HL IB Psychology

Treatment of Disorders: The Role of Culture in Treatment

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The Role of Culture in Treatment of MDD & Phobias

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Collectivist Cultures: an overview

- The **Sociocultural Approach** (examined on Paper 1) has **culture** as one of its main areas of focus e.g. culture and its effect on individual behaviour
- One of the key topics in the IB Psychology study of culture is **cultural dimensions** (which you can find, along with the other Sociocultural topics, on this site)
- The most-studied cultural dimension is the **Individualism/Collectivism** dimension
- The bulk of the theories and studies that you cover in IB Psychology (and this will apply if you go on to study Psychology at degree level) use research from **Western cultures** i.e. the USA, the UK, Western Europe, Australia which are all individualistic cultures
- Collectivist cultures can be **characterised** in the following ways:
    - An emphasis on **we/us** rather than **I/me**
    - Priority is given to the **group** rather than to the individual
    - **Cultural norms** may centre around behaviours which benefit the family/community/society e.g. living with **extended family**; sharing earnings with the family or the community as a whole; older people being awarded due respect and **status**; **rituals** and **ceremonies** which celebrate **long-established traditions**
- Collectivist cultures have been studied alongside individualistic cultures in **cross-cultural research** with an emphasis on comparison of both cultures on **key variables** e.g. **conformity**

Why is Culture an Issue in the Treatment of Disorders?

Cultural Relativism

- One of the problems with cross-cultural research is that it may result in **universal, ethnocentric** or **etic** conclusions being made i.e. the researcher(s) may (consciously or unconsciously) view their findings through the **prism** of their own **cultural perspective**
- **Cultural relativism** (**CR**) is the idea that not all cultures are the same and there is no one 'superior' culture: **diversity** should be respected and accounted for in research
- CR emphasises the idea that behaviour should be understood in the **context** of the culture itself rather than making judgements based purely on the behaviour in question
- Using a CR approach to research involves a lack of judgement of cultures which are different from the cultural norms of whomever is conducting the research
- CR means that a researcher should try to understand cultural practices from *within* that culture so that instead of making value-judgements about the culture, the researcher asks interested questions e.g. '*Why is it that **latah** exists in Malaysia and Indonesia?*' (latah presents as **hypersensitivity** to sudden fright, often with **echopraxia, echolalia,** command obedience, and **dissociative** or trancelike behaviour)

Culture & mental health

Culture & mental health

- The topic of **clinical biases in diagnosis** (which you can find on this site) considers **culture-bound-syndromes** (**CBS**), concluding that Western individualistic clinicians who are not familiar with CBS may **mis-diagnose** mental disorders due to a lack of cultural knowledge
- Different cultures have different values so trying to apply a universal model of treatment (specifically, the **biomedical model** with its emphasis on physiological **etiology** of disorders) across cultures does not account for CR
- Some cultures are wary of disorders such as MDD so their criteria for treating depressive symptoms will be based on their own cultural understanding of the condition rather than on a course of **antidepressants**
- In Ethiopia there is a CBS known as **zar** which a Western **clinician** may treat as **MDD** (as it involves weeping, **apathy, withdrawal**, loss of **appetite**), whilst ignoring the **cultural context** which is that symptoms are attributed to spirit possession with the possibility of the person developing a long-term relationship with the possessing spirit
- In China there is a CBS known as **shenkui** which a Western **clinician** may treat as an anxiety disorder such as phobia (as it involves panic), whilst ignoring the cultural context which is that symptoms are attributed to excessive semen loss from frequent **intercourse, masturbation, nocturnal emission** i.e. excessive **semen loss** is feared because it thought to be life-threatening

Which studies investigate the role of culture in treatment of MDD & phobias?

- **Hodge & Nadir (2008) –** A review of four therapeutic approaches to treatment of MDD and phobias
- **Hinton et al. (2005) –** the efficacy of CBT for Cambodian refugees

Both Hodge & Nadir (2008) and Hinton et al. (2005) are available as Two Key Studies of the Role of Culture in Treatment of MDD & Phobias: just navigate the Treatment of Disorders section to find them

Worked Example

The question is '*Contrast two approaches to treating disorders' [22]*

'Contrast' means that you should focus on the differences between two separate approaches, using relevant research with good use of examples and critical thinking. Here is an exemplar for guidance:

Research which is mindful and respectful of culture and its role both in diagnosis and treatment of disorders could be said to contrast starkly with the biological approach (using the biomedical model) to treating disorders. The biological approach leans heavily on drug therapy such as antidepressants which are based on theories such as the monoamine hypothesis (using biomedical model assumptions), placing the etiology of MDD on an imbalance of brain chemicals. Taking an approach which acknowledges the role of cultural relativism in treatments would likely ignore the use of drugs to treat culture bound syndromes and would instead use traditional treatments which align with their culture and make sense to the patient.

Two Key Studies of the Role of Culture in Treatment of Disorders

Key study one: Hodge & Nadir (2008)

Aim: To investigate the extent to which **Western-style counselling** practices are appropriate for other cultures.

Procedure:

- A **review** of research on the topic which looked at four commonly-used **therapeutic approaches** to the treatment of a range of mental illnesses such as **MDD** and **phobias**
- The four different types of counselling therapies included in the review were:
  - **Psychoanalytic therapy**
  - **Group therapy**
  - **Strength-based therapy**
  - **Cognitive Behavioural therapy** (**CBT**)
- The researchers were interested in investigating the provision of what they term '**culturally competent** services to Muslims' i.e. they were looking for evidence of therapies that are most aligned to a Muslim outlook and **cultural perspective** and which are most **congruent** with Islamic **values**

Results:

- Two therapeutic **models/treatments** were identified by the researchers as problematic for Muslim clients:
  - Psychoanalytic approaches - the emphasis on **individual introspection** is at odds with the importance in Islamic culture of **community** i.e. rather than looking **inwards** to analyse themselves, Muslims tend to look **outwards**, grounding their **identity** in **religious teachings, culture** and **family**
  - Group therapy – some Muslims may feel uncomfortable sharing **personal details** or **disclosures** in a group setting, particularly if the group included both males and females who are not related

- Two forms of therapy were identified as being more suitable to treating Muslims:
  - Strength-based approach – in this approach, strengths are identified, derived from a client's **faith**, family, culture and community: such values are more congruent with Islamic ideals
  - CBT the underlying principles of CBT are congruent with Islamic values e.g. focusing on solutions, using a 'here and now' approach
  - CBT, however, could be modified to substitute traditional **self-statements** (e.g. 'I *feel in control of my thoughts'*) with statements linked to Mulsims' **spiritual traditions**
  - This approach (cited in the above bullet point) has been successful in Taoist, Christian and Muslim cultural settings as it draws directly from **articles of faith** within that culture
  - The researchers state that this **adaptation** of CBT in order to align it with Muslim values is necessary, as from an Islamic perspective, the ultimate success of an individual's efforts is dependent upon God

Conclusion: Adaptations and modifications to existing treatments such as CBT should help to align these treatments with the client's values and to ensure that **treatment outcome** is positive.

Evaluation of Hodge and Nadir (2008)

Strengths

- This research has good **application** to an array of settings e.g. schools, hospitals, community health hubs which could be of great benefit given that most communities in the 21st century are **multicultural**
- The findings support the idea that CBT in particular is a **flexible** treatment which can be modified to suit a range of different needs and perspectives which may help to move therapy away from 'blaming' the client (which psychotherapy has a tendency to do)

Weaknesses

- The findings are a little **generalised**: the modifications suggested may not suit all Muslim clients, there are likely to be **individual differences** involved in the success of the suggested strategy as well as variations in Islamic beliefs so we should not consider all Muslims as homogenous
- A review analyses **secondary data** which may not be as **reliable** as **primary data** i.e. the researchers had no control over how the data was collected which could reduce the **reliability** of the findings

Key terms: Review Psychoanalytic therapy Strength-based therapy

Key study two: Hinton et al. (2005)

Aim:

- To investigate the **therapeutic efficacy** of **culturally adapted CBT** for Cambodian refugees with **treatment-resistant PTSD** and **panic attacks**
- To investigate the extent to which different treatment methods should be **prescribed** for refugees from different cultures
- Refugees often have severe PTSD and a range of **anxiety disorders** resulting from the **traumas** they have endured

Participants:

- 40 participants who had survived the **Cambodian genocide** between 1975–1979 and had fled to the USA, having no knowledge of **American culture** or the English language
- The participants were from rural, fairly isolated and **non-industrialised** villages so an extra **stressor** for them was having to adapt to **urban environments**
- The participants had undergone various types of therapy for whom all other treatments had failed (this is known as 'treatment-resistant'): they suffered from extreme panic attacks
- The CBT was designed by the therapists to be more in line with Cambodian culture i.e. with more emphasis on **collectivism** and **traditional values** than on **individualism**

Procedure:

- The participants were **randomly allocated** to one of two **conditions** of the **independent variable:**
  - **Initial treatment** (**IT**) condition - this refers to the first treatment given to a patient (it may be followed by other treatments if the initial treatment fails to be effective)
  - **Delayed treatment** (**DT**) condition - this refers to a delay in receiving the treatment i.e. the participants were on a '**waiting list**' for the CBT
  - There were 20 participants per condition
  - All participants continued **supportive psychotherapy**, which consisted of a meeting with a **social worker** every 2 weeks, and all of them continued to take their **prescribed medication:** an **SSRI** (to treat their MDD) and **benzodiazepine clonazepam** (to treat their panic attacks)

- Both groups were **measured** at the following time points:
  - At **baseline**, before they had started CBT
  - When the IT group had completed their 12 sessions of CBT
  - When the DT group had completed their 12 sessions of CBT
  - 12 weeks after each group had completed their therapy
- Both groups' symptoms were measured by a **bilingual** Cambodian researcher who did not know which treatment condition the participants were in, using **standardised tests** for PTSD and **general anxiety disorder** (**GAD**), panic attacks
- The CBT was **modified culturally** to be appropriate to the Cambodian participants
- A lot of the Cambodian's PTSD symptoms were **somatic** (e.g. **neck pain**, **dizziness)**, so the CBT was adapted to include **Sensory Reprocessing Therapy** (**SRT**), focusing on sensations and decreasing stress through **muscle relaxation** and **breathing training**
- The adaptation of the CBT also included **culturally sensitive** features such as asking the patients to visualise a **lotus blossom** spinning in the wind which encompasses Asian values of **flexibility**

Results:

- The participants in the IT condition improved significantly in comparison to those in the DT condition showing large **effect sizes** for all measures of PTSD e.g. 3.78 on the **Anxiety Sensitivity Index** (for guidance 0.8 is considered a large effect size)
- By the second assessment, 12 of the IT patients no longer met the **diagnostic criteria** for PTSD and 11 of these patients also no longer met GAD criteria
- The IT patients also found that their somatic symptoms had decreased
- The DT patients all met the criteria for both PTSD and GAD i.e. their symptoms remained **unchanged**
- At the third assessment i.e. once all of the patients had experienced the culturally-adapted CBT, 10 of the DT patients no longer met the PTSD criteria and 9 of them no longer met the GAD criteria

Conclusion:

- Culturally adapted CBT focusing on PTSD and panic attacks may be effective in reducing symptoms and distress for a range of anxiety disorders
- Receiving CBT as the initial treatment appears to result in the best outcomes for PTSD patients

Evaluation of Hinton et al. (2005)

Strengths

- Using a culturally-adapted form of CBT gives this study **external validity** as it could be used as a template for other culture-specific treatments for patients with anxiety disorders
- The use of the three time-point measurements means that the study has good **internal validity** as the researchers were able to assess the efficacy of culturally-adapted CBT across time

Weaknesses

- The participants who were allocated to the waiting list may have suffered from not receiving CBT as initial treatment which does give rise to some **ethical considerations** in terms of **protection of participants**
- The participants had endured a very particular type of extreme trauma so it is not known to what extent culturally-adapted CBT could be used for other disorders