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Cultural differences in conceptual models of depression

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Abstract

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

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

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

Keywords: Depression; Cultural differences; Illness representation; Conceptual models; USA

Introduction

Though depressive illness is common in many societies and has been defined in recent years as a major global public health problem, professional treatment seeking is relatively rare in many non-western societies and among immigrant and minority groups in the west. Recent studies of African Americans (Sussman, Robins, & Earls, 1987; Swartz et al., 1998), Latinos (Padgett, Patrick, Burns, & Schlesinger, 1994; Wells, Katon, Rogers, & Camp, 1994), and Asian Americans (Sue, Nakamura, Chung, & Yee-Bradbury, 1994; Ying & Miller, 1992) confirm that members of these ethnic groups are less likely than whites to utilize voluntary specialty mental health treatment.

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

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

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

Background: culture and the disease model of depression

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

On the other hand, studies carried out under the rubric of "mental health literacy" research suggest that "situational" models of depression are common even in advanced western countries, and that such models are often associated with negative attitudes towards professional treatment. Surveys of the general public in Australia and New Zealand (Jorm et al., 2000) and in Switzerland (Lauber, Nordt, Falcato, & Rossler, 2003) found that informal avenues of help were viewed as more efficacious for depression than mental health professionals, and "life style" remedies more efficacious than antidepressants. Notably, studies that have examined the influences of ethnicity and SES factors on attitudes towards depression treatment consistently find that attitudes towards mental illness correlate with education, with more educated respondents more likely to hold favorable views of professional treatment (Jorm et al., 2000).

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

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

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

The present study

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