

Triandis, H. C. (1989). The self and social behavior in differing cultural contexts. *Psychological Review*, *96*, 506–520.

Triandis, H. C. (1972). *Subjective culture*. New York: Wiley.

Tseng, W. S. (2001). *Handbook of cultural psychiatry*. San Diego, CA: Academic Press.

Tseng, W. S., Asai, M., Kieqiu, L., Wibulswasd, P., Suryani, L. -K., Wen, L. -K., Brennan, J., & Heiby, E. (1990). Multicultural study of minor psychiatric disorders in Asia: symptom manifestations. *The International Journal of Social Psychiatry*, *36*, 252–264.

Tseng, W. S., Asai, M., Kitanishi, K., McLaughlin, D., & Kyomen, H. (1992). Diagnostic patterns of social phobia: Comparison in Tokyo and Hawaii. *Journal of Nervous and Mental Disease*, *180*, 380–385.

Tseng, W. S., Mo, K. W., Hsu, J., Li, L. S., Ou, L. W., Chen, G. Q., & Jiang, D. W. (1988). A sociocultural study of koro epidemincs in Guandong, China. *American Journal of Psychiatry*, *145*, 1538–1543.

Tseng, W. S., Mo, G. M., Hsu, J., Li, L. S., Chen, G. Q., Ou, L. W., & Zeng, H. B. (1992). Koro epidemics in Guandong, China: A questionnaire survey. *Journal of Nervous and Mental Disease*, *180*, 117–123.

Tseng, W. S., Xu, N., Ebata, K., Hsu, J., & Cui, Y. (1986). Diagnostic pattern of neurosis among China, Japan and America. *American Journal of Psychiatry*, *143*, 1010–1014.

Vanderlinden, J., Van Dyck, R., Vanderdeycken, W., Vertommen, H., & Verkes, R. J. (1993). The Dissociation Questionnaire (DIS-Q): Development and characteristics of a new self-report questionnaire. *Clinical Psychology & Psychotherapy*, *1*, 21–27.

Waxler-Morrison, N. E. (1992). 'Prognosis for schizophrenia in the Third World: A reevaluation of cross-cultural research': Commentary. *Culture, Medicine and Psychiatry*, *16*, 77–80.

Weissman, M. M., Bland, R. C., Canino, G. J., Faravelli, C., Greenwald, S., Hwu, H. G., Joyce, P. R., Karam, E. G., Lee, E. G., Lellouch, J., Lepine, J. P., Newman, S. C., Rubio-Stipec, M., Wells, J. E., Wickmaratne, P. J., Wittchen, H. U., & Yeh, E. K. (1996). Cross-national epidemiology of major depressive and bipolar disorder. *Journal of the American Medical Association*, *276*, 293–299.

Westermeyer, J. (1987). Cultural factors in clinical assessment. *Journal of Consulting and Clinical Psychology*, *55*, 471–479.

World Health Organization (1973). *Report of the international pilot study of schizophrenia*. Geneva: Author.

World Health Organization (1980). *Schizophrenia: An international follow-up study*. Geneva: Author.

World Health Organization (1983). *Depressive disorders in different cultures: report of the WHO collaborative study of standardized assessment of depressive disorders*. Geneva: Author.

Yap, P. M. (1971). Guilt and shame, depression and culture: A psychiatric cliché reexamined. *Community Contemporary Psychology*, *1*, 35–53.

Zhang, A.Y. (1995). *Anthropophobia in Chinese young adults*. Unpublished Doctoral Dissertation, Pennsylvania State University, PA.

Zhang, A. Y., Yu, L. C., Draguns, J. G., Zhang, J., & Tang, D. (2000). Sociocultural context of anthropohobia: a sample of Chinese youth. *Social Psychiatry and Psychiatric Epidemiology*, *35*, 418–426.

Zhang, A. Y., Yu, L. C. J., Tang, D., & Draguns, J. G. (2001). Anthropophobia: Its meaning and concomitant experiences. *International Journal of Social Psychiatry*, *47*, 56–70.

Zhang, M. -Y. (1989). The diagnosis and phenomenology of neurasthenia: A Shanghai study. *Culture, Medicine and Psychiatry*, *13*, 147–161.