Frame and Context for Understanding Mental Health Problems across Cultures:

Language and the Social Self

Chinese Americans and Euro-Americans

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ABSTRACT

The interface between institutions and comunities, between service providers and their recipients, is informed and implicitly organized around certain cultural issues. In the present paper, it is the backdrop for once again raising and questioning certain funndamental assumptions that underlie the way in which we think and conceive of mental health problems. The goal is not to substitute an alternative "definition" of the phenomenon but to step back and view such problems in a comparative framework which brings us "up the ladder of abstraction." While language is the most explicit conduit through which the self gains expression, it is still far from a precise, analytical tool. One key to unlocking certain doors to the mental health question is the variable nature of the self as a social entity and perceptions of problems as they are thereby framed.

This paper is concerned with the development of a social frame or context for understanding mental health problems. I will begin, however, with an example somewhat more removed from this area in order to underscore the importance of cultural considerations in the delivery of services of any kind. In 1957, the U.S. Public Health Service anticipated an outbreak of the Asian Influenza. This occurred under the best of all possible structural conditions. There was no question about technological know-how or biological information about the disease, and the pharmaceutical industry's ability to produce adequate supplies of the vaccine was essentially limitless. Yet there were a number of social and cultural obstacles that severely impeded the successful implementation of policy from above. Chief among them was an unreceptive public, who because of a combination of religious convictions, medical beliefs, and cultural views, rejected, or at least failed to seek, the appropriate care being offered. Had the virus actually struck and been as lethal as anticipated, a large portion of the population would have been decimated (Margaret Clark in Dellums Hearings, 1981). A closer look, then, at the articulation between institutions and community, between the providers of service and their recipients, is vital to our understanding of a wide range of issues from the study of crime, work, or education to life and death matters of flu vaccine.

The puzzle.

My research on mental health problems among Chinese Americans began with a puzzle, a rather common-sense puzzle. On the one hand, the rate at which Chinese Americans utilize mental health facilities has been disproportionately lower than that of other groups (Sue, 1977; Sue and Kirk, 1975; Sue and McKinney, 1975; Berk and Hirata, 1973; Kitano, 1973; San Francisco Mental Health Services, 1969; Jew and Brody, 1967). The idea that something in the cultural fabric protects against mental illness has been put forth from different perspectives and is consistent with a commonly held view of them as a "model minority" (The issue of model minority has been discussed in articles by Cabezas, 1979; Suzuki, 1977; Kim, 1973; Kitano and Sue, 1973). Indulgent child-rearing practices (La Barre, 1946), cultural strategies for coping (Yee, 1980; Lum, 1979; Tong, 1978; Kung, 1962: 53), and family cohesiveness (Hsu, 1972) are some of the things said to foster mental health.

On the other hand, my own experience within the community gave me a very different picture. There were clearly stresses or "problems in living" that could be labeled as mental health problems in the broadest sense of that term. An economic profile of the group, moreover, does not necessarily conform to a picture of group success. In 1978, for example, the median annual income of Chinese males in four major SMSAs was equivalent to that of black males (Moulton, 1978: 39).[1] Public assistance or welfare, moreover, is rarely resorted to. In San Francisco, where the majority of Chinese Americans reside, only one out of ten poverty households in this group was receiving any kind of outside help (Fong and Cabezas, 1976: 18). Even among the apparently more suc-

cessful, high educational achievement is not always matched by commensurate rewards in terms of earnings (U.S. Commission on Civil Rights, 1978). At both ends of the continuum, moreover, they tend to be the most occupationally segregated of groups. If the sociological literature on mental health is consistent on any pattern, it is that the less well off one is economically, the greater the chances of being admitted for mental health problems and of receiving a more serious diagnosis. (Fried, 1976; Hurley, 1969; Hollingshead and Redlich, 1958).

Yet how are we to explain the fact that objective conditions for the Chinese do not produce higher rates of contact with mental health facilities? Social epidemiologists have made the distinction between "treated" and "untreated" cases to account for such discrepancies. There is reason to believe that many problems go "untreated" or unassisted by outside agencies given that the Chinese family has historically tended to insulate itself from dominant institutional arrangements. According to Ben Tong, this policy of "taking care of one's own," which he refers to as pao tin, was brought over from the motherland and transformed in the Chinese American context, serving as a survival mechanism, which in the late nineteenth century meant deflecting much violence and destruction directed against Chinese lives and property. This attitude behind "taking care of one's own" still exists today. He says,

> To give others the impression that you are satisfied with your lot, even if it is meager, and that you wish only to mind your own business, meant that those with power would leave you alone (Tong, 1971: 7).

In this context, are rates of psychiatric utilization an accurate

measure of mental health? Or is there something about the cultural perspective that requires that we modify the way in which we try to apprehend the empirical world? We can see from Tong's analysis that problems may exist yet not appear in the statistics insofar as historical factors shape social responses at the very level of identifying or ruling out certain avenues of help-seeking.

My own interest is in the interface between institutions and the community as it is articulated by cultural considerations having to do with perceptions of mental health problems. That is, I was not interested in assessing the level or nature of problems from a psychiatric perspective but from a sociological vantage point, which begins with cultural definitions of illness.

Facts can only be appreciated within a framework or context. I will use language as one kind of context or frame, and social conceptions of self as another. The analysis of language can be an aid in how we conceptualize problems for research. With the comparative focus (Chinese American vs. Euro-American), I discovered that social conceptions of self were related to culturally derived perceptions of need which, in turn, can help inform social policy. My hope is that the discussion will be broadly relevant to a more general set of questions about how one studies problems in a community.

Language and social meaning: physical and psychological concepts

Language is an important piece of the puzzle with which I began. It raises, moreover, some interesting epistemological questions about the nature of knowledge.

In Navajo culture, language is poorly developed when it comes to describing pain. Irving Kenneth Zola (1964: 357), for example, has pointed out that the language of this culture does not discriminate between various types of pain, such as "sharp, dull, searing, and so forth." If this is true, the next logical question, at least for me, was to what extent is experience thereby transformed by this particular lack of articulation? Is the experience of pain therefore fundamentally different? The absence of a language which differentiates between types of pain undermines a basic assumption on which diagnoses are usually based. The general problem is fascinating in that we can never get to or apprehend the inner self with any absolute certainty. We can thus never know whether the Navajo <u>really</u> experiences pain in the same way as we do. (Or even if our marriage partner of fifty years does, for that matter.)

What we <u>do</u> know is that the way in which we react to pain is not a simple organic response but one linked with how we identify, interpret, and thereby react to the experience. Studies have shown that individuals with the same <u>physical</u> disorder perceive and react to their illness differently, and in styles consistent with cultural or ethnic differences. In Zola's (1966) study of patients' presenting complaints, Italian and Irish with identical physical ailments had very different ways of describing their pain. The former saw their problem as diffuse: "Compared to the Irish, the Italians presented significantly more symptoms, had symptoms in significantly more bodily locations, and noted significantly more types of bodily dysfunction (Zola, 1966: 624)." Pain, moreover, was an important aspect of their experience, perceived by patients as affecting their interpersonal life in significant ways. The

Irish, on the other hand, tended to deny that pain was a feature of their illness or that it interfered with other areas of experience. They tended, moreover, to localize the problem in a specific function or area of the body. According to Zola, these tendencies towards either "dramatization" or "denial" are not merely expressive styles but defense mechanisms, culturally derived ways of coping. The ability to cope, I would add, depends much on how members attend to ideas that are identified in the culture as important. The Navajo's undifferentiated language for physical pain may indicate its residual status, reflecting a greater concern for the "psychological" dimension of health.

> ...Navajo customs concerning health stress the psychological aspect more strongly than the physical aspect of human welfare. A Navajo patient is likely to be severely troubled on the psychological matters of his treatment even though the physical aspects may be well cared for in the hospital (Toelken, 1979: 354).

It has been suggested, moreover, that language for the problem rivals the actual incidence of the phenomenon.

> There is an astonishing variety of recognized causes of mental illness among the Navahos; in fact, mental illness can be a consequence of so many different behaviors that we are led to suspect that it has a cultural importance far out of proportion to its actual incidence (Kaplan and Johnson, 1964: 207).

When I came to the issue of mental illness among Chinese Americans, I found an interesting parallel. Just as the latter fails to elaborate upon the phenomenology of physical pain, so Chinese language is relatively devoid of psychological concepts. Moreover, according to Wang (1964?), Chinese patients "rejected and resented inquiry into their

state of mind but thrived on attention given to their bodies." The fact that there is no really equivalent word in Chinese for "depressive mood" (Tseng and Hsu, 1969) as it is understood in English is significant. When Chinese talk about depression, they usually use somatic, i.e. bodily, terms -- such as "exercised heart" or "weak kidney." They tend not to label internal mood states per se. This is part of a cultural attitude that has been interpreted as a denial of psychological problems (Tseng, 1975; Lin and Lin, 1981).

But what does this mean? Historically, the emotions -- both positive and negative -- have had an important place in Chinese thought. Seven kinds of emotions are recognized -- happiness, anger, worry, desire, sadness, fear, and fright (Lin, 1981). In this context, somatic or bodily expressions may represent "metaphors" for psychological states, in which case it is not so much that psychological, mental, or emotional problems are denied but that they are conveyed in very different language, in somatic or bodily terms. So, for example, "exercised heart" in Chinese implies apprehension, and "weak kidney" is often associated with general malaise. In English, we have parallels in phrases such as "choleric," "bilious," "phlegmatic," "sanguine," and "melancholy" -- terms which are now used to refer to psychological temperaments but which have their original meaning in humoral theories of the body (Alexander and Selesnick, 1966).[2]

It is possible, however, that bodily expressions may <u>not</u> be colloquial metaphors for emotional states, in which case the absence of language which makes <u>explicit</u> reference to psychological states may mean a totally, or at least very different, experiential process. That is,

this experience may not have the psychological components basic to understanding depression in the West. For example, Chinese patients who are labeled as "depressed" by either Western-trained or culturally sensitive doctors are said to manifest "vegetative symptoms of depression, rather than symptoms of mood change, low self-esteem, or guilt" (Lin and Lin, 1981: 394; Marsella, 1977). Is it because Chinese clients deny to others as well as themselves that they have inner, psychological problems, such as guilt, for example? Or is there something about the culture's language, these bodily expressions I have been referring to, that alters the experience so that problems are not experienced as psychological ones? Apart from bodily ailments, many Chinese tend to see their problems as external. The following respondent expressed a characteristic attitude:

> The only kind of problems I have are external problems, and if I can ignore them, I'm fine...It's just the things that occur that make for problems. It's always exterior. It's like money problems, you know, boss problems, work problems... I don't think it's anything in terms of psychological problems or anything like that.

The problem is a complicated one, and mental health professionals disagree over the particulars. For example, it can be argued that Chinese patients really do experience radical changes in mood but cultural norms encouraging the suppression of emotions may make it difficult to perceive such changes. The larger point, however, is that we may need to know more about a culture in order to see whether it makes sense to treat something either as the same or as a different phenomenon?

Let me make the point another way. Say we were to determine or infer the extent to which Westerners experience that which corresponds to the Chinese meaning of feng k'uang. A simple literal translation might evoke images having to do with pneumonia or the common cold, associations which may come to mind when one hears the phrase "wind disease," the English translation of the Chinese ideograph (Lee, Ch'eng, and Chang, 1962; Veith, 1975). On the other hand, if the behavior to which this term applies were also to be pointed out, Western-trained psychiatrists might label it as manic excitement, depending on which variety of "wind disease" was being described (Tseng, 1973: 571). While confusion in the first instance (i.e. the imputation of pneumonia) stems from a crude literal translation, there is nevertheless the suggestion here of a different framework. That is, even were we to find further agreement about the behavior or its "symptoms," "wind disease" may still be linked with a whole set of assumptions about the phenomenon which do not neatly mesh with those, say, of "mental illness." According to the World Health Organization (1979), the predominant use of psychiatric notions from Europe and North America, and its implicit cultural bias, seriously limited ability to predict the course of schizophrenia across cultures.

For this reason, I tried to get at ways of thinking about mental health problems that are rooted in meanings emanating from strong cultural traditions. My own research, in fact, led me to see the necessity of comparing cultural frames, and by that process, attempting to understand the configurations therein. For the moment, let me simply emphasize that the interpretation of data, such as rates of contact with a mental health facility, depends on a certain ethnographic insight,

especially where constructions of social actors across cultures or social groupings may differ so fundamentally as to make comparative statements of an apparently singular phenomenon problematic. Insofar as different cultures have different ways of signaling how an idea is to be interpreted, these patterns need to be incorporated into our understanding, even when understanding is not impeded by language barriers.

The social self: the cultural creation of simultaneously complementary and conflicting needs

Insofar as every society seeks to control or manage deviance, deviance itself is patterned with respect to the particular social order which defines it (Yap, 1951). In this sense, individual deviance is not simply individual deviance but it implicates the norms or standards of the group (Durkheim, 1975).

Mental illness, as a form of social deviance, is a good example. Lu (1978) has suggested that one way of thinking about the kinds of problems exhibited by schizophrenics in American and Chinese societies is that they articulate social patterns where the "dynamics of stress point in opposite directions." In a society which emphasizes highly individualistic forms of self-sufficiency, mental illness takes the form of an inability to "cope with the demands for independence." In Chinese society, on the other hand, where the emphasis is on "collective achievement" and cooperation, deviance is defined in terms of individuals failing to control the tendency towards "individual competition." Let me turn to my own research as a way of further illustrating this point.

There are opposing "pulls" within any culture -- for example, that between Euro-American individualism and the social influence of Christianity, or between the social self as conceived of in Confucian thought and the more individualistic posture advanced by Taoism. In short, there are complexities or contradictions within any culture. For heuristic purposes, I have taken an analytical perspective which assumes a more individualistic conception of self among Euro-Americans and a more social conception among Chinese Americans. I am not positing that Euro-Americans are more individualistic in their behavior (they may well be, but that was neither my focus or concern). Rather, I am suggesting is that the range of individual behavior may be actually more circumscribed than we might think, given that the culture encourages individuality. In the following discussion, I'd like to illustrate how every culture creates a tension between two very general kinds of needs.

Over a period of three years, I completed a total of 40 interviews, 13 with Euro-Americans and 27 with Chinese Americans. The interviews were open-ended, some lasting several hours. Euro-Americans served more as a point of contrast than as a point of focus. All the interviews were done within the Bay Area, although the majority of those I talked to came from areas outside of the state. Subjects were chosen through an informal network of associates, the age ranging from 24 to 66, with the majority in their twenties and thirties. Just to give an idea of the range, I interviewed among Euro-Americans an optometrist, free-lance photographer, sports writer, naval officer, school teacher, and psychologist. Among Chinese Americans, an X-ray technician, grocery clerk, engineer, stock runner, meter maid, and campus minister. Along with the interviewing, I spent a good deal of time reading through the literature

comparing and contrasting what I heard with what I read. The interview data are only a small part of a larger work, and what I present here is a small segment of that part.

I began with an initial focus on mental health problems. However, I eventually saw the need to understand the relational dynamics of perceived intimacy. In particular, I was concerned with patterns of communication and expectations about support which approach some cultural ideal. I focused here specifically on two things: (1) those aspects which made the relationship "special and close," and (2) situations of typical, recurring, or significant conflict. In many ways, the interviews on intimacy and support provided a frame for understanding certain dynamics which occurred in the mental health context. The interviews on mental health problems similarly turned on some relationship in one's "close circle of family, friends, and acquaintances," but subjective closeness was not necessary since the breakdown of close relationships frequently precedes referral to some outside agency. More important was the perception of a problem "requiring more than the ordinary kind or amount of help, whether or not that help was eventually provided." The discussion below does not simply represent responses to this particular frame of questions. Rather, the responses themselves suggested another, alternative kind of frame.

All cultures create needs which are both <u>complementary</u> or <u>conflicting</u>. On the one hand, there are needs which are <u>extensions</u> of the dominant cultural orientation. Among Euro-Americans, the individual self achieves a celebrated status unheard of in most other societies. Social attitudes place a high value on individuality, autonomy and self-

direction. An individualistic orientation therefore encourages or exaggerates the need for a sense of independence, self-direction, or accomplishment which is highly particularistic to the self. In this sense, mental health problems are not simply highly individualistic deviations from the culture but expressions of the culture, albeit in the negative. For example, one Euro-American respondent pinpointed the source of his mother's unhappiness in the fact that her role as a mother did not allow her to realize certain personal goals or ambitions. He observes,

> ... people that meet my mother, nine times out of ten... generally only see one side of my mother. They see the side of her that is tremendously warm and personable and that selfless side of her that makes her a very good mother, which is all very very real... They don't see in her the side that has a lot of unfulfilled dreams. It's a basic dissatisfaction and unhappiness with her life. They also don't see the side of her that takes out her frustrations on members of the family. ...You know, in the course of her life she's sacrificed a lot but hasn't done enough to realize her own goals and ambitions.

In addition to such needs which flow from the direct espousal of certain cultural values, it is possible to talk about needs which are complements of these, i.e. which the culture generates almost by default. So, for example, where individuality as a valued way-of-being promotes separateness from others, there is an attendant longing for social connectedness, for a sense of "familyness" as one person called it. Likewise, the experience of freedom which is relatively unfettered may create in its wake a certain need for structure, guidance, or direction.

In general, an important feature of intimacy among Euro-Americans reflected this dual conception of or tension between needs. On the one

hand, there was an attraction to individuals who were "strong" or "independent" -- that is, role models of the culture from whom one could learn self-sufficiency. On the other hand, a fragmented sense of social belonging deepened the search for the fulfillment of needs more to the periphery of the culture, needs for mutuality, identity, or commonality with others.

Both the need to learn from, and to grow with, the other produce a peculiar tension. Ideally, the intimate relationship is one in which both persons feel "equally strong." The threshold of tolerance for possible dependency is thereby lowered. For example, a male respondent who had described the early stage of a friendship in which he felt "complimented" by the attentions of an older, graduate student after whom he modeled himself, later on felt very "uncomfortable" when this same person referred to him as his "best friend." The fear was "that he might be depending on me too much." The imperative to self-actualize or grow within an individualistic context can thereby become incompatible with the desire for mutuality and sharing. Yet the search for mutuality continues and derives from a need for validation or support of individual ideals or plans.

From the point of view of Chinese culture, we can similarly talk about complementary or conflicting needs. On the one hand, there is an all-important need for <u>fellowship</u> <u>and</u> <u>community</u>, arising out of the culture's emphasis on a more social conception of self, on the realization of self through a set of obligations and commitments. In this particular cultural context, the self and its activities are subordinated and implicitly tied to collective purposes and endeavors. The indivi-

dual, in other words, is born into a network which he or she can expect will be an important source of support throughout life.

For this reason, while a breakdown in relations is commonly recognized as precipitating referral in cases of imputed mental illness, the disruption of family relationships seems to have greater import for Chinese than it does in certain other cultural groups (Lin and Lin, 1981: 390).[3] A good part of my own data pointed to a loss of social moorings, social direction, and social support as a major source of an inability to cope. Two such cases described ended in suicide and a third in lifetime mental hospitalization. Moreover, while problems among Euro-Americans were associated with failures to achieve individual self-fulfillment or self-sufficiency, Chinese Americans were more likely to see some form of "self-centeredness" as the problem. Respondents, for example, looked critically upon individuals who appeared "frustrated" when they didn't get their way or who failed to live up to social obligations or commitments. Moreover, failures in reciprocity often arouse greater feelings of resentment or of being unappreciated for efforts on behalf of the other.

With acculturation, there is, as we might expect, a greater tendency to lean the other way, to be critical of the self-sacrifice that is often entailed in such relational commitments. A 28-year-old Chinese American male, for example, said about his mother,

> ... she's so self-giving that my sister and I talk about how she never really had an independent existence of her own. And housewives nowadays talk about self-fulfillment, self-satisfaction. She never even thought about that kind of stuff for herself. It was always putting us first and just a tremendous amount of denial, self-sacrifice, you know. Then

> you think, what's wrong with her that she does this? I still think that sometimes today. But I just have to think that's the way she was raised, to raise her kids -- just ultimate self-denial to the point of even if she had to die for us, I think she'd do that in a real servant attitude.

There is a remarkable absence of concern for individual self-fulfillment here. Chinese American mothers perhaps experience cross-cultural tension most poignantly when circumstances force them to come to grips with a reality which they have only known from a distance. So, for example, a second-generation mother struggled hard with the fact that her children were leaving home. While her problem may seem to be a typical one -- in fact, she refers to it elsewhere as the "empty nest syndrome" -- she described her loss as if she were at the same time trying to persuade herself that it is a normal thing for children to grow up and go away. She says,

> ... I always knew they were going to leave the nest, and they should. They should all leave the nest and have lives of their own. I knew all that and yet -- (and she goes on)

Apart from needs which are extensions of the dominant value orientation, there are those which the culture places less store in, such as the valuation of the individual above or apart from the group. Generational conflict between parents and offspring was fueled where the latter drew sustenance or legitimacy for individual views from the larger Euro-American context. Among those Chinese Americans, however, less restless for an individual sense of identity, the security of being a <u>supported</u> member of the group seems to compete strongly with this inclination towards individuality. So, while a 28-year-old second-generation, Chinese American expressed a desire to broaden her

friendship circle because she felt it would

> ...be an indication that I am more independent of someone, somewhat less reliant on my own ethnic group, my own social circle... It's kind of proof to me that I've accomplished something on my own rather than have it (i.e. friendship circle) develop all around me...

she feels a loyalty or greater attachment to her present circle which competes with this desire to expand her social network and which reflects the years of almost unconditional support it gave her. In short, there are these complementary and yet simultaneously conflicting needs, and their relative importance reflects a hierarchy of values and assumptions.

Staying with those patterns which I think are part and parcel of the more social conception of self in Chinese culture, let's look at the nature of verbal expressiveness among Chinese Americans because I would like to illustrate how communication about problems is very much constrained by social considerations, by attentiveness to the interpersonal dimension. Tong has made the point that an indirect measure of one's consideration or regard for others is to manage personal problems on one's own. In the following passage, for example, he says,

> ...Powerful, untidy feelings are to be managed entirely on one's own, without counsel or solace from other people. Turning to family and friends is a final recourse but here we have a paradox; one can always call on significant others, yet they are in fact to be regarded as the absolute last resort. An alliance or friendship carries with it the right to casually invade each other's privacy but this is not to be abused. A sign of love, therefore, is never having to make demands. One takes care of one's own, beginning with oneself (Tong, 1978: 86).

While the prescription to "take care of one's own" may seem, as Tong indicated, to contradict what has been said about supportive ties, I found a reciprocal side to "taking care of one's own." (By the way, I should mention that the idea of "taking care of one's own," as it is used here, is not the same as pao tin, mentioned earlier, but is translated in terms of a different Chinese ideograph.) That is, sensitivity to the problem of burdening others is ideally matched by the other's sensitivity or attentiveness to nuances possibly indicating one might be in need. Such perspicacity has special meaning for those who are close, for while intimacy among Euro-Americans almost by definition presupposes open confiding, among Chinese Americans it depends as much on the other's ability to detect a problem and then open the channels for communicating about it. Most difficult to communicate are those "powerful, untidy feelings" or delicate points of tension that one might have with the person in question. Because adaptability in interpersonal relations is highly valued, the culture frowns upon expressions of negative, and hence potentially volatile emotions which might upset social relations. Such feelings are rarely shared, and then only with tremendous difficulty. Sensing a problem is therefore a critical first step to confiding. One male, for example, described how it took two hours of continuous probing and prodding just to get his girlfriend to say what was bothering her. In turn, he himself felt equally constrained by his own inability to bring up problems, indicating, however, that his girlfriend was usually able to perceive something was the matter before he became "desperate."

In general, to the extent that the problems or issues in question somehow implicate the other as a responsible actor,[4] one-on-one or

unmediated attempts to resolve potential differences is a hazardous affair, for the very reason that while there is a great deal invested in such relations, there is little experience or practice with articulating sensitive issues in a sufficiently delicate way. Frequently, misunderstandings accumulate before it is possible to iron out the various concerns, and to the extent that a person feels he or she is reading situational cues or nuances accurately, there is even less incentive to initiate any communication. Saying nothing, moreover, seems to be the safer choice, especially since experience has often proved such undertakings to be extremely risky -- escalating into intense, highly explosive confrontations, and perhaps triggering the complete collapse of the relationship. In the following passage, a 26-year-old male recalled how an argument between his father and grandmother lasted for ten years, during which time neither exchanged a single word with the other. His grandmother, however, continued to keep the problem alive by denouncing her son to friends and associates.

> ... For some reason, she just blew it out of proportion and stayed angry over it for -- it must have been almost ten years... And she -- she has lots and lots of friends -- and she spread it out all over the place... (so that) my father became persona non grata for almost ten years. But the thing that made it abnormal... almost bordering on obsessive-compulsiveness, is that she kept bringing it up over and over and over... To everybody. Day in and day out.

The above account, then, suggests how a problem can ramify, get out of hand or out of control by virtue of the fact that individual disagreements are implicitly social concerns as well.

Policy Implications

I've attempted to contrast what I see as central orientations of two cultural perspectives and thereby suggest a possible frame for better understanding mental health issues. Given the thrust of my analysis, how might we characterize the general relationship that Chinese American and Euro-American communities have with respect to the delivery of mental health services? And how might this help piece together a part of the puzzle with which I began -- that is, reconciling low rates of psychiatric contact among Chinese Americans with an internal view of problems and stress? What I have attempted to do is to unravel select layers of meaning that might have relevance for how different groups perceive, think, or communicate about problems. Every culture has a hierarchy of values and assumptions which governs social life. It is important that therapeutic strategies for intervention reflect or take such values into consideration.

This is implicitly true in Western psychotherapy. The idea of the self as "individuated ego" is honored as a routine part of professional practice. The therapist seeks to be a neutral, nonjudgmental agent, supporting the client in his or her "self-actualization" or "growth," with "self-direction" (as in the way of insight) as an important means. Implicit, then, in existing institutions and their policies is a therapeutic intervention strategy which emphasizes Western conceptions of mental health, so that when we think about service delivery systems, it is usually in individualistic terms.

The very reason for psychotherapy's fit with Euro-American attitudes (i.e. its individual-centeredness) renders it less compatible with

the Chinese experience. Insofar as Western therapy is very individual-centered, it tends to be based heavily on verbal expressiveness, high tolerance for ambiguity, and a clear distinction between "physical" and "mental" states. Among Chinese Americans, however, there is in general a low tolerance for ambiguity or "talk" which does not lead to tangible, concrete accomplishments, and a decided preference for dealing with more "practical" problems in everyday life. Problems treated as "psychiatric" or "psychological" by the former tend within the Chinese American context to be considered products of social factors or circumstances.

There is no form of "psychotherapy" in Chinese culture that approaches problems expressly or strictly through psychological processes.[5] On the one hand, there is a general belief that how problems are perceived and the way in which energies and emotions are directed are important influences on mental health. Yet the very conception of the individual as a fundamentally social being leads to a focus on the person's external relationships rather than on internal, psychic processes. The very methods and goals of (what has been described as) "Chinese psychotherapy" is aimed at reorienting the individual towards the requirements of society, towards being one's reintegration as a fully participating member.

> ...the Chinese approach to therapy is reality-oriented, emphasizing the patient's role as a responsible member of society. For the patients to understand themselves better and to overcome their problems, they must understand what society is like, what its principles are, what people expect of them at home and at work, and how to act outside of the hospital. Feeling good about oneself involves making a contribution to society, a contribution that will be recognized by others; thus, self-esteem is a social phenomenon. The patients make social contributions through their productive labor and through their involvement in hospital work.

> All these activities that the patients engage in are considered part of their therapy. For the Chinese believe that people are social beings and that their mental health depends on their relation to society and upon the nature of the society in which they live...
>
> Chinese psychotherapy does not focus on the patient's emotions or childhood experiences; it does not attempt psychological explanations as we know them. The main concern is for the patients to develop logical, rational thinking and to develop good social values of cooperation. Then the patients can come to have happy, fulfilled lives through their ordinary social activities. In other words, because social life is fulfilling, the point is to participate in it (actively, of course, not passively following social dictates), and there is no need to engage in purely psychological -- i.e. personal analyses.
>
> ...The point is not to develop his "emotions" in the abstract sense of being more emotional generally; rather it is to be a good worker who develops himself socially, becoming analytical, creative, expressive. The Chinese believe such development cannot be accomplished abstractly by emphasizing certain parts of a person apart from fulfilling social life (Ratner, 1978: 26-28).

To the extent that help providers and recipients act in accordance with very different norms and expectations, the discrepancy may hinder the delivery of health care. Psychological tests of college students, for example, find Chinese Americans more socially introverted and withdrawn, and more likely to suffer from anxiety, loneliness, and feelings of rejection than Euro-Americans (Sue, 1973). The tendency for the former, however, is to underutilize campus psychiatric services and overutilize the Counseling Center (Sue and Kirk, 1975). This is not to suggest that those Chinese who make their way to counseling centers or other non-psychiatric facilities see themselves as having "mental health problems." Rather, the very perception of issues and problems is not likely to be framed in strictly mental health terms.

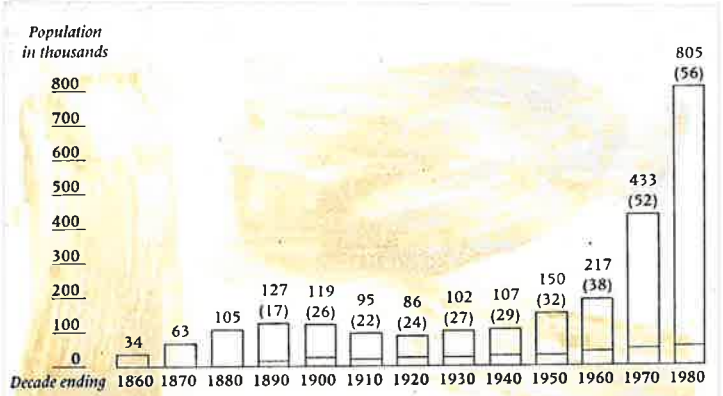
The inadequacy of culturally responsive mental health services is

partly reflected in delayed help-seeking, a high rate of attrition from these facilities, and consequently more serious admissions requiring hospitalization (Sue, 1977; San Francisco Community Mental Health Services, 1969). In fact, a seven-fold increase in Chinese hospitalization was observed over the past century (Berk and Hirata, 1973). While there are a combination of factors that may have conjoined to produce such a dramatic increase in official rates, hospitalization tends to be seen here as a last-resort measure which upsets a more general pattern of low utilization characterizing their use of other psychiatric facilities. Those most vulnerable to hospitalization in the past have been the elderly, single, male, and foreign-born populations. This is still the pattern today, although the historical and social circumstances are very different.

For historical and cultural reasons, there is much overlapping of social categories, such as to indicate greater stress and fewer facilities for coping. Most elderly Asian Americans, for example, are foreign-born, and in American society frequently lose the status accorded them in their traditional culture. They also have lower-status jobs, lower median incomes than the general elderly population, and proportionally few of them take advantage of available social security benefits or public financial assistance (Sue and Morishima, 1982). Similarly, many Chinese males are single, and this is more true among the elderly Chinese than for other elderly populations in the U.S. Historically, Chinese males were not allowed to bring over wives and dependents and consequently had to live most of their lives as bachelors (Nee and Nee, 1974), without the institutional support which is so important in the culture, i.e. the family. Not until the War Brides Act of 1945

in the culture, i.e. the family. Not until the War Brides Act of 1945 did Chinese women enter the country in significant numbers. While Chinese families thus began to form, in 1967 Tom and Lin were reporting widespread child neglect associated with economic hardship and long hours of work. In my own work, generational and intrafamilial conflicts among second and third-generation Chinese Americans manifested themselves in one of two extreme patterns, withdrawal and suppression of individual feelings, on the one hand, and explosive confrontation, on the other.

Beginning in 1975, the more recent Chinese immigrants have been refugees. They, along with other Southeast Asian refugees -- the Hmong, Lao, Mien, Khmer, and Vietnamese -- arrived with a family structure already strained by years of war and, often, by the ravages of a difficult journey. Almost every Southeast Asian family has experienced some tragedy, loss, and separation (Asian, Inc., 1983). Of the "boat people" who fled Vietnam in 1979, seventy percent were Chinese, most of them under 35 years old (Knoll, 1982: 266). The fact that this refugee population has helped to double the Chinese population in the past ten years (from 435,062 to 806,027 according to the 1980 census) has put greater pressure on existing resources.



Two: Cumulative totals of Chinese heritage in the United States and territories by decade from 1851-60 through 1971-80. Residents of Hawaii are shown at the bottom of the bar, and their numbers given parenthetically. (Source: U.S. Bureau of Census)

(Reprinted from Tricia Knoll, Becoming Americans, 1982, p. 310)

The sense of relative well-being that derives from having left harsh conditions in the homeland needs to be weighed against conditions in the more immediate social environment. The trauma of war and flight (and the attendant experience of "survivor guilt") converge with adjustment problems that accompany shifting roles, social isolation, and employment difficulties. Among the refugee population in California (284,000), more than half (a large percentage of whom are Chinese) were in 1983 on the state's welfare system, going against a policy of "taking care of one's own." Of the 175,000 registered as being in the country 36 months or longer, 152,000 are receiving the state's Aid to Families with Dependent Children (Beitiks, 1983). On the other hand, unaccompanied minors who have distant "relatives" in the United States often are not eligible for AFDC (Asian, Inc., 1983: 18). Refugee assistance programs in general were drastically cut in 1982 from three years to 18 months. The barriers of language and culture exacerbate adjustment problems in that they both impede efficient utilization of bureaucratic structures and eventually insinuate themselves as a wedge between members within a family.

On the more positive side, there is some evidence that bilingual, bicultural personnel facilitate the utilization of services in the community. In Seattle, an Asian American Counseling and Referral Service reported seeing almost the same number of Asian clients in one year as was seen by 17 other community mental health centers over a three-year period. In Oakland, 131 Chinese Americans showed up at a community-based mental health program in the first year of its operation, whereas a county-operated facility serving the general population had seen only three Chinese. Similarly, in San Francisco, more Asian Americans were

seen in the first three months of operation than in the previous five-year history of the same catchment area. Finally, a Los Angeles Asian/Pacific Counseling and Treatment Clinic served 700 Asian Americans in 1981, compared to the 40 seen by the County in the four years preceding the clinic's opening (Egawa and Tashima, 1981). These last few findings suggest that the problem is one of articulation between services available and the needs of a population.

Insofar as the rates we encounter are not the product of some simple relationship between need and service utilization, the important focus for further research is upon the process by which rates are created. Structural factors, for example, can be seen as creating the conditions for referral. How such problems are "translated" and understood depends on the context in which they are framed. In what ways, we might ask, do those who end up in the rates as having "affective" or "schizophrenic" disorders experience problems which transcend the boundaries of individual pathology.

CLINICAL DIAGNOSIS JULY 1982 - JUNE 1983

	CHINESE		JAPANESE		KOREAN		PILIPINO		VIETNAMESE		LAOTIAN		CAMBODIAN		AMERASIAN		SAMOAN		CAUCASION		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Affective Disorder	14	19	9	17	11	28	5	15	7	38	14	63	3	43	1	20			1	50	65	25.4
Schizophrenic Disorder	19	26	1	2	2	5	4	12	3	17			1	14	1	20					31	12
Anxiety Disorder	9	12	7	13	3	7	4	12	3	17	3	13	2	29							31	12
Adjustment Disorder	7	9	15	28	2	5	4	12	2	11							1	100			31	12
Paranoid Disorder	4	5	2	4																	6	2.4
Psychosexual Disorder							1	3													1	0.4
Disorder of Impulse Control	2	3																			2	0.8
Other Psychotic Disorder Not Classified					1	3	2	5	1	6	1	5			1	20					6	2.4
Organic Mental Disorder											1	5	1	14							2	0.8
Personality Disorder	12	16	15	28	14	35	7	21	2	11					1	20					51	20
Non-Psychotic Unspecified Disorder			1	2	1	3	1	3													3	1.2
Somatoform Disorder					2	5															2	0.8
Substance Use Disorder					1	3															1	0.4
Childhood Disorder	1	1			1	3	4	12			2	9									8	3.2
Marital Problem	4	5	2	4	1	3	2	5											1	50	10	3.9
Family Problem	3	4	1	2							1	5									5	1.9
Behavior Problem															1	20					1	0.4
TOTAL	74	100	53	100	39	100	34	100	18	100	22	100	7	100	5	100	1	100	2	100	258	100

(Reprinted from Asian Community Mental Health Services, Annual Report, 1982-83)

It is of interest to note that despite the fact that mental health professionals would tend to agree that Asian clients tend to express their complaints as somatic or bodily ones, the latter are not diagnosed as having "somatoform" disorders. It is probably that cultural or linguistic sensitivity on the part of counselors may provide the basis for interpreting or going beyond the presenting complaint of bodily discomfort. The clustering of Chinese patients in affective or schizophrenic categories, on the other hand, might be due to the fact that the most recent Diagnostic Statistical Manual (DSM iii) captures "major depressions" within these designations. The other irony, of course, is that "depression" is not a psychological concept which has the overtones or meanings it has in the Euro-American context. A delineation of the labeling process would contribute tremendously to the body of literature on mental health.

To sketch my approach to understanding the process or relationship between need and service utilization, we should include the following types of analyses: At one level, we must get a better sense of the issues and concerns that absorb persons in their everyday life, as well as those which do not. A comparative, ethnographic, cross-cultural approach would help generate some relevant theory and data, as would a look at demographic patterns produced by age, sex, or class. However, in addition to this horizontal comparative approach, we should examine a vertical cross-section of data as well, to develop different levels of abstraction. The counselor-client relationship, for example, would be a step towards examining the impact of certain policy issues and constraints within an organizational context. A study of historical trends (such as a comparison of institutional care in the U.S. and China)

might provide yet another level of analysis, although it could very well be done simultaneously with any of the others. The idea is to generate a data base across different contexts and to integrate micro and macro levels of analysis. Empirical data at the interface of these contexts (e.g. immigrants at the point of entry into this country or at other critical transition points, such as the period prior to termination of public assistance or at entry levels into the educational system) would permit some exploration of whether institutional responses were meeting service needs.

An analogy to crime statistics might help to illustrate my point. We know from the last two decades of research on the criminal justice system that rates of conviction and rates of incarceration do not give us a good picture of actual criminal activity. Less than 20% of select major crimes (auto theft, burglary) are cleared (i.e. processed) by arrest and conviction (Skolnick, 1966). So we should hardly be theorizing about crime from crime statistics. In the same way, there is a funneling of people to the mental health facilities, clinics, and psychiatrists' offices. If we use these statistics to theorize about mental health and mental illness, we will be far from the mark, and far from the empirical realities that should guide our increased understandings of this area. I am interested in pursuing research that gets at the process by which these rates are constructed. That could take me into organizational analysis, demographics, and of course, social structural issues like access to resources. But as Pierre Bourdieu reminds us, culture is capital, too. If I can sort among these dimensions and draw a thread through two or three of them, perhaps I will have come part of the way toward solving the puzzle of Asian mental health delivery.

Notes

1. Fifty-nine percent of Chinese Americans are concentrated in only five of the 243 Standard Metropolitan Statistical Areas (SMSA) in the United States (Cabezas and Fong, 1976: 9). In general, studies which find relatively higher levels of income for Chinese Americans are based on national or state averages. Because this population tends to be geographically concentrated in high-income states, this has the effect of artificially inflating its income relative to that of other parts of the country, since the cost of living in these states essentially cancels out the benefits of any added earning power.

2. While I am drawing attention to cultural contrasts, there are certain "coincidences" in expression. For example, in English the phrase "to have gall" means to have nerve. In Chinese, "loss of gallbladder" suggests cowardly feeling (which perhaps could be said to loosely parallel loss of gall or nerve). Similarly, the phrase "to be full of spleen" implies ill humor or bad temper, paralleling the Chinese phrase "opening of the spleen" which means relaxed feeling (raising the question as to whether the release of some noxious element, if not bad "bile" causing ill temperament, might be involved).

3. Unlike other forms of deviance, the phenomenon of mental illness in the Western world has meant a breakdown in common-sense understandings and hence "normal" social relations. Informal or lay imputations of "mental illness" therefore almost by definition imply such a breakdown. Yet a comparative analysis would do well to draw out more fully the differential meanings, impact, or implications of such behavior. In asking people to talk about "mental health problems" in a broader sense than that suggested by "mental illness," I tapped into understandings encompassing a wider range of behavior than that which was simply incomprehensible or bizarre.

4. Given that Chinese culture places such emphasis on self-control or internal control of the emotions, the mere fact of being upset can be construed as somebody <u>else's</u> fault. Someone or something <u>external</u> must be to blame.

5. If we were to imagine a psychotherapy that focused primarily on psychological processes and yet rested on a very social conception of self, the "quiet therapies" of Japan -- Morita, Naikan, Shada, Seiza, and Zen -- would be good examples. While the strategies here vary, the overall view is that pain and suffering are caused by centering upon the self.

   The misfocused mind is overly self-focused, selfish. The strategy of therapy, then, is to refocus the attention away from

everyday self-consciousness. Therapy can seek to flood awareness with self, as in Zen and seiza and Morita therapy's isolated bed rest, to induce a breakthrough to a deeper self (not subconscious but superconscious) or perhaps a surfeit of self-focus. Another tactic is to flood awareness with a negative self-consciousness, as in naikan; the result is a need to serve others and sacrifice the previously ungrateful, unaware self. The third tactic is to assign tasks that pull attention away from the self, as is done in the assigned mental work of shadan and the task focus of Morita therapy (Reynolds, 1982: 105, emphasis added).

BIBLIOGRAPHY

Alexander, Franz and Sheldon T. Selesnick, The History of Psychiatry, Harper and Row, New York, 1966.

Asian, Inc., Southeast Asian mental health conferences: executive summary , Asian, Inc., San Francisco, 1983.

Asian Community Mental Health Services, Annual Report, 1982-83

Beitiks, Edvins, "A hard look: culture shock among refugees," San Francisco Sunday Examiner & Chronicle, 1983. (October)

Berk, Bernard B. and Lucie Cheng Hirata, "Mental illness among the Chinese: myth or reality? " Journal of Social Issues, vol. 29, no. 2, pp. 149-166, 1973.

Cabezas, Amado Y. and Pauline L. Fong, Employment Status of Asian-Pacific Women, Asian, Inc., San Francisco, 1976. (August)

Cabezas, Amado Y., Myths and realities surrounding the socio-economic status of Asian and Pacific Americans, Asian, Inc., San Francisco, 1979. (May)

Dellums Hearings, Social and political implications of the OMB cuts in social research, Institute for the Study of Social Change, Berkeley, 1981.

Durkheim, Emile, "The normal and the pathological," in Theories of Deviance, ed. Stuart H. Traub and Craig B. Little, F.E. Peacock Publishers, Inc., Itasca, Illinois, 1975.

Egawa, Janey and Nathaniel Tashima, Alternative service delivery models in Pacific/Asian Americans communities, 1981. Pacific Asian Mental Health Research Project.

Fong, Pauline L. and Amado Y. Cabezas, Economic and employment status of Asian-Pacific women, Asian, Inc. (August), San Francisco, 1976.

Fried, Marc, "Social differences in mental health," in Poverty and Health, ed. John Kosa and Kenneth Zola, pp. 135-192, Harvard University Press, Cambridge, Massachusetts and London, England, 1976.

Hollingshead, August B. and Frederick C. Redlich, Social Class and Mental Illness, John Wiley and Sons, Inc., New York, 1958.

Hsu, Francis L.K., Americans and Chinese, American Museum Science Books, Garden City, New York, 1972.

Hurley, Rodger L., Poverty and Mental Retardation, Vintage Books, New York, 1969.

Jew, Charles C. and Stuart A. Brody, "Mental illness among the Chinese: I. hospitalization rates over the past century," Comprehensive Psychiatry, vol. 9, no. 2, pp. 129-134, 1967.

Kaplan, Bert and Dale Johnson, "The social meaning of Navajo psychopathology and psychotherapy," in Magic, Faith, and Healing, ed. Ari Kiev, pp. 203-230, Free Press, New York, 1964.

Kim, Bok Lim C., "Asian Americans: no model minority," Social Work, pp. 44-53, 1973.

Kitano, Harry H.L., "Japanese-American mental illness," in Asian-Americans: Psychological Perspectives, ed. Stanley Sue and Nathaniel N. Wagner, pp. 181-201, Science and Behavior Books, Inc., Ben Lomond, California, 1973.

Kitano, Harry H.L. and Stanley Sue, "The model minorities," Journal of Social Issues, vol. 2, pp. 1-9, 1973.

Knoll, Tricia, Becoming Americans: Asian Sojourners, Immigrants, and Refugees in the Western United States, Coast to Coast Books, Portland, Oregon, 1982.

Kung, S.W., Chinese in American Life, University of Washington Press, Seattle, 1962.

Lee T'ao, Ch'eng Chih-fan, and Chang Ch'i-shan, "Some early records of nervous and mental diseases in traditional Chinese medicine," Chinese Medical Journal, vol. 81, pp. 55-59, 1962.

Lin, Leh-ming, "Traditional Chinese medical beliefs and their relevance for mental illness and psychiatry," in Normal and Abnormal Behavior in Chinese Culture, ed. Arthur Kleinman and Tsung-yi Lin, pp. 95-111, D. Reidel, Boston, 1981.

Lin, Tsung-yi and Mei-chen Lin, "Love, denial, and rejection: responses of Chinese families to mental illness," in Normal and Abnormal Behavior in Chinese Culture, ed. Arthur Kleinman and Tsung-yi Lin, pp. 387-401, D. Reidel, Boston, 1981.

Lum, Rodger, Impact of mental illness on Chinese families, 1979. Dissertation. University of California, Berkeley

Marsella, Anthony J., Cross-cultural studies of depression: a review of the literature, 1976. Paper presented at the Symposium on Cross-Cultural Aspects of Depression. International Association of Cross-cultural Psychology. Tilburg, the Netherlands

Moulton, David M., The socioeconomic status of Asian American families in five major SMSAs: with regard to the relevance of commonly-used indicators of economic welfare, Asian, Inc., San Francisco, 1978.

Nee, Victor G. and Brett de Bary Nee, Longtime Californ': a documentary study of an American Chinatown, Houghton Mifflin Company, Boston, 1974.

Ratner, Carl, "Mental illness in the People's Republic of China," Far East Reporter: Answers to Some Questions About Cancer, Mental Illness, the Handicapped, Schistosomiasis, Family Planning, Venereal Disease and the Application of the Mass Line in the People's Republic of China, pp. 24-29 (February), 1978.

Reynolds, David K., The Quiet Therapies, University Press of Hawaii, Honolulu, 1980.

San Francisco Mental Health Services, San Francisco Chinese community citizens' survey and fact-finding committee report, 1969. Report of the Subcommittee on Health

Skolnick, Jerome, Justice Without Trial: Law Enforcement in a Democratic Society, Wiley, New York, 1966.

Sue, Derald and Barbara A. Kirk, "Asian-Americans: use of counseling and psychiatric services on a college campus," Journal of Counseling Psychology, vol. 22, no. 1, pp. 84-86, 1975.

Sue, Derald, Barriers to effective cross-cultural counseling, 1976. Paper presented at the Culture Learning Institute, East-West Center, Honolulu, Hawaii, August 4-25 for the Cross-Cultural Counseling Program

Sue, Stanley and Herman McKinney, "Asian Americans in the community mental health care system," American Journal of Orthopsychiatry, vol. 45, no. 1, pp. 111-118, 1975.

Sue, Stanley, "Community mental health services to minority groups, some optimism, some pessimism," American Psychologist, pp. 616-624, 1977.

Sue, Stanley and James K. Morishima, The Mental Health of Asian Americans: Contemporary Issues in Identifying and Treating Mental Problems, Jossey-Bass Publishers, San Francisco, Washington, London, 1982.

Suzuki, Bob H., "Education and the socialization of Asian Americans: a revisionist analysis of the 'model minority' thesis," Amerasia Journal, vol. 4, no. 2, pp. 23-51, 1977.

Toelken, Barre, The Dynamics of Folklore, Houghton Mifflin Company, Boston, 1979.

Tong, Benjamin R., "The ghetto of the mind: notes on the historical psychology of Chinese America," Amerasia Journal, vol. 1, pp. 1-31 (November), 1971.

Tong, Benjamin R., Extracting Learning Styles from Social/Cultural Diversity, pp. 70-93, 1978. Southwest Teacher Corp Network

Tseng, Wen-shing and J. Hsu, "Chinese culture, personality formation and mental illness," International Journal of Social Psychiatry, vol. 16, pp. 5-14, 1969.

Tseng, Wen-shing, "The development of psychiatric concepts in traditional Chinese medicine," Archives of General Psychiatry, vol. 29, pp. 569-575 (October), 1973.

Tseng, Wen-shing, "The nature of somatic complaints among psychiatric patients: the Chinese case," Comprehensive Psychiatry, vol. 16, no. 3, pp. 237-245, 1975.

Tseng, Wen-shing, "The nature of somatic complaints among psychiatric patients: the Chinese case," Comprehensive Psychiatry, vol. 16, no. 3, pp. 237-245, 1975.

U.S. Commission on Civil Rights, Social Indicators of Equality for Minorities and Women, Washington, D.C, 1978.

Veith, Ilza, "The Far East: reflections on the psychological foundations," in World History of Psychiatry, ed. John Howells, pp. 662-703, Bruner/Mazel, New York, 1975.

Wang, Stanley, San Francisco General Hospital: a clearing house for the local mentally ill Chinse, 1964?. Unpublished

World Health Organization, Schizophrenia, John Wiley and Sons, Chichester, New York, Bribane, Toronto, 1979.

Yap, Pow-meng, "Mental diseases peculiar to certain cultures: a survey of comparative psychiatry," Journal of Mental Science, vol. 97, pp. 313-327 (April), 1951.

Yee, Tina, Chinese American conceptualization of physical and mental well-being, 1980. Dissertation: Wright Institute

Zola, Irving Kenneth, "Illness behavior of the working class: implications and recommendations," in Blue-Collar World, ed. Arthur B. Shostak and William Bomberg, Prentice-Hall, Inc., Englewood Cliffs, New Jersey, 1964.

Zola, Irving Kenneth, "Culture and symptoms -- an analysis of patients' presenting complaints," American Sociological Review, vol. 31, no. 5, pp. 615-630 (October), 1966.