# The Relevence of Culture to Contemporary Psychology

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**Introduction**

As western cognitive-behavioural and psychodynamic conceptualizations of mental disorder are increasing applied across an international context, in countries far different to those in which they were originally developed, they encounter contrasting cultural accounts of the mind and the causes of mental distress. I will begin this essay by attempting to describe several of the contrasting perspectives on culture held by western psychology; I will go on to examine the ways in which diagnostic systems have attempted to account for the cultural differences in symptomology encountered by clinicians; from there I will explore the insights which may be gained from an examination of the differences between cultures; and I will conclude by considering the conflict between understanding cultures on their own terms, and ensuring equal access to health care and basic human rights.

**What is culture?**

No discussion of the importance of cultural awareness to the comprehension and treatment of psychological illness, can begin without attempting a definition. 'Culture' is a nebulous term, specifically referring neither to race, ethnicity, nationality, common history, religion, nor language; but implying a frame (MacLachlan, 2006), a shared schema for conceptual and situational comprehension, a set of implicit understandings, which may find its root in any or none of such commonalities (McKenzie & Crowcoft, 1994). Several distinct and mutually exclusive representations of the development and function of culture have been posited by contemporary psychology.

In evolutionary terms, culture can be defined as all common knowledge not directly heritable; the product of the action of social communication on innate evolved heuristics. To evolutionary psychologists, the very capacity for social learning is itself a product of

synthetic evolutionary selection, and thus cultural variations represent environmentally modulated settings on a multitude of inherited dimensions.

To this reductive view, culture is the content absorbed by evolved psychological mechanisms (Pinker, 1997), tailored to specific environmental inputs (Buss, 1998). Evolutionary psychologists assert that *all* human behaviours depend on the interaction of genes and developmentally relevant ontogenetic environmental conditions (Cosmides & Tooby, 1992), with cultural variation arising from 1) the 'combinatorial explosion' of developmental alternatives, 2) the responses of common evolved cognitive instincts to shared environmental stimuli, and 3) the inferential modelling (via inherited learning mechanisms) of the adaptive behaviours and communications of others – delivered within a matrix of reciprocal altruism (Trivers, 1971).

Richard Dawkins concept of memes (Dawkins, 1976), parasitic conceptual viruses inhabiting an ecosystem of common neurobiology, can be construed as an operationalisation of Durkheim's independent sociocultural forces (Marsden, 1998). Memetics, an offshoot of Dawkins universal Darwinism, sees culture as the output of a collective procedural learning, and cultural identity as a matrix of evolutionarily selected social software (Mansell, 2003); providing human 'gregorian creatures', tool kits of dynamic, ecologically adaptive behaviours (Dennet, 1995, cited in Mansell, 2003).

In striking contrast to the synthetic evolutionary and memetic perspectives, are collective and functionalist models of cultural development and transmission. Mythologist Joseph Campbell viewed archetypal myths as containers for the transmission of meaning and identity. Thus, to Campbell, fables were not simply morality tales, but rich communicative tapestries, derived from aspects of the Jungian collective unconscious (Campbell, 1949). The Italian social learning theorist Moscovici also viewed culture as composed of collectively emergent learning. In Moscovici's model meaning became anchored in shared social representations, 'systems of values, ideas and practises' (Moscovici, 1973, cited in Byford, 2002) implicit in a culture's use of language. Political psychologist Howard Ross (2002), marries Campbell's educative mythology to Moscovici's conceptions of sociolinguistic learning, in his concept of 'Psychocultural Narratives'; stories told to allegorically map a culture's sense of the world, and its relation to other groups.

These contrasting comprehensions of culture, as materially seated within an individually facilitated neurobiology, or by contrast supra-individually represented at a collective level (Byford, 2002), whether by functional forces, or infectious ideas, represent the current trichotomy of psychological cultural theory.

## Culture Bound Syndromes

Culture bound syndromes, culturally distinct and socially functional disorders have provoked a degree of controversy. On one side psychobiological purists allegedly see culture bound syndromes as direct analogues of extant Western conditions with biomedical roots. Occupying the contrary position are some critical health psychologists and radical social scientists, who view the very concept of a culture bound syndrome as an ironic reflection of Western psychology's positivist certainty that its own, culturally ascribed and functional mental illnesses are objective and universal.

MacLachlan, 2006, suggests that Diagnostic and Statistical Manual of the American Psychiatric Association IV-TR (APA, 2000) attempts to translate culturally diverse experiences of suffering to Western biomedical conceptions of disease; reducing wildly divergent apparent symptoms to local dialects common diagnostic categories; with the implicit assumption that the rationalist tradition of Western medicine is usefully objective, generalisable, comprehensive and ontologically finalised. All four such assumptions would be open to clear criticism if indeed the DSM-IV fit the straw man MacLachlan posits. Although real world clinical treatment of culture bound syndromes may (Korolenkoa et al, 1997) - or may not (Starcevic, 1999) (Helman, 1987) - take a prescriptive, translational approach, and despite the fact that the DSM-IV speaks of the universality of its categorisations, their 'particular symptoms, course, and social response…influenced by local cultural factors' (APA, 2000), it defines culture bound syndromes separately as 'localized, folk, diagnostic categories that frame coherent meanings for…sets of experiences and observations', which 'may or *may not* be linked to a particular DSM-IV diagnostic category' (emphasis added); failing to adopt the proscriptive, reductive stance accused by MacLachlan.

Beyond such criticism, the syndromal approach employed by the DSM and ICD-10 (WHO, 1992) to underlying illness is itself questionable.

Contemporary neuroscience and computational genomic techniques have had some success in identifying the disruption of underlying functional biology antecedent in a variety of syndromatically diverse conditions (Bracha, 2006); and it seems likely that the DSM-V will move further in the direction of culturally irreverent, genomically and neuropsychologically derived illnesses, with diagnosis focusing on cardinal symptoms rather than behavioural syndromes (Panksepp, 2006). One appearance of such an example is the disorders currently defined as OCD, ADHD and Giles de Tourettes Syndrome, which recent research refine as rooted in the disruption of alleles normally responsible for specific elements of neurotransmission on basal ganglia pathways, creating diathesis for certain forms of environmental and developmental stress (Casey et al, 2002).

In an interesting contrast, as the statistical normalisation of psychometric tests in the 20th century enabled the identification broadly representative measures of individual intellectual ability and behaviourally significant traits (Michell, 1999); the individuation enabled by genetic medicine, may transfer diagnosis and treatment from the population level to the level endophenotypic subgroup (Gottesman & Gould, 2003).

**Cross-cultural Psychological Insights**

Schumaker, 1996 (cited in McLauchlan 2006), investigates the variety of cross cultural insights Western psychology may gain through an examination of the 'folk psychologies' it currently deprecates; defining western psychology as both aetiologically individualist and syndromatically universalist. However, as previously stated, such cultural relativism can act as a convenient veil to underlying organic diathesis and psychosocial stresses. By deprecating the individualist aetiology of western psychology, Schumaker provides a space for the social function of illness to emerge, but in doing do, risks the tabula rasa relativism of social constructionists like Margaret Mead (Fabrega, 2004). Through the study of two cultures which appear to avoid the problem of depression, Schumaker

derives an anger centred model of its causation. Such a model, rooted in psychodynamic theory, contrasts with cognitive behavioural research implicating forms of learned helplessness in the development of depression (Ilgen & Hutchison, 2005); and exhibits the difficulty of objectivity in the consideration of cultural diversity.

Such attempts to consider culturally specific psychological illnesses on their own terms, risk falling pray to the implicit bias's of the researcher. Willis, 2002, paints a portrait of increasing African American suicide as rooted in decreasing collectivism, the deconstruction of institutions, helplessness etc. Such postmodern analyses ignore the Western, and in particular American, cultural blind spots of growing social inequality (Huckfeldt, & Kohfeld, 1989) and racial scapegoating (Skeem et al 2003). Internationally, social inequality results in the poorest individuals being exposed to the greatest variety of pathogens, whilst simultaneously having access to the poorest quality of medical services (Armelagos, 2005). Domestically in the United States, black American males are incarcerated at a mean rate of 7:1, in comparison to whites (Sorensen et al, 2002), live shorter lives, face socioeconomic and health outcome disadvantages (Hayward, 2000), and discriminatory psychological diagnosis (Mayo, 1974).

The Whitehall studies, I & II (Marmot et al, 1991), examinations of health outcomes related to position in the status hierarchy of the British civil services, have established inequality as a *direct* causal risk for health outcomes; through its mediation of aspects of control, integration and work fulfillment (Kreisler, 2002).

As we have seen, factors like social inequality, class, and learned helplessness, are enormously relevant in the exposition of the variety of culturally embedded syndromes (Simons & Hughes, 1986), and the exploration of the cultural incidence of psychological disorder. However, the utility of examinations of cultural constructions of mental health is in hermeneutic expositions of behavioural function, rather than the development of alternatives to western diagnostic procedures.

Hofstede's five cross cultural dimensions (Hofstede, 1980, cited in MacLachlan, 2006) describing a given society along continua of  power / distance, collectivism / individualism etc – too have diagnostic relevance, one that stands outside the epistemological space of culture bound, folk psychologies.

MacLachlan, 2003 (cited in MacLachlan 2006) provides a compelling graph, mapping Irish suicide annually to yearly change in GNP, which neatly reflects the apparent connection between socioeconomic inequality and suicide (Olafsson, & Svensson, 1986), but fails on its own to account for the risk factors unique to Irish culture which promote such direct increases in the rate of male suicide in response to economic growth; factors like Ireland's enormous drug culture - according to U.N figures Ireland has the second highest proportion of ecstasy use in the world (UN, 2003) - or the disillusion of traditional patterns of courtship and the family unit in the rapid sexual liberalisation of the past two decades.

Clearly the consideration of cultural facts – population statistics, incidence levels etc -, and insights – historical factors, and contemporary folk comprehensions -, while valuable, presents profound challenges, creating a tension between the need to escape ethnocentric assumptions, and the risk of relativising the pragmatic insights of contemporary medicine.

**Identity Politics**

Whether, as Durkhiem suggests, culture exists as a meta-individual 'collective representation' (Pickering, 2000), or as the sum of individually maintained consensuses of meaning, culture represents both collective and individual identity.

Berry, 2005, suggests that a strong sense of cultural identity affords individuals a greater degree of tolerance of divergent identities (Berry, 2005, cited in McLauchlan, 2006); by contrast social identity theory suggests the opposite – that in fact a strong cultural identity is adaptively intolerant (Tajfel & Turner, 1986). In fact, shared prejudice may be an important element of collective identity, rooted in traditional tribal and intergroup conflicts (Worchel, 2005), and in the in-group out-group dichotomy easily created by arbitrarily imposed deindividualising group differences (Haney & Zimbardo, 1998).

Islam is arguably the fastest growing religion in the world (Huntington, 1996). Nasser (1999, cited in MacLachlan, 2006), relates the western culturally bound syndrome of

anorexia (Giles-Banks, 1992), to voluntary veil wearing amongst Muslim women, in that both allow a reconfiguration of self to meet cultural ideals though a symbolic removal of the body. In another sense too, voluntary veil wearing may be seen as comparable to anorexia nervosa or self harm, as a socially normalised 'alternative' identity. This exemplifies the necessity of the treatment of the individual rather than the perceived culture, due to the wide variety of individual identities which may be facilitated by a particular culture, and distinct representations shared by regions, religious sects and other culturally camouflaged, and to western eyes uniform, social cleavages.

In a therapeutic environment, cultural identity is a vital variable in a patient's experience of illness and recovery. A consideration of cultural factors may be essential to ensure the equal provision of services in a multicultural environment, and the recruitment of representative research samples (Baquet et al, 2006). But here too, the consideration of individuated cultural identity – as a context dependent self definition, as much as an identity derived from ethnicity or gender, and as widely mutable across the dimension of genetically enabled behavioural variations, is essential.

In the United states, the popularisation of the self definition of individual identity, and the notion that collective sexual and racial identities are created through the action of patriarchy (Miles, 1986); has led to the development of identity politics, and the political correctness movement (Scott, 1992). Such socially constructionist (Burr, 2003) fixations on collective maginalised identities, demonstrate the myopia implicit in selectively fixating on specific aspects of subcultural identity; and have arguably provided a distraction from the institutionalisation of social inequality.

**Medical Relativism**

MacLachlan (2006) has developed a 'problem portrait technique' for the identification of the aspects of suffering most significant in a patient's experience of illness. While such techniques enable the avoidance of miscommunication, they run the risk of medical relativism; granting equal weight to magical, or animistic, explanations of causation. While the causal impact of belief can have significant impact on the individual

experience of suffering, and the interpretation and social function of disorder, medical relativism risks ignoring our underlying human biology and universal psychopathological commonalities.

Suggesting a sensitivity to culturally valid experiences of illness, in combination with conventional psychobiological treatment (e.g.: Castro-Blanco, 2005), is both reasonable and necessary; but granting clinical validity to supernatural disease causations risks reinforcing a patients view of the magical non-curative aetiology of their illness, and its perhaps violent treatment; as in the case of the assassination of a shaman blamed for the infliction of *jais* (disease spirits), by members of the Embera, an indigenous Columbian tribe (Pinerosa et al, 1998).

Medical relativism creates a false double bind; a conflict between the need for relative cultural evaluation (Williams, 2001) and the conception that 'patriarchal', 'developing' cultures 'need to evolve' to meet the standards of universal human rights (MacLachlan, 2006). Such carefully proscribed 'evolution' meets the criteria of cultural imperialism, in attempting to balance an ethnocentric neo-colonial desire for cultural 'conservation', with the external imposition of norms of civil and human rights assumed to be universally applicable. To suggest such proscribed social reform, is arguably to ignore the historical consequences of social engineering, from the enforced primitivism of the Khmer Rouge (Kiernan, 1999), to the impact of colonial exploitation on the Pan-African economy (Nunn, 2006), to the legacy of social unrest in nations partitioned without the consent of their native peoples (Fraser, 1984). The imperative imposition of western secular, individualist, moral universalism, by societies which as Sarson, 1974 (cited in MacLachlan, 2006), points out, themselves suffer from the disillusion of community and shared tradition, is a potentially dangerous and morally ambiguous proposition.

Thus a fine line needs to be established between making available the measurably effective products of Western medical research; and proscribing subjective Western, Judeo-Christian, moral and legal restrictions, on cultures with vastly differing ethical and social organisations.

**Conclusion**

Culture is inarguably of enormous relevance to contemporary psychology. Cultures, especially highly distinct, geographically or temporally distant cultures, provide a comparative basis for the identification of universal human traits and evolved psychological mechanisms (Pinker, 2002); highlight useful challenges to the assumptions of objectivity and completeness in psychological and psychiatric diagnostic systems (Richerter et al, 1997); and provide a rich bed for the study of the transmission of collectively shared values and representations (Sperber & Hirschfeld, 2004).

I have argued for an individualised cultural sensitivity, taking into account the growing body of neurological, genetic, and epigenetic factors underlying the diathesis of psychological problems which may manifest in culturally determined ways. To ignore these advances risks falling prey to an uncertain, value based, moral imperialism and cultural relativism; which though it may be imposed with the best of intentions, does a disservice to the individuality and common humanity of patients of every culture.

**References**

American Psychiatric Association (2002) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. USA: American Psychiatric Press

Armelagos G.J (2005) Evolutionary, historical and political economic perspectives on health and disease. Social & Medicine, 61, 4.

Baquet, C.A., Commiskey P., Mullins, C.D., Mishra, S.I (2006) Recruitment and participation in clinical trials: Socio-demographic, rural/urban, and health care access predictors. Cancer Detection and Prevention, 24-33.

Buss (1998) Evolutionary Psychology: The New Science of the Mind. US: Allyn & Bacon.

Burr, V. (2003) Social Constructionism. UK: Routledge

Byford, J (2002) Anchoring and objectifying 'neocortical warfare': re-presentation of a biological metaphor in Serbian conspiracy literature. Textes sur les representations sociales, 11, 3.1-3.14.

Campbell, J. (1949) The Hero with a Thousand Faces. Princeton: Princeton University Press.

Casey, B.J., Tottenham, N., Fossella, J. (2002) Clinical, Imaging, Lesion and Genetic Approaches Toward a Model of Cognitive Control. Developmental Psychobiology, 40, 237–254.

Castro-Blanco, D.R. (2005) Cultural Sensitivity in Conventional Psychotherapy: A Comment On Martínez-Taboas (2005). Psychotherapy: Theory / Research / Practice / Training, 42, 1, 14-16.

Cosmides, L., Tooby, J. (1992) The psychological foundations of culture. In Barkow, Cosmides, Tooby (eds). The Adapted Mind: Evolutionary psychology and the generation of culture. UK: Oxford University Press.

Dawkins, R. (1976) The Selfish Gene. UK: Oxford University Press.

Fabrega, H. (2004) Cultural challenges to the psychiatric enterprise. Comprehensive Psychiatry, 36,5, 377-383

Giles-Banks, C. (1992) 'Culture' in culture-bound syndromes: The case of anorexia nervosa. Social Science & Medicine, 34, 8.

Gottesman, I.I., Gould, T.D,(2003) The Endophenotype Concept in Psychiatry: Etymology and Strategic Intentions. American Psychiatry, 160, 636-645.

Haney, C., Zimbardo, P. (1998) The Past and Future of U.S. Prison Policy: Twenty-Five Years After the Stanford Prison Experiment. American Psychologist, 53, 7, 709-727

Hayward, Crimmins, Miles, & Yang (2000) M.D. Hayward, E.M. Crimmins, T.P. Miles and Y. Yang, The significance of socioeconomic status in explaining the racial gap in chronic health conditions. American Sociological Review, 65, 910–930.

Huckfeldt, R., Kohfeld, C.W. (1989) Race and the Decline of Class in American Politics. USA: Illinois

Ilgen, M.A, Hutchison, K.E. (2005) A history of major depressive disorder and the response to stress. Journal of Affective Disorders, 86, 2-3, 143-150.

Fraser, T.G (1984) Partition in Ireland, India and Palestine: theory and practice. UK: Palgrave MacMillan

Helman C.G. (1987) Heart disease and the cultural construction of time: The type A behaviour pattern as a western culture-bound syndrome. Social Science and Medicine, 25, 969-979.

Huntington, S.P (1996) The Clash of Civilisations and the remaking of World Order. New York: Touchstone.

Kiernan, B. (1999) The Pol Pot regime : race, power, and genocide in Cambodia under the Khmer Rouge, 1975-79. Thailand: Silkworm Books

Kreisler, Harry (2002) Conversation with Sir Michael Marmot, Redefining Public Health - Epidemiology and Social Stratification, Hosted: Conversations with History: Institute of International Studies, UC Berkeley Retrieved: http://globetrotter.berkeley.edu/people2/Marmot/marmot-con0.html

Korolenkoa, C.P., Prokofyevaa G.V., Belonosova O.P. (1997) Adjustment and post-traumatic stress disorders in post-totalitarian Russia. European Psychiatry, 12, 2, 161.

Marsden, P. (1998). Memetics and Social Contagion: Two Sides of the Same Coin? Journal of Memetics 2. Retrieved from: http://jom-emit.cfpm.org/1998/vol2/marsden_p.html

Miles, M (1986) Patriarchy and Accumulation on a World Scale: Women in the International Division of Labour. US: Palgrave.

Mansell, W. (2003) Universal Selection Theory: Implications for multidisciplinary approaches to clinical psychology and psychiatry. New Ideas in Psychology, 21, 2.

Marmot M.G., Davey Smith G., Stansfeld S.A., Patel C., North F., Head J. et al. (1991) Health inequalities among British Civil Servants: the Whitehall II study. Lancet, 337, 1387-1393.

Mayo, J. A. (1974) The significance of sociocultural variables in the psychiatric treatment of black outpatients. Comprehensive Psychiatry, 15, 6, 471-482

MacLachlan, M. (2006) Culture and Health. In Press.

McKenzie, K.J., Crowcroft  N.S., (1994) Editorial. Race, ethnicity, culture and science British Medical Journal, 309, 286-287.

Michell, J. (1999) Measurement in Psychology. Cambridge: Cambridge University Press.

Moscovici, S. (1976). La Psychoanalyse: Son Image et son Public. Paris: Presses Universitaires de France.

Nunn, N. (2006) Historical legacies: A model linking Africa's past to its current underdevelopment. Journal of Development Economics, In Press.

Olafsson, O., Svensson, P., (1986) Unemployment-related lifestyle changes and health disturbances in adolescents and children in the western countries. Social Science & Medicine, 22, 11, 1105-1113.

Panksepp, J. (2006) Emotional endophenotypes in evolutionary psychiatry. Progress in Neuro-Psychopharmacology and Biological Psychiatry, In Press.

Pickering, W.S.F (2000) Represenations as understood by Durkheim: an introductory sketch. In Pickering, W.S.F (ed) Durkheim and Representations. UK: Routledge

Piñerosa, M., Rossellib, D., Calderonb, C. (1998) An epidemic of collective conversion and dissociation disorder in an indigenous group of Colombia: its relation to cultural change. Social Science & Medicine, 46, 11.

Pinker, S (1997) How the Mind Works. New York: Norton.

Pinker, S. (2002) The Blank Slate : The Denial of Human Nature and Modern Intellectual Life. UK: Penguin

Ross, R.H, (2002) The Political Psychology of competing narratives: September 11 and beyond. In Calhoon, C. et al (eds) Understanding September 11. New York: New Press.

Scott, J.W. (1992) Multiculturalism and the Politics of Identity, October, 61, 12-19.

Simons, R.C., Hughes, C.C. (1986), The Culture-Bound Syndromes: Folk Illnesses of Psychiatric and Anthropological Interest. Boston: D. Reidel Publishing Company.

Starcevic, V. (1999) Neurasthenia: cross-cultural and conceptual issues in relation to chronic fatigue syndrome. General Hospital Psychiatry, 21, 4, 249-255.

Skeem, J.L., Edens, J.F., Sanford, G.M., Colwell, L.H. (2003) Psychopathic personality and racial/ethnic differences reconsidered: a reply to Lynn (2002). Personality and Individual Differences, 35, 6, 1439-1462.

Sorensen, J., Hope, R., Stemen, D. (2002) Racial disproportionality in state prison admissions: Can regional variation be explained by differential arrest rates? Journal of Criminal Justice, 31, 1, 73-84

Sperber, D., Hirschfeld, L.A. (2004) The cognitive foundations of cultural stability and diversity. <u>Trends in Cognitive Sciences</u>, 8, 40-46.

Tajfel, H. and Turner, J. C. (1986). The social identity theory of inter-group behavior. In S. Worchel and L. W. Austin (eds.), <u>Psychology of Intergroup Relations</u>. Chicago: Nelson-Hall

Trivers, R.L. (1971). The evolution of reciprocal altruism. Quarterly Review of Biology. 46: 35-57.

WHO (1992) <u>International Statistical Classification of Diseases and Related Health Problems</u>. US: American Psychiatric Publishing.

Willis, L.A., Coombs, D.W., Cockerham, W.C Frisond, S.L. (2002) Ready to die: a postmodern interpretation of the increase of African-American adolescent male suicide. <u>Social Science and Medicine</u>, 55, 6, 907-920.

Williams, S. (2001) Sociological imperialism and the profession of medicine revisited: where are we now? <u>Sociology of Health and Illness</u>, 23, 2, 135.

Worchel, S. (2005) Culture's role in conflict and conflict management: Some suggestions, many questions. <u>International Journal of Intercultural Relations</u>, 739-757.