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The Lay Concept of 'Mental Disorder': A Cross-Cultural Study

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Abstract Lay concepts of 'mental disorder' were investigated in three countries (U.S.A., Romania and Brazil). Participants judged whether a sample of conditions – some falling inside and some outside the borders defined by DSM-IV – were mental disorders, and rated them on features invoked in professional understandings of 'mental disorder.' The concept of mental disorder was considerably more inclusive and convergent with the DSM-IV in the American sample than in the Brazilian sample, and disorder judgments showed only moderate agreement across cultures. Several features of the concept were culturally distinctive, amounting to a more 'internalist' or intrapsychic understanding in the American sample.

Key words Brazil • cultural differences • lay concepts • mental disorder • Romania

A basic mission of transcultural psychiatry is to examine the ways in which psychiatric phenomena, and folk understandings of them, vary across cultures. Researchers inspired by this mission have studied culturally specific manifestations of psychiatric disturbance and its treatment, and laypeople's beliefs about the causes and remedies of particular forms of disturbance (e.g. Guimón, Fischer, & Sartorius, 1999). However, little systematic empirical attention has been paid to folk beliefs about the very nature or meaning of 'mental disorder,' especially from a cross-cultural

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perspective. Although ethnographic studies have addressed related questions (Kirmayer, 1994), they typically yield qualitative analyses of concepts of disorder in a single culture, and more often than not focus on a narrow range of psychiatric phenomena.

Although the comparative study of concepts of mental disorder has been neglected by empirical researchers, it may be of considerable intellectual and perhaps pragmatic importance. The issue of how 'mental disorder' should be defined – and whether definition is even possible – has recently become heatedly controversial (Clark, 1999). Some authors, such as the developers of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) (DSM-IV; American Psychiatric Association [APA], 1994), have argued that an explicit definition of the concept is both possible and indispensable. They maintain that a set of criteria – such as statistically non-expectable distress, impaired functioning or psychological dysfunction – can in principle be developed for picking out mental disorders. Others contend that 'mental disorder' can not be classically defined, and that it is instead a prototype-based or 'Roschian' category with unavoidably fuzzy and shifting boundaries (Lilienfeld & Marino, 1995). By this account, mental disorder is 'intrinsically polysemous' (Kirmayer & Young, 1999, p. 451), 'a fundamentally messy construct [that is] an irreducible mixture of personal, social, cultural and scientific beliefs' (Pressman, 1993, p. 80). The conditions that are taken to be mental disorders at a particular time and place would therefore be loosely bound together by local practices, values and beliefs.

This issue of the definability of 'mental disorder' has clear implications for the cultural variability of folk concepts of disorder and, perhaps, of disorder itself. If 'mental disorder' can be classically defined, its meaning fixed by a set of necessary and sufficient criteria or a conceptual essence, we would expect to find substantial consistency across cultures in what is taken to constitute and exemplify disorder. This is especially true when the criteria are grounded in a biological or evolutionary theory of disorder, such as Wakefield's (1992) 'harmful dysfunction' analysis. This analysis proposes that mental disorders represent dysfunctions of evolutionarily designed psychological mechanisms that produce harmful consequences (e.g. distress or debilitation), and has had considerable appeal within clinical psychology and psychiatry because it offers a principled and universalistic way to adjudicate the status of controversial conditions. If, however, 'mental disorder' is intrinsically fuzzy and heterogeneous, based on prototypes and a complex ensemble of features, we would expect its meaning to vary as a function of culturally salient images and beliefs. Investigating the extent to which concepts of mental disorder vary across cultures may, therefore, shed some light on fundamental questions about the status of 'mental disorder' as a concept.

Studying cross-cultural variations in lay concepts of mental disorder may illuminate these questions in another way. Theorists who formulate formal definitions of 'mental disorder' typically employ a method of conceptual analysis that relies on widely shared intuitive judgments of what are and what are not disorders. If a particular definition fails to converge adequately with these lay judgments, it can be called into question. Consequently, if intuitive judgments of disorder vary widely across cultures, particular definitions of disorder will be deficient and no universal concept of mental disorder will be tenable.

Several additional, more pragmatic reasons can be given for examining cross-cultural variations in mental disorder concepts. First, doing so may help us to understand how those experiencing psychiatric phenomena in different cultures are differentially subject to stigma.

Second, it may clarify why people of different cultural backgrounds are more or less likely to seek out mental health services for particular conditions. Third, discrepancies between institutionalized understandings of mental disorder, such as the DSM-IV (APA, 1994), and laypeople's concepts may show how popular beliefs deviate from professional practices, and suggest directions for public education. When these institutionalized understandings have originated in markedly different cultural contexts from those in which they are applied, these discrepancies might alert professionals to possible failures of their nosology to map onto the models of those whom they serve.

One way to investigate lay concepts of mental disorder would be simply to ask for people's definitions directly. However, it is unlikely that most people hold readily articulated beliefs about this concept, just as their understandings about many other concepts are primarily implicit. A more promising method is to infer people's concepts from the criteria that they use in making judgments about whether conditions exemplify mental disorders. If, when presented with a set of conditions that may or may not qualify as mental disorders, people's judgments systematically correlate with particular perceived attributes of the conditions, it can be inferred that the attributes reflect aspects of their concept. To our knowledge, two previous studies have approximated this methodology. In a classic study, Campbell, Scadding, and Roberts (1979) investigated lay and physician judgments of whether 38 conditions were diseases, with the conditions systematically varied according to medical subspeciality and whether they were definable by cause, structure, function or syndrome. However, this study examined the concept of 'disease' in general rather than mental disorder in particular, included only a few psychiatric conditions and had no significant cross-cultural aspect. More recently, Kirk, Wakefield, Hsieh, and Pottick (1999) conducted a more directly relevant study of mental disorder judgments, but employed a restricted set of case vignettes, a single

psychiatric phenomenon (adolescent antisocial behavior), and a group of social workers from one culture rather than laypeople from several.

In view of the lack of comparative research on lay concepts of mental disorder, we conducted a cross-cultural study of these concepts in three countries (U.S.A., Romania and Brazil), following the rationale described above. These countries were not selected to be representative of any particular set of world cultures, but simply to explore the nature and extent of variations in concepts of mental disorder in three distinctive national contexts. The U.S.A. is a dominant force in Western psychiatry, the home of the DSM classification, where psychiatric matters are highly salient in public discourse and mental health services are relatively extensive. Psychiatry's institutional and popular presence in Romania is much more limited, with a very large stigma attached to mental disorder and its treatment. Brazil is in some respects intermediate, but is also distinctive for its great ethnic, socio-economic and cultural heterogeneity.

To reveal their intuitive judgments and implicit concepts of 'mental disorder,' participants in each culture judged whether a large sample of conditions – some recognized disorders and some questionable – were mental disorders, and rated them on a common set of features that are frequently proposed in definitions of mental disorder presented in textbooks and the professional literature (e.g. APA, 1994; Wakefield, 1992). We focused our analysis on cultural differences in the inclusiveness or breadth of the respective concepts, in their degree of convergence with the definition of disorder implicit in the internationally dominant DSM-IV system, and in their distinctive features.

Method

Participants

Efforts were made to select participants in the three countries that were roughly comparable in age, level of education, and lack of formal exposure to the study of psychopathology. To this end, three samples of undergraduate students were obtained. The American sample consisted of 31 undergraduates at a New York City college, who volunteered at the beginning of several introductory psychology classes for a study of 'Beliefs about mental disorders.' The sample included 24 women and 7 men, with a mean age of 21.0. The Romanian sample consisted of 52 undergraduate students at the Polytechnic University of Bucharest, with a mean age of 22.5. The sample included 11 women and 41 men. The Brazilian sample consisted of 49 undergraduates at universities in Sao Paulo (27) and Rio de Janeiro (22), including 37 men and 12 women, whose mean age was 23.6. None of the participants in any sample had formally studied abnormal psychology or

completed an introductory survey course in which it was discussed, so they were assumed to be naïve about scholarly definitions of 'mental disorder.' All participants were recruited and debriefed in similar fashion and, with the exception of the Brazilians, paid for their participation.

Materials

Participants completed a questionnaire that contained paragraph descriptions of conditions to be rated on a series of items that corresponded to elements of formal definitions of 'mental disorder.' A sample of 68 conditions was chosen, 47 of which corresponded to DSM-IV disorders and 21 of which did not. The DSM-IV disorders were sampled to represent all major classes of adult disorders. The classes (and their sampled disorders) were as follows: 'disorders usually first diagnosed in infancy, childhood, or adolescence' (mental retardation); 'delirium, dementia, and other cognitive disorders' (delirium due to a medical condition, Alzheimer's dementia, amnestic disorder); 'substance-related disorders' (alcohol dependence, alcohol abuse, alcohol withdrawal, nicotine dependence, opioid abuse); 'schizophrenia and other psychotic disorders' (schizophrenia, schizoaffective disorder, delusional disorder, brief psychotic disorder); 'mood disorders' (major depressive disorder, dysthymia, bipolar I disorder, cyclothymia); 'anxiety disorders' (panic disorder without agoraphobia, specific phobia, social phobia, obsessive-compulsive disorder, generalized anxiety disorder, post-traumatic stress disorder); 'somatoform disorders' (somatization disorder, conversion disorder, pain disorder, hypochondriasis, body dysmorphic disorder); 'factitious disorders' (factitious disorder); 'dissociative disorders' (dissociative amnesia, dissociative identity disorder); 'sexual and gender identity disorders' (hypoactive sexual desire disorder, male erectile disorder, fetishism, pedophilia, gender identity disorder); 'eating disorders' (anorexia nervosa, bulimia nervosa); 'sleep disorders' (primary insomnia, nightmare disorder); 'impulse-control disorders' (pathological gambling, trichotillomania, kleptomania); 'adjustment disorders' (adjustment disorder with mixed anxiety and depressed mood); 'personality disorders' (antisocial, schizoid and dependent personality disorders).

The 21 non-DSM-IV conditions were selected to represent a range of states that are not currently recognized as mental disorders but reside near the boundary of psychopathology as it is defined within North American psychiatry, or whose status is controversial. Although some of these conditions may be symptoms or associated features of recognized disorders, none are themselves recognized as psychopathological syndromes within DSM-IV, indicating that they represent an appropriate set of non-disorder controls. Some conditions are often adjudged to reflect

character flaws, moral failings or legal transgressions (i.e. recurrent adultery, obscene phone-calling, malingering, gluttony, chronic lying, enviousness, thievery, assaultiveness). Some are often considered bad habits (i.e. finger-nail biting, procrastination), and others are conceptualized as primarily neurological or medical rather than psychiatric (i.e. hypothyroidism, parkinsonism, epilepsy, migraine headache). Some are diagnostic categories proposed for further study in DSM-IV (i.e. premenstrual dysphoric disorder, post-concussional disorder) or otherwise controversial (i.e. chronic fatigue syndrome). Some conditions do not fit under any of these rubrics (i.e. bereavement, obesity, identity problem, homosexuality).

Descriptions of the 68 conditions were written to render their primary characteristics – diagnostic criteria for the DSM-IV disorders – in easily comprehended, non-technical language. Consequently, psychiatric terminology was minimized, symptoms were occasionally exemplified, and generally duration, cut-off and rule-out requirements of DSM-IV conditions were not included. The names of the conditions were not provided (see Appendix I for examples).

Following each description in the questionnaire were 21 items rated on a Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). Sixteen items operationalized conceptual features often considered in the professional literature to be relevant to the definition of 'mental disorder.' These items were therefore intended to tap potential features of our participants' implicit mental disorder concepts. Several corresponded to positive features of possible definitions (i.e. the condition being: 1, statistically abnormal; 2, categorically distinct from normality; 3, due to a malfunction of a psychological mechanism; 4, an unexpectable response to life circumstances; 5, environmentally caused; 6, appropriate for treatment by a mental health professional; 7, associated with emotional distress; 8, impaired functioning; 9, incomprehensibility; 10, irrationality; or 11, psychological conflict). Other items referred to features that have been proposed as exclusionary criteria (i.e. 12, the condition being biologically caused; 13, a conflict with society; 14, a form of social deviance; 15, a product of flawed character; and 16, under the person's control). Items were written simply to convey these conceptual features (see Appendix II). One item directly assessed participants' intuitive judgments about whether the condition in question was a mental disorder (i.e. 'These people have a mental disorder'). Four additional items were included for exploratory purposes unrelated to the study. Items were presented in a standard, randomized order. No participants reported difficulty comprehending any of the items, with the exception of a small number of Brazilians who were unsure of the discreteness item (feature 2 above).

Eight alternative forms of the questionnaire were developed. Four samples of 17 conditions were selected from the 68, each including 11 or

12 DSM-IV disorders and five or six non-disorders. Two alternative orders of each sample of 17 conditions were constructed, one with the DSM-IV disorders preceding the non-disorders, and the other reversed.

Questionnaires were translated from English into Romanian and Portuguese by bilingual speakers native to Romania and Brazil. Independent bilingual speakers back-translated these translations into English to ensure their adequacy, and any inconsistencies were resolved. The mean length of the paragraph descriptions was 45.5 words in English, 50.5 words in Romanian and 47.7 in Portuguese. 'Mental disorder' was translated as 'boala mintala' in Romanian and as 'distúrbio mental' in Portuguese. These terms are widely used equivalents of 'mental disorder' in the respective countries, although 'doença mental' (mental disease) is also popular in Brazil. Translations of DSM-IV in Romania and Brazil use different terms ('tulburare mentala' and 'transtorno mental,' respectively) that are more restricted in use and formal in connotation.

Procedure

Within each sample, participants were randomly assigned one of the eight alternative questionnaire forms, signed a consent form, and were instructed either to take the questionnaire home and complete it at their leisure or to complete it immediately in a classroom provided for that purpose. Consequently, each condition was rated by 7 or 8 American participants, 13 Romanian participants, and 12 or 13 Brazilian participants. Participants were debriefed and paid after their participation. In all samples, the questionnaire took about 45 minutes to complete.

Results

Shared understandings of 'mental disorder' were the focus of study, so participants' ratings were aggregated. In each sample, the effective data set for the analyses therefore consisted of the mean ratings, across the participants, of 68 conditions on the 17 items of interest.

Breadth of the Concept of Mental Disorder and Correspondence with DSM-IV

We first assessed the breadth of the mental disorder concept in the three samples by examining the proportion of conditions that participants judged to be mental disorders, operationally defined as those with a mean rating above 4.0 (neither agree nor disagree) on the pertinent item ('These people have a mental disorder'). These proportions are presented in Table 1, which suggests that the concept of mental disorder in the American,

Romanian and Brazilian samples becomes progressively narrower. In the Brazilian sample, fewer than one-third of all conditions and of the DSM-IV disorders were judged to be disorders. In each sample, the proportion of conditions judged to be disorders was significantly less than the proportion recognized as disorders by DSM-IV, although the difference was marginal in the American sample (American: $\chi^2 = 3.71$, $df = 1$, $p = .06$; Romanian: $\chi^2 = 10.73$, $df = 1$, $p < .001$; Brazilian: $\chi^2 = 21.45$, $df = 1$, $p < .001$).

Table 1 also reveals the extent to which judgments of mental disorder in the three samples correspond systematically to the definition of mental disorder institutionalized in DSM-IV. The American sample's judgments converged rather strongly with the DSM-IV ($\chi^2 = 14.01$, $df = 1$, $p < .001$; $\phi = 0.43$), in that DSM-IV disorders were much more likely to be judged to be disorders than were non-disorders. The Romanian sample's judgments were convergent to a similar degree ($\chi^2 = 9.07$, $df = 1$, $p < .005$; $\phi = 0.35$). However, the Brazilian sample's judgments showed absolutely no correspondence with the DSM-IV ($\chi^2 = 0.01$, $df = 1$, $p > .9$; $\phi = 0.01$).

Features of the Concept of Mental Disorder

To determine the basic features of the concept of mental disorder in the three samples, we examined correlations between the mental disorder judgment item and the other 16 definition-relevant items across the 68 conditions. Items that correlate systematically with judgments of disorder should point to features of the concept. Table 2 presents these correlations as well as significant differences in their magnitude across the samples as determined by Fisher's Z statistic.

Table 2 lays out several important findings. First, in each sample the items appear to capture important features of the local concept of mental disorder, demonstrating an assortment of substantial associations with mental disorder judgments. In each case, the 16 items accounted for a substantial majority of the variance in these judgments ($R^2 = .82$, $.65$ and $.73$ for the American, Romanian and Brazilian samples, respectively). Second, four items (statistical abnormality, irrationality, incomprehensibility and flawed character) correlated with disorder judgments to similar

TABLE 1
Number (percentage) of conditions judged to be mental disorders

	<i>U.S.A.</i>	<i>Romania</i>	<i>Brazil</i>
DSM-IV disorders ($n = 47$)	32 (68.1)	25 (53.2)	14 (29.8)
DSM-IV non-disorders ($n = 21$)	4 (19.0)	3 (14.3)	6 (28.6)
All conditions ($n = 68$)	36 (52.9)	28 (41.2)	20 (29.4)

TABLE 2
Correlations between disorder-related items and mental disorder ratings in the three samples

	<i>U.S.A.</i>	<i>Romania</i>	<i>Brazil</i>	<i>Difference</i>
Psychological malfunction	.85***	.34**	.58***	U > R, B
Treatability	.72***	.25*	.60***	U, B > R
Psychological conflict	.63***	.44**	.28*	U > B
Non-expectable response	.58***	.08	.58***	U, B > R
Emotional distress	.56***	.36**	.16	U > B
Impaired functioning	.54***	.09	.24	U > R, B
Statistical abnormality	.44***	.62***	.60***	
Irrationality	.38**	.39**	.55***	
Incomprehensibility	.30**	.20	.26*	
Flawed character	.25*	.24	.39**	
Biological causation	.24	.42**	-.13	R, U > B
Conflict with society	.18	.29*	.20	
Discreteness	.16	-.10	.13	
Social deviance	.02	.19	.33**	
Environmental causation	-.01	-.02	.15	
Personal control	-.19	-.26*	-.37**	

*** $p < .001$; ** $p < .01$; * $p < .05$.

U, U.S.A.; R, Romania; B, Brazil.

degrees in the three samples, pointing to features of the concept of mental disorder that are common to them all, and others were unrelated to mental disorder judgments in any sample (the assumption of discreteness or of environmental causation). Third, there was moderate agreement among the samples in mental disorder judgments across the 68 conditions ($r_s = .48, .53$ and $.57$, all $ps < .001$). These three findings all imply some cross-cultural consistency in the concept of mental disorder.

At the same time, however, 7 of the 16 items show significant ($p < .05$) differences in magnitude across the samples, implying discrepancies in mental disorder concepts. These discrepancies permit cautious inferences about the distinctive features of the mental disorder concept in the three cultures. The mental disorder concept in the American sample emphasized the malfunction of normal psychological capacities or mechanisms, psychological conflict, emotional distress and impairment in functioning, and was closely associated with judgments of treatability by mental health professionals. In the Romanian sample, statistical abnormality and biological causation appeared to be somewhat distinctive core features of the concept of disorder, and mental disorder judgments were very weakly associated with judgments of treatability. In the Brazilian sample, finally, the most distinctive features of the concept were statistical abnormality,

non-expectable response to life circumstances, treatability by mental health professionals and irrationality.

Discussion

The findings of the present study present a mixed picture. On the one hand, the concepts that participants in our three samples used to judge whether conditions were mental disorders showed substantial overlap, and yielded moderate judgmental agreement. On the other hand, the findings offer several pieces of evidence for distinctive aspects of the mental disorder concept in the three samples. The samples varied widely in the apparent breadth or inclusiveness of their concepts, in the degree of convergence of these concepts with the DSM-IV, and in the features that were most central to them.

The apparent differences in the inclusiveness and correspondence to DSM-IV of the respective concepts of mental disorder are to some extent unsurprising. It is perhaps unremarkable that the concept of mental disorder most resembles the DSM-IV in breadth and composition in the U.S.A., given the origin of the nosology in that country, the high visibility of mental health concerns in its public discourse, and the cultural salience of psychological idioms of distress. These conditions would be expected to yield a relatively broad and differentiated understanding of mental disorder, and a relatively firm anchoring of this understanding in the professional discourse of psychiatry. Outside the U.S.A., 'mental disorder' would be expected to have a more restricted domain of relevance, and American professional definitions of disorder would be expected to have a weakened relationship to lay concepts. Both expectations appear to have been confirmed in the present study.

It is very risky to attempt an encompassing account of each culture's distinctive mental disorder concept, especially in view of the unrepresentativeness of the study samples and the well-known difficulties of translation. For example, although the Brazilian and Romanian samples were comparable with the American sample in being composed of university students, such students are a much narrower segment of the population in the former countries and hence are likely to be less socio-economically representative. Equally, there is no way to ensure that even careful translations of items that include terms such as 'psychological conflict' retain precisely the same connotations or implications across cultures, so an item's differential correlations with 'mental disorder' judgments cannot necessarily be taken completely at face value.

Despite these grounds for caution, some tentative speculations can be drawn. With respect to the American sample, as noted above, the most striking findings were the inclusiveness of the concept, its relatively strong

correspondence with the DSM-IV, and its tight link to judgments of appropriateness for treatment by mental health professionals. Together these attributes indicate that the lay concept of mental disorder in the U.S.A. is a reasonably close match to the concept as it is employed within organized psychiatry in that country. In addition, the conceptual features that seem most central and distinctive for the American sample – malfunction of normal psychological capacities or mechanisms, psychological conflict, emotional distress, and functional impairment – correspond to many of the core conceptual features invoked in DSM-IV. They correspond strikingly to Wakefield's (1992) 'harmful dysfunction' analysis, with harm represented by subjective distress and objective impairment and an item assessing dysfunction of a psychological mechanism correlating a massive .85 with disorder judgments. Overall, the mental disorder concept in the American sample could be described as broad, professionalized and 'internalist,' emphasizing the intrapsychic and subjective aspects of mental disorder (i.e. psychological malfunction and conflict, and emotional distress).

The Brazilian sample's mental disorder concept serves as a clear contrast. The concept in the sample appeared to be substantially narrower than in the American sample, being exemplified by only about half as many conditions. Remarkably, the concept showed absolutely no convergence with the DSM-IV in our sample of conditions. In addition, its apparently central features – statistical deviance, violations of expected behavior, irrationality and flawed character – arguably represent a more 'externalist' understanding of mental disorder, one that emphasizes the observer's rather than the sufferer's perspective on disorder. That is, these features bring to the foreground aspects of deviant conduct that run contrary to social expectations and norms, and de-emphasize the elements of subjective distress and intrapsychic malfunction or conflict that are crucial to the American concept. Although the Brazilian sample is weighted heavily to a nationally unrepresentative socio-economic elite so that its pattern of findings cannot be generalized to any mythically unified 'Brazilian culture,' we would expect its members to be more exposed to and aligned with global and 'Western' values and belief systems than most of their compatriots. The sharp discrepancies between the Brazilian and American samples therefore become all the more striking, and may underestimate the true differences between American and Brazilian concepts of 'mental disorder.'

In some respects, the Romanian concept of mental disorder, at least as revealed by our sample and measures, is intermediate between these two perspectives. Intrapsychic and subjective aspects of disorder such as psychological conflict and distress tend to figure less prominently than in the American sample, but somewhat more prominently than in the Brazilian sample. At the same time, behavioral deviancy and the violation of

social norms tend to be less central features of the Romanian concept than they are of the Brazilian concept.

Apart from being intermediate in this way, however, the concept of mental disorder revealed by the Romanian sample was distinctive in two further respects. First, presumed biological etiology was significantly associated with judgments of mental disorder in this sample alone, whereas etiological beliefs otherwise showed no systematic relation to any disorder concept. Second, judgments of mental disorder in this sample were much less strongly associated with judgments of appropriateness for treatment by a mental health professional than in the other two samples. The first finding may reflect a more medicalized understanding of mental disorder in Romania than in the other cultures. This interpretation was supported by an exploratory factor analysis that found a factor that resembles a view of mental disorder as disease – involving biological etiology, statistical abnormality, relatively severe distress and absence of personal control – to be the most strongly associated ($r = .60$) with mental disorder judgments. The second finding may reflect the reluctance of Romanians to seek out mental health services for all but the most severe psychiatric conditions. This reluctance is reflected in the lowest mean treatability rating of the three cultures and is driven by financial constraints and the stigmatization of people who receive services. The disjunction of judgments of disorder and of treatability also appears to reflect a disbelief in the power of psychiatrists and psychologists to treat biologically based conditions. That is, the 'biomedical' factor that powerfully predicted disorder judgments was unrelated to treatability judgments ($r = .09$).

A fuller analysis of the distinctive features and ranges of the respective mental disorder concepts would require an in-depth ethnographic study of each culture. This was not the intention of the present study, which focuses on more general implications of the comparative findings. These implications are not entirely straightforward, as the findings demonstrate extensive similarities as well as differences between the three samples, and could be taken to support universalist, as well as relativist, views of mental disorder concepts. However, the differences between the respective concepts are perhaps more noteworthy, given recent attempts to develop implicitly universalist accounts of mental disorder (e.g. Wakefield, 1992) and the increasing widespread use of the DSM nosology, which imposes a universal understanding of what constitutes disorder.

With respect to formal definitions of 'mental disorder,' the findings suggest that the concepts operating in the three cultures manifest important differences, and yield only moderate levels of agreement in judgments of disorder. In relation to Wakefield's (1992) 'harmful dysfunction' analysis, in particular, the findings indicate a very close correspondence to the lay concept in the U.S.A. but a rather weak correspondence in the other two

cultures, and Brazil in particular. Although the findings therefore offer good support for the harmful dysfunction analysis in its country of origin, and suggest that it passes the 'conceptual analysis' test of correspondence to intuitive judgments there, they argue against its claims to being a fully adequate universalist analysis.

With respect to the DSM's implied definition of disorder, the findings clearly demonstrate limits to its mapping onto locally salient concepts of disorder. DSM-IV presents a demarcation of disorder that is consistently broader than all of our samples' concepts, and one that especially failed to capture disorder judgments in Brazil. Our findings suggest that when Brazilians use the term 'distúrbio mental' they may not be referring to anything like the same class of psychological conditions as a diagnostic system (the DSM-IV) that is becoming widely used in their country. This apparent discrepancy between lay and professional concepts of disorder may have important practical consequences. If it is true, Brazilians experiencing a wide range of officially recognized disorders may not consider their conditions to be appropriate targets for professional help, and others may seek help from mental health professionals who consider their conditions to be outside the boundaries of their expertise. The discrepancy might also generate a resistance or inability on the part of people who seek treatment to understand their conditions in the manner that professionals employ. This divergence between lay and professional discourses is to some degree universal, but if the discrepancy is as wide as it appears to be in this case, despite being based on an unrepresentative sample of Brazilians, the possibilities for mutual misunderstanding are especially great.

Although our findings are intriguing, it would be inappropriate to draw from them any generalized conclusions about lay concepts of 'mental disorder.' First, and most obviously, our samples are unlikely to be representative of their nations' populations, and lay concepts of mental disorder probably vary as a function of subculture and demographics in ways that have yet to be charted. Second, although considerable care was taken in translating the questionnaire, subtle differences might distort findings regarding the distinctive features of the respective mental disorder concepts. Third, each culture has terms other than 'mental disorder' for designating the psychiatric domain – English also has 'mental illness,' 'madness' and 'nervous breakdown,' for example – and the content and extension of these alternatives may differ substantially. As a result, inferences about a culture's concept of 'mental disorder' may not fully capture how its members think about psychiatric phenomena. It is possible, for instance, that the Portuguese term 'doença mental' might show a closer correspondence to the DSM-IV and the American concepts of 'mental disorder' than the strict translation ('distúrbio mental') that we employed. These considerations limit our capacity to draw firm conclusions about

cultural differences and similarities. Nevertheless, our study clearly indicates the risks of assuming the existence of a single, universal concept of 'mental disorder.'

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Appendix I

Sample Descriptions of the Conditions

Obsessive–compulsive disorder: ‘These people experience recurring thoughts, impulses or images which they try to ignore or suppress and that cause anxiety and distress (e.g. thoughts of being contaminated, doubts about having locked a door, aggressive impulses and unwanted sexual images). They also perform repetitive behaviors, such as excessive hand washing and silently counting backwards, in response to these thoughts, impulses and images.’

Schizophrenia: ‘These people have a variety of disturbances in thinking, perception, language and emotion. They have delusions (often bizarre false beliefs), hallucinations (e.g. hearing voices that aren’t really there), incoherent or peculiar speech, disorganized behavior (e.g. inability to maintain personal hygiene) and a lack of emotional responsiveness.’

Appendix II

Items Used to Assess Definition-Relevant Features of ‘Mental Disorder’

Statistical abnormality: ‘These people are rare’

Discreteness: ‘People are not like this to a greater or lesser extent: they are either like this or they are not’

Psychological malfunction: ‘These people are experiencing a malfunction of a normal psychological capacity or mechanism’

Non-expectable response: ‘What these people have is not an expected, predictable or normal response to their circumstances’

Environmental causation: ‘What these people are experiencing is caused by their environment and life experiences (e.g. family life, economic circumstances, traumatic events, schooling, social influences)’

Emotional distress: ‘These people are more emotionally distressed than most people’

Impaired functioning: ‘These people have an impaired ability to cope with the demands of everyday life, such as functioning socially or at work’

Incomprehensibility: ‘It is difficult to understand why these people are the way they are’

Irrationality: ‘These people are thinking or behaving irrationally’

Psychological conflict: 'These people are experiencing a psychological conflict'

Biological causation: 'What these people share has a physical cause (e.g. bacterial or viral infection, brain abnormality, genetic defect)'

Conflict with society: 'What these people are experiencing is due to conflicts that they have with society'

Social deviance: 'Basically these people are just engaging in socially deviant behavior'

Flawed character: 'These people have a character problem or flaw'

Personal control: 'What these people are experiencing is under their control: they could change it'

Treatability: 'It would be appropriate for these people to seek help from a psychiatrist or psychologist'