

Cultural differences in conceptual models of depression

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Abstract

Members of ethnic minority groups are less likely than white middle class people to seek professional treatment for depression and other mental health problems. One explanation is that the former conceptualize depressive symptoms as social problems or emotional reactions to situations, while the latter are more apt to view depression as a disease requiring professional treatment. Though considerable evidence supports this hypothesis, it is rarely explored directly through cross-cultural comparisons. The present study compares conceptual models of depressive symptoms in two diverse cultural groups in New York City (USA): 36 South Asian (SA) immigrants and 37 European Americans (EA) were presented with a vignette describing depressive symptoms and participated in a semi-structured interview designed to elicit representational models of the symptoms.

Results indicate pervasive differences in representational models across the two groups. SA participants identified the “problem” in the vignette in largely social and moral terms. Suggestions for management and health seeking in this group emphasized self-management and lay referral strategies. EAs, by contrast, often proposed alternate, sometimes contradictory, explanatory models for the depressive symptoms. One model emphasized biological explanations ranging from “hormonal imbalance” to “neurological problem.” The second model resembled the “situational stress” or “life problem” model described by SAs.

The implications of these findings, and directions for future research, are discussed.

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Introduction

Though depressive illness is common in many societies and has been defined in recent years as a major global public health problem, professional treatment seeking is relatively rare in many non-western societies and among immigrant and minority groups in the west. Recent studies of African Americans (Sussman, Robins, & Earls, 1987; Swartz et al., 1998), Latinos (Padgett, Patrick, Burns, & Schlesinger, 1994; Wells, Katon,

Rogers, & Camp, 1994), and Asian Americans (Sue, Nakamura, Chung, & Yee-Bradbury, 1994; Ying & Miller, 1992) confirm that members of these ethnic groups are less likely than whites to utilize voluntary specialty mental health treatment.

Several hypotheses have been proposed to account for ethnic/cultural differences in treatment seeking. One of these is the somatization hypothesis (Ryder, Yang, & Heine, 2002). This hypothesis proposes that people from traditional cultural backgrounds either deny psychological distress, interpret such distress as somatic illness, or present distress as physical illness in medical settings. Recent research, however, suggests that somatic

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symptoms are strongly associated with psychological stress in western as well as traditional societies (Gureje, Simon, Ustun, & Goldberg, 1997), and that depressed patients from ethnic minority groups are no more likely than European Americans to deny emotional distress (Kirmayer, Robbins, Dworkind, & Yaffe, 1993). A second hypothesis focuses on stigma, suggesting that cultural or ethnic differences in treatment seeking are accounted for by the greater stigma with which non-western and non-middle class people regard mental illness (Durvasula & Mylvaganam, 1994; Tsai, Teng, & Sue, 1980). Again, some recent data raise the question of whether traditional interpretations of psychiatric illness are less stigmatizing than psychiatric models (Jenkins, 1988) and whether concerns over stigma constitute a significant barrier to health seeking among ethnic minority groups (Sussman et al., 1987).

A third hypothesis frames a broader argument, attributing cultural differences in treatment seeking to differences in conceptual models of depressive symptoms across cultures. Evidence suggests that while members of white middle class communities in western societies may be uniquely apt to view depression as a medical problem requiring professional treatment, more traditional groups conceptualize depressive symptoms as social problems or as emotional reactions to situations (Jacob, Bhugra, Lloyd, & Mann, 1998). Yet this hypothesis has rarely been explored explicitly through cross-cultural comparisons. The present study uses a vignette methodology and a multi-dimensional model of illness representation from the health psychology literature to compare conceptual models of depressive symptoms in two groups of New Yorkers: a white, middle class group and a traditional immigrant group.

Background: culture and the disease model of depression

The biopsychiatric model of depression, a disease model which emphasizes the roots of the disorder in anatomy, heredity, and disease processes, is more common in western societies than elsewhere (Keyes, 1985). Conversely, a “situational” model that describes psychological distress in the context of social and interpersonal situations may be a more common explanatory strategy in traditional societies and minority communities in the west (Patel, 1995).

On the other hand, studies carried out under the rubric of “mental health literacy” research suggest that “situational” models of depression are common even in advanced western countries, and that such models are often associated with negative attitudes towards professional treatment. Surveys of the general public in Australia and New Zealand (Jorm et al., 2000) and in Switzerland (Lauber, Nordt, Falcato, & Rossler, 2003) found that informal avenues of help were viewed as

more efficacious for depression than mental health professionals, and “life style” remedies more efficacious than antidepressants. Notably, studies that have examined the influences of ethnicity and SES factors on attitudes towards depression treatment consistently find that attitudes towards mental illness correlate with education, with more educated respondents more likely to hold favorable views of professional treatment (Jorm et al., 2000).

One explanation for these consistent findings is that medicalized models of depressive illness among educated lay people represent a form of “acculturation.” Such acculturation occurs as a function of the level of exposure to biopsychiatric models generated through professional psychiatric discourse. Education, as well as immigration, is a major source of such acculturation and is likely to have an impact on the conceptual representation of illness categories (Angel & Thoits, 1987).

A small number of studies in non-western societies conducted by anthropologists and cross-cultural psychiatrists have examined conceptual models of depressive symptoms. In a recent review of the literature on explanatory models of mental illness in sub-Saharan Africa, Patel and his colleagues (Patel, 1995) found that while the understanding of psychotic illness closely resembled that of western societies, conceptual models of neurotic illness differed sharply from western models. These conditions were commonly regarded as life situations. Vignette studies conducted by these authors in India (Patel, Pereira, & Mann, 1998) similarly found that depressive symptoms were viewed as a relatively normal reaction to severe social, personal threats and losses.

Studies of attitudes towards mental illness and culture among minority groups in the United States rarely examine conceptual models of mental illness directly. Most studies examine only a few of the dimensions of these models, such as symptom attribution or concepts of treatment. However, such studies provide hints that underlying cultural models of depression influence cultural differences in treatment seeking (Sussman et al., 1987; Karasz, Sacajiu, & Garcia, 2003).

The present study

We used a model from the health psychology literature called the illness representation model (IRM) (Leventhal, Nerenz, & Steele, 1984) to explore multiple dimensions of participants’ illness representations. The model proposes a five-dimensional structure of illness representation, which includes symptom label, the cause of symptoms, consequences, timeline, and management. Most studies based on the IRM have employed quantitative methods (Meyer, Leventhal, & Gutmann, 1985; Baumann & Leventhal, 1985;

Baumann, Cameron, Zimmerman, & Leventhal, 1989; Cameron, Leventhal, & Leventhal, 1993); however, the present study used qualitative interviews to generate narratives of depressive symptoms that might provide a richer understanding of the underlying logic of these representations. The analyses in the study focused on two goals: (1) to test the hypothesis that European American (EA) representations would more closely resemble a biopsychiatric model of depression than those of South Asians (SAs), while SA representations would reflect a situational model; and (2) to generate a rich description of the conceptual representations of depression in each group.

Methods

Sample

The goal of the study was to examine differences in illness representation in two cultural groups that would be expected to vary along the variable of interest: in this case, exposure to the biopsychiatric model of depression. To this end, a purposive sampling strategy was employed to select two theoretically diverse cultural groups. Married, upper middle class EA women from two affluent New York City neighborhoods were sampled to represent the “high exposure” group, while a group of mostly married working class, non-English speaking, SA immigrant women from a largely immigrant community in Queens were selected to represent the “low exposure” group. Since the goal was maximum variation in the two groups, no efforts were made to match them on socio-economic factors. The sample included 37 EA women and 36 SA women.

The study utilized a “snowball” or acquaintance sampling strategy. Women were asked to nominate friends or acquaintances similar to themselves. Specifically, we asked EA women to suggest other white, educated, married women living in their neighborhoods. SA women were asked to suggest friends and relatives whom they viewed as “traditional” in orientation: we assumed—correctly as it turned out—that this strategy would result in a sample of relatively recent immigrants.

Though the snowball method obviously calls into question the representativeness of the sample, it is deemed necessary in this particular case. The author’s

previous experience conducting research in the SA immigrant community (Karasz, 1997), as well as that of other researchers, suggests that privacy concerns among SAs make alternative sampling strategies unlikely to meet with success.

Procedures

The analyses presented here were part of a larger study examining vignette responses, health history, and symptom questionnaire data. Subjects were presented with a vignette describing a woman with emotional symptoms of depression (see Table 1). Subjects were asked to generate a representational model of the depressive symptoms utilizing a semi-structured query that focused on each of the five IRM dimensions, including: (1) identity of the illness, (2) antecedents or causes, (3) consequences and seriousness (the latter defined on a scale of 1–3), (4) timeline, and (5) treatment or management strategies which might be appropriate for these symptoms. Subjects were also asked to discuss their reactions, in an unstructured way, to the vignettes.

In addition, subjects were administered a demographic questionnaire that included questions about income and education, and, for the SA group, variables that have been associated with acculturation, including the ability to speak and read English, patterns of socialization, and details about the person’s immigration history. A composite measure of acculturation was devised using these variables, for the purposes of the present study.

The interview was developed in English and translated into Bengali, Gujarati, and Hindi/Urdu. The back-translation method was used to assure the linguistic equivalency of the interview. The interviews were taped. The interviewers (mostly master’s level psychology graduate students) transcribed the taped interviews, translating non-English interview responses into English. Special attention was given to SA vocabulary for illness and emotion states. Such terms were included in the English transcriptions along with their English translation or range of translations. Those that were ambiguous were discussed in detail by the research team. The interview took about two hours, and was conducted in the participant’s home. The interview was taped and transcribed. Subjects participated in an informed

Table 1
The vignette

For the past two weeks Sara/Monica had felt that something was wrong with her. When she sat and read the newspaper in the mornings before going to work, she could not concentrate on the words. Often during the day her eyes filled with tears, and she felt an intense sadness. Her friends at work tried to cheer her up, but they had no success. When her closest friend persuaded her to go to a movie they had both wanted to see, Sara/Monica could not pay attention. She felt she had no interest in anything she had once enjoyed.

consent process. The study was approved by the Albert Einstein College of Medicine Committee on Clinical Investigations.

Analyses

Hypothesis testing: The goal of this phase of the analysis was to test hypotheses about conceptual differences in models of depression across the two groups. It was hypothesized that EAs would report a more biopsychiatric model of depressive symptoms than SAs. “Biopsychiatry” was defined as the degree to which participants’ conceptual representations shared features of the western psychiatric disease model of depression. Conversely, it was hypothesized that SAs would report a more situational model of depression than EAs, with “situationalism” defined as the view of depressive symptoms as a reaction to life events and situations. “Biopsychiatry” and “situationalism” were conceptualized as non-orthogonal dimensions lying along a continuum, but individual representations could be “high” or “low” on both dimensions when, as was often the case, participants generated alternative explanations for the symptoms in the vignette.

To test the hypotheses about cultural differences, and, as an additional goal, to begin the preliminary development of a rating scale that might be used in future studies, narrative data from the study were quantified in order to generate variables for statistical analyses. A set of propositions derived from the research literature was combined into two rating scales. The first scale is called the biopsychiatric model scale (BPM). It consists of five items: “The problem is labeled as a disease or illness.” “The problem has a biological cause.” “The problem is rated as serious or very serious.” “The problem has a chronic or deteriorating course.” “Professional treatment is appropriate for this problem.” The second scale is called the situational model scale (SM). This consists of five items: “The problem is labeled as a situation or emotional reaction to a situation.” “The cause of the problem is an external event or situation.” “This problem may remit naturally.” “Recovery is linked to the underlying situation.” “Lay help seeking will help resolve this problem.” Each of the scale items was rated dichotomously and scale scores ranging from 0–5 were computed for each set of items.

Once these scales were developed and tested on a subset of the depression vignette responses, a trained rater blind to group identity and study hypotheses used the two rating scales to score the entire data set of 71 depression vignette responses. Psychometric tests found high rates of inter-item reliability ($\alpha > 0.75$) for each scale.

Descriptive analysis: The second goal of the study was to generate a detailed description of differences in the

conceptual representation of depression across the two cultural groups. This phase of the analysis involved the development of a content-oriented coding scheme. The coding scheme consisted of categories generated by participants, which were grouped into broad categories based on the dimensions of the IRM. Since the goal of this analytic phase was descriptive, rather than hypothesis testing, coders at this phase of the analysis were not blinded to overall study aims. Accordingly, this phase was accomplished by the investigator along with two research assistants. In a first step, small subsets of the data were coded by each of three pairs of coders. Since the codes were simple and descriptive, few differences in coding decisions emerged at this early stage. Any differences that did come up were resolved by discussion. In a second step, research assistants coded the complete data set. A sample of this coded data was again checked by the investigator: again, few discrepancies were noted. Examples of coded responses could include “label/ sad,” “cause/hormonal imbalance,” “timeline/ will get better soon.” The interview data were uploaded and coded in N-Vivo, a qualitative computer analysis program that facilitates the rapid retrieval and comparison of thematically grouped data.

Once coded in N-Vivo, summary matrices were prepared. Data within categories were subjected to a series of reductions in order to group similar responses and facilitate description and analysis (Miles & Huberman, 1994). Again, a group process was used for this task. The matrices were uploaded into a spreadsheet program and frequencies were calculated to create a numeric description of responses that would illustrate similarities and differences between the two groups.

Results

Demographics (see Table 2): Though the groups were similar in age, they differed significantly on education and income. The EAs reported high levels of income and education. EAs were twice as likely as SAs to work

Table 2
The sample

Group	EAs (<i>n</i> = 36)	SAs (<i>n</i> = 35)
Mean age	39 (19–61)	39 (23–62)
Mean years of education	18 (14–24)	13 (0–18)
Mean income (in \$1000)	106 (35–200)	46 (0–250)
Works out of the home	90%	40%
Mean years in US		11 (0–35)
Reads English		70% %
Speaks English		50%
Socializes with non-SAs		2%

outside the home. Acculturation and immigration data for the SA group suggest low levels of acculturation. Though many spoke English, only a small number preferred English as their language of interview, and all but one reported socializing exclusively with members of her SA community.

Hypothesis testing study: Results supported the hypotheses. On the BPM scale, EAs rated significantly higher than SAs (mean = 4.36 vs. 1.97; $p < .001$); while on the SM scale EAs rated significantly lower than SAs (mean = 1.77 vs. 3.43; $p < .001$).

Analyses of relationships between the scales with other variables found that the BPM scale was highly correlated with income ($r = .533$, $p < .001$) in the SA group, moderately with education, and weakly with the measure of acculturation; the situational model was correlated only with acculturation in the expected direction. For the EA group, the BPM was weakly positively correlated with income, while the situational model was weakly negatively correlated with education.

Descriptive study

The interview generated a series of structured narratives punctuated by interviewer questions. In general, participants in both groups responded readily to the vignette, and no one seemed to find it uninterpretable. A major difference across groups was that EA responses were much longer. In general, SAs were usually content to generate a single explanatory model for the vignette, while EAs were more likely to generate multiple, often conflicting, models.

Label

The results of the descriptive analysis of the labels used for the vignettes found strong differences in patterns of responses. EAs preferred to label the vignette as a mental disorder, depression being the most common term, though there were also a few others such as “hormonal imbalance” or “seasonal affective disorder.” Among SAs, by contrast, responses were much more varied. SAs often used English vocabulary terms, such as “problem,” “tension,” or “depression.”

Some SAs labeled the problem in the episode not by its symptoms, but by the situation that had caused the symptom.

What would you call this problem? I think she has a “problem” (English word) at home. What kind of problem? With someone at home—husband, in-laws, or kids. So then she probably feels sad and hopeless (SA respondent).

Many women said that the problem “had no name,” suggesting that its identity lay in its social context.

What would you call this problem? It has no name. If she is married then she probably has problems with her husband or her in-laws. And if she is not married maybe she is worried about her future. Or maybe she is in love with someone and her parents did not let her marry him (SA).

Many participants used descriptive emotion terms for the symptoms in the vignette. Importantly, emotions were described in context, as a reaction to a social situation.

She is probably worried or upset about something. About what? Maybe something about her family, husband, kids, or even some close relatives. Like someone may be sick (SA).

The English word “tension” was often used in conjunction with “thinking too much,” a category describing obsessive worry:

Tension. What do you mean by tension? She is thinking thinking always. She is turning something over and over in her head only thinking of that one thing (SA).

The largest response for label was the English word “depression,” used in nearly a third of SA responses.

What would you call this problem? Depression. Could you describe it to me? Something has happened to her personally, her life at home or at work, that makes her really sad (SA).

These responses contrasted dramatically with those of the American women. Though common usage in English permits the word “depression” to be used with an indirect object (“depressed about something”), it was often not used in this sense in the EA group. Although most referred specifically to social context, they often distinguished between a “life problem” and depression:

Maybe she is going through a bad time or situation, but it also sounds like it could be depression ... If it wasn't [depression] I would say it was a specific situation that she is going through ... lost her job, broke up with her boyfriend, something like that (EA).

Cause

Three-quarters of EA participants mentioned a biological cause as one potential cause of the problem.

I think it's brain chemistry. I think there are lots of things that add, but I think a true depression is brain chemistry (EA).

If she was older I would probably look into beginning Alzheimer's ... Actually I might even consider some neurological stuff. Ya know possibly a brain tumor, something like that (EA).

Despite the strong biological bent of many of the American representations, EA women generated twice as many social as biological attributions for the symptoms. Usually these elements were not presented within a single explanatory model but were proposed as part of contrasting, often mutually exclusive models.

The cause could be if she felt trapped in her life the way it was structured or if she was sad or a shift in brain chemistry happened due to a postpartum illness, like a postpartum depression, or the stressors of life (EA).

Interestingly, the two groups differed sharply in the types of social causes they listed. EA women tended to focus on life events, such as deaths, divorces, and, in nearly half of cases, a non-specific "life event":

It sounds like something terrible happened, like she broke up with somebody or her parent died or she had a miscarriage, something related to a tragic event (EA).

One idea that came through strongly in the EA data but was much less common among SA responses was the notion of the origins of depressive symptoms as mysterious or unknown. 19/36 EAs, compared to 6/35 SAs, expressed this idea.

I also think that there are a lot of things that you know, that things may have gone wrong for Monica and that she might not be able to put a finger on what it is that happened ... That's my impression of depression (EA).

Some respondents distinguished between a biological depression and a situational depression. Situational depressions were viewed as being temporary and easier to control than biological depressions.

If it's a what you would consider a more average depression it could be the result of some kind of a loss, a death, a divorce, losing a job, having an apartment fire ... If it's a clinical depression then it is much more serious (EA).

Another common notion, linked to psychodynamic theories of causation, referred to social context as a "trigger". The idea of a trigger, or a mysterious cause, was associated with the notion that events from the past might be causing depression.

I think the causes can be from the past that you never dealt with before. Something can trigger this in you. Let's say she was reading the newspaper and the

story was about a plane crash and her childhood friend died in a plane crash and she didn't even remember (EA).

Among SAs, 85% of all causes nominated focused specifically either on a situation or on an emotional reaction to a situation. In contrast with the American group, SAs were much more likely to focus on ongoing problems and stressors rather than discrete life events. Nearly half of the respondents mentioned either problems with the husband (31%) or, more generally, family or home problems (12%) as the likely cause of symptoms.

I think she must be having a problem with her husband. Maybe he is seeing someone else ... or if her kids are older, they could be the problem ... like if they are not studying well in school or they are staying out too much (SA).

A common explanatory category in the SA group, completely absent in the EA group, was the notion of "thinking too much." Among SAs, thinking too much and worrying about a problem was viewed as a destructive reaction.

She is worried or upset. If she thinks too much about it ... then she could feel worse. It depends on how ... much she thinks about the real problem. If she keeps thinking about it then it will last long and become a serious problem (SA).

The permissiveness or severity of others was a major factor in SA responses:

I don't know, maybe it depends on a woman's in-laws, her husband and her parents. How much support she has from them. And how strict her parents are, if she is unmarried (SA).

Consequences

We asked participants to rate the episode in the vignette on a 1–3 scale for seriousness. Responses ranged from 1 (not at all serious) to 3 (very serious). The groups differed strikingly in the seriousness they associated with the episode. EAs rated the episode as very serious (2.8 on a 3-point scale) while SAs rated the episode as only somewhat serious (2.0).

When we asked about specific consequences of the symptoms, there were similarities across the two groups. About a third of all responses focused on consequences to work roles. Unsurprisingly, SAs tended to focus on domestic role failure, while the Americans often referred to problems with paid work. Social dysfunction was a very common category among EAs:

[The symptoms] could keep her from wanting to leave the house ... It could cause her to lose some

friends if they get frustrated with the fact that she's always a downer and she doesn't give them an explanation for why (EA).

This idea of "losing friends" was uncommon in SAs, perhaps because of the greater voluntary nature of social relationships in the EA group.

As noted above, most EAs viewed the consequences of the symptoms as very serious. The greater seriousness of the consequences for Americans appeared to involve two features: first, the idea that depression affected all spheres of life, and second, that depression often involved a "downward spiral," getting worse and worse over time:

Oh it would affect a lot. You could lose your job. You could lose your friends. Break-up of marriages, relationships. More health problems. I think it could just send you on a horrible downward spiral if you don't take care of it (EA).

In the SA group, by contrast, there was more variation on the "seriousness" dimension. Eight SAs rated the symptoms as "not at all serious," while none of the EAs made this rating. SAs who rated the symptoms "not at all serious" tended to conceptualize them as a brief, passing emotional reaction to an interpersonal conflict or problem. The general view among the SAs was that if the problematic situation resolved quickly, there would be little effect on the woman. But when women thought the underlying social problem might not get solved, severe consequences were envisioned:

If she is having problems with her husband and it gets worse, they could get divorced—this could have a very bad effect on her. She could get sick. She could catch an illness, get a fever. She could go crazy if she kept thinking about her problems. Then she would not have control over her behavior (SA).

A striking difference between the two groups was the perceived health consequences of depressive symptoms. SAs were much more likely to say that depressive symptoms could lead to becoming *pagal*—"crazy"—or to becoming physically ill. Usually, the pathway from depressive symptoms was mediated by "thinking too much" or by feeling too much "tension":

She will think and think and she will think it is this or that and she will become *pagal*—insane (SA).

If she does not find a solution it can get worse. She could get worse ... it would have a bad effect on her mind ... Or she could get a heart attack ... or hemorrhage in the brain ... The nerves would burst ... (SA).

Thinking too much, associated with "tension", could cause headaches. The idea of pressure associated with

blood pressure and a feeling of pressure in the head was associated with depression:

She will have headaches and always be worried. She will have her health deteriorate. She will get weak, if a person is worried, then sometimes, he doesn't eat and concentrate. It can be serious. Because with worries, a person can get sick also. If a person has too much tension, they can have a heart attack (SA).

Thus, an analysis of the "consequences" dimension of the representations suggests that while EA women in general viewed the symptoms as more serious, SA women were more likely to envision consequences to the physical health of the person, often associated with humorally influenced notions of body temperature.

Management and treatment

Across the dimensions of the illness representational model, the most striking differences lay in the area of treatment. EAs were far more likely to recommend professional treatment than SAs, while a higher percentage of SA responses related to self-help. In the professional category, interestingly, SAs were somewhat more likely than EAs to suggest seeking treatment with a "doctor." This appeared to relate to their concern about the physical sequelae of emotional distress. Similarly, SAs and EAs were equally likely to mention a "psychiatrist," a relatively rare response. However, EAs were much more likely than SAs to suggest seeking treatment with a psychotherapist. Seventy percent of EAs mentioned the possibility of psychotherapy, compared to 5% of SAs; similarly, 70% EAs proposed psychotropic medication, compared with 5% of SAs.

The notion of needing professional help rather than relying on friends and family appeared to be associated with the idea of the cause of the depression being unknown or obscure. Among both EAs and SAs recommending professional treatment, a common notion was that one could go to a professional in order to learn about the cause of the depression. Specifically, a professional would be able to determine whether the depression was biological or not and whether biological treatments would be likely to work:

A psychologist, social worker, or a psychiatrist ... could help figure out what this depression is, figure out if medication is likely to help (EA).

Lay help seeking was an important source of support in both groups. Interesting differences arose in the sources of lay referrals suggested. SAs were proportionately much more likely than EAs to turn to their husbands for help, and were more likely to suggest other family members such as parents, mothers, and daughters.

We asked subjects to describe the types of help they could expect from lay referral sources: these responses were classified into three categories: emotional support, advice, and concrete help. In both groups, the most commonly mentioned category was “emotional support,” and the two groups were equally likely to make responses in this category. Among SAs, an important aspect of emotional support was that it gave a person a chance to talk about her problems. It was considered crucial to talk about the problem rather than “thinking too much.” Women often suggested that if you did not talk about it, you could get sick.

If it is an emotional problem you must talk about it with someone. Because if you don't it gets worse. You keep thinking about this by yourself, and you feel negative ... (SA).

SAs were much more likely to propose “advice” and “concrete help” than EAs. Concrete help and advice were linked to the troubling problem and were often associated with the acknowledgement of a woman's dependence on others. For example, SA women were very likely to suggest that a husband could help by taking the woman to the doctor. In other cases, powerful family members could help by intervening at the source of the problem:

If you were in her place, who would you talk with about a problem with your husband? My mother, father, or sister ... they would try to talk to my husband, advise him that he should not do this or that (SA).

There were also striking differences in categories of self-management. EAs were more likely to mention physical self-management strategies such as changing the diet or, commonly, getting more exercise. Among SAs the largest self-management category represented “emotional control or distraction.” This was not present among the Americans. This was related to the idea that “thinking too much” exacerbated symptoms and distress.

Who would you talk to about this problem? My husband, my friends, my mother ... What kind of help could they give? I know that if I talk to my husband he will change the subject, divert my attention, he will say let's go for a walk or something ... (SA).

Discussion

The use of the IRM as a basis for query and analysis permitted a detailed examination of the ways in which culture shapes illness representations. Conceptual models of depressive symptoms described by the two groups

differed sharply. Even when SAs actually used the label depression, which they did with some frequency, they viewed this condition quite differently from European Americans. Among EAs, the symptoms of sadness described in the vignette are symptoms of a medical disorder; while SAs interpret them in situational terms—as an emotional reaction to a pathogenic situation. The lack of a label (“It has no name”) illustrates the lack of fit between symptoms and a diagnostic category.

Participants in both groups readily recognized the symptoms described in the vignette, and no one seemed to have any difficulty interpreting them. Results suggest that cultural differences between the groups lie not in concepts of depression-as-feeling but in depression-as-disease. Many other differences in the representational dimensions of the models followed from this basic difference in the identity of the phenomenon. The disease model was associated with greater perceptions of severity, with a chronic or deteriorating timeline, and with the necessity of professional treatment seeking. The situational model by contrast emphasized underlying social context, and social context structured perceptions of cause, consequence, timeline and management. In the current study, the disease orientation was associated with acculturation in the SA group and with SES in both groups, presumably because this orientation increases with greater access to technical/professional models of mental disorder disseminated through education and media. Interestingly, the situational model was less strongly linked to these variables.

It has been suggested (Lutz, 1985) that the disease model of depression embodied both in the DSM nosological system and in middle class western culture, reflects a more general western ethnopsychology of the emotions. This western ethnopsychology defines emotions as internal, often biological, unintentioned, distinct from thinking and cognition, and above all “a feature of individuals, rather than situations, relationships or moral positions.” EA responses in the present study reflected this ethnopsychological position as many (though not all) participants described the depressive symptoms represented in the vignette as divorced from a social context in everyday life. However, participants struggled to reconcile this view with an alternative model, more similar to that of SA participants, in which the symptoms in the vignette were viewed as a response to an event in the social world. The solution was often to propose alternate, contrasting models in the same response.

Often, EA responses suggested that if the depression related to an event or situation, it was likely to be a minor, temporary problem and one that a person could control herself. This view contrasted sharply with the SA perception that social contexts can be exceptionally toxic precisely because individuals cannot control them. In the EA view, a serious, “true” depression was defined both

by its lack of cause and by the inability of the person to control it. The notion of a hidden, secret cause of depressive symptoms was often used to explain the logic of professional consultation: professionals were viewed as being likely to uncover the hidden causes of depression. Interestingly, many EAs seemed to advocate a distinction between situational depressions and “real depressions.” Their model reflects a theoretical distinction in psychiatry, now cast into doubt, which formerly differentiated between reactive and endogenous depressions.

Since middle class western concepts of depression have been little examined in previous studies—perhaps because of the assumption that they are factually or medically correct—there has been no previous work examining how individuals reconcile conflicting models. A recent ethnography of psychiatric training (Luhman, 2000) found the profession of psychiatry torn by two competing models of mental disorder and personality: the biopsychiatric and the psychodynamic models. No mention was made of the situational model, perhaps because the professional discourse studied by Luhman would be likely to emphasize those models that locate the source of disorder within an individual and are thus amenable to conventional treatment. But the results of the present study suggest that educated, middle class people take a situational model into account when they attempt to conceptualize depression (and perhaps, other mental disorders). It may be that the apparently conflicting models reported by some EAs may reflect a view that situational interpretations were more appropriate for milder depressions, while psychiatric interpretations were appropriate for more severe or chronic illness. More work is needed to understand the implications of these models in understanding patients’ treatment seeking decisions and evaluations of treatment.

Illness representation as a mirror of culture

Results of the study suggest that illness representations, in addition to being constitutive of culture—of shaping experience through symbols and categories reflecting larger scale disease taxonomies and categories—also act as a mirror reflecting cultural realities. When European Americans talked about social contexts, as they usually did in their mixed models, they refer to a sharply different social reality from that of SAs.

SAs’ narratives focused almost exclusively on the world of the family. This emphasis on family problems, particularly conflicts with the husband and in-laws, reflects the difficulties associated with marriage and traditional gender roles for SA women. The theme of husbands, in particular (“she must have a problem with her husband”), suggests how critically important it is for SA women to satisfy their husbands and get along well

with them (Karasz, 1997), and also hints at women’s lack of control within the family context. The emphasis on concrete sources of help, completely absent in EA responses, reflects both women’s lack of direct access to resources and also the therapeutic importance of strengthening disturbed family relations lying at the root of the problem. For example, women often proposed that an older, more powerful person could help with the problem by intervening directly with the husband in a marital conflict—“telling him not to do this or that.” Similarly, when participants proposed that the husband could help his wife “by taking her to the doctor,” this suggestion reflects women’s dependence, immobility, and lack of access to financial resources. It also proposes a powerful symbolic gesture of support. In taking his wife to the doctor, the husband acknowledges the problem and demonstrates his willingness to spend resources (time, effort, doctors’ fees) on her. In other words, he asserts her value (Nichter, 1981).

Among EAs, however, to the contrary, depression representations emphasized discrete life events such as deaths, job losses, or divorce. The greater variety of these events reflects the broader experience of EA women, who inhabit several social worlds at once, including the world of work, family, and friends. Often precipitating events were labeled in the abstract as “life events,” and were not fleshed out; they rarely refer to ongoing, intractable difficulties embedded in social roles. It is not clear why EAs prefer the “life events” model, while SAs prefer the “role strain”(Pearlin, 1989) model of stress and suffering. One possibility is that, given the theoretical flexibility and voluntary nature of work and family roles in American society, EAs may assume that roles which generate misery and depression may be relatively easily abandoned and are thus an unlikely cause of the symptoms described in the vignette.

Another possible explanation is that life events discourse, a dominant explanatory model in American social psychology and epidemiology, has filtered down through professional discourse and is influencing lay models. Life events discourse, like trauma discourse, fits more clearly than “role strain” discourse with the overall disease model characterizing western thinking about distress and disorder. Like a pathogen, the life event occurs, disrupts, and requires “adjustment.” Therapy offers the opportunity to regain control by embarking on an individual quest for healing through rational therapeutics, and drama in EA narratives usually involved the struggle to acknowledge or recognize the need for such therapy.

Becoming a patient

Our data offer insight into the question asked at the beginning of this paper: “Why do SAs (and by

implication, persons from other traditional societies and ethnic minority groups) rarely seek treatment for depression?" The data suggest that depressive emotional symptoms do not constitute depression-as-disease in the SA context. For the majority of SAs in the study, depressive symptoms reflect painful and threatening real-life problems. "Treatment" involves one of two strategies: solving the problem or avoiding "thinking" about the problem. Individual treatment, whether aimed at a "chemical imbalance in the brain" or at an unresolved trauma, does not fit with SA conceptual models.

A question that is not answered by our data is the question of what constitutes depression-as-disease (or its equivalent) in the SA group. If sadness and loss of interest do not qualify, what does it take to get "sick"? As Beiser (1985) has suggested, it may be that "what it takes to become a patient" differs across western and non-western societies. The present data hint that among SAs, sadness becomes "serious" when you become "crazy" from it, or when you develop severe medical problems. Thus, the present results suggest that depressive episodes in SAs which result in treatment seeking would be more likely to include psychosis or perhaps conversion symptoms than in white middle class Americans. Existing data on culturally shaped disorders on the SA subcontinent support this hypothesis. These often include depressive as well as somatic symptoms. Leucorrhoea, a vaginal discharge that is feared as highly dangerous (Nichter, 1981; Janakiramaiah, 1983), or koro, an anxiety/depressive syndrome that incorporates the somatic delusion that one's genitals are disappearing into one's abdominal cavity, are good examples. Arguably, it may be only in western, middle class communities that dysphoria alone is enough to precipitate treatment seeking. Future analyses of data collected in the larger study will address this question more specifically.

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