

Cultural and subcultural definitions

Conceptions of abnormality differ *between* cultures and this can have an enormous influence on the diagnosis and treatment of mental disorders. Subcultural differences relating to ethnicity, social class or gender within our own culture, are also thought to influence diagnosis and treatment.

Culture bound syndromes

Some abnormalities, or disorders, are thought to be culture specific. For example, the disorder *shenjing shuairuo* (neurasthenia) accounts for more than half of psychiatric outpatients in China. It is listed in the second edition of the Chinese Classification of Mental Disorders (CCMD-2) but it is not included in the American diagnostic classification system for mental disorders (DSM) used in the western world. Tseng (1986) questions whether this reflects a high prevalence of the disorder in China, or whether it is merely related to diagnostic procedures. Many of the symptoms of neurasthenia listed in CCMD-2 are similar to the symptoms that would meet the criteria for a combination of a mood disorder and an anxiety disorder under the DSM-IV. The APA has now formally recognized *culture-bound syndromes* by including a separate listing in the appendix of DSM-IV (1994). However, as Fernando (1988) points out, many of these “exotic” conditions actually occur quite frequently, but as long as they are limited to other cultures then they will not be admitted into mainstream western classification. Western psychiatry maintains that most of these are merely variants of known syndromes and do not warrant new diagnostic entries.

Depression, which is common in our own culture, appears to be absent in Asian cultures. In trying to understand the reason for this, it has been observed that Asian people tend to live within an extended family, which means that they have ready access to social support. However, as Rack (1982) points out, Asian doctors report that depression is equally common among Asians, but that Asians consult their doctor for physical problems only and rarely with *emotional* distress. They do not see this as the responsibility of the doctor and instead they tend to sort it out within the family. They might seek help for the physical symptoms of depression - such as tiredness, sleep disturbance and appetite disturbance - but would probably not mention their mood state. Socio-cultural differences in the prevalence of depression may, therefore, reflect the statistical likelihood of seeking professional help for emotional states.

One of the major difficulties with studies using diagnostic data is that figures are based on hospital admissions, which may not reflect the true morbidity rates for particular ethnic groups or particular disorders. Low admission rates found in many minority ethnic groups may reflect cultural beliefs about mental health. Cohen (1988) explains that in India, mentally ill people are cursed and looked down on. Rack (1982) points out that in China, mental illness also carries a great stigma and therefore the Chinese are careful to label only those whose behaviour is indisputably psychotic (i.e. where thinking and emotion are so impaired that the individual is out of contact with reality).

Culture bias in mental health

Research statistics have shown that there are significant differences in the prevalence rates for mental disorders between different ethnic or cultural groups in Britain. For instance, there is an over-representation of black (African-Caribbean) immigrants among those diagnosed with schizophrenia, of between two to seven times the rate for whites (e.g. Cochrane 1977). Cochrane and Sashidharan (1995) claim that this does not appear to be confined to first generation immigrants because studies (e.g. Thomas et al.1993) indicate that, if anything, the relative risk may be greater in the second generation. In contrast, Cochrane (1983) reports that he has found rates of admission for schizophrenia among South Asians (from India, Pakistan, Bangladesh, and Hong Kong) to be comparable to whites. However, for less severe disorders, admission rates for South Asians and African-Caribbeans were significantly less than for whites.

An immediate explanation for these differences is that diagnostic figures merely reflect high or low morbidity rates for a particular disorder in the population of the country of origin. However, this cannot explain the high figures for schizophrenia diagnosis among African-Caribbeans in Britain because, as Cochrane (1983) points out, this has not been found to the same extent anywhere else in the world. How, then, can these differential diagnoses be explained?

Cultural stereotyping in British psychiatry

Fernando (1988) claims that stereotyped ideas about race are inherent in British psychiatry. For example, there are stereotypes of black violence and the belief that blacks cannot *use* help and are therefore not suitable for open hospitals. Research has shown that the compulsory detaining of African-Caribbean patients in secure hospitals is higher than for any other group. Ineichen *et al.* (1984) examined hospital admissions in Bristol and found that non-white groups (West Indian plus other non-white) accounted for 32 out of 89 compulsory admissions, but only 30 out of 175 voluntary admissions. In a survey conducted by McGovern and Cope (1987) on hospital-detained psychotic patients in Birmingham, it was found that two-thirds were African-Caribbean (both migrants and British born), with the remaining one-third white and Asian. Table 10.3 lists some British research of practical importance, cited in Fernando (1988).

Culture 'blindness' in diagnosis

Cochrane and Sashidharan (1995) point out that it is a common assumption that the behaviours of the white population are normative and that any deviation from this by another ethnic group reveals some racial or cultural pathology. Conversely, as Rack (1982) points out, if a member of a minority ethnic group exhibits a set of symptoms that is similar to that of a white British-born patient, then they are assumed to be suffering from the same disorder, which may not actually be the case. For example, within the culture of one ethnic group it might be regarded as normal to see or hear a deceased relative during the bereavement period. Under DSM-IV criteria this behaviour might be misdiagnosed as a symptom of a psychotic disorder. Cochrane and Sashidharan (1995)

suggest that practitioners are almost forced into assuming that mental illnesses such as schizophrenia, depression and neurosis, which are commonly found in European patients, are also found in non-European patients. They claim, furthermore, that the system does not easily allow for other disorders to be identified, which do not conform to those recognized in white patients, because British psychiatry is 'shot through with Eurocentric bias'. They claim that so-called 'culture bound syndromes' receive academic discussion, but they are doubtful that this influences clinical practices in GP surgeries or busy hospitals.

Table 10.3 Research studies on ethnicity and mental health

British research of practical importance

1 Over-diagnosis of schizophrenia in:

- West Indian and Asian immigrant in-patients (Cochrane 1977; Carpenter and Brockington 1980; Dean et al. 19 81)
- Patients of West Indian ethnicity admitted compulsorily in Bristol (Harrison et al. 1984) and in Birmingham (McGovern and Cope 1987)

2 Excess of compulsory admission of:

- Patients of West Indian ethnicity in Bristol (Harrison et al. 19 84) and in Birmingham (McGovern and Cope 1987)

3 Excessive transfer to locked wards of:

- West Indian, Indian and African patients (Bolton 1984)

4 Excessive admission of *offender patients* of:

- People of West Indian ethnicity in Birmingham (McGovern and Cope 1987)

5 Overuse of ECT for:

- Asian in-patients in Leicester (Shaikh 1985)
- Black immigrant patients in East London (Littlewood and Cross 1980)

Stressful life-experiences

Fernando (1988) points out that being a member of a minority ethnic group could be stressful owing to the exploitation, deprivation and harassment often experienced and, therefore, it might be expected that there would be a higher incidence of psychological problems among people from minority ethnic groups. However, ethnic differences are not

reflected in the statistics, which attempt to correlate stress and psychological problems in minority ethnic groups. Nevertheless, as Cochrane and Sashidharan (1995) point out, racism and prejudice have a significant impact upon psychological well-being. They also explain that migration from third world to first world countries means that the first generation of migrants is likely to be exposed to economic uncertainty, substandard housing and harsh working conditions, which in themselves may have mental health implications. These may then mistakenly be attributed to ethnicity.

Social class and mental health

It has long been established that there is an association between social class and mental illness. For example, major psychiatric disorders, such as schizophrenia, are diagnosed more often in people from socially disadvantaged backgrounds. Conversely *neurotic* disorders are diagnosed more often in people from higher socio-economic groups. Several reasons have been suggested for these differences.

Stressful life-experiences

The literature has indicated that the higher prevalence of severe mental disorders in socially disadvantaged groups is largely due to their exposure to more stressful life experiences, compared with those in more advantaged social groups. The first large-scale survey to support this hypothesis was the Midtown Manhattan Study (Srole et al 1961, and Langner and Michael 1962) The study found the lowest levels of psychiatric impairment in the upper classes, slightly more in the middle classes, and the highest levels in the lower classes. When symptoms of disorders were mild to moderate the levels were very similar in all three social classes, with the highest level of mental well-being in the upper classes. These findings were supported in a British study (Cochrane and Stopes-Roe 1980), which also found that lower social status was associated with higher risk of psychological problems.

A major study by Brown and Harris (1978) found a high incidence of depression among working-class housewives in Camberwell, London. The main vulnerability factors they identified were long-term periods of adverse circumstances, together with the cumulative effect of short-term life events, combined with factors such as lack of paid employment. However, the major finding in such studies was that high levels of stress correlate with greater susceptibility to mental disorder, regardless of social class. It has been proposed, therefore, that there are additional factors associated with social class and mental problems. For instance, those in the middle and upper classes have more *positive* life experiences to offset the *negative* and those in the lower classes have less control over their environment.

Coping resources

The Brown and Harris (1978) study also revealed that when faced with stressful events, the lack of a close confiding relationship was a strong indicator of vulnerability to mental illness, suggesting that social support may be an effective “coping resource.” It has been

noted that those in the middle and upper classes more readily access “coping resources” than those in the lower classes. Therefore, the greater prevalence rates for less severe “neurotic” disorders in the higher socio-economic groups may simply reflect their greater tendency to take advantage of professional services for psychological problems. Cochrane (1995) explains that people living in high-rise flats are more prone to psychological problems than those in traditional accommodation. People who have been re-housed in tower blocks report a drop in the quality of relationships with neighbours. This may be an important factor in mental health, because neighbours are a potential source of social support. However, Cochrane points out that neighbours can also be a source of irritation and even fear. Halpern (1995) claims that if a neighbourhood becomes labeled as a dumping ground for “problem families” then people who were not originally a 'problem' themselves may develop adverse reactions which may affect their mental health.

The drift hypothesis

An explanation for the higher incidence of serious mental disorder in lower socioeconomic groups is that the early onset of a major mental disorder, such as schizophrenia, might reduce the chances of establishing a career. The person may then subsequently *drift* down the socioeconomic scale. This indicates that social class is largely a consequence of, rather than a contributory factor in, mental disorder. Support for this is found in cases where the initial onset of schizophrenia has occurred later in life. It has been noted that many such individuals had previously established a good career.

Cochrane (1983) points out that the higher incidence of schizophrenia in poor areas could reflect the number of people who move to those areas after the onset of their illness, because it is all they can afford, rather than that they had lived there all their lives.

Bias in classification and diagnosis

A study by Umbenhauer and DeWitte (1978) investigated the effects of social class upon the attitudes of mental health professionals. They found that upper-class people received more favourable clinical judgements and were more likely to be offered psychotherapy than lower-class people. On the other hand, Johnstone (1989) pointed to studies showing that regardless of symptoms, more serious diagnoses were given to lower-class patients. They were more likely to spend longer periods in hospital and more likely to be considered as having a poorer prognosis. Working-class patients were more likely to be prescribed physical treatments, such as ECT and drugs and less likely to be offered psychotherapy. Johnstone asserted that health professionals justify this by claiming that working-class patients were less able to benefit from verbal therapies because they were less articulate. She concluded that working-class patients, who were the least powerful and who experienced the most social and economic hardship, ended up receiving the disabling rather than the *empowering* psychiatric treatments. This served to deprive them even further of any remaining autonomy and independence and also served to *diffuse legitimate protest* about the likely social origins of their problems, such as unemployment and poverty.

While there was a great deal of research conducted in the 1960s and 1970s on social class and mental illness, over the past ten to fifteen years this has declined. It is unlikely that social class bias has disappeared completely. The recent political climate, however, has raised the profile of gender and culture above that of social class.

Gender bias in mental health

Mental health statistics indicate that certain mental disorders are diagnosed more frequently in men while others are diagnosed more frequently in women. It has been suggested that this can be explained through biological differences. However, this view has been challenged by those who claim that the differences merely reflect stereotyped judgements among mental health professionals.

Biological differences

Schizophrenia is more prevalent in males, but equally prevalent in both sexes beyond the female menopause. It has been noted that this is when female estrogen levels subside, which has led to the suggestion that estrogen may be a protective hormone against psychosis. However, there is, as yet, insufficient evidence to support this claim. It has long been thought that women suffer more from depression because of fluctuations in hormonal states related to the menstrual cycle, childbirth, the use of oral contraceptives and menopause. An extensive review by Weissman and Klerman (1981) found mixed support for this belief, but in the main they concluded that there is insufficient evidence to relate mood changes to hormonal changes.

Stereotyped judgements

Broverman et al (1981) thought that since certain behavioural characteristics have traditionally been ascribed to either male or female genders, it is likely that clinical diagnosis of mental disorders will reflect these distinctions. They conducted an important study on "sex-role stereotypes and clinical judgments" and found that clinicians have different concepts of health for men and women and that these differences do tend to parallel the sex-role stereotypes prevalent in our society. They asked 46 male and 33 female mental health professionals (clinically trained psychologists, psychiatrists and social workers) to rate the characteristics of the healthy man, the healthy woman and the healthy adult. They found that the healthy adult and the healthy man were rated in a similar way, as assertive, decisive and relatively independent. The healthy woman was regarded as more submissive, dependent and emotional than the healthy man.

In the light of their study, Broverman et al. suggest that a double standard of mental health exists within clinical diagnosis, with certain behavioural characteristics thought to be pathological in members of one sex, but not in the opposite sex. It is generally believed that health consists of good adjustment to one's environment. Men and women are trained from birth to fulfill different social roles, and therefore healthy adjustment for a woman is to accept the behavioural norms for her sex, even though these behaviours

may be considered less healthy for the generalized healthy adult. If the *adjustment* notion of health is accepted, then it would be maladaptive for a woman to exhibit characteristics that are considered to be healthy for men but not for women. One of the dangers of mental health professionals adopting the adjustment notion of health is that they actively reinforce and perpetuate sex-role stereotypes.

Gender and the environment

Howell (1981) points out that women's experience in this culture predisposes them to depression and therefore clinicians are diagnosing a situation rather than a person. Cochrane (1995) explains that depression can be related to the long-term effects of child abuse and also to gender role socialization, which produces increased female vulnerability. He points out the adverse effects on women of power relationships and sex discrimination. Despite the vast amount of evidence relating women's depression to socio-cultural factors, clinicians continue to ignore environmental circumstances and convey the message that the problem lies in the person's illness (Johnstone 1989). Johnstone believes this also applies to men. She points out that unemployed men have a high rate of psychiatric breakdown and by labeling the problem as a mental disorder, not only does the person have the stigma of a psychiatric label, but the problem is seen only in individual terms rather than in the wider political and social context. Bennett (1995) believes that the socialization of men in industrialized societies has created masculine stereotypes that alienate men from seeking help for psychological problems.

Gender bias in the DSM-IV

Gender differences are particularly marked in the prevalence rates for specific personality disorders (see Table 10.4). It has been suggested that this differential diagnosis may reflect gender bias in the diagnostic system, rather than actual differences. In a study by Hamilton et al. (1986) clinicians were given client descriptions consistent with the symptoms of Histrionic Personality Disorder (see Table 10.4), which has traditionally been diagnosed more in females than males. In the descriptions the sex of the client was varied but the symptoms were identical.

Clinicians consistently rated female clients as more histrionic than males. Narcissistic Personality Disorder (see Table 10.4) is diagnosed more frequently in males, but does this statistic truly reflect the prevalence of the disorder in males? The diagnostic symptom criteria in DSM-IV list behaviours, which reflect stereotypical male gender roles much more than female - for example: shows arrogance; has a sense of entitlement; has a grandiose sense of self-importance.

Table 10.4 DSM-IV diagnostic description for personality disorders more prevalent in males or females

Histrionic Personality Disorder (diagnosed more frequently in females)

- A pervasive pattern of excessive emotionality and attention seeking.

Dependent Personality Disorder (diagnosed more frequently in females)

- A pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation.

Narcissistic Personality Disorder (diagnosed more frequently in males)

- Pattern of grandiosity (in fantasy or behaviour), need for admiration and lack of empathy.

Obsessive-Compulsive Personality Disorder (diagnosed more frequently in males)

- A pervasive pattern of preoccupation with orderliness, perfectionism and mental and interpersonal control, at the expense of flexibility, openness and efficiency.

Section summary

What constitutes abnormal behaviour, and in turn what would be regarded as a pathological problem, has been found to differ between cultures. As a consequence, there are no universal definitions for 'abnormality'. This indicates that the concept of 'abnormality' should perhaps be regarded as a social construction.

There are many ways in which bias can occur in mental health. Culture bias can occur if cultural differences are not taken into account by the clinician. Stereotyped views relating to culture, social class or gender may influence the over-diagnosis or under-diagnosis of certain disorders and the type of treatment received. It is believed by many psychologists that the extent of racial, class and gender bias that exists within society finds expression through the agency of mental health professionals who have enormous powers of social control.

Table 4 Focus: Sexism in assessment and diagnosis

Worell and Remer (1992) claim that sexism occurs in assessment and diagnosis in four ways:

Disregarding environmental context

Assessment and diagnosis focus primarily on traits and behaviours of the individual without regard to the environmental context, such as poverty, patriarchy and powerlessness. Judgements are often made without taking into account the person's response to the environment, and so, if the clinician holds strong gender stereotypes, behaviour can either be dismissed as an over-reaction, or regarded as abnormal or pathological.

Differential diagnosis based on gender

If female and male clients present the same symptoms but different diagnoses are made, then gender bias is occurring. This is most likely to happen if symptoms mirror traditional sex-role stereotypes and if diagnostic classifications use descriptions such as 'dependent' or 'submissive', which are more likely to be associated with a female stereotype.

Therapist misjudgement

Because of sex-role stereotyping, therapists may have pre-conceived ideas about particular symptoms and may therefore perceive those symptoms more readily in either males or females. Because people are often unaware that they hold stereotypical beliefs, therapists may be unaware that they are making these assumptions.

Theoretical orientation sex bias

Diagnosis is often made on the basis of the therapist's own theoretical orientation. If that orientation is sex-biased, then it is more likely that the assessment made by the therapist will also be biased.