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Cultural diversity and mental health Towards integrative practice

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Abstract

Adopting an integrative approach to mental health is especially important when working with people from diverse cultural backgrounds. In order to render culturally sensitive practice, we need to be immersed in the philosophical, contextual, and experiential considerations of the cultural group with whom we work. Comprehensive assessment and intervention involves bridging disciplines to gain a more holistic appreciation for the group's situation and experience. Thus, we have taken a transdisciplinary approach (a) to provide a framework for understanding and improving mental health in the context of cultural diversity and (b) to promote legitimate practice, or the unity of reflection, research, and action, in mental health in different cultures. We provide an example of how we use this framework in our work with the Portuguese immigrant community. The framework is not only limited to assessing the needs of individuals but draws on anthropology, philosophy, political science, and religious studies to understand the social, cultural, moral, and religious domains. In addition, community psychologists and social activists provide models of how to intervene at community or societal levels. The unique contribution of the integrative practice framework is that merges considerations that are typically studied in isolation. Needs, norms, context, values, and social change are not always studied in an integrative fashion. Thus, the article offers a way of considering seemingly disparate but highly complementary practice deliberations.

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1. Introduction

For many years the role of culture in the expression of psychological symptoms was neglected (Ware & Kleinman, 1992). At best, there were studies investigating minority help-seeking behaviors or the prevalence rates of psychiatric disorders cross-culturally, but these were often ethnocentric, assuming that the North American paradigm of symptom expression and treatment was the ideal to which all clients should adhere. It was not until recently that psychologists introduced the notion that culture profoundly impacts the experience of people's afflictions (Arredondo et al., 1996; Sue et al., 1998). Cross-cultural researchers have also recently acknowledged the importance of the role of culture in the expression of psychological symptoms, and have called upon the *American Psychological Association (APA)*, 1993 to provide guidelines for practitioners when relating to clients of diverse cultural backgrounds.

Sue et al. (1982) published a report calling for cross-cultural competencies in the mental health professions, and both the American Counseling Association (ACA) and the APA have responded to this call by issuing guidelines for providers of psychological services (ACA, 1995; APA, 1992, 1993). These guidelines have been operationalized and "fleshed out" over the years (Arredondo et al., 1996; Sue et al., 1998). Essentially, practitioners are to integrate multicultural and culture-specific awareness, knowledge, and skills into counseling interactions. Practitioners are to: (a) be aware of their own cultural values and biases; (b) be aware of the client's worldview; and (c) utilize culturally appropriate intervention strategies (see Arredondo et al., 1996, for discussion).

While these guidelines are in effect, there have been critics of the implementation of the guidelines:

... the call for infusing multicultural competency criteria into standards of practice has been vocal, loud, and compelling. Yet, as a whole, the profession has not always been a willing participant in the recognition, endorsement, or infusion of multiculturalism into our standards of practice, code of ethics, and training programs. At best, the mental health professions can be characterized as unenlightened and reluctant to consider the racial/cultural issues in counselling and psychotherapy; and, at worst, they have been downright hostile, antagonistic, and guilty of cultural oppression. (Sue et al., 1998, p. xi)

In an attempt to shed light on the relation between culture and mental health, medical anthropologists suggest that mental health problems have a social as well as a biological course and that there is a reciprocal relationship between the body and society (Becker, 1998; Good, DelVecchio Good, & Moradi, 1985; Kleinman, 1986; Kleinman et al., 1995; Ware & Kleinman, 1992). This theory, deemed the socio-somatic formulation (Kleinman, 1986), contends that a person's context (e.g., relationship with others, what is morally at stake, stressful life events, and social support, etc.) influences the severity and type of symptoms experienced. Furthermore, the loop is recursive; for symptom expression transforms the patient's social context. In China for instance, symptom expression in epilepsy patients can lead to isolation and family shame and, thus, the disorder may be disguised or the afflicted person hidden from the public, artificially deflating the incidence rate of the disorder

(Kleinman et al., 1995). Thus, the person's social world influences and is influenced by the illness.

A connection between illness and the religio-moral domain has been evident in various historical periods. In ancient Israel, where rules for cleanliness and diet were contemporaneously moral, religious, and judicious, illness epidemics were linked to a disregard for the prohibitions outlined in the Bible (Thomas, 1997). In classical antiquity, we encounter a tradition where illness was caused by an imbalance of humours and epidemics were a consequence of miasma—impure air. This tradition then spread to countries, such as early modern England, where Christianity was firmly in place and people believed that all events were determined by the will of God and that sinners were punished by physical illness, through mechanisms in the body. The result was the coexistence of multifactorial models of disease causation. For instance, the bubonic plague was interpreted as punishment for sins, the effect of corrupt air, and the presence of evil humours; a “multiple theory of disease causation with divine providence and Galenic theories being simultaneously invoked” (Thomas, 1997, p. 17).

In an integrative view of health, the political, the economic, the moral, and the medical are inextricably linked (Kleinman & Becker, 1998). Rather than conceiving of symptom clusters and prognosis as universal, the social course of illness is shaped by the local world of the afflicted. This happens because different environments privilege different symptom clusters, forms of treatment, coping strategies, and social roles.

We seek to privilege that adopting an integrative approach to mental health is especially important when working with clients from diverse cultural backgrounds. In order to demonstrate how that can be accomplished, we take a multidisciplinary approach (a) to provide a framework for understanding and improving mental health in the context of cultural diversity and (b) to promote legitimate practice, or the unity of reflection, research, and action, in mental health in different cultures. Lastly, an example of how we use this framework in our work with Portuguese immigrants is described.

2. Framework for the pursuit of mental health in different cultures

The framework we propose consists of four complementary considerations: *philosophical*, *contextual*, *experiential*, and *pragmatic*. These four elements should guide mental health practice in diverse cultural contexts (for other helpful holistic frameworks, see Arredondo et al., 1996; Sue et al., 1998). In general, practice refers to the unity of theory and action. In this article, we use integrative practice to refer to a cycle of activity that includes philosophical, contextual, experiential, and pragmatic considerations. These four considerations form the basis of a framework designed to help us bridge disciplines and integrate values, research, and action. In addition, these practice elements combine what is desired and needed by citizens with philosophical analysis, social research, and social action.

The framework presented in Table 1 derives from the need to balance different orientations in psychology and the social sciences. Integrative practice should be based on criteria that will facilitate the completion of the cycle entailing reflection, research, and action. Our four

Table 1

Complementary considerations for the pursuit of mental health in different cultures

| Considerations | Key questions | Main voice and resources | Outcomes |
|----------------|--|---|--|
| Philosophical | What is the vision of the good person, the good life, and the good society in the clients' society and in the helpers' society? What values are dominant in each culture? | Moral and political philosophers, religious leaders, and social commentators in helpers' and clients' societies. | Understanding of the good person, the good life, and the good society in the clients' society and in the helpers' society? |
| Contextual | What are the social, cultural, religious, and moral norms prevailing in the clients' and helpers' societies, and how do these norms affect the conceptualization of mental health? | Social scientists, psychologists, and researchers surveying economic, social, and cultural trends affecting mental health in clients' and helpers' societies. | Identification of prevailing norms and social conditions affecting the construction of, as well as the actual mental health of the population. |
| Experiential | What is missing from the particular social context in order to improve the mental health of individuals and communities? | Community members' voices gathered and examined through life experience and grounded theory research. | Identification of human needs related to mental health as expressed by clients and community members themselves. |
| Pragmatic | What can be done to improve the mental health of individual clients and of the community at large in the particular context of interest? | Agents of personal change like therapists and agents of social change like social activists and experts on resource mobilisation and social change theory. | Personal and social change strategies that respond to the local context and that are sensitive to the needs of individuals and communities. |

considerations derive from two main criteria (Prilleltensky, *in press*). First, there is the need to reach a balance between philosophical and grounded input. A balance between philosophical and grounded input is needed to complement deductive with inductive approaches to knowledge and action. Abstract philosophical analyses of what values and practices can lead to wellness are useful but limited. What good is it to have an internally consistent framework of values that does not reflect the living realities of most people? The corollary of this question is that moral philosophy is not enough. Conversely, we can ask what is the point of knowing people's needs and aspirations if that knowledge is not processed into principles for action? The main corollary of this question is that grounded knowledge is not enough (Kane, 1998). Moral philosophy and grounded experience are complementary. Theories of values have to be validated with lived experience. Otherwise, we can end up with notions that are theoretically flawless but practically worthless. This is why we need a framework that attends to philosophical as well as to contextual and experiential considerations.

Second, we need a model that reaches a balance between understanding and action. This is required to ensure that knowledge does not remain the sole object of intellectual interest. The ultimate purpose of values like caring and compassion is to promote personal and collective wellness. To improve the well-being of people, our theoretical sophistication has to be followed by action. This is why we require the pragmatic element in the framework in Table 1.

But the urge to act should be tempered by the need to know; to know our culture and the culture of the people we work with. Otherwise, our urgency may neglect serious differences between our predilections for the good life and those of people from other backgrounds.

The two criteria stipulated above combine to create a framework that gives equal attention to philosophical, contextual, experiential, and pragmatic considerations. These complementary considerations are put into practice by asking a set of key questions, attending to different voices, and achieving a set of outcomes. These are clearly articulated in [Table 1](#). The unique contribution of the practice framework is that it integrates considerations that are typically studied in isolation. Needs, norms, context, values, and social change are not always studied in an integrative fashion. The article offers a way of considering seemingly disparate but highly complementary practice deliberations. Practice-literacy requires familiarity with the cycle and integration of reflection, research, and social action. Yet it seems that many academics and practitioners engage only in one piece of practice or another, thereby falling short of achieving the aim of practice, which is the translation of ethical reflection and social research into social action.

[Table 1](#) shows the four sets of considerations of our framework with their respective unique features. Each set answers a key question, deals with a particular subject, represents a particular voice, calls on different analytical and disciplinary resources, and leads to a specific outcome. We discuss next the unique contributions of each set of considerations. Following a presentation of their distinctness, we offer reasons for their inseparable and mutually enhancing nature.

We present in the following sections issues germane to each of the four considerations presented in [Table 1](#). At the end of each subsection of the framework, we elaborate on the desired outcome of paying attention to each set of considerations.

2.1. Philosophical considerations

Philosophical considerations have to do with the vision of the good life, the good person, and the good society in life. Before we attempt to understand mental health in different contexts, we need to appreciate each society's vision of the good life and the good society. Otherwise, we cannot understand how social values shape the conceptualization and the social construction of mental health.

Social values, for instance, are bound to have an impact on our conceptualizations of mental health. Individualistic societies favor self-determination and personal development over collectivist values such as distributive justice ([Prilleltensky, 1997](#)). These notions will shape clinicians' conscious or unconscious predilections for changing clients. In an individualistic context of achievement and personal advancement, therapists may promote personal gain over sacrifice for the collective ([Doherty, 1995](#)). For example, [Doherty \(1995\)](#) speaks of working with a client who wanted to abandon his children after his divorce because it was too painful for him to visit them. When discussing these issues with the client, Doherty realized that he was trained to approach clients' experiences in terms of their self-interest and he was at a loss for clinical resources and models that discuss moral obligation or commitment.

A particular question that we need to consider is whether clients value individualism and self-determination, or whether they uphold community perspectives. Liberal societies, for instance, emphasise autonomy, self-determination, and the rights of the individual. Although these are worthy ideals, in excess they may lead to unmitigated individualism. These societies are reluctant to promote too much state intervention because they are afraid that governments will end up dictating to private citizens how to run their lives. Communitarian societies, on the other hand, promote collective measures that may interfere with the goals of individuals but that assure the well-being of the community as a whole. Communitarian thinkers claim that we have gone too far in meeting the needs of individuals and that we have sacrificed our social obligations in the pursuit of private satisfaction (Etzioni, 1993; 1996; Lerner, 1996; Mulhall & Swift, 1996; Sandel, 1996; Shapiro, 1995). Communitarian philosophers argue that for citizens to fulfil their dreams they need one another. A vision of mutual help and commitment to the welfare of the collective benefits the individual as well, for the attainment of one's aims depends on collaboration from others. However, communitarian thinking is not without risks. Collectivist societies may expect great sacrifices from their members for the benefit of the public good. Citizens may feel coerced to do things they do not like and they may experience state intervention as oppressive (Melnyk, 1985). The Israeli kibbutz, for instance, used to expect a great deal of personal sacrifice from its members. While this demand was reasonable in the early stages of the kibbutz, when communal effort was essential to the survival of the collective, this expectation became too onerous in later years. Members denounced expectations for heavy personal concessions and started to request more personal freedoms. This realization led to more liberal policies regarding employment, family practices, and opportunities for personal development.

The importance of learning about clients' philosophical ideals regarding mutual commitment and self-sacrifice brings to mind an African American client. The client had taken care of others, as a nurse, all of her life as well as caring for her ailing husband who had recently passed away. After she retired from nursing, the client became very depressed and, consequently, she consulted a therapist. The therapist said that now that she had retired and she was no longer burdened with taking care of her husband, she could now take care of "number one." However, the client had a hard time thinking of activities that she would like to do for "number one" and had an even harder time following through on the homework assignments of doing these things for herself. After feeling frustrated with the client's lack of compliance, the therapist finally asked her about her notions of a good person. It was evident that, according to the client's religious and philosophical ideals, a good person took care of other people. The client then pointed out that she could still be a caregiver by volunteering at a nursing home. Once the client started her new volunteer job, her depression improved dramatically. Thus, in this case, not asking about the client's philosophical ideals was an impediment to treatment.

Our implicit and explicit notions of what constitutes the good life and the good society are going to have an impact on our notions of mental health and appropriate treatment. For instance, a client may feel that a good person should not contradict the "expert" therapist and would, therefore, be unwilling to tell the therapist if the therapy was not useful or appropriate. In many cultures, because of the tremendous stigma attached to therapy, a good person would

not even seek the help of mental health providers. Similarly, for some clients, a good family is one where family conflict is not discussed outside of the family and particularly not in front of a stranger, the therapist.

All societies develop ways to account for illnesses that reflect their moral and philosophical ideals (Brandt, 1997). Similar to the example given earlier of the bubonic plague, multifactorial models of disease causation (Rosenberg, 1997) are still commonplace today but now the causal agents take the form of the weather, work stress, difficult relationships, or diet to account for illnesses. The moral causal ontology also continues to coexist contemporaneously. Presently, disregard for health behavior is a question of personal morality (Thomas, 1997) and those who do not have control over their body through restricted food or alcohol consumption or regular exercise are depriving themselves of the good life—freedom from disease (Brandt, 1997). Given that these moral causal ontologies are culture-specific, it is not surprising that we have a particularly large number of people suffering from eating disorders in North America. Within this culture, thin is seen as healthy and “good,” but this is not a cultural universal. In Fiji, for example, thinness is a social disgrace because it is an indication that the community is not taking sufficient care of that person (Becker, 1995). Another example of a culture-specific ideal in North America is that a good child sits and listens attentively to learn. Again, this is not a universal assumption and a more active and interactive approach is taken in many cultures. Thus, it is not surprising that North America has the greatest proportion of children diagnosed with and treated for attention deficit and hyperactivity disorders (Diller, 1998).

There are also accounts of the invocation of multifactorial models of disease causation globally. For example, Shweder, Much, and Mahapatra (1997) found that in India suffering and illness were most commonly linked with moral transgressions and religious beliefs. Similarly, a study by Murdock (1980) suggests that religio-moral causal ontologies of suffering are not just prevalent in India but in sub-Saharan Africa, East Asia, and the Mediterranean region as well. These findings demonstrate the importance of considering the religio-moral domain in cross-cultural research on the illness experience.

Thus, there is evidence to support the notion that symptom expression is linked to a person’s social and religio-moral context. There is a connection between the somatic and the moral that is dialectical and that Kleinman (1997) has labelled “satomoral.” Unlike distinctions in modern medicine, there is no difference between psychological, physical, and religio-moral pain. Through such a lens mental illness is no longer limited to a list of symptoms but rather seen as a link to the religio-moral domain. For instance, in the 17th century, before mental illness was medicalized, writers wrote about depression as the experience of pressing down, and as a falling spirit (Kleinman, 1997). Thus, the emotional state and the religious domain were linked.

This somatomoral framework also provides an expanded framework for considering suffering. Suffering is no longer seen as situated only within the individual but takes on a social–religious meaning as well. It connects the sufferer to him/herself by highlighting what is really important for the person. It connects the sufferer to others and to the Divine, transforming the interpersonal and divine space. For instance, in the Judeo-Christian tradition, the suffering body is a place where lay people can meet the Divine (Perkins, 1995). Suffering

connects people not only to others and the Divine, but also to prior generations who also suffered such as the ancient martyrs. Suffering is also linked to the past in that, like all cultural forms that mediate our experience, it has a prehistory. Long (1986) suggests that everything from religious intuition to bodily perceptions are manifestations of something already there, something given.

In clinical psychology theory, the religious convictions of clients are often not considered in a positive light. Although there has been substantial research on how religion and religious beliefs affect coping and adjustment (see Pargament, 1997, for discussion), often these insights are not incorporated into the clinical setting. According to the socio-somatic formulation, however, understanding the moral and religious worlds of clients is crucial. Long (1986) reminds us that

The religion of any people is more than a structure of thought; it is experience, expression, motivations, intentions, behaviors, styles, and rhythms. Its first and fundamental expression is not on the level of thought. It gives rise to thought, but a form of thought that embodies the precision and nuances of its source. (p. 7)

2.1.1. Desired outcome of examining the philosophical considerations

A thorough consideration of the philosophical domain gives us an appreciation of the social values that dominate the group with which we are working. We accomplish this by consulting the group's moral and political philosophers, religious leaders and texts, and traditional healers. In our practice, we aim to promote the values of the group rather than our own. In order to do that we also identify our own vision of the good life and the good society and contrast our vision to the group's vision. Any contradictions are warning signals indicating domains in which we could unintentionally privilege our own values. Thus, the goal of this phase is to learn as much as possible about the group and ourselves so that in our practice we can promote the values of the group with which we are working.

2.2. Contextual considerations

Contextual considerations explore *what is the actual state of affairs* in which people live. Psychologists' and social scientists' practice is enhanced if they strive to understand what the social, economic, cultural, and political conditions of a specific community are and how they affect mental health. This line of inquiry helps us to determine social norms and cultural trends influencing people's choices and behavior (Trickett, 1996). A contextual assessment is necessary to understand the subjective experience of residents of a particular community. Individualist and collectivist societies differ markedly with respect to socialisation, customs, and visions of the good society. Poor and rich communities vary with regard to the importance they ascribe to basic necessities. Different ethnic communities celebrate unique traditions and uphold distinct values. An analysis of culture and context draws on resources from history, anthropology, sociology, communications, economics, and cultural studies. These sources of information combine to provide a picture of the context so that we can understand the values of the group with which we are working.

Values attain their meaning within a social context. The meaning of self-determination in an individualist society is vastly different from its connotation in a collectivist environment. In a totally collectivist society, citizens may yearn for more autonomy and could resent state and communal intrusion. Examples include “curtailing individual rights in the name of community needs; suppressing creativity in the name of conformity; and even suppressing a sense of self, losing individuality in a mesh of familial or communal relations” (Etzioni, 1996, p. 26). In an individualist environment, on the other hand, citizens may wish to experience more sense of community and less selfishness.

We understand values more fully when we comprehend the set of circumstances within which they are embedded (Avineri & De-Shalit, 1992; Bell, 1993; Etzioni, 1993; Sandel, 1996). Pushed to extremes, values lose their merit. Excessive collectivism may violate one’s right to privacy, while flagrant individualism could numb our sensitivity to others and potentially lead to desolation. It is incumbent upon us, then, to watch out for signs of value immoderation (Kane, 1994). The moment one principle takes too much space, others shrink proportionately. Applied to North American society, this means that collectivist values such as solidarity, sharing, co-operation, and social justice have shrunk in reverse proportion to the increase in individualism (Saul, 1995). This trend is reflected in conservative preventive programs and policies that concentrate on person-centered approaches (Albee, 1996; Albee & Perry, 1995).

2.2.1. *Social and cultural norms*

We will now explore how the aforementioned discussion applies to clinical psychology in North America. Expanding the field of inquiry in clinical psychology to include the social domain raises some complex issues. For instance, how are social problems constructed and treated in clinical psychology? Upon reflection, it appears that at times societal problems are labelled and treated at the level of the individual, rather than at the level of society. For example, in the case of a person who has been abused, the victim receives a diagnosis—posttraumatic stress disorder. Much of the help that we offer is at the level of the individual, such as individual therapy, rather than also intervening at the level of society, such as a community intervention for violence prevention. Similarly, we realize that the portrayal of women in the media in our society is linked to eating disorders for a large number of women. Again, our interventions are at the level of the individual, in the form of psychotherapy, rather than challenging how women are portrayed in the media, a societal intervention. Thus, social ills become medicalized as a problem at the level of the individual, instead of being linked to social context.

Another issue raised by consideration of the social domain in clinical psychology is universalism. As Shweder (1991) points out, psychology has presumed that there are universal laws of nature such as a central processing system, a stable core character, and a universal cognitive style and developmental trajectory. Clinical psychology, in particular, also adheres to other universals such as systems of diagnosis and psychotherapy. Although there is often a gap between psychotherapy theories and clients, particularly if they are from other cultures, universalism suggests that we can use our psychological yardsticks and therapies on everyone. This, however, is not always the case. For instance, O’Neil (1996) documented a culture-specific variation of depression within the Flathead Indian community in the United

States. O'Neil found that the disorder did not neatly fit into standard psychiatric nosology because it went beyond psychological symptoms and extended into the realms of morality, relationality, history, identity, and religion.

Medical anthropologists (Kleinman, 1986; Lock, *in press*) point out that symptom expression is socially determined and depends on local knowledge and reactions from others and social institutions. Thus, it is important to recognize that our system of diagnostic categories and psychotherapy are social constructions and, therefore, they may not be relevant to cultures outside of our own.

An investigation of the domain of culture in clinical psychology illuminates cultural assumptions implicit in the theories. One of the cultural assumptions in North American psychology is that our theories about emotions apply globally. It is assumed that the lexicon used to express emotions and the amplitude of emotional reactions are universal. Instead these behaviors are culture-specific and, therefore, theories generated within the dominant North American culture will not apply to everyone. Similarly, it is assumed that somatic symptoms are a result of pent-up emotional baggage and that healing is only possible through free expression of one's inner turmoil (Shweder et al., 1997). It is important to understand that this purely psychological conception of symptom expression is culture-specific and that it is not consistent with the worldview of many peoples. For instance, we have treated clients from a number of cultures (Nepal, Portugal, and Cape Verde) who presented strictly with somatic symptoms and talking about their feelings was not part of their traditional discourse.

A second cultural assumption encountered in clinical psychology is the notion that language use is epiphenomenal. Because so much of clinical psychology is dependent on language, it is important to realize that language is rooted in context. Thus, expressions such as "I have ants in my brain" might be indicative of delusion in one context but be an everyday expression in another culture.

Similarly, the meaning of symptoms is local; it is dependent on local knowledge about the body and pathology. Anthropologists have found support for this notion by demonstrating that symptoms are linked to the social context of the client. In Fiji, Becker (1998) found that new mothers often suffered from a form of sadness and isolation similar to postpartum depression. The symptoms, however, varied greatly from Western notions of the disorder and she determined that it would be more accurate to describe the syndrome as the culture-bound disorder, *na tadoka ni vasucu*, than postpartum depression. Becker also demonstrated how the symptoms of this disorder had meanings that clearly reflected the Fijian social context and that the treatment was social (i.e., friends rallying around the afflicted) rather than medical.

Cultural categories also seem to affect which symptoms will be culturally acceptable. For instance, there is convincing evidence from Lock (*in press*) that symptoms of menopause, something usually understood as a biological universal, vary greatly between the United States and Japan. Thus, she frames her discussion of menopause as a "biocultural" social construction. In addition, other researchers have found that social institutions such as the organisation of health care services and social reaction to the illness all affect the illness experience (Clarke, 1996; Young, 1995).

Given the tremendous complexity, the notion of etiology becomes a socially constructed and often contested domain (Brandt, 1997). The complexity is captured by Gusfield (1997) when

he suggests that “a condition of the body can be viewed from different points of view or from several at the same time by the same person” (p. 203). What one may see as a treatable medical disorder others may see as part of the human condition, or a religious or moral concern.

2.2.2. *Religious norms*

A consideration of religion in clinical psychology highlights assumptions implicit in our theories that need to be investigated. First, an assumption of the medical model is that there is no meaning in suffering. However, for many religious groups suffering strengthens their bond with others and with the Divine (James & Haskell, 1999). Long (1986) points out that

... through [suffering] a language of the sacred is revealed—a language that describes human immersion in life—in this case as confrontation with the sacred. The language or structure of the sacred is a way in which [psychologists can] insert themselves into the [psyche] of the other. The use of every structure whether biological, aesthetic or religious points to a common endeavor to find a common form for the self and other which is the object of interpretation. Structure, [in this case suffering], is a vehicle for communication. (p. 46)

A thorough investigation of the client’s religious and philosophical notions regarding suffering at the initiation of treatment would have been a helpful approach with Rose, a Roman Catholic client treated at our clinic. Rose had chronic pain and she tirelessly talked about her pain session after session. Consistent with a solution-focused approach (De Shazer, 1988), the therapist asked her to talk about the times that she did not have pain. This seemed to heighten the severity and frequency of the pain. What the therapist had not fully realized was that, for her, suffering was part of being a good Christian and it was redemptive. Thus, talking about when she did not have pain was like talking about when she was not a “good Christian.” The therapist eventually learned that Rose’s suffering, and its network of meaning, needed to be understood not just removed. He also learned that listening to her suffering was a way to build a relationship with her. She expected friends and God to listen tirelessly and compassionately to all of her various physical complaints and she assumed that a therapist should do so as well. Once Rose felt that her suffering and symptoms were taken seriously, she was then able to move on to discuss other topics such as her dire economic situation and difficulties with her husband.

A second assumption implicit in clinical psychology theories is that the only agency is human agency (Shweder, 1991). It is assumed that the only intervention possible is by the therapist or the client and that Divine intervention is not something to be discussed, even though for people from many cultures the healing power of the Divine is the highest power.

A final assumption that we often hold in psychology is that religion is reducible to psychology (Spero, 1992). For instance, although Freud said that Ignatius of Antioch, a martyr, was “bordering on mania,” it can be argued that a religio-cultural interpretation of this case is preferable to a strictly psychological interpretation.

2.2.3. *Moral norms*

Although psychology purports to be a value-free science, a critical reading of psychotherapy texts and training manuals reveals that there are moral assumptions implicit in all theories of psychotherapy (Prilleltensky, 1994; Toukmanian, 1998). Each school of psycho-

therapy has implicit notions of what is a good person and a good family. For instance, within the psychoanalytic framework a good person is verbal, assertive, and autonomous. A good person is also insightful; a Baconian view of insight is adopted in which it is beneficial to question internalised values rather than simply accept the values passed on by parents. Even though those notions of a good person are not universal, those who do not fit well with the theory may be seen as lacking insight or poorly differentiated and perhaps pathologized. For instance, in our capacity as cultural consultants to clinicians having difficulty treating clients from other cultures, we have often heard clinicians state that clients from the immigrant group with whom they work are “lacking insight” to such an extent that they are unable to do insight therapy with them. In family systems theory, on the other hand, a good family promotes autonomy and individuation, maintains a family hierarchy (i.e., parental subsystem above the sibling subsystem), and talks openly about their problems in front of a stranger, the therapist. These are not universal notions of a good family and we have often heard clinicians speak about immigrant families as enmeshed and as having poor boundaries. Lastly, the cognitive–behavioral paradigm adopts a pedagogical stance and, therefore, a good person can read, complete questionnaires, and rate their behaviors. Also, a good person is rational, assertive, has high self-esteem, and can understand a causal explanation of their behavior. Again, these are not global notions of a good person and those that do not fit may be seen as irrational or lacking social skills. For instance, we have encountered therapists frustrated with their client’s “resistance” to completing questionnaires and activity logs, when language abilities and cultural differences were really the issue.

2.2.4. Desired outcome of examining contextual considerations

Considering the contextual domain helps us to understand the social, cultural, religious, and moral norms of the group with which we are working. We do this in order to understand how these norms affect the group’s conceptualization and experience of mental health. Gathering this information is a multidisciplinary exercise in which we consult not only psychologists, but also other researchers investigating the economic, social, and cultural contexts of the group. Similar to the process of examining the philosophical considerations, an identification of one’s own context is crucial so that personal and professional norms are not imposed on the group. To do this we identify cultural and moral assumptions implicit in clinical psychology theory as they provide indications of the limitations of our theories when working with other cultural groups.

2.3. Experiential considerations

Philosophical and contextual considerations have to be infused with real life sentiments. Visions of the good society have to be complemented with the lived experience of community members and with the knowledge of social scientists (Kane, 1998; Montero, 1998). Individuals may suffer because of prevalent social and cultural norms. We should not accept unquestioningly the moral legitimacy of certain cultural practices because they may be prejudicial towards certain sections of the population. This is why we need to listen to the plight of the people themselves in other cultures. It is important to understand their cultural context and their philosophies, but it is equally crucial to attend to the voice of the people themselves.

Experiential considerations contribute to the framework by answering the questions *what is missing* and *what is a desirable state of affairs* for community members. This set of considerations pays explicit attention to the voice of the people with whom we partner to improve their well-being. Psychologists have to elicit the needs of people in a position of disadvantage or suffering from mental health problems. Grounded theory and lived experience serve to identify basic human needs of people in context.

Qualitative studies and ethnographies of people's struggles, aspirations, conflicts, frustrations, and joys provide a picture of what people regard worthwhile in life; parents disclose their doubts about how to raise children, children share their fears and pleasures, and minorities relate experiences of discrimination. These accounts disclose their needs and aspirations.

By asking people what they want, need, and consider meaningful in life, we learn about the ingredients of an appealing vision. This is not to say that whatever people say should be acceptable. For it is quite conceivable that the majority of people in a society may be wrong or malicious. History could prove that majorities are capable of endorsing and enacting vicious attitudes. Just like moral visions have to be checked against human needs, human needs have to be subjected to careful philosophical scrutiny. What we have, then, is a dialectical process of eliciting moral values through philosophical and empirical means, and examining each set of values for their philosophical clarity and empirical validity. Grounded input should be assessed using moral criteria, while philosophical notions should be verified through studies of human needs.

An example of how ethnographies can be used to learn about personal struggles is provided by two studies conducted by medical anthropologists. First, a study of female patients with chronic fatigue syndrome (Ware & Kleinman, 1992) found that most of the patients' premorbid energy and activity levels were extremely high: These patients were described as "superwomen," who devoted much of their time to caring for others. The disorder forced them to slow down and take control of their hectic lives. Similarly, Kleinman (1995) describes a Puerto Rican client for whom her "ataques de nervios" (somatization disorder which includes symptoms such as dizziness, fainting, heat in the chest and head, and memory loss) was her last vestige of power. Her illness encouraged others to rally around her and offer support. The researchers suggested that symptoms were an acceptable forum for the disempowered to voice their distress and negotiate for more resources.

2.3.1. *Desired outcome of examining experiential considerations*

An investigation of the experiential considerations gives us an appreciation of what is needed in the social context to improve the mental health of the group with which we are working. In order to understand this context, community voices are heard through lived experience and ethnographic and grounded theory research. Thus, we can identify the needs related to mental health in the community from the community members themselves.

2.4. *Pragmatic considerations*

Whereas the previous sets of considerations examined actual, ideal, and desirable states of affairs in society, pragmatic considerations concern *feasible change*. Unlike previous

deliberations, which asked *what is, what is missing, or what should be*, the main question answered by this set of considerations is *what can be done*. This question is meant to bridge the gap between the actual state of affairs on one hand, and desirable and ideal visions on the other. Feasible change draws our attention to what social improvements can be realistically accomplished—a therapeutic as well as a social goal.

It is important not to limit interventions for mental health only to therapy. Social action and community interventions have much to offer to improving community mental health (Prilleltensky & Nelson, 1997). By reflecting on previous efforts at social change and learning from agents of change, we can hope to close the gap between the ideal and the actual. A specific outcome of pragmatic thinking is a plan for social action.

Personal and social agents of change translate moral values and grounded input into action. These are the professionals, para-professionals, politicians, volunteers, and activists who combine values with human experience to improve the welfare of a particular population. Agents of change strive to promote wellness by combining values with knowledge of what people want, need, and regard important in life. Agents of change bridge between the abstract notions of philosophers and the lived experience of children, parents, and community members. They try to adapt ideals of the good society to specific contextual realities. In that sense, all of us who work in communities are agents of change.

Within the social sciences in general and within psychology in particular, community psychology is one of the few disciplines explicitly concerned with community mental health and with oppression and social change (Prilleltensky & Gonick, 1994; Rappaport, 1977). Thus, incorporating the contributions of community psychology in the domain of mental health across cultures would enhance psychologists' work. For instance, as a clinician working with the Portuguese community, I (James) came across many cases of domestic violence. I could treat people when they finally came to the clinic as a last resort, but I wanted to try to prevent this from happening in the first place. I did not feel that I had the tools to intervene in this way, so I am collaborating with community psychologists (Geoff Nelson of Wilfrid Laurier University and Isaac Prilleltensky of Victoria University of Melbourne, formally of Wilfrid Laurier University) to develop and implement domestic violence prevention strategies through the formation of partnerships with women's groups in the community.

2.4.1. Desired outcome of examining pragmatic considerations

An examination of pragmatic considerations provides insight about what can be done to improve the mental health of individuals and the community at large. Resources on effecting change are gleaned through agents of personal change such as psychotherapists, agents of social change such as activists, and agents of resource mobilisation and social change theory such as community psychologists. With this information, we aim to implement personal and social change strategies that respond to the local context and that are sensitive to the needs of the individuals and communities.

The complementary nature of the four sets of considerations now becomes apparent: without a philosophical analysis we lack an understanding of what each society values; without a contextual analysis we lack an understanding of social forces; without a needs

assessment we lack an idea of what people want; and finally, without pragmatic thinking we lack a plan of action. The interdependence of these deliberations makes it impossible to privilege one set of considerations over another.

3. Working with the Portuguese immigrant community

So far we have primarily focused on the first two columns of the framework (Table 1), the key questions and resources. Now we will focus on the application of the framework by demonstrating how we used the framework when we worked with Portuguese immigrants in the United States (Boston, MA) and Canada (Cambridge, ON). More specifically, we were working with people who emigrated from the Azores, nine Portuguese islands in the Atlantic Ocean.

3.1. Philosophical considerations

Portuguese religious and literary texts, community and religious leaders, and traditional healers were consulted to gain insight into the philosophical considerations of the Azorean immigrants. This was an important exercise because many of the values espoused by the Azorean community were different from the values of the North American dominant culture and the culture of clinical psychology. Within the Azorean community, a good person serves others, the family, and the Divine, and endures suffering if it is necessary. Thus, when Azorean clients are facing a difficult situation they may not actively try to change their situation because of the inherent value of suffering or because they are counting on Divine intervention. In contrast, an underlying assumption of all therapies is that the only agency is human agency. Thus, many of the therapists interviewed characterized Azorean clients as “passive” rather than realizing the philosophical context in which the client’s behavior was embedded. Additionally, from an Azorean perspective, insight into feelings and behaviors and verbalizing needs are not part of what constitutes a good person. Thus, analytic and behavioral therapists interviewed, who value such insights, were frustrated by the apparent “lack of insight” of clients from the community. For the Azorean immigrant community, a good family is one in which you can depend on others and they can depend on you. Similarly, suffering for others in the family is part of being a good person and their vision of a good family. The family therapists, however, working from theories that value autonomy and individuation, conceptualized the families as enmeshed and lacking boundaries. Lastly, a good society is not defined or considered in the psychotherapy literature because much of the focus is at the level of the individual and family. Within the Azorean community, a good society is one where, consistent with their religious beliefs, there is mutual help and commitment.

Unlike the medical model, where suffering has no meaning, suffering for members of the Azorean community has complex links to their social and religious contexts. Suffering links Azoreans to others and to the Divine, creating a mind/body/spirit holism that is often not mentioned in clinical psychology theory.

3.2. Contextual considerations

A thorough analysis of the contextual considerations revealed that symptom expression is closely tied to the cultural context for this community. It also revealed that when health providers ignored the context, it led to misdiagnosis and treatment. The discovery of a culture-specific somatic phenomenon, *agonias* (meaning the “agonies”), challenges the assumptions of universalism that are implicit (if not explicit) in the systems of diagnosis and treatment (James, 2002; James & Clarke, 2001).

Interviews with clinicians revealed that *agonias* is baffling for them because the meaning and symptomatology of *agonias* is remarkably idiosyncratic, ranging from indigestion to someone “on the brink of death” (James, 1998). When clinicians were asked about how they conceptualize and treat *agonias*, they unanimously stated that *agonias* is “anxiety” or “anxiety and depression” and that the treatments are medications (particularly antianxiety medications) and psychotherapy.

The meanings clinicians ascribed to *agonias* were very different from those of the community members. Rather than an individualistic conceptualization of *agonias*, community members’ explanations were more related to their socio-religious context. For instance, some participants suggested that a person can experience *agonias* because of spousal abuse or because they have had a premonition that an impending catastrophe will strike another community member. Others linked *agonias* to their religious beliefs; some said that it was God-given so that there was no cure; others said that prayer was the cure; while others said that people experience *agonias* because they are anxious about sin (James, 2002; James & Clarke, 2001).

An analysis of the cultural assumptions in clinical psychology theory revealed that the diagnostic system encourages an understanding of disorders that privileges internal experience and ignores the concomitant cultural and social dynamics (O’Neill, 1996). Thus, psychiatric categories are limited when trying to classify idioms like *agonias* that refuse to be strictly psychological. Consequently, *agonias* does not fit neatly into one of the psychiatric categories because it “encircles a broad semantic domain that extends well beyond narrowly defined psychological distress into the realms of morality, relationality, identity and religion” (O’Neill, 1996, p. 8).

The treatment of *agonias* also reveals cultural assumptions within our theories and practices. In the Azores, distress and *agonias* are treated by community compassion. In North America, on the other hand, where *agonias* is seen as a psychiatric disorder, community compassion, in the form of help from health professionals, is commodified and medicalized. Additionally, although the problem may be at an interpersonal level, for example spousal abuse, the treatment that clinicians described for *agonias* exclusively targeted internal symptoms in the form of medications or individual therapy for anxiety or depression.

When investigating the moral assumptions of the clinicians treating this population, we noticed that many of the mental health providers talked about their Azorean clients as “concrete” and “not psychologically minded,” as if this group was not capable of understanding the causal relationships in a psychological world. A possible explanation for this assessment is that implicit in psychotherapy theories is the assumption that the

theories apply to everyone. Thus, if a client does not fit the paradigm, the generalizability of the theory is not questioned, but rather the ability of the client to have a valid experience is contested.

3.3. *Experiential considerations*

To understand the experiential dimensions of the Azorean community, ethnographic interviews were conducted with 50 community members (James & Haskell, 1999). Themes that emerged for the participants were the hardships that they had endured and the solace that they receive from their religious beliefs. For them, suffering, no matter how difficult presently, is not going to continue forever but merely exists in the present world. One woman remarked

I think that many women, especially in the reality of domestic problems, like domestic violence, marital issues, and problems with their children are saying “is my cross to bear”. . . They see a purpose in their suffering, if not in this world in the other world.

With regards to healing, the melding of the mind/body/spirit was again evident. The participants all reported that when they are ill they seek medical care. Besides consulting a health provider, the majority of patients also consult other systems of healing; some pray or consult the priest, others visit a traditional healer, while others go to all three healers. Thus, seeking healing in multiple domains is a common occurrence for this group.

3.4. *Pragmatic considerations*

We are in the process of developing and implementing two social change strategies. The first strategy targets the misdiagnosis and treatment of *agonias*. For clinicians and medical interpreters to learn about *agonias*, we are conducting workshops with providers who frequently serve this population. The workshops also aim to bridge the gap among allopathic, religious, and traditional healers. Thus, religious and traditional healers also attend the workshops so that the health providers can learn from their experiences.

In addition to publishing reports and academic papers on *agonias*, we are developing a bilingual website on Portuguese health issues where clinicians can find the results of our study. The advantage of having a bilingual site is that it caters to the Portuguese community by providing information in their mother tongue while at the same time providing information for clinicians who do not speak Portuguese. Lastly, we are distributing the results of the study to community members through community agencies and by providing an information sheet about *agonias* that community members can take to their health care providers.

The interviews were conducted in a manner that allowed participants to voice their concerns on issues that were salient for them. Through that framework, it emerged that, for some women, *agonias* was brought on by domestic violence and the number of incidents reported was quite high. We feel that individual therapy is not enough to address this problem and, therefore, we are initiating a program at the community level as well. We are forming a partnership with an advisory committee of local Azorean women to help us tackle this issue.

We will be starting with a needs assessment to determine social supports that are already in place. With the committee, we will work to develop a culturally appropriate strategy for providing more support for victims of domestic violence as well as developing a program to target prevention within this community.

4. Conclusion

To reflect our concern for an ecological understanding of mental health, contextual, experiential, and pragmatic considerations are further divided into micro-, meso-, and macrolevels of analysis. We can use the framework presented in [Table 1](#) to guide our clinical work with ethnic minority clients. From a philosophical perspective, we need to learn about the clients' values and notion of the good life, the good family, and the good society. For a further understanding of this domain, we can consult the philosophical, political, and religious writings of the client's culture and talk to religious and traditional healers from that community. It is also important to compare those responses to our (the helper's) values and notion of the good life and well as those values implicit in our psychotherapy theories. From a contextual standpoint, we can look at how the social, cultural, religious, and moral norms of the clients' society affect the conceptualization of mental health and again contrast that with our own. For the experiential level of analysis, we can ask our client and others from his or her community about changes at the societal level that would improve mental health in the community. Lastly, from a pragmatic perspective it is important to ask the client what the client perceives as helpful for his or her problem and let that guide the course of action.

The framework presented in [Table 1](#) can also be used to posit a hypothesis regarding our field's attention to each one of the issues on the left hand side of the table. Thus, we could speculate that psychology pays only minimal attention to philosophical analyses of society's vision of the good life, and that we are relatively uninformed about values affecting mental health in different cultures. At the level of pragmatic assessments, for instance, we could say that psychology pays attention to change processes at the micro- and mesolevels, but that we could be more attuned to macrosocial change. Assessing the attention (from low to high) given to the various complementary considerations can stimulate discussion in psychology about our priorities and future directions ([Table 2](#)).

Table 2

Hypothesis regarding psychology's attention to complementary considerations in pursuit of mental health in different cultures

| Considerations | Level of attention | | |
|----------------|--------------------|----------|-------|
| | Micro | Meso | Macro |
| Philosophical | moderate | low | low |
| Contextual | high | moderate | low |
| Experiential | high | moderate | low |
| Pragmatic | high | moderate | low |

We suggest that our field is stronger in the microlevel analyses than in meso- and macrodynamics affecting the mental health of individuals in other cultures and in our own cultures as well. In our view, there is differential progress in our understanding of micro-, meso-, and macrocontexts. We are clear on how personal, family, work, and school contexts influence basic human needs and corresponding values, but we have not yet understood clearly the role of cultural and political norms in wellness (Levine, 1998). A similar observation can be made about research on needs. Whereas we inquire in needs assessments about personal, familial, and mesolevel needs, we seldom explore what changes should take place at the macrolevel in order to foster basic human needs. The relative lack of attention to macrolevel contextual considerations extends to pragmatic issues. In psychology, pragmatic considerations leading to change are limited to micro- and mesolevel institutions. The challenge of social change is still awaiting an operational paradigm (Prilleltensky, 1997).

Although we are presenting this chart to evaluate psychology's attention to multiple levels of analysis, it can also be used to evaluate one's own attention to those levels of analysis. For example, evaluating one's own work using the chart will identify personal biases in research and practice and identify domains that have not been given equal consideration and deserve more attention.

In order to render legitimate practice, we need to be immersed in the philosophical, contextual, and experiential considerations of the group with which we are working. Comprehensive assessment and intervention involves bridging disciplines to gain a more holistic appreciation for the group's situation and experience. Thus, we have provided a transdisciplinary framework to aid in achieving integrative practice when working with people from diverse cultural contexts. The framework is not limited to assessing the needs of individuals but draws on anthropology, philosophy, political science, and religious studies to also understand the social, cultural, moral, and religious domains. Additionally, community psychologists and social activists can provide models of how one can intervene at various levels.

The unique contribution of the integrative practice framework is that it merges considerations that are typically studied in isolation. Needs, norms, context, values, and social change are not always studied in an integrative fashion. Thus, the article offers a way of integrating seemingly disparate but highly complementary practice deliberations. This practice can help to make disciplinary boundaries more permeable by encouraging dialogue between people from different academic backgrounds.

The framework is general enough that it can be used when working with people from other cultures in areas other than mental health. For instance, it would also be helpful for considering other aspects of immigrants' experience such as acculturation, discrimination, poverty, employment opportunities, and community development. It would also be helpful for people posted in foreign countries, with development agencies, businesses, and embassies. Often such personnel face tremendous cultural gaps between themselves and the host nationals with whom they are working. Thus, the framework would be helpful for identifying how one conceptualizes problems in the host culture and where to find resources.

Although particularly salient when working with people from other cultures, the framework can also be used when working with people from the same culture. When working with

people who appear to be similar, we often assume that their values and norms are identical to ours. This, however, may not be the case and, therefore, it is important to use the framework to ensure that their values and experiences are the ones being privileged and not our own.

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