2. Multicultural And Crosscultural Assessment: Dilemmas And Decisions

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Cross-cultural psychologists aspire to scientific objectivity and cultural sensitivity. These two objectives are pursued simultaneously, yet they often exercise a pull in divergent directions. If the investigator's concepts, instruments, and procedures are designed to maximize cultural appropriateness, they may not be usable within other cultures. If, however, comparability is the principal consideration, sensitivity to the unique culture that is being investigated may be compromised.

The assessment of disturbed behavior across cultures is not exempt from these two pressures. In this chapter, four objectives are pursued. First an attempt is made to take stock of the present state of multicultural assessment. Second, the choices that are open to the contemporary investigator and practitioner of cultural assessment of psychological disturbance are articulated. Third, some preliminary suggestions are proposed for dealing with the challenge of simultaneously achieving cross-cultural comparability and cultural sensitivity. Fourth, proceeding from this proposal, generalizations are formulated about the culturally distinctive components of the experience and expression of psychological disorder and about their integration in the course of assessment. All of this information is brought to bear upon the practical issues of assessing distressed and/or disabled

individuals in culturally diverse environments. Before this body of accumulated relevant findings is applied in multicultural assessment, a number of complications must be identified and, if possible, resolved.

Because the activities of culturally oriented assessment have potent consequences for better or worse, those engaged in this enterprise should be warned against dangers and pitfalls, such as equating different and unfamiliar behavior with the bizarre and the dysfunctional. It should also be emphatically pointed out that the comparison of complex and meaningful behaviors across cultures does *not* imply the superiority or inferiority of any group at either pole on any psychological dimension. The history of the last 30 years of cumulative, organized research in cross-cultural psychology (Berry, Poortinga, Segall, & Dasen, 1992; Brislin, 1983; Kagitcibasi & Berry, 1989; Segall, 1986) decisively demonstrates that socially relevant behavior can be compared realistically and sensitively, without the investigators either extolling or devaluing any of its culturally characteristic variants. Thus, the unfortunate and long history of comparisons of intelligence across racial, ethnic, and cultural lines has, so far, not been repeated by the contributors to the modern enterprise of cross-cultural psychology. Moreover, cross-cultural psychologists have by and large been successful in avoiding the pitfall of equating cultural differences with deficits (cf., Cole & Bruner, 1972). Time may now be ripe for applying the results of the culturally oriented assessment effort to the solution of practical problems in community, educational, psychiatric, and other settings. To this end, however, certain specifications and distinctions must be introduced.

SETTINGS, CONCEPTS, AND METHODS: INITIAL AND TENTATIVE SPECIFICATIONS

Cross-Cultural and Multicultural Settings

Cultural barriers are encountered and, in the fortunate case, overcome in two contexts. First, there is the worldwide panorama of psychiatric symptoms across political and cultural frontiers and geographic obstacles and distances. It is possible and worthwhile to compare the anxiety responses of the Inuit of the Arctic with those of the urban Canadians of Metropolitan Toronto or the symptoms of the hospitalized depressives in Germany and in Japan or the coping responses under conditions of extreme stress during the earthquakes in Mexico in 1985 and in India in 1993. Second, the ethnocultural diversity of many localities in the United States provides both challenges and opportunities for the recording, comparison, and investi-

gation of the humanly universal and the culturally variable aspects of psychological disturbance. Moreover, cultural diversity is not unique to the United States. Ethnocultural groups share their habitat in Canada, Brazil, India, Singapore, Australia, Kenya, and Nigeria, to name but a few of the multicultural nations. Although culturally homogeneous nation states do exist, as exemplified by Japan, Korea, and Iceland, voluntary and forced population movements of the past few decades have contributed to making monocultural nations the exceptions to the worldwide trend of an ever greater degree of interethnic mingling in residential and working environments.

There are then two kinds of cultural challenges to be considered: across national frontiers, geographical, and physical barriers and within the multicultural microcosm of many contemporary communities in North America and elsewhere. The problems faced by the investigators of these two kinds of diversity are in some respects similar, although important distinctions should also be kept in mind. Members of several ethnic groups within a region or city are seemingly easier to compare than people who live thousands of miles apart, speak different languages, and stake out their livelihood by radically different means. Yet hidden disparities in interethnic comparisons within a region or city should not be overlooked. The first and foremost among them is the uneven distribution of power, privilege, and opportunity, both as a current condition and as a historical memory (cf., King, 1978; Sue, Sue, & Sue, 1981). The second challenge is posed by the interactive and complex influences to which the several ethnic groupings of a multicultural society are exposed. These influences reverberate within the members of these ethnic groupings to produce complex patterns of acculturation and identity. Compounding this complexity, there is the problem of multiple and overlapping group membership and the difficulty of converting the naturally fuzzy intergroup boundaries into clearly delineated categorical entities. In the prototypical case, nothing appears to be easier than deciding whether a person is Japanese, Portuguese, or Finnish. The task calls for a binary, either-or, inclusion-exclusion judgment. However, in the multiethnic environment of the United States and Canada as well as many other sites, the seemingly straightforward activity of assigning an ethnic or cultural label to an individual becomes exceedingly complex. Thus, there are the several criteria of ethnic group membership to be considered, similar but not identical in the typical case, yet exercising a subtle and simultaneous pull into a number of directions. These topics are discussed at greater length in another section of this chapter. (See *Identity*, *Acculturation*, *Biculturalism*.).

One of the distinctive dangers in assessment across culture lines is to equate the deviant with the disturbed and "to blame the victim" in the process of assigning responsibility for his or her problems and entanglements. Another ubiquitous pitfall is stereotyping for which the blatantly prejudiced persons are not the only ones at risk. Closely related to it is the potentially distorting effect of pre-existing attitudes and expectations; again, these variables need not be negative or derogatory to obscure or confuse the observer's view. Later in this chapter (see *Diagnosis as Social Interaction*) opportunities are provided for immersion into these complexities. For the time being, the priorities of this undertaking should be spelled out. The present chapter draws upon both multicultural and cross-cultural sources. Its thrust, however, is to disentangle the assessment issues as they apply to a geographically delimited, but culturally diverse environment, as exemplified by, but not restricted to, the contemporary population composition of the United States.

Culture Around and Within Us

Herskovits (1949, p. 9) defined culture as the human-made part of the environment, implicitly encompassing within this statement both artifacts and ideas. LeVine (1984) made this inclusion explicit by referring to culture as "a shared organization of ideas that includes the intellectual, moral, and aesthetic standards prevalent in a community and the meanings of communicative actions" (p. 67). Triandis (1972) introduced the concept of subjective culture and identified a great many subtle and complex indicators of its operation. In particular, subjective culture comes into play in determining interrelationships between concepts, in tying together concepts, roles, and behaviors, and in articulating implicit cognitive assumptions that underlie various actions in everyday life. Generically, subjective culture can be equated with the fund of knowledge, attitudes, and beliefs shared within a cultural milieu. Its tenets are silently assumed rather than articulated by its members while engaging in social interaction and representing it cognitively. Thus conceived, subjective culture becomes a potentially important mediator of meanings and behaviors within a cultural milieu and a possible determinant of both adaptive and dysfunctional patterns of experience and action.

At a more abstract level, culture remains a complex concept several steps removed from the observable. It is yet to be unpackaged. The progression which the field of assessment has begun to traverse is from culture as a variable "which makes things happen" or, retrospectively, as an entity that is invoked after its putative effects have been

observed. Instead, the question to be answered is: "What about the culture is responsible for various characteristic behaviors among its members?" Thus reformulated, the concept of culture could generate meaningful hypotheses, instead of serving as a convenient source of post hoc explanations. Betancourt and López (1993) have pointed out that cross-cultural investigators have often neglected to specify the characteristics of culture that are crucial for influencing behavior. Thus, little is learned about the components of culture that have contributed to its relationship with behavioral variables. According to these authors, the optimal course of action is to incorporate culture into the research design prospectively and explicitly rather than invoke cultural influences as explanation for the results obtained on a post hoc basis. This recommendation is equally applicable to both basic and applied research. Its implementation "would result in instruments and interventions that are more sensitive to the reality and cultural diversity of society and the world" (Betancourt & López, 1993, p. 636). As an example, López, Hurwicz, Karno, and Telles (1992) were able to trace the greater frequency of hallucinations among Mexican American patients, as compared to their Anglo counterparts, to the intense religiosity in the Mexican culture which tolerates and explains supernatural experiences.

Assessment, Diagnosis, and Measurement

Assessment is an inclusive term that encompasses the appraisal of a person's characteristics in quantitative and/or qualitative terms. Measurement constitutes the quantitative aspect of assessment and is embodied in a multiplicity of tests and scales. At this point, the field of cross-cultural and multicultural assessment of psychological disturbance largely relies upon qualitative procedures. It has not reached the point of thorough and consistent quantification of its observations, judgments, and inferences. Its data are typically couched in qualitative terms of which the diagnostic activity of clinical practitioners of assessment provides a prominent example. To be sure, there are scales, tests, and other measures of specific aspects of psychological disturbance, exemplified by the multiple measures of depression. In cross-cultural usage, however, these instruments remain in an auxiliary role. They provide valuable and important information that contributes to, but does not by itself determine decisions concerning diagnostic formulations or treatment and intervention, which constitute the most important justification for assessment.

Assessment is often focused upon diagnosis. In the restrictive sense, diagnosis refers to the assignment of individuals to qualitatively distinct categories of mental disorder. In its broader meaning,

diagnosis extends beyond categorization and labeling and encompasses all the information that is relevant for therapeutic intervention. The current official diagnostic and statistical manual, DSM-IV (American Psychiatric Association, 1994), attempts to fulfill this objective. It includes five axes, which both divide and amplify the task of diagnosis, and supplement it with the appraisal of stress imposed and of demonstrated adaptive assets at the person's disposal. Assessment then is often geared toward diagnosis; diagnosis is one of its goals, although virtually never its sole concern.

Psychological Disturbance by Many Names: Its Current Conception.

The objective of assessment for the purposes of this chapter is variously referred to as psychopathology, psychological disturbance, or mental disorder. It roughly corresponds to the scope of the syndromes included in DSM-IV, the current version of the official American diagnostic manual. The fundamental criteria for inclusion of a behavior pattern in DSM-IV are *distress* and *disability*. The criteria of mental disorder are described by the authors of DSM-IV (American Psychiatric Association, 1994) as follows:

> In DSM-IV each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable response to a particular event, e.g., the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior, e.g., political, religious, or sexual, nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the person, as described above. (pp. xxi—xxii)

This statement articulates another important distinction; it sharply differentiates mental disorder from social deviance. This difference is crucial in the application of DSM-IV to ethnically and culturally diverse populations (cf. Good, 1993).

The immediate predecessor of the current manual, DSM-III-R, has generally received positive evaluations for its markedly increased reliability by comparison with the earlier versions of DSM. DSM-III-R has also been praised for reducing the ethnocentric bias toward the

mainstream Anglo-American culture of these early documents, although it has not eliminated misdiagnosis of culturally atypical individuals (cf. Good, 1993). In DSM-IV, several further steps have been taken toward incorporating cultural sensitivity into the diagnostic process. Specifically, its authors have listed and described several points that are essential for the diagnostician to consider in arriving at a culturally sensitive formulation and in assessing the impact of the individual's cultural context. This listing includes: (a) the cultural identity of the individual, (b) the cultural explanations of the individual's illness, (c) the cultural factors that may be related to the individual's psychosocial environment and his or her levels of functioning, (d) the cultural elements of the relationship between the individual and the clinician, and (e) an overall cultural assessment for both diagnosis and intervention. Moreover, the cultural ramifications of diagnosis have been addressed on the conceptual plane in the introductory portion of the manual. Another novel feature included in DSM-IV is a glossary of culture-bound syndromes. Even though most of these conditions, exemplified by *Amok, Koro,* and *Susto,* are not likely to be encountered within the clientele of most North American clinicians, this roster should sensitize the users of the DSM-IV to the possibility of unusual symptom patterns by culturally atypical clients. The authors of DSM-IV recognize that culture-bound syndromes can be fitted into the existing nosological grid with difficulty, if at all. Cultures just have not shaped their patterns of maladaptation with the available slots of DSM-IV in mind! The final culturally sensitive innovation in DSM-IV pertains to Axis 5, which is concerned with the assessment of the adequacy of person's global functioning. On this axis, DSM-IV has incorporated a provision for culturally patterned modes of functioning.

These modifications go a long way toward making the diagnostic process and its results more culturally sensitive and informative. However, it would be hasty to conclude that all of the psychometric, clinical, and cultural limitations of the diagnostic system have thereby been overcome. There is no doubt that DSM-IV will be critically and searchingly scrutinized, last but not least for its adequacy in assessing mental disorder and maladaptation in a culturally diverse environment.

Anticipating these critiques, Fabrega (1992) entertained the possibility of incorporating an additional axis into the future version of DSM. This axis would assess the extent of the influence of cultural factors upon the patient's clinical condition and his or her accessibility to treatment. Somewhat similarly, Eisenbruch (1992) emphasized the inadequacy of the existing DSM categories such as post-traumatic

stress syndrome in providing information relevant for intervention with patients from other cultures. The cultural bereavement of Cambodian refugees, for example, defies being fitted into the preexisting DSM diagnostic grid. More important, it does not allow for the recognition of indigenous, within-culture distinctions, which are taken into account by traditional Cambodian healers in choosing among the several available intervention strategies. In Eisenbruch's view, a cross-culturally applicable nosology must strive toward capturing the cultural meaning of the patients' suffering and its incorporation into diagnosis. It is difficult to envisage how this objective would be accomplished within the concrete framework of future DSMs. In any case, an important threshold has been crossed in acknowledging the relevance of cultural factors in diagnosis. The dialectic interplay between biological and social components of human distress continues to pose a challenge to diagnosticians and assessors in multicultural milieus. The further course of making diagnosis both factually based and clinically sensitive is envisaged as an open-ended or, in Fabrega's (1992, p. 6) words, an "interminable" progression.
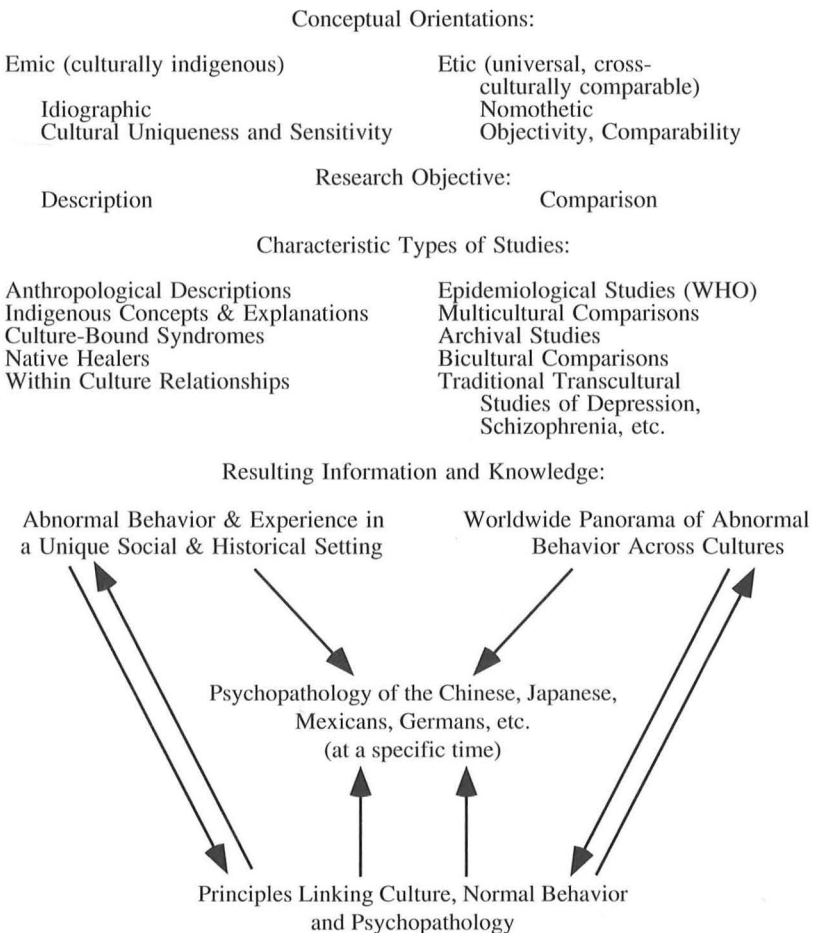
Beyond these critiques, however, an important unsolved problem, inherited from the preceding versions of the manual, remains to be addressed: that of the fuzzy outward boundaries of DSM-IV. At what point does disorder stop and normal functioning begin? At what point are distress and/or disability so slight, fleeting, or self-corrective as to pass unnoticed by the outside observers or fall below the implicit threshold of disturbance? Clues to these answers may be sought in the context of diagnostic criteria for the several specific disorders; no generic set of decision rules has been formulated that could be applied across all of the diagnostic entities. Thus, as the authors of DSM-IV explicitly recognize, diagnostic decisions continue to be based on clinical judgment. The other limitations of DSM-IV pertain to its applicability beyond the milieu for which it was constructed: the socially and culturally diverse, contemporary United States. Conceivably, even within the United States the DSM-IV may not provide sufficient guidance and may misdirect the diagnostic process in the case of atypical, and isolated cultural groups, outside of the social mainstream of modern North America, despite the culturally sensitive features introduced into the manual. Certainly, there is no assumption that DSM-IV provides a universal diagnostic framework, to be used anywhere around the world. Rather, everything that is known about the manifestation of psychological disturbance strongly suggests that this is not the case. Although some diagnostic entities, as will be seen, approximate worldwide distribution, it would be

extraordinary if a compendium of disorders and rules for diagnoses developed by a committee of American psychiatrists in the late twentieth century—with inputs from a number of their international colleagues—were valid across time and space in all cultures.

ASSESSMENT PROCESS AS A SERIES OF CHOICES AND DECISIONS

The conceptions that guide this chapter are organized around a series of choice points and decisions with which the investigator or practitioner of assessment across cultures is faced. Schematically, these choices are represented in Table 1. It concentrates on the

Table 1. Cultural Research in Psychopathology: Contrasting Options

Conceptual Orientations:

Emic (culturally indigenous)	Etic (universal, cross-culturally comparable)
Idiographic	Nomothetic
Cultural Uniqueness and Sensitivity	Objectivity, Comparability

Research Objective:

Description	Comparison

Characteristic Types of Studies:

Anthropological Descriptions	Epidemiological Studies (WHO)
Indigenous Concepts & Explanations	Multicultural Comparisons
Culture-Bound Syndromes	Archival Studies
Native Healers	Bicultural Comparisons
Within Culture Relationships	Traditional Transcultural Studies of Depression, Schizophrenia, etc.

Resulting Information and Knowledge:

Abnormal Behavior & Experience in a Unique Social & Historical Setting	Worldwide Panorama of Abnormal Behavior Across Cultures

Psychopathology of the Chinese, Japanese, Mexicans, Germans, etc. (at a specific time)

Principles Linking Culture, Normal Behavior and Psychopathology

diverging paths taken historically by the investigators who have worked in this area and represents options open to the practitioner of assessment. It represents the several steps in the research program, from its conception through the accumulation of observations to its implementation in a case-centered assessment.

Briefly restated, the investigator and/or assessor starts out with the choice between a universal (etic) *or* an indigenous (emic) orientation. There is a point of contact here, as Clark (1987) has recognized, with the idiographic versus nomothetic dichotomy in personality theory and research: the attempt to capture a phenomenon's unique qualities *versus* the endeavor to place it in relation to all other comparable phenomena regardless of their context of occurrence. These two conceptions are then bolstered by arrays of observations and data, which elucidate respectively their relationships to antecedents, concomitants, and consequents within a unique cultural milieu or place them in reference to a variety of norms collected at various localities and periods. These two sources of information are then respectively brought to bear upon the assessment of an individual. In the ideal case, an integration of these two perspectives is accomplished. However, this objective is ambitious and difficult to attain. At this point, it represents an ideal to be pursued more than a standard that is routinely met in practice.

The Emic-Etic Distinction

Pike (1967), a prominent linguist, coined the terms emic and etic to describe two traditions of inquiry, applicable across a variety of cultural fields and disciplines. *Emic* refers to an inside perspective and is derived from the word phonemic. Its prototype then is the study of the sound systems within a language. *Etic* is a contraction of phonetic and it signifies a comparative investigation, of sounds or any other phenomena, across several languages. Within cross-cultural psychology, especially of abnormal behavior, the emic tradition of inquiry capitalizes upon the description of occurrences within their culturally unique context. The point of departure may be an indigenous concept such as *Latah*, *Windigo*, or *Amok*, to mention but three of the indigenous names for the culture-bound syndromes that have been reported to occur at various sites around the world (in the case of these three, in Malaysia, among the Algonquin Indians, and in the Philippines and elsewhere in South East Asia, respectively). The manifestations of these disorders have been described within the contexts of their occurrence (cf. Pfeiffer, 1994; Simons & Hughes, 1985). Once these initial data have been gathered, the road is clear for the collection of information on the distribution of these disorders,

treatment techniques for dealing with them, positive, negative, and mixed outcomes for them, as well as the prevailing explanations of their causes. In general, emically oriented investigators stay within the universe of the culture they are investigating. Kleinman (1982, 1986, 1988a, 1988b) in a series of studies that were focused upon the experience of distress in Mainland China discovered the prevalence of fatigue and ill-being which approximated the old and discarded Western diagnostic category of neurasthenia. This symptom pattern, however, exhibited many points of contact with depression, a point on which Kleinman found himself in disagreement with the official consensus of Chinese psychiatrists. In the Chinese psychiatrists' view, neurasthenic symptoms in the form of chronic fatigue and general malaise were *sui generis*; from Kleinman's perspective, they represented a cultural idiom of distress for communicating depression. Although the concepts he employed are not purely emic, Kleinman's focus upon the phenomena and experiences *within* a culture is in keeping with the emic tradition of inquiry. Thus, a rich, culturally unique tapestry of interrelationships is woven around a locally observed and conceptualized phenomenon. These results lend themselves to generalization across cultures and populations only with difficulty, and the data of such studies defy incorporation into formal multicultural or bicultural research designs, precisely because of their culturally shaped, unique, and incomparable nature.

In another context, Kinzie, Manson, Vinh, Tolan, Anh, and Pho (1982) were faced with the need for developing a depression scale for Vietnamese refugees in the United States. They started out by translating the widely used Beck Depression Inventory (BDI) (cf. Beck, Steer, & Garbin, 1988) into Vietnamese, but supplemented this procedure by adding and discarding items based on their perceived meaningfulness and appropriateness for Vietnamese clients. Particular attention was paid to generating statements pertaining to somatic and behavioral changes that could be attributed to depression. The list of items so generated was pretested with a small group of Vietnamese adults. Upon the completion of all of these preliminary steps, Kinzie et al. constructed a 45-item scale that was then submitted to validation in a depressed group and to a matched community sample. The resulting set of 42 differentiating items constituted the Vietnamese Depression Scale (VDS). It was later reduced to a 15-item list that collectively accounted for a very high share of the total variance.

It is noteworthy that only four of the 42 statements retained were from the BDI. An entirely new instrument was developed through the several steps of transformation described above. Kinzie et al. then

classified the symptoms tapped by the VDS into three groups pertaining to physical states, depressed or sad mood, and those not related to either lowered mood or the Western concept of depression, as exemplified by "being angry, feeling shameful and dishonored, feeling desperate, and having a feeling of going crazy" (Kinzie et al., 1982, p. 1279).

A similar procedure was followed by the research team of Zeldine et al. (1975) in Senegal who found that they had to discard one-third of the original items of the Hamilton (1967) Depression Scale because of their irrelevance in the Senegalese context. Local informants were consulted and several new items were added that reflected the locally prevalent complaints and manifestations. Thus, the object of study remained constant, but the operational measure changed beyond recognition. Neither Kinzie et al. nor Zeldine et al. proceeded in a purely emic manner, but both of their studies illustrate the willingness of contemporary, culturally sensitive investigators to walk an extra mile to arrive at an understanding of the culture's internal frame of reference and to discard a lot of the imported concepts and measures in the process.

The difficulties experienced and overcome by these investigators should not overshadow the observations of those researchers who have used the translated and adapted versions of the BDI closer to its home base. In at least four Western countries (Canada, France, Germany, and Spain), and in three languages (French, German, and Spanish), no difficulties were reported in translating or validating the scale and no changes other than minimal ones were found to be necessary (Bourque & Beaudette, 1982; Conde, Esteban, & Useros, 1976; Delay, Pichot, Lemperiere, & Mirouze, 1963; Kammer, 1983). On a subtler level, a series of studies in Hawaii with Caucasian, Japanese American, and Chinese American students (Marsella, Kinzie, & Gordon, 1973) revealed ethnocultural differences in depressive experiences related to the body and the self. Two reports of multinational comparisons of the Self-rating Depression Scale (SDS) by Zung (1969, 1972) demonstrate the cross-cultural applicability of this instrument. In the first study, Zung (1969) found that the SDS scores were comparable in samples of depressive patients in seven countries: Australia, Czechoslovakia, England, Germany, Japan, Switzerland, and the United States. Moreover, at all of these sites, SDS scores were higher for depressed than nondepressed psychiatric patients. These scores also were positively correlated with other depression rating scales and were useful for predicting patients' response to therapeutic interventions. In the second study, Zung (1972) succeeded in demon-

strating a reasonably close correspondence between the average SDS scores of normal nondepressed groups of persons in six countries (Czechoslovakia, England, Germany, Spain, Sweden, and the United States) and the suicide rates of the same nations. It is of interest to note that this report, with its thrust on etic comparability, also uncovered ethnic nuances in the experience of depression. Upon principal factor analysis, the first factor was labeled dissatisfaction in Czechoslovakia, hopelessness in England, emptiness in Germany, fatigue in Spain, and confusion in Sweden. All of these results should be replicated and extended before they are accepted as definitive. Even in their present state, these findings suggest that self-reports of depressive symptoms are comparable across a fairly wide range of cultures, and that these indicators reveal cultural differences in both baselines of depression and in its preferred modes of expression.

These examples can be contrasted with the etic investigation of an overlapping phenomenon. The World Health Organization (1983) has been involved in a series of investigations of depression in various regions of the world. Their samples consisted of hospitalized depressed patients in Switzerland, Canada, Iran, and Japan. These studies yielded findings on the most cross-culturally constant symptoms of depression. This is a finding that no series of emic investigations could have conclusively and objectively produced. Important as it is, especially if it is replicated in other countries by similar cross-national investigations, it conveys little of the "local color" of the experience of depression in Geneva, Montreal, Teheran, or Nagasaki. To be sure, some of these features can be recaptured by shifting focus upon the specific sites of the investigation, as has been done in the case of Japan (Radford, 1989).

Neither the emic nor the etic perspective is inherently superior or inferior. The etic approach, as exemplified *par excellence* by the World Health Organization's multi-country projects on schizophrenia and depression and by a host of studies organized on the basis of conceptions that have originated in the investigator's cultural framework (i.e., are broadly Western), provides an unsurpassed panoramic view, somewhat akin to viewing Paris from the top of the Eiffel Tower, but offers no substitute for the immersion into the hustle and bustle of street life, normal or disturbed, within a specific milieu.

Both the etic and emic frameworks then have their respective places in the research enterprise and also in individual assessment. However, bridges between them can also be built, as has been shown in a classical article by Berry (1969). Berry's acknowledged preference was for a "radically emic" approach (Berry, 1972). He recognized the

unavoidable necessity of transporting the prevalent concepts from one's own culture and employing them provisionally across cultural lines as though they were etic. In the process of further study, this, the so-called "imposed etic" is gradually modified and eventually discarded in the course of obtaining more data, until a true etic (i.e., a concept genuinely relevant to and applicable across cultures) can finally emerge.

And, of course, there are no arguments against the sequential investigation of the phenomena of interest—except for the very real considerations of cost, time, and commitment. In practice, studies with a shifting emic or etic focus are exceedingly difficult to implement. A practitioner, however, may have more flexibility in shifting from a within-culture to across-cultures orientation and, finally, incorporating both perspectives into his or her appraisal of the person.

In the end, both perspectives merge in producing an integrated body of pertinent information that can be brought to bear upon a specific culture and can be applied toward formulating the general principles linking cultural factors with the experience and manifestation of psychological disorder.

POPULATIONS TO BE STUDIED: ANOTHER LOOK

Cultural and Ethnic Categories

What are the limits of a cultural group? How is the pool of subjects to be delimited and defined? Some anthropologists (Naroll, 1970) insist upon a rigorous, narrow definition of a cultural group, as exemplified by traditional tribes such as the Navajo or the Kwakiutl. For better or worse, investigators of psychopathological variables have rarely chosen to be so restrictive. Practical interest has dictated the choice of more inclusive groupings, largely corresponding to ethnic, national, and related categories used in popular discourse. Many of the concepts of ethnic groups are implicitly based upon a prototypical case with extremely fuzzy outside boundaries. Thus, the complexities of casting the net too broadly are readily apparent. It is relatively easy to start with the prototype of a German American. Such a person would have strong personal and cultural ties to his or her country of origin, would practice and observe many German customs, and be proficient in the German language. But does this category encompass the Amish farmers of Pennsylvania who cling to a German dialect, but have lost virtually all contact to their ancestral country (Hostetler, 1980), the descendants of nineteenth-century German immigrants who are monolingual in English, and the recently

arrived bilingual university graduates from Germany (Billigmeier, 1974; Winawer-Steiner & Wetzel, 1982)? In an even more complex manner, the term Hispanic refers to a supraordinate administrative category that includes persons whose descent is traceable to Mexico, Puerto Rico, Cuba, Dominican Republic, Colombia, and many other countries (Bernal, 1982; Casas & Vasquez, 1989; Falicov, 1982; Garcia-Preto, 1982; Rivera-Ramos, 1984). For psychological purposes it is hardly meaningful to include all of these in one group; dealing with Hispanics as a homogeneous category runs the risk of producing a lot of error variance. Trimble and Fleming (1989) have warned against glib generalizations about American Indians and have emphasized the tremendous variety in background, outlook, and adaptive strategies within the inclusive American Indian population. Most investigators are in agreement that targeting research operations upon a reasonably homogeneous group in ethnic descent and membership is preferable to a vague and overinclusive criterion.

In cross-national research, culture is all too often equated with country. Little thought is given to the ever increasing pluralism within most national borders. Another important category to consider is the regional differences which, in the case of Italy for example, have the reputation of being a lot more numerous, pervasive, and intense than they appear to be in the United States.

Identity, Acculturation, Biculturalism

Finally, in reference to both national and international samples, the person's cultural identity may be important to ascertain. This point marks the transition of ethnic or cultural membership from a categorical to a continuous variable. How Australian, for example, is this specific person who was not born in but resides in Australia? This question can be answered on the basis of an empirically validated Australianism scale (Taft, 1977). In multicultural settings, acculturation scales provide useful data. Their use and interpretation, however, is complicated by the existence of several kinds of acculturation. Berry (1990) identified four varieties of acculturative experience: integration, assimilation, separation, and marginalization. Contemporary investigators of acculturation, committed as they are to multiculturalism, tend to favor integration over the other three options. As yet, however, there is little evidence for any clear-cut advantage, in relation to vulnerability to disorder, of integration over either assimilation or ethnic encapsulation. There is no question though that the remaining quadrant in this fourfold table, that of marginalization, is associated with susceptibility to mental health problems.

There are three established ways of determining a person's ethnicity (Isajiw, 1974). First, a person's ethnic self-designation can be ascertained; the individual is then assigned to the ethnic category of his or her own choosing. Second, ascriptive and concrete criteria can be used as a basis for ethnic categorization, such as the person's own or parental birthplace, family name, skin color, other physical characteristics, etc. Third, ethnicity can be determined on the basis of consensus, by either in-group or out-group members or both.

Recent trends, however, have focused upon behavioral and lifestyle indicators of ethnicity (Phinney, 1990; Sodowsky, Kwan, & Pannu, 1995). Thus, ethnic group membership can be inferred from a person's participation in activities and rituals, membership in organizations, preferences and aversions, language use, and other choices and decisions. This approach is consonant with the shift from external and concrete to internal and subtle criteria of ethnicity (cf. Isajiw, 1990). The complexity and ambiguity of which criteria to use, what weights to assign to them, and how to incorporate them into some kind of a composite or global score or judgment are as yet not resolved, but the rationale of current ethnic identity determination is clearly moving away from ascriptive and toward psychological indicators.

This development is epitomized by a host of acculturation scales (e.g., Szapocznik, Scopetta, Kurtines, & Aranalde, 1978) which have been typically applied to populations of immigrants and their descendants. Where a person stands in relation to several possible group memberships is assessed by a host of such instruments. Usually, these instruments capitalize upon the identification with a specific group, and it is difficult to envisage a generic acculturation measure. Hence, these instruments have to be adapted and revised, often radically, as they are extended beyond their original target population. Recently, however, steps have been taken toward developing a generally applicable measure of acculturation (Sodowsky, Lai, & Plake, 1991; Sodowsky & Plake, 1991). This scale was originally designed for studying international students. It was then modified for use with members of minority groups, such as Hispanic and Asian Americans. Data on the construct validity of this instrument are promising. There is the prospect then of an instrument by means of which groups of normal and/or disturbed subjects of different provenance and ethnicity could be compared in the degree and nature of their acculturation. In assessing psychological disturbance in culturally diverse populations, it is desirable to go beyond the categorical labels of ethnic or cultural membership and to include a standardized and quantitative indicator of the person's adaptive functioning within

his or her original cultural milieu and in various culturally pluralistic host-culture settings.

The obverse of acculturation scales is constituted by various instruments that tap retention of the culture of origin. In combination, these two kinds of measures provide indicators of a person's stand in relation to both his or her culture of descent and that of current residence. From these data, various combinations result that have given rise to Berry's (1990) fourfold typology composed of integration of elements from the cultures of origin and adoption, assimilation into the host culture, isolation in the community of one's compatriots, and marginalization, which is tantamount to the inadequate mastery of skills necessary for functioning in either of the two settings.

In a culturally diverse and dynamic social structure like that of the contemporary United States an even more complex situation is encountered. Sodowsky et al. (1995) have conceptualized the process of maintaining or changing ethnic identity in a host culture as a conflict that can be resolved in four ways corresponding to Berry's options of integration, assimilation, isolation, and marginalization. Shifts to and from any one of these four reference points are possible and indecision, tension, and erratic changes are also accommodated within this model. Along similar lines, Szapocznik and Kurtines (1993) have addressed the problems of Cuban American adolescents who are pulled in several directions by the family, their peers, and the larger society, with each of them representing somewhat different cultural frameworks. According to these authors, the simultaneous operation of these forces generates opportunities for conceptualization, investigation, and application of the several value orientations. As yet no instruments have emerged to quantify and objectify these variables. Szapocznik and Kurtines have proposed the concept of embeddedness to encompass the simultaneous membership of several interacting groupings. This notion is exemplified by the research undertaken by Szapocznik and Kurtines, which involves the study of the person within the family context while the family is embedded in its cultural milieu. Potentially, the construct of embeddedness can be applied to the situation of the bicultural or multicultural person trying to reconcile and integrate several strands of ethnic or cultural influence (e.g., from the mainstream or majority culture, ethnically homogeneous or mixed peers, and a traditional ethnic family).

Psychological Disturbance and Its Indicators

How is the presence and degree of disturbance determined in a person? The identification of criterion groups is essential for the

development of indicators of mental disorder and related characteristics. Such identification is also indispensable for the investigation of the interplay between psychopathology and the culture in which it occurs. Several research strategies have been applied to this end.

The first of these approaches has been to start with extreme populations that are usually hospitalized for psychiatric reasons, especially in developed countries with a fully developed network of psychiatric services. This was the research strategy of the World Health Organization (WHO) investigators in their landmark cross-national projects on schizophrenia (WHO, 1979) and depression (WHO, 1983). This mode of data collection yields valuable data; it also has the advantage of starting out with populations whose behavior patterns are observable on a continuous basis. Problems of cross-cultural comparability, however, ensue as the criteria for hospitalization at the various participating research sites are considered. Disparities in reasons for voluntary or involuntary hospitalization may have accounted for the often cited finding of the WHO (1979) investigators of the *inverse* relationships between socioeconomic and educational status of schizophrenic patients and their favorable prognosis in two developing countries, Nigeria and India. This finding is exactly the opposite of that reported consistently in technologically and economically developed countries (Dohrenwend & Dohrenwend, 1969). A possible explanation that may be explored in any future attempts to replicate this finding is that only the most serious and chronic cases of schizophrenia of higher occupational and educational status would be found in public institutions of developing countries. At this point, the idea has the status of an alternative hypothesis, which remains to be scrutinized in light of any pertinent future data. This unexpected and, at first glance, counterintuitive result serves to illustrate the complexities and ambiguities of the relationship between psychopathology and culture. It also provides a note of caution lest the results of formal cross-cultural psychopathology research be mechanically and automatically applied to assessment at the case level.

The second strategy is essentially based on self-definition and self-referral. It encompasses ambulatory clients who have sought mental health services on their own initiative or have been referred for them, but who have in any case exercised their judgment in establishing and maintaining clinical contacts. It is generally recognized that geographically separate cultures and spatially proximate ethnocultural groups differ in access to and patterns of utilization of mental health services. Studies based on these populations are open to criticisms because of the disparities at the point of entry into the system.

An even greater share of information on the role of ethnic and cultural variables is contributed by the third category of studies, which concentrate on patients with a uniform diagnosis. Even though the disorder may be identically labeled, the bases for the label may interact with the culturally determined modes of self and distress presentation and with the diagnosticians' biases and selective perceptions, especially when there is ethnic or cultural disparity between the patient and the diagnostician.

Finally, the fourth solution to the selection and criteria/problem is invariably costly and large-scale. One may envisage an epidemiological study with identical selection criteria and information-gathering techniques at several culturally removed sites. On the basis of these data, individuals identically diagnosed would be selected for further cross-cultural comparisons. Even more ambitiously, one could imagine within the context of this hypothetical investigation conclusive cross-cultural or cross-ethnic comparisons of the incidence of various mental disorders. Such a task, however, has so far not been undertaken.

One can imagine the size of the subject pools that would be necessary for carrying out this utopian project. Even the World Health Organization has not attempted anything comparable to this scale! It is, however, possible to realize some of these objectives in the microcosm of ethnically diverse communities, such as in Hawaii (Katz, Sanborn, Lowery, & Ching, 1978) or in California (López, Hurwicz, Karno, & Telles, 1992) and/or in a sequential series of studies rather than in a comprehensive giant undertaking. In the absence of such findings, however, it behooves the culturally sensitive practitioner to keep in mind the available, piecemeal, and fragmentary results despite their inevitable major methodological limitations. Thus, it can be concluded that there are genuine cultural differences in the modes of expression in psychopathology. This conclusion has remained valid from the earliest (cf. Draguns, 1973, 1980) to the most recent (López et al., 1992) studies. At the same time, it should be emphasized that the exact nature and extent of these differences remains uncertain. In many cases, they have to be "purged" of various distortions that are traceable to hidden disparities between samples of even identically diagnosed patients of different cultures or ethnicities. These impurities for the most part are broadly social, without being specifically cultural. An example would be an ethnic difference in symptom expression, which turns out to be traceable to discrepancies in socioeconomic status, age distribution, or gender composition of the two populations. A definitive resolution of the

issues raised must await the replacement of the samples of convenience and opportunity with those based on representativeness and randomness. In the meantime, the interested practitioner of mental health services is well advised to retain the proverbial grain of salt.

CLINICAL SENSITIVITY VERSUS THE OBSERVER'S BIAS: THE DUAL CONTRIBUTION OF THE CLINICIAN

Diagnosis as Social Interaction

Contemporary theorists (e.g., Kleinman, 1986) conceptualize the experience of psychopathology as a transaction during which distress is communicated through multiple channels and is subjected to several obstacles, distortions, and disguises. All of these consideration come into play in disentangling the intricacies of interaction between the diagnostician and the patient across an ethnocultural gulf. Such encounters are a daily occurrence in the multicultural settings in the United States and many other countries.

DeHoyos and DeHoyos (1965) were among the first to document the tendency of white American "mainstream" clinicians to record fewer subtle, less visible, affective symptoms in their African American patients and to note a greater number of conspicuous manifestations of disorder often related to violence and aggression in that population.

The other finding contributed by DeHoyos and DeHoyos (1965) pertained to the significantly smaller number of symptoms recorded for African American patients as compared with their majority group white counterparts. Quite likely, these two trends are related; if fewer symptoms are noticed, they are probably among the most extreme, bizarre, and dramatic. Since then, these findings have been corroborated in several investigations and extended to a variety of other ethnic and minority groups. Good (1993) concluded that "evidence continues to cumulate that misdiagnosis is higher among minority patient populations in the United States than among patients from the majority population. Given the potential consequences of misdiagnosis— inappropriate use of medication, labeling, and mistaken treatment within mental health services—this pattern should be viewed with great concern" (pp. 430–431). This statement reverberates with Adebimpe's (1981, 1984) conclusion that African American psychiatric patients are at greater risk for error in diagnosis and assessment than are their majority group counterparts. Moreover, Adebimpe's reviews recapitulate the observations by earlier authors that African Americans are more likely to receive the diagnosis of schizophrenia and less likely to be diagnosed as suffering from affective disorder. These tendencies are not confined to one

major minority group. Findings on Hispanics, American Indians, and Asian Americans also substantiate nonrandom diagnostic errors; their nature and direction parallel in some respects and diverge in others from those observed for African Americans (cf. Good, 1993; López, 1989; Mukherjee, Shukla, Woodle, Rosen, & Olarte, 1983).

Not all of these errors, however, point in the same direction. In a sample of 118 licensed mental health professionals in California, López and Hernandez (1992) documented a tendency to underestimate, rather than to overestimate, the severity of psychopathology in their minority-group clients. Moreover, this bias occurred in a group of diagnosticians who reported a high degree of awareness of the importance of cultural factors in clinical intervention. López and Hernandez (1992) warned that "clinicians may be at risk to dismiss psychopathology as being representative of culturally normative behavior" (p. 605). The antidote that they recommend is the clinicians' sensitivity to the heterogeneity that exists within most minority groups and their recognition of the limitations of the relevant empirical literature.

It is easy and tempting to attribute many of the diagnostic errors to prejudice and racism, but these phenomena are both more frequent and complex. Instances of blatant prejudice and virulent hostility toward minority groups are probably rare among the contemporary members of mental health professions, yet diagnostic biases remain widespread. As Ridley (1989) noted in a different context, "prejudiced people stereotype, but people who stereotype are not necessarily prejudiced" (p. 59). López (1989) concluded that "evidence that therapists err in their judgments of patients from groups who are not traditionally subject to discrimination supports the notion that errors based on patient variables are the results of selective information processing rather than of the previously assumed prejudicial sentiments" (p. 193). Other evaluators of this research evidence (Adebimpe, 1981, 1984; DeHoyos & DeHoyos, 1965; Good, 1993) have arrived at similar conclusions. In fact, there appears to be a consensus among the experts in this area that systematic diagnostic errors cannot be reduced to prejudicial and rejecting attitudes on the part of the diagnosticians. Practical implications can be drawn from this recognition. López (1989) contrasted the old, traditional model designed to promote reduction and elimination of prejudice with the new conceptualization that is focused upon more efficient and effective problem-solving strategies. To quote López (1989):

> This conceptual framework has several implications for future research. First of all, systematic errors in judgment based on patient variables may pertain to all clinicians and not just to those clinicians

with prejudicial attitudes. This suggests that less emphasis should be placed on therapists' social values and more emphasis should be placed on the general processes that lead to judgment error. Second, investigators should give careful consideration to the symptoms or disorders used as their clinical stimuli, at least among studies of gender and racial/ethnic bias. Third, if there is evidence for bias with the present conceptualization, then the implications for training clinicians to prevent such biases will differ greatly from the original model. Although never addressed, the training implication of the old model was to change attitudes or values. The present conceptualization suggests that clinicians can be trained to improve the way in which they process information. (p. 194)

An alternative explanation of the diagnosticians' biases would take into account the expectations of the clinicians based on their personal experience with their own cultural group and other ethnic categories. The complex results of these processes are illustrated in a study by Li-Ripac (1980) who documented the divergent perceptions of Chinese-American and majority group clinicians of their Chinese and Caucasian clients. These results demonstrate a greater readiness to understand a client of one's own ethnicity and a more realistic view of his/her presenting problems. Generally, Caucasian therapists rated their Chinese clients as more depressed and inhibited and less socially poised by comparison with the ratings of the Chinese-American colleagues. Conversely, Chinese-American therapists assigned higher ratings of disturbance to Caucasian clients than did their white counterparts. Similarly, Berman (1979) reported that African American counselors emphasized the social character of their African American clients' problems, whereas the Caucasian counselors were inclined to see intrapsychic sources of the African American clients' difficulties. There is no ready way of establishing who was "right" and who was "wrong" in these two cases. The only conclusion that can be drawn is that mental health professionals proceed from their specific perspective, which is rooted in part in their cultural experience, and react to the social reality from their socially determined vantage point. This process results in partially veridical and partially incomplete or even distorted perception.

Empathy and Social Distance in the Diagnostic Process

To take an additional inferential step, one may relate diagnostic sensitivity to the clinician's affective distance from the client. Within the context of the above formulation, accurate perception and judgment of internal distress, prominently exemplified by depression, is facilitated by the experience of empathy. To tune in to another

person's subjective affective state, however, is more easily accomplished in cases of low social distance (i.e., in interacting with individuals in similar and familiar social categories). Perhaps that is why depression and other expressions of distress often remain unheard when they are uttered across a social gulf, whether it be determined by age, socioeconomic status, culture, or ethnicity. Overlooking of the subjective and subtle depressive manifestations and capitalizing upon the more readily visible expressions of schizophrenia in a group with which personal and reciprocal contacts may have been few may be conceptualized as an instance of this principle. As stated elsewhere (Draguns, 1973):

> Across the cultural barrier, the observer tends to see the patients as though he were viewing them from afar. Consequently, he may selectively perceive conspicuous or dramatic symptoms and may miss some of the subtler expressions of disorder. Empirically these effects have been demonstrated to occur even across subcultures, as in the case of a white psychiatrist interviewing a Black patient in the United States. These findings suggest that the clinician's prized tools—his empathy and sensitivity—suffer impairment as they are applied outside his cultural domain. As a consequence, the record obtained runs the risk of being quantitatively and qualitatively impoverished. (p. 13)

Future work may put these expectations to a test by studying the relationship of empathy and diagnostic sensitivity in patient-diagnostician dyads of different ethnicities and by investigating the effect of increased social contact across ethnic lines upon the reduction of diagnostic errors, especially as they pertain to affective disorders.

National and Cultural Tendencies

Apart from social distance, social baselines are germane to cultural styles and tendencies toward diagnostic assignment. The results of the U.S.-U.K. comparison of the diagnostic operations of the psychiatrists of these two countries are well known (Cooper, Kendell, Gurland, Sharpe, Copeland, & Simon, 1972). Briefly, British psychiatrists were found to diagnose depression much more readily than their American colleagues, whereas the Americans displayed, in the DSM-II era, a penchant for the diagnosis of schizophrenia. Other, less firmly substantiated differences among diagnosticians across national boundaries have also been recorded. These findings may be explained on the basis of cultural differences in sensitivity to various psychological symptoms. Cultures then may set different markers in establishing the minimal standards of acceptable social behavior. In

England, the general public may have a lower "threshold" for taking notice of and action in depression than in the United States; the opposite pattern of socially consensual reaction may obtain for instances of bizarre and visibly "crazy" behavior that may result in the eventual imposition of the diagnosis of schizophrenia in the United States and in the United Kingdom. It is, however, not immediately clear why in England the diagnosticians should be selectively sensitized to depression, which, apparently, as an affect is widely experienced and accepted in that country, and why the socially deviant behavior exemplified in schizophrenia should be so poorly tolerated in the United States and especially in its socially heterogeneous and impersonal cities. Although the explanations advanced above on a post hoc basis carry a certain plausibility, the opposite pattern of results could conceivably be explained equally well by recourse to the same arguments and observations. The fact remains, however, that mental health professionals in their diagnostic capacity remain the guardians of the social limits of eccentricity. This is a state of affairs that radical critics of mental health practices and concepts such as Szasz (1961) bemoan. Many mainstream mental health professionals would accept this social function as legitimate. However, there is no denying that the confounding of the "technical" aspects of diagnosis with social judgment (Phillips & Draguns, 1971) greatly complicates the attainment of diagnostic comparability across ethnicity and culture.

Body versus Mind as a Cultural Medium of Distress

One of the major themes in the cross-cultural literature on psychopathology is the frequency of bodily complaints among the patients referred for psychological and psychiatric problems from several culturally distinct groups, especially Asian (Sue & Sue, 1987). Kleinman's (1986, 1988a, 1988b) observations of the prevalence of neurasthenia in mainland China have already been briefly mentioned. These and other findings raise the question of the locus and meaning of somatic symptoms in states of psychological dysfunction and distress. As White (1982), Kirmayer (1984), and Kleinman (1986) point out, it may be ethnocentric to dismiss these manifestations simply as a result of a lack of "psychological mindedness." Rather, culture may foster a selective sensitivity to either psychological or physiological processes that are both components of the experience of stress. "Psychologization" of stressful experiences may be the modal reaction in certain segments of the population in various European and American settings. Similarly, experience and communication of distress in China and in various other cultures may be focused upon

bodily sensations and reactions, which may then be reported in greater specificity and, perhaps, with greater sensitivity and accuracy. Thus somatization, in culturally or ethnically different clients should not be dismissed as a deficit of psychological sophistication; it can be construed as a genuine skill in attending to and reporting somatic processes.

In a thorough clinical investigation of over 200 outpatients in an internal medicine clinic in Nanjing, China, Ots (1990) blended concepts drawn from Chinese traditional medicine with Western phenomenological methods of inquiry. He was able to establish connections between intense, but verbally unexpressed emotions and bodily symptoms. Thus, liver was implicated in the experience of anger, heart in anxiety, and spleen in depression. Among heart patients, 85% were found to experience anxiety and insecurity, often brought on by a threatening event, such as a challenging promotion, difficult examination, or prospect of loss of status or position.

Moreover, the contextual aspects of symptom presentation should be considered, especially as they occur across cultural lines. Encounters between a mental health professional who represents the mainstream American culture and a patient of a different cultural background may be conducted across a gap or even a chasm that many culturally different help seekers find difficult to cross. Under these circumstances, bodily distress becomes an easily communicated and perhaps a readily relieved component of a vague tangle of adverse experiences that defy being put into words to a stranger and in an imperfectly mastered language.

This is especially likely to happen if in the patient's culture somatic distress customarily evokes sympathy and concern, whereas verbal communications of aversive personal reactions are often overlooked. Such a situation has been described in China (cf. Kleinman, 1986), but may also exist in many other cultures. The Western clinician should keep in mind the prominence of the somatic channel for experiencing aspects of psychic distress in his or her clients of a different cultural provenance. In such instances, hasty referral outside of the range of personal counseling and mental health services for exclusively biomedical treatment should be avoided.

Equating Extreme Deviance with Disturbance: A Dangerous Trend

Episodic information from a variety of sources has been accumulating of instances in which conspicuous nonconformity and/or defiant disregard of social norms are all too readily assimilated into the category of psychological disturbance, usually in its most extreme varieties, often as schizophrenia. Behavior is torn from its cultural

context and is quickly absorbed into the preexisting notions of a mental disorder. It will be recalled that DSM-IV explicitly cautions against this danger in its definition of mental disorder. Nonetheless, the risk of such misdiagnosis has not been removed once and for all. Two of its manifestations must now be addressed.

The most extreme instances of this distortion involve the misattribution of normal behavior patterns of an unfamiliar and highly different social group to mental disorder. This diagnostic error presupposes lack of familiarity with the potential patient's culture, a high level of cultural and social naiveté, and perhaps, inadequate conceptual understanding of diagnostic rationale, apart from gross stereotyping and, quite likely, prejudice. With the increase in cultural sophistication and diagnostic skill, it is expected that these gross diagnostic misattribution errors will decline in frequency and perhaps disappear. In any case, they should be increasingly amenable to being prevented, spotted, reversed, and corrected. Still, there are occasional shocking reports of such malfeasance in the media, one of which is recapitulated by Sue in the present volume. Another documented case study in the professional literature (Jewel, 1952) describes the hospitalization of a male Navajo for 11 months as a catatonic schizophrenic—just because the man was speaking his native language, which no one on the hospital staff was able to understand. In Trimble and Fleming's (1989) words, "it's not a pleasant article to read" (p. 177). It is indeed difficult to construe these cases of misdiagnosis and of the resulting mistreatment other than as instances of gross incompetence, negligence, and irresponsibility on the part of the clinical staff. They are only mentioned here as the factually verified extreme of the consequences of cultural insensitivity and the ultimate tragic result of equating strangeness with disturbance.

Much more insidious and frequent are the instances of misdiagnosis, usually in the direction of greater chronicity or disturbance, on the basis of the interactive, and very likely multiplicative, effects of conspicuous social deviance and abnormality. In Pennsylvania, the Amish have long had the reputation among some of the local psychiatrists to be susceptible to schizophrenia (Egeland, Hostetter, & Eshleman, 1983). Thorough and conclusive epidemiological research conducted as part of the search for the genetic source of affective disorder (Egeland & Hostetter, 1983; Hostetter, Egeland, & Endicott, 1983; Egeland, Hostetter, & Eshleman, 1983) has decisively dispelled this impression and has established instead the presence of bipolar affective disorder. Yet, in light of explicit and

reliable Research Diagnostic Criteria (Spitzer, Endicott, & Robins, 1977), manic-depressive disturbance among the Amish was misdiagnosed by experienced and qualified local diagnosticians as schizophrenic in 22 out of 28 cases. The reason for these errors, as some of the practitioners admitted on interview, was the conviction of the existence of a strong link between social deviance and schizophrenia and the inability to distinguish the two sources of disturbance. Egeland et al. (1983) quoted one of the local psychiatrists as saying: "I know the diagnosis immediately, all our Amish patients are schizophrenic" (p. 68). The tendency to overdiagnose schizophrenia in members of minority groups, as recapitulated earlier in this chapter, may be another case in point. It remains to be demonstrated that the symptoms of minority group patients were by some objective standard more socially extreme or conspicuous than those of the majority group or mainstream patients.

Interim Conclusions

Perhaps the principal conclusion from the findings summarized in this section is the recognition that the assessment operations of clinicians are susceptible to errors that can be traced to cultural barriers and disparities. This inference, however, should not be overgeneralized; numerous culturally atypical clients are realistically diagnosed by mainstream professionals, and the clinicians involved in cultural and ethnic assessment should be warned against adopting a position of extreme cultural relativism. Good (1993) concluded: "It takes a great deal of naiveté, plus a very selective reading of the literature to argue for extreme cultural relativism in the study of psychopathology. Anthropological efforts to reduce psychopathology to cultural psychology are as mistaken as psychiatry's reduction of suffering to disordered physiology" (p. 430). The cross-national surveys of schizophrenia (WHO, 1979) and depression (WHO, 1983) referred to earlier in the chapter were successful in documenting constant core symptoms of these two disorders. The cumulative results of cross-cultural research on psychological disorder provide no comfort for the proponents of radical relativist (e.g., Benedict, 1934) positions. As Good (1993) put it, "One crucial area in which research should be pursued is in investigating the cross-cultural validity in diagnostic categories, specific differences in diagnostic criteria cross-culturally, and the role of culture in the diagnostic process" (p. 430). In the remaining portions of this chapter, the reader will be guided through the succession of the available choices in this enterprise.

CONCEPTUAL AND METHODOLOGICAL OPTIONS IN CROSS-CULTURAL RESEARCH AND ASSESSMENT: NUMEROUS AND IMPERFECT

Equivalence: An Abiding Concern

Cross-cultural psychologists have refined and differentiated the concept of equivalence. They have not as yet proposed a definitive solution to this thorny and persistent problem. Table 2 presents a condensation of the array of choices open to the investigator of cross-cultural assessment issues. In the ideal case, the stimuli to be investigated or applied should, in several cultures, be identical physically and semantically, stand in the same relationship to the concepts from which they were derived, display the same functional relationship to key behavioral variables, and have the same metric properties.

This ideal is never attained in the real world. Thus, the investigator is left to his or her choice regarding which of the above aspects of equivalence are to be emphasized and which are to be de-emphasized. Although much has been written about the psychological equivalence of stimuli that are physically nonidentical, there have as yet been no studies in which equivalent, but physically different stimuli have been used in the same research design. For example, the meaning of a specific item on a verbal scale may vary across cultures. Yet it would be rash to substitute an item equivalent in meaning, but discrepant in content, and to use it in cross-cultural comparisons as though it were textually identical at both sites of the investigation.

The situation is somewhat different in case-oriented assessment. The Minnesota Multiphasic Personality Inventory (MMPI), for example, has been extensively revalidated outside of the United States and is in use in numerous languages around the world (Butcher & Clark, 1979). It broadly fulfills the same purpose in these settings of providing diagnostically oriented assessment information. Its revalidation around the world, however, has inevitably introduced modifications in the context of its items and in their relationship to scales. Such modifications have been deliberately kept at a minimum in order to preserve as much as possible the relationship between the MMPI scores and the various characteristics of the instrument. The evaluators of this effort (Butcher & Clark, 1979) have concluded that in its translated versions, the MMPI continues to perform its assessment function well, although invariably to different degrees, depending on the version, the country, and the specific purpose. General trends have also been noted. By and large, the so-called psychotic tetrad composed of elevations of Scales 6, 7, 8, and 9 has remained

Table 2. Conceptual and Methodological Problems Relevant to Cross-Cultural Assessment of Abnormal Behavior

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Equivalence of stimuli and instruments:
      (1) physical
      (2) conceptual
      (3) contextual

Problem: Comparing equivalent stimuli that are not physically identical and physically identical stimuli that are not equivalent.
Solution: Limit comparisons to stimuli meeting criteria of (1), (2), and (3).
Cost: Restriction of range of the stimuli compared.

Comparability of samples and populations:
      (1) in distress and disability (DSM-IV-R definition of mental disorder)
      (2) in diagnosis
      (3) in demographic and social characteristics
      (4) in (premorbid) personality characteristics
      (5) in nonpersonality variables (e.g., intelligence)
      (6) in the manner of recruiting

Problem: Comparing samples/groups widely divergent in relevant characteristics.
Solution: Concentrate on (reasonably) comparable samples, use appropriate statistics (e.g., partial correlation, analysis of covariance, multivariate methods), record and note remaining discrepancies.
Caution: Avoid artificial matching.
Cost: Restriction of the scope of comparisons, limitations of generalizations.

Comparability (or identity) of concepts
      (1) diagnostic (e.g., schizophrenia, agoraphobia)
      (2) affective-motivational (e.g., anxiety, depression)

Problem: Making sure that identical words carry constant meanings.
Solution: Obtain systematic empirical data on the equivalence of concepts, use explicit rules of diagnosis and group assignment, use objective measures if valid and appropriate; employ a multimethod approach and conduct a series of studies.
Cost: Incomplete understanding of the meaning, context, and social consequences of the concepts employed.

Special Problems:
      (1) Translation of verbal materials:
            (a) back-translation
            (b) decentering
      (2) Constancy of demand characteristics and contextual variables:
            (a) verbal questionnaires
            (b) brass instrument experimentation
            (c) personal interview (intrusion)
      (3) Observer's/tester's demand characteristics:
            (a) in behavior
            (b) in subjects'/testees' perception

reasonably constant throughout translations and revalidations and can be interpreted in a convergent fashion; the neurotic triad made up of Scales 1 through 3 has shown a moderate degree of fluctuation in various cultures, which is probably traceable to a joint effect of test and person variables; and Scale 3, which measures depression, has displayed a general tendency toward elevation in translated versions by comparison to the original MMPI. None of these trends have as yet been noted on the recently revalidated MMPI-2 on the basis of the cumulative translation, adaptation, and revalidation effort, which is too new to have been applied and researched in other language areas. A network of closely related tests based on the original MMPI has been created which, however, are textually and otherwise nonidentical. In light of information on the psychometric properties of these translated and revalidated versions of the MMPI, they are capable of performing highly similar functions at their respective sites of adoption. Empirical comparisons of these cross-national adaptations, however, are frustrated by the problem of "adding apples and oranges"; even though the scales are identically numbered and labeled, they are based on highly overlapping, yet inevitably and invariably somewhat different pools of items. Thus, they can only provide the "raw materials" for comparisons on the inferential and interpretive, and hence inescapably speculative, level.

The example of the use of the MMPI across cultures and languages illustrates a problem that defies being overcome, that of physical or, in the case of verbal stimuli, textual equivalence. The other more sophisticated aspects of equivalence can and often are accommodated, but only by means of subtraction and eliminations of the questionable stimuli or items that have failed to meet the test of equivalence.

Several possible solutions to this dilemma come to mind. The investigators may construct specially designed stimuli for the purpose of a specific cross-cultural research project that would be acceptable and appropriate at the several research sites. As an alternative, simple face and/or content valid stimulus materials may be selected that would not require adaptation or revalidation at new and culturally different locations. Finally, one may envisage the simultaneous development and validity of measures at several points across cultures and their subsequent application at the several research sites. Instances of the first two methods are legion in the modern cross-cultural literature. As a rule, however, these research reports do not lead to sequential, continued, and cumulative use. They tend to remain isolated and discrete instances of application of their specially designed stimuli. The symmetrical multicultural approach of con-

structing stimuli of equal relevance and applicability for all the cultures to be compared has been repeatedly recommended (e.g., Draguns, 1977, 1982), but as yet has not been fully implemented in relation to the assessment of maladaptation or disturbance. Apparently, intractable practical issues stand in the way of converting this ambitious objective into reality. The available solution remains, as indicated in Table 2 (i.e., to start out with a pool of items selected at a specific point in space and time). This set of items would correspond to what Berry (1969) called the imposed etic. Its adaptation would largely entail elimination of those items that would fail to meet the criteria of nonphysical equivalence: conceptual, functional, and metric. These would be replaced by more culturally appropriate items that would also be closer to the original in the three additional criteria of equivalence. These modifications would enhance the validity and sensitivity of the instrument in the new locale; they would not, however, benefit cross-cultural research application.

MMPI in American Minority Groups: An Illustration

At this point, the present account will digress to consider an issue of practical importance in clinical assessment. The MMPI, in its original and now in its revalidated version, constitutes in the United States the most widely used self-report measure centered upon diagnostic variables. For several decades (cf., Gynther, 1972) its validity, sensitivity, and utility for use with ethnocultural minority groups, especially African Americans, has been the subject of considerable debate and argument. Gynther (1972) argued that it amounts to a prescription for discrimination to rely mechanically for diagnostic purposes with African Americans on the original MMPI, which was validated on an unrepresentative majority group sample in Minnesota in the 1930s. Pritchard and Rosenblatt (1980) countered this argument by contending that the increase of false positives (i.e., instances of misdiagnosing of African Americans free of psychological impairment) has never been demonstrated for this population. A comprehensive review by Greene (1987) has been conducted of all MMPI research involving four major American minorities: African Americans, Hispanics, American Indians, and Asian Americans. The results of this exhaustive analysis have put to rest at least some of the legitimate apprehensions concerning the use of the MMPI with minority clients. Greene's (1987) conclusions deserve to be presented in his own words:

> First, the failure to find a consistent pattern of scale differences between any two ethnic groups suggests that it is very premature to begin to develop new norms for ethnic groups. It appears that

moderator variables, such as socioeconomic status, education, and intelligence, as well as profile validity, are more important determinants of MMPI performance than ethnic status. Definitely, research is needed that examines the role of identified cultural factors on MMPI performance when appropriate controls are instituted for the multitude of factors that can affect the results. (p. 509)

Thus the conclusion of Greene's definitive review dispels the notion that the MMPI is an inherently misleading tool of diagnostic assessment for members of minority groups. It does not close the books on the issue of its appropriateness and sensitivity for minority group members or for various sections of these populations. In fact, Greene specified several urgent problems in need of research-based resolution. In keeping with a point made earlier in this chapter, he called for the assessment of subjects' identification with their ethnic group. Other suggestions include the incorporation of moderator variables, such as socioeconomic status, education, and intelligence; the identification of empirical correlates of any interethnic differences that may be established; and the extension of comparative ethnic research beyond the standard clinical scales of the MMPI to various special scales that have been designed for this instrument.

It is well worth emphasizing that these conclusions apply to the MMPI before its recently completed revision. However, because the standardization sample for MMPI-2 includes proportionate numbers of members of several prominent minority groups, it is unlikely that the problems examined in Greene's review have become more severe. Specifically, 12.5% of the subjects in the revalidation sample were African American, 3% Hispanic, 3% Native American (Butcher, 1990; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989; Graham, 1993). These figures suggest statistically proportionate representation for African American and Native Americans. It could be argued that Hispanics as well as Asians, who constitute two of the most rapidly growing ethnic groups in the United States, continue to be underrepresented. Moreover, given their rapid increase through immigration, the norms obtained may not be valid in the future. Butcher et al. (1989) have provided normative information for the four minority groups in an appendix to the MMPI-2 manual. The results that have trickled in suggest that the gap on clinical scales between African Americans and Caucasians has narrowed but not disappeared (Shondrick, Ben-Porath, & Stafford, 1992). Analogous findings have been obtained for Hispanics (Velasquez & Callahan, 1990); no relevant findings have as yet appeared for Asian or Native Americans. However, unresolved issues remain, even though steps in the right

direction have been taken with MMPI-2. Greene's (1987) lead of exploring specific and limited effects of ethnicity rather than their broad overall impact has not been systematically pursued with MMPI-2. Dahlstrom, Lachar, and Dahlstrom (1986) asserted that not all interethnic differences are artifactual; this admonition should be kept in mind by users and investigators of MMPI-2.

The conclusion is still justified that the MMPI is a usable, but imperfect, tool of appraisal within the multicultural American setting, especially for the limited purpose for which it was originally designed (i.e., as a diagnostic aid). This point is well worth making in order to help steer clear of the extremes of skepticism that eventually result in psychometric nihilism and rejection of any and all tests for persons who are culturally atypical. In the case of the MMPI there appears to be no justification for this extreme course of action nor is there need for a less extreme but laborious remedy, that of developing separate norms for each minority group. However, it should also be recognized that the MMPI-2 does not as yet address the complex problems of culture by psychopathology interaction. Continuous, systematic, and sequential research remains a necessity.

THE ISSUE OF COMPARABILITY: A REPRISE

Populations and Samples

It is necessary at this point to go over the ground that has already been covered in the earlier portions of this chapter. The problem to which we now return is that of comparing members of populations that are discrepant in social and cultural background and that may be located in different habitats. In Table 2, six moderator or control variables are listed, which in the ideal case, should be equated in validational and other research across cultural boundaries. Yet, just as in the case of stimulus equivalence, this lofty goal remains beyond the range of realistic attainment. The investigator is faced with the need for spelling out priorities and deciding which of these several factors to consider important enough to control and which to disregard. There is no absolute a priori basis for this determination; the researcher is free to use his or her judgment on the basis of the needs and requirements of the research project and subjective curiosities and preferences. The ultimate test of the "correctness" of the researcher's choices would be the plausibility of alternative hypotheses that could be invoked in reference to those variables that have been left uncontrolled. In the complex and imperfect world in which, of necessity, cross-cultural research is conducted, progress toward

eliminating or at least reducing the obtrusive disparities can probably only be achieved in a gradual fashion by conducting a series of studies while controlling successively for the several variables. This procedure would still leave any possible interaction effects unexplored, such as those that were revealed in the mosaic on ethnic research on the MMPI. It would, however, help the observers of the field and the users of the research findings to move closer to the objective of untangling the culture's relationships with possible moderator variables in determining the manifestations of psychological disturbance.

More comprehensive solutions can be envisaged in the form of using representative samples, as is done in modern epidemiological studies. Unfortunately, cross-cultural study of psychopathology has not yet moved beyond the reliance, dictated by circumstances, upon samples of opportunity and convenience, with all the pitfalls of haphazard selection that this mode of research implies.

Virtually all the writers on this subject are in agreement with the avoidance of artificial, individual matching across culture lines (Brislin, 1977; Brislin, Lonner, & Thorndike, 1973; Campbell & Naroll, 1972; Draguns, 1977, 1982; Guthrie & Lonner, 1985; Malpass & Poortinga, 1986). This is a seemingly rigorous technique that increases the danger of Type 2 errors while it lessens the risk of Type 1 errors. In the process, however, it generates a host of intractable problems of conceptualization and interpretation. Prominent among these is the virtual impossibility of generalizing beyond the artificially constructed samples, especially when the discrepancies between these two groups are major. Let us suppose that a match must be found for an American divorcée who, moreover, is a college graduate, professionally employed, and the mother of two young children. Let us further imagine that this woman's counterpart is sought in a hypothetical society in which divorce is exceedingly rare, women's educational opportunities are limited, and professional employment for them is virtually unknown. The result of matching, if successful, would pair a fairly typical member of the contemporary United States society with a person of exceptional opportunities and achievement in another culture. To whom could the results of such a comparison be generalized? Thus, a lot of painstaking effort often results, especially if it is applied to milieus with widely different social indicators, in findings that are virtually inapplicable to any populations within one or both settings. There is the risk, however, that the atypical, laboriously chosen subjects at one or both of the sites of the comparison will be overlooked and the results will be mindlessly extended to the typical and representative members of the two populations.

What other expedients exist for intergroup comparison? Brislin and Baumgardner (1971) proposed a simple and straightforward solution that has remained relevant to this day. They advocated the comparison of samples in their existing state, with all the discrepancies in their demographic indicators. However, they also counseled the investigators to record carefully and completely these characteristics for purposes of more refined comparisons or replications in the future. Although this suggestion continues to be viable, the development of flexible and sophisticated statistical techniques provides potential alternatives for isolating, partialing out, or otherwise reducing and perhaps eliminating disparities between samples.

Diagnostic Concepts

Little remains to be said about the operational definitions of diagnostic concepts, such as schizophrenia or depression.

The advent of rule-based diagnosis, together with computerized conversion of symptoms into diagnostic categories, has opened new avenues for checking and controlling the subjectivity and the fallibility of the clinician as well as the culturally determined slants and biases. This development has contributed to making these distortions objects of research rather than sources of uncontrollable error. The objectification of diagnostic judgments is a tremendous advance for the entire diagnostic enterprise. For culturally sensitive assessment, it has created the possibility of research-based objective diagnosis and of identifying its culturally characteristic features.

In the past, national diagnostic systems differed in the scope, nomenclature, and defining features of diagnostic entities. Thus, identical terms often masked differences in manifestations and identical symptom patterns were encompassed within differently named entities (cf. Draguns, 1980). The different modes of expression for and the diverging connotations of depression across cultures are a case in point (cf. Marsella, 1980). These effects have been shown to operate within the professional mental health community and in the lay public (cf. Tanaka-Matsumi & Marsella, 1976), sometimes in a parallel manner (cf. Townsend, 1975).

Verbal Instruments

The procedures for assuring the equivalence of verbal scales and tests across language (Brislin, 1970, 1976) are well known and widely practiced and scarcely need to be reiterated at this point. They hinge on the pivot of independent back-translation as the indispensable safeguard for textual equivalence across language. This problem can be

considered to have been technically solved. A still open issue concerns the connotations of specific words, phrases, and terms and their affective valence, not only across languages, but also across cultural and ethnic groups within the same linguistic community. In the case of bilinguals, the connotations of words and statements in their first language, which often persists as the means of communication of subjective and affective experience, remain to be systematically investigated. As yet, there are no bases for recommending a specific course of action in these situations for the clinicians involved in assessment.

Formats and Contexts of Investigation

Interviewers and examiners immersed in their professional activity may assume intercultural uniformity in the prevailing modes and formats of assessment. In particular, the limited-option group format of testing has long been a fixture of the United States educational system and of personnel and employment settings. It is all too easy to overlook the culture-bound character of these activities. Boesch (1971) in Germany has made the point that self-disclosure is a worldwide phenomenon, but its expression through the true-false, forced-choice, or Likert-scale format is a development that originated and spread at a specific point in time and space. As yet, there are no systematic comparisons of reactions and attitudes to this mode of testing across cultures. Episodic observations and anecdotal evidence suggest that both normal volunteers and hospitalized psychiatric patients in continental European countries (e.g., Germany) are a lot more resistant to responding to biographical and personal inquiry by the objective, limited-options methods than are their counterparts in North America. Conceivably, similar ambivalence and reluctance may also be experienced by members of some ethnic groups within the United States. This phenomenon appears to be worth exploring, the more so since the worldwide trend toward automatization and computerization may cause it to wane and eventually to disappear. Even then, however, there may remain culturally mediated differences in readiness to share personal information with nobody in particular, on somebody else's terms.

A striking, if isolated, demonstration from Japan by Lazarus, Tomita, Opton, and Kodama (1966) points to the global affective effects of testing overriding the valence of specific arousing stimuli. Japanese subjects showed increased skin conductance across all conditions of the experiment, in contrast to Americans who displayed the expected variations to arousing vs. neutral stimuli. Lazarus et al. tentatively interpreted this finding as indicative of the Japanese

subjects' increased sensitivity to the global experimental situation. This finding needs to be extended and replicated before any conclusions are drawn concerning the interplay of cultural and social factors that have produced it. At this point, it only suggests the possibility of culturally variable meanings of the formats and contexts of assessments.

Social Climate or Atmosphere: The Examiner's or Observer's Contribution.

Diaz-Guerrero and Diaz-Loving (1990) recently have called attention to a hitherto neglected source of cross-cultural variation to the assessment enterprise. In a comparison of personality characteristics of school children in Mexico City and Austin, Texas (Holtzman, Diaz-Guerrero, & Swartz, 1975), examiners were found to display strikingly different demeanor, even though they were identically trained to administer the project measures. In the words of Diaz-Guerrero and Diaz-Loving (1990),

> The American tester was detached and, to the Mexican observers, cold. The American child was absorbed, challenged, and involved with the tasks. He/she gave to most of the observers the impression of competing with the tester. The noise level and commotion were minimal. The Mexican tester was vehement and expressive—to the American observers, overly warm. The Mexican child was responsive and involved in the interpersonal relation; it seemed that he/she wanted to please the tester with good answers to the tests. The noise level and commotion seemed high to the American observers. (p. 491)

Holtzman et al. (1975) decided to accept these divergent interactions as components of the cultures they were studying. Another option, open to future investigators, is to incorporate these variations into the research design and to establish their impact upon the subjects' responses. As yet, this step has not been taken. Once the contribution of the examiner to the social climate of the assessment experience is established, interviewers and testers could accommodate to the culturally based expectations of their clients and thereby facilitate optimal responsiveness and self-expression.

CONCLUSIONS

The field of cross-cultural assessment of psychological disturbance is in a state of flux and precarious balance. It is torn between the imperative of equivalence and the ideal of sensitivity. Simultaneously, culturally oriented researchers strive to both capture per-

sonal experience in its culturally unique richness and complexity while they try to fit these observations into some kind of a universally comparable mold. All too often, however, they find that the pursuit of these two goals cannot be easily reconciled. The partial solution to this dilemma that comes to mind combines rigor in the research phases of this undertaking with flexibility in its application in a practical service context. Precision and objectivity are called for in determining the person's relationship to both his or her original and host cultures, and the field of cross-cultural assessment has made a significant spurt toward developing empirically based and practically applicable instruments to that end. Diagnostic instruments and scales have moved considerably from their intuitive, subjective and often culture-bound beginnings. Most important, the new diagnostic system, embodied in DSM-IV, has incorporated cultural considerations into its rationale and has recognized the relevance of cultural information for diagnostic activities. Moreover, the advent of objectified and explicit rules of diagnosis represents a tremendous advance in research determination of psychological disorder. Yet it is at the very least incautious to apply such rules in a practical context in which decisions about living persons are involved. The mindless use of cutoff scores of tests in educational, mental health, personnel, and counseling contexts is to be avoided, especially with a multicultural clientele. The impact of culture upon adaptation is best conceived as a dynamic interplay of forces rather than as a static and finite entity that affects the person's functioning once and for all.

Starting out as the younger sibling of the better developed field of the cross-cultural assessment of cognitive and other abilities, the assessment of psychological disturbance has made inconspicuous and undramatic, but still perceptible progress over the last 30 years. One has only to compare the impressionistic and semi-intuitive pronouncements of the post-World War II culture-and-personality era and the confounding of evidence, inference, and speculation that characterized that period of time with the methodological and conceptual self-consciousness and sophistication that have by now emerged in research and practice. Cross-cultural assessment of psychological disorder has experienced nothing like the advance that the related and more inclusive field of cross-cultural measurement of aptitudes and abilities has achieved. There is nothing in it to compare with the two landmark conferences on mental tests and cultural adaptation (Cronbach & Drenth, 1972) and human assessment and cultural factors (Irvine & Berry, 1983). Nonetheless, there has been accretion of sound data, development of new methods, and evolution

of more fitting concepts (Draguns, 1990a, 1990b). The future of the field, to the extent that it can be discerned, is likely to be characterized by a flexible reliance on a multimethod and multiperspective approach, with the prospect of a definitive integration into a multifaceted and complex cognitive structure of facts, concepts, and their interrelationships. Recognition has been gaining currency that cross-cultural assessment is difficult, yet possible to implement.

In evaluating the results of a major conference on human assessment and cultural factors, Cronbach (1983) suggested that "the search for universal relationships is self-defeating" (p. VIII). As I understand his statement, Cronbach voiced skepticism concerning the prospect of discovery of main effects of culture upon behavior and experience that would be simple to formulate and easy to assess. The search for such universals on the planes of both conceptualization and assessment is reminiscent of the quest for culture-free or at least culture-fair tests of intelligence about 50 years ago. By now the hope of ever constructing such a generally applicable instrument has been largely abandoned. Instead, investigators in the field have redirected their efforts toward designing measures of intelligence for specific populations at their respective sites and contexts. Similarly, the agenda for the cross-cultural assessment of adaptive and maladaptive patterns of behavior calls for a multitude of piecemeal efforts toward describing the predicament of human beings as they struggle with their frustrations and challenges in their specific cultural milieus. To this end, the clinician should be on guard against two major and grievous cognitive errors. One of them involves pigeonholing clients into their respective standard diagnostic rubrics and the other entails stereotyping persons on the basis of their culture or ethnicity. Especially ominous is the conjunction of these two tendencies which, in their extreme form, results in equating social deviance with psychological disturbance. The danger of glossing over individual differences within cultural and/or diagnostic category must ever be kept in mind and the possibility of reciprocal, interacting, and dynamic influences linking culture and psychopathology should not be overlooked. Moreover, a sensitive assessment effort would involve both ability and readiness on the part of theoreticians, researchers, and practitioners to shuttle their perspectives between the emic and the etic, the quantitative and the qualitative, the categorical and the continuous, and the personal and the contextual. If such flexibility is attained and maintained, there is reason to hope that culturally specific and humanly universal facets of a complex human structure will be disentangled. Such a development has the potential of elucidating the

process of coping with challenges of adaptation on the basis of individual resources, cultural assets, and general human potential. How these threads intertwine is a story that is gradually unfolding as information is accumulated about people of different cultural backgrounds coping with their aspirations, stresses, and problems.

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