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THE CULTURAL INFLUENCE AND INTERPRETATION OF DEPRESSIVE AND
ANXIETY DISORDERS

An Honors Thesis

Submitted in Partial Fulfillment of the

Requirements for Graduation with

Undergraduate Research Honors

Georgia State University

2011

by

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Date

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ANXIETY DISORDERS

by

JOY MESSERSCHMIDT

Under the Direction of Dr. Cassandra White

ABSTRACT

The diagnosis and treatment of depressive and anxiety disorders has changed rapidly in the past century. Western medicine has produced diagnostic criteria, pharmaceuticals, and different therapies, increasing public awareness of these conditions. This research investigates the potential and perceived cultural, familial, and political influences on anxiety and depressive disorders in the current biomedical system; analyzes the effects of this system on the patients within it; and compares the causality, diagnosis, and treatment of these conditions cross-culturally. To accomplish these research goals, I conducted in-depth interviews with people affected by depression and anxiety in the Atlanta area. I will present my analysis of the interview data collected, focusing on the extent to which each participants' familial and cultural backgrounds and attitudes towards biomedicine affected their choices and experiences with treatment. I also explore the role of pharmaceutical advertising and marketing strategies in patients' perceptions of their disorder and treatment options.

INDEX WORDS: depression, anxiety, medical anthropology, senior thesis, psychology

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An Honors Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Bachelor of Arts and Sciences

in the College of Arts and Sciences

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2009

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INTRODUCTION

Major depressive and clinical anxiety disorders have been recognized as mental illnesses for a short period in human history, given that disquiet and dysphoria have been present in our species for millennia. This transition from emotional response to biological disease was the result of advances in medical technology, shifting cultural perceptions of illness and health, and developments in the pharmaceutical industry (Healy 1999, Kirmeyer 2001, Kleinman 1981). Depression and anxiety disorders are now relatively common, with 16.5% of the United States' adult population suffering from chronic depression and 5.7% from generalized anxiety disorder (NIMH 2005).

The anthropological community has contributed greatly to the understanding of these disorders in the context of the cultural background. Arthur Kleinman (1981, 1985, 1991) has published extensively on the role of cultural belief systems, social and interactional rules, and the ideology of alternative medical systems on the diagnosis, treatment, and symptomatology of mood disorders in Asian cultures. His definitive work on the concept of the illness experience provides medical professionals with a contextual guide to discovering- and utilizing- all aspects of daily life that are highly influential on the manifestation, progression, and ultimately, resolution of extended periods of ill physical and mental health (Kleinman 1988).

Emily Martin (2000) discusses the necessity for an anthropological perspective in neuroscience. The Western medical system, or biomedicine, has shifted much attention in research on depressive and anxiety disorders from the realm of cognitive psychology and psychiatry to the chemistry-based neurological field. There are inherent problems,

however, with the conceptualization of human emotions, relationships, and personalities as strictly biological processes limited to synapses and enzyme exchange (Kirmeyer 2001, Martin 2000, Pettus 2006). Though this may be all that is testable in a laboratory setting, the social scientist knows better. Culture is a primary environmental factor in human behavior, and societal norms and standards create a significant difference in the amount of variability in the manifestation of the affective disorders categorized today (Kirmeyer 2001, Kleinman and Good 1985, Martin 2000).

The anthropologist cannot be exclusionary, however. Rather, it is essential for all branches of the social sciences, psychological and psychiatric communities, and biology to instead collaborate to present a larger picture of these disorders (Kleinman and Good 1985). Inasmuch as these disorders have begun to be described and medically classified, more exceptions, subcategories, and reorganization of conditions has taken place, with four, soon-to-be five, revised volumes of the Diagnostic and Statistical Manual for Mental Disorders (DSM) available today (Grob 1991, Healy 1999). This reiterates the need for collaboration between disciplines, as the anthropological perspective explains, in many cases, the variations seen that result in the continual adjustment of diagnostic criteria and categorization of mental health disorders.

Diagnosis of an affective disorder is only part of the illness experience for the individual. The progression and, hopefully, resolution of the condition is handled differently in every culture; even within cultures, multiple treatment paths are available. Consider the Navajo, who have at least four different healing systems with which to treat corporal and mental health problems, yet live within the boundaries of contemporary American culture as well (Storck et al. 2000). The rapid acceleration of globalization is

forcing innumerable cultural systems, both medical and otherwise, to exist in theoretical harmony. This can have considerable impact on patients' willingness to adhere to their treatment plan, especially when it conflicts with their own etiological models, concepts of health and disease, and attitudes towards acceptable forms of treatment (Kirmeyer 2001).

To assess the degree of influence that the biomedical model, family history and beliefs, and cultural ideals about mental health have exercised on individual illness experiences, I conducted ten in-depth interviews with participants who had received a medical diagnosis of one or both of these disorders. In this research, I discuss the ways in which the culture of families in the United States affects the experience of depressive and anxiety disorders, the potential attitudes of patients towards treatment options, and the implications these findings hold for further research in the anthropological and psychological communities.

THE CULTURAL LENS

Applying Significance to Cultural Influence

At present, the globally established and politically recognized set of health and medical standards is known as the Western medical system, or biomedicine, a system categorized by its utilization of randomized controlled trials to achieve the highest degrees of validity and reliability in scientific inquiry. This system claims the biomedical model of human illness and disease etiology, a model that resulted in the astounding successes of antibiotics and vaccinations. Yet this system, due to its dependence on the participation and interaction between many different cultural groups, from physicians to

research participants, is intrinsically infused with cultural biases and moral beliefs. This is especially true for the disciplines of psychiatry and psychology, which rely on reported symptoms, interpretation of illness dialogue that is rich in metaphor, and responses that are strictly dictated by cultural rules of social conduct (Kirmeyer 2001, Kleinman 1980,1988).

The physiobiological processes that occur when a patient experiences an emotional response in his or her brain are the same cross-culturally, but the way in which that emotional response goes from chemical exchange to illness concept is both deeply personal and highly cultural (Kleinman 1980). Addressing the universality of psychiatric disorder has allowed psychiatrists and medical anthropologists to assess the degrees of cultural influence present in the manifestations and descriptions of mental illness. Arthur Kleinman (1980:148-9)', whose research has focused primarily on psychiatric disorders in Chinese culture, found and described three distinct ways that the Chinese tend to deal with periods of prolonged depression or anxiety. Unlike many contemporary Westerners, who are encouraged and perhaps even comfortable discussing feelings of worry of distress with a therapist, the social rules in China, and many other Asian cultures, do not necessarily permit overt discussion of personal emotions (Kleinman 1980, Kirmeyer 2001, Kitanaka 2008). Instead, Kleinman (1980) explains that Chinese patients minimize or deny their feelings, dissociate their feelings in a seemingly unrelated action or outburst, or report physical symptoms (sleeplessness, headaches, etc) in lieu of emotional ones. Though these physical complaints, known as somatization, are symptoms of depressive and anxious states in other cultures, the set of symptoms a culture chooses as

appropriate and important for medical discussion are based largely on social rules and less, perhaps, on the severity of the symptoms.

Linguistic Barriers and the ‘Culture-Bound Syndromes’

In a discipline reliant on conversation, language is a critical aspect of psychiatric diagnosis, and also highly culturally variable. Aside from the obvious difficulties in diagnosing a patient who reports symptoms in an unfamiliar language, even when doctor and patient share the same language, subtle differences in word choice and descriptive metaphors can make it challenging for the experiences of the patient to be translated into an effective diagnosis and path of treatment. This is especially true when considering the culture-bound syndromes, or folk illnesses, terms that encompasses a group of mental health disorders found almost exclusively in a single culture.

The trend in psychiatry has been to categorize these disorders under preexisting groups, but anthropological research has indicated that though folk illnesses, such as *susto*, *nervios* and *amok*, may share symptoms with depressive and anxiety disorders, these conditions are culturally distinctive and cannot be lumped with the equally culturally influenced disorders decided upon by Western medical institutions (Carr and Vitaliano 1985; Kleinman 1980, 1988; Weller et al 2008). A study done by Weller et al. (2008) on *susto* and *nervios* in Latin American cultures revealed that the onset of *susto* was associated with a specific etiological model, namely, an intensely frightening or shocking experience. This experience resulted in the primary symptom of ‘soul loss’, accompanied by more traditional symptoms of sleeplessness, loss of interest, and general malaise. Weller and colleagues (2008) emphasize the importance of studying culture-

bound syndromes outside of the confines of specific psychiatric diagnosis, explaining that the purpose of such research is to “understand the meaning that folk diagnoses have within the community and as possible risk factors for morbidity and mortality,” (2008:409).

Causality and Categorization

Patient’s etiological beliefs and perceptions of illness symptoms are also culturally variable. Kleinman illustrates this fact, and the diagnostic problems associated with it, in the introduction to *Rethinking Psychiatry* (1988) where he presents a hypothetical situation in which psychiatrists were asked to assess the mental states of Native Americans following the death of a spouse or loved one. Kleinman points out that in many Native American cultures, it is common and even expected for the bereaved to speak with the deceased for a period after the burial, but in this hypothetical scenario, the psychiatrists would assess these as delusions and describe a psychotic state, when actually the bereaved were behaving appropriately based on cultural standards (1988:11). This hypothetical situation, along with the other previously discussed examples, reveals the fundamental problems associated with such a rigid and culturally-sterile set of diagnostic criteria as is utilized by many medical professionals today.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) was created in an effort to more closely align mental health research and diagnosis with the biological medical standards of testing and classification (Healy 1997, Pettus 2006). The DSM does succeed in increasing the reliability of psychological diagnosis, but it fails to increase the validity of the categories being utilized. Though psychologists can now consistently group individuals with mental illnesses based on shared symptoms, the scientific

legitimacy of those groups has not been proven (Healy 1997, Kleinman 1988, Pettus 2006). In essence, this results in a set of invalid diagnostic criteria that can be consistently applied across the general population (Pettus 2006).

A Universal Set of Diagnostic Criteria: The Anthropological Perspective

This fallacy is well-documented in psychological and ethnographic studies. Storck and colleagues (2000), in their work with the Navajo Healing Project, discussed an interview with a depressive patient who utilized multiple healing models to cure her illness. The patient experienced grief for three months following the death of her father, and the DSM-IV categorizes grief as a depressive episode if it persists more than two months after the loved one has passed (DSM-IV 1994:327). The patient did experience amelioration from her grief after participating in several traditional healing ceremonies, but never utilized psychological services and did not experience symptoms prior to her father's death (Storck et al 2000). The benefits of diagnosing this patient as depressed due to an arbitrary grieving period limit are few, and the patient improved after seeking out her own methods of treatment outside of traditional psychological options.

Though there is no concrete agreement in Western psychology about the etiology of depressive and anxiety disorders, patients whose models differ from those that are widely accepted can present diagnostic issues for mental health professionals. Kleinman (1980) recalls a young Taiwanese patient who was suffering from anxious feelings, sleep loss, nocturnal emissions, and assorted physical complaints. The patient saw several Western physicians, a traditional Chinese doctor, a Taoist monk, and finally, Kleinman himself (1980:125). From each of these healers, he received a different diagnosis, ranging

from neurasthenia to broken kidney. Upon speaking with Kleinman, the patient reveals compulsive masturbation and associated guilt, anxious thoughts, and immense frustration at being responsible for his own ailments. Though he was referred to a psychiatrist, the patient failed to complete his treatment (1980:125). The wide array of the patient's symptoms failed to fit one diagnostic category, and the patient himself was dissatisfied with all the diagnoses he received. This case illustrates precisely the role of anthropological research in obtaining a well-rounded, multidisciplinary approach to appropriate diagnosis and treatment of depressive and anxiety patients.

HISTORICAL CONTEXT

Background of Psychiatric Biomedicine

Though variations of depressive and anxiety disorders have likely been burdening humans for thousands of years, the classification of these conditions as mental illnesses is confined to the last century. Even more recent is the development and use of antidepressant and anti-anxiety drugs to treat these illnesses. This paradigm shift from emotional response to treatable disease reflects a change in cultural attitudes towards illness that closely followed the successes of antibiotics and vaccinations (Healy 1999). Psychiatric conditions were slowly incorporated into the medical mindset, and psychologists eagerly searched for pharmaceutical remedies, hoping for the 'magic bullet'— the penicillin for depression or anxiety (Healy 1999).

Prior to the conceptualization of these disorders within biomedicine as potentially treatable 'diseases', psychiatrists and the general public were primarily concerned with

severe mental illness—madness or insanity, as they were labeled at the time. The accepted treatment for this condition was the institutionalization of the patient in one of the oppressive and isolating asylums that had dominated mental healthcare in America and Europe for centuries. In the early 1900's, the United States sent out two censuses pertaining specifically to those with severe mental illness in an attempt to discern the number of dependent mentally ill patients in the country (Grob 1991). Due to the restraints given with the census, researchers were confined to utilizing categories that could be easily checked off, with little room for explanation. This created a need for a distinctive nosology, and from this point onward, psychiatry began developing, and constantly updating, new classification systems for mental illness (Grob 1991).

As the United States returned from World War II, a major shift was occurring in the medical community. Unlike the cure-all tonics from years before, doctors were using the scientific method and advances in technology to find specific diseases, and equally specific treatments for them. The first volume of the Diagnostic and Statistical Manual for Mental Diseases (DSM-I) was published in 1952, the same year the first antipsychotic was developed, and contained 106 disorders (Grob 1991, Healy 1999). With each subsequent update, new research findings resulted in the addition and subtraction of various conditions and potential treatments. Though psychotherapy, electroshock therapy, and even neurosurgery were treatment options, the pharmaceutical remedies seemed to hold the most potential (Holtzheimer and Mayberg 2011).

Discovery and Evolution of Psychotropic Drugs

Early antidepressants were synthesized from antipsychotic medications devised for use with schizophrenics (Healy 1999). Chlorpromazine (Thorazine), the first of these antipsychotics, was used to treat the majority of patients in every asylum in the United States, and in 1955, Smith, Kline, & French (currently GlaxoSmithKline) made \$75 million from the drug (Healy 1999:46). The prospect of cashing in on the new market for psychopharmacology interested other prominent companies, and a new sense of urgency was given to the search for novel drugs. Initially, the medical community felt that the tranquilizing effects of these antipsychotics were beneficial in schizophrenics, but would have little application in treating depression or anxiety (Healy 1999). However, in a search for an antihistamine, a variation on Thorazine was synthesized that, upon further investigation, seemed to hold potential for treating depressive episodes. Imipramine (Tofranil) was a tricyclic antidepressant that was successful in relieving depression symptoms in 60% of patients, a statistic that remains the same for antidepressants in use today (Healy 1999, Holtzheimer and Mayberg 2011).

The creation of antidepressants is, in many respects, responsible for the conceptualization of depressive illness itself (Healy 1999, Pettus 2006). The psychiatric community, though familiar with the symptoms, had not conceived of the condition as a disease, but rather the result of environmental, social, and biological factors interacting to produce a disordered state (Grob 1991, Healy 1999). Those affected sought treatment very infrequently, due to the association between mental illness and full-fledged madness that was widely established. Because of this stigma, the percentage of the population

suffering from these disorders was not known, and certainly not speculated to the 17% that seek diagnosis today (Healy 1999, Pettus 2006). It was only upon the availability of a so-called ‘magic bullet’ remedy that psychiatrists began to consider depression as a biological disease, because the drugs revealed neurological factors that were previously unknown (Healy 1999).

Deinstitutionalization and Efficiency: Capitalism and Capsules

At the outset, the accessibility of these medications to the general public was relatively limited, as trials were conducted primarily in institutional facilities, especially in the antipsychotic studies of the 1950’s. Though institutions claimed that the vast majority of their residents were schizophrenic, the nosology of psychiatric diagnosis had not yet permeated these establishments fully, and many patients were actually suffering from mood or panic disorders (Healy 1999). The cost of keeping institutions for the mentally ill operational was extremely taxing to the United States’ budget, and Congress began investing in the development of psychiatric pharmaceuticals in the late 1950’s (Healy 1999). The grant entered the international scientific community through the National Institute of Health (NIH) under the guidance of a board consisting of an animal behavioral scientist, two pharmacologists, and a physiologist, but only one psychiatrist (Healy 1999:95). The ultimate goal was to discover a pharmaceutical treatment that would, ideally, allow for the increased functioning and, contiguously, independence of the mentally ill population in the United States.

The intentions behind this movement are noble in some respects; increased functionality from those with mental health problems would allow them to more fully

participate in society and would likely result in a substantial increase in the patient's quality of life. However, the influence of American capitalism cannot be ignored. The market economy relies on efficiency and cost reduction for increased profits that can be reinvested into future growth. The United States government, and that of any democratic capitalistic government, is run largely like a business, and requires trillions of dollars to operate and provide public services. It is also responsible for the safety of its citizens, who are additionally customers, and from this, a stark conflict of interest emerges (Pettus 2006). The initial investment from Congress, by way of its citizen's taxes, provided the psychiatric pharmacological community with funds to carry out the studies that resulted in the synthesis and testing of many of today's pharmaceutical treatment options for mental health disorders (Healy 1999).

The role of the American government in mental healthcare has sustained itself to the present day. Though mental healthcare has been deinstitutionalized, patients' access to care and treatment is still largely influenced by the location of government funds and support (Healy 1999, Pettus 2006). This involvement will increase substantially when President Obama's proposed health care plan becomes fully enacted and a greater portion of the population will be utilizing government-provided health insurance. Medicaid, government-provided health insurance for those citizens 65 and older, has already followed the prevailing trend in private insurance companies to push primary care physicians (not psychiatrists) towards handling mental health issues and prescribing medication in lieu of other, more costly treatment options like psychotherapy (Pettus 2006). The transfer of mental health patients from specialized therapists and psychiatrists

to primary-care physicians has resulted in a massive decrease in patients receiving an ‘acceptable standard of care’, down to 12.7 percent (Pettus 2006).

There can be positive effects from this, however. Many psychologists argue that this results in more patients seeking treatment that would otherwise not have seen a mental health professional (Marcus and Olfson 2010, Pettus 2006). This is reflected in current statistical data, showing an increase of over two million patients seeking outpatient treatment for depression in the United States in 2007 (Marcus and Olfson 2010). However, the quantity, not the quality, of the treatment is the focus here. Less specific treatment plans and shorter periods of patient-doctor communication may result in more people being diagnosed, but the quality of treatment those patients receive is decreasing, and the attention of physicians is shifting from those who are seriously mentally ill to those with minor disorders and intermittent symptoms (Pettus 2006).

The public is becoming increasingly familiar with psychiatric conditions. The World Health Organization, Center for Disease Control, and American media outlets have been more vocal about the prevalence and signs of these disorders, and more recently, advertisements for psychotropic drugs have appeared on cable television. Unlike alternative treatments, which cannot be advertised as distinct products in sixty-second sound bytes, pills can be marketed towards consumers in between segments of their favorite programs. Ads for antidepressants and anti-anxiety medications are also a source of information for the public and have been shown to affect perceptions of prevalence, lifetime risk, and treatment choice in both mentally ill and healthy members of the American population (An et al. 2009, Donohue et al. 2004, Park and Grow 2008).

THE ROLE OF ADVERTISING

The Federal Drug Administration (FDA) released guidelines for pharmaceutical direct-to-consumer (DTC) advertising in 1997 (Pettus 2006). This resulted in a massive surge in pharmaceutical company spending on ads, including those for psychiatric medications (Park and Grow 2001). By 2004, \$193 million had been spent on DTC ads for antidepressants alone (Pettus 2006: 90). Exposure to the television and print ads for these drugs has had profound effects on patients' perceptions of the prevalence of these disorders, the susceptibility of the population to them, and the likelihood of a patient to choose drug therapy over alternative treatments (An et al. 2009, Donohue et al. 2004, Park and Grow 2008).

Physicians are subject to advertising influence just as much as the general population. One study revealed that patients reporting symptoms of depression to their primary care physician will specifically request a brand of drug—and are very likely to get it (Pettus 2006). Even patients who reported some symptoms, but did not warrant a clinical diagnosis, were being prescribed psychotropic drugs (Pettus 2006).

Television and print are not the only types of marketing utilized by these companies. Representatives from drug corporations visit doctors and psychiatrists at their offices, often paying for lunch and always leaving free samples. Having access to free pills can sway the prescriber's choice of medication, which may mean a less specialized treatment plan for the patient (Pettus 2006). This is especially relevant when considering the last

decade's 150 percent increase in the number of mental health patients soliciting treatment from their family doctors (Pettus 2006:44).

These advertisements are not merely effective at selling drugs. They also serve to educate the public about the symptoms of the condition. On television, actors are used to illustrate the behaviors and thought patterns of someone with a depressive or anxiety disorder, prompting viewers to self-diagnose, and, talk to their doctors about the specified medication. However, these ads are short- around a minute- and filled with side effects which, in many cases, occupy over half of the total length of the commercial. This time restraint leaves very little room for actual information. A recent commercial for the antidepressant Cymbalta followed a dreary opening dialogue with a partial list of symptoms that only included sadness, loss of interest, and anxiety. These symptoms are among those most frequently reported by depression patients, but they are also natural responses to many of life's experiences, and are certainly not sufficient to diagnose an individual based on the standards for Major Depressive Disorder in the DSM-IV.

These advertisements also serve to guide public perception of MDD/GAD patients. A commercial for Wellbutrin XL emphasizes repeatedly that this antidepressant has a 'low risk of sexual side effects', which implies that others don't. From this, it could be inferred that many people on antidepressants suffer from sexual dysfunction or other sexual problems. Revealing a personal side effect such as this on cable television could result in stigmatization towards individuals taking these medications.

A study by An and colleagues (2009) revealed that college students which had no previous experience with depressive symptoms, either personally or through a friend or family member with depression, were more likely to have a positive opinion on

antidepressants as a treatment option after viewing DTC ads. This could result in these individuals seeking out antidepressants as a rapid fix for the everyday stresses of being a student (An et al. 2009). Several studies have shown that patients requesting antidepressants from their physicians were far more likely to receive the drugs, even in those where the condition was not severe enough to require them (An et al. 2009).

Park and Grow (2001) discovered a link between exposure to DTC antidepressant ads and personal beliefs about the risk and prevalence of depression, especially in men. Those who are familiar with DTC antidepressant commercials perceive the prevalence of depressive disorders as higher than it actually is (Park and Grow 2001). Males already felt their risk of developing depression in their lifetime was much greater than reality indicates, with those from the study reporting a perceived 32% risk compared with the well-documented 13% risk that has been found (Park and Grow 2001). One consequence of this is a rise in doctor's visits and prescription use in situations where neither are necessarily warranted, meaning higher healthcare costs and exposure to serious side effects that could otherwise be avoided.

Most critically, however, commercials and print ads for psychotropic drugs influence the choices of the consumer. Donohue et al. (2004) found that during periods of increased spending on DTC ads for antidepressants, there has been a corresponding increase in the number of depression patients seeking therapy with psychotropic drugs. Though this has positive implications and many individuals are helped by antidepressants, there is no room for evaluation or education regarding alternative treatments, such as psychotherapy, lifestyle changes, or even ECT, the most successful option for severe depression (Holtzheimer and Mayberg 2011). These methods are not

products that can be easily advertised, like pills. When this is considered in light of the shift of mental healthcare responsibility from a specialist to a primary care physician, it becomes apparent why such alternatives are falling by the wayside.

My research, and that of many others, has indicated that individuals with a MDD/GAD in the United States would benefit immensely from more specialized treatment plans, greater degree of choice in treatment options, and increased attention from medical professionals to the non-biological components of these disorders. Accomplishing these goals will require a greater degree of influence from the social science community to rebut the reductionist ideals that are gaining ground today (Martin 2000).

METHODS

After drafting in-depth interview questions (Appendix) and obtaining the approval of the Georgia State Institutional Review Board, I recruited participants for my study with flyers posted around the city of Atlanta and by word-of-mouth. To participate, an individual must have been over 18 years of age and have received a diagnosis of a major depressive disorder or generalized anxiety disorder by a licensed medical professional. Qualifications were evaluated on participant's answers and non-qualified respondents were not interviewed or compensated. For those that did qualify, a \$25 compensation was given following the interview. All participants signed an IRB-approved consent form prior to beginning the interview which provided for the recording of the session on my personal computer. Pseudonyms were assigned to all participants before the start of the

interview. Interview questions were asked as was relevant to the experiences of the participant, so interviews varied in length.

Seven women and three men, ranging from 18 to 54 years of age, were interviewed. Three were African-American and seven were Caucasian or Mixed European. Six suffered exclusively from depression, one from anxiety, and three participants had both.

RESULTS

Discussion of Results

Participant's responses to the interview topics were varied, but several commonalities were observed. The most pervasive theme was that of family history. Nine out of ten participants had at least one immediate family member who had been diagnosed with a depressive or anxiety disorder. Many individuals cited this as having a crucial role in their perceptions of themselves as they began experiencing symptoms. Though every participant was experiencing symptoms of their disorder at the time of interview, only six were seeking treatment of any kind. Three were using pharmaceutical therapy, two were engaging in psychotherapy, and one was utilizing over-the-counter supplements and lifestyle changes. Half of those interviewed had previously used one or more prescribed medications for treatment, but ceased due to negative side effects, inefficacy, or both. Two participants actively refused medication and felt that it was not an acceptable treatment option for them. Despite there being no interview questions regarding significant life trauma, seven participants openly mentioned a traumatic event or ongoing experience as being relevant to their condition in some way.

When considering the role of culture in these disorders, it is especially important to examine familial beliefs about mental health. Family acts as a vector to transfer cultural information through generations, and nine out of ten participants had an immediate family member who was diagnosed with a depressive or anxiety disorder. This statistic was the most prominent finding in my research, and leads me to hypothesize that although genetics may predispose people to these illnesses, family life and culture play a substantial role in treatment seeking, attitudes towards treatment, and the understanding of depressive and anxiety disorders.

Familial Behavior Patterns

This concept has been thoroughly documented and observed by the mental health community. Dickstein and colleagues (1999) discuss the role family storytelling holds in developing children's ideas about life experiences, social norms, and ultimately, the transmission of symptom sets and depressive behavioral tendencies in a family with at least one depressed parent. In their extensive review of relevant literature, Hozel et al. (2011) compiled a list of the most frequently documented risk factors for chronic depression, citing family history as the third most reported factor leading to the evolution of a depressive episode to a chronic depressive illness. Regarding anxiety disorders, Schrock and Woodruff-Borden (2010) explain the dynamic relationship between an anxious parent and anxious child, and map the interplay of behavioral patterns and authority in the development and understanding of symptoms by the child.

The ethnographic techniques utilized by anthropologists can yield a more complete picture of the critical role family plays in the evolution and acquisition of

cultural attitudes towards mental illness. Kleinman (1980:134), in his observations while conducting research in Taiwan, explains that the Taiwanese conceive of the family group as transcending the lives of the individuals within it. As such, the afflictions, including illness, that affect an individual radiate upon the entire family. Emotional expression is limited to within the family circle, the setting in which the most important relationships will be formed. These cultural beliefs rigidly structure the family dynamic and shape the behaviors and social patterns of the children. When applying this information to the illness experience of a Taiwanese young adult with a mental health disorder, the critical role of family in the potential diagnosis and treatment-seeking behavior is apparent. This is well-illustrated by Kleinman's description of the young Taiwanese man with anxiety due to compulsive masturbation mentioned previously. The patient's mother followed him to all of his doctor's appointments, meetings with traditional Chinese medicine practitioners, and finally, a visit with a monk, in a effort to guide her son to treatment for his embarrassing and stigmatized condition. This story reveals the degree of influence family beliefs and customs, in addition to relationships, can have on the illness experience of a young adult with a depressive or anxiety disorder.

Today's intensifying search for cures in the human genome has been inconclusive about the precise involvement of heredity and the development of depressive and anxiety disorders. A study in 2001 found that only 30% of the variance in the manifestation of anxiety disorders was accounted for by genetic factors (Schrock and Woodruff-Borden 2010). Pettus (2006) points out that the exact genes involved in the hereditary transmission of these disorders have not been located due to the immense complexity of the task.

My own research, as well as that of numerous members of the mental health and anthropological communities, has suggested another possible vector- that of family behavioral patterns- which may be just as influential in the development of these disorders. A parent, child, grandparent, or sibling with the symptoms of a MDD or GAD shares their attitudes and beliefs about their condition with the other members of the family. The readiness of children to emulate the behaviors of those they love and trust may lead to the development of similar behaviors in the child, making the transmission of these disorders appear more genetic than actual research has revealed. My findings, and those who have published previously on this topic, reflect the fact that behavioral tendencies within families can lead to a generational trend in the manifestation of these conditions.

Of the nine participants who had an immediate family member with a depressive or anxiety disorder, five were young adults (18-25) that experienced the first onset of symptoms in early to mid-childhood. When asked about the prevalence of these disorders within their families, and how this affected the experience of their own condition, each participant felt that the behaviors and attitudes of their depressed or anxious family members had an influence on their treatment choices and understanding of the condition.

Discussion of Interviews

Greg, 25, male

Greg was diagnosed with a depressive disorder in his early teens. Both parents and his only sibling, a brother, had also been diagnosed with a depressive or anxiety disorder and all were taking medication for the condition. Greg recognized many shared behaviors between himself and his parents, such as his pessimistic attitude, something he felt contributed to his depressive episodes.

“Growing up in a house with people that were depressed contributed to me becoming depressed. I learned their behaviors, I learned the things that they were doing, and I thought those things were normal, and I still struggle with those things. They’ve been naturalized, in a of lot ways. I have to make an extra effort to be reflexive in how I’m thinking and what I’m doing... and I see that in my mother, I see that in my father, and I definitely see in in my brother, those behaviors are definitely present.”

He explained that he was not surprised to find out that he had depression, but was instead surprised by the eagerness of his psychiatrist to prescribe medication.

“I was very resistant to the idea of taking medication, I recognized that I didn’t feel like I was normal, but the idea of taking medication, I felt, made me feel more abnormal. Something about the idea of taking medication really bothers me.”

His therapist and his parents encouraged him to try the antidepressants, and he took Effexor, Lexapro, and Wellbutrin, among others, over a period of his teen years. He

experienced serious side effects with no noticeable improvement. At one point, he decided to secretly stop taking his antidepressants, and had migraines for several months. It was only when he complained to his mother and mentioned that he had ceased taking the pills that she explained the serious potential for withdrawal complications that are associated with certain antidepressants. Greg mentioned that his therapist did not discuss potential side effects or withdrawal problems associated with any of the antidepressants.

His dissatisfaction with Western psychotherapy options led him to his own self-help treatment method, which included the occasional use of tryptophan, an essential amino acid, and rigorous daily exercise. Though he did see some improvement with these lifestyle changes, he still experienced episodes of severe depression that limited his ability to enact these changes.

When I asked him how he felt he developed this condition, he said that although he was not totally discordant with the biological model, he felt that, most importantly, "...it was being raised by people that suffered from the same things. I picked up their behaviors, I started to see the world the way they saw it." In addition, he felt himself personally responsible for his depression in some ways, and mentioned several ongoing traumatic experiences, including divorce and abuse, as part of his etiological beliefs.

Darrell, 21, male

Darrell was diagnosed with Generalized Anxiety Disorder and additionally suffering from a minor depressive episode. Unlike Greg, Darrell was diagnosed less than a year prior to my interview, and had not experimented with multiple treatment options.

His father had also been diagnosed, primarily with depression, but Darrell felt that his father concealed his disorder well.

“I’ve just got his traits, that’s it. It didn’t really affect me. Seeing him, it wasn’t really noticeable.”

He also noted that his family never had an open dialogue about the mental health conditions that affected them. It was handled as a private matter, and Darrell only discussed his symptoms with his psychiatrist. He does not participate in any talk therapy on a regular basis. His therapist did, however, mention some side effects and possible interactions when taking the drug. Darrell had previously engaged in binge drinking and partying on a regular basis, but when his psychiatrist told him to avoid alcohol consumption while taking the medication, he complied for the most part. He did feel improvement on the pills, saying that prior to beginning pharmaceutical treatment,

“I’ve been stressed since I can remember in life, just worrying about stuff constantly, stuff that may not even matter at all. I think I need to be on [the drugs].”

Darrell differs from Greg substantially. They suffer the symptoms of two different disorders, they have had opposite attitudes towards treatment paths, and they have extremely different life histories. However, both men saw a connection between their depressed or anxious family members and the development of their own disorders. Greg, whose parents were open and participatory in the early diagnosis and treatment process for their son, had an extended period to experiment with alternative treatments before ultimately rebelling against his parent’s beliefs and choosing his own methods. Darrell, however, did not have an open dialogue in his home about mental illness, despite his father having the condition for most of his adult life. His behavior patterns reflect this; he

spoke only with his psychiatrist, was diagnosed only after he sought medical attention for his own reasons, and remained relatively private about the disorder and his treatment with family and friends. This mimics the same behavior pattern of his father, illustrating the clear influence behavioral choices and family ideas regarding mental health can have on the treatment choices of young adult patients.

Alice, 24, female

Alice received her first diagnosis of depression in early childhood, during family therapy sessions. In the years following, she saw several psychiatrists, and was additionally diagnosed with GAD. Alice presents an especially interesting case in my research because she is adopted. Her adopted father was a physician and also suffered from severe depression, which ultimately resulted in him taking his own life. She believed her biological parents, though not officially diagnosed, to also suffer from depressive and anxiety disorders. Alice was on a variety of antidepressant and anti-anxiety drugs before ceasing this treatment option and choosing her current method of weekly psychotherapy sessions.

Alice's adopted parents aligned their mental health beliefs closely with today's Western medical standards, though her mother was generally opposed to psychotropic drugs. These beliefs were undoubtedly influenced by her father's career and his personal experiences with depression, and he was Alice's primary care doctor until his death. Following the loss of her father, she was encouraged to begin seeing a psychiatrist, who immediately insisted that she be on medication, despite her and her mother's reservations. Her first prescription, unbeknownst to her, was for Risperidone, an antipsychotic used in

schizophrenics, though she was not, and has never, experienced any of the symptoms of schizophrenia, and would have been extremely young (at 15) for the average age of onset of this disorder. The medication did not relieve any of her symptoms and she suffered serious side effects, so she researched the pills on the Internet and discovered their intended use. When confronted about this, her psychiatrist switched her to an antidepressant, followed by another, and finally an anti-anxiety medication, over a one-year period. She felt no marked improvement on any of the pills, and has not taken any since.

Despite her immersion in Western psychiatry and pharmacology, Alice has developed her own etiological model for mental disorders that is a combination of beliefs from several perspectives.

“[Genetics] are important, I think, to a degree. I know a lot of people in my (biological) family have struggled with depression... but I don't see it like “Stop Depression!” in the way you stop heart disease, or something. And I don't think of depression as being much of a disease, I think it's a state of mind you get into from time to time.”

Alice's adopted mother and biological father share this idea, though to a more exaggerated degree. Her biological father doesn't feel that the disorder warrants any treatment, including psychotherapy, and has been disapproving of her continuing to seek this treatment method. Her mother, however, has become more supportive, and was pleased that Alice was still seeking treatment after discontinuing her pharmaceutical use. She explained that her mom noticed the improvement in her mood and behavior after

stopping the medication, although, like Greg, she did this without her parent's knowledge, running the risk for withdrawal complications.

MJ, 22, female

MJ, like Alice, has been diagnosed with depression and anxiety, and has a father employed in the medical industry. However, their attitudes towards mental illness and the treatment of it differ on many accounts. MJ's parents have been diagnosed with depression and both take antidepressants to alleviate the symptoms. She was diagnosed in early childhood and has been on psychotropic medications periodically with differing degrees of effectiveness. She is currently taking Zoloft, which is designed to treat the symptoms of both disorders, and participating in psychotherapy sessions with positive results.

Though MJ and Alice were both raised in households that subscribed primarily to Western psychiatric models, it is important to note that the ideology of their mothers differ significantly. MJ's mother has been diagnosed with depression and is treating it with medication, whereas Alice's mother has never been diagnosed and is opposed to psychotropic medications. MJ explained that her mother's disorder had a notable impact on the initial manifestation of her own anxiety symptoms.

"It kind of sparked for me when my mom was really stressed out. My dad was living in Atlanta, and we were in Wisconsin, and she was trying to sell her business. I fed off her stress, I guess, and that's when I started getting the anxiety."

MJ explained that her depression symptoms began in early high school. She had also been diagnosed with Attention Deficit Disorder (ADD) and dyslexia, and she felt

that these conditions inhibited her performance in school. Her difficulties in class discouraged her, and she sought relief from the resulting depressive symptoms with her psychiatrist. He prescribed Wellbutrin XL but it exacerbated her anxiety, and he later switched her to Zoloft, which she uses today with more success.

MJ added that she felt her experience with mental illness was greatly improved by her family's openness about their own experiences.

“[My parents] understand. They help me cope with [my anxiety] and help me identify it. It was easier, actually, than I think it is for most people, because I understood what was going on.”

This open dialogue, a product of her parents' conditions and their ideological beliefs about the etiology and treatment of those conditions, was highly influential on MJ's illness experience. Her early diagnosis can be attributed to her parents' awareness of mental health issues, making them perceptive, and perhaps even anticipatory, to the manifestation of symptoms in their daughter. Parents with alternative concepts of mental health who have not directly suffered from a disorder themselves, such as Alice's mother, may be less likely to recognize the symptoms in their children, and thus be less participatory in the diagnosis and treatment process.

Stella, 22, female

Stella has been diagnosed with an anxiety disorder, major depression, and another psychological condition that she could not recall, explaining that she did not feel it was a valid assessment. She began experiencing symptoms tAt the time of the interview, she was experiencing some depression symptoms but her anxiety had largely resolved. Her

father had been suffering from severe depression for the majority of his life and was treating it effectively with antidepressants for many years. However, Stella did not feel that her family was very open about their shared mental health problems, and was only made aware of her father's condition when she asked to see a therapist to alleviate her own symptoms.

“We didn't really talk about it in my family... It was only after [I asked to see a therapist] that he said, ‘Okay, this runs in our family, I've been going through this my whole life’, and *then* we started talking about it.”

Her initial experiences in psychological treatment only utilized psychotherapy, but after being referred to a psychiatrist from her therapist was she told she needed medication. Her new psychiatrist was not open to discussing other treatment options, and her father also encouraged her to try antidepressants, as they had successfully treated his condition. She was concerned about some of the serious side effects that she had heard about, but her doctor insisted she try the medication and that Stella could call her if she experienced suicidal thoughts or anxiety attacks. Reluctantly, she tried three different psychotropic drugs and with varying degrees of relief and many adverse side effects, including exacerbation of her original symptoms.

When she asked to change her medication, her psychiatrist insisted that she be patient and give the drug a little more time to take effect. Stella waited, but the side effects worsened. She was having a very difficult time finding the motivation to complete daily tasks, saying, “It was like, I don't leave the house, I don't get dressed, I don't make food, I don't want to talk to anybody, I don't want to take this [drug] anymore.” Her psychiatrist allowed her to cease the treatment, but said that she must take prescription

medication or she would be unable to manage her emotions and relationships effectively. Stella disagreed, and discontinued seeing that psychiatrist after that time. She has not taken medication for her symptoms since then, and explained that she did not believe her condition was severe enough to warrant the risk involved with psychotropic drugs.

Though her father had taken antidepressants for an extended period, her mother was critical of her condition. Stella felt that both of her parent's beliefs were too extreme, so she instead adapted her own ideological constructs of her mental health to be somewhere in the middle.

“My mom is the opposite of my dad. She's like, ‘That's bullshit, you're not depressed, if you're sad, do something about it. You don't need pills,’ and then my dad is like, ‘It's a condition, you have to take pills for it, there's nothing you can do, you just have to take pills for it.’. They're polar opposites, but I'm neither.”

Stella is distinct from MJ and Alice in that she was diagnosed in her late teen years and pursued treatment independently of her parents. Similarly, Greg, whose parents were vocal about their mental health problems, was diagnosed at a young age; comparing this to Darrell, whose father kept his own condition private, leaving Darrell to seek treatment later in life. My research, though limited in scope, does provide evidence of a clear association between parental candor in the discussion of family mental health experiences and the early diagnosis and aggressive treatment of these disorders in their children.

Findings

The five participants discussed above do possess commonalities- they all had parents with a depressive or anxiety disorder in their childhood homes, and all, in turn, had experienced onset of these disorders in themselves. However, the variations in parent's behavioral patterns were seen to be highly influential on the recognition and treatment of these disorders in their children. Children whose parents were open with them about their depression or anxiety were diagnosed at an earlier age than those whose parents kept their symptoms private.

In the sample discussed, there was also a notable parallel between the symptomatic parent's experiences with pharmaceutical therapy and the beliefs of the child towards these treatment options. MJ, whose parents both had positive experiences with medication, was open to this type of treatment and felt it was effective. Conversely, Greg, who observed the negative effects of antidepressants in his parents and experienced similar effects in his own treatment, was dissatisfied with pills as a treatment method. This trend was also present with Darrell, and somewhat in Stella, who first aligned with her father's perspective, but later found herself in agreement with her mother and ceased taking her medication.

Another point of considerable relevance is the general dissatisfaction of the participants with pharmaceutical treatment options. Of the ten total interviewed, seven had a negative attitude towards antidepressants or anti-anxiety medications. Out of the five highlighted above, only one was currently using prescription drugs with success. All of the young adults in the study were offered pharmaceutical therapy as the primary

recommended treatment choice by their doctors. Yet this is did not appear to be satisfactory, as forty percent of total participants were not currently seeking treatment of any kind at the time of interview. This indicates a need for a more case-specific treatment plan, where a specialist in mental health considers the full illness experience of the patient, as described by Kleinman (1989). This includes further investigation into family history, with special attention paid to etiological beliefs, family transparency and openness about mental health issues, and familial attitudes about appropriate treatment options. Gathering this additional information would allow for the open line of communication between patient and practitioner that is crucial to the safe and effective management of these disorders.

The utilization of more specific treatment plans would require the employment of a greater variety of treatment choices. Currently, antidepressants are used to treat approximately 75% of outpatient depression cases (Marcus and Olfson 2010). Intercultural differences in the manifestation, symptomatology, and etiological concepts regarding mental illness have been well documented, and the complexity that is intrinsically associated with emotional disorders merits increased diversity in treatment options (Kleinman 1980,1988; Pettus 2006). The two most dominant forms of treatment for depressive and anxiety conditions in biomedicine, psychotherapy and psychotropic medication, are only effective at relieving symptoms in 60% of patients (Healy 1999, Marcus and Olfson 2010). This further reiterates the need for more research in, and application of, alternative treatment plans.

THEORETICAL ANALYSIS

In the Epilogue of *Culture and Depression* (1985), Kleinman and Good compile a set of guidelines for the continued research on affective disorders from a multidisciplinary perspective. Of the seven areas that warrant further investigation, two were especially fundamental in the formulation of my research model. The authors describe a need for more in-depth study of the role that local power dynamics, from massive political entities to the rules of family and social interactions, play in the experience of depression symptoms and treatment (Kleinman and Good 1985:499). They also reiterate the necessity for deeper analysis of the suitability of psychiatric categories and diagnostic criteria for the understanding and treatment of affective disorders in other cultures (Kleinman and Good 1985: 497-8).

It is with these principles that I structured my endeavors. I sought to utilize Kleinman's (1988) definitive model of the illness experience as the most appropriate tool for gathering significant qualitative data to address these questions from the anthropological perspective. The ethnographic techniques he employed in his assessment of chronic pain patients are indeed applicable in both the medical and social science communities; they enable researchers to acquire a thorough representation of all elements of life, from family relationships to employment status, and their effects on the symptomatology, progression, and outcome of lifelong health conditions (Kleinman 1988).

When engaging in a multidisciplinary study of this nature, it is critical to draw influence from several perspectives. Lawrence Kirmeyer (2001) has also analyzed the

indubitable place of culture in the development of affective disorders, but through the psychological lens. He challenges researchers and practitioners to assess the current methods of diagnosis and treatment, and argues that the employment of a more personal, investigative diagnostic and treatment process, similar to Kleinman's (1988) illness experience, would result in a dramatic increase in the effectiveness and adherence to treatment plans. The responses of my participants clearly indicate a desire for this approach in the current mental healthcare system.

Kirmeyer (2001) also stresses the importance of the structure of the healthcare system itself. The present reality for mental health patients in the United States is a limited scope of treatment options, often with expensive price tags and serious side effects (Healy 1999, Pettus 2006). Our busy lifestyles limit the opportunity for alternative treatments that are more longitudinal, and thus time-consuming, such as psychotherapy, exercise, or even hobbies and pastimes that provide respite and distraction from the daily stress of careers, family, and relationships. The healthcare system is, of course, a cultural product, based on the American ideals of efficiency, independence, and cost-effectiveness (Healy 1999). Yet this cultural product shapes, as Kirmeyer (2001) explains, the attitudes of those within it towards available treatment options, prevalence, and even the manifestation of a describable symptom set. The limitations this imposes on those with affective disorders were echoed in my study, with many participants expressing dissatisfaction with the current system and a desire for greater variability in their management of the disorder.

Martin (2000) and Healy (1999) suggest a significant cultural factor that must be given further consideration regarding the continuation of research on this topic. The

economic system of contemporary American capitalism was directly responsible for the initial investment in psychopharmacological research. The evidence of the further involvement of the American government in the testing and marketing of these medications is reflected in my analysis on advertisements and their role in the perceptions the population has towards the symptoms, etiology, and treatment of affective disorders. In addition, Martin (2000) discusses the development of modern American citizens as ‘mini corporations’ and the parallel cultural desire for accomplishment and personal investment. This concept, she suggests, could spark dramatic social change when coupled with the dogma that behavior is dictated exclusively by neurological exchange.

Martin (2000) also raises awareness of a critical issue- the reductionist ideology that reduces human behavior to chemical process is a considerable threat to anthropological contributions on the further research of affective disorders.

“As a discipline, cultural anthropology is threatened by the move to neuroreductionism because whole chunks of our sister disciplines... are operating on models that ignore the social dimensions of experience. We will not be called on as experts in those fields.”

We cannot permit the exclusion of such vital cultural information in further research. It is essential that anthropologists incorporate our skills of ethnographic research and the significant qualitative data that is required for a thorough and holistic understanding of these disorders. This does not, however, permit us as anthropologists to succumb to the same mistake. We cannot disregard the valid contributions that neuroscience, psychology, and psychiatry can make to developing additional knowledge on a meaningful etiological model.

This is precisely why a more applied form of anthropology is essential to catalyzing real social change for mental health patients and their families. We must maintain our theoretical potency while still utilizing our results to benefit the population that is so greatly in need of diversification and alternative perspectives in the mental healthcare system. The suggestions made by Barbara Ryklo-Bauer and colleagues (2006) call for pragmatic engagement of the discipline into relevant and pressing social issues. This desire to educate ourselves and the public has always been a guiding lamp for our research goals, but today this lamp must increase with intensity. There is always more to learn, and there is little concern that the sanctity of academia will be overthrown. Yet with the exponential expansion and intermingling of so many distinct cultures, and the dominance of so few, anthropologists must now focus on marrying our theoretical foundations with the positive and culturally-informed social change that is essential to addressing the societal problems and global conflicts of our time.

CONCLUSIONS AND IMPLICATIONS FOR FURTHER RESEARCH

This study was constrained by the nature of the project. Given the financial and temporal impediments to the use of a larger sample, I chose instead to conduct in-depth, one-on-one interviews that were structured more casually to allow for better dialogue and a comfortable environment. Participants were encouraged to discuss any details that they felt were relevant to their experience, thus forming a more complete narrative of their disorder. This resulted in dense and highly informative qualitative data. Acquiring a thorough picture for a smaller number of individuals assists in the discovery of intricate differences between patients that have a significant impact on the final outcome of their

disorders (Kleinman 1989). These intricacies are frequently missed in the massive statistical surveys associated with biomedical research, but are critical to the successful treatment of mental health conditions (Kirmeyer 2001, Kleinman 1988).

Despite the limitations upon the scope of this research, my findings indicate the need for further investigation into the relationship between family behavioral tendencies, thought patterns, parenting methods, and the manifestation of depressive or anxiety disorders in children living with a disordered parent. The preliminary results of this study suggest there is an association between parents' openness to discussion of their condition and the age of diagnosis and onset of symptoms. Continuing research on this could indicate the need for a dialogue with parent and psychiatrist about positive ways to explain mental health issues to children, when it is necessary to seek medical attention for potential symptoms in children, and discussion of alternative therapies.

Paramount to the continuation of research on the interaction between culture and psychological illness is the application of the knowledge that has already been acquired by members of the anthropological, sociological, and psychological communities. The authors cited in this analysis are but a few of those who have published extensively on this topic. The goal of medical anthropologists continuing this field of study should therefore evolve into a harmony of extensive ethnography and practical implementation of data collected to the advantage of the population.

Barbara Ryklo-Bauer and colleagues (2006) argue that it is critical for anthropology to maintain relevance in the cultural problems of today, a principle called pragmatic engagement. They propose a merger of sorts between theoretical anthropology and applied anthropology, where each subfield contributes its strengths to the benefit of

the group in need (Ryklo-Bauer et al. 2006). “A meaningful convergence of methodologically-sound, critical, reflexive, and engaged anthropology... will free us up to focus on differences that actually do matter in the real world... (Ryklo-Bauer et al. 2006:187). This approach preserves the scientific integrity of the discipline while still translating data into observable improvements for those whose needs are revealed through thorough ethnographic research, and it is precisely this approach that will ultimately result in increased standards of care and a greater range of treatment options for depressive and anxiety patients.

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APPENDIX: Interview Questions

- What is your age?
- What culture(s) or ethnicity(ies) do you consider yourself a part of?
- Does anyone in your family suffer from a depressive or anxiety disorder?
- If yes, have they been diagnosed by a licensed professional?
- If yes, are they seeking treatment for the condition, and if so, what kind?
- If yes, how has this affected you personally?
- Do you have any ideas about your family's attitudes or beliefs about mental illness?
- If so, what are they?
- Do you think these beliefs are specific to your family or to other families with a similar cultural background that you know of?
- How did the official diagnosis of your condition affect you and your daily life?
- Did it change your perceptions of yourself? In what ways?
- Did it affect the way you interact with those around you? If so, how?
- Are you seeking treatment of any kind? If so, please describe.
- How and why did you choose this treatment option (if you chose it)?
- If someone else made the initial treatment option for you (a relative, for example), who was it?
- What role, if any, do other family members have in your treatment decisions?
- Did you (or your family) consider other options?
- Are you happy with your choice of treatment?
- Do you find it to be effective?
- Are you taking a prescription medication for this condition?
- If yes, what do you know about this medication?
- What did your doctor tell you about the medication?
- Did you do any research of your own about the medication?
- Did your doctor suggest the medication or did you request it?
- Did you see any advertisements about the medication?
- How do you feel you developed this condition?
- Do you think genetics are important?
- Do you ever feel responsible in some way for your condition?
- Do you feel that others are responsible in any way?
- Do you think that your illness could have been prevented?
- Have you experienced any stigma or preconceptions because of your condition among family members? friends? People at work? Others?
- If so, can you give some examples?
- Do you tell other people about your condition?
- Who do you tell or not tell, and why?
- Did you have any preconceived ideas about these conditions prior to your diagnosis?
- If yes, what were they? Have they changed? How so?

Do you feel that your ethnic or cultural identity has influenced your experience of your illness and its treatment?

Do you feel that your socioeconomic class or status has affected your experience with depression and anxiety, and if so, how?