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THE ROLE OF CULTURE IN THE DEVELOPMENT OF PARANOID SYMPTOMATOLOGY

Christina E. Newhill, Ph.D.

The impact and role of cultural factors in the development of paranoid symptomatology are explored and illustrated by clinical vignettes. General principles of intervention, with emphasis on cultural sensitivity, are discussed and suggestions for improving mental health services to a multicultural clientele are proposed.

Demographic trends noted since 1980 clearly suggest that the population in many parts of the United States is changing radically from primarily white to primarily nonwhite. For example, recent research by Policy Analysis for California Education *(Guthrie & Kirst, 1989)* has shown that, at present, one out of six California schoolchildren is an immigrant and one out of four has a primary language other than English. By the year 2000, 58% of California's children will be nonwhite and only 42% will be white. The projected ethnic breakdown of this nonwhite population is 62% Hispanic, 22% Asian, and 16% black. In the U.S. as a whole, the proportion of whites is expected to decline from its current level of 85% to about 77% by the year 2040 *(McLeod, 1989)*. The number of Hispanics, alone, in the U.S. has increased by 34% since 1980 to a current total of 20 million *(Valdivieso & Davis, 1988)*.

These demographic changes challenge U.S. policy makers in every arena, but significant to this article is the impact of these changes on mental health services. A major issue for many of the recent Hispanic and Asian immigrants is that they suffer disadvantages that their earlier counterparts did not. For example, many recent Asian immigrants are from war-torn countries such as Laos and Cambodia. Such individuals often suffer from post-traumatic stress due to war, they face tremendous cultural changes, and they are from poorer and less educated backgrounds than many previous Asian immigrants. Central American refugees suffer similar disadvantages, and Hispanic immigrants overall have long been handicapped by low levels of education and ethnic discrimination *(Valdivieso & Davis, 1988)*. Low socioeconomic status (SES), the stresses of immigration, and the general disadvantages associated with minority status are significant issues in understanding the mental health concerns of these groups. This article will address these issues by focusing on one psychiatric category, the paranoid disorders, and on the ways in which cultural and societal forces shape the development and manifestation of paranoid illnesses. Case examples from the author's practice are included for clinical illustration, and implications for mental health professionals' training and intervention strategies are discussed.

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SOCIOECONOMIC STATUS

Dohrenwend and Dohrenwend *(1974)* reported that the most consistent result found in analyses of social class and mental illness was an inverse relationship between overall rates of psychopathology and social class. Faris and Dunham's *(1939)* classic study of the ecology of psychiatric disorder in Chicago produced results demonstrating that the rates of first admission to hospital for most psychoses, including schizophrenia, were highest in the central slum sections of the city and decreased steadily as the well-to-do suburban areas were approached.

It is not uncommon for the expression of paranoid beliefs to be rooted in socioeconomic quality-of-life issues rather than in individual psychopathology. Mirowsky *(1985)* theorized that paranoid beliefs are often adaptive mechanisms to cope with the constant threat and danger inherent in the life experiences of those persons of low SES. Many studies have shown that such people are much more likely to be victims of personal crime, e.g. purse-snatching, assault, robbery, and rape *(Hindelang, Gottfredson & Garafalo 1978; Parisi, Gottfredson, Hindelang, & Flanagan, 1979).*

The realistic appraisal and response to the common fears of everyday life by those of lower SES may eventually be the development of paranoid mistrust as a common element in interpersonal relations. Mistrust as an adaptive mechanism is often found where opportunities and resources are scarce, where protection by social institutions and agencies is weak, and where exploitation and victimization are common. In such situations, mistrust and the development of paranoid beliefs can be rational responses toward the world *(Mirowsky, 1985).*

HEALTHY CULTURAL PARANOIA

The concept of "healthy cultural paranoia" as an adaptive mechanism for coping with a life that is plagued by prejudice and discrimination must be differentiated from paranoia as a functional illness. As an anthropological term, culture may be defined as:

> The categories, plans and rules people use to interpret their world and act purposefully within it . . . the grammar used to construct and interpret behavior. Culture is learned as children grow up in society . . . Culture is a plan for behavior, not behavior itself. *(Spradley & McCurdy, 1974, p. 2).*

An illustration of healthy cultural paranoia lies close to hand: the socialization of blacks in the United States provides a primary etiology for such a development. Grier & Cobbs *(1968)* asserted that the black person's response to an oppressive environment must be a self-protective, defensive stance so as to avoid the pain that would otherwise be inevitable. A common result of viewing every white person as a potential enemy and every social system as adversarial is a reluctance on the part of blacks to engage in personal self-disclosure that would reveal their inner psychological world and thus leave them open to ridicule, humiliation, and disparagement *(Ridley, 1984).* It should be remembered, however, that the notion of racism as inherent solely in black-white relations is simplistic; racism is ubiquitous enough to cause hostility between minority groups, also.

Although self-protective defensiveness on the part of blacks can be an effective shield, it may be perceived by others, especially nonblacks, simply as paranoid behavior. For example, Triandis et al. *(1976)* conceptualized self-protective defensiveness as "ecosystem distrust," a syndrome characterized by lack of trust in other people, suspicion of the motives of others, uncertainty about the sequence of events, a sense of individual powerlessness, and sense that caution is necessary to avoid trouble.

A close examination of these characteristics reveals clear correspondence to the classic characteristics of a clinically paranoid style of functioning. Lack of trust in others and suspicion of their motives correspond to paranoid suspiciousness and mistrust. Uncertainty and a sense of individual

powerlessness correspond to the paranoid fear of loss of autonomy. The need for caution reflects suspiciousness and corresponds to the paranoid need for constant mobilization against perceived threat. On the surface, therefore, a black person experiencing eco-system distrust can appear to be suffering from functional paranoia. Without further data, it could be impossible to tell the difference. Therefore, differential diagnosis must address the following issues: the person's etiology in several areas (physical, social, cultural) to determine whether the paranoid behavior is based on an adaptive adjustment (e.g., suspicion as a healthy psychological reaction to reality-based racism) or whether pathology is present; and the role that the paranoid beliefs play in the individual's psychic economy (e.g., serving to ward off psychotic decompensation). Effective differential diagnosis between functional paranoia and cultural paranoia is essential; otherwise, true paranoid illness may be minimized or a healthy cultural adaptation mislabeled as psychopathology.

The following vignette illustrates how healthy cultural paranoia and functional paranoid illness can coexist in the same individual. In this case, both client and therapist struggled to overcome two major obstacles to establishing a positive therapeutic relationship: the black male client's mistrust of the therapist because she was female and white; and his general mistrust of the therapist as a function of his paranoid psychopathology, unrelated to issues of gender and race. Although some trust was eventually established, the client's double mistrust forced him to create a safe distance by moving from a face-to-face interaction with the therapist to irregular telephone interactions which severely limited the therapist's ability to help him.

Case 1

Mr. B, a 33-year-old married black railroad engineer, walked into the psychiatric emergency service to request "legal advice." He was neatly attired, polite, but very guarded with the evaluator. He asked to speak with a black male doctor but, since none was available, he reluctantly agreed to talk with a triage clinician. The clinician was a white, female clinical social worker. Initially, he told the social worker that he wanted legal advice to help him pursue a complaint of racial discrimination. He explained that he had come to the conclusion that the management of the railroad company for which he worked had a conspiracy of prejudice against him because of his color, since all his white colleagues had succeeded over the years in securing promotions while he was continually passed over. The clinician perceived this as a reasonable conclusion in light of the facts and of her awareness of racial prejudice in this country. However, she was curious about Mr. B's choice of a psychiatric emergency service for legal advice. He was visibly uncomfortable with the question and again asked if a black clinician were available. When told that no black clinicians were employed by the emergency service, he decided to go ahead anyway.

In a very guarded manner, Mr. B stated that he had with him substantial evidence that his wife had been having affairs with several men, both black and white. His suspicions had begun two years ago when he found a business card with a man's name on it in his wife's purse. Immediately, he accused her of having an affair, which she denied. Over the ensuing months he continued to collect more "evidence." This included shopping lists proving, he claimed, that his wife was meeting her lover at the local grocery store, books of matches "proving" they had been at a motel together, and some blurred photographs of streets and buildings he claimed as clear evidence but which, when examined by the clinician, showed nothing overt. Mr. B felt he had reached a point at which, if his wife would not admit her infidelities, he was going to have to kill her. The situation was compounded by the fact that the white men of whom he was suspicious were his work colleagues. Remarkably, during all this time he had maintained a good work record and had avoided any overt conflict with his fellow workers. Mr. B exhibited no schizophrenic or affective symptoms but was clearly very suspicious and angry about both the racial discrimination issue and his wife's suspected infidelity.

The clinician concluded, after a thorough diagnostic assessment, that Mr. B's complaint of racial discrimination was probably based in reality and should be pursued via legal channels. This did not appear to be true of his complaints about his wife, whom the clinician called to give warning of Mr. B's threats, in accordance with the Tarasoff mandate *(Tarasoff v. Regents of the University of California, 1976)*. During their conversation, Mrs. B was adamant that she was not now, nor had ever been, involved with other men; she was, she said, at her wits' end with her husband's threats and accusations. The clinician concluded that

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Mr. B was experiencing both a functional paranoid reaction, in terms of his suspicions about his wife, and a healthy cultural paranoia in terms of his perceptions about his job situation. After referring him to an affirmative action complaint board for the job-related problems, the clinician worked with Mr. and Mrs. B on resolving their conflict, including his suspicions of her infidelity. This short-term intervention consisted of two sessions at the clinic, at which time the clinician was able to convince Mr. B to see the psychiatrist and take some antipsychotic medication. Subsequently, however, he refused to return to the clinic because he didn't like the side effects of the medication, although he did contact the clinician from time to time by telephone. At last contact, he told her that his homicidal urges had retreated and that, although he could not give up the suspicions about his wife, he had "learned to live with it."

In this case, the lack of availability of a clinician of the same race and gender as the client may have been a factor in the client's failure to follow through with more than two clinic sessions. Another factor was the resistance to intervention characteristic of paranoid clients in general, irrespective of race or gender. In spite of these obstacles, the clinician was able to sort out accurately the difference between the paranoid symptoms that were based on reality and those that represented psychopathology. Furthermore, she allowed the client to pull back to the distance he required to continue the contact (telephone vs face-to-face) without pushing or rejecting him, and this had some positive results inasmuch as his homicidal urges eventually went into remission.

CULTURAL FACTORS

Although the major mental disorders such as the paranoid disorders appear to be a universal phenomenon, there are some syndromes that are culture-specific and, within diagnostic categories, their symptoms may be culturally influenced. Clinicians encountering patients from other cultures often have difficulty distinguishing culturally acceptable ideas and behavior from psychopathology. A major issue for differential diagnosis is whether the patient can distinguish the boundaries of fantasy and reality and whether the patient can understand the limits within which culturally meaningful symbols and behavior are meant to operate *(Nash, 1983)*. Even if the thought content is comprehensible, mental illness is indicated if the cultural beliefs are used in idiosyncratic, exaggerated, or inappropriate ways within the interpretive context of that particular culture.

Salzman *(1960)* emphasized that delusions often represent those areas that reflect the patient's greatest source or lack of esteem, depending on the individual's own culture and value system. For example, in a family that values good works, the expression of paranoid grandiosity may involve the pursuit of total religious devotion, with delusions revolving around interferences with the fulfillment of such goals. If the patient's culture glorifies machismo as a desirable male ideal, paranoid grandiosity may be expressed in terms of success in sexual pursuits and paranoid delusions are likely to contain fears of homosexual assault by others *(Salzman, 1960)*.

The literature on culture-specific paranoia discusses five distinct syndromes: amok *(Swanson, Bohnert, & Smith, 1970)*, Witico psychosis *(Cooper, 1933; Nash, 1983)*, voodoo death *(Cannon, 1942; Richter, 1957)*, Puerto Rican Syndrome *(Mehlman, 1961; Ramirez, et al., 1956)*, and nightmare death in Southeast Asian refugees *(Tobin & Friedman, 1983)*. It is beyond the scope of this article to address all these syndromes in detail; therefore, only voodoo death will be briefly examined via a case illustration.

In a recent study, Ndetei *(1986)* reported that evil spirits, witchcraft, voodoo, and magic are common sources of imagined injury, particularly within African, Jamaican, and other Caribbean cultures. Voodoo death may be viewed as a cultural construct based on the belief that one person can possess the power to inflict mortal harm on another by magic *(Nash, 1983)*. What physiological reaction actually causes the death has been the subject of much speculation. Cannon *(1942)*, after observing several voodoo

deaths in Australia, Haiti, and South America, concluded that a sustained excess of adrenalin produced by fear in the victim caused a fatal state of shock. Richter *(1957)* theorized that such deaths are caused by vagal overstimulation. Whatever the physical result is, however, the trigger appears to be a total belief in the power of the magic to kill. Cases of voodoo death constitute clear demonstrations of how a paranoid mode of reaction can be detrimental rather than adaptive.

The following case describes a man's paranoid reaction following a voodoo death curse within a cultural context which granted voodoo the power to cause human death. His wife's reaction to the curse was similarly paranoid, and eventually a *folie a deux* developed. A central clinical issue was to determine where the cultural construct ended and the psychopathology began.

Case 2

Mr. and Mrs. A, a young Jamaican couple who had recently emigrated from their native country to the United States, were brought to the emergency room by the police after Mr. A had been arrested for setting fire to some homemade "dolls" in his yard. The police initially suspected arson as the motive, but after interviewing Mr. and Mrs. A, they decided that psychiatric intervention was necessary. Upon evaluation, both Mr. and Mrs. A presented as grossly delusional and fearful.

The social worker succeeded in calming them somewhat, and Mrs. A reported that, six months before, a witchdoctor in Jamaica had placed a voodoo curse on her husband. He had immediately become very sick, confiding to his brother that he felt that his penis was shrinking and his strength was draining out of his body. In spite of his sickness, his wife was able, with family help, to move her husband with her to San Francisco. The family assured them that the magic could not follow them so far, particularly over water. However, although her husband initially felt some relief, he soon became convinced that the witchdoctor's magic had followed them and that he would soon die. He had burned the dolls in an effort to repel the power of the magic. By now, Mrs. A was convinced that she, too, would die from the power of the magic. The couple remained so terrified and agitated that both required immediate admission to the local psychiatric inpatient unit. Separated from her husband, Mrs. A's psychotic symptoms cleared rapidly. Mr. A, however, remained acutely paranoid.

Death by voodoo curse was an accepted cultural belief in Mr. A's community. The fact that he experienced the curse as a feeling that his penis was shrinking and his strength was draining out of his body was unique to his particular psychodynamics. The curse itself did not specify this reaction. Once Mrs. A had stabilized, she told the crisis social worker that Mr. A had always prided himself on his strength and virility. To lose these would be a loss of one of his greatest areas of self-esteem.

This case had the additional facet of being a *folie a deux*. The recognition of this was essential in determining the best initial intervention, e.g. separating the two spouses. In *folie a deux*, or shared paranoid disorder per *DSM-III-R (American Psychiatric Association, 1987)*, one of the two persons is a dominant paranoiac with fixed delusions (Mr. A) and the other is a dependent suggestible person who adopts the delusional beliefs when the two are together but readily gives them up upon intervention and separation (Mrs. A). After stabilizing, Mrs. A admitted to the crisis social worker that she had no reason for feeling that she was going to die, since the curse had been placed only on her husband and, according to her own beliefs, curses do not spread to others. It is here that the cultural construct no longer applied, rendering her paranoid symptoms a function of her partnership in the *folie a deux*. The major clue was Mrs. A's admission that her former delusion of sharing the curse was not in accordance with her culture's belief system regarding voodoo.

In light of our knowledge of voodoo death, it can be speculated that, if no intervention had occurred and Mr. A's extreme fear of the voodoo curse had escalated, he would probably have died. At discharge, Mrs. A was completely stabilized but Mr. A still retained much suspiciousness and anxiety. Soon afterward, Mr. and Mrs. A moved away, presumably in another attempt to escape the curse, and were not heard of again.

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IMMIGRATION

Paranoid psychopathology has commonly been associated with the stresses of immigration. Linguistic barriers, problems with acculturation and assimilation, prejudice, and unfulfilled expectations are some of the commonly cited influential factors *(Ndetei, 1986; Rack, 1982)*. The question that now emerges is whether the available empirical research supports such assumptions.

Carpenter and Brockington *(1980)* compared the first admission rates to psychiatric care for three groups of immigrants living in Manchester, England, with those of white British natives. The results of the study showed consistently higher rates for all three groups of immigrants in comparison to the control group. The immigrant groups were more likely to be diagnosed as schizophrenic with delusions of persecution, while the British patients were more likely to be diagnosed as depressive neurotic.

One issue not addressed by Carpenter and Brockington, but which may help explain the reported higher incidence of *perceived* paranoid psychosis in immigrant populations, is misdiagnosis by the clinician as a result of cultural misunderstandings and what may be referred to as the "cultural relativity of delusions" *(Eke, 1981)*. To make a reliable diagnostic judgment on this issue requires a measure of cultural understanding which may not be within the grasp of the evaluating clinician.

Cultural paranoid attitudes are often representative of adaptive ways of coping as opposed to individual psychopathology. Eke *(1981)* reported from his work with Nigerian immigrants that the development of paranoid psychosis in new immigrants is more likely to be the result of "ethnic prejudice, social incompatibility, poverty and failure to achieve the desired goals" rather than functional impairment. In addition, misinterpretation of an event can result in a paranoid reaction by the immigrant *(Jack, Nicassio, & West, 1984)*.

In general, immigration is a potentially stressful event. The more socially distant the newly arrived immigrant is from the predominant culture of the host country, the greater the stress is likely to be. If such a situation is compounded by an inherent vulnerability to paranoid thinking patterns, a paranoid psychotic reaction may result. Constructive intervention in such cases requires sensitivity and understanding of the immigrant's culture and of the associated precipitating stresses. It also involves efforts to mobilize supportive community resources.

The next case example is of a Southeast Asian immigrant who suffered from posttraumatic stress syndrome secondary to war experience, plus cultural stresses associated with immigration. These stresses included encounters with prejudice, isolation from others, cultural estrangement, and paranoid type of misinterpretation of the actions of others.

Case 3

Mr. C, a 30-year-old, single, Cambodian refugee, came to the psychiatric emergency service on his own, asking for help. Upon evaluation, he was polite and cooperative but very constricted and guarded. No Southeast Asian clinicians were available, but Mr. C spoke English fluently and the assessment was completed without the necessity of an interpreter. Mr. C told the clinician that he had been feeling sad for the past three months and had been experiencing chest pain and headaches. Two days ago he had had a thorough physical examination at the county hospital and been told that there was no organic basis for his complaints. The nurse had then referred him to the community mental health crisis clinic. Mr. C told the clinician that he had arrived in the United States only six months before and had had a difficult time adjusting to American cultural life. His good command of English came from his attendance at a university in England and a subsequent stay there for two years before returning to Cambodia. He made it clear to the clinician that he was not Cambodian, but Chinese, and that he felt that he was experiencing some prejudice because of the misconception that he was Southeast Asian. He denied suicidal feelings, did not want to see a doctor, but did want to talk about his situation. After seeing Mr. C for several sessions in the emergency clinic, the reasons for his sadness became clearer. In the early 1970s, Mr. C identified himself as a Communist but, over the course of the Vietnam war, his political ideas changed and he abandoned the Communist Party but was con-

fused as to what political ideology to adhere to. Since his arrival in the U.S., he had been impressed with the ideal of democracy, although he perceived its reality as being quite different. However, he had become increasingly fearful of being identified as a former Communist and deported, or of being found by a Southeast Asian death squad and killed. Mr. C insisted that there were many such death squads in the U.S. and that their mission was to hunt down Communist defectors like himself and assassinate them. He worked as a computer programmer and had recently come to believe that his coworkers were talking behind his back and accusing him of being a Communist. He felt helpless to do anything about his situation and was preoccupied by the prospect of death or deportation.

Although the crisis clinic sessions seemed to be constructive in terms of providing support and a forum for Mr. C's fears, the clinician did not feel that her help was sufficient for his unique cultural stresses. She therefore contacted the local Catholic Charities agency, which had an attached Southeast Asian refugee counseling center. Although the counselors were paraprofessionals, they were able to give Mr. C some very helpful assistance and the kind of understanding that can come only from someone who has endured similar circumstances. Within a few weeks, Mr. C reported that he felt much better and less fearful, and the paranoid complaints about his work colleagues diminished.

Although Mr. C did not exhibit the stress response syndrome described by Tobin and Friedman *(1983)*, he did manifest some comparable clinical features. The sadness, chest pain, and headaches were probably symptomatic of depression, anxiety, and paranoia in the same way that sleeping and breathing difficulties were for Tobin and Friedman's client. Although the issue of "survivor guilt" was not explored with Mr. C by the clinician, it was probably another explanatory variable.

The fact that Mr. C's psychological stress took the form of paranoid symptoms can be further explained by the extreme cultural differences he encountered in the U.S., by his own political ambivalence, by his experience of Americans' prejudice toward him, and by his misinterpretation of the conversations among his colleagues that resulted in his paranoid fear of being accused of Communist sympathies.

There is also the unanswered question as to the state of Mr. C's mental functioning before he experienced the stresses of war and immigration; that is, whether he previously manifested chronic neurotic patterns of adjustment or a premorbid susceptibility to psychiatric problems. Although a thorough diagnostic assessment was not completed by the clinician, all available indicators suggested that Mr. C probably had an underlying obsessive compulsive personality style which, under severe stress (in this instance, war and immigration), evolved into a paranoid reaction. Shapiro *(1965)*, for example, argued that the premorbid background of a paranoid decompensation often turns out to be obsessive-compulsive and that paranoid and obsessive character styles are very closely associated empirically.

Clinical expertise, clinician sensitivity, and a desire to help were not completely adequate to help Mr. C. Fortunately, the clinician recognized the need for additional social support and assistance based on a more thorough knowledge of Mr. C's culture, and acquired the services of a refugee counseling center. These counselors, because they were from the same cultural background and similar life experiences, were able to understand from direct experience why Mr. C reacted as he did to his circumstances and the role his culture played in his emotional and physical distress. They were also able to communicate with him in his native language. Although Mr. C was fluent in English, finer nuances of meaning, expression, and mutual understanding were often lost. Furthermore, because Mr. C *believed* the refugee counselors would understand him better, he was able to open up to them more easily about his fears and problems.

DISCUSSION

When evaluating an individual from another culture who believes that he or she is being persecuted, it is important to address several questions before making assumptions about the presence or absence of psychopathology.

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2, p. 9) suggested the follow-

ing: *1)* Could the complaints of persecution be true? Do others in the client's community behave the way he or she is describing? *2)* Even if people in the U.S. do not behave in the way described, are the client's suspicions explicable in terms of past experiences? *3)* If none of this is so, is the client nevertheless describing something that is a common *belief* in that community? *4)* Is the complaint merely a figure of speech, a way of expressing anxiety, not intended to be taken literally? *5)* Does the truth lie somewhere between the last two alternatives?

If the answer to any of these questions is affirmative, it suggests that culture is an important variable to take into consideration in both diagnostic assessment and treatment planning. Treatment strategies and interventions, however, must vary according to the etiological factors underlying the particular paranoid manifestation.

For example, in the case of Mr. and Mrs. A, great fear of voodoo curses was common in their community in Jamaica. In this context, the fear made sense and was understandable. However, Mr. A suffered from both culturally based paranoia and a functional paranoid illness. The voodoo curse placed on him triggered his psychosis but a true functional illness compounded the pathology. The dynamics with Mrs. A were different. She also believed in voodoo but the psychotic proportion of her reaction was because of her role in the *folie a deux* with her husband. Separated from him, she stabilized.

Although Mr. and Mrs. A shared a common culture, their paranoia was compounded by different factors and therefore required different interventions. Mr. A benefited from the structure and control of a locked inpatient unit and the administration of neuroleptic drugs. He also needed psychotherapy and social supports, but without drug therapy he would not have stabilized. For Mrs. A, supportive counseling and separation from her husband's influence were all she needed to recompensate. She did not require drug treatment, nor did she really need a locked unit. In fact, after a couple of days she was able to stay on an open ward. Reunited with her husband, however, she could again be susceptible to the influence of any recurring pathology on his part.

For Mr. B, multiple past experiences of oppression and racism provided a context within which his feelings of persecution, associated with being passed over for promotion, made sense. However, the suspicions about his wife did not make sense, even within the context of his community and culture, thereby suggesting the presence of functional paranoid illness. Again, the two sources of paranoia suggested different tracks of intervention. The complaints of racism were addressed by a referral to a discrimination complaint board. The delusions about his wife, however, were symptomatic of functional illness which would respond best to medication and psychotherapy (individual and couple). A neuroleptic drug was introduced, but Mr. B dropped out of treatment. However, the continuance of counseling contact by telephone did provide some relief from his symptoms although without drugs he did not fully stabilize.

Mr. C's fears of death squads and of accusations that he was a Communist make sense given his past traumatic experiences. Although the paranoid feelings about his coworkers had reached delusional proportions, the clinician did not think that referral for medication or hospitalization was necessary. In this case, the client had enough intact ego strength to mobilize his abilities and utilize the psychotherapeutic interventions of the clinician and the social supports of the refugee counseling center.

Treatment Implications

This article, through the examination of three different clinical cases, has illustrated the role of cultural factors in the development of paranoid symptomatology. As these cases demonstrate, a client's culture is a crucial contextual variable that must be considered when evaluating his or her psychi-

atric status. If this is not done, the clinical picture will be inaccurate and the treatment interventions may be inappropriate. It is imperative, therefore, that clinicians develop an adequate awareness and sensitivity to the cultural issues specific to each client and assume responsibility for finding adjunct resources as necessary.

Most mental health professionals are trained in symptom identification, but without sufficient emphasis on the impact of cultural status on a particular symptom or syndrome. As these three cases illustrate, paranoid symptoms do not necessarily stem from functional psychopathology alone (particularly with minority clients) and thus sociocultural factors must be considered in both diagnostic assessment and treatment planning. To address this adequately, psychopathology texts need to be rewritten so as to take account of cultural aspects in diagnosis and treatment. Moreover, traditional theories of intervention must also be modified to include consideration of cultural variables. As discussed previously, the intervention strategies needed are different with different sources of paranoia. e.g., cultural issues vs functional illness.

More minority clinicians should be recruited to meet the burgeoning special needs of minority clients. Efforts must focus on encouraging young people still in secondary schools to pursue careers in the helping professions, together with special funding for the costs of their education and for improved monetary rewards for direct-service public mental health clinicians. However, these changes alone are not a panacea for the issues this article has addressed. Minority clinicians may provide a "face validity" for clients of the same minority group and this can help to get a client involved in treatment. It will not, however, eliminate the suspiciousness associated with functional paranoid psychopathology, nor is it a substitute for clinical expertise.

If the minority clinician is not thoroughly trained in sociocultural factors vs pathopathology, little will be accomplished. Good intentions and empathy alone do not ensure effective clinical treatment. The key lies in providing *all* clinicians with training based on a thorough consideration of the role of cultural variables in psychopathology.

Educators and mental health policy makers must recognize that the cultural fabric of our clientele, particularly in public mental health settings, is changing rapidly. Professional training schools need to respond with a committed focus on understanding the multicultural variables to be faced by prospective clinicians in direct practice. In addition, it is imperative that comprehensive in-service training programs be implemented for clinicians already in practice.

Many minority groups are challenging old assumptions about psychopathology and are insisting on a recognition of the significance of cultural antecedents in the development of psychiatric distress. Mental health services must respond effectively to meet the needs of these new populations. If we fail to make this adjustment, we will fall seriously short of providing competent, ethically sound mental health care in the 1990s.

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For reprints: Christina E. Newhill, Ph.D., 58 Zephyr Cove Circle, Sacramento, CA 95831