

Why Should Researchers Care About Culture?

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Summary: Analysis of the existing literature together with case experience reveals at least 4 implications of culture for the conduct of mental health research. Culture helps define the field of study, assists in identifying research gaps, shapes research paradigms, and supports the evolution of a cosmopolitan view of mental health.

(Can J Psychiatry 2003;48:154–160)

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Highlights

- To maximize its effectiveness, clinical practice should inform, and be informed by cultural research.
- This review highlights the roles culture and context play in shaping research, and its relevance for effective practice.

Key Words: *cross-cultural research, research ethics, research paradigms, community participation, transcultural psychiatry*

Clinicians and institutions increasingly recognize the role of culture in caring for individuals and families affected by mental illness (1–3). However, with few exceptions (4), the mental health research literature has paid scant attention to the role culture plays in defining the phenomena that researchers study, in helping to identify both the gaps in research agendas and why they occur, and in shaping research paradigms. Paying attention to culture and to cultural differences can help mental health professionals abandon egocentrism in favour of cosmopolitanism.

Culture Shapes Study Phenomena

A great deal of research comparing distress across cultures is based on the implicit assumption that disorders described in official nomenclatures such as the DSM or ICD occur more or less universally and do not vary in form. In contrast to this universalistic perspective on mental disorder, cultural relativists

(5–9) assert that culture is powerful enough to create unique forms of mental suffering in different societies.

Arguments about universalism and relativism continue to rage in research circles. Prior to the American Psychiatric Association (APA) publication of the DSM-IV (10), I received an invitation to a conference jointly sponsored by the APA and the US National Institutes of Mental Health (NIMH). The conference was organized to help ensure that this fourth version of psychiatric nomenclature would be more culturally sensitive than its predecessors. The colleague issuing the invitation is a well-known expert in the meeting ground between psychiatry and anthropology; he stressed that it was particularly important that I attend because the conference organizers wanted to ensure representation from both universalists and relativists. When I asked him what I was, he told me I was a universalist: “You believe that mental illnesses happen everywhere and in the same form.”

Simplistic generalizations often incite emotively coloured and sometimes less-than-optimally collegial responses, and this interaction was no exception. I told my colleague that the issue was not, and should not be, one of belief. Rather, it should be subject to empirical investigation and to interpretation based on data. I pointed out that most research results are consistent with the proposition that many conditions which

The Canadian Journal of Psychiatry acknowledges support in part for the *In Review* series courtesy of an unrestricted educational grant from



Western mental health experts call mental illnesses are ubiquitous, and that similarities in expressions of distress are more impressive than are differences (see, for example, 11–17).

Constraints on human physiology and cognitive process probably limit the varieties of human suffering to a finite number of symptoms and symptom complexes—many, if not all, of which may be recognizable across cultures (11, 12, 14, 15, 18). Nevertheless, culture still makes a difference. Culture dictates whether and how symptom complexes are defined—as illnesses, metaphysical occurrences, or artifacts of everyday life (19–21). Sociocultural forces such as expectation and attitudes regarding expendability play an important role in defining illness, if not in creating illness phenomena. To illustrate the point, I offer the following personal experiences.

In the late 1960s and early 1970s, I worked as lead investigator with colleagues from the World Health Organization (WHO) and the University of Dakar on a study of mental health among the Serer, a tribal group in Northern Senegal (22–26). As in many other places in Africa, desertification and overpopulation were forcing Serer youth to leave their traditional homes in rural villages and migrate to cities such as Dakar, Senegal's industrial and political capital. Our study's guiding hypothesis was that the acculturative stress (see 27, 28) consequent to rapid urbanization would jeopardize mental health.

As a first step in developing the study's mental health measures, we interviewed indigenous healers, attended healing ceremonies, and visited healing shrines to determine whether there was any match between Western and indigenous conceptualizations of psychiatric disorder. There were striking overlaps: clusters of behaviours described in the DSM-III (the dominant diagnostic system at the time) under labels such as schizophrenia and other psychoses, mental deficiency, and epilepsy not only occurred among the Serer but were considered illnesses requiring treatment (23–25). Although the Serer lexicon contained no terms describing “milder” conditions such as anxiety disorders, that situation would soon change.

Several years after the study finished, I returned to Senegal. Before we left Dakar for an informal return visit to the villages, my guide, Thierry, shared some misgivings. “Beiser,” he said, “you should know that when we go back to the villages, people are going to have questions for you, and you need to have answers. They want to know why so many people got sick after the study.”

To my considerable relief, there was no postsurvey epidemic of mental disorders in the villages. The people complaining of illnesses characterized by sleep disturbances, digestive upsets, relentless fatigue, vague feelings of apprehension, and periods when they felt like crying had complained about the same symptoms 3 years earlier. The difference was that they

had not considered themselves sick at the time of the survey. Now, they did.

The surveys had been major events in the villages. Typically, the study teams stayed for 2 to 3 days, conducting interviews, taking chest x-rays with elaborate portable equipment, and drawing blood samples to test for malaria and anemia. As a partial *quid pro quo* for the villagers' cooperation, the medical team tried to examine and treat current cases of illness. Since we had been able to obtain antibiotic samples from various drug companies, we performed a few “miracles”: some people who might have died as a result of severe respiratory infections or febrile meningitis recovered instead, thanks to our medications.

After the survey came to an end and the medical expertise and impressive paraphernalia disappeared, the villagers apparently made a few deductions. First, there appeared to be resources available to some people elsewhere that were not available to them, and these resources could make people feel better. Second, if conditions that had seemed hopeless were in fact curable, perhaps there were also cures for more mundane problems, such as sleeplessness, apathy, and vague anxieties. The fact that the University of Dakar research team had asked about these phenomena within the context of a health survey conveyed the message that experts from far away thought they were illnesses. If they were illnesses, then there were probably cures for them, just as there were for severe fevers (26).

Attitudes about expendability can also powerfully determine definitions. Although there was some overlap between what the Serer called “illnesses of the spirit” and DSM-classified mental disorders, the Serer lexicon contained no category resembling dementia. At first, I suspected that people did not live long enough to become mentally enfeebled. However, watching children guide old people who had lost their way around their small villages disabused me of that thought. A condition that Westerners consider an illness and that has achieved wide currency under such overly inclusive labels as Alzheimer's disease was an apparent phenomenological reality in rural Senegal, but one that the villagers did not consider to be an illness. My Serer informants explained that the phenomenon had a name, which translated roughly as “becoming a child again.” The term did not, however, denote an illness, nor was it a metaphor. The Serer believed in reincarnation: sometimes, people overstayed their time on earth and, literally, became children again before they had the chance to be reborn in a physical state that matched their behaviour. Their helpless behaviour resulted from a natural accident and not from an illness.

Although Serer elderly with dementia needed help, just as children do, the village was able to provide support for many of their needs. Further, despite being otherwise enfeebled,

many old people remembered stories from the past and were often skilled in recounting them. In a culture in which oral transmission is the only means of ensuring historical memory, the elderly have a significant and enduring role. The Serer elderly were not expendable.

North American towns and cities have no baobab trees under whose shade children gather to listen to stories recorded only in the heads of elders. A society on the move, North America has evolved a culture that stresses independence, often to the detriment of the elderly, enfeebled or not. With no particular role, the elderly become increasingly expendable. If they develop disabilities with care needs that exceed the capacity of small households, they become a social burden. Biotechnology holds the promise of help, or even future cures, for elderly people afflicted with forgetfulness and confusion; however, the contrast between becoming a victim of dementia in North America and “becoming a child again” among the Serer highlights the importance of culturally determined social roles and of social exclusion in defining the purview of mental health. Cultural context helps explain whether a particular condition is ignored by a particular society or whether it is officially categorized—as a religious violation, as criminal behaviour, or as an illness (20,21,24).

Paying Attention to Culture Can Help Identify Research Gaps

The dazzling technologies associated with genetic research, together with the promise that genetic investigations hold for the cure of many diseases, have vaulted this field into its current preeminent position. Cross-cultural study, however, can be an important antidote to overly enthusiastic promotion of overly reductionistic models of illness. Our survey of the mental health of the Serer included not only a structured interview but also standardized blood pressure readings. One of the strongest findings reported in the research literature at the time (the early 1970s) was that blood pressure increased with age and that this trend was much stronger among US blacks than among US whites. Genetic difference was the favoured explanation. However, the Serer in Senegal did not have a steep rise in blood pressure with age. Indeed, their age slopes were even more benign than those shown by US whites (22). By contrast, the anthropologist Norman Scotch had conducted a study of blood pressure among the Zulu of South Africa in the early 1960s and had reported a steep, age-related rise in blood pressure similar to that observed by US-based researchers (29). In attempting to reconcile these contradictory findings, my colleagues and I argued that the official apartheid then being practiced in South Africa and the unofficial but palpable apartheid in the US might be placing their respective victims of racism, marginalization, and lack of opportunity at risk for elevated blood pressure (22). Conversely, in the black

republic of Senegal, the Serer enjoyed relative freedom and access to opportunity.

The field of genetics has even more cachet today than it had in the 1970s. In this context, recent research highlighting a link between the risk of hypertension and psychological states such as depression, most particularly among blacks (30), and other studies suggesting a possible relation between experiences of racial discrimination and hypertension among African Americans (31,32) are extremely important. The findings illustrate a potentially important contribution by sociocultural factors to a “physical” problem; they demonstrate why researchers should think about context and how considering context can help militate against reductionism in explaining the health disorders of humankind.

Culture can and should inform clinical trials. Zhang-Wong and colleagues found that white men suffering a first episode of psychosis required higher dosages of haloperidol to control their symptoms than did their ethnically Asian counterparts (33,34). These investigators also found that drug requirements for white women were in the same range as those for ethnic Asians of either sex. The irony is apparent: although prescribing manuals and prescribing habits tend to be based on studies of white men, this group in fact represented the deviant cases in the studies by Zhang-Wong and others. Methods employed in clinical trials must account for ethnocultural variation; alternatively, the reported results must be qualified by explicit statements about the generalizability of results derived from investigations wherein research designs have made insufficient accommodation for ethnocultural variation.

Canadians pride themselves on their multiculturalism, on the fact that Canada was the first country in the world to enact a multiculturalism law, and that struggles within Canada to achieve equity have not erupted into the violence and chaos troubling many other countries. Achievement has, however, failed to keep pace with nationalistic rhetoric—a fact that is nowhere more apparent than in health research. The National Longitudinal Study of Children and Youth (NLSCY), conceived and carried out by Human Resources Development Canada and Statistics Canada, is an example. The NLSCY inception cohort—25 000 children aged 11 years and under—purportedly represents Canadian children. However, the NLSCY sample contains only about 600 immigrant or refugee children, despite the fact that almost 20% of children in the study age range who currently live in Canada were either born outside the country or were born to immigrant families.

If whatever is found about the health and development of native-born children also applies to their immigrant and refugee counterparts, the latter’s underrepresentation may be justifiable. There are, of course, difficulties in identifying and

recruiting immigrant samples, and the expense of translating study instruments is not inconsiderable. These factors militate against including immigrant and refugee children in surveys. However, a publication by our research team reveals the perils of extrapolating results based on native-born children to other populations (35). Our analyses compared the mental health of children living with native-born parents and that of their counterparts living in foreign-born families. We also compared the mental health effects of poverty in both NLSCY subsamples.

The data revealed some grim facts. When the NLSCY began, 13% of all families in Canada were living in severe poverty. The situation was even worse among immigrant families resident in Canada for less than 10 years: 33% were living well below the officially defined poverty line. Since poverty is one of the most powerful risk factors for children's mental health, it would be logical to predict higher rates of mental and behavioural problems among immigrant children, compared with the national sample. The results, however, reveal a curious and potentially important paradox: although immigrant children were almost 3 times more likely to live in poverty than their nonimmigrant counterparts, they had fewer mental health and behavioural problems.

Surprises like this argue in favour of studies to address some important questions raised by these preliminary results. Does the good news about the mental health of immigrant children—who have, like native-born children, been spared atrocities—also apply to refugee children, many of whom have been exposed to horrific events no child should ever be forced to experience? Are there particular strengths in immigrant families that protect children, despite economic disadvantage? Does the good news about immigrant children persist, or does their apparent resilience eventually succumb to the indisputable stresses of immigrant life in Canada, such as discrimination (36,37) and the high rates of un- and underemployment experienced by their parents (38)?

Culture Shapes Research Paradigms

In the 1960s, the vocabulary of research began to change. Before this time, the lines were clear: there were investigators and there were subjects, and the former studied the latter. However, new words began to creep into the research vocabulary—words like “participants” instead of “subjects.” Similarly, “partnerships” appeared—a term connoting research as a collaborative enterprise rather than a relationship in which one party to research is ascendant over another. Partnership also implies that benefits have to be shared.

Affirming devotion to the new paradigm of research as a partnership rather than an enterprise in which a privileged few satisfy their intellectual curiosity is easy—so easy, in fact, that the sentiments are in danger of becoming clichés. Partnerships

are usually more difficult to practice than to advocate. I offer the following personal experience to demonstrate that working with communities in a responsible and responsive fashion is not only necessary but more than worth the bother.

Flower of Two Soils is an investigation of mental health and academic achievement among First Nations children living on 2 Canadian reserves and 2 US reservations (17,39,40). Before beginning the fieldwork for this study, I recruited community advisory panels of educators, leaders, and tribal elders to help guide the project throughout the 3 years of data-gathering. One day, during a meeting on a Chippewa reserve, I asked the community advisory panel to look over the mental health measures I proposed to use. The measures of psychopathology were the most current and most widely accepted instruments to assess depression, anxiety, attention deficit disorder, and conduct disorder (17). To all this, I had added something new: measures of psychological health that I felt were much needed (39,40). I was proud of this instrument, a potent brew with a base stock of state-of-the-art psychopathology measures and added ingredients that I thought would not only contribute something new to the field but would also please a community used to having its negative characteristics amplified and its strengths—both as individuals and as a collective—ignored. The committee members, however, were decidedly underwhelmed. Although they reassured me that there was nothing wrong with the proposed questions, they kept telling me that something was missing. The “something” was, however, “too hard to explain.”

Hours passed in desultory discussion. The northern sunlight changed to a dark purple twilight, but no one bothered to switch on the overhead lights. With no cue that I can now recall, someone suddenly said to me, “Do you ever take your kids to funerals?” Oddly enough, I had recently been wrestling with this issue, following the death of an aunt. I explained to the group why I had decided against taking my 3 sons to the funeral: they were very young and had not experienced any losses, not even the death of a pet. I did not think they were ready to deal with death. As the group became shrouded in shadows, the discussion became increasingly surreal. A disembodied female voice said, “You know, we take our kids to funerals. We do it all the time.” I replied that I had heard about that. “D’you know why we do it?” another voice challenged and, without waiting for a reply, continued, “You probably think we’re morbid. We’re not. Funerals aren’t for the dead; they’re for the living. When somebody dies, the whole community goes over to the house to let the family know they’re not alone. That’s why we take our kids. It’s never too early for them to learn that they have a duty to the community.”

Then came the final word: “That’s what we’ve been trying to tell you all afternoon. All those things you want to measure about kids have to do with them as individuals. One of the problems our kids have in your schools is that they’re taught that they have to compete to survive. We teach them that they have to be responsible to the community; that way, they’ll not only survive but so will everyone else. That’s what we mean by mental health.”

No amount of reading about Chippewa culture would have made either the revelation or the resultant action possible. The committee and I developed a new mental health scale, which we called Community Mindedness, and which has subsequently proved to have satisfactory psychometric properties (data not yet published).

Abandoning Egocentrism in Favour of Cosmopolitanism

Cross-cultural psychiatry began with a fascination for what is different. Previous generations of researchers looked for the “culture-bound syndromes,” such as *koro* and *windigo*, that make up the DSM-IV’s nod to the importance of culture, but which few practitioners can ever expect to see. Recent attempts to look for difference—for example, the search for cultural influence on the construction of symptoms—have been more subtle. Depression has been a favourite subject, with various theoreticians proposing that certain cultural groups do not experience emotion in the way that Europeans and North Americans do but, instead, suffer bodily rather than psychologically (5–7,41). The apothegm “Asians somatize, North Americans psychologize” sums up a great deal of this kind of thinking.

The proposition does not hold up to research scrutiny, however. West Africans, Southeast Asians, and First Nations children report depressive symptoms in psychological terms, and although there are subtle cross-cultural differences, the clustering of psychological and somatic symptoms among different cultural groups is more similar than different (11–13,17,20,23).

As in the case of symptoms, measures of well-being seem remarkably invariant across cultural groups (13). Cross-cultural invariance may apply not only to end states like symptoms and feelings of well-being but also to psychological processes that determine these end states. Consider, for example, “alexithymia,” the inability to recognize, describe, and express feelings. Kenneth Fung has provided important data about the cross-cultural applicability of this construct, which is seen as a major deterrent to psychotherapy. Fung’s research demonstrates that, contrary to widely held stereotypes, the concept of alexithymia is probably as relevant for the Chinese

population as it is for other ethnocultural groups, and it is, moreover, equally subject to interindividual variation (42).

Although there is nothing inherently wrong in looking for differences, this approach must be balanced by an equal appreciation for what unites people and by investigations aimed at getting behind the veil of culture to glimpse the shared anxieties, aspirations, and hopes that transcend the gloss applied by culture.

The Canadian Dictionary of the English Language (43) defines “cosmopolitanism” as “having constituent elements from all over the world or from many different parts of the world.” Following from this definition, mutual respect and mutual learning are essential building blocks for true cosmopolitanism.

This dictionary also offers a second definition: “pertinent or common to the whole world.” This definition implies that researchers should abandon parochialism, substituting in its place appreciation, empathy, and a sense of responsibility for people beyond those in their immediate field of vision. Researchers who work with ethnocultural communities in their own countries, or with communities abroad, have to recognize that not only they but also the communities with whom they choose to work need to benefit from research.

What can communities gain from participating in research? For one thing, they can acquire a sense of mutual respect. For example, indigenous peoples and ethnocultural minority groups must be assured that ethical standards will be adhered to as rigorously as they are when research takes place among politically powerful communities. Although less dramatic than cloning or patenting genetically altered life forms, the ethical challenge of ensuring cross-cultural transferability of guidelines to protect human subjects is no less real.

In North America, informed consent has become a *sine qua non* for ethical research. Usually formulated in individual terms, the concept may not, however, be universally appropriate. In Senegal, in Nigeria, and in many other traditional societies, individuals have no meaning apart from the collective. Trying to secure an individual decision rather than a group consensus to take part in a study is worse than discourteous: it can violate the basic tenets of communal life. These considerations are not just pertinent to research in Africa and other exotic places: identifying the appropriate locus of decision making to ensure informed consent is a challenge for anyone working with cultural communities, whether in the developing world, or in North America, or in Europe (26).

Typically, communities that participate in research are offered vague promises about improved services. My research among the Serer was financed by the WHO, with the idea that the data obtained would provide a basis for planning mental

health services in rural areas of Senegal. However, for the WHO, as for many international bodies, politics too often trumps humanitarianism (44). Before anything was ever done for the Serer, WHO priorities changed, and the project was abandoned (26).

It is important—but far from easy—to work with communities in need without raising unrealistic expectation that researchers can directly effect change. Researchers are seldom in a position to directly affect either policy or the distribution of resources. They can, however, offer knowledge, and communities increasingly recognize not only that knowledge is power but also that researchers have a responsibility to share information and expertise with them. This creates new challenges for research across cultures. How can researchers provide information in a form that communities find accessible and useful for their own community-building and lobbying efforts? How can researchers transfer not only knowledge but skills, so that communities can become more independent of imported know-how? How do researchers ensure that they do not cross the line between responsibility to provide useful information and advocacy—a position that compromises the research enterprise and damages credibility? How does one negotiate ownership of information? How do the parties to a research enterprise resolve potential disputes if the community prefers not to have data released, but researchers feel that the data have important implications for science?

A Final Word About Culture and Research

There are communities—ethnocultural communities, immigrant and refugee communities, and indigenous peoples' communities—who deserve, and need to be the focus of, specific study. Although health and illness states may be more alike than different, needs for care in these communities differ from those in dominant and more powerful societies, as do the determinants of health and illness. Responding to these communities requires knowledge of the extent and types of those needs, of community expectations for care, and of community resources. This knowledge base is still emerging.

Culture—what societies learn and pass down over generations—should be considered in so-called “mainstream” research endeavours as well as in cross-cultural inquiries. Research samples inevitably represent a compromise between population representativeness, feasibility, and the need for certain constraints on heterogeneity. One result is that drug trials will almost always have limited generalizability—a limitation that must be acknowledged. Considerable research using family aggregation studies supports the conviction that genes play a major role in schizophrenia. However, the evidence is not consistent across ethnocultural groups. This means that either the basis for the genetic claim is not as strong as some would think or that there are different conditions

subsumed under a common rubric awaiting better classificatory schemes. In the realm of standardized treatment studies, manualized psychotherapies seem to offer considerable therapeutic promise, but most reports fail to address important questions, such as for whom and under what circumstances they will be offered (45). Developments in medical ethics over the past decade have been breathtaking, but this domain of scholarship, like other parts of the research enterprise, requires constant vigilance and a strong dose of humility to guard against Western imperialism.

In a world still struggling with the fallout of social upheavals that began in the now mythical 1960s, the pursuit of cosmopolitanism in research must be defined as a moral imperative. Nevertheless, researchers must recognize—but not be deterred by—the fact that the loftiness of this ambition will be leavened by daunting challenges to its achievement.

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Manuscript received, revised, and accepted January 2003.

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Résumé : Pourquoi les chercheurs se soucieraient-ils de culture?

Sommaire : L'analyse de la documentation existante de même que de l'expérience des cas révèle au moins 4 implications culturelles dans la conduite de la recherche en santé mentale. La culture aide à définir le champ de l'étude, contribue à déterminer les écarts de la recherche, façonne les paradigmes de la recherche et soutient l'évolution d'une vision cosmopolite de la santé mentale.