"Cultural Cognition:" What Mental Health Researchers Might Learn From the Climate Change Debate

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COMMENTS, CRITIQUE, AND INSPIRATION COLUMN

“Cultural Cognition”: What Mental Health Researchers and Clinicians Might Learn from the Climate Change Debate

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Individuals lack the time to collect and evaluate all of their own evidence about the world, so they often rely on their cultural values and experts who they perceive as sharing those values. “Cultural cognition” is this natural human tendency to evaluate risk and selectively reject or emphasize information based on the extent to which it threatens or affirms one’s cultural values (Kahan, 2010). This information processing mechanism has been used to explain why public attitudes about anthropogenic climate change remain polarized even though the scientific community is in general consensus (Cook et al., 2013).

Previous theorists have attributed this polarization to a lack of scientific literacy among members of the public (e.g., Weber & Stern, 2011), but this would imply that attitudes become less polarized as individuals’ scientific literacy increases. On the contrary, recent evidence has shown that members of the public actually become more polarized as their scientific literacy increases (Kahan et al., 2012). Because one person’s beliefs cannot change the climate but can ostracize that individual from his or her social support networks, one risks less by misinterpreting scientific evidence than by adopting beliefs that potentially threaten one’s group affiliation. With increasing scientific literacy, one may develop increasingly more sophisticated, creative ways of interpreting and framing information so that it further affirms loyalty to one’s group and thus minimizes potential suffering. In other words, it is specifically because members of the public are rational that they evaluate evidence based on their cultural values. Cultural cognition is not simply a bias or heuristic, but a natural mechanism by which human beings collect and interpret information.

Cultural cognition might help explain why mental health care practitioners, researchers, and patient advocacy groups who share a common goal of ameliorating psychic distress can have such mutually exclusive agendas for achieving that goal (e.g., Kahan, Braman, Monahan, Callahan, & Peters, 2010). Many psychological processes influence people’s competing attitudes towards mental health conditions and treatments, and deeper awareness of these processes might help people interpret scientific research more open-mindedly. Although many factors are involved in clinicians’ and patients’ interpretations of research, this column focuses on cultural cognition because it is still relatively under-discussed and under-acknowledged in mental health research and practice.

To help curb the effects of cultural cognition, Kahan (2010) has proposed that scientific research be communicated to public audiences via framings that affirm rather than threaten those audiences’ respective values (see also Cohen, Aronson, & Steele, 2000). Psychiatric researchers might accomplish this in a number of different ways, including (1) encouraging a more diverse range of experts to help disseminate scientific research (Kahan, 2010), and (2) more carefully considering the ways in which these diverse experts’ preferred vocabularies threaten and affirm divergent audiences’ values.

ENCOURAGING A MORE DIVERSE RANGE OF EXPERT STAKEHOLDERS

Kahan (2010) has proposed that a more diverse range of experts disseminate scientific evidence, because people are more open-minded to potentially dissonant evidence presented by an expert who shares their cultural values. If a patient’s identity and values are too deeply threatened by a clinician’s translation of a particular research study, then this patient may develop distrust for psychiatric research in general, rather than the individual clinician’s translation of that one particular study.

Traditional psychiatric researchers similarly reject and credit evidence based on whether it threatens or affirms their cultural values and professional identities. The American Psychiatric Association’s president, Joseph Lieberman, recently

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homogenized many critics of psychiatric diagnoses as anti-
psychiatric “ideologues and self-promoters who are spreading
scientific anarchy” (Lieberman, 2013; paragraph 5), while
fellow psychiatrist Judy Stone responded that it is actually
psychiatrists like Lieberman who are ideologues blinded
by personal interests. These lines of argument appear
superficially similar, but Stone emphasized that Lieberman
is unable to interpret psychiatry as “objectively” as people
who incorporate critical c/s/x (consumer/survivor/ex-patient)
perspectives and legitimize the knowledge that these individ-
uals have gained from their lived experiences (Stone, 2013).
Stone’s legitimization of “expertise by experience” underscores
Lieberman and Stone’s differences, because Stone endorses
a multiple perspectives research paradigm (Rose, Thornicroft, &
Slade, 2006) that invites a broader variety of expert stakeholders
to the psychiatric conversation.

RESPECTING DIVERSE STAKEHOLDERS’ PREFERRED
VOCABULARIES
To our knowledge, no empirical work has compared the lan-
guage employed by people who have recovered from severe
mental distress to the language employed by those who have
not. In fact, less biased or more therapeutically effective vocab-
ularies may not even exist because languages are neither static
nor universal. Various biogenetic, psychosocial, and spiritual
languages all play highly individualized roles in suffering and
healing processes, and this bricolage (Corin, 2007) is constantly
evolving in tandem with the diverse vocabularies of one’s in-
terpersonal relationships and identities. Any vocabularies that
are determined to be less biased would likely be more biased
in alternative times and contexts where the terminology has be-
come more heavily imbued with competing cultural values and
connotations.

For example, in the dominant biomedical vocabulary, “sympt-
oms” are necessarily symptoms of some more fundamental
underlying dysfunction or disease process. When a patient’s ex-
periences are translated into this vocabulary of medicine by a
provider, this experiences becomes isolated from the original
sociocultural contexts in which they developed and thus less
useful in the clinician’s agenda to understand his or her patient.
Imbuing the patient’s experiences with potentially alien values
and assumptions also constructs a hierarchy between the clini-
cian and patient instead of a more egalitarian knowledge-seeking
relationship. Even a clinician who does not think of voices as
“symptoms” may inadvertently communicate this medical hi-
erarchy when using the word “symptom” in the context of a
therapeutic encounter, and it may be this power dynamic itself
rather than any particular terminology that acts to threaten his
or her patient’s values and undermine their trust in psychiatric
practice and research.

We are not implying that clinicians should rhetorically ma-
nipulate their patients in order to gain their trust (see also Kahn
et al., 2010). Quite the contrary, we propose that knowledge
of natural psychological mechanisms, like cultural cognition,
may help illuminate the rhetorical manipulations inherent in all
human communications, helping both traditional clinicians and
critical c/s/x groups more open-mindedly evaluate psychiatric
evidence and disseminate their interpretations of that evidence
in ways that are accessible to audiences with divergent cultural
values and identities.

CONCLUSION
The psychiatric conversation will not be depolarized so much
by new normative generalizations about which vocabularies and
types of evidence are more “objective,” but by encouraging a
wider variety of stakeholders to disseminate psychiatric infor-
mation, and more carefully analyzing the ways in which these
stakeholders’ psychiatric vocabularies alternatively affirm and
threaten the respective values of diverse audiences. Psycholog-
ical processes like cultural cognition may indeed preclude the
perfect, unbiased interpretation and dissemination of scientific
evidence, but it is a goal to which we might aspire. Greater
knowledge of our psychological barriers in doing so will help
facilitate this progress.

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