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Introduction to Culture and Psychopathology

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Culture and Psychopathology

Both trained psychologists as well as lay people often mean different things when they discuss culture. It is a commonly used and more commonly misused word. Many use the words "culture," "ethnicity," and "race," as if they mean the same thing. Culture is often defined as a way of life of a group of people. However, this definition is quite simplistic; culture is more of a complex, multi-layered concept. The word culture comes from the Latin word *colo –ere*, which means to cultivate or inhabit. The term culture was first used in the social sciences by an anthropologist, Edward B. Tylor in 1871 (Tylor, 1974), who defined culture as "that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society." Since Tylor's initial definition, various individuals and organizations have offered perspectives that emphasize a more comprehensive view as shown in the examples that follow:

> Culture is a configuration of learned behaviors and results of behavior whose component elements are shared and transmitted by the members of a particular society.
>
> (Linton, 1945, p. 32)

> Culture is the collective programming of the mind which distinguishes the members of one category of people from another.
>
> (Hofstede, 1984, p. 51)

> Culture should be regarded as the set of distinctive, spiritual, material, intellectual, and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions, and beliefs.
>
> (UNESCO, 2002)

These definitions imply that culture is composed of values, beliefs, norms, symbols, and behaviors, which are essentially learned. Thus, culture is defined

as a general way of life or behaviors of a group of people which reflect their shared social experiences, values, attitudes, norms, and beliefs; is transmitted from generation to generation, and changes over time. In general, culture has been conceptualized as something that is learned, changes over time, is cyclical or self-reinforcing, consists of tangible and intangible behaviors, and most important of all, is crucial for survival and adaptation. Cultural traits and norms do influence how we think, how we respond to distress, and how comfortable we are expressing our emotions.

Although we rarely acknowledge it, culture also has many dimensions. A broader discussion and definition of culture is important to fully understand the precedents of mental illness. Culture includes ethnicity, race, religion, age, sex, family values, the region of the country, and many other features. Culture can also include similar physical characteristics (e.g., skin color), psychological characteristics (e.g., levels of hostility), and common superficial features (e.g., hair style and clothing). Culture is dynamic because some of the beliefs held by members in a culture can change with time. However, the general level of culture stays mostly stable because the individuals change together. The beliefs and attitudes can be implicit, learnt by observation and passed on by word of mouth, or they can be explicit, written down as laws or rules for the group to follow. The most commonly described objective cultural groups consist of grouping by ethnicity, race, sex, and age. There are also many aspects of culture that are more subjective and cannot be seen or linked easily to physical characteristics. For example, nationality, sex/gender, religion, geography also constitute different cultural groups, each with their own set of prescriptions for behavior. Understanding the dynamic interplay of cultural forces acting on us can greatly enhance how we face the world and how we optimize our way of life. This book will describe how such cultural backgrounds influence the recognition, reporting, treatment, and prevalence of different mental illnesses. In this chapter, we provide a broad introduction to how culture interacts with mental health.

Culture and Mental Illness: Underlying Theoretical Perspectives and Research

Culture influences how individuals manifest symptoms, communicate their symptoms, cope with psychological challenges, and their willingness to seek treatment. It has been argued that culture and mental illness are more or less embedded in each other (Sam & Moreira, 2002) and that understanding the role of culture in mental health is crucial to comprehensive and accurate diagnoses and treatment of illnesses. Castillo (1997) identified several ways in which culture influences mental health. These include:

1. the individual's own personal experience of the illness and associated symptoms;
2. how the individual expresses his or her experience or symptoms within the context of their cultural norms;

3. how the symptoms expressed are interpreted and hence diagnosed;
4. how the mental illness is treated and ultimately the outcome.

The role of culture in mental health is best summarized in a statement by the US Surgeon General's Report on mental health that "the cultures that patients come from shape their mental health and affect the types of mental health services they use. Likewise, the cultures of the clinician and the service system affect diagnosis, treatment, and the organization and financing of services" (U.S. Department of Health and Human Services, 1999).

To have a better understanding of how culture influences mental illness, we first need a brief overview of the underlying theoretical positions in cross-cultural studies. The absolutist view assumes that culture has no role in the expression of behavior. This view implies that the presentation, expression, and meaning of mental illness are the same, regardless of culture. At the other extreme is the relativist position with the view that all human behavior (including the expression of mental illness) ought to be interpreted within a cultural context. The universalist view takes more of a middle position, with the assumption that specific behaviors or mental illnesses are common to all people, but the development, expression, and response to the condition is influenced by culture (Berry, 1995).

In support of the universalist position, an extensive study sponsored by the World Health Organization (WHO) confirmed that whereas respondents from different countries reported sad mood, anxiety, tension, and lack of energy as common symptoms of depression, western respondents reported additional symptoms of feeling guilty, while nonwesterners reported more somatic complaints (Draguns, 1990). Studies like these have led to the conclusion that the vegetative symptoms of depression are somewhat universal, while feelings of guilt may be related to cultural factors such as individualism and religion (see Draguns, 1997 for review).

Classification, Diagnoses, and Meaning

The assumption that the *Diagnostic and Statistical Manual of Mental Disorders – Text Revision – DSM–IV–TR* (APA, 2000) and the *International Classification of Diseases – ICD-10* (WHO, 1992) categorization of mental illnesses applies to all people also stems from a universalist perspective. This notion presupposes that psychological principles derived from research in western societies can be directly applied to nonwestern cultures, which is not necessarily true. As discussed later in this book, more recent editions of the *DSM* emphasize the importance of the cultural context in conceptualization of mental illness. Mental health professionals are encouraged to seek knowledge about the cultural background of their patients and to work towards cultural competence.

Arguing from the viewpoint that culture's influence on symptoms and presentation of mental illness, and following studies that have consistently reported symptoms in particular regions that have not been found in other regions,

recent editions of the *DSM* have included a new category known as culture-bound syndromes (APA, 2000). Although culture-bound syndromes may share some similarities with some other mainstream psychological disorders, they are unique in that they are recognized in a specific region (or cultural group) as psychopathological. An example that has been often cited is *shenjing shairuo* or neurasthenia in China, which appears similar to the *DSM* classification of major depression, but patients report more somatic complaints and less sad mood. Other forms of culture-bound syndromes that appear similar to some common *DSM* psychological disorders are, *hwa-byung*, a Korean syndrome similar to *DSM–IV* major depression; and *taijin kyofyusho*, a Japanese disorder similar to *DSM–IV* social phobia. Several other culture-bound syndromes are discussed throughout this book.

It is worth mentioning that many nonwestern cultural groups have their own informal as well as formal ways of classifying, diagnosing and treating mental illness. One such example is the *Chinese Classification of Mental Disorders (CCMD)*, with the most recent edition *CCMD–3* published in 2001 by the Chinese Society of Psychiatry (Chen, 2002). The *CCMD–3* is similar to the *ICD* and *DSM* in categorizations, but certain symptoms and conditions that are unique to that particular culture are emphasized as in the case of *shenjing shaijo*, discussed earlier. Also several psychological illnesses that are unique to Chinese such as *koro* (a sudden extreme worry that one's sexual organs will recede into the body and ultimately cause death) are discussed. Although some may view the *CCDM* as extremely relativist, many mental health professionals who work with predominantly Chinese patients believe its strengths outweigh any weaknesses that exist.

Health-Seeking Behaviors and Coping

Whether or not individuals seek help for a psychological disorder depends on the extent to which they trust the mental health professional or the mental health system as a whole. Research on counselor dissimilarity, cultural mistrust and willingness to self-disclose has established that these factors influence health-seeking behaviors and premature termination rates among black clients (Carlos Poston, Craine, & Atkinson, 1991). In their paper about comfortableness with conversations about race and ethnicity in psychotherapy, Cardemil and Battle (2003) emphasize the utter importance of including important elements of cultural background (specifically race and ethnicity) in psychotherapy by default.

Even after an individual makes the decision to seek professional help, culture influences the symptoms that the patient presents. It has been suggested that cultural norms that encourage avoidance coping among Asians and Asian Americans often result in reports of physical complaints associated with stress and not emotional complaints, as the latter is viewed as unacceptable (Iwamasa, 2003).

A group's perception of an illness and cultural worldview also influences how well the individual and close relatives cope with mental illness. People from

cultures in which mental illness is linked with supernatural causes (e.g., sorcerer, witchcraft, evil eye) are less likely to seek help from a mental health professional and more likely to seek help from a traditional healer or medicine man (Mateus, dos Santos, & de Jesus Mari, 2005). Similarly, James Myers, Young, Obasi, and Speight (2003) report that for many persons of African descent, "pathology in the individual is presumed to be reflective of dysfunction in the larger social group and context, and, healing would be required for the collective, as well as the individual."

The importance of cultural competence among mental health professionals is best summarized in the report on psychological treatment of ethnic minority populations presented by the Council of National Psychological Associations for the Advancement of Ethnic Minority Interests (2003). This report emphasizes that mental health professionals:

- are *aware* of and sensitive to their own racial and cultural background and biases;
- have *knowledge* about their own cultural heritage as well as that of their patients and acknowledge how they influence their perceptions; and
- actively seek to understand themselves and other cultures with a goal of developing important *skills* needed to work with specific cultural groups.

Sociocultural Influences on Mental Illness

Symptoms of mental illnesses are manifested within the background of certain cultural concepts and constructs. These include ethnicity, race, or nationality, acculturation, individualism-collectivism, ethnocentrism, power-distance, and uncertainty avoidance.

Ethnicity, Race, and Nationality

Ethnicity, race, and nationality are often used interchangeably in our society. It is common to hear someone describing an individual's behavior, values, or beliefs by saying "he is African" or "she is Asian." These descriptions may be factual since the individual identifies with a country within those continents. However, after close interactions with the person you may find that they prefer a more specific description, such as Indian or Ghanaian. Furthermore, it may be even more important to them to identify with a specific ethnic or tribal group (e.g., Gujarati for the Indian, Ashanti for the Ghanaian, and Dina (Navajo) for a First Nations person). Interestingly these generalized descriptions are commonly made by people in the western world, but it is very rare to hear westerners describe themselves as Europeans or North Americans. Regardless of our assumptions, it is imperative to inquire about how an individual or a group views themselves.

Although we tend to use these terms loosely, the first, obvious, descriptive impression to us is race or skin color. The term race is used in two ways – biological and sociocultural. Biological definitions of race tend to focus on people sharing physical and genetic qualities such as skin color, hair texture, and eye color, which have resulted in historical classifications of Caucasoid (white), Mongoloid (Asian), and Negroid (Black). However, the biological classifications of race have been challenged (Relethford, 2002; Smedley & Smedley, 2005), and some authors have argued that race is used as an easy way out of a complex situation (Atkinson, 2004). The sociocultural definition of race is related to geographic migration of different groups and also for the purpose of identity formation. Mio writes that the sociocultural concept of race refers to:

> the perspective that characteristics, values, and behaviors that have been associated with groups of different physical characteristics serve the social purpose of providing a way for outsiders to view another group and for members of a group to perceive themselves.
>
> (Mio, Barker-Hackett, & Tumambing, 2006, p. 9)

In other words we continue to use race as a classification because it helps us describe people, regardless of the fact that these descriptions have been artificially constructed. The current consensus based on existing evidence is that racial groups are not genetically discrete, reliably measured, or scientifically meaningful although the labels have many social consequences as regards to how people treat one another (Eberhardt, 2005; Smedley & Smedley, 2005; Sternberg, Grigorenko, & Kidd, 2005).

Ethnicity and nationality are other ways of viewing an individual. An ethnic group refers to a group of people with common ancestry, who often have similar physical and cultural attributes, such as language, physical features, rituals and norms. Nationality on the other hand refers to a political community, which typically shares common origin or descent. Although it is easier to assume aspects of a person's background based on their race, it is imperative that mental health professionals be more cautious and conduct a thorough interview of the individual, as racial categorizations do not necessarily provide salient background information. For instance, based on the US Federal classifications of racial and ethnic minority groups, people from the Dominican Republic may identify their ethnicity as Hispanic or Latino and their race as black. A true understanding of a person, then, requires that professionals go beyond obvious categorizations to a much deeper level of inquiry and meaningfulness.

Acculturation

Our world is becoming more and more global because of rapid increases in traveling and migration for different reasons. Increased migration rates have made acculturation a crucial topic to be considered. Acculturation is a

transition in which an individual gradually accommodates and eventually takes on some of the values and beliefs of a new culture. Berry (1992) described acculturation as a process of "culture shedding and culture learning," that involves intentionally or unintentionally losing selected cultural values or behaviors with the passage of time, while adopting new values and behaviors from the new group. Generally, acculturation depends on how open the host culture is to interact, and also how willing the immigrant group is to adopt the norms and values of the host group (Berry, 2001): A kind of mixing of the original and new cultures in a way that maximizes the individual's transition into the new culture.

Being acculturated may mean different things to different people and there have been many approaches to studying acculturation (Padilla, 1980). Roland (1990), who has studied and compared various cultures, sees the acculturation process as primarily entailing the adoption of one culture at the expense of the other. In contrast, Berry, Trimble, and Olmedo (1986) define four models of acculturation. Berry (1970) described four different forms of acculturation based on the extent to which an individual has preference for his or her own culture and the extent to which he or she prefers the values and norms of the new culture. They are integration, assimilation, separation, and marginalization. Integration is when the individual (or immigrant) is willing to adopt behaviors and adapt to the host culture, while also maintaining their own cultural norms and values – some form of a balance between the two. This is different from separation, in which the individual focuses almost exclusively on adopting the cultural norms of the host group (or country) and basically disregards their own cultural heritage. Assimilation is more or less the opposite of separation. With assimilation, the person puts most of their efforts toward maintaining their own cultural heritage, and very little effort toward adopting the norms of the host group. Last, marginalization refers to an individual who neither adopts their own cultural heritage, nor that of the host or dominant group. Marginalization is the least preferred type of acculturation and has been associated with diverse adjustment challenges, some of which will be further explored later in this book. Figure 1.1 summarizes the basic process involved in acculturation and how the four different forms of acculturation come about.

Berry (1998) argues that acculturation does not necessarily result in serious psychological challenges. In summarizing his views he identified three levels at which acculturation could influence an individual's mental health. The first level involves letting go of behaviors that are not helpful in adapting to the new culture, while learning new behaviors and skills that are useful for the new culture. This level of acculturation involves mild to moderate conflict. The second level of acculturation involves moderate to significant conflict. This level of conflict occurs when the process of learning new skills and unlearning old skills becomes more of a challenge and results in acculturative stress. The final level is associated with severe conflict and psychological disorders. It represents a situation in which the changes involved in acculturation are overwhelming and beyond the individual's ability to cope (see Berry, 1997 for review). Degree of

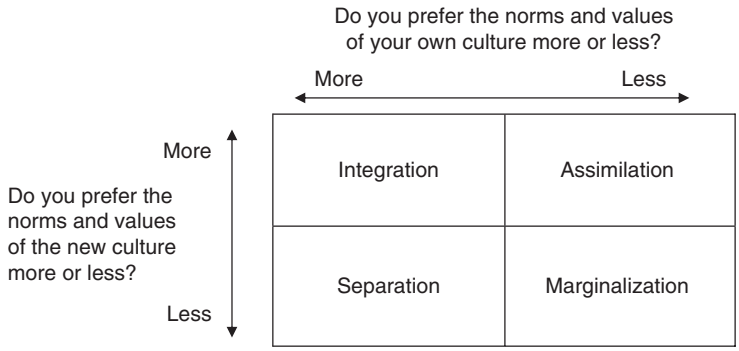

Figure 1.1 Depiction of different types of acculturation based on Berry's conceptualization (Berry, 1970)

acculturation and one's sense of identity are therefore crucial to accurate assessment, diagnosis, and treatment outcome.

Attending to acculturation and ethnic identity takes us beyond the basic cultural differences in mental health. For example, African Americans have been found to have higher rates of mental disorders as compared to European Americans and Mexican Americans but these findings vary with acculturation level (Robins, Locke, & Regier, 1991; Ying, 1995). In many cases, greater acculturation is associated with better mental health (e.g., Landrine & Klonoff, 1996) although this is not the case for all ethnic groups or with physical health. Higher acculturated Mexican Americans, for example, have been found to be more depressed than recent immigrants with lower acculturation scores (Vega, Kolody, Aguilar-Gaxiola, Alderete, Catalano, & Caraveo-Anduaga, 1998).

Individualism and Collectivism

It has been argued that psychotherapy is a product of western culture and thus, counselors tend to emphasize individualism and promotion of the self, as opposed to collectivism and promotion of the group (Dwairy & van Sickle, 1996). Individualism refers to a person's general affinity towards independence, self-reliance, and competitiveness while collectivism refers to a preference for the group, our need to fit into the group, and increased concern for harmony within the group. Hofstede (1983) originally presented individualism and collectivism as two opposing views, with individualism emphasizing independence and collectivism emphasizing interdependence. A review of studies suggests that portrayal of either cultural construct depends on the situation as well as the national background of the individual (Triandis, 1995).

Triandis (1995, 2001) has further identified two levels each of individualism and collectivism, namely, horizontal individualism – HI; vertical individualism – VI; horizontal collectivism – HC; and vertical collectivism – VC (Triandis &

Table 1.1 Self-statements portraying Triandis' different types of individualism/collectivism

	Individualism	Collectivism
Vertical (hierarchy)	Vertical individualism "I want to do better than everyone else"	Vertical collectivism "I want my in-group to do better than all other groups"
Horizontal (equality)	Horizontal individualism "I want to do as well as everyone else"	Horizontal collectivism "I want my group to do as well as the other groups"

Source: Berry (1970).

Gelfand, 1998). HI pertains to a desire to be distinct, but not necessarily better than one's group and VI applies to a desire to be distinct and better than the group (connoting competitiveness). On the other hand, HC refers to an individual who emphasizes interdependence or the willingness to share common goals with others group, while VC describes an individual who places his or her group's goals over their personal goals. The differences between the four levels of individualism/collectivism are shown in Table 1.1.

Individualism and collectivism influence how individuals perceive and respond to mental illness. Heinrichs, Rapee, Alden, et al. (2006) asked respondents from eight different countries (Australia, Canada, Germany, Japan, Korea, the Netherlands, Spain, and the USA) to evaluate the extent to which an actor's behavior was socially acceptable. Participants from collectivistic countries were more accepting of socially reserved and withdrawn behaviors than were those from individualistic countries. Furthermore, on a personal level, those from collectivistic countries reported higher levels of social anxiety and related symptoms than their counterparts from individualistic countries. Their results suggest that people who had experienced significant levels of social anxiety were also more accepting of social withdrawal. These findings have implications for counseling and psychotherapy, especially when the therapist and client have different cultural perspectives.

In their argument against directly applying western psychotherapy in Arabic societies, Dwairy and Van Sickle (1996) explain that "individuals [in Arabic societies] live in a symbiotic relationship with their families, seeing themselves as extensions of a collective core identity … individualism will be viewed as deviant and will face condemnation." The authors further identify ways in which western psychotherapy may be at odds with core values in many Arabic societies and pose as barriers in psychotherapy, which could be easily misinterpreted by the therapist. These include low levels of self-disclosure, avoidance of self-exploration, differences in emotional expressivity, and differences in conception of time (see Dwairy & Van Sickle, 1996 for review). Similar conditions and experiences may exist in other collectivist cultures in Africa, Asia, and South America (Sue & Sue, 1990).

Ethnocentrism

Therapists and counselors have been encouraged to consider their clients' cultural background more seriously. However, it is equally important that they are aware of their own stereotypes and biases. Some studies have demonstrated that stereotyping and wrong diagnoses are mostly due to cultural misinterpretations (Cheetham & Griffiths, 1981). A common way in which stereotyping occurs in interactions between mental health professionals and individuals seeking help is ethnocentrism. This refers to the assumption that an individual or his/her group is superior to other individuals or group. Simply put, it reflects an attitude of "us-better–them worse" (Berry et al., 1992). Typically ethnocentrism occurs because we are likely to perceive our norms and expectations as the basis or standard for judging others. Anyone reflecting on the vignette presented in the preface probably has his or her views about what the normal process of bereavement should be, based on their own experiences, expectations, and justifiable reasons. But is our way necessarily the right way (even if there is scientific research to support it)?

Ethnocentrism is often difficult to identify, especially when it comes from the dominant cultural group. Take the example of arranged marriages in certain cultures; is it fair to assume that the couple may not have a happy marriage? Are passion, romance, and love at first sight, crucial to the conceptualization of marriage? Or do successful marriages hinge more on practical factors like companionship and economic sustenance? Responses to these questions may vary, but unless a person's history and cultural background is considered, it is unfair, presumptuous, and may even be unhealthy psychologically to judge their views or behaviors. Part of being a good scientist-practitioner is being open to experience and systematically investigating a behavior before making judgment. As mentioned earlier, the new emphasis on cultural influences adopted in the *DSM–IV–TR* may help decrease levels of ethnocentrism and other cultural biases.

Power Distance

Power distance is "the extent to which the less powerful persons in a society accept inequality in power and consider it as normal" (Hofstede, 1986, p. 307). Although inequality in power exists in every society, each one differs in the extent to which the inequality is accepted or at least tolerated. Hofstede (1980) studied employees of a multinational corporation spanning over 40 countries and noted that societies with small power distance scores believed in equal rights for all, power should be based on formal position, and that the use of power had to be legitimate (among others). The other end, were societies with large power distance scores such as Malaysia and Panama. They believed that the powerful have privileges, power is based on family, friends, and the use of force, and that whoever holds the power is right.

Power distance may have implications for prevalence rates, health seeking behaviors and treatment. Rudmin and colleagues (2003) analyzed data from 33 nations, over a 20-year period and reported, among other findings, that power

distance was a negative correlate of national suicide rates. That is, overall, nations with high power-distance levels had lower suicide rates. However, they noted that this was not the case for the young women in their sample. The authors attempted to explain the results for young women by hypothesizing that whereas the inflexibility observed in high power-distance societies may offer a sense of security and success for most people, it could have an adverse effect for women in societies that do not value gender equality. Findings such as these buttress the importance of cultural constructs for psychological well-being.

Another way in which power distance could influence mental health is in intervention methods. People in high power-distance societies have been found to sanction a norm of submissiveness to superiors and preference for leaders to make decisions for them (Hofstede, 1980). In essence this cultural construct is related to social class and privilege. The latter may have implications for psychotherapy, where clients may view the therapist as the superior and hence expect to merely follow his or her directions without necessarily involving them in the decision-making.

Uncertainty Avoidance

Uncertainty avoidance is "the extent to which people within a culture are made nervous by situations which they perceive as unstructured, unclear, or unpredictable, situations which they therefore try to avoid by maintaining strict codes of behavior and a belief in absolute truths" (Hofstede, 1986, p. 308). Hofstede (1980) found Denmark, Jamaica, and Singapore to have low uncertainty avoidance scores, while Greece, Guatemala, and Portugal were on the high end. In general, he noted that the nations on the high end of uncertainty avoidance were more active, aggressive, emotional, and intolerant than those on the low end of the scale.

Uncertainty avoidance has been found to predict differences in levels of subjective well-being across nations. Nations with low scores have been found to have high scores for subjective well-being (Arrindell, Hatzichristou, Wensink, et al., 1997). In another study involving 11 countries (Australia, East Germany, Great Britain, Greece, Guatemala, Hungary, Italy, Japan, Spain, Sweden, and Venezuela), Arrindell, Eisemann, Oei, et al. (2003) found a significant relationship between scores on uncertainty avoidance and phobic anxiety. They reported that high uncertainty avoidance scores predicted high national scores and national levels on fears of bodily illness/death, sexual and aggressive scenes, and harmless animals.

Diverse Perspectives on Cultural Influences on Mental Health

A final point of consideration is to provide a framework for which to understand how culture influences behavior and mental health. In considering a

framework for sociocultural influences on mental health, let's first review some of the approaches that have been presented over the years. These include the sociobiological, ecocultural, and biopsychosocial perspectives.

The *sociobiological* approach emphasizes how biological and evolutionary factors influence human behavior and culture. The notion of a sociobiological view suggests that culture is not static, but instead changes with time for the benefit and survival of the society. The *ecocultural* approach focuses on the link between culture and ecology. According to proponents of this perspective, our environment influences or shapes our behavior and beliefs, our behavior in turn and influences our environment. The third viewpoint, the *biopsychosocial* approach, holds that biological, psychological, and social factors combine to influence behavior. In other words, this approach culture's influence on mental health stems from an interaction of biological, cognitive, and affective factors in our social interactions (Mio, Barker-Hackett, & Tumambing, 2006). Although the utility of taking a biopsychosocial approach has already paid dividends, there is still a need to better incorporate research on diverse cultural backgrounds. The fact is that it is really not enough of a "socio" focus in the "biopsychosocial" approach (Keefe, Smith, Buffington, Gibson, Studts, & Caldwell, 2002). Indeed what we do and why we do it is shaped by a variety of factors, and our well-being is no exception. A *biopsychocultural* approach (Gurung, 2006) might provide clinical psychology with stronger direction for it not only incorporates the social nature of our interactions, but explicitly acknowledges the role that culture plays in our lives.

Another perspective that has become increasingly important in our post-modern world with much migration and resettlement is *multiculturalism*. It literally means many cultural views. It is a view that emphasizes importance, equality, and acceptance for all cultural groups within a society, supported by a strong desire to increase awareness about all groups to the benefit of the society as a whole (see Mio et al., 2006 for review).

Discussions in this chapter thus far point to the importance of culture in conceptualization of psychological illnesses. As summarized by Draguns (1997), "the most general implication for working counselors is an attitudinal one. It behooves them to be aware of and open to the cultural factors in their clients' experience, expectations, and self presentation." This book will clearly illuminate these cultural factors. Our approach is one that represents an integration of main themes from the approaches described earlier. It is the biopsychocultural approach, which stresses that cross-cultural differences and similarities in behaviors and processes are influenced by a combination of biological, psychological, social, and cultural factors. The biopsychocultural model is not new. It is a model that flows naturally from the biopsychosocial perspective and has been used quite extensively in the forensic sciences (Silva, Leong, Dasson, Ferrari, Weinstock, & Yamamoto, 1998) and also in consideration of multicultural models of training in psychiatry and other medical fields (Lu, Nang, Gaw, & Lin, 2002). It is also closely related to the views of the psychosociocultural approach applied extensively in the area of multicultural

psychology (Gloria & Ho, 2003; Gloria & Rodriguez, 2000). As you will see in the following chapters, adopting this approach is crucial because it is comprehensive and considers intercultural and intracultural variables that directly and indirectly influence behavior.

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