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Cultural-clinical psychology: An introduction

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Bruna Fujimoto, 49 years old, the daughter of Japanese immigrants who arrived in Brazil in the late 1950s, grew up in a small town with a sizable Japanese minority, where she worked as a receptionist. She married a Brazilian of Italian origin at age 19 in order to please her parents, who wished for her to stay close to home. However, not marrying a Japanese and never having children disappointed her parents. In her early 40s she got divorced and has moved to Rio de Janeiro five years ago, where she says she is "catching up on lost time".
Ms. Fujimoto presents symptoms of fatigue, irritability, low appetite, and social withdrawal. She attributes her symptoms to worries about securing steady employment, lack of a support network in Rio de Janeiro, and guilt about her ailing mother who's alone after her father's recent death. As well, she has been facing difficulties in finding a stable romantic partner, expressing concern that her age and her ethnicity ("in between Japanese and Brazilian") is making it difficult for her to find a match. She finds that she is increasingly keeping to herself and reports mounting anxiety over the past few weeks, particularly about her way of gazing at and being with others, which has become reserved (isolated).

To make sense of Bruna Fujimoto's suffering, we need to understand it in cultural context. In this case, we have an array of contexts to choose from, yet none of which precisely match the North American and Western European settings in which most psychology research is conducted (Henrich et al., 2010). Do we try to understand Ms. Fujimoto as Japanese? As Brazilian? As a second-generation migrant? As a rural-to-urban migrant? Even the cultural psychology literature is of limited help here — although there is a large literature on the Japanese conducted in both Japan and in North America, research on other areas of the world is sorely lacking (Molnar et al., 2018).

Moreover, there is an unfortunate implicit assumption in much of this research that people migrate from the global south to the global north, especially to English-speaking countries. Each sending country is understood as a homogeneous block, whereas receiving countries — such as Australia, Canada, or the United States — are seen as multicultural, and increasingly so. Brazil is one of many countries that defy this assumption. The territory now called Brazil includes more than 300 indigenous groups who long predate the onset of Portuguese colonialism in the 1500s (Fundação Nacional do Índio, 2013). Waves of migration since have brought Spanish, Africans, Italians, Germans, Japanese, Syrian-Lebanese, and many others to Brazil over the past several centuries. Indeed, multiculturalism is so fundamental to Brazilian society that cultural variation is more often discussed in terms of race and socioeconomic status; for example, skin color is the main criterion used by the demographic census (Fish, 2008; IBGE, 2010).

A richer database, including both international research that includes Brazil and intranational research that incorporates Brazil's own diversity would doubtlessly help better understand Ms. Fujimoto clinical case. At the same time, the complexity of individual clients will always outstrip what we can learn by studying groups. A research database that definitively teaches us how to work with second generation Japanese Brazilians, might take so long to be created that by then our clients will have found a different solution (or not). We are therefore faced with the twin objectives of building a more representative database while using the research available to help us develop an approach tailored to individual sufferers. To these ends, the overarching goal of this chapter is to introduce one way of thinking about this problem and to consider the potential implications of this approach for the Brazilian multicultural context. We hope this chapter's

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lasting contribution will be to provoke a dialogue between pertinent psychological traditions in the Lusosphere and Anglosphere.

Cultural Psychology & Clinical Psychology

What is the best way to proceed, as psychologists, with the oftentimes bewildering complexity of culture and the myriad ways in which it shapes psychological functioning? Over the past decade or so, an increasing number of scholars have addressed this critical question, arguing in favor of *cultural-clinical psychology* (Chentsova-Dutton & Ryder, 2019; Gone, 2015; Maercker et al., 2018; Ryder & Chentsova-Dutton, 2015; Ryder et al., 2011). While there is a long history of psychological research on mental health in different cultural contexts, the field has lacked a unifying perspective on how this ought to be done. Notable exceptions notwithstanding, most psychological studies in this area are either: (a) clinical studies that happen to be conducted in 'other' (i.e., 'non-Western') countries or in ethnic minority samples; or (b) cross-cultural studies that happen to include psychosocial adjustment measures as outcomes. The consequence is that the psychological contribution to the interdisciplinary literature on culture and mental health has often been marginal.

The first obstacle is ontological: mainstream psychology emphasizes an individualistic, decontextualized, even atomized human subject who is at the same time similar enough to all other human subjects that any psychological process worth investigating is assumed to be universal (for a sustained objection to this view, see: Henrich et al., 2010). The second obstacle is epistemological: an emphasis on tightly controlled and replicable methods yielding quantitative results (M. Doucerain et al., 2017). Neither of these characteristics of mainstream psychology should be abandoned utterly, however. Indeed, we believe that cultural-clinical psychology will best be in a position to fully contribute to the ongoing interdisciplinary conversation if it remains identifiable as *psychology*. Psychology is, of course, the study of mind; however, given the discipline's 'Western' origins, the model of mind that predominates is an individualistic one (Geertz, 1979; Gergen, 2009; H. R. Markus & Kitayama, 1991; Nisbett et al., 2001). While correctives to this are needed, we believe that – given the context of other disciplines pushing the reduction of the individual person to biological and/or social forces – cultural-clinical psychology contributes in part by insisting that mind (self, psyche, the individual person, etc.) cannot be forgotten.

Psychology has been described as a 'hub science' (Boyack et al., 2005; Cacioppo, 2007), and although the discipline has not always been comfortable with the requisite tensions, this position is an important strength and it is maintained through a continued emphasis on mind and its links to both brain and culture. The two constituent subdisciplines of cultural-clinical psychology facilitate this bridging: clinical psychology emphasizes mind-brain connections, and does so with a greater attention to mind than is typical of contemporary psychiatry; cultural psychology emphasizes mind-culture connections, and does so with a greater attention to mind than is typical of anthropology.

Let us begin with cultural psychology (H. R. Markus & Kitayama, 1991; Shweder, 1991), as it is here that cultural-clinical psychology's claims of making a break with mainstream psychology can be observed most clearly. Over the past few decades, several different fields have taken as a central issue the interrelation of culture and psychology, and many more researchers have taken on cross-cultural comparisons within mainstream psychology. These fields vary widely in terms of how the key term, *culture*, is understood. Although influenced by several of these perspectives, we emphasize a cultural psychology approach, whose core claim is not simply that ethnic groups differ but rather that culture and mind exist in a relation of *mutual constitution*. Neither can be understood without the other, nor can one be reduced to the other; in the words of Shweder (1991), they "make each other up". We emphasize this approach because of its particular conception of how culture and psychology interrelate, and because it points to particular research strategies.

An important aspect of cultural-clinical psychology is the focus on the *person-in-context* as the unit of analysis. This aspect is prompted by concern for the individual sufferer, but at the same time moving closer to anthropology. The differentiation between 'culture' and 'cultural group' is central here: the former should not, indeed cannot, be reduced to the latter. Cultural groups are at best fuzzy categories and their main purpose is to facilitate research, although when defined carefully they may well map onto socially meaningful labels. For example, several studies of somatic symptom presentations in depression have compared a Chinese sample with some kind of 'Western' sample (Parker et al., 2001; Ryder et al., 2008). This research design permitted direct empirical testing of Kleiman's (1982) longstanding claim that somatic symptoms are presented more commonly by Chinese depressed outpatients.

Yet, one must be cautious not to fall into the trap of assuming that culture, here, is the simple fact of being in the Chinese or 'Western' group. From cultural psychology we adopt the view that although identifying group differences can be a useful first step, we should then proceed to 'unpack culture' by testing specific hypotheses about *why* the cultural groups differ. For example, Ryder and colleagues (2008) demonstrated that differences between Chinese and Westerns' presentation of depression symptoms could be explained by cultural tendencies to focus on external stimuli (e.g., describing a situation) or internal stimuli (e.g., analyzing one's own thoughts and feelings in a situation). Such findings not only allow us to better understand why the groups differ, they

also permit predictions as to which individual people in a given group will deviate from the general pattern—an important consideration for clinical work, especially if we want to avoid reducing clients to group characteristics. Once we appreciate that individual group members can adhere to, partially adhere to, or reject a given belief or practice, we can start investigating specific aspects of culture and how they shape individuals in different ways.

The 'cultural group' perspective is bidirectional, which means that we can also consider how these different and differently situated people contribute to their cultural context. Meanings and practices are distributed so that different people within a cultural context can think and act in different, even contradictory, ways that are equally culturally meaningful. Culture cannot be reduced to mind, and indeed it is much more useful to understand culture as taking place 'among' or 'between' minds. Neither can mind be reduced to culture, as people are also shaped by their idiosyncratic biographies—by their upbringings, learning histories, immediate friendship networks, chance events, and so on. Behaviors are understood by actors and observers in terms framed by a consensually-shared meaning system, and the very fact that these behaviors are enacted and observed contributes to shaping this system. In other words, culture happens 'in the head' but equally 'in the world'—and in this world, people do not simply behave. Rather, they perform what Bruner (1990) called "acts of meaning".

Turning now to clinical psychology, we find both an empirical discipline and an applied profession, one that understands psychopathology at the level of mind and, increasingly, due to neuroscience's influence, at the interface of mind and brain (Ilardi & Feldman, 2001). This influence echoes similar developments in psychiatry (Insel & Quirion, 2005) although perhaps with a greater retention of mental, primarily cognitive, concepts. The concern for mind-brain links, particularly combined with the typically greater skepticism towards psychiatric categories, is a major contribution of clinical psychology to cultural-clinical psychology (Ryder et al., 2011). We believe, however, that mainstream clinical psychology research is adopting an increasingly impoverished view of mind (Miller, 2010). There is a tendency to equate mind with brain, or with certain characteristics of brain, and with that a tendency to see mind as locked in the head with the brain. The alternatives to this tendency risk committing Descartes' error all over again by claiming that mind and brain are different entities (Gobert, 2013), what was criticized as "the ghost in the machine" (Ryle, 1949).

Psychology and the neurosciences are replete with arguments to the effect that mind is subsumed by brain, or is at best a subjective epiphenomenon of brain: the mind is a reflex of the brain. We take a different view, and one that is not that distant from the mind-brain dualism in the traditional sense (Ryder & Chentsova-Dutton, 2015; Ryder et al., 2011). Nothing happens in the mind that is not reflected in brain activity but at the same time, there are limits to the brain's explanatory power. The most obvious limit relates to complexity, as relatively simple ideas at the mind-level may be extremely difficult to describe as complex and changing neural patterns. We do not need to deny that cars and busses are composed of atoms in order to dismiss the utility of an atomic theory of traffic patterns; similarly, preference for mental explanations of certain phenomena does not require us to deny the brain.

Does this mean that the mind-level is merely a tool of convenience; a shorthand to help us talk about complex brain patterns? To an extent, yes — but one may go further. There is a view emerging from philosophy, cognitive science, and cultural psychology that understands the mind as fundamentally social and tool-using (Hutchins, 1995; Valsiner & Van der Veer, 2000; Vygotsky, 1978). One of the most famous examples is the *extended mind hypothesis*, which argues that there is little practical difference between a cognitive module and a physical tool for problem solving (A. Clark & Chalmers, 1998). In this sense, the relation between mind and brain is similar to that between culture and mind, or brain and culture: overlapping partially, but not completely (Ryder & Chentsova-Dutton, 2015).

In one example, A. Clark and Chalmers (1998) compare a person who uses their memory to walk to a desired location to a person with a memory problem who habitually writes down directions and then uses these notes to walk to the same location. The idea of 'tools', moreover, can be broadly interpreted to include other people. Perhaps Ms. Fujimoto habitually used phone calls to her mother and affectionate physical contact with her best friend in order to calm down when stressed. In her new environment, she now encounters more and unfamiliar stressors while having greatly reduced access to important aspects of her emotion regulation system. Reducing Ms. Fujimoto's stress, increasing her distress tolerance, encouraging her to meet new people who could play a similar role, or using technology to maintain more regular contact with her mother and best friend, are all plausible ways of helping her to adjust to her new circumstances.

The brain is an integral part of any holistic systems view of human psychology (Chiao, 2009; Han & Northoff, 2008; Kitayama & Uskul, 2011) as it appears to be adapted quite specifically for the acquisition of culture, responding to cultural inputs with marked plasticity (Wexler, 2006). Still, marked does not mean infinite; as well as the range of possible physical and social environments is vast, but also limited (Ryder et al., 2011). The brain is vital to our understanding of human psychology and culture not because it is a fixed entity from which all causal arrows proceed, but precisely because it is evolutionarily adapted and environmentally responsive, astoundingly flexible and also constrained (Siegel, 2012).

Treating culture-mind-brain as a single system with mul-

tiple levels has implications that include but go beyond the traditional tripartite division of the biopsychosocial model. To begin with, not even specific claims about a given disorder can be easily compartmentalized to a single level (Ryder & Chentsova-Dutton, 2015). Researchers once searched for the distinction between endogenous and reactive syndromes, hoping that the former would reflect a 'brain depression' responsive to biological intervention and the latter would reflect a 'mind depression' responsive to psychological intervention (Kendell, 1976; Mendels & Cochrane, 1968). Instead, research has now firmly established that pharmacological intervention affects self-concept, personality, and relationships with others; it has also established that psychotherapy changes the brain, and that beliefs about psychotherapy or pharmacotherapy help shape cultural norms about treatment options (Knutson et al., 1998; Linden, 2006; Pescosolido et al., 2010; Serretti et al., 2010).

We propose that if psychology could endorse a holistic vision of culture, mind, and brain, promoting research to link these levels, the designation 'cultural' would no longer be needed. 'Cultural psychology' would simply be 'psychology'; 'cultural-clinical psychology' would simply be 'clinical psychology'. Suspecting that fulfillment of this goal is far in the future, we choose to emphasize culture-mind links as a corrective to the increasingly neurobiological leanings of contemporary psychology. We do not wish, however, that this critique of neurobiological reductionism becomes some kind of anti-biological alternative, but rather a call for thoughtful and sustained integration. This integration has a long history in psychology, dating back to Wundt's *volkerpsychologie* (Allolio-Näcke, 2014), and we believe that research conducted in this integrative tradition has much to offer (Cole, 1998).

The Emergence and Maintenance of Psychopathology

The starting point for cultural-clinical psychology is very broad indeed (Ryder et al., in press): the universe potentially accessible to our perceptions demands radical simplification. That is, we selectively attend to objects that move us towards desired ends and away from undesired ends (Hirsh et al., 2012; Lang et al., 1997). A given 'object' cannot be understood separately from its constituent parts, its potential uses, and the situation in which it is encountered, not because objects lack structure but because that structure can be multiply construed (Hacking, 1999). Moreover, 'desired' and 'undesired' ends are by no means fixed, given that there are an enormous variety of possible human goals. Even universal goals are subject to considerable elaboration beyond evolved biological considerations. For example, the culturally-shaped requirements of a religious fast can profoundly modify biologically-shaped goal of pursuing food when hungry (Ryder et al., in press).

Our goals are shaped by the social contexts in which we socialize, through cultural schemas that direct our attention to elements that allow us to build something meaningful both personally and consensually (Carey, 2009). Schemas both shape and are shaped by the perceived environment. Memory recollection is easier when remembered events are consistent with schemas (H. R. Markus & Schwartz, 2010; Savani et al., 2010). Similarly, new information is not only interpreted through schemas, but also serves to reinforce them (H. R. Markus & Schwartz, 2010; Savani et al., 2010). Well-established schemas profoundly shape how self, others, and the environment are perceived, and can only change through substantial amounts of important new information (Brewer & Treyens, 1981; H. Markus, 1977; Rumelhard, 1984).

Some of the mechanisms through which cultural schemas guide attention are scripts: an organized sequence of behaviors that are shared intersubjectively, which means that the sequence is known and understood by others from the same cultural context (Wan et al., 2010). Whereas schemas are primarily described as *in-the-head*, scripts involve sequences of action that can be enacted and observed by others *in-the-world* (Bower et al., 1979; Schank & Abelson, 1977). Ms. Fujimoto may not know what is wrong with her when she presents at the clinic, but at least she knows what to do when she arrives: she sits down, looks through a magazine, and makes her way to the consulting room when her name is called. Moreover, she finds the procedure in Rio de Janeiro is not really so different than the one she remembers from her hometown. Instead of planning out each step deliberately, she can instead devote her limited resources to reading an interesting article, planning dinner, or worrying about how best to describe her experiences once she meets with the psychologist. There is a particular sequence that gets her from her front door to the scheduled appointment, a sequence known to Ms. Fujimoto, the psychologist, the receptionist, and the others in the waiting room. Indeed, someone who repeated all these steps in answer to the question, "how was your visit to the clinic," would be seen as rather odd. The model is part of the background of meaning, the shared context in which isolated behaviors become meaningful acts (Bruner, 1990; Searle, 1980).

The notion of scripts has been subsequently adopted and broadened by linguists interested in cultural models of behavior and cognition (Goddard & Wierzbicka, 2004) as well as cognitive anthropologists and sociologists (D'Andrade, 1981; DiMaggio, 1997). In their case, scripts refer to interpretive rules by which one understands behaviors, emotions, social relationships, and so on; for example, one might describe a cultural script for 'having a friend' (M. M. Doucerain et al., 2018). Therefore, cultural scripts can be understood in a continuum that goes from the specific and concrete to the general and abstract. The closer a given script is to the former, the more it will adhere to the specific expectations of cognitive research; indeed, such research could be used to

determine whether one is working with this kind of script.

Each set of specific symptoms is part of a larger set of potential symptoms: experiences grounded in our physical and existential reality that could, in some contexts, be experienced and expressed as symptoms (Ryder et al., in press). Many of these experiences may in fact be surprisingly common, at least in mild forms, and they come and go: the majority pass by unnoticed, others are noticed momentarily but are deemed unworthy of attention, others still might be identified as strange or annoying, but not especially alarming. In short, our phenomenological fields continuously register *potentially symptomatizable experiences* (Ryder & Chentsova-Dutton, 2015). These aches, worries, ambiguous interpersonal exchanges, even transient odd experiences, are part of the background noise that might — but most often does not — emerge as a distressing symptom.

This background noise fluctuates for all kinds of reasons, which become part of the proximate cause of a particular symptom. Different circumstances elicit different emotional reactions, which come with various sets of physiological sensations, subjective experiences, and behavioural responses, as well as their own associated cultural scripts. There are also individual differences in the likelihood of having and attending to particular experiences (Kirmayer & Sartorius, 2007). Demographic characteristics (e.g., age); personality traits (e.g., neuroticism); social roles (e.g., a subordinate position); or gender, in sexist societies (Zanello, 2018), might increase the likelihood that one might attend to chest pain or a shift in mood, or even feel about to have a "*crise de nervos*" ("nervous breakdown", Duarte, 1986; Silveira, 2000). Individual differences also emerge through variations in personal biography as different people have lived different experiences. Past history of heart attack might increase vigilance for chest pain; having a depressed family member might cause one to attend more to shifts in mood; a period of unemployment, as the one currently faced in Brazil, might increase concern about interactions with one's boss or job.

For a variety of reasons, certain experiences within this chaotic and shifting background noise are identified as worthy of sustained attention. These experiences might violate *cultural scripts for normalcy* — our consensually shared understandings of how people normally think, feel, and act, as well as how they *ought to* think, feel, and act (Chentsova-Dutton & Ryder, under review). For example, different cultural contexts have different scripts for negative emotions: how valued they are, when one should display them, what beliefs do we have about someone who shows them frequently, and so on. Russian cultural contexts foster beliefs to the effect that a full life includes a range of emotions, including negative ones; Chinese cultural contexts emphasize the importance of restraining both positive and negative emotions; American cultural contexts promote the view that the good life involves many positive emotional experiences and few negative ones (Chentsova-Dutton, Senft, et al., 2014; Eid & Diener, 2009).

Certain experiences are identified as deviating sufficiently from these norms that they are seen not just as different but as abnormal: they are pathologized (Haslam et al., 2007). These *cultural scripts for deviancy* are therefore in the unusual position of normalizing the abnormal, or at least of rendering the abnormal sufficiently comprehensible to guide thought, feeling, and action. These scripts help the sufferer to make at least partial sense of his or her suffering (Chentsova-Dutton & Ryder, under review). Indeed, the literature on labeling of mental illness illustrates both the advantages and disadvantages of 'making sense' in this way. Many patients report a sense of relief that comes with knowing that their chaotic and frightening experiences are a specific known entity, one that comes with its own expected symptoms, explanations, and prognosis (Chentsova-Dutton, Ryder, & Tsai, 2014). On the other hand, there is evidence that the application of a label, and hence priming the implied scripts for how one is supposed to think, feel, and act, can imprison a patient's responses within the expectations that come with the label (Link & Phelan, 1999).

Considering that diagnostic systems, and therefore labels, are culturally construed, cultural issues should be taken into account when assessing patients. For example, 'tearfulness' is often cited in diagnostic classification manuals as indicative of 'sadness', one of the main criteria in the diagnosis of a depressive episode (Zenello, 2014). In sexist cultures, expressions of vulnerability, such as tearfulness, are socially repressed in men (Windmöller & Zanello, 2019), but allowed and even encouraged in women (Zanello, 2018). Therefore, it is possible that epidemiological differences between men and women in the world-wide prevalence of depression — much higher for women (WHO, 2008) — are, at least partially, a reflex of cultural constructs regarding gender roles. In that case, it would be important that Ms. Fujimoto's clinician considers the meaning of her symptoms in the Brazilian cultural context. For example, in respect to preoccupations regarding her love life: what does it mean to be single for a woman, who's no longer considered young, in a sexist cultural context (Zanello, 2018)?

Similarly, Ms. Fujimoto's clinician should consider whether the duration and severity of her symptoms could be understood as bereavement, given her recent loss. In a depressive reaction to bereavement, we begin with the expectations for the emotional range considered normal within a given cultural context. In the immediate wake of bereavement, we observe an experience of profound sadness, lethargy, and sleeplessness; reactions that are at once unusual and normal under the circumstances. At a certain point — differing markedly depending on the cultural context — this normal bereavement shades into pathology. In 'Western' contexts, if it is too intense and it goes on too long, al-

though it can still be partially understood in reference to the bereavement experience, it can also be understood through cultural scripts pertaining to what might be called Major Depression. Finally, there is a small subset of people, whose response to bereavement involves manic giddiness, violating even the expectations of a cultural script for Major Depression (Chentsova-Dutton & Ryder, under review; Morgan et al., 2001).

Cultural scripts lead people to attend to particular experiences when they occur, but attentional processes also contribute to the emergence of these experiences as symptoms. By leading people to devote more attentional resources to scanning particular features of their phenomenological field, scripts increase the likelihood of detecting an instance of it. If one expects to have a particular emotional response, scanning for signs of that response increases the likelihood of detecting it, and can even make it stronger (Ryder & Chentsova-Dutton, 2015). Moreover, particularly in the case of thoughts, scanning for something can actually help to create an instance of it. If a person enters a church concerned about having a blasphemous thought, the very fact of self-monitoring for such thoughts will increase their likelihood (Ryder et al., in press). Meanwhile, all kinds of other thoughts, emotions, sensations, which are also potentially symptomizable experiences, are taking place simultaneously, but they fade into the background as they do not fit the available interpretive lenses.

Symptoms thus emerge as the consequence of loops, wherein the response to a particular experience further exacerbates it. For example, the cognitive-behavioral model of social anxiety posits that fear of negative evaluation leads one to self-monitor for signs that one is not doing well socially. The consequence is that ambiguous signs, common in social interactions, are more likely to be interpreted negatively as evidence of social failure. As anxiety mounts, self-monitoring increases along with physiological arousal; moreover, dedicating attentional resources to closely tracking one's social performance might lend a 'forced' quality to the interaction, increasing the likelihood to the very negative evaluation that is so feared (D. M. Clark & Wells, 1995). A person with social anxiety is failing at the culturally valued goal of self-confidently and presenting a positive 'true self' to others. In societies where people frequently have to enter new social situations, such anxieties can be quite damaging (Sato et al., 2014).

Similar social loops can be observed in Japan, but there the predominant concern is with offending other people or making them uncomfortable. The result is a somewhat different set, albeit overlapping, set of symptoms; for example, concerns about subtle eye movements or even body odor, a syndrome known as *taijin kyofusho*. Far from being concerned about confident self-presentation, many socially anxious Japanese are concerned about inadvertently revealing more of one's interior thoughts and feelings than would be appropriate (Sasaki et al., 2013). In contrast, to the North American and Western European settings where most social anxiety research has been conducted, Japan is characterized by relatively low levels of relational mobility. Maintaining harmony is much more important than confidently winning over new people. Indeed, perceptions of relational mobility have been shown to mediate the presentation of Japanese social anxiety symptoms, with low mobility increasing the likelihood of a symptom presentation consistent with *taijin kyofusho*.

The attention-directing effects of these scripts do not stop with the emergence of a symptom or a set of symptoms. Rather, the identification of a symptom can bring with it further interpretations, which can trigger emotional responses, which themselves come with a whole set of potential somatic, cognitive, and behavioural consequences. These more acute *positive feedback loops* are joined by more chronic *negative feedback loops* which can serve to maintain pathological patterns. A person with social anxiety might suffer through a conversation, paying so much attention to the signs of failure that they do not even notice what goes well, reinforcing the belief that conversations are highly negative experiences. Or they might take the opportunity to avoid the conversation entirely, feeling a surge of relief — again, reinforcing the belief that conversations are highly negative experiences (D. M. Clark & Wells, 1995; Ryder & Chentsova-Dutton, 2015).

It is our understanding that these loops do not emerge from a specific level, but rather from links throughout the culture-mind-brain system, ranging from specific brain circuits to social institutions (Ryder et al., in press). The distinction between disorders with a higher versus lower propensity to show these kinds of loops may prove to be a more useful distinction than that between 'mental disorders' and 'physical disorders'. Cases in which *the consequences of a disordered system loop back to further shape that system* highlight the importance of an approach that understands culture-mind-brain as an integrated system.

For example, depression may lead to a constant need for reassurance, leading to an interpersonal style that alienates close others, and, consequently, influences the experience and expression of the depression itself (Hudson et al., 2018; Joiner, 1994; Starr & Davila, 2008). A broken leg may also elicit responses from close others and the larger society. We can talk about the subjective experience of a broken leg, social representations of a broken leg, a cultural script for recovery from a broken leg, and so on. Indeed, we can even imagine a society where a broken leg is stigmatized (Olyan, 2008). Although these aspects of a broken leg pertain to the sufferer's experience and the context of his or her suffering, none of them affect the location or severity of the break. In depression, by contrast, personal experiences and social un-

derstandings act as feedback loops that further shape the disorder.

Some Implications of Cultural-Clinical Psychology

Cultural-clinical psychology is grounded in an empirical literature from psychological science and adjacent disciplines. At the same time, there is much work still to be done, not least because core ideas of cultural-clinical psychology imply approaches to research that are not yet widely represented in the literature. A 'culture-mind-brain' perspective can remind investigators that other levels of analysis should be considered. However, much more is possible. In fact, an interdisciplinary team in Brazil is conducting exciting research of this kind. Dressler (2012) has proposed the *cultural consonance* approach, in which the degree to which one can live in accordance with local cultural models is associated with various health outcomes. For example, Dressler and colleagues have identified a culture-gene interaction in predicting depressive symptoms, finding that (a) consonance of one's actual family life with the local model of a good family life interacted with (b) serotonin receptor polymorphism to (c) predict depressive symptoms (Dressler et al., 2016; Dressler et al., 2009).

There is also a need for more collaborative, interdisciplinary research on the emergence of symptoms. Presently, much of the work in this area documents cross-cultural symptom differences without necessarily documenting the specific mechanisms by which specific symptoms emerge in specific contexts. Inspiration can be drawn from research documenting the wide range of symptoms that can emerge in response to expectancy effects (Schwarz et al., 2016). For example, studies of people who report somatic symptoms in the presence of electromagnetic radiation, such as wifi signals, suggest that exposure to media reports can increase symptom reporting (Bräscher et al., 2017; Rubin et al., 2010; Witthöft et al., 2018). The mechanisms at work here have been linked to the so called 'nocebo effect', in which descriptions of possible placebo pill side-effects increase the likelihood that these symptoms will spontaneously occur (Benedetti et al., 2007). 'Cultural expectancies' about mental disorder might be studied similarly to investigate how link individual and consensually-held beliefs influence cultural group variation in symptoms (Chentsova-Dutton & Ryder, 2019).

Cultural-clinical psychology also has implications for clinical practice, and indeed the perspective reviewed here may seem to make this work more complicated. In this chapter we have questioned both cultural and diagnostic categories, yet evidence-based assessment and treatment in clinical psychology has largely depended on these categories. A 'culturally competent' practitioner might be expected to know that *Test A* is valid for *Disorder B* in *Culture C*, leading one to deliver *Treatment D*. The question is: could such an approach be used to help someone like Ms. Fujimoto? Should the clinician use standard American norms, Brazilian norms, or Japanese norms when testing? Would the test yield a diagnosis that fits the problems? How then to proceed with treatment? Is it reasonable to *ever* expect tests normed to Brazilians of Japanese origin or standardized treatments for this population? Are the alternatives either to ignore culture and proceed with standard practice or to engage with culture in an intuitive manner?

Recall that towards the beginning of this paper we argued that the unit of analysis in cultural-clinical psychology ought to be the *person-in-context*. This perspective, combined with recent developments in assessment and treatment, point to some potential solutions. The Cultural Formulation Interview (CFI) has been proposed in DSM-5 as a means by which clinicians can learn more about the cultural contexts of their patients (Lewis-Fernández et al., 2013). Crucially, the CFI orients clinicians towards the patients' accounts of their own beliefs and beliefs prevalent in their communities, and away from stereotyped perceptions about 'Brazilians' or 'Japanese'. In the literature on evidence-based treatment, meanwhile, we are observing a move away from treatments designed for specific diagnoses to those designed for transdiagnostic problems in living. This move is facilitated by a renewal of interest in the evidence supporting specific interventions rather than heterogeneous treatment packages (Barlow et al., 2017; Hayes & Hofmann, 2018). We believe such approaches hold promise as a way out of the apparent dilemma between evidence-based practice and culturally sensitive care (Gone, 2015).

Cultural-clinical psychology will be able to help Ms. Fujimoto's clinician — and hence, Ms. Fujimoto — through joint attention to the global and the local. Globally, a growing multicultural and multinational database will help researchers and clinicians alike. The point here is not to add to the list of broad national groups about whom generalizations are made. Rather, the goal should be to broaden the range of possibilities considered when working with diverse experiences of suffering and healing. Ms. Fujimoto's clinician does not need to know the specific literature on Japanese emotional disorders or ethnic minority experiences in Brazil; rather, she should learn about the many ways in which culture shapes depression or minority experiences impact well-being. Such learning requires vastly improved communication across linguistically and culturally separated research communities. We hope this document might serve as a small step towards this end.

Locally, the clinician should work with the person-in-context, understanding her patient as embedded in what anthropologists sometimes call 'local social world'. Informed by knowledge about what works in general, Ms. Fujimoto's clinician will be much better able to deliver a treatment that makes sense for this particular sufferer, in this particular context. Global collaboration and local engagement will both be

needed to help us meet this challenging goal.

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