

Cultivating Pluralism in Health Psychology

MALCOLM MACLACHLAN
Trinity College Dublin, Ireland

MALCOLM MACLACHLAN is a senior lecturer in psychology and Fellow of Trinity College Dublin. His major research interests concern the interplay between culture and health, embodiment and international aid.

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ADDRESS. Correspondence should be directed to:
DR MALCOLM MACLACHLAN, Department of Psychology, Trinity College, Dublin 2, Ireland. [email: Malcolm.MacLachlan@tcd.ie]

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Abstract

Historically health, illness and healing operated through a single medium, or idiom, within relatively culturally encapsulated societies. Our increasingly porous societies now present us with a plethora of cultural explanations for our states of 'being'. Health 'seekers' can now turn to a variety of health 'providers'. The complexities of this situation are illustrated by reviewing research from Africa on cognitive tolerance. In many western societies the clinician is also faced with the challenge of having to work with a plurality of complex ideas about health and illness, which he or she may be unfamiliar with. The Problem Portrait Technique (PPT) is presented as a means of assisting practitioners (and researchers) to assess the interplay of culture and health. It is argued that health psychology should cultivate pluralism both by acknowledging the influence of culture on health and by embracing the diversity of methodological and conceptual perspectives within itself.

Keywords

cognitive tolerance, culture, health, pluralism, Problem Portrait Technique

THIS ARTICLE is about pluralism. Primarily it is concerned with considering different culturally constructed ontologies of health and illness and how these impact on patients, clinicians and health service planners. At another level it is concerned with methodological pluralism, or how incorporating different approaches to collecting data can enhance our understanding of cultural factors in relation to health. This article also argues that no one perspective on health is sufficient in its own right and that to be truly pluralistic health psychology must incorporate a diverse array of practical techniques and theoretical perspectives. While many have argued for the importance of conceptualizing health and illness in a cultural perspective (e.g. Airhihenbuwa, 1995; Berry, 1997; Helman, 1994; Kleinman, 1980; MacLachlan, 1997; Swartz, 1998), there has been little attempt to address the practical complexities that result from doing so. This article attempts to make some contribution to redressing this imbalance.

To the extent that cultivating pluralism in health psychology is about taking into account a broader range of models, it is essentially about inclusivity. A good deal of the research cited in this article was undertaken in Malawi, Africa, a continent which has been largely excluded by western research agendas (Airhihenbuwa, 1995). However, before exploring how the complexity that necessarily comes with cultivating pluralism can be managed, it is important to consider how incorporating pluralism into clinical practice has its difficulties; how, in fact, it may complicate and possibly compromise the practice of health care.

A clinical challenge of pluralism

The first case study concerns a Malawian woman who in 1978 was brought to a *sing'anga* (traditional healer) because of her strange behaviour, including wandering aimlessly, entering other people's houses and attempting to undress herself in public (Smyth, 1998). The *sing'anga* treated the woman for *vimbuza* (being troubled by spirits) and the treatment is likely to have included making some sort of offering to appease the spirits and being part of a ritualistic dance/ceremony, which possibly included others of her family or social network. This

intervention seems to have worked to the degree that she did not seek further treatment for 15 years. Then, in 1993, she presented at a psychiatric hospital run by African nurses along a western-orientated biomedical psychiatric model. Here she was prescribed antipsychotic medication for the same sort of behaviour that she had presented with in 1978. Again she went through a period of being symptom free, this time for five years, and then in 1998 she presented to a small rural psychiatric facility, with voices telling her not to eat or talk and directing her actions. This admission coincided with a change in her medication necessitated by the fact that her local dispensary had run out of her prescribed drug.

Various staff were involved in her assessment at this stage, but the diagnosis arrived at differed between European expatriate and local African staff. The local staff, who had been trained in the western biomedical model, diagnosed the woman as psychotic and wanted to prescribe chlorpromazine (an antipsychotic drug). Expatriate staff, however, felt that much of her behaviour was explicable in terms of cultural norms, but that she was depressed, and they wanted to prescribe imipramine (a non-psychotic antidepressant). It would seem that both expatriate and Malawian staff were trying to be pluralistic in the sense that they were taking into account cultural beliefs beyond their own. Ultimately a diplomatic 'compromise' diagnosis was made: psychosis with depressive features! The woman was prescribed chlorpromazine and imipramine. Thus, while the clinicians illustrated a degree of pluralism in the explanatory models involved, their choices of treatment clearly 'privileged' (Shweder, 1991) a biomedical model. Although different approaches to health and illness may exist alongside each other, they are rarely integrated; each treatment context seeks its own (partial) solutions to problems presented in a broader pluralistic environment (MacLachlan, 1997).

An ethical challenge of pluralism

The second case study, also from Africa, arose in 1994, when the psychology department at the University of Malawi (where I worked) was asked to advise on the possibility of securing

truly informed consent from parents for post-mortems on their children, to be undertaken as soon as possible after a child had died from malaria. It is important to appreciate that malaria is still the most common cause of death in children in Malawi, where one in five children die before reaching the age of five years. The motivation for carrying out postmortems was to identify the nature and location of pathogens, in order to provide more effective treatment. The postmortem would require the permanent removal of several body parts, including the brain and liver. Other body parts removed would be returned to their place in the body prior to burial. Truly informed consent, which would be emotionally difficult for parents in most cultures, therefore required parents to appreciate that as soon as possible after their child had died, he or she would be 'cut-up', but with most of the body parts being returned to the family for burial.

Clearly the parents' feelings and those of close relatives and friends were important areas to consider. So too were burial practices, as in the local culture it is customary to bury people as soon as possible after they die. A range of beliefs (arising from Christian, Muslim and indigenous religions) was important to consider, especially the belief regarding the child's future spirit life.

An important issue concerned the state of the body with regard to the afterlife. Briefly, the predominant Chewa culture, within which the postmortems would take place, puts great importance on the spirit life after death (Wilkinson, 1992), a life which is considerably longer than the physical one. In order to transcend successfully to the spiritual realm it is important for a person's physical body to be intact. Thus someone who experienced decapitation may not be able to ascend into the spirit life and may be 'stuck' in a limbo between physical death and spiritual being.

The clinicians to whom we presented our report had a very uncomfortable ethical dilemma: whether to 'fudge' the issue of complete and frank informed consent, and in doing so possibly gain information that could be instructive in saving countless young lives, or to respect the cultural beliefs held by the parents (that removal of body parts would prohibit transcendence into the spirit world), and in all

likelihood be refused permission to undertake postmortems on the children.

While the specific cultural meaning of this dilemma may be particular to Malawi, at the time of writing, the issue of informed consent for removal of body parts during postmortem is currently being debated in the UK and Ireland. For instance, in Ireland parents have been distressed to learn that for the past 10 years in children's hospitals it has been routine practice to remove and retain brain tissue from deceased children without their parents' knowledge or consent.

Cultivating pluralism through managing complexity

The cases described above illustrate some of the difficulties that may be encountered in working with more than one cultural construction of health and illness. The evolution of western psychology has been a story of shifting paradigms that have represented single-modal ontologies (i.e. a philosophy of cause and effect that acts through a single medium, e.g. through social interactions rather than, say, biological or spiritual mechanisms). Whether these philosophies of cause-effect relationships have been concerned with introspection, behaviourism or cognitivism, they have all suffered from decontextualization. The importance of context has previously been emphasized in health psychology (e.g. MacLachlan, 1998; Marks, 1996; Murray & Chamberlain, 1997). One difficulty with taking context into account is that it tends to complicate the situation and thereby appears to make it more difficult to manage. The contention is, of course, that the more complex the account is, the more likely it is to lead to more ecologically valid and effective intervention. Landrine and Klonoff (1992) have called for psychology to give more recognition to cultural factors in health since '...the health beliefs of professionals and lay persons alike are structured and informed by a cultural context from which they cannot be separated and without which they cannot be fully understood ...' (p. 267).

Cognitive tolerance

In a study of the attributions made by patients for their admission to Zomba Mental Hospital in

Malawi, MacLachlan, Nyirenda, and Nyando (1995) asked patients what had caused the problems that led to their admission, and subsequently categorized their responses (translated from Chichewa into English) as falling into traditional, psychological or medical, or more than one of these categories. The largest number of attributions fell in the traditional category (e.g. 'He is bewitched by his workmates, or relatives, because he works hard and is married to a beautiful woman'), then the psychological category (e.g. 'She is worried her husband is intending to marry another wife because she is infertile') and then the medical category (e.g. 'He is mentally sick due to *chamba* [marijuana abuse]'). This indicates that across the group of people there was a range of attributions. However, there was also a range of attributions within some of the individuals who were admitted; that is, their attributions fell into more than one category. An example of this was a man who, replying to our question in English, said 'I was working hard and getting quite tired . . . [psychological attribution] . . . I had dizzy spells and my heart would jump and beat very fast . . . [medical attribution] . . . because of the success I had achieved, other people were jealous and put a spell on me [traditional attribution]'.

This latter quote exemplifies what could be called a 'mixed-modal model'. It allows for more than one mode of cause and effect linkages; it mixes together different ontologies (different entities presupposed by any one theory, e.g. germs and spirits). Most importantly it shows acceptance or tolerance for a pluralistic approach to understanding problems.

In studies of malaria and schistosomiasis (Ager, Carr, MacLachlan, & Kaneka-Chilongo, 1996), epilepsy (Shaba, MacLachlan, Carr, & Ager, 1993), mental disorder (MacLachlan, Banda, & McAuliffe, 1995; Pangani, Carr, MacLachlan, & Ager, 1993) and AIDS (MacLachlan & Carr, 1994b) we have found evidence of such mixed-modal models. For instance, using a structured interview format, allowing for open-ended answers, Ager et al. (1996) questioned a quota sample of rural Malawians (age range 5–50 years) about their beliefs regarding the cause, risk reduction and treatment of malaria and schistosomiasis. Following content analysis of their responses, statistical analysis revealed that

neither understandings of the cause of malaria or schistosomiasis, nor beliefs regarding prevention, were tied to preferences for treatment. In fact, the majority of individuals sought medical treatment for malaria and schistosomiasis despite many of them attributing the cause of these diseases to non-medical factors. Traditional beliefs about the cause of malaria and schistosomiasis included non-material factors such as spirits and witchcraft.

The point of the above example, and indeed all of our studies on cognitive tolerance, is not to question the validity of different ontologies, but to illustrate that these can be mixed, even though they may appear in some way 'inconsistent' to those embedded in a particular (narrower) single-modal ontology. Nor is such a 'mixture' of ontologies restricted to any one group, country or region. In Ireland, for instance, many people suffering with cancer seek spiritual, psychological and medical help. To juxtapose the existence of mixed-modal models with Festinger's (1954) influential idea of cognitive dissonance (where one experiences discomfort on realizing that there is inconsistency among one's beliefs and/or behaviours), we have described an individual's or a community's ability to entertain more than a single-modal model as *cognitive tolerance* (MacLachlan & Carr, 1994a). While both ourselves and others (e.g. Elliott, Pirrs, & McMaster, 1992; Ensink & Robertson, 1999; Peltzer, 1993) have recognized this tolerance of pluralism in the African context as something positive, it does present significant problems for health service planners.

Pluralism at the population level

In a study of social science students we explored the credibility ratings of different sources of information for the prevention of AIDS (MacLachlan & Carr, 1994a). Using factor analysis we found that the rating of these sources clustered together into three distinct factors that can be interpreted as a biomedical factor (nurses and medical doctors), a traditional factor (traditional healers, friends, family, religious advisers) and a modernity factor (radio advertisements, newspapers and government posters). There was no relationship between

how credible individuals rated biomedical clinicians to be on the one hand, and how credible they rated traditional healers to be on the other—once again a strong belief in one approach did not preclude a strong belief in another approach, at least for some respondents. One interpretation of this finding is that different forms of healing and/or prevention may have credibility in different contexts. In a rural context a traditional healer may have greater credibility as a source of information about the prevention of AIDS, while in an urban hospital medical doctors and nurses may have greater credibility. By working together in the same clinical team it may be possible to raise the credibility of each group. For instance, credibility associated with traditional healers in rural settings may transfer to nurses or doctors who work alongside traditional healers in these settings; and vice versa for traditional healers who work alongside nurses and doctors in more urban settings.

More recently we sought to develop a statistical model that could explicitly deal with the uncertainty that mixed-modal models give rise to. Using the MacLachlan and Carr (1994a) data, we further investigated the relationship between endorsing the credibility of biomedical practitioners and endorsing modernity (relatively modern means of communication). Using non-linear regression techniques we found that for those people who did not endorse the credibility of traditional sources (e.g. traditional healers) there was a very strong linear relationship between endorsing modernity and biomedicine. However, for those who strongly endorsed the traditional factor there was no significant linear relationship between biomedicine and modernity (see Watters, Carr, & MacLachlan, submitted). In essence, the more strongly people endorsed the tradition factor, the less linear was the relationship between the endorsement of the biomedicine and modernity factors.

Such multivariate models, though complex themselves, illustrate how the complexity of pluralism can be managed at a population level, where the gross demand and supply of different sorts of services is the major issue. For the efficient development of health services, planners need to be able to predict the likely uptake of new services, be they biomedical or traditional in orientation. In the context of the

present example, even in areas where certain aspects of modernity seem to be endorsed, it would seem wasteful to increase biomedical health services without taking into account the extent to which traditional approaches still have currency. It is to be hoped that such an understanding may contribute to the provision and development of more effective health services in developing countries (Carr, McAuliffe, & MacLachlan, 1998).

Pluralism at the individual level

While it is of great importance to understand the relationship between cultural values and health behaviour at the population level, it is equally important to do so for individuals. An inner city general practitioner in London cannot, however, be expected to be expert on the great range of cultures that he or she will come across on a daily basis. Yet in clinical practice it is important to try and find out what notions of cause and effect are influencing a client/patient. Indeed this endeavour may be considered key to the therapeutic relationship and, as such, a crucial component of therapeutic effectiveness (Hubble, Duncan, & Miller, 1999). When the patient comes from a culture quite different from that of the clinician, the difficulties involved in accessing each other's world can seem insurmountable. The *Problem Portrait Technique* (PPT), following the definition of a portrait, offers a 'likeness of a real person' through a 'vivid description in words' (Chambers' Twentieth Century Dictionary). This portrait, while directed by the patient, is facilitated by the clinician in a collaborative investigation of the patient's sociocultural construction of his or her presenting problem.

The PPT has three distinct stages which are summarized below (see MacLachlan, 1997, for a more detailed description), to illustrate how to work practically with the challenges that pluralism presents. First, as shown in Figure 1, the patient's description of his problem is placed at the centre of a blank piece of paper. Here, Mr Lim, a Chinese immigrant, has been referred to a psychologist because of irritable bowel syndrome, which he describes as 'digestive problems'. He is asked what he thinks has caused these problems and he gives two explanations: (1) food poisoning has produced dangerous

bacteria and his body is trying to 'flush them out', thus causing diarrhoea; after further probing he suggests that (2) he has been feeling run down because of overworking and his body has generally been feeling 'weaker'. On further probing about what other causes he thinks are possible, he says he can't think of any other causes. This may be quite true, but it may also be a reflection of how he reads the clinical social situation of the consultation, and what he thinks are appropriate ideas to talk about in this context. To broaden the net of investigation to other ideas that may have some influence on his thinking we can ask him about 'significant others' in his life and what they might think the cause of his 'problem' to be.

Asking Mr Lim about how other members of his family view his problem allows a slight distancing from his personal views, and yet his family's perspective may be salient to his own construction of his problem. In the example given in Figure 1, Mr Lim's mother (3) believes that he has upset the spirit of his father by adopting western attitudes and mocking traditional Chinese values, the consequence of this being that he has experienced the misfortune of illness. Other causes concerning cultural beliefs about infidelity (4) and the failure of Mr Lim and his wife to conceive a child (5), the comments of a close (indigenous) friend about the effects of

eating foreign food (6), and finally what his general practitioner said to him (7), all represent possible influences on his own beliefs regarding the problem.

The above process thus allows us to develop a sort of 'word map', or 'picture' of the ecocultural context in which Mr Lim experiences his presenting problem. However, within such a portrait we are as yet unable to identify what is figure (foreground—most influential) and what is 'ground' (background—less influential) from his own perspective. In the second stage of the PPT (see Fig. 2) a causal web for these elicited beliefs can be drawn by getting Mr Lim to rate the strength of each of the beliefs on visual analogue scales radiating from a central disc (labelled with his presenting problem). The third stage of the PPT then involves exploring what I have called 'consequential treatments', that is, treatments which would be appropriate to the ontology encapsulated in the different potential causes that Mr Lim has articulated.

These treatments can also be mapped and Mr Lim's estimation of their value for his present circumstances can be measured, again on visual analogue scales radiating from a central disc (see MacLachlan, 1997, Fig. 2.4). The resultant treatment web may be quite pluralistic with high ratings for several of the consequential treatments, or it may effectively endorse a

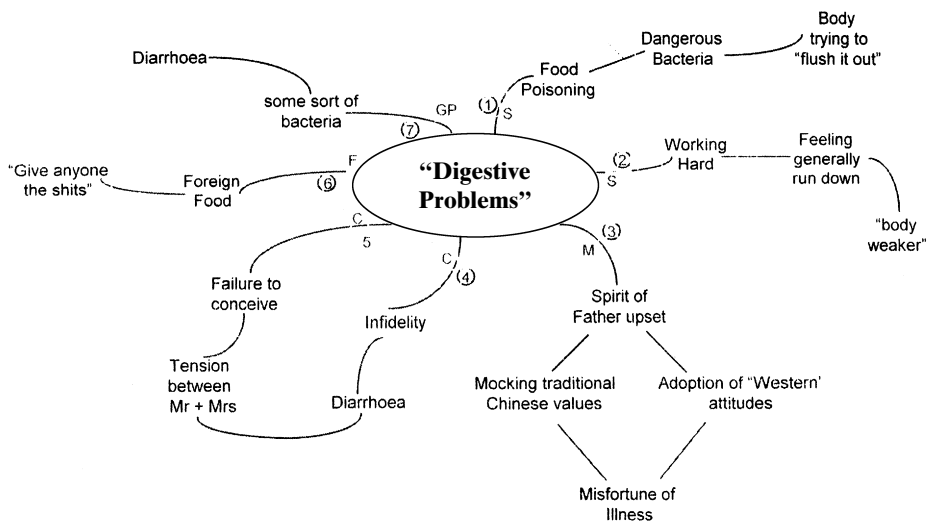


Figure 1. The Problem Portrait Technique (Reproduced with permission from MacLachlan, 1997)

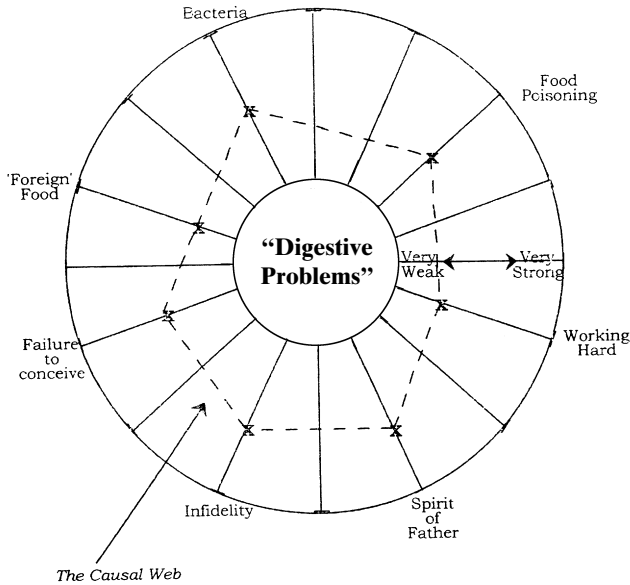


Figure 2. The Problem Portrait Technique (Reproduced with permission from MacLachlan, 1997)

single-modal model, with one treatment being rated far above the others. Hopefully what emerges is a truer impression of the clients'/patients' beliefs about the cause(s) of and treatment(s) for their 'problem'. Thus the original presenting problem may be refined, redefined or embellished through applying this process of assessment. It may, for instance, result in complementary (or 'alternative') medicine being incorporated into the treatment process, a trend which is becoming increasingly popular in western society (Furnham & Vincent, 2000).

The PPT therefore offers a medium through which clinician and client can attempt a more comprehensive assessment of a problem than might otherwise be the case. The scalar properties of the PPT also present the opportunity for quantitative statistical analysis of, for example, the extent of pluralism in different sorts of problems and different sorts of clients. It would, for instance, allow us to explore more fundamental conceptual issues regarding the nature of pluralism. Is it the case that the greater the number of factors that are believed to be associated with the cause of an ailment, the weaker is the average strength of these factors? In other

words, does believing in more than one cause dilute the overall influence of each cause, or on the other hand, does understanding the broader context in which they operate increase their influence (this is an issue we are currently studying using the PPT at admission and discharge with 100 South African patients suffering from tuberculosis) (Peltzer & MacLachlan, in preparation).

There is one important issue, both conceptual and practical, that should be clarified regarding the PPT: how is a clinician to work with a patient whose beliefs about the cause of his or her ailments and the treatments he or she thinks will be efficacious fall outside the purview of the clinician? It is not being suggested here that clinicians should stray outside the boundaries of their professional competence. Rather the PPT is a way of making clinicians aware of the broader sociocultural context in which their clients' ailments are operating. It would be naive to assume that not asking patients about their spiritual or other types of belief would prevent them from pursuing help in these different domains. The PPT may facilitate communication, and indeed collaboration, between

'conventional', and 'complementary' practitioners (or immigrant traditional healers), but its core purpose is to help the clinician (of whatever orientation) to understand the broader context of the problem from the patient's perspective.

Plural dialogue

Multiculturalism, whether in the less industrialized countries of the 'Third World' or the more industrialized countries of the 'First World', is now a pervasive global force (Hermans & Kempen, 1998; Moghaddam & Solliday, 1991). Indeed a recent millennium supplement of *National Geographic* entitled *Global Culture* estimated that only 5 percent of the world's population still retain a strong identity as members of an indigenous culture (Davis, 1999). The rest of us encounter, to varying extents, some degree of cultural mix and indeed, at times, the failure of cultures to mix. Classically, cross-cultural psychology has been concerned with the core of cultures rather than their interface and, as Hermans and Kempen (1998) state, 'More attention should be given to the contact zones between cultures' (p. 1117). . . . and ' . . . multivoicedness and dialogue . . . are closely related to cultural complexity . . . self and identity can be conceived of as a dynamic multiplicity of different and even contrasting positions or voices that allow mutual dialogical relationships' (p. 1118). It is the contact zones between cultures that gives rise to the need for pluralism in health care (see also Mulatu & Berry, 2000), so that the complexity of 'multivoicedness' (or perhaps 'plural dialogue' would be a better term in this context) can be worked with, using cultural constructions as a vehicle for healing rather than as a barrier to understanding (MacLachlan, 2000).

While multiple cultural influences are certainly (on average) more geographically localized than, say, 100 years ago, we need look no further than the 'culture' of health services to recognize multivoicedness, or plural dialogue. Stainton Rogers (1994), for example, has described seven metaphors that are used to explain health and illness (including robust individualism, the body under siege, the body as a machine and inequality of access to resources), and different health professions can be seen as

endorsing these metaphors to varying extents. Thus a multidisciplinary meeting is a form of multivoicedness where, ideally, different professionals each give their own (and different) perspectives on the case at hand, and in doing so generate plural dialogue. Ingram and Desombre (1999) have recently argued for the potential of such teamwork to meet the needs of patients better.

The challenge for health psychology

Health psychology is an incredibly broad discipline and as such encounters many metaphors for, and explanations of, health and illness. For instance, the mediating biochemistry of psychoneuroimmunology (e.g. Ader & Cohen, 1985) and the health consequences of inequalities inherent in social hierarchies (e.g. Blane, Brunner, & Wilkinson, 1996), each representing relatively proximate and ultimate causes of health, sit comfortably side by side in health psychology texts. The breadth of the discipline is further emphasized by the buzzphrase 'biopsychosocial interactions'. However, if health psychology restricts itself to biological, social and psychological influences on health, it will have failed to reach for the goal of incorporating personal meaning into the study of health and illness. It is important to incorporate personal meaning because assessments and interventions will be valued and believed to the extent that they take cognisance of a person's own experience of his or her situation (Helman, 1994; Kleinman, 1980; MacLachlan, 1997; Pick, 1997).

In this article I have argued that health psychology needs to take cultural diversity into account, but that doing so presents very real practical challenges to patients, clinicians and health service planners. I have therefore given two very different examples of how, to understand a greater range of meanings, a plurality of methodology is necessary (e.g. using qualitative and quantitative techniques such as the PPT and non-linear regression). No one methodology is sufficient to capture the breadth of either the personal or the population issues that arise by accepting pluralism. To study pluralism one needs to be pluralistic! Thus while discourse analysis and qualitative techniques sit well within a 'critical' perspective on health

psychology, we must not focus on them to the exclusion of other perspectives.

Much of my own work in health psychology has tried to 'scale up' health problems to their broader sociocultural context. However, Weick (1984) has argued that scaling up problems may make them seem insurmountable and paralyse efforts to overcome them. Being 'reductionist' seems to imply 'scaling down' problems. Certainly we want to retain an account of an individual's problems at the level of his or her personal experience (and meaning). However, this should not preclude being pluralistic and both scaling up and scaling down the problem.

Perhaps the ultimate challenge to health psychology is to cultivate pluralism within itself; that is, not only by acknowledging different cultural perspectives, but also by meaningfully incorporating diverse methodological (e.g. quantitative and qualitative research) and conceptual (e.g. social constructionist and psychoneuroimmunological) perspectives. There are few other disciplines as well placed to integrate proximate and ultimate, molecular and cultural, influences on health. This therefore confers both a great opportunity and a great responsibility on health psychology.

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