Pathologizing Culture

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Abstract

In this paper, I will critique the lack of cultural competence within the fields of Western psychology and psychiatry to warn against the dangers of pathologizing behavior without considering a patient's socio-cultural context. To do this, I first explore the fields of psychology and psychiatry over time, examining some of the shortcomings they have experienced in terms of taking an overly ethnocentric approach to addressing mental health. I then consider one hypothetical and several real life examples to demonstrate what the pathologization of culture looks like. And finally, I put forward a few suggestions regarding how to begin incorporating a more multicultural approach.

Keywords: cross-cultural psychology, cultural relativity, cultural competence

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The following is a clinical report resulting from a private practice psychotherapy session with a 21-year-old male client who sought help due to an interpersonal conflict with a friend. The client has complained of a lack of support from his friends, many of whom have distanced themselves from him, citing his self-centeredness and excessive need for attention—although the client does not think they are being truthful and instead believes they are envious of him. The client regularly expresses a desire for admiration and rarely goes more than a few hours without seeking validation from others. However, seeing others succeed, particularly his friends, causes the client to feel threatened and act envious by failing to recognize their achievements or intentionally trying to bring them down. Relationships with others tend to be superficial and seem to exist for the primary purpose of regulating the client's self-esteem. The client has exhibited attention-seeking and grandiose behavior and has demonstrated a preoccupation with fantasies of success and fame, frequently exaggerating his achievements. From this clinical assessment, the client meets the DSM-5 criteria for Narcissistic Personality Disorder and should pursue further psychotherapy.

Considering this report alone, it probably seems clear that someone who has received a clinical assessment from a psychiatrist or psychologist and is exhibiting these kinds of features is most likely showing signs of Narcissistic Personality Disorder, right? However, what if I were to tell you that in reality, this client's behavior has been grossly misinterpreted and taken out of context? Would it change your mind if I were to explain that everything the client spoke to the clinician about and all of his "attention-seeking and grandiose behaviors" took place on a social media platform such as Facebook or Instagram? Knowing this, the diagnosis now seems

questionable because this kind of behavior has been deemed as acceptable and completely normal on social media. Thus, this passage is meant to reveal some of the hidden obstacles psychologists and psychiatrists face everyday when determining whether a client meets the criteria for a certain disorder. The risk of a misdiagnosis or the misinterpretation of "symptoms" can be especially serious for those whose social or cultural context is not understood by the clinician at all. In this paper, I will critique the lack of cultural competence within the fields of Western psychology and psychiatry to warn against the dangers of pathologizing behavior, meaning treating something as if it were a medical condition, without considering a patient's socio-cultural context. To do this, I first explore the fields of psychology and psychiatry over time, examining some of the shortcomings they have experienced in terms of taking an overly ethnocentric approach to addressing mental health. I then analyze the passage above and give real life examples to demonstrate what the pathologization of culture looks like. And finally, I put forward a few suggestions regarding how to begin incorporating a more multicultural approach.

The clinical diagnosis above was written using a similar technique as seen in "Body Ritual of the Nacirema" by Horace Miner, which employed ethnographic language in order to critique the field of anthropology at the time and the way it tended to "other" different cultures (Miner, 1956). In his paper, he wrote about this exotic other, the Nacirema, in the same way that many anthropologists wrote about the communities they studied; however, the twist was that "Nacirema" spelled backward is "American", so he was really writing about Americans in this othering manner. In the same way, this essay is meant to be a critique of the ways in which Western psychology and psychiatry often pathologize aspects of different cultures due to a lack of cultural and contextual understanding. Because of the seemingly straightforward and

"objective" language of the criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which is used by clinicians to diagnose the presence of various mental disorders, there is a serious threat of taking these guidelines as fact (American Psychiatric Association, 2013). While the newest version, the DSM-5, created by the American Psychiatric Association, for the most part is built on decades of empirical evidence and has tried to address many of the shortcomings critiqued in previous editions, it still relies on a few major assumptions: 1) that the criteria listed in the DSM-5 can accurately differentiate individuals with a specific mental disorder from the rest of the population, 2) that there are objective definitions for what normal and abnormal thoughts and behavior look like, and 3) that the criteria and disorders listed in the DSM-5 are universal and apply cross-culturally. However, I argue that these three huge assumptions need to be carefully evaluated.

The pathologization of normal behavior is not a new concept in the field of mental health. Discussions regarding clinical disorders, who has them, and whether or not clinicians are over-diagnosing clients have and will continue to be in constant debate. However, the addition of a cross-cultural component still seems to be lacking. For a discipline created by primarily wealthy white men, it should not be surprising that incorporating cultural relativity into the field has been a long and slow process. However, there are a few authors, researchers, and practitioners that have started pushing for the introduction of a cross-cultural lens into the fields of medicine and mental health. Cultural competence, or the ability to work with patients and clients with a diverse set of beliefs and values, is starting to make its debut in the health care industry. For example, in *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* Anne Fadiman writes about the experience of a refugee family from Laos after they are resettled in California (Fadiman, 1997). She explores the cultural clash

between the family and the doctors, citing a general lack of understanding within the practice of medicine as the ultimate cause of the loss of their daughter. Mary Pipher, a cultural anthropologist and psychologist, also addresses many of the issues resettled refugees from across the globe face when it comes to dealing with doctors in the United States, particularly with respect to mental health professionals in *The Middle of Everywhere* (Pipher, 2002). Pipher explains that health care professionals have a moral obligation to be as culturally competent as possible when suggesting treatment options and making diagnoses, considering aspects like language barriers and conflicting cultural norms and values.

Thus, it is imperative for context to be considered when trying to determine how to diagnose and treat clients effectively within psychotherapy. My earlier example of a young man's social media habits being misinterpreted as Narcissistic Personality Disorder, while somewhat silly, I think still provides an interesting and perhaps more easily digestible interpretation of what it looks like to pathologize an aspect of culture. I decided to use social media because it provides a tangible platform to use as a metaphor for the space in which cultural context is occupied. If you notice, I did not once mention in my initial diagnosis that this behavior was happening on social media. As a clinician, this is problematic because the behavior now has been taken out of the cultural context surrounding it. In this particular case, this type of seemingly "narcissistic" behavior, like attention seeking and posting content that exaggerates your achievements, is acceptable on social media. Therefore, we see how something that according to the DSM-5 may be abnormal, in this context is actually a very normal and reasonable occurrence.

As such, I wish to complicate one of the key assumptions in the DSM-5 that there is an objective "normal" and "abnormal." Rather than bringing into question the value of the existing

research that has been done on this, I simply wish to add on another layer by highlighting how deeply connected these assumptions are to cultural norms. For example, "homosexuality" was categorized as a clinical disorder in the DSM until the 1970s, demonstrating how dependent our notions of abnormal are upon dominant ideologies. Therefore, I argue that recognizing the fact that these symptoms and categories of mental illness are not completely objective and do not exist in a culture-less vacuum is the first step to improving cultural competency in the mental health domain. Of course, this is not to say that Western psychology is useless—this would certainly make my decision to major in it a questionable life choice. There is indeed value in a clinical diagnosis as it can allow someone to seek and gain access to treatment. Also, empirically studied research is crucial in this field because we always want to ensure that the therapies we use are effective, and we especially want to be sure that they are not causing additional harm. I'm simply offering up a warning about the dangers of what can happen when we take this one approach to addressing mental health as an all-encompassing, unbiased "truth," when in fact, it is made up of a variety of deeply rooted cultural norms and values regarding what is normal and abnormal.

In her ethnography, *The Middle of Everywhere*, Mary Pipher elaborates on how this issue is affecting people in a very real way (Pipher, 2002). She specifically discusses how many resettled refugees' thoughts and behaviors are taken out of their cultural context and passed off as abnormal due to a lack of knowledge on the clinician's part. While many clinicians are quick to diagnose refugees with a whole host of mental disorders such as anxiety, depression, and Post-Traumatic Stress Disorder, an official diagnosis without considering contextual information may not be useful or completely accurate, and in the worst case scenario, it could even be harmful. Pipher illustrates this by explaining how almost all of the Afghani women she worked with

seemed to meet the criteria for depression; however, she states that because of everything these women have gone through, it is not really useful to call this depression, which implies pathology, because reacting to trauma is actually a normal and even healthy response. Additionally, many refugees do not wish to seek treatment in the first place for a variety of reasons, such as language barriers, lack of financial resources, and mistrust of authority figures. But when they do, such as one Vietnamese girl Pipher worked with, many often refuse to talk about the traumatic experiences they have gone through. Rather than viewing this as resistance to therapy or symptomatic of some kind of pathology, it is crucial to consider the fact that the values of catharsis and individualism in American culture may not necessarily universal. Some cultures may not talk about issues of mental health because such topics are taboo or highly stigmatized, and some believe that to cope with trauma, it is best not to talk about it—for example, while Americans conceptualize illnesses (mental or physical) as only getting better when it is treated directly, the Vietnamese have a saying that, "A wound will only heal if it is left alone" (Pipher, 2002).

I cannot stress enough how important it is to approach psychology from a less ethnocentric perspective that views Western psychology as the only valid way to address issues related to mental health, especially as our interactions become increasingly multicultural. This whole idea that "our way is the right way" is simply outdated, and if we begin to make the area of mental health more inclusive and welcoming of diverse perspectives, we may all benefit. A push for more cross-cultural research must be made on a larger scale. Practitioners must also be better trained to understand their own cultural biases, and they must also be trained to recognize when and how to effectively incorporate multicultural elements and contextual knowledge into their diagnoses and treatment recommendations. For example, building off of the previous

example of the Vietnamese refugee girl who did not wish to share her traumatic experiences, it is important for the clinician to recognize that individual treatment in a sterile, hyper-clinical setting may not be best in this case. Perhaps a more collective approach involving group therapy with others who have gone through a similar experience or who share similar values would be more useful. Of course, this is just one example; however, more broadly, a cross-cultural understanding of mental health needs to be incorporated at the curriculum level for all students interested in pursuing psychology or psychiatry, and developing training sessions designed to educate clinicians on how to work with different communities ought to be prioritized in the field.

Finally, I want to clarify that I am not arguing for psychology and psychiatry to be separated from culture, for that is an impractical and impossible task. Rather, I push for the recognition that in a world that is increasingly becoming more and more multicultural, it is crucial for the fields of psychology and psychiatry to keep up with this trend and to recognize the need for a shifting cultural and contextual lens. Our research questions, assessment tools, and treatment plans must evolve to fit the needs of the diverse global population along the lines of culture, gender, sexual orientation, age, ability, class, nationality, race, ethnicity, and so many other identity markers that shape the way people experience the world. I write this with the hope that an approach that first and foremost recognizes these multicultural experiences while considers the socio-cultural context of each individual will one day become the norm.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Fadiman, A. (1997). *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures.* New York: Farrar, Straus, and Giroux.

Miner, H. (1956). Body Ritual Among the Nacirema. *American Anthropologist, 58*(3), 503-507.

Pipher, M. (2002). *The Middle of Everywhere*. New York: Harcourt, Inc.

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