Understanding Adolescent Depression in Ethnocultural Context

Asian-American adolescents often are regarded as a "model minority" and as being less likely to experience depression than adolescents of other ethnic groups. African-American adolescents are more often diagnosed with schizophrenia than depression. Do these epidemiologic phenomena reflect the real facts, or are these just artifacts shaped by cultural bias or insensitivity prevailing in this society? This article explores the diagnostic bias resulting in misdiagnosis of adolescent depression and reviews the role of culture/ethnicity in mental health and the ethnocultural variations in depression among African-American, Hispanic-American, and Asian-American adolescents. By discussing the issues, this article guides nurses to enhance cultural competence in nursing care.
Key words: *adolescent depression, African American, Asian American, cultural competence, culture, ethnicity, Hispanic American*

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THE MAIN feature of the current US society is diversity. According to estimates of the US Census Bureau,[1] ethnic minorities constitute almost 30% of the total US population as of November 1, 2000 (Hispanic American 11.9%, African American 12.2%, Asian American 3.8%). Ethnic minorities have continuously increased in numbers. Ethnic diversity is prominent, particularly in youths under age 18 years.[2]

In this diverse society, culturally competent care for ethnic minority youths is needed more than ever. Culturally competent care begins with cultural awareness, which is a process of health care providers assessing their own biases about other cultures.[3] Cultural competence requires that nurses obtain cultural knowledge and cultural skills. It is finally achieved through "immersing oneself into the cultural reality of another group," which is a process of cultural encounters.[3,4(p686)] In reality, knowledge of ethnic minority youths' unique mental illness experiences is limited and biased.[5] Although the Western construct of mental

Adv Nurs Sci 2002;25(2):71–85

illness has been thought to be universal, resulting in standard care for all, in fact, certain mental disorders are misdiagnosed or underdiagnosed among ethnic minorities.[6]

In light of the increasing need for culturally competent care for ethnic minority youths, this article examines the cultural bias embedded in the US mental disorders classification system, particularly the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the cross-cultural applicability of the classification system. The second objective of this article is to discuss the role of culture and ethnicity in mental illness experiences and to explore cultural variations in adolescent depression. The overall goal of this article is to guide nurses to enhance their own cultural awareness, knowledge, skill, and encounters with the aim of culturally competent nursing care.

DEFINITIONS OF CULTURE AND ETHNICITY

Essential to an understanding of cross-cultural psychiatry is a review of definitions and historical development of two integral concepts: culture and ethnicity. The concept of culture has evolved with social changes and been defined in many ways in different disciplines. Culture is defined in nursing as: "the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guides their thinking, decisions, and actions in patterned ways."[7(p47)]

One of the most important changes in the definition of culture today is recognition of the dynamic nature of culture (creative and ever-changing) and attention to social processes and not just the psychological aspects (eg, values, beliefs).[8] This new perspective broadens the definition of culture and brings out the multidimensional aspects of the concept. Culture is neither an inherited product from one generation to the next, nor the people who are the recipients of the culture. Culture and people interact and negotiate, thus transforming and developing each other. It is a process of continuous modification.

Ethnicity refers to a group that shares common nationality, culture, or language, and the concept often is used interchangeably with race and even with culture.[9] Compared to race, ethnicity is a more useful concept in health research and practice because it contains information about beliefs, values, and behaviors beyond just the biological characteristics of a person.[10] Although the use of ethnicity as a grouping variable in health research has brought on continuous argument owing to lack of a clear definition and objective measures for the concept,[11–13] ethnicity is still an indispensable tool in identifying high-risk groups for certain diseases and providing culturally competent care for them.

Ethnicity is inseparable from culture. Gaw delineates the relationship between culture and ethnicity as follows: "The root concept for the term 'ethnicity' is culture. Ethnicity is a derivative concept that recognizes the in-group values conceptualized by a particular cultural group, such as Italian Americans, or French Canadians."[14(p16)] Culture is the most inclusive term; however, being a member of a certain ethnic group does not promise adherence to all of the cultural values and customs that sustain the ethnic group.[8] Thus, in this article, to embrace both ethnic and cultural components in understanding variations in experiences and expressions of adolescent depression, an extensive term "ethnocultural group" will be used.

WHAT WE KNOW AND WHAT WE BELIEVE ABOUT DEPRESSION IN ADOLESCENTS

The fourth edition of the DSM lists the criteria of two common depressive disorders of adolescence: dysthymic disorder and major depressive disorder.[15] Both are distinguished by depressed or irritable mood, decreased interest or pleasure in daily life, failure to thrive, sleep disturbance, psychomotor agitation or retardation, decreased or increased appetite, fatigue or loss of energy, diminished energy, feelings of hopelessness or worthlessness, poor concentration or indecisiveness, low self-esteem, and suicidal ideation or behavior. Do all depressed adolescents present these symptoms regardless of their ethnocultural backgrounds? Can we apply the diagnostic criteria universally to all ethnocultural groups of adolescents?

Cross-cultural data on the epidemiology of adolescent depression that can answer the above questions are currently insufficient, fragmented, and contradictory.[16] As a result, how adolescent depression is understood and expressed in different ways across ethnocultural groups is not yet well understood. According to the limited cross-cultural epidemiologic data,[17] prevalence of depression among adolescents was lowest for Chinese Americans (2.9%) and highest for Mexican Americans (12.0%). Anglo Americans showed a midrange of prevalence (6.3%) within the sample. In a study by Siegel et al,[18] Hispanic Americans also reported more symptoms of depressed mood than other ethnic groups of adolescents. In general, Asian-American adolescents, like Asian adults,[19] consistently reported lower rates of depression than other ethnic groups across the different studies. However, the suicide rate among Asian-American adolescents is comparable to the rates of other ethnic groups and even higher than the national average.[20]

It is reasonable to ask, then, whether the prevalence of depression truly is low in Asian-American adolescents? Or is this statistic simply an artifact of the cultural bias embedded in clinical judgment and the diagnostic criteria in this society? Before concluding that Asian Americans are mentally "healthy" on the basis of existing data, we need to answer these questions first. To do so, it is important to review what has been done to understand the roles of culture and ethnicity as they relate to the mental disorders classification system and how viewing mental illness in a cultural context might provide different conclusions.

CULTURE AND DSM

Although the Western population (Europeans and North Americans) makes up only one-sixth of the world's population, a Western diagnostic framework has been accepted as a gold standard for all. Along with the gold standard perspective, one of the most prevailing myths is that ethnocultural variations in the symptoms of mental illness are regarded as minor variations, whereas Western symptoms are considered the central patterns of the illness.[16] Another misguided perspective regarding the relationship between culture and

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illness is that culture relates only to ethnocultural minority groups. In reality, no one can live in a cultureless vacuum. Culture governs all types of illness experiences among all individuals. The concept of culture should be viewed as a basis for psychiatry rather than as a peripheral concept.[14] Therefore, "cultural psychiatry" needs to be diagrammed as a larger circle embracing psychiatry, which is a subset.[14]

Since the DSM was first published in 1952, it has been widely used as a classification system and as the common language among mental health professionals. It has since gone through a number of revisions; DSM-IV, the most recent version, was developed to reflect the increasing need for cultural awareness in psychiatric diagnosis. DSM-IV acknowledges the significance of culture and ethnicity in understanding depression, as follows: "culture can influence the experience and communication of symptoms of depression. Underdiagnosis or misdiagnosis can be reduced by being alert to ethnic and cultural specificity in the presenting complaints of a Major Depressive Episode."[15(p324)]

The most significant improvement in the DSM-IV compared to the previous version, DSM-III-R, was inclusion of special sections for ethnic and cultural consideration. Efforts to incorporate a cultural perspective in the DSM-IV are reflected in three areas:[15]

1. inclusion of the special section discussing culture-related features and the influences of culture on the presentations of specific disorders
2. provision of information about culture-bound syndromes in an appendix
3. an outline for the cultural formulation that is intended to incorporate a cultural perspective in the existing multiaxial DSM diagnostic system

DSM-IV demonstrated startling progress in acknowledging the role of culture in mental illness and opened the gate to a new era of cross-cultural research and practice. However, a number of cross-cultural psychiatrists have raised questions about the cultural sensitivity of the newest version of the DSM.[6] A major critique of the DSM-IV is its failure to capture the full reflection of fluid and multidimensional culture on mental health. Dissecting the influence of culture in shaping emotional expressions and behaviors is more complicated in children and adolescents. The DSM-IV Axis IV (psychosocial factor) and Axis V (global assessment of functioning) still hold ethnocentric perspectives and do not reflect the cultural variations in children's and adolescent's experiences.[6] Analyzing psychosocial factors related to the disorder and determining the individual's level of functioning rely on the practitioner's judgment, which is mainly influenced by Western cultural norms.

The question of whether duration of mental illness is universal across ethnocultural groups is another debatable issue in the diagnostic process.[21] For example, according to DSM-IV, to be diagnosed with major depression, an adolescent should have dysphoria for 2 weeks. However, it may take more than a month for an adolescent to be recognized as having abnormal symptoms or significant problems in certain ethnocultural groups.[21] Thus, duration as one of diagnostic criteria may be another culturally biased ruler.

ROLE OF CULTURE IN CHILD DEVELOPMENT AND MENTAL HEALTH

To what extent and through what processes does culture influence mental health? There

are three perspectives on the influence of culture on mental health outcomes.[22] The first viewpoint, an absolute orientation, presumes biologic factors to be critical in forming human behaviors and in mental health outcomes. According to this perspective, generalizable biologic features determine human behaviors, and mental health and cultural factors have only limited impact on them. Thus, this perspective assumes that child mental health and behaviors could be assessed without understanding of cultural context. The opposite standpoint is a relative orientation. This perspective emphasizes the influence of environmental and cultural factors when explaining human behaviors, and it assumes that group differences in behaviors are due to cultural differences.

The last perspective, a universal orientation, tries to incorporate both extremes and take both biologic or genetic factors and cultural or environmental factors into consideration for understanding human behaviors. This orientation assumes existence of universal features of human development and mental health across different ethnocultural groups. Based on basic and common features, observable behaviors, expressions of emotion, and the manifestations of mental illness are shaped by environment and/or culture. Interaction between universal features and cultural and/or environmental influences is emphasized in this orientation. This universal orientation served as a theoretical basis for this article.

If human behaviors and mental health outcomes are formed by interaction between biologic/genetic and cultural/environmental factors, how do the latter factors act in the process, particularly among growing children and adolescents? Mohler[22] reviewed two leading models, the problem-suppression model and the adult-distress model, which explain the process of how culture influences mental health outcomes and behaviors of youths. The problem-suppression model explains the pathway of cultural influence on development and mental health outcomes as a direct one. Through a child's own experience of cultural norms and environments, the child learns how to control culturally acceptable and unacceptable behaviors. The experience and insight ultimately shape the child's developmental pattern and mental health.

On the other hand, the adult-distress threshold model focuses on the adults' role in this process. According to this model, a child is indirectly influenced by adults' experiences, perceptions, and beliefs concerning child behaviors. The child's behaviors and mental health are formed by culture through adults' influences. A child is described as likely to be a passive recipient in this process. These two models describe extremes in pathways of cultural influences. In real life, however, child mental health outcomes and behaviors may form by the combination of two pathways, direct and indirect. If nurses acknowledge the significance of both adolescents' and adults' experiences and perceptions of cultural norms, they can work effectively within the environmental/cultural context of the adolescents and invite families and communities to participate in the nursing process.

Assessing mental illness experiences related to culture is important, particularly in adolescents, because culture is an indispensable ingredient of child-rearing practice and the development of emotions, morality, and self-concept, which are key factors underlying child and adolescent psychology. Culture also forms standards for classifying normality and abnormality.

Normally accepted behaviors and norms in one culture may not be favorably accepted in another culture. For example, obedience, filial piety, and taciturnity, which are highly valued in Asian culture, are often viewed as lack of self-confidence, assertiveness, and ability to express oneself in American society. Adolescents usually take passive positions in reporting and seeking health services, and parents, teachers, and other significant adults weigh "normality" for children with their culturally formed scale. Thus, acknowledging the role of culture in mental illness experiences and the differences in the concept of normality are essential for early identification and treatment of cases.

ETHNOCULTURAL VARIATIONS IN ADOLESCENT DEPRESSION

Culture and ethnicity can influence the epidemiology of adolescent depression and the diagnostic process in two ways. First, culture and ethnicity affect both personality variables and surrounding social conditions, which are important determinants in prevalence of adolescent depression. Feelings of isolation and anxiety among Asian Americans, fatalism among Hispanic Americans, and self-hatred among African Americans are commonly observed culture-related personality traits.[2,9] Racism, prejudice, and low socioeconomic status are social situations in which ethnic minority youths are usually placed.[23] Second, in some illnesses, practitioners' misunderstanding and misinterpretation of culture-related illness or cultural variations in illness experiences may be another reason for epidemiologic differences and biased diagnoses.

In view of the significant role of culture and ethnicity in adolescent mental health, this section reviews current knowledge on the ethnocultural variations in adolescent depression. To provide specific information for culturally competent care, this section addresses ethnocultural variations focusing on African Americans, Hispanic Americans, and Asian Americans. When discussing the variations, this article emphasizes distinctive characteristics that represent each ethnocultural group. These characteristics are not necessarily unique to each ethnocultural group, but they are the most significant factors influencing mental health. At the end of this section, culture-bound syndromes that prevail in each ethnocultural group and their resemblance to depression are reviewed. Culture-bound syndrome is defined as "a recurrent, locally-specific pattern of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category."[15(p844)]

African-American experiences

Despite the fact that African Americans are the oldest ethnic minority group in this country, the published studies of depression among this group have been sparse. Underresearch leaves many holes in our knowledge of distinctive features of depression among this group. Indigence, devaluation, and discrimination are the typical words used to describe the African American's life and social position in this country, even after the civil rights movement.[23] Culturally competent care for African Americans should begin with awareness of the social and economic oppression that they face.[24] About 22.1% of African Americans are living in poverty.[25] This far exceeds the national poverty rate of 11.3%. Disadvantaged socioeconomic status is known to be a significant risk factor for adolescent depression.[26]

Besides low socioeconomic status, other sociocultural factors such as unique family dynamics, prejudice, and religious beliefs that influence the African-American experience and subsequent manifestations of mental health are discussed in this section.

Family dynamic and child-rearing

Family is the basic unit of a culture and plays a key role in transmitting cultural values and norms to the next generation. Matriarchy is one of the unique features of the African-American family.[27] More than 40% of African-American family households are headed by a single mother.[27] This is the highest figure among all ethnic groups. Absence of a father figure impedes establishment of steady human relationships, positive self-esteem, ethnic identity, and trust, which are vital nourishment for adolescent mental health.[15]

Furthermore, about 65% of African-American single-mother families originate from an out-of-wedlock birth, whereas white single-mother families are more likely to be the result of a divorce. The marital status of single mothers may be an important indicator of socioeconomic environment for children in the families. Divorced single mothers usually have more education and better economic status than mothers who have never been married.[27]

Diagnostic bias

Overdiagnosis of psychotic disorders or schizophrenia among African Americans who actually are suffering from depression is another noteworthy phenomenon.[28] Until recently, African Americans were believed to be too inferior to become depressed, as was noted early by Wilson and Lantz.[29] The prejudice and devaluation of the population still mingle in this society and emerge in health care practice. Baker[30] reviewed possible contributing factors for mis/underdiagnosis of depression among African Americans in the historical and cultural context.

The most significant factors are clinicians' diagnostic bias arising from deep-rooted prejudice and their misunderstanding about the way of expressing depressed feelings. Compared to their white counterparts, African Americans tend to choose relatively strong words to express their anguish and emotions.[6] Also, increased anger, aggression, and irritability, rather than hopelessness, sadness, and depressed mood, are common ways of exhibiting depression.[30] These unique expressions are diagnosed more often as schizophrenia than depression.

Strengths of the African-American culture

Although low socioeconomic status and sustained social stress put African-American adolescents at higher risk for depression than adolescents of other ethnic groups, other cultural factors may work as buffers against depression. The first resource is a strong bond with family and family ties.[14] Family, here, includes extended family. A cohesive family or family support has been regarded as one of the strongest resources protecting against mental distress in adolescents.[31,32] Also, inherited cultural heritage and wisdom from their grandparents provide them an asset to build a strong ethnic identity. A stronger ethnic identity is regarded to be associated positively with emotional well-being among adolescents.[33] The positive relationship between ethnic identity and coping, sense of mastery, self-esteem, and optimism has been observed across diverse ethnic groups.[33]

Another cultural factor that prevents African-American adolescents from becoming depressed is religiosity. Strong religious belief has been a primary source of strength for African-American adolescents to endure sustained social stress. African-American adolescents with devoutness believe that stressful experiences take them closer to God, and that God provides care and protection for them.[34] Churches also have satisfied their needs for socialization and psychological supports.

On the other hand, overcredulity or overdependence on religion may delay treatment for mental illness. African Americans often seek pastors for psychotherapeutic consultation and use professional mental health care providers as the last resort.[6] Thus, for nurses who are working with African-American adolescents, being in collaborative partnership with churches and assessing mental illness experiences of these adolescents in the context of the sociocultural circumstances addressed here are critical to providing culturally competent care.

Hispanic-American experiences

Understanding Hispanic-American mental illness experiences should begin with recognizing the diversity within the ethnocultural group. Hispanic, the "pan-ethnic" label, is used by the US Census Bureau to designate people who use Spanish as their native language and/or who move from areas where Spain or Spanish colonizers governed.[2] The term connotes heterogeneity within the group, and literature warns against using this broad term without considering intragroup diversity.[6] As of 2000, Hispanic Americans comprised the following subgroups: 66.1% Mexican, 14.5% Central and South American, 9% Puerto Rican, 4% Cuban, and 6.4% other Hispanic.[35] People in this group have varied socioeconomic statuses and immigration backgrounds/histories, not just diversity in race. However, these people use the same language, Spanish, and share similar cultural elements, which are critical constructs in mental health. Owing to similarity in native language and other cultural elements, they are usually lumped together and categorized as "Hispanic American."

Education level

Low education level is a significant factor to consider when working with Hispanics. Only 64.1% of Hispanic youth ages 18 to 24 years have completed high school. This is a significantly low number compared to other ethnic groups (white: 91.8%; African American: 83.7%; Asian American: 94.6%).[36] The level of education is often confounded with the ethnocultural influences on mental health and shapes language and expressions for depressed feelings.

Culture-related risk factors: fatalism and pessimism

Hispanic-American adolescents, particularly those of Mexican descent, have consistently reported the highest prevalence of depression among all ethnic groups.[17,18] A number of explanations for the phenomenon have been proposed, and the most persuasive are fatalistic (a belief in external control) and pessimistic viewpoints toward life stress. One hypothesis is that fatalistic and pessimistic viewpoints are intensified when these adolescents encounter stressful life events such as immigration.[37] When faced with stressful situations as part of the acculturation process, they rely primarily on external control rather than their own

power and display a negative cognitive style, typically a passive attitude.[38] Although fatalism retains some positive aspects (eg, faith in God), pessimistic attributional cognitive style is closely related to hopelessness and becomes a major risk factor for depression.[37]

Self-identity and gender role

Identity formation becomes a complex task for immigrant adolescents who are growing between new and traditional cultures. Complexity of establishing a gender role among immigrant adolescents is intensified when cultural expectations for a certain gender are contradictory between two cultures. A girl who has been raised in Hispanic culture emphasizing femininity in women often experiences identity and gender role confusion when she is exposed to American culture permitting an independent, active, and relatively free female figure.[39] Identity or gender role confusion is closely related to developmental crisis and ultimately emotional distress, including depression.[40]

On the other hand, an immigrant boy who has been inspired with Hispanic male gender identity, machismo, often finds himself struggling with new language, peer relationships, and environment in a new culture. Belief that expressing his emotional struggle will hurt his machismo forces him to express this emotional struggle with aggressive and hostile behaviors or involvement in gangs.[41] These acting-out behaviors typically conceal a sense of powerlessness, lack of self-confidence, loneliness, and even suicidal ideation.[41] Somatic complaint is another culturally acceptable way of expressing depressed mood for macho men.[41]

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Expressions for depression and related issues

One of the challenges in diagnosing depression among Hispanic Americans is understanding culture-bound syndromes. Culture-bound syndromes resembling depression for each ethnocultural group are summarized in the box entitled "Culture-Bound Syndromes Related to Depression." Reviewing and differentiating these syndromes from depression are important to make a culturally sensitive diagnosis of depression for adolescents from diverse ethnocultural backgrounds.

Besides these culture-bound syndromes, Hispanic Americans use a variety of expressions to describe emotional distress: "*Mal del cerebro o de la mente* (bad in the brain or in the mind); *nerviosidad* (nervousness); *espiritualmente debil* (spiritually weak); *locura* (craziness); *perdiendo control* (losing control of oneself); *ido* (gone, usually accompanied by a gesture pointing to the head)."[6(p39)] Depression is often expressed in terms of complaints of nerves and headache.[15] Becoming familiar with the language for emotional distress and understanding cultural beliefs embedded in the expressions are critical steps for culturally competent communication between nurses and adolescents.

Asian-American experiences

Asian Americans have been believed to be a "model minority" because of their high levels of academic and economic achievement.[43]

Culture-Bound Syndromes Related to Depression

African American

Brain fag: Observed among African American adolescents.[16] Common symptoms of the syndrome include multiple somatic complaints and problems with concentration and thinking.

Hispanic American

Mal de ojo (evil eye): Results when someone who has a strong eye (evil eye) admires a child without touching the child.[16] Symptoms of mal de ojo are anxiety, depression, vomiting, fever, and diarrhea.

Susto (fright or soul loss): Caused by emotionally traumatic events or social stress. Typical symptoms are "appetite disturbances, inadequate or excessive sleep, troubled sleep or dreams, feeling of sadness, lack of motivation to do anything, and feelings of low self-worth or dirtiness."[15(p848)] Somatic complaints are also common, and this syndrome is assumed to be related to depression.[15]

Asian American

Shenjing shuairuo (neurasthenia): Chinese version of depression.[42] Symptoms include fatigue, insomnia, problems with concentration, memory loss, multiple somatic complaints, and irritability. The symptoms meet the DSM-IV diagnostic criteria for depression.[15]

However, they are one of the most segregated ethnic groups and the least studied group, particularly regarding mental health issues. Knowledge of Asian-American children's and adolescents' mental health issues is very limited.[44]

Development of self-concept

Self-concept is "the set of attributes, abilities, attitudes, and values that an individual believes defines who he or she is."[45(p445)] The concept is shaped by both children's own cognitive capacities and the responses of others. Responses of others are a reflection of the cultural values of the society. Self-esteem is one component of self-concept that evaluates and judges one's value. Adolescents from communalistic cultures, such as Asian Americans, highly value the well-being of others and find meaning in their behaviors and lives from satisfying others, especially families.[43] Thus, development of their self-esteem is influenced by their relationships with others, and this tendency is often observed in their expressions of depression. For example, in a study by Marsella et al,[46] Japanese tended to exhibit difficulties in their interpersonal relationships as a symptom of depression, such as "unable to get along with other people," rather than focusing on their emotions. The study revealed that Asians (Chinese and Japanese) still stick to their traditional cultural value of collectivism and tend to define "self" in the larger social nexus even if they are third-generation immigrants.

Understanding how individuals view themselves is a critical step to culturally competent care.[3] Going further than assessing the static self-concept, Schwab-Stone and her colleagues[47] emphasize that practitioners should place importance on the process of self-development to understand adolescents' stressful experiences and their vulnerabilities related to the process. Focusing on the process is particularly important when nurses are caring for ethnic minority adolescents who are growing up between two distinct cultures.

Family dynamics and child-rearing

The main role of the father in the Asian family is discipline, and the mother is a source of emotional support. The mother often attaches much more strongly with her children than with her husband and overinvolves or overprotects her children.[43] Children often are considered the property of their parents. However, traditional family dynamics are altered by immigration to a new society. Immigrant adolescents acquire new language and culture faster than their parents (asymmetric acculturation), and thus usually serve as translators and cultural brokers for their parents (role reversal). These phenomena threaten the traditional hierarchical relationship between parents and children and create conflicts in immigrant families. Living with two different cultural values, traditional and new, often brings emotional distress in adolescents.[40]

In Asian culture, education is exceedingly valued, thus parents and teachers often mistakenly believe students who demonstrate high academic achievement are mentally healthy. In fact, Asian adolescents are more likely to experience lack of social skills and difficulty in social relationships than adolescents of other ethnic groups.[2] Adolescents who fail to satisfy their parents with good grades in school become a shame to their parents and feel anxious and depressed.[43] Asian adolescents' submissive and sincere attitudes often conceal their emotional struggle and mental illness, particularly internalizing disorders such as depression. Or, they may be tardy for school, fall asleep in class, or just fool around in school rather than express their depressed mood and ask for help.[43]

Expressions of depression

In the less verbally expressive Asian cultures, parents are more likely to express their affection for their children implicitly and assume that their children are aware of their love. Also, parents consider independent and verbal adolescents as problematic and rebellious. Adolescents who learn this implicit communication pattern may exhibit similar styles when they express their depressed feeling. They are told that expressing their emotions in public will hurt "face" and bring disgrace on their family. Asian culture, which is built on Confucianism and collectivism, stresses conformity and does not tolerate deviancy well. Asian culture has a firm boundary of normality. Hence, instead of verbally expressing their feelings, depressed adolescents may become more withdrawn and introverted and often report vague somatic complaints.

Somatically expressed depression is observed in other ethnocultural groups of adolescents as well, but the tendency to express depressed feelings somatically is high among Asians. In a nationally representative sample, Asian adolescents reported the highest somatic symptom scores, followed by Anglos, American Indians, and Hispanics.[48] Commonly exhibited somatic complaints

among adolescents are headache, abdominal pain, muscular-skeletal pain, weight loss, and decreased appetite and libido.

Nurses should be alert for messages expressed nonverbally. An uneasy smile is a common way of expressing depressed mood among Asians.[49] Also, nodding the head does not always mean that they understand or agree with nurses. Asian adolescents are educated to be obedient to authority and older people, thus they often smile and nod their heads to show their respect, even when they do not understand or agree with what nurses say. Those with limited proficiency in English may smile and nod their heads to save face. Thus, nurses should not be misled by vague expressions and should ascertain mutual understanding of messages between nurses and the adolescents. Creating a receptive atmosphere and developing a relationship of trust with the adolescent are essential for effective communication.

BEYOND STEREOTYPE: IMPLICATIONS FOR CULTURALLY COMPETENT NURSING RESEARCH AND PRACTICE

No one can overlook the role of culture and ethnicity in nursing research and practice today. This article has reviewed the cultural debate concerning the mental disorders classification system and ethnocultural variations in expressions of adolescent depression that are applicable to nursing research and practice. With the limited current knowledge of the adolescent experience of depression in general, it is challenging to discuss ethnocultural variations of depression in depth. However, this article at least may be able to elicit further debate and discussion on this issue. Also, this article is not intended to provide a definitive guide, but it does provide a knowledge base for culturally competent nursing care for adolescents from different ethnocultural groups. Thus, the reader is cautioned not to use this information as another source for labeling, stereotyping, or overgeneralizing these ethnocultural groups of adolescents.

In practice, keeping a balance between "integrity" and "flexibility" of care is not easy, but it is critical in a culturally diverse society.[47(p734)] The problem that confronts us is how to embrace the needs of patients from diverse ethnocultural backgrounds within the framework of standard care. Although culturally competent care is not a new concept anymore in nursing, specific guidelines for culturally competent nursing practice generally are not available. Thus, this article makes several suggestions for culturally competent care, particularly focusing on the organizational or community level beyond the individual practice level. Effective culturally competent nursing care requires organizational or community-level collaboration and efforts. The efforts to develop culturally competent nursing care include:

- activating inservice education or seminars that can increase nurses' knowledge and understanding about adolescents from different ethnocultural backgrounds
- collaborating with professionally trained interpreters to minimize language barriers
- ensuring ethnic diversity in nursing staff
- providing family-focused interventions rather than individual interventions for adolescents from family-centered cultures

- developing coalitions with ethnic communities and existing community services

Coalitions with the community or existing community services are critical for providing culturally competent care and for maximizing utilization of services among the adolescents from diverse ethnocultural backgrounds.

In research, testing direct and indirect effects of culture and ethnicity on child development and mental health remains a challenge. The majority of cross-cultural nursing research is descriptive, comparing mental health outcomes across different ethnic groups. Although this is an important step, inquiry into the dynamic process of ethnocultural influences on child development and mental health is needed as the next step.

Because of the complexity and vagueness inherent in the concepts of culture and ethnicity, these two concepts are necessary but not sufficient for understanding unique mental illness experiences in nursing research and practice. Not only culture, but also an individual's physical and psychological makeup shape mental illness expressions. Thus, nurses should analyze the ethnocultural influence on mental health in a specific context for each adolescent rather than generalize the phenomena. Beyond categorizing adolescents on the basis of their ethnocultural groups, deeper understanding of what it feels like for each adolescent to live as an ethnic minority in this society is required.

Furthermore, other variables such as level of acculturation, acculturative stress, chief motives for immigration, and ethnic identity, in addition to culture and ethnicity, need to be introduced in nursing research and practice. Ethnic minority groups that have been discussed in this article are becoming more heterogeneous because of the influx of immigrants from other countries. As these ethnic groups become more heterogeneous, intraethnic/cultural group variation is another emerging concept to be contemplated. In research, conducting qualitative research could be the way to lay a cornerstone for understanding these complicated concepts and ethnic minorities' lived experiences.

For a long time, ethnic minorities have been underrepresented and underserved in the US health care system. Although there are many possible reasons for this phenomenon, this article focused on the lack of knowledge regarding the role of culture/ethnicity in mental health. Cultural competence should be regarded as a basis for nursing, not an ultimate goal for nursing. Now, as cultural brokers, nurses should open the gate of health care systems for these adolescents who have different needs and diverse cultural backgrounds. Nurses are important players in developing the keys for the gate.

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