SOCIAL AND CULTURAL INFLUENCES ON PSYCHOPATHOLOGY

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"I, the man of color, want only this: That the tool never possess the man. That the enslavement of man by man cease forever. That is, of one by another. That it be possible for me to discover and to love man, wherever he may be."

F. Fanon, Black Skin, White Masks (42, p. 231)

Fanon’s hope for mankind is a useful starting point for any study of man and particularly one that addresses social and cultural influences in human behavior with specific references to psychopathology. His hope that the tools never possess the man is our belief that research never mystify the man; his hope that the enslavement of man cease forever speaks to our principle that researchers must not participate in the process of oppression.

This review article begins with this particular perspective and with real concerns about the political implications of the subject. It takes as its point of departure the previous review in the Annual Review of Psychology (31). It examines the literature published between 1974 and 1976 which employs a social and/or cultural perspective toward mental illness, but is ultimately concerned about the implications for mental health.

The majority of articles, books, and dissertations reviewed agree on at least one point, “namely, the relevance of social and cultural factors to individual thoughts, personality, and psychopathology” (152). It is unfortunate that only a small propor-
tion address issues beyond the individual, i.e., how society and culture maintain their own psychopathology (53, 72, 100, 101) or how the vast majority of persons maintain and promote their own health. This is an area needing exploration.

The task of this review is to examine the growth and advance made in the critical area of psychopathology since 1974. It attempts to raise, from the author's vantage point, some questions with regard to present findings which may further inform the process and elucidate the nature of the progress. An in-depth analysis is not possible. We struggle rather for a general analysis as a summary guide to the researcher in the field, to acquaint him with recent findings on the most central issues, to inform the reader of the primary studies and the possible directions for future research exploration.

The review of this literature, which comes from 86 journal sources, is organized under five major headings. They are:

1. THEORETICAL PREAMBLE, which includes questions raised by the prior review and also operational definition of concepts.
2. RESEARCH DATA, which primarily focuses on analysis of the published literature with specific emphasis on diagnosis and etiology.
3. RESPONSE TO THE PROBLEM, which explores mainly social methods of amelioration.
4. METHODOLOGICAL ISSUES, which examines the frame of reference for the research, the research designs, issues of measurement, and cross-cultural comparison.
5. IMPLICATIONS AND CONCLUSIONS, which deals with directions for future action.

With each discussion we will be guided by a simple format of definition, raising the critical questions of the area, presenting the research findings, and developing analysis.

THEORETICAL PREAMBLE

One of the fast developing bodies of literature in the field of psychology deals with the interrelationship between social and cultural parameters with psychopathology. The literature, however, is still without a paradigm to facilitate a critical perspective and a set of consistent theories to guide an historical understanding of psychopathology. It is very common to find completely divergent findings in the field based on identical questions (51, 98, 152), or to find wholly contradictory explanations for the same set of findings (3, 144, 150), or to find the same explanation for two entirely different outcomes (105, 109). Just by way of example we can underline the last point by pointing to Hoffman's (57) data in 1890 and recent findings on the incidence of

2Throughout this paper we will use the masculine gender to apply to both sexes, with apologies to all women.

3Psychopathology is used interchangeably with mental illness, abnormality, and health problems throughout the text.
psychopathology in a black population (91). Hoffman, in three studies on a black population, reported the absence of suicide, depression, and susceptibility to acute alcoholism. He concluded that these were further instances of "the inferior physiological status of the Negro." In numerous reports since that time (9, 25, 125, 144) the high frequency of suicide, depression, and alcoholism is now attributed to genetic theory cast in the pseudo-explanation of "downward drift" social theory (3). The absence of critical theory, however, does not diminish the importance for exploration of this literature.

The findings themselves raise some interesting questions about the whole emerging literature. Many of these questions were previously raised in an excellent review of the literature by Dohrenwend & Dohrenwend (31). Included among their concerns was the issue of "true prevalence," i.e. the valid frequency and distribution of the measured events across the entire defined population as opposed to frequencies based on self-referrals, hospital admission rates (9, 26), or some other subjective preselection phenomena. This still remains a central question. Tied into this is the issue of what constitutes "a case," which in turn leads to the questions of diagnosis and the validity of measuring instruments utilized to develop diagnostic categories (13, 127). The Dohrenwends, in their review, indicated the general improvement in handling issues of diagnosis but also pointed out the continuing methodological problems.

Another question raised by the prior review was one based on etiology, the attempt to look at the causal relationship between social phenomena and psychopathology. One of these questions deals with the relationship between class and psychopathology. Do the stresses and pressures of a lower socioeconomic class reality and life struggle influence psychopathology, or does a history of regressive psychopathology (assumedly genetic) produce a "downward drift" of people to the bottom of the socioeconomic ladder? The review (31) points out that, although the fascinating body of descriptive data raises new issues, the fundamental question is still unresolved.

We will examine this issue again and particularly the tendency in psychology to so readily attribute cause to biological predisposition and quickly search for genetic explanation in the absence of penetrating analysis of fundamental social and cultural realities. One wonders whether this tendency is a function of essentially misunderstanding social and cultural parameters or a function of class-conditioned values or both (72, 73). An examination of social and cultural influences cannot adequately proceed without a critical and historical perspective, but neither can it be divorced from real political (sociohistorical) questions about the nature of the society. Issues of class and race which so pervade the literature under review are fundamentally tied to the political realities of the human condition (45, 48). We must be constantly reminded of this influence. The researcher that relies exclusively on psychobiological explanations and paradigms, in keeping with the politically influenced traditions of psychology, limits the search for truth. This understanding is fundamental to any emphasis on the social and cultural influences in psychopathology.

Also of critical importance in this preamble are the definitions and central questions of the three key words in the title: social, cultural, psychopathology.
Social: this word summarizes a multiplicity of events in the human environmental sphere and usually includes social status, economic status, institutional affiliation, age, sex, race, class, nature of ecological stress. We see social in the context of the here and now. Social, however, also implies the prevailing social structure, the degree of autonomy, mobility, and legitimate power in it (48, 73). The attempt in the literature in this area is to examine the relationship between these factors, singularly or in combination, and their “within” variations and the incidence of mental illness. The central question directs attention to the ways in which the social conditions make it significantly more likely for the occurrence of psychopathology. The major body of studies appearing in the period reviewed and which address social issues concentrated almost exclusively on socioeconomic status (18, 19, 30, 34, 37, 55, 65) and race (9, 12, 16, 25, 55, 76). There was relatively little attention to the other social parameters listed above and almost no research looking at all the social factors comprehensively, although some review studies (31, 34, 54) addressed the full range of issues. The literature seems to suggest quite clearly that neither race nor socioeconomic issues serve to explain adequately the higher frequency of one class more than another among the mentally ill (9, 18, 19, 25, 84, 135). A more holistic social view is apparently necessary.

Culture: this word summarizes a multivariate entity, from child-rearing practices to kinship systems (148). We see culture as a function of history. It is the total way of life of a group of human beings, primarily the shared patterns of values, beliefs, and feelings which are characterized by a distinct world view, codes of conduct, definition of reality to satisfy biological and psychological needs (53, 70, 73). Culture guides values which serve as its major premise and foundation. The central concern with regard to culture and psychopathology is how behavior is structured, organized, and influenced by underlying cultural rules or the extent to which cultural reality creates conditions of vulnerability, making the advent of mental illness more likely for individuals, groups, or the culture as a whole (73, 81, 87). The question is, of course, not separate from the prior social question, i.e. the degree of psychological tension and anxiety created by the cultural elements.

The major body of studies reviewed, and which addressed the cultural issue, examined global distinctions between cultural groupings by virtue of their separate geographic locations and national groups (58, 110, 146). With few exceptions (109, 122), very little attention was paid to any examination of the specific value dimensions of a society which make it more likely to encourage psychological tension and anxiety. In the absence of any definitive study in the area of values, we are left to wonder what real meanings of the variations found in the numerous studies imply.

Psychopathology: the literature does not have any common meaning, although what is examined are the types of problematic behaviors described in diagnostic manuals in the field of psychiatry and psychology and concerned with the study of maladaptive behavior, its etiology, development and diagnosis, or “as operationalized by the various epidemiological investigators” (31). Generally the area covers behaviors which are grossly disturbing to others and the inability to function in various spheres on psychosocial grounds. Perhaps the most critical problem with
focus on psychopathology has been the failure to develop some base line data on what is mental health as opposed to illness (72, 99). In the absence of this, there will be continuous problems in attempting to define states of nonhealth both within and across cultures. We will now attempt a systematic exploration of what at this moment is an unsystematic body of literature.

RESEARCH DATA

The research data seeks to explore the relationships between and among social, cultural, psychopathology. The extensive literature under review will be organized into five areas of critical questions addressed by researchers. These are: (a) diagnosis and labeling, (b) incidence and prevalence, (c) patterns of psychopathologic response, (d) etiology, and (e) special parameters.

Diagnosing and Labeling

The subject area addresses the problems inherent in the attempt to arrive at a definition of what constitutes psychopathology and to what extent diagnosis or labeling is influenced by the given sociopsychological and sociocultural context. The critical question raises issues relative to perception and context (10, 11, 24, 33, 70, 83, 114, 123, 124, 151). Is there an objective reality to diagnosis, or is it merely a value choice of the particular society and culture (4, 75, 76, 140, 142)?

There has been deliberate and concerted effort by researchers to try to improve classification and develop more adequate diagnostic schema, but the efforts still lack clarity and consistency. Conception and theory fell short of adequate formulations (31, 33, 124). The overall evidence as to interpsychiatrist reliabilities in applying current diagnostic categories points to a satisfactory level of agreement in only three categories—mental deficiency, organic brain syndrome, and alcoholism. Only fair agreement is reached for psychosis and schizophrenia (124). For the rest of the categories agreement is fairly poor.

We have worked from an implicit viewpoint of the "normal," consistent with central tendencies in Western culture but not broad enough to encompass variations in persons who, in spite of or because of deviations from the norm, lift the average (151). This narrow tendency has limited a fuller exploration of social phenomena.

There is strong suggestion in the literature that diagnosis is but an inappropriate alliance of morality, psychiatry, and politics in the labeling process (114, 123). We seem to engage, as one author puts it, in "diagnosis through divination" of our own value assumptions which we try to apply universally without an adequate transcultural definition of normal mood, thought, and behavior. This usually leads to the exclusive use of Western psychiatric signs and symptoms as the major tool of classification with a built-in kind of cultural arbitrariness which merely reflects the value choice of society (6, 114). Draguns (33), for instance, points to the values reflected in psychopathology in the West. He discusses the influence of the Protestant ethic in which the emphasis is on evaluating distrust, ideational distortion, and self-centered preoccupation on the assumed nature of psychopathology. Hammom-
Tooks (53), in contrast, points to an African world view which presents a fundamental difference in ideas of causation, moving beyond the self and psychobiological explanation to social and natural environmental explanation.

We can engage in three levels of analysis of the literature raising questions on diagnosis; first, we can look at the perception of the diagnostician in the context of his model, medical or otherwise; second, we can look at the perception of the individual or community in its context; third, we can examine the objective manifestations of signs and symptoms in the person being diagnosed.

A function of this first level of analysis, the culture of the diagnostic agent, is an outcome which reflects deviation from or conformity to the dominant values or particular belief structure. One of these values, for instance, addresses the race and sex question. There is a greater tendency to diagnose the black person seeking treatment as schizophrenic or psychotic or borderline and the white person seeking treatment as obsessive-compulsive and depressed (9, 16, 64, 110). There is also greater tendency to label men as personality disordered and women as depressives (14, 61, 64, 110). Another of these values seems associated with social class differences. Greater mental illness labeling was reported in the lower socioeconomic class, supporting the previously found trend of an inverse relationship between socioeconomic class and psychological disorder (29, 31, 47, 116, 127).

Studies (29, 47, 62, 63) have found that the variance between affective and other diagnostic categories was accounted for by the demographic variables to a significant degree and by sociocultural variables to a lesser degree. One of these demographic type variables was status. Baldwin et al (10), and Wilkinson (149) examined the relationship between status indicators and psychiatric diagnosis. They found support for the hypothesis that patients with ascribed low status are more likely to be diagnosed as psychotic rather than neurotic or healthy, although Baldwin (10) indicated that the single most powerful demographic predictor variable was the race of the patient.

Culture makes its impact on the formulation of the diagnosticians as well as on their diagnostic instrumentation. We need to begin to reexamine the cultural products of our training institutions and particularly the development of measurement tools. We rely too much on paper and pencil tests or value-laden Western formulations. We impose these cultural realities on the process of diagnosis.

This general research area supports the hypothesis that both primary and secondary socialization of the agents of diagnosis affected their socially constructed outcome (10, 70, 149). The clinical judgment of these agents suggests, from their relative consistency, values of a professional culture (85, 108, 131) whose world view, values, and assumptions need to be examined.

A second level of reality in diagnosis focuses on social and cultural perception of the individual and social group given their context, definition, and conception of psychopathology. Do these perceptions parallel the views of the professional culture or are they divergent, and what are the implications? Rabkin (106) has done major review work in the area of public attitudes toward mental illness. He points to the education campaign in American life to persuade the public to accept a medical model of mental illness. In general he found that there was in the West, based on
this education, a tendency toward more congruency between public and professional attitudes consistent with a medical model. This appears to be in contrast to the non-Western attitude, with less emphasis on a medical model, less education of the public, less congruency between professional and public attitudes, and less willingness to label deviant (23, 24, 139, 140).

A third level of analysis in diagnosis focuses on objective manifestations of signs and symptoms. How do we know the problem is manifest in various societies and cultures? Draguns (33), for instance, points to three sources of contrast in interculturally differentiating trends. In Argentina, as opposed to the U.S., there is a penchant for passive, as opposed to active, symptomatology. There is a tendency toward distortion and elaboration, as opposed to deficit in the sphere of ideational symptoms; there is greater concern with social relations in the symptomatology. He goes on to suggest that in the throes of psychological disturbance, Latins feel less socially isolated, less ideationally active. Psychopathology is experienced as a suspension of cognitive effort and not a severing of interpersonal ties. In large segments of African societies, visions, hallucinations, and spirits seem legitimate expectations within the belief system (33, 53, 110). The culture-bound syndromes as seen in Amok of the Malay culture (22) or neuroses in Qatari women (38) may, in fact, exist in more subtle tones in every social grouping (130, 132, 137). Objective diagnosis ought to take into consideration that people with different life experiences express distress differently and that this raises questions of what is measured as signs, symptoms, and meaning (66, 117, 140). In the social as opposed to cultural context, if women score higher than men, is it because of a higher level of distress or because of a more spontaneous expression of distress? The same general question applies to the issue of socioeconomic class. Are we dealing with equivalent objective manifestations of signs or symptoms? The research findings to date have not resolved these questions.

These three levels of analysis point to three prevailing influences that profoundly shape diagnosis in mental illness (40, 138, 140). There has been over the last few years a growing body of research which, in pursuit of a more valid cross-cultural diagnosis, attends to the private constructs of meaning in the culture and/or social grouping (14, 26, 40, 61, 71, 86, 88, 103, 105, 110). Binitie (14) and Zeldine (155), for instance, attempted to determine whether (a) depressives in African cultures, in contrast to American culture, showed typical signs of sin and guilt and (b) whether depressives showed suicidal tendencies. Results which showed the absence of sin, guilt, and suicide among most African depressives are quite contrary to findings on American depressives. The findings indicate two different depressive syndromes suggesting that sin, guilt, and suicide, to a large extent, are culturally determined. The United States-United Kingdom Cross-National Project (142) set out to examine similar diagnostic questions with regard to schizophrenia and the tendency for greater frequency in the usage of the label schizophrenia in the United States than in the United Kingdom.

We have some excellent attempts to develop valid diagnostic proceedings. Srole (126, 127) used measurement and classification in his study as a means to hypothesize testing about the relationships between a set of social factors, singly and in
combination, to psychopathology. He developed two types of 12 social factors: (a) those independent of adult mental health status to include age, sex, parental socioeconomic status (SES), generation in the U.S., religion, nationality of parents; (b) reciprocal factors, i.e. those likely confounded with prior mental health status to include marital status, migration, self-achieved SES, SES of parents, own religious affiliation and religiosity. The study not only had the benefit of a longitudinal perspective and a community focus but also a computer-derived mental rating system which further facilitated diagnosis.

The two basic models of mental disorders, the medical model and sociological model, at the moment have not generated adequate methods of diagnosis. Bates (11) suggests that they are not only limiting but the status, power, and dominance of the medical model allows medicine to label and assume control over large numbers of people. There is need for new models like that of Srole’s (127): models that move away from single dimensions and rigidities, models that are conscious of the context of diagnosis, the type of information employed, the style of information gathering, the nature of the examinations, and the culture (professional or otherwise) of the examiner (69, 83). Srole points us to the practice. Fourcher (44) points us to theoretical formulations which may help move us into more adequate developments of methods. He places psychopathology in a context of human reciprocity. Reciprocity is that social dialectic circumscribing the way that the experiences of persons develop relative to one another. It includes a psychological dimension of individual development and a sociological dimension of interactive development. Within this context, psychopathology can be conceptualized as both formally distinguished from other types of experience and existentially continuous with all experience. It is this type of formulation that must be explored in the development of diagnostic methodology.

Incidence and Prevalence

The issues of incidence and prevalence are key study areas in the literature. They raise questions about the relative distribution of psychopathology within given societies and cultures as well as new psychopathologies and their manifestation. Prevalence defines the shift of studies of the occurrence of events (incidence) from institutions to community. Srole (127) offers the following definition of prevalence:

... the total number of cases of a disorder, first occurrence and otherwise (per 1000 corresponding general population), extant during one of several possible time frames. Three main types of prevalence time units have been used: 1. Point prevalence, covering a single, relatively narrow unit of time, such as one day or “in recent week”; 2. Interval prevalence, covering a longer but limited period, such as a year; and 3. Life-time prevalence, covering people who have ever been ill at any point in their lives (127, p. 349).

Perhaps the definitive work in this area has been done by Dohrenwend (30–32) and Srole (126, 127). The solid studies of Dohrenwend explore some of the central issues while the work of Srole and his colleagues is an excellent example of an interdisciplinary, cross-sectional investigation of mental health differences, their frequencies and their sociocultural antecedents and correlates in a general popula-
tion. Srole, in his brilliant follow-up 20 years later to the classic Midtown Manhattan Study, summarizes the major problems faced by the researcher attempting to ascertain true prevalence roles. In trying to define "the case" there is the problem of defining "onset" when most psychopathologies are insidious in their development. Another problem was the lack of standardization in criteria and classification of the problem condition. His team in this major longitudinal study was able to develop a system for standardization in criteria and classification of community-focused investigations, as well as develop a computer-derived mental health rating system. This work has particular importance for cross-cultural studies given the cultural variations, meanings, and subjective experiences in psychopathology (138).

One of the frequent questions deals with the universality of psychopathology generally and of specific forms, e.g. schizophrenia, depression (109, 121, 137, 141). Studies reported over the years under review have been done in over 30 countries, all of which demonstrated the occurrence of mental disorder. Two studies reviewed (137, 141) directly dealt with schizophrenia. One finding noted that prevalence of schizophrenia in developing countries is roughly correlated with degree of Western acculturation and exposure to Western technology; and further, that there were no reports of process schizophrenia among "bush" individuals with no exposure to Western technology (137). The second finding, a pilot study that examined 1203 people (550 males and 652 females) from nine selected countries, reported that similar groups of schizophrenics can be identified in all countries studied (141). The comparison between country or culture dimension does not contain any variation in prevalence and therefore no real clue to etiology.

SOCIAL VARIABLES

Of specific interest was research on distribution of psychopathology within the culture as a function of social variables—age, sex, race, religion, social class, and social stress on the one hand, and culture on the other. Some general patterns will be reported to give the reader an overview of these findings and directions.

Age We first note an evening out of the distribution of mental illness across all ages, apparently based on the greater frequency of psychopathology among the youth in recent years (101, 124, 135). Beyond this, the literature contains very little in the area of social and cultural issues from a developmental perspective. A second general finding was based on a cross-national survey of the frequency of occurrence of various diagnoses among the elderly. It indicated a higher frequency of organic and a lower frequency of functional disorders among those admitted to U.S. hospitals than those in England (26). These findings could not be easily interpreted.

Race Numerous studies addressed the race issue directly (15, 25, 76, 83, 84, 107, 135, 144). The central consistent finding was that race alone could not account for the prevalence of mental illness and seems not to be a primary etiologic factor when trying to account for differences in the rates of psychopathology. Rabkin (107), in an epidemiologic study, examined four ethnic groups—blacks, Puerto Ricans, Jews, Italians—and found that both income and ethnicity factors must be used to predict rate of hospitalization.
Religion  Religion as a social variable was not adequately addressed in the literature. It is the single most dominant normative force regulating behavior in the Arab world, in Ireland, Israel, and also in Latin countries (43, 68). There are important differences between Christians and Moslems in prevalence rates (68) in the direction of greater frequency of mental illness problems among Moslems, but these trends are not explained. We could speculate that the methods of diagnosis may have been biased in favor of the Christian world.

Class  Numerous studies examined prevalence relative to class (3, 34, 35, 55, 64, 127, 143). These studies were in keeping with trends, explored by Dohrenwend & Dohrenwend (31), that there was an inverse relationship between SES and mental illness. The reason for this trend is not at all clear. The overrepresentation of one class has perhaps many levels of explanation. The class variables are not at all well defined in the literature. One is not sure if the cause is exclusively an economic reality or the sum total of varying social conditions or status relative to other groups. The issue of prevalence is complicated by an almost exclusive preoccupation with, and an overrepresentation of, the lowest class in the research. Is this because they are more readily accessible or exploitable than any other class? Embedded in this question, in fact, may be the primary diagnosis to be made about the group—not that they are mentally ill, but that they are oppressed (73). Another level of explanation is based on value premises represented with language, expectations, world views, beliefs, and life styles of those at the lower end. Diagnostic instrumentation may be reliably picking up the differences but invalidly assuming deficit or deviance. The class questions are in need of urgent reexamination.

Social stress  The social stress-psychopathology relationship is one that is now occupying a great deal of attention, particularly with our new ecological consciousness. Critical questions have been asked about mental health and the urban environment, and the impact of rapid social change (7, 35, 37, 67, 74, 101). The general conclusion is that there is not much evidence to be evaluated regarding the possible impact of neighborhood and residential parameters on mental well-being. When such evidence exists (7, 35, 67, 109, 118) the findings seem tenuous. There is only limited support for a positive relationship between high stress and mental illness, but we must be careful not to misread this finding. Researchers did not make the distinction between objective stress and that mediated by the subject. We must be aware of the variation in the perception of the urban environment (8, 41, 99). We must proceed with this kind of research.

In general, the studies on prevalence covering specific social variables did not significantly contribute to a greater understanding of true prevalence rates, but they are important because they raised issues in need of examination.

Culture  Studies looking at cultural issues or specific cultural groups failed to examine the parameters of culture and instead focused on prevalence within the culture as a whole (17, 38, 92, 104, 109, 118, 121, 133, 134). These studies were not
systematic with some referent point for understanding clearly the cultural variation in relation to the mental health problem. We are, therefore, not sure of the meaning of the following reported findings—lower psychiatric disorder and almost complete absence of overt anxiety among Australian aborigines (61); higher incidence of schizophrenia and mental illness among Puerto Ricans in New York (109); greater prevalence and characteristics of epidemic hysteria among predominantly rural Malay children (133, 134). Further exploration of specific cultural variables seems required.

**Patterns of Psychopathological Responses**

Patterns of psychopathological responses are closely related to the issue of incidence and prevalence as indicators in psychopathology. They raise questions about the manifestation and direction of responses of the individual and the group as well as the differences between types of psychopathology in different social and cultural groupings. The central question has to do with variation and modulation given the occurrence of the event. Given the prevalence of depression both in India and America, for example, what distinguishes depression in one country from that which occurs in the other, and what are the sociocultural antecedent conditions?

There appears to be a clear sociocultural aspect as to how psychopathology is manifested. This is based on prevailing beliefs and world views (97, 146, 148, 153). Values growing out of these beliefs and views influence the content (33, 35) and in some cases the structure, i.e., signs and symptoms (38, 47, 78, 79), of the manifest problem. Reliance on the professional framework rather than the analysis of meaning and subjective experience via research methods which utilize “emic” or cultural-relative approaches could be misleading (131, 134). In some cultures the experience may be embedded in a different cultural context which thus alters its meaning and subjective appraisal. Women do differ from men (12); social classes show variation (12, 82, 134); there are culture-bound syndromes (78).

One study by Binitie (14) on depression serves to underline and give some direction to the issues raised. He attempted to determine whether (a) depressives in African cultures show typical signs of sin and guilt, or (b) whether these depressives showed suicidal tendencies. The results indicate that depression in the African cultures studied emerged principally as depressed mood, somatic symptoms, and motor retardation. In the European cultures studied, depressive symptoms included guilt, suicidal ideation, anxiety, but less somatic symptoms. Both groups lost interest in work and in the social setting. Guilt and suicidal ideas or acts were uncommon in African subjects, which suggests that guilt and suicide to a large extent are culturally determined (33, 35, 61, 146). Other research findings serve to highlight the fact that sociocultural factors impinge on the individual or group to produce or promote differing symptom formation. In Papua, New Guinea, these forces precipitate the clinical entities of the spirit possession syndrome and those associated with cargo cult activities (20); in Colombian families it produces “Elduende” and other incubi (79); in Malaya it produces the culture-bound reactive syndrome of Amok.
(22, 147); in Qatari women the neurosis is initiated, bound, and maintained by sociocultural expectations (38). The same is true for the Dhat syndrome and depression in India (87, 118).

These varying patterns should allow some exploration of the behavior in question and some determination of the process by which it is induced, maintained, or altered by sociocultural variables. Unfortunately, these studies lack a methodological sophistication. Pfeiffer (105) carried out a field study on psychoses in a culture with strong traditions in a Sumatran island. Culture, in fact, did not appear to determine anything but the content of fears and anxiety. The underlying psychological condition was similar to that of the West (71). Rin (110) examined the social structure and psychopathology in Taiwan and Japan. He analyzed the symptomatology of 816 Japanese and 809 Taiwan Chinese mental patients. The factor analysis of the patterns showed both cross-culturally applicable and culturally specific symptom factors.

Although the literature reviewed seemed to suggest that distinctive cultural values are expressed in psychopathological behavior as well as in socially appropriate or desirable behaviors (27, 33, 146), much more work needs to be done in this area. If abnormal behavior represents a continuation, by unrealistic and inappropriate means, of learned mechanisms of behavior and application of a culturally shared store of social learning, we should be able to define more clearly the nature of social and cultural influences on these patterns.

Etiology

The search for specific causes of psychopathology is the major emphasis of a great deal of the research undertaken, and indeed the great majority of studies reviewed addressed the question of cause. In the examination of etiology the central question goes beyond the mere association or correlation of events. The research, in our case, is looking specifically for social or cultural parameters whose presence is associated with psychopathology and whose absence is associated with no psychopathology. This is indeed a difficult challenge. The establishment of such a clear-cut relationship does not often occur in the phenomena being studied. Very often researchers can only approach true cause and make inferences about the possibility. The questions raised by research in the area of sociocultural influences, in large measure, can only direct attention to the ways by which social or cultural factors directly affect social conditions making psychopathology significantly more likely or create conditions within the person so as to increase susceptibility to breakdown. Social and cultural factors can only create conditions of vulnerability within the person and/or social environment. The degree of vulnerability appears to be related to the extent and quality of internal psychological and organic changes that result from the continuous interaction between person and environment. Myers (99) suggests that the consequences of these stress-induced changes from the individual may be positive or negative depending on the success of their stress-mediating efforts. Unsuccessful stress mediation can potentially result in interference with adjustment, adaptation, and effective functioning (40, 41). The role of social, cultural, and sociocultural forces in this etiological process leading to psychopathology will now be examined.
We will follow this with the very central but often ignored opposite reality, that of the role of social and cultural parameters in the process leading to immunization against mental illness.

SOCIAL Social forces, both as a function of the individual's reality (age, sex, SES, etc) and the context in which the person operates, appear to exert their influences through stress (3, 60, 75, 77). These forces confront the individual with stressful roles. The individual may exceed his stress tolerance threshold due to the frequency and amount of social change (77, 80). This appears to be the process.

A classic debate has been waged in the literature as to whether individual vulnerability, assumed to be endemic and almost genetic, produces a social class high in psychopathology or whether psychopathology is a response to high social stress in a particular social class. The debate has centered on, and is in fact clouded by, the inverse relationship between social class status and frequency of mental illness (3, 18, 31, 63, 115, 145, 150). Two lines of inquiry have been pursued: (a) social causation hypothesis which assumes that the social stress of poverty, deprivation, and other environmentally induced stressful conditions on the individual produce mental illness; (b) social selection hypothesis which assumes genetic processing, i.e. the drift down the social scale by those whose symptoms and impairments have attenuated their abilities to function, such persons seeking a less demanding milieu that is more tolerant of deviant behavior (3, 34, 63).

The debate is a false one; first, because a historical process of social selection is being compared with a phenomenal process of social stress. Implicit in the historical process is the operation of social stress as a cause. Second, social class is governed by society's values. A society designates poverty levels, classifies certain behaviors as abnormal. Values influence not only the numbers assigned to poverty level and the definition and treatment of psychopathology, but also the relationship between poverty and psychopathology. The social process influencing poverty, the meanings culturally assigned to it, and the language expressing our attitudes toward the poor conjoin to produce and accentuate psychopathology (34, 115).

These class-conditioned debates limit full exploration of the relationship between inner human needs and those which stem from an absence of personal centeredness. The former are induced by the society; the latter may or may not originate in an oppressive society (95). The reasons for vulnerability are rooted in the individual as well as in society. Brown and her associates (18), in an excellent study of social stress and psychiatric disturbance among women in an urban population, found definitive evidence that vulnerability within lower socioeconomic classes (LSES) could be attributed to absence of intimacy with an available confidant; loss of mother by death or separation before 11 years; having three or more children aged 14 or younger at home; lack of full or part-time employment. Although the researchers did not study another income group, it seems to be clear from other studies that these findings have more universal application (20, 54, 60, 109). There is a need for this kind of well-designed research to study the issues within a dynamic, longitudinal model in order to advance a more comprehensive understanding of the interrelationship between social characteristics, family functioning, and individual behaviors (60,
100, 119, 143). Williamson (150), as an example, in a study on socialization, mental health, and social class, examined the specific issues of parental rejection, perceived parental punitiveness, feeling of parental distance, stability of emotional climate in the home, and sibling relationship. These variables were more salient in distinguishing between problem and nonproblem children than any other broad social parameter, as for example LSES.

Numerous other social factors, such as rapid change from traditional values (36, 51, 63) and changes in sex role (1), need to be more specifically examined to understand how they contribute to increasing the vulnerability to psychopathology.

CULTURE Every culture contains general and specific stress factors which are potential hazards to some individuals confronted with them (152). There appears to be mental illness in all cultures (58, 102). Some cultures have higher rates than others and appear to be more vulnerable to mental illness (97, 98). What is the role of culture in inducing mental abnormality? Is it culture or variations within culture that set conditions for mental abnormality? There is no real evidence that cultures are more or less pathogenic, i.e. that cultures produce mental illness (58, 102). There is evidence to suggest, however, that variation within culture or specific cultural stress factors are related to mental illness vulnerability (43, 49, 50, 77). Rubins (112) saw these as parental attitudes particularly in the area of child-rearing; representative social conflict based on contradictory values, goals, or expectations present in the culture; cultural norms. Wittkower & Dubreuil (152) identify three categories of cultural stress factors that relate to mental illness: cultural context (e.g. taboos, value saturation, value polymorphism, and role deprivation); social organization (e.g. anomie, social rigidity, and minority status); sociocultural change. Singer (121) explored more critically the relationship between depressive disorders and cultural variables, looking at ideas of sin, guilt, child-rearing patterns, and cohesion. He found two main patterns: one associated with guilt, sin, and anxiety; the other not so associated, and manifested more as mania than depression. He found no evidence of any relation between child-rearing and depression, or for depression among cohesive groups. We should not assume from this, however, that cohesion as a single independent variable produces immunity to depression. Cohesion usually means high intensity of interpersonal relationships. Gorney (50), in his research, found that low intensity of interpersonal relationships is associated with low incidence of aggression and mental illness.

Culture, through parental attitudes, exerts a major formative influence on the child's personality. Among factors which seem to create predispositions to mental illness are overprotectiveness, smothering love, harsh or authoritarian domination, emotional distance, coldness or actual physical neglect, and excessive expectations or standards (18, 21, 43, 60, 95, 125, 143, 150).

Culture penetrates in other ways. Laosa (76) and his colleagues investigated the effects of culture on the development of logical thinking and degree of emotional disturbance in normal children in two cultures—Mexican and Anglo-American. Results showed significantly higher amounts of disturbed thinking, anxious and hostile response content in Anglo-American than in Mexican subjects, attributable
to cultural differences in family structure and styles of coping. For instance, the Anglo-American encouragement toward early independence promotes higher anxiety, thought disorganization, and irritability. Albert (2) describes this condition as an anomic American society.

SOCIOCULTURAL There is strong evidence to point to a basic unity of man across cultures which is reflected in common personality types, common basic forms of psychological disturbance (28, 39, 52, 58). Culture is, in its essence, history. There is an inherent limitation in specifying cultural variables as an influence on certain pathological behaviors without an adequate understanding of history. Researchers undertake their task at a concrete moment in history. The behaviors they examine are a product of history and at one time were eminently functional in the development of the group. What perhaps requires more specific examination is the reason for their persistence in the face of social change requiring alternative strategies. We should look at the relationship between change generated from within and that generated from without. Until the role of history is more fully understood, the study of culture in psychopathology will remain mere description of moments of history (46, 73).

There is, however, some research in the general direction of understanding the interrelationships between historical or cultural forces and social forces (47, 75, 98, 104, 111, 128, 129, 136). By far the majority of these studies took a multivariate approach with emphasis on sociocultural factors rather than social and cultural factors separately (30, 33, 35, 39, 52, 93, 96, 152). Dohrenwend (30) reviews three bodies of evidence which suggest that sociocultural and sociopsychological factors are important in the genesis of functional psychiatric disorders. Dunham (35) examines the process by which selected sociocultural factors “make their ingressio into the personality” and emerge as mental disorder. His major conclusions were that schizophrenia and manic-depression were differentially distributed; that schizophrenia was heavily concentrated in LSES but that social class was not an etiological factor; that no sociocultural factor has been conclusively demonstrated to play a role in development of schizophrenia; that social change does not produce a situation that causes mental disorder; and that culture determines content but not the form of psychopathology.

There is perhaps a parallel question to Dunham’s that ought to be raised, i.e. the process by which social and cultural factors penetrate the sociocultural structure and emerge in social and/or cultural conditions which create a context for human breakdown or for positive mental health. This issue remains largely unexplored. It is the issue of social oppression.

Torres-Matrullo (136), in an indirect and tangential sense, examined this issue. He studied the acculturation of Puerto Ricans moving to the United States; subjects low on acculturation seemed more inclined to higher depression and scored lower on scales of self-confidence, self-control, and lability. A key question that this raises is what in both culture and social condition better facilitates acculturation? Murphy (98) examined indirectly the question in a study of sociocultural change and psychiatric disorder among rural Yorubas in Nigeria. His evidence did not indicate that
change or modernization or Westernization causes psychiatric disorder. Those who
were in a position of disadvantage or suffered functional breakdown during the
change lacked social support, self-realization, and seemed confused by the two
dominant religious orientations. Gobar (49) studied mental patients in Afghanistan
to evaluate the role of cultural and social forces. The influential factors reported
were: (a) child-rearing based on close and supportive family ties; (b) a strong
Islamic tradition emphasizing determinism, contributing, with family relationships,
to strong defenses; (c) community attitudes emphasizing denial of mental illness.
These forces in combination resist rather than facilitate social change. There is still
much, much more to be done in this area to understand more critically the nature
of the impact of social and cultural forces.

IMMUNIZATION

We have attempted to examine the interrelationships between social and cultural influences on psychopathology. The prior evidence in this is very well summarized by Dohrenwend (30), Kaplan (64), and Segal (116). Levine (80) postulates that if industrial society maintains its present set of conditions—weak social structures, diffuse and rapidly changing values, vague adult gender roles—that the incidence of disorder will undergo a continuing and substantial increase. This not only prompts but underlines the necessity for the next question: What in the cultural or social structure facilitates the prevention of, or susceptibility to, psychopathology?

The issue of immunization raised by Dohrenwend & Dohrenwend (31) has not been at all adequately examined. The literature is mainly speculative, never quite addressing how emotional responses and cognitive capacities of the individual adapt to the changing conditions of society and culture (70, 81). There is some evidence that groups with structures or rituals for relieving guilt, anxiety, and grief, that allow children to deal with supportive adults, and provide status for women and elderly persons have low depression and psychological disorder (50, 71, 120, 121). There is also clear evidence that individuals or groups that are able to maintain some continuity of change, but still maintaining cohesion through custom, language, worship, life-style, and ceremonies develop a buffer against the breakdown characterized by persons without roots (23, 148). Abernethy (1) suggests also that the changing roles of women will have a positive impact on both men and women as a result of increased flexibility in gender role specifications. In the years to come this may become a central debate in this field. At present, however, this whole area of focusing on health is in dire need of examination.

Special Parameters

The examination of social and cultural influences in psychopathology requires, at least in the American context, a special focus on the issues of ethnicity, sex, and class. We have to some extent explored the class variable somewhat independently of ethnicity with which it is so closely linked in American life (3, 29, 37, 84). These three variables constitute very critical sociocultural parameters because of continued racism, sexism, and class oppression as social phenomena endemic to American
life. But ethnicity, class, and race are also important because imbedded in them are differing child-rearing practices, values, expectations, norms, and life styles as cultural phenomena (1, 55, 135, 143).

We are forced to confront directly the findings of the literature under review which suggest some major trends. First, we examine the race issue, with specific reference in most instances to the group most frequently studied, black persons; that blacks emerge from the diagnostic process appearing more disturbed and more pathological than whites who show the same behavior (25, 101, 107, 144); that the same behavior in black women is called schizophrenic while in white it is called neurotic (15, 101); that there is a greater frequency of depression labeling in whites and a greater frequency of personality or character disorder labeling in blacks (107, 147) that black hospital admission rates are much higher than whites (3, 9, 25, 107) and of this group blacks are heavily concentrated in the category of psychoses to the relative exclusion of other categories (9). Second, we examine the sex issue; that there is a greater frequency of mental illness in females (12, 101), that women show more depressive symptomatology and men more character disorder (144, 145), and that in almost all cases of reported culture-bound syndromes the sex affected is female (38, 133, 134). There also continues to be some disturbing trends found in the literature such as the influence of race on diagnosis (9, 16), on admissions to and releases from the hospital (9), on range of services offered (25), on differences in treatment (89, 90), and, finally, the influence of sexism in psychotherapy (1).

The findings above introduce value questions, including the tendency of the mental health specialist to reduce all explanations to psychobiological reality (73); the tendency to use one value frame of reference in perceiving the behavior in question (56, 84). Race and sex as biological entities are the first to which society responds. There are few objective differences in clinical presentations in blacks and whites or in males and females (56). Nevertheless, blacks are perceived as having more symptoms, more complaints of persecution, more suspiciousness than non-black patients. Diagnostic differences do not necessarily imply cause. Differences may be a function of the misperception of the researcher of language, cognitive style, appearance (75, 90), the white male domination in the questions asked, information gathering and processing, or the problem of constructing adequate measuring devices to explore the defined parameters (155).

These data bridge social and cultural considerations. We argued in the introduction of this review for an understanding of the political implications inherent in any study of psychopathology. Fortunately the research has reached a level of scientific integrity that no researcher reviewed suggests, nor do the findings indicate that race or sex is a cause of mental illness (19, 101, 135). When race and sex are combined with LSES, however, there appears a disproportionate trend toward mental illness (3, 12, 144). Race or sex alone is not a primary etiologic factor when trying to account for differences in the rates of mental illness between races or sexes (144).

The ability of blacks, other minorities, and women to survive and function in a biased society ought to be seen as a positive. We should be in search for the strengths of these groups which allow them to function competently and not pursue only our
almost exclusive search for psychopathology. The research needs more critical expansion into all of the cultural groupings that make up the multiversity of the world community.

RESPONSE TO THE PROBLEM

The individual, the family, and the society develop methods to ameliorate or change the psychopathological condition. The central question addresses the nature of this response to the problem and the social and cultural influences that determine the response or the therapeutic encounter.

The response to the problem of psychopathology from a personal, familial, or social vantage point is a function of the conception of psychopathology and the values, prevailing beliefs, and world views. These concepts range anywhere from object or spirit intrusion, including witchcraft or sorcery, to the disease notion of the medical model. Researchers who have examined public concepts of mental illness have found three prevailing conceptions: first, that it is biologically determined, and very often going along with this is the conception that it is incurable; second, that it is a psychological problem, that the individual is partially responsible for his condition and that with maturation and help he can improve; third, that it is a supernatural condition requiring appeasement of the spirits or gods. These conceptions seem to be on a continuum from spiritual to medical to functional, based on knowledge, awareness, and education about mental illness. Traditional cultures still hold to spirit conceptions, rural and small-town Americans still hold to exclusively physical illness conceptions, and urban Americans now readily entertain functional conceptions. The conceptions which affect the professional community seem also to affect the youth, that is, there is some implicit education ongoing.

Yet the response to mental illness is also influenced simultaneously by prevailing world views, values, and beliefs. Together they constitute sociocultural variables which modify the manner in which symptoms or signs are shaped, perceived, recorded, and treated by individual, family, and society. They also influence provider attitudes and administrative policy. Wilson, for instance, argues that the acceptance of a medical or physical view indicates a lack of confidence that mental illness can be treated successfully. This no doubt led to the development of asylums and the abandonment of the mentally ill. The greater acceptance of a functional reality may have led to the development of the community mental health center approach.

Perhaps the major determinant of response is the degree to which ongoing systems of interaction are threatened or disrupted by problematic behaviors. The nature and importance of these systems are a function of custom, value, belief, and practice. The disruption is accompanied by signs or symptoms viewed from the perspective of the sociocultural reality. How do people respond to this? Mechanic found that very little systematic work has been done in studying the social development of different disposition or choice of pathways of response that focuses on personal responses to psychological disorder. He discusses the literature on help-seeking
disposition, pattern of utilization, effects of the structure of health delivery on utilization, and the process of illness attribution. He concludes that "the type of care selected depends on socio-cultural predisposition, the assessment of the locus of causality of the problem, the immediate social context and the character and accessibility of available helping services." Clausen & Huffine (24) studied sociocultural and sociopsychological factors affecting social responses to mental disorder. They conclude that response will depend on the attributions of motivation or causation. Social order, via diagnosis, decides which behavior threatens to disrupt the social order, and this process informs this social response. Both authors were largely addressing Western world reality.

Generally speaking, in traditional culture there is little of the formal diagnosis that characterizes the Western world. "Diagnosis is by divination," and when it's made it's more serious. Treatment involves intense supportive short-term action in which a ritual performed by priest, shaman, or witch doctor is the placebo effect in the cure of the patient (25, 154). Application of any other procedure to deeply traditional society gives rise to difficulties. These folk healers minimize the social distance between primary care-giver and the person served. This constitutes the classic deprofessionalization model. For a long time, in such countries, the services of traditional healers will be indispensable in the treatment of mental illness (59, 113). The larger social response is still lacking (5).

In more industrialized nations there is reliance on a professional model of formal diagnosis, specialized psychotherapy, and long-term action. There is less tolerance of unusual behavior (70) and more reliance on institutional arrangements of hospitals and community health centers for the care and treatment of patients. But even in such countries, Lorion (83) assesses fewer than one-third of those experiencing psychological symptomatology currently seek aid from health professionals. There was no reported study to determine what kind of help-seeking aid is sought from nonprofessionals.

Singer (122) underlines the importance of the cultural perspective for effective social response. There is need to investigate more systematically and intensively the conceptual and cultural variations of psychopathology and the interpersonal dynamics in specific social and cultural groups in order to develop more adequate therapeutic responses. The requirements and needs of the mental hospital should not determine the symptoms of the patient (140); neither can the assessment of the person be considered in the absence of the person's living conditions, family structure, and interpersonal style (83). These are critical in setting therapeutic goals and approaches. Social response toward mental illness must also begin to explore the larger role of society in setting the conditions for fundamental social change in the interest of reduced mental health problems (73, 94).

METHODOLOGICAL ISSUES

The problem of social and cultural influences in psychopathology is a very difficult one, consisting of the interaction of multiple variables in a range of locations over differing time periods. Research on this subject area requires a historical and system-
atic methodology if critical and valid statements are to be made about the complex relationships of this interactive process. The fundamental question now being raised relates to the appropriateness of methodology for the central problem being investigated. Researchers had a choice of designs, methods of observation, range of measurement techniques, and types of analyses. Was their methodological chain congruent, fitting together, and appropriate to the research problem? But even beyond this, what was their level of data interpretation?

Despite the obvious improvement in the research methodology in this area since the last review (31), a general statement can be made that only a minority of the studies reviewed carried with them the methodological sophistication necessary for some form of generalization (18, 20, 29, 68, 126). The majority of studies had no clear conception of the problem, ill-defined theoretical bases, weak designs, and questionable analyses (74, 86, 98). We can examine some of these.

Perhaps a major social and cultural influence in psychopathology begins with the theories and frames of reference of the researcher. His theory affects the view of the problem, the question raised, the design instrumentation, and the interpretation of data. An adequate statement of the problem is one of the most critical aspects of research. If one wants to solve a problem one must know what the problem is. Yet in a majority of studies examined there was no clearly established frame of reference or objective analysis of research perspective (3, 27). Underlying this problem is a basic failure in most of the research to address the issue of normality as a point of departure for the study of abnormality. We are never sure whether we are addressing a statistical problem, ideal mental health, or the presence of certain behavior sets; whether we are dealing with biological issues as implied in "downward drift" theory (31), psychological issues (38), or value questions having political implications (48, 73). This issue ought to be immediately resolved by researchers. Researchers should begin with explicit statements of their value premises and theoretical bases so that they begin to more fully understand how much research is not value free. This is of particular concern in the examination of the problem area under review (73, 99).

Research designs grow out of one's theoretical base. They provide answers and control variance in the research pursuit; they set up a framework for testing the relationships among variables, guide observations to be made, determine to make and analyze them. Designs, in the research reviewed, largely fell into two major categories: correlation and ex post facto, with a few scattered studies in the area of survey, field observation, case study, and true experimental designs. While the emphasis on naturalistic design procedures was in keeping with the complex nature of the problem under review, there was very little indication of a serious attempt to correct the structured weaknesses inherent in such designs, that is, those that result in no control or poor control of the independent variables, one-shot case study, or assumed or imagined independent variables (19, 39).

The continuing major problem in the research in general is absence of adequate controls or assumed or imagined existence of independent variables which, in our case, are the social and/or cultural influences. Studies report, for instance, that severe life events and major long-term differences occurring in the year before onset of psychopathology play an important etiological role (78), without reporting the
nature of the comparison group or any adequate control of extraneous independent variables. In fact, the independent variables under investigation are so ill defined as to affect everyone, and we are therefore not able to answer any research questions.

Despite this continued major limitation, however, some very sound work has been undertaken and accomplished in the field (18, 29, 62, 127). We have already addressed the unique longitudinal study of Srole (127) and the in-depth study of Brown and colleagues (18).

Binitie (14) used a factor analytic design to study depression across cultures, looking at variations in depression as a function of cultural realities. Guntern (51), in a longitudinal study, examined the relationship between social change and mental health in a remote village in the Alps. He was able to initiate measures before the independent variable (social change) had already occurred. Thus he was able to build adequate controls against which to make valid comparisons.

Srole (127) enumerates the improvements made in the field over the past few years in the area of methods of observation and measurement. These include the advances mainly in the field of sociopsychiatric epidemiology. These are (a) a shift from inpatient to community populations; (b) a shift in the mode of data gathering from institutional care records to multihour face-to-face interviews; (c) a move from psychiatry's rigid categories to issues of degree of severity form of classification; (d) a move from exclusive focus on mentally ill to the entire spectrum of mental health differences; (e) a shift from mere incidence to prevalence as a more meaningful measure of frequencies of mental health states; (f) a move from cross-sectional to longitudinal type studies; (g) a new emphasis on subjects' strengths as well as their deficits.

Srole's own study utilized these new improvements, but numerous other studies developed unique methods for improving methods of measurement (13, 26, 65, 135, 144). Beiser and his colleagues (13) developed, by means of factor analysis, a valid scale for measuring psychoneurotic behavior in cross-cultural settings. Bain (8) did a study on the geographer's approach in the epidemiology of psychiatric disorders, neatly introducing another level of observation and developing techniques for the measurement of environment. Derogatis and his colleagues (29) evaluated the nature and degree of differences between three measures of clinical status often used as primary indicators of mental illness: (a) general severity score, combining information on both numbers of symptoms and intensity of distress; (b) a symptom distress score, reflecting only intensity of distress; (c) a pure enumerative indicator, reflecting only number of symptoms. They were able to go beyond mere confirmation of the inverse relationship between social class and psychopathology and to demonstrate that the existence of such a relationship is conditional. Other useful measurement strategies were developed by Reed & Jackson (108) and Zeldine (155).

Of special methodological concern is the whole issue of cross-cultural comparability. Usually researchers (a) use concepts from one culture and investigate them in another, their studies being concerned with antecedents and consequences, (b) replicate a study from one culture in another, (c) examine the subjective culture of each cultural group separately, (d) design and standardize tests in one culture and administer it to another. Can behavior be predicted from any of these approaches?
The answer is an unqualified no, although the data searches reveal useful information (129).

Before researchers can make any adequate comparison they need to penetrate the meaning of the culture. This means gaining access to the culture, matching samples, developing meaningful questions, i.e. questions that have some equivalence and social reality and a rationale that is based in the culture rather than in the researcher. The study by Marsella and colleagues (88) on the cross-validation of self-report measures of depression among three cultural groups complied with the rules suggested above. Other studies in this trend include those by Tenando (43) and Murphy (99).

Finally, there is an issue which grows out of methodological reality, one of interpretation. The social class issue for instance is laden with interpretive difficulties. It is difficult to attempt to explain differences by class since we have no power to manipulate SES and no power to randomize. We never know if class is a determinant or a correlate. We run the risk of improper interpretation by not being sensitive to alternative explanations. This is of particular concern in the area fraught with narrow value assumptions, meaning, and beliefs which in some instances continue to result in racism, sexism, and oppression. We must become sensitized to these realities and remain constantly vigilant so that as we seek to discover relationships in the world we recognize limitations (73).

IMPLICATIONS AND CONCLUSIONS

Implications

We tried to understand the implications from this very vast literature by looking at it in various ways. This review examines 155 publications. At level one, a breakdown with regard to designs utilized would roughly look like this: 9 true experimental, 44 review type articles including books, 31 ex post facto, 41 correlational; about 21 were collaborative, i.e. with indigenous researches; there were roughly 23 surveys, 11 case studies; there were only 14 studies on children; subjects came from roughly 40 countries; the major measurement or assessment technique was by observation or specialist interview. At level two, an examination of the general findings from all these studies can be summarized as follows: that psychopathology is universal; that its prevalence across countries is roughly the same, although special groups within social structures may have a higher or lesser frequency; that manifestations of psychopathologic signs and symptoms differ from culture to culture; that the basic etiological processes, with exceptions like the culture-bound syndrome, are generally the same for all cultures but also contain their basic expressive differences; that minority groups (class or race) and women in every society studied were overrepresented in the general mental illness category. At level three, we note from tentative data that most of the researchers were males from majority groups; that implicit in their formulation of mental illness was a medical model of disease; that mere observation of the list of journals in the references cited indicated either that the topic is not sufficiently important to most of the major psychological journals, or that the major researchers are sociologists, or that the nature of the
variables is such that true experiments were not possible and therefore were excluded from the mainstream of psychological thought. Less than 20 of the published listings come from what are the leading American Psychological Association journals. We can perhaps be comforted by the trend because this is an improvement over the last review (31). What are the implications to be drawn from these three data levels?

We began this review by stating that we would examine the advance and progress in this field since the last review. The last reviewers concluded that

... this field has reached the stage where a fascinating descriptive data has posed a set of major substantive issues. It is moving toward the stage in which increasing sophistication will be brought to bear on the methodological problems that stand in the way of resolution of these issues ... (31, p. 447).

From our review we are forced to conclude that either the advance is very slow or the stage is very large. Not only is the present state of methodological techniques and substantive knowledge far from being satisfactory, but the implications of most of the research are far from clear. We have only scattered islands of hard data based on sound procedures, fragments of uncoordinated valid information whose significance is obscure. So perhaps the first immediate implication is the need to correct the methodological problems now so pervasive in the literature (31, 64). Srole (127) has made some suggestions in this regard. The central problem requiring correction is in the area of establishing adequate controls or entertaining alternative hypotheses or examining alternative independent variables.

Perhaps ever prior to this is the necessity for more explicit frames of reference and theoretical bases. One of these theoretical formulations of critical importance affects the race, sex, class issues. There is some real implication in the research of the existence of an oppressor-oppressed relationship in the examination of psychopathology. King (73) suggests that we too readily look for the degree of pathology in the oppressed, overlooking the pathology of the oppressor. We need critical reevaluation of assumptions and paradigms in order not to perpetuate oppression.

Yet another issue that seems central to advancing our present growth is the whole area of the relationship between health and ill health. We need to focus more on issues of health not limited by the one-dimensional data levels that we utilize—biophysical, intrapsychic, phenomenological, and behavioral. We need to develop multivariate approaches to include issues of power and politics (72, 94) or transactional analysis.

Finally, there is deep concern that very little attention is being given to life span developmental studies. We need to look at social change as well as simultaneously essential human development changes. The next reviewer should be able to examine many more children studies.

Conclusions

Our review was a general analysis of the 1974–76 literature on social and cultural influences in psychopathology. The data suggest that indeed there is a relationship between social and cultural forces in the emergence of mental illness. We are unable
to generate major definitive statements beyond this very general and somewhat obvious conclusion. The data, however, are very important, in particular for future research directions. We have built some banks of descriptive data and have begun struggling with issues of diagnosis, cross-cultural comparison, and developing measurement constructs that will serve the future researcher well.

With Dohrenwend & Dohrenwend (31), we feel that this is now a very exciting time in the field. The vastly improved international communication systems make the world a smaller stage. The interpenetration of cultural values and the exchange of cultural forms ostensibly bring people closer together. What is the meaning of this for our growth and development, with particular reference to our strengths and limitations? The field under review can meet the challenge. We are heading for a new world order, and Fanon's (42) personal pleas at the opening of this review must not be forgotten. We must search for new ways through our research to allow the individual and the group by the same act and at the same time to serve their own advantage, that of the group and that of humanity.

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