What Can Clinical Psychology Learn from Cultural Psychology: a series of case studies examining distress, diagnosis, and therapy.

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Thesis Abstract

A wide range of traditions has taken up the task of understanding mental suffering. Clinical psychology is a recent addition to this landscape, distinguished from others by its affiliation with science. This relatively new systematic attempt to understand mental suffering has yielded valuable insights. However, its aim to discover generalisable psychological laws comes at a cost. Treating psychological principles as natural and universal prevents an understanding of how psychological life is interwoven with the symbolic and material resources of the cultural world. This thesis argues that clinical psychology could overcome this limitation by incorporating the perspectives of cultural psychology. Namely, that society, history and ideology have a constitutive role in constructing psychological meaning and experience. Such a perspective challenges the notion of a uniform and unchanging human nature, and brings the interpretive knowledge in the humanities back into clinical psychology. I argue that this integration is not only valuable for cross-cultural work but also for a more nuanced understanding of mental health within Western societies. To substantiate this claim, the thesis explores several contemporary issues that traditionally lie within clinical psychology's boundaries (distress, therapy, and diagnosis) from this perspective. Three case studies were undertaken with the hope that each could contribute to the theoretical research in each respective area.

The first study examined the psychological experience of distress during the COVID lockdown and its relationship to the meaning of time. This qualitative diary-based study conducted in the early weeks of the pandemic explored the cultural co-construction of time as it unfolded week-to-week. A semiotic perspective proved helpful in highlighting how seemingly disparate discourses coalesced into several coherent narrative structures that helped format this experience. The second case study examined psychological therapeutic apps and how they position the concept of care. Using a postphenomenological lens, it was found that care was made private and convenient by these apps, albeit at the cost of becoming mechanistic, impersonal, and non-relational. Despite the initial appeal of this kind of care, users often abandoned it, frequently blaming themselves for not being able to measure-up to its standards. The last case study explored how adult ADHD diagnoses might be understood if it were conceptualised as a socio-cultural niche for a particular way of being. Rather than seeing it as merely a neurological deficit, it found that the ADHD niche provided opportunities as well as restrictions. It could help mediate gender- and career-expectations, as well as facilitate social arrangements that were difficult to arrange elsewhere.

The sum of these findings suggests that, despite everything clinical psychology has been able to offer in terms of our understanding and response to suffering, it is not without its blind spots. It has a particular vulnerability to over-incorporating Western values, like neoliberalism and individualism, into its construction of universal truths. A more critically aware approach to mental health could incorporate this lesson into the many aspects of clinical psychology: clinical formulation could look 'outward' into the cultural environment, while psychological interventions could be designed with explicit consideration for how they interact with and are shaped by prevailing cultural discourses.

Statement of originality and certification of thesis

This is to certify that to the best of my knowledge and belief, the content of the research presented in this thesis is my own work except in the circumstances where an acknowledgement has been made. This thesis has not been submitted for any degree or any other institution. Grammarly and Microsoft Spellcheck were used to correct errors in spelling, grammar, and sentence mechanics. Mendeley was used as a reference management tool to organise sources and generate citations. Apart from this, no generative AI was used in the construction of this thesis. I certify that the intellectual content of this thesis is the product of my own work and that all assistance in the preparation of this thesis and sources have been acknowledged.

This Thesis is the work of Jesse N Ruse except where otherwise acknowledged, with the majority of the contribution to the papers presented as a Thesis by Publication undertaken by the student. No editing service has been used in the preparation of this thesis. This thesis is not more than 100,000 words in length, including quotes and exclusive of tables, figures, appendices, bibliography, references, and footnotes.

Jesse Ruse, 08/06/2025

Authorship attribution statement

The research presented in this thesis is the work of the candidate, Jesse Ruse, in conjunction with the School of Psychology at the University of Sydney. The Candidate is the principal author and lead researcher, coordinating the research under the supervision of Professor Paul Rhodes. Ethics approval was obtained from the University of Sydney Human Research Ethics Committee and is attached as Appendices. Chapters 2 and 3 are published in peer-reviewed journals (details on page 5). Chapter 4 has been reviewed and is awaiting publication at the time of writing.

The text was formatted, with headings and paragraphs organised for better readability. The spelling of English words adheres to the standards of Australian English, which predominantly reflects British spelling, to align with the conventions of the country where this thesis is submitted for examination.

Chapter 2 of this thesis is published as Ruse, J. N., Rhodes, P., Tateo, L., & Luca Picione, R. D. (2023). Remaking time: Cultural semiotic transformations of temporality during the early days of the COVID-19 pandemic and lockdown. *Integrative Psychological and Behavioral Science*, *57*(1), 235-255. The Candidate was responsible for identifying the epistemologies, methodologies, theoretical perspectives, and methods used in the studies under the supervision of Professor Paul Rhodes. P. Rhodes and L. Tateo were responsible for the initial advertising of the study, while The Candidate was responsible for recruitment. The Candidate was responsible for theory development and data analysis. The Candidate, P. Rhodes, L. Tateo, and R. Luca Picione assisted in a secondary analysis of the qualitative findings. The Candidate was responsible for composing the manuscript.

Chapter 3 of this thesis is published as Ruse, J. N., Schraube, E., & Rhodes, P. (2024). Left to their own devices: the significance of mental health apps on the construction of therapy and care. *Subjectivity*, *31*(4), 410-428. The candidate developed the study and theoretical concepts, wrote the manuscript and submitted the article for publication. The candidate, P. Rhodes, and E. Schraube were involved in refining the discussion and responding to reviews.

Chapter 4 of this thesis is currently under review as Ruse, J. N. & Rhodes, P (2025). ADHD in ecosocial niches: an exploration of Adult ADHD in-context at *Culture, Medicine, and Psychiatry.* The Candidate was responsible for identifying the research topic, developing the theory, recruiting participants, conducting interviews, analysing data, and composing manuscripts. P.Rhodes and The Candidate were responsible for refining the discussion and responding to reviews.

Jesse Ruse:

Date: 08/06/2025

As supervisor for the candidature upon which this thesis is based, I can confirm that the authorship attribution statements above are correct.

Professor Paul Rhodes

Date: 09/06/2025

List of Peer-reviewed publications:

- Ruse, J. Rhodes, P. Tateo, L., De Luca Picione, R. (2022). Remaking time: Cultural semiotic transformations of temporality during the early days of the COVID-19 pandemic and lockdown. Integrative Psychological and Behavioral Science. 56.

- Ruse, J., Rhodes, P., Schraube, E. (2024). Left to their own devices – Qualitative study of e-mental health interventions. Subjectivity. *31*(4), 410-428

List of publications under review at the time of writing:

- Ruse, J. & Rhodes, P.. (2024) Psychopathology in cultural eco-social niches: cultural influences on Australian adults with late-diagnosed ADHD. *Culture, Medicine and Psychiatry* [under review as of June 2025]

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[1] To the University of Sydney and my examiners, this is NOT an admission of academic plagiarism.

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Chapter 1

Abstract:

This chapter, split into three parts, explores a fundamental tension in clinical psychology between universal and culturally specific approaches to understanding psychological suffering. In part 1a, I contextualise clinical psychology within its historical, geographical, and political frameworks, demonstrating how the field's alignment with scientific traditions has shaped its understanding of psychological constructs. I argue that the field has traditionally aligned itself with scientific paradigms seeking universal laws of behaviour, and that such an approach inadequately captures how psychological phenomena are co-constructed through cultural processes. In part 1b, I then tackle the task of defining and conceptualising culture. I trace its etymological roots and examine its evolution in academic discourse, particularly through the lens of cultural studies and the subsequent 'cultural turn' in social sciences. Through this analysis, I articulate a cultural psychology framework that views psychological phenomena as emerging through dynamic person-environment interactions, challenging clinical psychology's tendency to treat culture as peripheral to supposedly universal psychological processes. This theoretical groundwork establishes the basis for examining how clinical issues are fundamentally shaped by historical, material, and social forces, with implications for developing more culturally informed clinical practices. In section 1c, I finish by discussing the methods and analyses that are used in the remainder of the thesis and introduce the case studies which will follow. I finish by introducing how this framework will be used in three case studies examining contemporary clinical phenomena: pandemic-related distress, the transition to digital therapy, and the rising number of adult ADHD diagnoses.

Chapter 1a: Contextualising and problematising traditional clinical psychology

Introduction and broad summary of problematisation:

Clinical psychology is the sub-discipline of psychology concerned with understanding and alleviating psychological problems and distress. Pioneering clinical psychologist Lightner Witmer defined it as "the study of individuals, by observation or experimentation, with the intention of promoting change" (Witmer, 1907, p. 9). More contemporary definitions, such as that found in Encyclopedia Britannica, more narrowly define it as "the branch of psychology concerned with the practical application of research methodologies and findings in the diagnosis and treatment of mental disorders**"** (The Editors of Encyclopaedia Britannica, 2024)**.** A crucial tension exists within the field regarding how best to understand and treat psychological suffering: should it seek universal laws of human behaviour, or should it understand behaviour as inseparably tied to specific cultural contexts? This tension has shaped two distinct intellectual traditions, which have been used to understand psychological distress, suffering, and relief:

Scientific psychology, as an intellectual tradition, is "the study of the mind and behavior. Historically, psychology was an area within philosophy and emerged from it. It is now a diverse scientific discipline comprising several major branches of research" (American Psychological Association, 2018)[2]. This approach rests on the foundational assumption that there exist some generalisable principles that govern behaviour and thought. Such theories implicitly assume there to be some universal human nature; one that, beneath surface-level variations in behaviour and expression, consists of underlying mechanisms and processes (Valsiner, 1986, Chapter 1). In its recent history, this tradition has demonstrated a preference in its approach, favouring timeless principles over historical contexts, identifying underlying causes over surface expressions, using objective measurements over subjective interpretations, and theorising behavioural laws over cultural customs. It is important to acknowledge that the 'scientific tradition' itself is not homogenous; diverse methodologies and more reflexive approaches do exist within the broader psychological sciences, even if they have not historically dominated the mainstream in psychology. However, prevailing tendencies in scientific psychology have meant that concepts like ‘universal’, ‘natural’, and ‘impartial’ are valued over the ‘localised’, ‘constructed’, and ‘political’.

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[2] This is similar to definitions in other major national psychology peak bodies, e.g: "Using scientific principles, psychology explores human emotions, cognitive ability and biological functions to help us better understand how and why we think, feel, behave and react" (Australian Psychology Society, 2024)

Anthropology, the study of cultures, similarly seeks to understand thinking and behaviour. Anthropologists attempt to understand a particular community, organisation, society, etc, rather than theorising about universal laws. These studies typically focus on how local histories, power struggles, gender relations, material environments, and social structures are reflected in the practices, beliefs and artefacts of a society. Given the widespread variations being documented, over time the field became suspicious that some universal and objective conceptualisation of ‘human nature’ could be constructed outside of ‘culture’. Traditionally, this field studied people in far-away places, whose customs and practices looked quite different to those of the researchers observing them (Trouillot, 2003). These origins have opened up anthropology to the criticism that it is “the science of the Other” (Greenfield, 2000, p. 571).

Cultural psychology emerges as a bridge between these approaches, examining how all minds are constituted and shaped by broader social, political and historical contexts. In this thesis, I will contend that clinical psychology could lean more heavily on cultural psychology to understand contemporary issues in mental health. While mainstream scientific psychology sometimes acknowledges cultural factors, they are often subjugated in importance and seen merely as the superficial “media through which abstract laws of behaviour expressed themselves” (Danziger, 1994, p. 94). Cultural psychology avoids the universalising tendencies of scientific psychology, which are inadequate for understanding ‘meaning’. Cultural Psychology also avoids the pitfalls of anthropology, which has grappled with the complexities of representing the ‘other’.

In this chapter, I will describe mainstream clinical psychology, which must be understood through its history, its geographical context, and its allegiance to the methods of the physical sciences. I will then go on to highlight what I believe are some limitations of the field, primarily relating to its Western and scientific upbringing. I finish by posing a question about the possibility of seeking input from other research traditions, namely those used to explore culture.

A note on definitions

This thesis focuses on how clinical psychology can more fruitfully integrate culture into its understanding of its subject matter. An important first step in this argument is to define some key terms. Defining important terms is rarely easy and is never neutral, as will become evident in the following passages. To define a term is to take a stance on its meaning. And meanings, as I will argue later in this chapter, are contingent upon historical, geographical and political forces. This means that definitions change over time, between places, and between people. As such, one term may have multiple meanings depending on these contexts. That said, in order to have some shared understanding of what is being discussed, I feel that it is necessary to give a preliminary definition of ‘clinical psychology’ and ‘clinical psychological research’ and thereby (temporarily) freeze some meaning in-place

Clinical psychology is likely the most common speciality within the field of psychology globally (Lunt & Poortinga, 1996). The largest psychological association in the world, the American Psychological Association (APA), defines clinical psychology as “the subfield of psychology that focuses on the prevention, assessment and treatment of psychological maladjustment, disability and discomfort” (APA, 2012, para. 1). This definition will be contextualised historically, geographically and politically in the coming paragraphs. But, for now, it is uncontroversial to suggest that this definition is largely well-agreed upon within and outside the field. Historian of psychology Eugene Taylor suggests that “the term clinical psychology most often refers to a broad subfield in which qualified professionals trained in some aspect of mental health deliver therapeutic services” (Taylor, 2000, p. 1). Taylor’s definition echoes the APA’s emphasis on mental health (“psychological maladjustment, disability and discomfort”), whilst adding that clinical psychologists “deliver therapeutic services”. This addendum specifies that clinical psychology is an applied practice, rather than a theoretical research field. Nevertheless, there is research related to " psychological maladjustment, disability and discomfort” (i.e. mental health), which informs clinical practice. And journals, such as *The Journal of Clinical Psychology,* publish research on this matter. It is in this sense that I use the term ‘clinical psychological research’.

Below, I go on to contextualise clinical psychology, showing that the definition above gets its meaning from certain contexts. First, I contextualise clinical psychology within its historical epoch and then move on to situate it geographically. Next, I situate clinical psychology within certain practical and theoretical orientations (within medicine and science, respectively). This method of contextualisation serves two purposes. First, in its content, by showing that clinical psychology is somewhat blind to culture. Second, by its form, highlighting how processes of contextualisation can enrich understanding.

Clinical Psychology beginnings: in historical context

Clinical psychology has its roots in academic departments in North American universities (Hersch, 1969). Unlike psychiatry's practical origins in the asylum, clinical psychology developed first as an academic discipline grounded in laboratory research (Hersch, 1969; Kazarian & Evans, 1998). American psychologist Lightner Witmer is often credited with first coining the term ‘clinical psychology’ (Benjamin Jr, 2005). He and his colleagues established what some consider the first formal psychology clinic in the early 20th century in Pennsylvania. He treated children referred for “moral defects which rendered them difficult to manage under ordinary discipline.” (Witmer, 1907, p. 1).[3] In its earliest formal iterations, the psychology clinic was concerned with helping children with cognitive and emotional problems, or what might be called ‘child guidance’. Witmer proposed that clinical psychology involves “the study of an individual mind, by observation and experiment, and treatment applied to effect change" (Witmer, 1907, p. 9). Today, Clinical psychology emphasises empirical study, individual intervention, and clinical treatment, whilst having broadened its focus from children to individuals of all ages.

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[3] While Whitmer primarily treated children with learning difficulties and behavioural concerns, he suggested that, theoretically, “clinical psychology does not exclude from consideration other types of children that deviate from the average, for example, the precocious child and the genius. Indeed, the clinical method is applicable even to the so-called normal child.” (Witmer, 1907)

Routh and Barlow (2014) trace the roots of clinical psychology through three significant traditions that were developing in European and American thought in the early 20th century. These being the empirical tradition, the psychometric tradition, and the clinical tradition, which I will briefly explain. The empirical tradition emphasised scientific methods and laboratory research applied to psychological phenomena. It emerged as a challenge to philosophical idealism’s dominance in the study of mental phenomena. The psychometric tradition was a quantifying practice which developed methods for measuring individual differences. Initially, this was to aid in child-guidance practices, and later to facilitate military recruitment and personnel ranking. And lastly, the clinical tradition, which emerged out of European psychiatry and psychoanalytic circles, with its aim to diagnose and treat mental disorders. Routh and Barlow (2014) contend that these three movements provided the “solid foundations” for the formation of clinical psychology.

The services of clinical psychologists expanded most rapidly in the period following the Second World War (Bazar, 2015). Demand was driven by the increased need to treat those who returned from war and their families. The Second World War legitimised the involvement of clinical psychologists in the assessment and treatment of adults (Hersch, 1969). Following this period, the field moved from being mostly a psychometric tradition to one focused predominantly on psychotherapeutic treatments (Bazar, 2015). Moreover, as the field grew, so did the need for a standardised model to align the disparate institutions training clinicians. The scientist-practitioner model (SPM) emerged as a leading framework for the newly organised field of clinical psychology (Baker & Benjamin Jr, 2000). The SPM emphasised that clinical psychologists ought to stay abreast of current research literature, apply scientific findings in their clinical work, and use empirical methods to evaluate their treatments.

The scientific approach in clinical psychology helped legitimise the profession in the eyes of the public (Boyle, 2011; Spring, 2007).[4] Indeed, this alignment with scientific principles was instrumental in establishing psychology as a legitimate discipline distinct from philosophy and unverified speculation (Coon, 1992). This scientific orientation to mental suffering arose partly in response to the ineffectiveness of moral treatments and a need to differentiate from religion (Reisman, 1991). The rise of scientific explanations for mental distress displaced moral and existential languages for making sense of suffering (Brinkmann, 2014). For example, clinical psychology used concepts that aligned with modernist secular values and away from religious approaches that constructed suffering as purposeful or redemptive.[5] This shift, from a moral to scientific framework, provided a new language for the understanding suffering (Brinkmann, 2016) and new tools for predicting and controlling distress. Whilst the tradition continued to undergo theoretical changes, it has continued to be guided by the principles and values of science.

Situating Clinical Psychology alongside Social Work and beneath Medicine

Just as psychological theory situates itself within the scientific tradition, clinical psychological practice situates itself alongside other practices. It often sits closely below medicine (in particular, psychiatry) and alongside other so-called ‘allied health’ practices (particularly social-work). Historically, clinical psychology followed psychiatry, the sub-field of medicine concerned with mental problems. It borrows many of psychiatry’s elements such as its emphasis on clinical formulation in assessment, its use of talk therapy as an intervention, and its focus on the mind as a cause and solution to suffering. Some suggest that the relationship with psychiatry is insecure and psychologists are cognisant of the possibility of merely being handmaidens to authority and expertise of psychiatrists. As such, clinical psychology is differentiated from psychiatry in some respects, too. Clinical psychologists, in general, have a more uneasy relationship with psychiatric diagnosis, which some psychologists see as overly medical and limiting. Moreover, clinical psychologists, in general, are more likely to incorporate social context into their formulation, thereby problematising the disease-entity construction of mental suffering more popular in medicine (Coles & Mannion, 2017).

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[4] Clinical psychologist Mary Boyle also suggests that clinical psychology situates itself within the more established fields of medicine and science partly due to insecurity of its status in the eyes of academia and the wider public (2011). Bonnie Spring (2007) suggests that scientific approaches are partly driven by policy decisions, as a means to allocating resources, enabling governments and insurance companies to know which interventions to fund.

[5] Arguably, however, psychiatry and clinical psychology retain many social elements of Christian practices: clinicians emulate priests, research articles emulate sacred texts, clinics emulate confessionals, and pills emulate prayers (Whitley, 2008).

Clinical psychology also aims to differentiate from social work, whose predominant focus is on the social conditions that create suffering (including mental suffering). As stated above, while clinical psychologists are implored to incorporate social conditions into their formulations, the interventions to address these conditions are often quite different to those in social work. Clinical psychologists generally don't include issues of power and justice in their definitions of clinical problems and tend to focus on personal rather than political change in clinical practice (Prilleltensky, 1997). This is despite the widespread understanding that political and economic arrangements are common causes of distress and psychological problems. Meanwhile, social workers have a proud tradition of advocating for political and economic change as a means of ameliorating suffering, which dates back to the very birth of the profession (Healy, 2008). Lastly, social workers and clinical psychologists differ in their orientation to therapeutic intervention. While social workers commonly help secure practical needs like employment and housing, psychologists generally avoid such direct intervention, viewing it as both paternalistic and beyond their professional role.

Clinical psychology: in its Western context

As well as being situated historically, clinical psychology can also be situated within social, geographical, and ethnic contexts. As discussed above, the tradition grew out of philosophical and clinical traditions that originated in North America and Western Europe. Contemporaneously, this is reflected in the number of psychologists working in a 'clinical' capacity (i.e. in mental health care) around the world. Whilst in North America and Europe, there are around 3 psychologists per 100,000 people of the population, there are many fewer in Asia (0.02 per 100,00), the Eastern Mediterranean (0.2 per 100,000) and Africa (0.05 per 100,000) (Saraceno & Saxena, 2002).

With regards to ethnicity, clinical psychologists in these Western countries overwhelmingly tend to be White, with around 83% of the American psychology workforce identifying as ‘non-Hispanic white’, while around 90% of registered psychologist practitioners in the UK identify as ‘white’ (Kanceljak & Calia, 2023; Lin et al., 2018). The majority of people who consume clinical psychology services tend to be white, despite findings that minority ethnicities tend to have proportionally higher rates of mental health problems (Collaborating Centre for Mental Health, 2023; Shim et al., 2009). Moreover, at least in the UK, persons of White-British background generally have the most favourable outcomes after accessing psychological therapy (Arundell et al., 2024). Within published psychological research, the vast majority of articles published in leading APA psychology journals are by American (predominantly) and European (secondarily) researchers (Arnett, 2008). The vast majority of psychological research subjects in these articles are from Western Educated Industrialised Rich Democratic populations (Henrich et al., 2010; Nielsen et al., 2017).

Situating Clinical Psychology within Science

Before moving on to situate clinical psychology within science, it is worth defining the key term ‘science’. This is no easy task, given that an entire academic discipline (the History and Philosophy of Science) grapples with this very question. Feyerabend (2020) contends that there is no single set of methods or procedures shared by all sciences. He was able to show that what connects astronomy to palaeontology to particle physics to psychology is not a common set of tools for evaluating knowledge, but its connection to a *tradition*. The scientific tradition evolved in Europe during the Enlightenment era, emphasising the values of rationalism (logic-based reasoning), empiricism (systematic observation), and scepticism (questioning compelling but potentially false conclusions) (Bristow, 2010). The tradition that the psychological sciences follow most closely is that found in the so-called natural sciences, such as physics and chemistry (Gone, 2011). These traditions are most engaged with discovering the laws that govern the physical world, using analytic tools such as measurement and quantification, in pursuit of the ideal of control over the natural world (Lacey, 1999).

Since its inception, clinical psychology has unapologetically situated itself within the field of science. Indeed, the notion that the field is scientific is a crucial claim in its bid for legitimacy compared to other healing traditions. (Boyle, 2011). Major governing bodies of clinical psychology implore psychologists to be guided by science. The British Psychological Society's (BPS) Division of Clinical Psychology authoritatively states that the clinician aims to “apply scientific knowledge about human behaviour to ameliorate psychological problems” (Division of Clinical Psychology, 1996, p. 3). The Psychology Board of Australia requires that clinicians adhere to several key competencies, the first being that the clinician “applies and builds scientific knowledge of psychology to inform safe and effective practice” (Psychology Board of Australia, 2024, p. 5). As to why clinical psychology might situate itself within the scientific tradition, this may relate to the ideal of ‘objectivity’ in science, its ‘reliability’ in predicting outcomes, and the hope that this could provide greater control over (human) nature. (Lacey, 1999).

The values of reliability, prediction and control have been embraced by clinical psychological research. First, science elevates the concepts of rigour, reliability and validity in knowledge creation. These systematic attempts to reduce biases are appealing to a public that is sceptical of belief-based spiritual and moral constructions of mental suffering (Whitley, 2008). Second, the scientific tradition brings with it the promise of universality: the idea that some universal principles govern how the natural world unfolds. Through science, the mind and its problems can be understood as a natural phenomenon, and behaviour can therefore be predicted via discoverable universal principles. Just as physics uses scientific principles to predict the motion of planets, for example, clinical psychology could do the same to uncover universal laws governing human behaviour and mental processes. Lastly, the scientific perspective proved to be successful in the 19th-century in the natural sciences leading to impressive progress in medicine and engineering (Danziger, 1994, p. 49). It was hoped that science might similarly help clinical psychology create therapeutic technologies, such as talk therapies, that could improve social wellbeing.

Criticisms of scientific clinical psychology

There have been numerous criticisms of clinical psychology's over-involvement in the scientific tradition. Here, I discuss criticisms pertinent to this thesis. These are: problems with science as a hegemonic discursive practice, the inadequacy of the scientific epistemology for understanding human suffering, and the obfuscation of agency inherent in scientific ontology.

Science as a discursive practice: Scientism

The discursive power of scientific rhetoric, or so-called "scientism" (Danziger, 1994, p. 49), refers to the power science has merely as a discourse. Danziger argues that the success of scientific methods in achieving progress in the natural sciences during the twentieth century led to the belief that scientific practices were the only ones capable of providing useful knowledge about anything (1994). Increasingly, truth became synonymous with scientific knowledge, which itself became synonymous with observable facts. Clinical psychological research aligns itself discursively with science by borrowing concepts and metaphors from the physical sciences (Kimble, 1990) and by its keenness for complex mathematical models (even when inappropriately used (Sokal, 2015)). Boyle argues that alignment with the physical sciences serves to support the status of clinical psychology and justify its knowledge claims (2011; see also Fish, 2000). Moreover, psychological research knowledge loses credibility when it borrows from outside this paradigm, such as when applying field research, arts-based methods, or interpretive analyses (Schwartz, 1992). Coles and Mannion (2017) suggest that such an emphasis on science serves to enhance the reputation of clinical psychology rather than its practice.

Unhelpful reductionism

Clinical psychology also takes its epistemological values from science by importing its study design from other scientific disciplines. In the so-called hard sciences, such as physics and chemistry, laboratory research is highly favoured due to its value in controlling for unwanted outside influences. A perfect theory in physics, for example, creates a model “which can be expressed mathematically, which can be measured, exposed and reproduced experimentally” (Vihalemm, 2007) p. 230). Similarly, in clinical psychological research, research is often conducted via experimental laboratory studies (Osborne-Crowley, 2020). Laboratory studies aim to discover psychological principles in their ‘purest’ form, unsullied by non-psychological (e.g. historical, cultural) influence. Laboratory research in psychology effectively extracts research subjects (persons) from the historical, social, political, and economic circumstances that shape their everyday lives in order to reduce the influence of confounding (outside) influence (Osborne-Crowley, 2020). This follows from the discipline’s ambition to uncover universal psychological laws and produce psychological theories that are a-contextual and a-historical.

Greenfield (2000) suggests psychologists have a “fascination with universals and the reductionistic desire to explain human beings by a limited number of principles” (p. 573). He argues that this fascination has blinded research to considerations of culture and history, considering them as barriers to generalisable principles. Psychological researchers have constructed theoretical models that claim universality by seeking universal psychological truths that transcend culture and time. Often, however, such theories tend only to describe a relatively narrow group of persons; predominantly White Educated Industrialised Rich Democratic (WEIRD) individuals (Henrich et al., 2010). Consider, for example, that when empirical research is conducted on participants from the USA, it is less likely to specify the ethnicity or country of origin of the population in both the title (Cheon et al., 2020) and abstract (Rad et al., 2018) of the article, compared to research conducted with cultural and ethnic minorities. Such a bias tacitly suggests that research conducted on WEIRD populations applies to all humankind (i.e. is more generalisable), compared to research conducted on non-WEIRD populations, where culture may be a barrier to generalisability (Rad et al., 2018).

Naturalist Science: A ‘monist’ metaphysics disinterested in ‘meaning’

A certain type of metaphysics within the physical sciences holds that there is one relevant perspective on the nature of reality. This metaphysical stance suggests that whatever this perspective entails, it should be seen as primary and not conflict with the ‘facts’ of the world. The quest of science, on this view, is a “quest for a unified system of knowledge of the natural and social worlds” (Kirschner, 2006, p. 155). This perspective generally eschews, or hides, the perspective that there can exist multiple, essentially inequivalent, ‘meanings’ to the same phenomena. Here, ‘meaning’ refers to what something refers to or implies to someone (Chandler, 2017). Some event or interaction, for example, might imply different things to different people at different times.

Consider that Vihalemm (2007) makes a distinction between two different ways of doing science, which he calls Φ-sciences and Σ-sciences. He suggests that Φ-science is the paradigmatic and idealised science, mostly modelled on classical physics. The other (Σ-sciences) is most closely aligned with research in the Humanities. Following Kull (2009) I shall call the former ‘physical’ science and the latter ‘semiotics’. Kull argues that the study of the physical world is best captured through the physical sciences, which employ physical descriptions, create models that adhere to universal laws, and pursue universal, unchanging principles. It assumes a ‘faultless world’ model and seeks to uncover universal laws of nature. It tends to deal best with “phenomena which can be expressed mathematically, which can be measured, exposed and reproduced experimentally” (Vihalemm, 2007, p. 230) Physical sciences work within a what Kull (2009) calls a monist ontology. In a physical science model, some *thing* (e.g. variable) means (refers to) only one thing. That is to say, it *means* only one thing in the scientific model.

What distinguishes minds from mere physical systems is that physical systems lack referential ability – they cannot, on their own, be about or point to something else. This is a characteristic only mental phenomena seem to possess. For us, phenomena can have multiple meanings. For example, some action might have an ethical meaning (is it right or wrong?), a normative meaning (is it correct/appropriate?), an existential meaning (does this matter?), a political meaning (who does it benefit?), a personal meaning (what does this say about me?), a causal meaning (what caused it to happen?), an intentional meaning (did someone intend to do it?), a clinical meaning (is it healthy?) and many others depending on its context and other background understandings at-play. In this sense, Kull (2009) suggests that semiotics works within a ‘pluralist’ metaphysics, seeking local codes to uncover the many meanings that might exist (also see Kirschner, 2006). Semiotics is best suited to studying those things that only living systems (such as humans) can do, such as ‘knowing’, ‘interpreting’ and making choices.

These two approaches are complementary rather than opposing, and both can be used to come to a more complete understanding of living systems. However, research that uses only a monist understanding of meaning misses much of what clinical psychology deals with. Those who come to see psychologists often want help to interpret and make sense of the world (made possible through research using the semiotic method). And help to control and change the world (made possible through the physical science model)

Science as a ‘value-free ideal’.

Science often represents itself as a value-neutral practice.[6] However, scholars from numerous traditions in the Philosophy of Science have shown that science always embodies some tacit value system. This is embodied in the questions researchers choose to investigate, the methodologies they employ, how they interpret results, and what constitutes acceptable evidence. Feminist scholarship has demonstrated how background assumptions reflect social values that shape what constitutes a proper question in science (Longino, 2013). Marxist critiques have shown how dominant political and economic values shape what research gets done and what remains ‘undone’ (Frickel et al., 2010). Sociological analyses have shown how the concepts scientists use to categorise the world, e.g.

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[6] This is given clearest expression in the following quote by Poincaré: “Ethics and science have their own domains, which touch but do not interpenetrate. The one shows us to what goal we should aspire, the other, given the goal, teaches us how to attain it. So they never conflict since they never meet. There can be no more immoral science than there can be scientific morals.” (1923)

what counts as a ‘disease’ versus a ‘difference’, are constructs laden with values that cannot be separated from their cultural, historical, and political contexts (Rabinow & Rose, 2006).

Science, with its value-free ideal, implicitly hides certain moral and epistemic assumptions. This is inappropriate on both epistemic and ethical grounds. It is inappropriate on epistemic grounds, given that science presents as objective and absolute what is, in fact, subjective and relative. Ethically, it is dubious for psychology to imply and affirm one value system without being explicit about it. This may lead to the subjugation or oppression of persons whose values do not support such an ideal (Prilleltensky, 1997)

Psychological science is not immune to these criticisms, either. The discipline's fundamental constructs: mental health, intelligence, personality, development, and normality are themselves inherently evaluative. Social constructionist Kenneth Gergen (Gergen, 2001, 2011) has shown how theories in psychology reproduce cultural ideologies: individualism shapes attributions of behaviour and self-interest informs theories of rationality. Western conceptions of the self inform theories of development (Valsiner, 1998) and ideological forces, both local and geopolitical, shape theories of educational psychology (Walkerdine, 2003). In clinical psychology, notions of productivity and adjustment influence definitions of psychological well-being (Prilleltensky, 1997) and ideals of self-reliance shape theories of therapeutic change (Kirmayer, 2007). Therapeutic psychology, despite seeing itself as objective and neutral, implicitly holds on to these cultural ideologies and risks reproducing the forms of suffering it hopes to alleviate (Prilleltensky & Fox, 1997).

Alternatives within Clinical Psychology: Power Threat Meaning (PTM) Framework.

Before moving on to discuss cultural psychology, it is worth taking note of a framework in clinical psych ology developed as a conceptual alternative to psychiatric diagnosis. The Power Threat Meaning Framework (PTM) was developed through a British Psychological Society Division of Clinical Psychology-funded programme explicitly calling for a “paradigm shift” away from functional psychiatric diagnosis toward a conceptual system not based on a disease model (Johnstone & Boyle, 2018).

The framework replaces the diagnostic question 'What is wrong with you?' with 'What has happened to you?' (Johnstone & Boyle, 2018). It aims to map how different forms of power (economic, ideological, coercive) pose threats to the individual’s core needs (safety, identity, belonging). The individual then constructs a meaning of these events based on available cultural discourses, giving rise to threat responses, behaviours often misclassified as symptoms (Johnstone & Boyle, 2018). It is grounded in the assumption that what are commonly called symptoms are often understandable, protective responses to adverse or constraining environments, and that these responses reflect human capacities for meaning-making and agency. The PTM framework is one of the most clear expressions of the scepticism that clinical issues in psychology can be understood separately from culture.

Summary and link to cultural psychology:

These criticisms have led to scepticism that clinical issues in psychology can be understood separately from culture. These criticisms involve the assertion that clinical psychology over-relies on the scientific tradition, constructs universal ‘facts’ that are often culturally relative, is limited in its understanding of meaning despite this being central to clinicians' work, and hides evaluative assumptions thereby obscuring its moral orientation. The response to such scepticism has been a search for other traditions that may assist psychology in its understanding of mental problems. Incorporating knowledge from other disciplines involves de-centring science as the key tradition on which to base clinical psychological research and practice. De-centring science allows clinical psychology to incorporate the traditions used to investigate culture, such as anthropology, ethnology and cultural studies. The explicit inclusion of culture into psychology can be justified by what Schwartz (1992) called the incompleteness theory:

> *The incompleteness thesis asserts that human nature is radically incomplete if taken in its biological component, including the generic psychological consequences of that biology. The existence of a normal, living human body and brain does not guarantee characteristically*

> *human behavior. That brain and body, if they are to manifest human behaviour, must physically incorporate an enculturative structure derived from participation in any human culture. The enculturative structure is as important as the nervous system that enables it.* (p. 25)

Following Schwartz, I agree that understanding psychological phenomena requires the incorporation of culture if it is to be complete. In response to the criticisms of the Western, scientific traditions that have traditionally been used to guide clinical psychology, I pose the following research questions:

- A) How do the biases inherent in a scientific and universalist conceptualisation of psychology miss the ways the psychological suffering and relief are intertwined with local social, historical and political issues? And,
- B) Can clinical psychology borrow from those traditions that study culture to more meaningfully understand psychological suffering and relief as socially, politically and historically situated?

However, this question is itself incomplete. While I have explored and criticised traditions in clinical psychology, I have not given the same attention to cultural research, let alone given a clear conceptualisation of culture itself. While I have constructed problems relating to the limitations of a scientific, a-cultural version of clinical psychology, I have not yet shown what the inclusion of culture might look like. With regard to question B), one must understand what culture is, how it has been studied, and previous attempts to incorporate culture into clinical psychology. In the next section, I explore the role of culture in understanding clinical issues in psychology. I will begin by defining and conceptualising culture. I will then discuss the so-called cultural turn in academia, including psychology, and explore various versions of cultural psychology. I will finish with what I believe to be a productive version of cultural psychology, which I call an ‘interactionist’ one.

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Chapter 1b: Incorporating culture into clinical psychology

Summary:

In this section, I explore the concept of culture and the various ways it has been used to help understand psychological distress and adjustment. I begin by exploring the complexities in defining 'culture’. I trace the etymological origins and contemporary academic usages of the term. I then go on to explore how the disciplines of anthropology and cultural studies have historically engaged with the term, assessing their respective contributions and limitations. From here, I discuss the emergence and foundational principles of cultural psychology. I then interrogate various schools of thought within this sub-discipline, including cross-cultural, macro-cultural, and cultural-clinical psychology. At each turn, I evaluate which approach might best address the criticisms of mainstream clinical psychology I presented in section 1a .

Building upon this critical review, I articulate a specific conceptualisation of cultural psychology, positing an interactionist perspective wherein psychological phenomena are understood as co-constituted through the dynamic interplay between individuals and the inherited cultural artefacts and practices of their environment. I then return to address the research gap that I partially identified above: Can cultural psychology offer a robust theoretical lens for analysing distress, diagnosis, and psychotherapy within modern Western societies as culturally and historically situated phenomena? If so, I suggest that the implications of such will be the challenging ethnocentric biases and the fostering of a more critically self-aware clinical psychology.

Definitions of culture:

The term ’culture’ intuitively seems simple to define, yet evades clear definition on deeper inspection. As a concept, it has been notoriously difficult to pin-down. Kroeber and Kluckhohn (1952) reviewed over 160 definitions of the term as it appears in academic discourse. Cultural critic Raymond Williams believed it to be the second or third most complex word in the English language

(Williams, 1983). Furthermore, when Williams' influential text was updated in its second edition some 50 years later, the authors note that the term has since broadened substantially. Meanwhile, historian James Clifford posited that culture is ''a deeply compromised idea,'' but one he ''cannot yet do without'' (Clifford, 1988, p. 10). I will use two approaches to define *culture:* first, etymologically, and second, by an analysis of its modern academic use.

Cultural psychologist Jaan Valsiner (2014) traces the etymology of the word back to three roots, in German, French and English. The German *kultur* connotes an individuating and unique character of a group, such was the case for the individual German states before the unification of the German Empire. This is the sense that we discuss subtle and overt cultural differences between, for instance, the Bavarians and the Saxonians. The French term *culture*, in contrast, has a meaning that comes closer to 'civilised', such that cultured practices might contrast with savage practices. It is in such a way that colonialists might assert that they bring 'culture' newly colonised nation. Lastly, the English origins of the term culture build on the horticultural metaphor of 'cultivation'. This definition denotes human intervention or improvement upon the supposedly natural world, such as the *cultivation* of rugged land into a neat English garden.

When taking stock of modern uses of the term *culture*, Bennett et al. (2013, pp. 63–77) highlight how multifaceted and contested the word has become. Anthropologists and sociologists explore street culture (Dance, 2012), gay culture (Woods, 2017), drug culture (Blackman, 1996), dance culture (Harris et al., 2012), black culture (Spillers, 2006) and so on. Used in this way, 'culture' refers to a complex framework for understanding social dynamics and human behaviour. The term can also refer to aesthetic elements of a particular historical period, such as when discussing cultural heritage, cultural appropriation and cultural regeneration (Matthes, 2019). Ethicists also discuss cultural relativism and cultural markets (Sassoon, 2002), using the term to signify how groups socially segment and differentiate by creating esoteric internal logics of value and distinction. The term can sometimes have politicised connotations, such as when referring to the Culture Wars or cultural imperialism, suggesting that culture is a manifestation or vehicle for certain political arrangements. Lastly, in information sciences, culture refers to the way knowledge is transmitted between and across persons in a non-explicit way, such as when one refers to cultural flows or the cultural transfer of knowledge.

Anthropology: the study of culture:

The scholarly field of cultural anthropology has long engaged with the concept of culture through in-depth analysis of community life, conducted via intensive fieldwork over extended periods. Traditional cultural anthropological definitions emphasise culture's acquired nature and transmission between individuals. Margaret Mead defines culture as “the whole complex of traditional behavior which has been developed by the human race and is successively learned by each generation” (Mead, 1937, p. 17). Bidney defines culture as consisting of “the acquired or cultivated behavior and thought of individuals within a society, as well as of the intellectual, artistic, and social ideals which the members of the society profess and to which they strive to conform.” (Bidney, 1942, p. 452). Ruth Benedict suggests that “culture is the sociological term for learned behaviour, behaviour which in man is not given at birth, which is not determined by his germ cells as is the behaviour of wasps or the social ants, but must be learned anew from grown people by each new generation.” (Benedict, 1947, p. 13) These definitions frame culture as something behavioural, learned, and passed between generations, highlighting processes of cultural acquisition and inheritance, and invoking the distinction between nature and culture.

Much of the project of 20th and early 21st century anthropology was to construct and document the cultures of non-Western ‘other’ peoples (Trouillot, 2003). However, constructivist critiques in anthropology have problematised this project, partly due to the essentialising consequences of such analyses (Trouillot, 2003). These criticisms perhaps have something to do with anthropology’s colonial history and its propensity to construct classifications which aided racial stereotyping (Abu-Lughod, 2002; Baker, 1998). These criticisms problematise anthropology’s propensity to create hierarchical distinctions between the knowing subject (i.e. researcher/anthropologist) and the societies to be known (the anthropologist's object of study). From the perspective of post-colonialists and post-structuralists, the idea that the (Western) researcher can omnisciently and objectively understand the (non-Western) ‘other’ has been criticised (Greenfield, 2000; Trouillot, 2003).

A good example of dubious anthropological approaches to clinical issues can be found in the concept of the ‘culture-bound syndrome’ (e.g. Yap, 1967). Medical anthropologists conceptualised a category of illness that was supposedly intimately linked to cultural conditions and expressed via culturally idiosyncratic means. These were described as ‘folk illnesses’, expressed via distinct ‘idioms of distress’ (Nichter, 1981). Such syndromes were symptom constellations that were not intuitively recognised via the categories familiar to the researcher. As such, such syndromes were often understood in contrast to ‘real’ diseases, which had supposedly more scientific, often biomedical, underpinnings (Ritenbaugh, 1982). The ethnocentric bias of those undertaking this research often meant that it was predominantly non-Westerners whose suffering was understood in such a ’culture-bound’ way (Karp, 1985; Kleinman, 1997; Ritenbaugh, 1982).

Partly due to this ethnocentric bias (and other political currents in the 1960s (D’Andrade, 2000)) an alternative academic tradition emerged as a way of studying culture. Its focus was the deconstruction of Western and modernist cultures which the researchers were embedded within. This interdisciplinary tradition has been given the name ‘Cultural Studies’.

Cultural studies and the ‘cultural turn’:

In the 1960s and 1970s Cultural Studies emerged as a new political and academic field in sociology departments. This new field examined and critiqued forms of cultural expression, such as in film and advertising, to elucidate the ideologies and politics they supported. Such studies often problematised and relativised modern Western cultural sources, thereby diverging from the dominant domain of classical anthropology. Within this field, an early influential (yet vague) definition from Raymond Williams suggests culture is “a particular way of life” (Williams, 1961, p. 53); one which seems ordinary to those who inhabit it, while foreign to those who don’t (Williams, 1958). A more recent definition from this tradition takes culture to be “the whole pattern or configuration of values and meanings” of a particular people, period, or group (Centre for Contemporary Cultural Studies, 2013, p. 83). These definitions suggest that culture is both all-encompassing and, at the same time, implicit and hidden from view. Moreover, they place particular emphasis on the centrality of meaning and its inseparability from values, power and ideology.

Analytically, cultural studies have been interested in integrating political theory, history, philosophy, aesthetics, and literary theory with the social sciences (Dorfman, 2007). According to Dorfman, the novelty of Cultural Studies stemmed, in part, from its integration of power and ideology into the concept of culture, alongside a greater emphasis on celebrating contemporary 'popular culture’. The emergence of Cultural Studies initiated what has been termed the 'cultural turn’ in the humanities and social sciences (Best, 2007). In its broadest conception, the cultural turn represented a departure from rationalist and modernist approaches in social scientific inquiry. This involved rejecting the search for universal logical systems and instead highlighting the contingent, contested and locally specific nature of social processes. This paradigmatic shift subsequently influenced multiple disciplines, spawning sub-disciplines such as cultural history, cultural geography, cultural biology, and cultural psychology.

While the ‘cultural turn’ highlighted the role of social and historical forces, it largely retained a anthropocentric ‘humanist’ orientation (Braidotti, 2013). Such an orientation assumes that meaning and agency are the exclusive properties of human subjects, relegating the non-human world (e.g. objects, technologies, nature, biology) to the status of passive matter (Lewis & Owen, 2020; Braidotti, 2013). This anthropocentrism is an artefact of the construction of the individual as the "liberal humanist subject" (Burman, 2017, p, 1599). In this construction, individuals are rational, autonomous, and clearly bounded entities, distinct from the material world they inhabit (Burman, 2017). Burman argues that developmental and clinical psychologies have historically relied on this model, thereby obscuring the ways in which the "human" is constantly co-constituted by external forces. By centring this autonomous subject as the sole author of experience, psychology risks overlooking the ways that material objects, technologies, and biological forces actively shape, constrain, and facilitate psychological life. Overlooking the non-human world risks ‘psychologising’ mental suffering (e.g. explaining material or political issues like poverty or marginalisation in exclusively individual psychological terms).

In response to the limitations of the humanist orientation, a post-humanist philosophy rejects anthropological universals and denies any fixed properties or essences to the human (Braidotti, 2013). Instead, what it is to ‘be human’ is uniquely constructed within the culture from which it emerges. While many definitions of culture foreground human-made worlds, a post-humanist philosophy treats non-human entities as participating in the construction of experience. Psychological life is co-produced and performed through encounters with artefacts, environments, and bodies (Latour, 2013; Lewis & Owen, 2020). Lewis and Owen (2020) argue that research must move beyond the human/world binary to attend to the entangled relationships between bodies and the more-than-human world (see, for example, Latour, 2013; McLeod, 2017).

Cultural Psychology

The so-called cultural turn affected psychology much like other social sciences, resulting in the discipline of Cultural Psychology (Seeley, 2003). Broadly, cultural psychology is interested in the way that human psychology is socially, politically, and historically situated and constructed (Shweder & Sullivan, 1993). Like cultural turns in other social sciences, cultural psychology aimed to integrate the humanities with the study of psychology. Early texts borrowed notably from literary theory (Bruner, 1990), history (Danziger, 1994), political theory (Fox et al., 1997), feminism (Ussher, 1991), and post-colonialism (Martín-Baró, 1996). Though cultural psychology encompasses diverse approaches (explored later in this chapter), certain core principles are shared across its various branches.

Cultural Psychology contends that individual minds cannot be understood separately from the social, political and historical contexts within which they are situated. This contention involves three contextualisations. First, cultural psychologists tend to reason in the direction from the social to the individual, assuming that groups, communities and societies are the materials that construct an individual's psychology. Following Jean-Luc Nancy, cultural psychologists start from the position that "Being is always being-with, "I" is not prior to "we," and existence is essentially co-existence."(Nancy, 2000, as quoted in Di Nicola, 2019).

The second principle is the emphasis on the historicity of psychological phenomena – that psychological phenomena are always historically situated and contingent (Harre & Margolis, 2020). This means that our understanding of phenomena in the present is "built on top of" the past (Tateo & Valsiner, 2015), and that future psychological phenomena might unfold differently from how they do in the present (Harre & Margolis, 2020). The emphasis on history is one way cultural psychology differs from many mainstream strands of social psychology, which have often tended to prioritise generalisable, present-focused explanations of social interaction. Social psychology is "the scientific investigation of how people's thoughts, feelings, and behaviour are influenced by the actual, imagined, or implied presence of others." (Allport, 1968). While still interested in how individual psychology emerges from groups, cultural psychology also accounts for how individual psychology is an emergent property of historical forces. In this sense, it is able to investigate how meanings and emotions, for example, are inherited from the past and carried forward into the future.

This is not to suggest that social psychology has no interest in history. Gergen's (1973) classic paper *Social Psychology as History* (1973) explicitly frames social psychology as historically bound, proposing that social psychological theories are "primarily reflections of contemporary history" (p. 309). However, despite Gergen's critique, the mainstream discipline has frequently retained a commitment to the natural science model, often seeking to isolate variables in "decontextualised segments of interaction" (Gergen, 1973). The distinction is one of analytic emphasis: while social psychology has debated its historical nature, cultural psychology makes historicity a primary explanatory resource. It explicitly emphasis how meanings and emotions are constructed in, and contingent upon, a specific time in history. This is in contrast to much of mainstream social psychology has focused on shorter time-scales and more immediate situational drivers. Therefore, the turn to cultural psychology in this thesis is not a rejection of social psychology, but rather a commitment to the specific historical ontology that Gergen (1973) advocated.

The third tenet is a broad rejection of objective and ultimate truths in psychology. Cultural psychology is generally more relativistic concerning concepts like truth and knowledge, and engages in critical efforts that expose underlying assumptions and values that support such truth claims. This includes those values and assumptions found in 'mainstream' psychology itself (Fox et al., 1997). As such, a key task in cultural psychology is an exploration of how knowledge, truth and meaning are constructed from socio-historical materials. This approach recognises that meaning-making processes are fundamentally embedded in larger systems, including local histories, power structures, and moral frameworks. This meaning-making process also extends to clinical psychologists, too. Cultural psychologists would contend that psychological theories, including those used clinically, do not emanate from spaces beyond culture and history. Instead, they are formulated in particular times and places, and embody local and era-specific moralities, priorities, and concerns. In the last chapter, I argues that these moralities and concerns are those of the modern West.

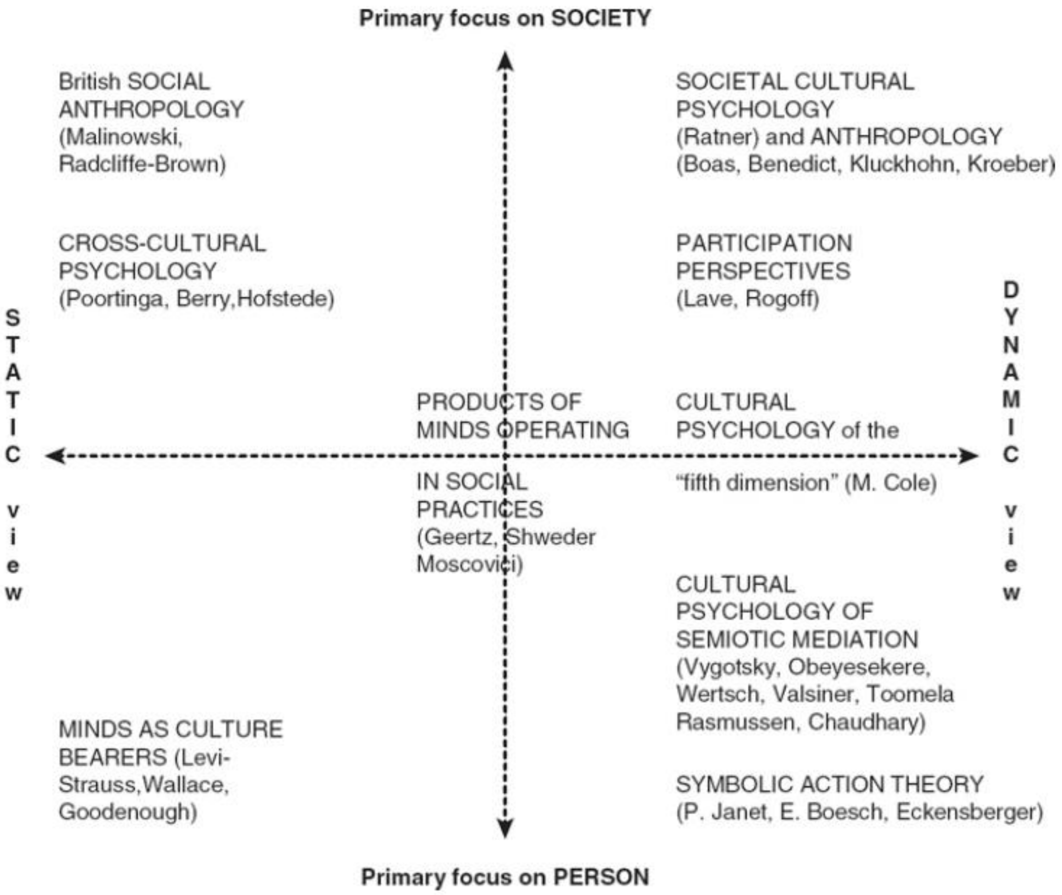
To explore how clinical psychology can integrate findings from cultural psychology, I will first critically explore different versions of cultural psychology. In the following section, I review a few schools of cultural psychology and ask which might be most helpful for clinical psychology.

Different Cultural Psychologies:

Jahoda (2012) critically summarised the concept of culture found in selected psychology texts and found that a key difference is whether they locate culture as internal or external to the individual. Internal conceptualisations locate culture in cognitive functions and mental representations, which are manifestations of a culture's beliefs and values. Externalist conceptualisations locate culture in the environment - such as in artefacts, institutions and collective practices - which act as drivers of different ways of acting and thinking. Similarly, Valsiner (2016) details the various ways that different schools of cultural psychology are positioned, as seen in *Figure 1*. Broadly, he sees different schools of thought locating culture somewhere on two dimensions: the unit of analysis (focus on society VS on the individual) and the ontology of culture (culture as a process VS culture as a static variable). The unit of analysis (individual VS society) roughly parallels Jahoda’s (2012) internal VS external dimension. The static VS dynamic dimension relates to whether one’s psychology is conceptualised as a set of fixed traits or as the emergent property of dynamical processes. Static views include those that might create taxonomies of various traits or attributes which might differ

Figure 1:

The many different ways cultural psychology has been conceptualised


Primary focus on SOCIETY
British SOCIAL ANTHROPOLOGY (Malinowski, Radcliffe-Brown)
SOCIETAL CULTURAL PSYCHOLOGY (Ratner) and ANTHROPOLOGY (Boas, Benedict, Kluckhohn, Kroeber)
CROSS-CULTURAL PSYCHOLOGY (Poortinga, Berry,Hofstede)
PARTICIPATION PERSPECTIVES (Lave, Rogoff)
STATIC view
DYNAMIC view
PRODUCTS OF MINDS OPERATING IN SOCIAL PRACTICES (Geertz, Shweder Moscovici)
CULTURAL PSYCHOLOGY of the "fifth dimension" (M. Cole)
CULTURAL PSYCHOLOGY OF SEMIOTIC MEDIATION (Vygotsky, Obeyesekere, Wertsch, Valsiner, Toomela Rasmussen, Chaudhary)
MINDS AS CULTURE BEARERS (Levi-Strauss,Wallace, Goodenough)
SYMBOLIC ACTION THEORY (P. Janet, E. Boesch, Eckensberger)
Primary focus on PERSON

Note: Jaan Valsiner's (2016, p. 30) schematisation of the different cultural psychologies relative to where culture is located (vertical; in the person or in society) and how it is considered (horizontal axis; dynamically changing, or static and unchanging).

between, for example, ethnic groups. Dynamical views, instead, explore the processes that occur within and between minds; for example, in dialogue between person and society (Bell, 1998) or from the participation in a community of practice (Lave, 1996).

Firstly, I will argue that the 'static' conception of culture, exemplified in 'cross cultural' clinical psychology studies, is problematic on ethical grounds. Secondly, I will suggest that an emphasis solely on society at the expense of the individual, as exemplified in macro-cultural psychology, is unhelpful for clinical applications.

Static conceptions of the enculturated mind: Cross-cultural clinical psychology

The discipline of cross-cultural psychology has helped show how thinking and behaviour vary widely between groups. Cross-cultural psychologists have highlighted how supposedly universal psychological truths are, in fact, often unique to Western individuals (Henrich et al., 2010). For example, influential studies in cross-cultural psychology suggest that there are biases in orientation towards the favouring of the betterment of one's group versus one's self (so-called individualist vs collectivist cultures), depending on the region of the world one originates from (Triandis, 2001).

Grouping individuals by geography or by their membership in certain ethnic groups makes an easy proxy for the variable of 'culture'. Cross-cultural psychology is largely interested in the comparison between cultures on some pre-defined 'dependant variable'. In such a model, the different 'cultures' act as independent variables. Studies in cross-cultural psychology assume there to be some difference between the two independent variables ('cultures') that will result in a difference in outcome measures (for example, on some cognitive task or behaviour). Such a model must define culture as "a consistent entity, rather than a dynamic process" (Keller & Greenfield, 2000) p. 53).

A paradigmatic example is given by May et al. (2014), who compare "differences between the Australian lay public and the Iraqi and Sudanese refugee communities" on mental health literacy. In this experimental study, researchers presented participants (who were of differing ethnicities) with vignettes that told a story of an individual who was ostensibly displaying behaviours consistent with a psychiatric disorder. They found that "Australian participants recognized the presented symptoms as specific disorders significantly more than Iraqi and Sudanese participants and reported causal and treatment beliefs which were more congruent with expert beliefs as per the model of mental disorder" (p. 757). This claim is justified by their finding that the refugee communities were unable to "recognise" the behaviours of those in their vignette as symptoms of mental illness. They were more likely to attribute this behaviour to spiritual causes and less likely to attribute them to biological causes. Such is evidence that these refugee populations show "misconceptions regarding the causes of mental disorder” which “highlight potential deficits in knowledge regarding mental disorder” (p. 767).

Whilst cross-cultural psychology can help understand some psychological phenomena, I believe it does not address the criticisms of scientific psychology that I made above. Methodologically, questionnaires are the most frequent methodological tools in cross-cultural studies published in the Journal of Cross-Cultural Psychology and the International Journal of Psychology (Keller & Greenfield, 2000). Such a methodology suits an understanding of ‘culture’ as an independent variable; one that can be simplified into a single meaning unit. These studies may risk stereotyping ethnic or national groups in pursuit of simplified models. Moreover, as can be seen in the example above, cross-cultural studies can sometimes contain questionable assumptions regarding the status of different meaning systems. These studies can sometimes unintentionally imply that there is some a-cultural universal truth (usually a scientific truth) to which different cultures are either closer-to or further-from. In practice, cross-cultural psychology research most commonly compares localised or Indigenous knowledge (which is presumed to be naïve) to globalised scientific knowledge (presumed to be truth)

Culture without persons: the case of macro-cultural psychology

Macro-cultural psychology represents a different theoretical perspective of cultural psychology. It focuses on how large-scale cultural systems and societal structures constitute fundamental psychological processes, including cognition, emotion, and development. Macro-social forces include socio-economic systems, technological revolutions, urbanisation, religion, and political arrangements. Carl Ratner, a pioneer of this discipline, asserts that “the central tenet of macro cultural psychology is that psychological phenomena are elements, or parts, of macro cultural factors” (Ratner, 2012, p. 207). He asserts that the broadest level of analysis, the macro-social, accounts completely for all levels below it, including individual psychology. Ratner impressively shows how individual psychological properties, like emotional temperaments and cognitive abilities, both originate in large-scale cultural movements, like capitalism and nationalism (Ratner, 2000).

While a macro-cultural perspective provides insight into how cultural systems influence psychological processes, this perspective often undervalues individuals' capacity for agency and resistance within cultural contexts. The construction of the individual, in this theory, is primarily as a carrier of cultural patterns, rather than a negotiator of cultural meanings. Markus and Kitayama (2010) note that, when it comes to understanding individual psychology, there is a tension between recognising socio-cultural influence and acknowledging individual autonomy. Macro-cultural psychology, with its heavy ‘top-down’ model of cultural influence, risks inadvertently reproducing a form of cultural determinism that parallels the biological determinism it often criticises.

This type of cultural psychology often has deterministic undertones. It lends itself too easily to the view that there is a unidirectional causal relationship between the macro-cultural and the individual. This deterministic framing becomes particularly problematic when it's applied to mental health research. If cultural forces fully determine psychological processes, it becomes difficult to explain how individuals can critically engage with culture and change their mental health. I believe that this perspective, if taken exclusively, does not fully account for the ways that individuals influence their environment and, therefore, their psychology.

Cultural-clinical psychology: culture without ideology

Andrew Ryder and his colleagues are the pioneers of a subfield of cultural psychology referred to as cultural-clinical psychology (Ryder et al., 2011, 2019, 2021; Ryder & Chentsova-Dutton, 2015). Cultural-clinical psychology is based on the core idea “that culture, mind and the human brain are mutually constitutive [and] must be understood as part of a single, multilevel system” (Ryder & Chentsova-Dutton, 2015, p. 404). And, while these ‘levels’ can be analytically separated, it is always the “person-in-context that is the unit of analysis” (Ryder et al., 2019, p. 424) In contrast to macro-cultural psychology, this fundamental principle of the mutual constitution of mind and culture acknowledges that individuals influence culture, just as culture influences individuals. And, in contrast to cross-cultural psychology, it distinguishes between ‘culture’ (as a process) and ‘cultural groups’ (e.g. ethnic group), arguing that dynamic and interactive conceptualisation is more useful than a static one (Ryder et al., 2019)

Cultural-clinical psychology explores clinical problems through the lens of the principle of culture-mind co-construction. Ryder offers caution to clinicians who may consider oversimplified methods for incorporating culture into their practice, like ‘cultural competence’ training, which can unintentionally “essentialize cultural groups, treating them as more clearly defined and internally homogeneous than they really are." (Dutton & Ryder, 2019, p. 384). Moreover, they warn of the most recent trend in clinical psychology (and psychiatry) to understand the mind as being equivalent to the brain, thereby de-emphasising cultural explanations of psychopathology (*ibid*., p. 365), suggesting that such a view lacks explanatory power.

Ryder’s cultural-clinical psychology provides illustrative examples of the marriage between cultural psychology and psychological problems. In particular, their approach has led to interesting model as to the emergence and maintenance of psychopathology. Ryder & Chentsova-Dutton (2015) posit that psychopathology can be understood with the help of the concept of the ‘cultural script’. Such scripts are the intersubjectively shared “broader interpretive rules for behaviours and social encounters” (p. 406). These scripts are intersubjectively shared and tacitly learned within the cultural environment. These scripts direct individuals’ attention to specific sensations, colouring them with significance, amid the ongoing phenomenal “background noise” of sensations and thoughts characteristic of daily life. Such attention and interpretation might itself prompt further thoughts and sensations (e.g. worries, increased heart-rate, etc.), resulting in an ongoing self-sustaining loop characteristic of psychopathology. A loop might originate at any level of analysis (brain/mind/culture), and intervention (arresting the loop) can similarly begin at any level.

This approach, however, seems to maintain its focus on ethnic minorities and those from non-Western backgrounds, despite urging clinicians and researchers otherwise. In the majority of articles introducing cultural-clinical psychology principles, authors primarily discuss understanding and treating those from foreign cultural contexts (e.g., Ryder et al., 2011; Ryder & Chentsova-Dutton, 2015). Or, they address ways to understand and treat those navigating multiple cultural influences (e.g., Ryder et al., 2019). Moreover, it often appears that one of the field's primary aims is to broaden the scope of clinical psychology to non-Western populations, rather than position it as a Western indigenous practice. In doing so, it advocates primarily for tailoring the core elements of clinical psychology, such as (Western) diagnostic labels, rather than their conceptual deconstruction. As such, this approach suggests that what truly matters are the ideas from clinical psychology (psychometric assessment, cognitive-behavioural therapy), but these must be presented differently based on cultural considerations (Dutton & Ryder, 2019, pp. 381–385). For these reasons, this approach does not take a critical approach to the core concepts of clinical psychology, such as diagnosis and psychotherapy, and their relationship to power and ideology.

My definition of cultural psychology: the interaction between persons and the environment

Santamaría et al (2019) highlight that there are differing opinions as to where cultural psychology sits within the broader field of psychology. They suggest that a central debate in the field concerns whether all psychological phenomena should be examined culturally, or if cultural psychology represents one of multiple valid viewpoints on psychological phenomena. Shweder (1990) conceptualises cultural psychology as a branch of psychology devoted to studying "the way cultural traditions and social practices regulate, express, transform and permute the human psyche" (p.1). It is therefore complementary to other branches, such as cross-cultural or social psychology. He suggests that cultural psychology is a way of doing psychology rather than a subject matter of a more general psychology. Following Shweder (1990), I posit that psychological phenomena can be investigated culturally, just as they can be investigated using the perspectives of neuropsychology, personality psychology, cognitive psychology and so on. I suggest that the power of cultural psychology is the insights that are missed due to the biases of mainstream psychology (ethnocentrism, scientism, a-historicism).

For this thesis, I conceptually define culture as that which is created (cultivated) by humans, such as languages, material artefacts, habitats, discourses, customs, signs, etc. We each inherit these creations from others, including those who came before us. These take concrete forms: physical artefacts we can touch, visual signs we can see, and spoken discourses we can hear. These cultural artefacts are, on their own, meaningless, and only become meaningful through active use and interpretation. A cultural custom, for example, only exists when it is practised by a person or group (DiNicola, 1997, p. 98). Cultural artefacts carry their specific histories and enduring legacies and are constitutive of psychological phenomena, such as thinking, behaving, feeling etc. Therefore, following Shweder (1990) I contend that culture is not merely a means of expressing more fundamental psychological mechanisms, instead, culture forms one's psychology. To study an individual's thinking, for example, as enacted through language and discursive practices, means to study both the individual's cognition and the inherited cultural legacy (in this case, language/discourse).

Those phenomena that we call psychological (feeling, thinking, behaving, etc) must be inferred via concrete means (language, discourse, action, etc). The study of an individual's psychology, therefore, always involves culture. This analytic perspective makes it possible to see how shared culture (ideologies, values, beliefs, social structures, etc.) is reflected in individual psychology (subjectivity, perception, beliefs, action, etc). When the mind is viewed as developing and functioning within cultural conditions, it is possible to link individual thoughts and expressions to the larger socio-historical forces of which they are a part. This perspective suggests that the individual is active, and not a mere passive product of culture. Individuals use cultural resources (discourses, artefacts, beliefs) to live their individual lives. That is to say, individuals require the inherited artefacts of culture to inform and enable their creativity and freedom, which, in turn, contributes to the evolution and cultivation of further artefacts.

I view the effects of the external social-historical environment and the possibility of autonomy within these environments as the domain of cultural psychology. This interactionist perspective allows me to examine how culture, reflected in discourses and artefacts, both enables and restrains certain kinds of thinking and acting. This perspective allows me to link contemporary forms of suffering and distress back to social, historical, material, and political forces. It also allows me to explore how these cultural means can be used by individuals to change the world and themselves (e.g. their mental health/distress).

Research gap and research question:

Culturalising Western, Modern, Scientific subjects.

As discussed in section 1a, the field of clinical psychology has traditionally positioned itself within the scientific tradition, emphasising universal psychological principles whilst treating cultural factors as secondary or peripheral. In section 1b, I posited that, while anthropology recognises the cultural influences in mental health, these considerations are often limited to studying ethnic minorities or "other" cultures. Effectively, this has drawn a diagnostic line between “those seen as culturally other and those who are not” (Bredström, 2019, p. 348). The gap created by these two traditions has meant that Western psychological frameworks remain largely unexamined as culturally specific constructs. This has resulted in an ethnocentric bias where Western distress becomes a-cultural and ‘natural’, while ‘other’ expressions of distress are marked as cultural variations. Implicitly, this situation privileges the Western subjectivity and subjugates all others as culturally variant.

I then go on to posit that this biased orientation is partly due to clinical psychology’s understanding of culture itself. The most common way clinical psychology handles culture is by analytically separating it from ‘underlying’ psychological processes. In mainstream clinical psychology, culture is often identified as the surface level, outward expression of some more inner, fundamental cognitive or biological process (e.g. Berrios, 2013). This approach to culture creates a significant gap in understanding how cultural processes fundamentally shape all psychological phenomena, including those of Western, modern, affluent persons. By conflating contemporary Western subjectivity with a universalist psychology, this both relegates the status of non-Western knowledge and leaves contemporary issues in clinical psychology underexamined from a cultural perspective.

In this thesis, I suggest that Cultural Psychology can offer an antidote to both universalising practices (inherent in 'mainstream' scientific psychology) and ethnocentric biases (e.g. culture-bound syndrome). Cultural psychology offers a framework that can adequately capture how clinical psychological phenomena are co-constructed through ongoing interactions between individuals and their cultural environments, without privileging any particular cultural perspective as universal or culture-free.

Returning to my research questions, this thesis will explore:

- A) How do the biases inherent in a scientific and universalist conceptualisation of psychology miss the ways the psychological suffering and relief are intertwined with local social, historical and political issues? And,
- B) Can clinical psychology borrow from cultural psychology to more meaningfully understand psychological suffering and relief as socially, politically and historically co-constructed?

Kazarian and Evans (1998) suggest that an important task of cultural-clinical psychology is the awareness and examination of one's own culture. In this thesis, I aim to show how cultural psychology can be a productive perspective when seeking to understand phenomena in clinical psychology, such as distress, disorder and psychotherapy. I aim to position contemporary Western subjectivity as a cultural psychological phenomenon. Through a theoretical analysis of the cultural problems described here (in chapter 1), and a series of case studies (chapters 3,4, 5), I explore how cultural psychology can contribute to clinical psychological theory. Rather than examining the exoticized 'culture variations' in psychological phenomena of people in faraway places, these case studies explore modern, emerging issues in Western contexts.

Implications:

This research makes several important contributions to clinical psychological theory. First, it provides new theoretical tools for understanding how psychological distress and therapeutic practices are fundamentally shaped by cultural processes - not just for ethnic minorities, but for all individuals. This helps address the field's problematic tendency to treat Western psychological frameworks as universal while "culturalizing" only non-Western experiences. Second, by examining clinical psychology itself as a cultural practice, this work contributes to the field's capacity for critical self-reflection by making visible the cultural assumptions embedded in current theories and practices. This reflexivity may help researchers and practitioners avoid inadvertently imposing culturally specific assumptions onto others. Lastly, this research offers insights for clinical practice by demonstrating how cultural meaning-making processes constitute psychological distress and coping. This can inform therapeutic approaches to recognise how both distress and therapy emerge through dynamic interactions between individuals and their cultural contexts.

Summary and link to methods section:

To explore these questions, I will examine three contemporary case studies from Western clinical psychology contexts. Each case represents an emerging issue where cultural artefacts are actively used to construct psychological phenomena in ways that mainstream approaches might overlook. These cases explore the COVID-19 pandemic's disruption of meaning-making, the rise of digital therapy apps, and the rise in adult ADHD diagnoses among Australian women. Each study offers a unique perspective into how psychological distress and relief are culturally co-constructed even in supposedly 'culture-neutral' Western settings. Each case exemplifies how supposedly psychological experiences are shaped by specific historical moments, technological developments, and social movements.

This approach, I believe, requires a deliberate departure from traditional positivist psychology to investigate cultural-clinical phenomena with appropriate sensitivity and depth. In order to address

Western-centric biases requires an ontology that prioritises difference and dynamic processes over fixed universals. And in order to allow for a dynamical view of meaning-making requires an epistemology that acknowledges that knowledge is co-created rather than discovered. In order to view psychological phenomena as inherently culturally embedded requires a rejection of quantitative reductionism and an embrace of qualitative complexity. And lastly, in order to embrace a pluralistic conceptualisation of meaning-making requires theoretical breadth and an investigation of diverse psychological phenomena. In the next section, I outline the ontological, epistemological and theoretical perspectives that allow me to address these research questions.

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1c: Methods and Analysis

Intro and summary:

In this section, I detail the philosophical assumptions and analytic methods that are used to address the research questions posed above. The choice of theoretical framework was made in response to several questions. The first question regarded whether psychological phenomena are conceived of as stable or dynamic. Are there enduring 'laws' of psychological functioning? Or is the psyche inherently creative and transformative, poorly captured by mechanistic rules? Secondly, I needed to consider how culture was to be studied. Should culture be studied as an inherited 'structure' that frames human psychology (Lévi-Strauss, 1983)? Or is culture best studied as a 'process' (Greenfield, 1997); the name given to the ongoing interaction between persons, groups, and things? Lastly, I was forced to confront the question of the kind of knowledge that this research aims to produce. Should this research aim to provide an explanation of cultural-clinical phenomena, highlighting causal mechanisms in order to predict and control these phenomena? Or should I aim for rich and thick descriptions of cultural-clinical issues, which might allow for a deeper understanding of how culture can inform clinical psychology?

After detailing my answer to these questions, I position myself relative to the research. This then leads into an introduction to the individual studies in the thesis, which I call 'case studies' – examples of ways contemporary cultural developments in clinical psychology can be contextualised socially, politically, and historically.

Philosophical assumptions:

Philosophical assumptions are inherent in any method of analysis, regardless of whether researchers explicitly acknowledge them or not. A researcher's fundamental beliefs about the nature of reality and knowledge – their ontological and epistemological assumptions – form their research paradigm. The choice of this philosophical perspective has cascading effects throughout the research process: it guides the selection of methodological approaches, influences decisions about data collection and analytical techniques, establishes a position on objectivity versus subjectivity, and shapes how research findings are disseminated (Braun & Clarke, 2022).

Research in psychology typically operates from positivist assumptions, borrowing research approaches from natural science methods without much critical examination (Boyle, 2011; Ussher, 2012). This positivist orientation requires researchers to identify clear cause-and-effect relationships, leading to standardised definitions of psychological concepts which hide their relativistic and contested meanings. Cultural psychology challenges the dominant assumption of psychological universalism that tacitly operates in clinical psychology (Danziger, 2006). Cultural psychology, therefore, necessitates non-positivist methods capable of capturing the dynamic interplay between psychological manifestations and their socio-cultural contexts.

The research within this thesis aligns with a broadly process-relational ontology (concerned with becoming rather than static essences), a social constructionist epistemology (concerned with how knowledge is made in socio-historical practices), and a interpretivist–hermeneutic philosophy of inquiry (concerned with meaning). In this sense, the thesis is closer to post-positivist, anti-foundational approaches, rather than positivist accounts of universal psychological laws. A more thorough account of this philosophical orientation (including its ontological and epistemological assumptions) will be give below.

Ontological orientation:

When considering the nature of reality (ontology), clinical psychology faces an ethical challenge: it often treats Western psychological experiences as universal while viewing non-Western experiences through a cultural lens. To address this bias, I propose an ontology, following Deleuze and Guattari (1988), that emphasises difference over sameness. This approach suggests that differences between people and cultures are fundamental, while any classifications we create (like 'ADHD' or 'Australian') are secondary, temporary groupings of a set of differences. This allows me to view diagnostic categories and cultural labels as temporary, socially constructed ‘convenient coalitions’ of people and instances, rather than fixed universal types. This perspective denies that there is any fixed universal psychological or cultural experience that serves as the fundamental standard from which others deviate (Nichterlein & Morss, 2016).

In this view, psychology is not a collection of unchanging facts but a process of constant transformation. Psychological experiences emerge through interactions between people and their environments, and these cultural environments are themselves fluid and evolving (Seligman et al., 2016).[7] By positing ontological 'difference' as primary, I can explore how psychological phenomena emerge from specific cultural and social contexts.

The ontological position herein may be described as material-discursive, such that I suggest that meaning (culture) and matter (material contexts, technology) cannot be separated. By this I mean that bodies, practices, material arrangements, and meanings are treated as dynamically co-constituted rather than as separable "inner" and "outer" domains. I posit that psychological distress is never purely 'mental' nor purely 'biological'. Rather, it is an emergent property of the interaction between human bodies and their material-cultural environments. Therefore, the 'culture' in this Cultural Psychology is not limited to the realm of ideas and symbols; it encompasses the material ecosystems in which human psychology is enmeshed.

This orientation overlaps with socio-material and 'new materialist' work (Fox & Alldred, 2019) in its insistence that culture and psychological life are not located only in the head, but are distributed across environments, artefacts, institutions, and collective practice. However, the thesis does not engage socio-/new materialism as a dedicated theoretical tradition (e.g., with its distinct vocabularies of matter, agency, and intra-action) because the analytic emphasis remains on meaning-making in lived practice. While I acknowledge the agency of the non-human world, my primary clinical interest is how human subjects construct meaning with the material world.

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[7] This view might help explain the frequent failure to replicate psychological studies across different contexts (Wiggins & Christopherson, 2019), given that psychological phenomena are continuously shaped by ongoing cultural and environmental factors.

Clinical psychology has a specific ethical obligation to the human subject. New Materialist ontologies often seek to 'flatten' the hierarchy between human and non-human actors (Burman, 2018). While philosophically robust, such a flattening presents challenges for Clinical Psychology, a discipline fundamentally predicated on the ethical priority of the human subject and the alleviation of human suffering. Therefore, this thesis engages with the material world not for its own sake, but strictly in terms of how it affords or constrains human meaning-making. Therefore, I adopted a material-discursive orientation which acknowledges that materiality is entangled with human narrative rather than a "New Materialist" one (which risks de-centring the human to the point of clinical irrelevance).

Epistemology

This study embraces social constructionism as its epistemological foundation (Gergen, 1985). The key principle of constructionism is that knowledge is created, not discovered, via “active, cooperative enterprise of persons in relationship” (Gergen, 1985, p. 267). Unlike approaches that seek to uncover pre-existing truths, social constructionism recognises that knowledge is always constructed through a certain engagement with the world and others. As Nichterlein (2021) explain, "(e)mpirical thought is not a description – a representation – of an essential truth of sorts, but an engagement in the construction – a sensible construction – of a sustainable possibility of life." (p. 267)

I also embrace a reflexive orientation to the construction of knowledge. This position posits that the research practices and findings are inseparably linked to those who conduct the research (Gergen & Gergen, 1991). This means that the researcher’s values and interests shape the choice of research question, and the researcher’s observations and interpretations are shaped by their prior experiences and understanding. This does not mean that the researcher’s observations are solely a reflection of the researcher's cognitive predispositions, as in constructivism (Gergen & Gergen, 1991, p. 77). Instead, a reflexive orientation means that the goal or research isn't to eliminate the researcher's influence but to understand and acknowledge how it shapes her findings. This perspective shifts the focus from methodological rigour (the attempt to capture some objective "true" reality) toward an honest exploration of how social positions, my own included, shape understanding

Analytic Method

Analytic approaches in psychological research are often divided into two: quantitative and qualitative. Quantitative methods, in one way or another, aim to count the number of certain phenomena to make interpretations as to their significance. This requires researchers to abstract and simplify such phenomena into countable units. Qualitative methods, in contrast, embrace the opposite of abstraction and simplification – complexity - seeking to explore the rich nuances that make each instance unique (Brinkmann et al., 2014) This methodological choice becomes crucial when studying the intersection of psychology and culture.

Clinical psychology primarily addresses what Szasz (1960) termed "problems of living" – complex human experiences that are problematic to those who have them. Quantitative frameworks pre-determine the nature of these experiences through pre-defined variables. Valsiner & Brinkmann (2016) critique this "psychology of variables," where complex experiences are reduced to quantified units of meaning (Valsiner & Brinkmann, 2016). They argue that this approach often reifies adverbs, e.g. turning a "depressed outlook" into having "depression", thereby creating an illusion of objectivity while missing the subtleties of human subjectivity. This reductionist approach becomes particularly problematic when considering the cultural embeddedness of psychological phenomena.

Geertz (2008) suggests psychological experience emerges from the endless "webs of meaning" in the cultural environment. Quantitative approaches, with their emphasis on generalizability, risk overlooking these endlessly complex contextual connections. Instead, qualitative inquiry allows for the possibility of following these webs through their interwoven social, historical, and material connections. It allows for exploring how psychological phenomena connect to their cultural contexts while preserving the complexity and richness of human experience. This appears to be an appropriate analytic method, given that this research is interested in the embeddedness of psychological phenomena in their cultural context

Personal statement:

Hans-Georg Gadamer contends that the belief that we could somehow step outside our historical situation to achieve a completely prejudice-free viewpoint is itself an unfounded prejudice (Malpas, 2003, sec. 3.1). Enlightenment sciences, he argues, are most guilty of this prejudice against prejudices. Due to our involvement in the world, our understanding of it is always coloured by the sum of our experiences, cultural background, and language. Therefore, what is needed is consciousness of our own prejudices, which is the foundation for genuine understanding.

As it relates to this thesis, this is particularly challenging, as cultural issues can be the most difficult to identify when they're closest to home. As Raymond Williams (1958) notes, culture seems ordinary to those who inhabit it, while foreign to those who don’t. Following on from the principle of reflexivity mentioned above, I will attempt to acknowledge my own prejudices; not only because they are unavoidable, but also because, when reflected upon, they will allow for the creation of new understandings.

First, being positioned as a practising clinical psychologist has undoubtedly shaped my research. Through my work in private clinics and community mental health teams, I feel I’ve gained special access to the contemporary themes and issues that arise in numerous encounters with patients and clients. Working in such a role has influenced my understanding of clinical settings, the language often used to describe distress, and the dynamics of therapeutic encounters. My firsthand experience of observing unchallenged background assumptions in the clinic, both among colleagues and clients, led me to select specific case studies. It was the uncritical acceptance of reductionist, supposedly 'objective', universalising discourses around, for example, ADHD or automated therapy, that prompted me to explore these topics in research. Later, I noticed that cultural explanations for distress and pathology were only ever deployed when the client was non-Western, alerting me to the under-utilisation of cultural psychology when clients were White, Western, and educated.

The research participants in these case studies were predominantly white, predominantly Australian, predominantly ‘middle class’, and predominantly tertiary educated. These are the same demographics to which I myself belong. As such, the major socio-historical influences that constituted their experience of the world are, in these respects, quite similar to my own. In this sense, it can be difficult to identify culturally specific assumptions that support our shared understanding, as they may appear 'common sense' rather than contingent.

Nonetheless, sharing these demographic markers with many of the participants may have also enabled us to exchange cultural references, tacitly yet consciously, within such a mutual cultural context. Perhaps having greater insider familiarity with certain ways of speaking and acting enabled me to notice certain nuances that would otherwise be missed. By engaging with the data not as a complete outsider, but as someone who navigates a similar cultural environment, I could more easily explore these webs of meaning.

My identity as a Western, white, male, and educated individual places me within prevailing cultural narratives and power dynamics. This positioning might make these dynamics and their effects on meaning-making less visible to me. For instance, dominant beliefs about individualism or the value of rationality might subtly creep into my interpretations, considering how pervasive these are in my cultural environment. By recognising these intersecting influences, I aim to reflect on them and thereby foster a more nuanced and ethically sound inquiry.

The case studies:

As discussed above, a series of case studies were undertaken to explore how emerging clinical issues in psychology are co-constructed by historical, material and social forces. In my personal statement, I discussed how these case studies highlight contemporary issues in clinical psychology that became culturally significant during the period in which I wrote this thesis. They link to the areas often considered core to clinical psychology: distress, diagnosis and psychotherapy. The choice specific analytic method within the qualitative paradigm was linked to specific phenomena under investigation. As such, each case study studied culture from a different analytic perspective.

Case study one: Semiotic Cultural Psychology

The first study explored how people made meaning of distress and time during systemic disruption. This study was contextualised by COVID-19 pandemic, which provided an opportunistic example of disruption to everyday meaning-making processes. In this study, the meaning-making process was more 'exposed' than normal: there was an opportunity to study, in real-time, how people narratively constructed a distressing event as it was taking place. This required an analytic lens that could interpret how culture, which is ultimately familiar, frames new, unfamiliar, incoming information. The theory of signs (semiotics) provided a good analytic tool for understanding this process, given its rich history in analysing how cultural communication frames information (Chandler, 2017). Therefore, in this case example, the psychology of semiotic dynamics (Salvatore, 2018; Valsiner, 2014) was employed to study this process of cultural meaning-making. Semiotic cultural psychology views human psychological development as being mediated by cultural signs, symbols, language, narratives, and myths. Knowledge is viewed as emerging through interaction with these cultural signs. At its core, semiotic cultural psychology adopts a social constructionist[8] epistemology.

Case study two: Postphenomenology

The second study shifted attention to another emerging site of meaning-making in clinical psychology; the digital smartphone therapy app. This study examined how perception itself is always-already mediated by cultural artefacts, which guide values in the direction of cultural preferences. An investigation of this kind turned my attention to material culture. The post-phenomenological lens provided a good theoretical orientation for this task. The phenomenological tradition is well-suited to exploring experience from the point of view of the subject. As a philosophical tradition, phenomenology aims to study the world as it appears to thinking and acting human beings (Giorgi, 2006). Postphenomenology continues the tradition by remaining faithful to the careful description of subjective, lived experience. However, it does away with the pretence that one can bracket away one's prior assumptions of the world to get to a 'pure' description of phenomena (Jensen & Aagaard, 2018). Ihde's postphenomenology takes a particular interest in the way that technology mediates subjective experience (Ihde, 1990). From this perspective, cultural artefacts act as resources for constructing meaning. This is because we are always-already embedded in a world where our actions and perceptions are made possible by engaging with material resources (Ihde, 1990; Rosenberger & Verbeek, 2015)

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[8] In this thesis I treat constructionism as my primary epistemological frame, emphasising how meanings are generated through coordinated social activity rather than private mental representation.
While some authors use "constructivism" and "constructionism" loosely, I follow McNamee (2018) in distinguishing them by the locus of construction: constructivism foregrounds individual mental construing, whereas constructionism locates meaning-making in relational and discursive practices.

Case Study three: Cultural eco-social niches:

The third study examined how clinical psychiatric diagnoses operate as resources for cultural meaning-making, specifically focusing on the surge in Adult ADHD diagnoses among Australian women. Colloquially, culture is sometimes viewed as emerging over long periods and within large ethnic or national groups. This study, however, emphasised how cultural processes function at multiple spatio-temporal levels (Kirmayer et al., 2020), from broad societal patterns down to individual interactions. Theoretically, this study draws on ecological niche theory (Chase, 2011), extending it to consider how cultural spaces, alongside material environments, affect individual and group meaning-making.

This required a theoretical orientation that allowed me to examine how ADHD diagnoses function not as objective categories but as emergent properties of cultural understanding. Epistemologically, this required me to resist the temptation to view diagnoses through vertically layered ontologies, with reductionist explanations of meaning that appeal to abstract concepts. Vertically layered ontologies search for underlying principles in reality. This is useful in the natural sciences where creating taxonomies of meaning ostensibly 'carve nature at its joints'. However, this kind of epistemology is inadequate for studying the way people make meaning (van Dijk & Withagen, 2014). Instead, I oriented to the contexts in which cultural materials were used and exchanged between people in horizontal ‘ecologies’. It is via this exchange between people that these words, signs and artefacts obtain their meaning.

Conclusion:

This thesis addresses a fundamental problem within contemporary clinical psychology based on its aim, as a modern approach to understanding suffering, to discover universal and generalisable laws of human nature. This approach resonates with many Western enlightenment ideals derived from the classical sciences: the aspiration for control over nature, the pursuit of universal truths, and the endeavour to quantify reality. These ideals and practices would not be problematic if they were contextualised as one or many possible ways of understanding suffering. Instead, it is often positioned as the definitive authority on "maladjustment, disability and discomfort" (APA, 2012, para. 1) despite its claims frequently resting on research from a narrow and specific population.

To overcome these limitations, I suggested that clinical psychologists could view the world through the contextualistic prism of culture, rather than the naturalistic lens of science. This is the approach taken by other academic traditions such as anthropology and Cultural Studies, and these perspectives have been incorporated into psychology through the sub-discipline of cultural psychology. I suggest that clinical psychology would benefit from incorporating the perspective of cultural psychology, much like it has benefited from the perspectives of biological psychology, neuropsychology, and personality psychology. I set out to find a way to achieve this.

Finding an antidote to the craving for generality found in scientific psychology requires a specific methodology that is sensitive to nuance and context. I therefore chose to conduct a series of distinctive qualitative case studies, each offering varied insights into different clinical phenomena. These phenomena were issues that emerged contemporaneously at this moment in history, in my part of the world, amongst people whom I was surrounded by. Each case study addressed emerging cultural phenomena in an area that clinical psychology has traditionally claimed within its boundaries: distress, psychological therapy, and clinical diagnosis. In this thesis, however, the aim is not to extract a generalisable understanding of these phenomena, but rather to contextualise them with cultural nuance.

The first study in this series is an exploration of distress and coping during the COVID-19 pandemic-enforced lockdown period. While the lockdown was novel, the attempt to understand how people adapt and respond to crises has long been of interest to psychologists (Heanoy & Brown, 2024). Clinical psychology has tended to lean heavily on individualistic understandings of how people respond to crises (Schwarz, 2018; Ungar, 2004). These conceptualisations risk overlooking the socio-cultural resources that shape distress and how personal narratives of distress can draw from shared cultural pools of meanings. This (potentially) generation-defining moment provided a rare, real-time window into the narrative construction of this cultural event. In particular, it was an opportunity to see the way that the meaning of a distressing experience was constructed in real time.

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Chapter 2: Remaking time: Cultural semiotic transformations of temporality during the early days of the COVID-19 pandemic and lockdown.

Abstract

This paper investigates one aspect of meaning making that occurs in the wake of systemic change. It addresses the question of how time is re-configured by socio-material changes resultant from the COVID-19 pandemic. Employing a semiotic perspective, we aim to describe a process of disruption and distress, which leads to a recognition of the oddness of 'covid-time.' This is characterised by distressing 'suspended waiting', a despairing frozen temporality. After this, this odd covid-time is semiotically assimilated into the old and familiar. Distressing 'suspended time' is transformed into 'productive time', 'normal time', and 'transformational time' as an attempt to regulate affect. By highlighting this semiotic shift, the theory of the Cultural Psychology of Semiotic Dynamics (Valsiner, 2014) is used to highlight how meaning is constructed using cultural resources.

Keywords: COVID; cultural-semiotics; distress; time; coronavirus; temporality.

Introduction

COVID-19

Beginning in late 2019/early 2020, the SARS-COV2 (Covid-19) virus began to spread from Wuhan, China, to all corners of the world. In early March 2020, the World Health Organisation (World Health Organisation, 2020) declared the spread of the virus a pandemic.

As the outbreak of the virus spread from one country to the next, governments, businesses and citizens began to adopt novel, unexpected and sometimes controversial policies to contain the virus or slow its spread. This included severe restrictions on travel, mandates to stay at home (lockdown; Jacobsen & Jacobsen, 2020), social/physical distancing when outside the home (Lewnard & Lo, 2020) and mandatory mask-wearing, among others.

It is in the midst of the calamity of the pandemic that “the loss of a sense of normalcy is widespread” (Walsh, 2020. p.901). The social construction of meaning is foregrounded in times of traumatic rupture to one’s normal experience. Traumatic events can prompt a reconstruction of the meanings in one’s life, such as after bereavement (Gillies & Neimeyer, 2006), illness (De Luca Picione et al., 2017; Freda & Martino, 2015), and organised violence (Park et al., 2012). In the wake of such events, common assumptions concerning the way the world works and our place in it are reconsidered. Brutally, the mind is forced to find meaning making resources to cope with such a cataclysm (Park, 2010; Tedeschi & Calhoun, 2004).

Despite the radical change brought about by the COVID pandemic, collectively the event is made sense of through familiar and enduring cultural symbolic resources (see also Tateo, 2021). The meaning of the event is neither something solely inherent in the event itself, nor completely subjective to the individual, but socially constructed through the resources made available by culture (Valsiner, 2007).

Time

Since early in the pandemic, scholars have speculated on how time/s might be semiotically reconfigured under the COVID pandemic (Flexer, 2020; Venuleo et al., 2020; Wagner, 2020, Bailey et al., 2020). Time is amenable to culturally-semiotic research if we consider that time is both “real” and something that we make-up to guide our actions. Just as we as humans create, rather than discover, place (Mels, 2016), time is semiotically constituted; mediated by cultural understanding (Adam, 2013; Simão et al., 2015; Tateo & Valsiner, 2015). The experience and understanding of time is highly situated and socially constructed to properly suit the needs of the context wherein that understanding is grounded.

For example, Nowotny (1994) notes that during the transition from the pre-modern to the modern period, European cultures underwent transformation from “God’s time” to “Traders’ time.” Modern time was conceptualised as linear and could be broken into divisible units of minutes, hours and weeks. Virtues such as ‘punctuality’ and goals such as ‘saving time’ became part of life. The new concept of time fit with in the cultural revolution of the enlightenment era in which progress and transcendence over nature was possible. Later, during the transition from the modern to the postmodern era, time again bends to culture. The laboratory and computer-mediation further widen the gap between humanity and nature, making possible a non-stop reality of availability; a world wherein present time reigns over future time. Such temporal regimes, argues

Nowotny, are internalised, changing the phenomenological experience of temporality itself. Such an internalised temporality necessarily constrains the possible ways time can be experienced, by also making possible several ways of talking about one's experience of time.

Brockmeier (2000) identified several temporal narrative models of autobiographical time found in common cultural discursive artefacts. These include the linear model (narratives told in as a sequence of ordered events occurring one after the other), the cyclical model (narratives experienced as repetitive structures in which the same types of events occur over and over), and the static model (in which narratives are centred around one, often traumatic, event that provides the frozen horizon of meaning for all possible past and future events.) These temporal narrative models gain expression in numerous autobiographical accounts of different types (memoirs, psychotherapy sessions, interviews etc). Brockmeier contends that these models are culturally reproducible "formatting guidelines" that give an understandable structure to new experiences. These guidelines frame perceptual and affective meaning-making, therefore shaping judgements and actions that follow.

Such guidelines therefore constrain the possible ways in which time can be experienced and expressed. In doing so, they provide members of a culture several possibilities to (unconsciously) choose from when novel experiences are made-sense-of. When a strange and new experience occurs, these formatting guidelines and temporal regimes can be used to make the foreign familiar. The rupture to the 'normal' brought about by the COVID pandemic ought to stimulate a search for cultural narratives that 'make sense' of the phenomena and regulate affect in doing so.

Meaning and the Pandemic

The cultural semiotician Yuri Lotman (2005) suggests that individual minds are always situated within a larger cultural space. These cultural-semiotic spaces (called semiospheres by Lotman) can be considered an amalgamation and extension of individual minds.

Indeed, these cultural spaces might be regarded as *the v*ery condition of interpersonal communication (Semenenko, 2005). Consider that the perceptual phenomenological experience of each organism is organised by the ecological needs of the specific organism in a specific environment. This means that each person's phenomenological experience is somewhat unique from all else (these assumptions form the tenets of the field of ecological psychology, see Lobo et al. (2018) for review). Between unique phenomenological realities (or *umwelten;* Von Uexküll & Mackinnon, 1926) cultural signs translate messages between persons. Interpersonally, the semiotic universe of signs translates esoteric meanings between persons, while intra-personally this semiotic universe comes to constitute individual experience. It is in this way that the individual is unavoidably using cultural meanings when unconsciously interpreting their own experience.

Umwelten configurations constitute quasi-stable ecological and symbolic contexts by selecting parts of the environment to be perceived and acted upon. Changes to the environment, therefore, may result in changes in signs and shared meanings in the symbolic universe of meanings. Therefore, cultural signs are constantly changing as new connections are made between new phenomena and pre-existing meanings. The individual is themself an active sense-maker, continuously involved with finding culturally meaningful ways of experiencing reality (Salvatore, 2018; Valsiner, 2007; De Luca Picione, 2020).

Valsiner's Cultural Psychology of Semiotic Dynamics (2007, 2014) contends that each act of interpretation is channelled by generalisable meanings within the cultural milieu. These generalisable meanings comprise the affect-laden 'universe of sense' (Salvatore et al., 2019) that each person thinks, feels and acts within. The onslaught of incoming sense data is vitalised through past cultural meanings by foregrounding some aspects of reality while backgrounding others (De Luca Picione & Valsiner, 2017; De Luca Picione, 2021), enabling a quasi-stable frame of experience. New stimuli are interpreted by referencing the signs in cultural memory, such that cultural semiotic universe provides the possibility and limits of interpreting new phenomena. The signs within this space include natural language, myth, art and symbols (Valsiner, 2007). As such, phenomenological reality, including the experience of time, is an interpretation based on the internalised cultural semiosphere.

This study explores how changes in the everyday lives of persons in the pandemic might influence temporalities (the subjective experience of time), and therefore the shared meaning of time. The liminal experience of moving from life as it was before the pandemic to an unstable and undefined pandemic-existence prompts the expectancy of a post-pandemic existence. It is this liminal space, between the pre-pandemic and the unknown post-pandemic existence, that time requires definition and understanding.

Aims:

The unique experience of time during the COVID pandemic must be slotted into cultural models that gives it some meaning, otherwise it loses its moorings and becomes impossible to comprehend. As such we expect that the participants of this study will connect cultural narratives with their individual experience via their shaping of time. The focus in this study will be the exploration of people's use of various cultural narratives to make sense of a novel experience, thereby regulating the affective experience of living through a pandemic

The aims of the study are twofold: to explore the cultural narratives that are used to make personal meaning of subjective temporality, and to consider how such a process mediates affect.

- This study aims to identify the cultural models of time participants use to make sense of the transition from life as it once was to life under the pandemic. Within the field of cultural semiotics, it is assumed that individuals will use readily available cultural models and metaphors to understand their personal experience of the pandemic.

- This study aims to explore how such semiotic resources regulate affect. In this sense, this study aims to understand how time, used as a semiotic resource, enables participants to cope with the psychological distress of the pandemic.

Method and participants:

Method and rationale: Diary Study

In order to address the research aims, it was determined that an unstructured qualitative diary method may be employed to capture people's narrative reflections over the course of the pandemic in their natural setting. The use of diaries to collect research data is an established methodology (Elliott, 1997; Jones, 2000; Lundh, 2015). The unstructured diary in qualitative research is considered “self-revealing record that intentionally or unintentionally yields information regarding the structure, dynamics and functioning of the author’s mental life” (Allport, 1942. p. xii). In non-research settings, personal journals are often used to reflectively and introspectively make meaning of one’s own experience. The use of diaries as a research method is suited to investigating the way that a novel phenomenon, such as the COVID-19 pandemic, is transformed into a culturally meaningful experience.

Through the process of narration, every act and event necessarily gains a temporal frame (Bruner, 1990) guided by the cultural semiospheres it exists within. A diary study provides an ideal way of exploring how people in lockdown experience time and how their experience of the pandemic is shaped by cultural narratives. Participants were asked to submit diary entries as the pandemic was unfolding in real-time, making it possible to assess the meanings that emerged week-to-week, thereby reducing retrospective distortion. This study was initiated by author three at the University of Oslo (ethics details in Appendix 2). This author asked selected participants to keep a diary during the pandemic for a study of shared meaning-making of disparate individuals in a time of collective crisis.

Participants:

An expression of interest advertisement was made to friends and associates of researchers two and three of this paper. Those invited to participate self-selected to be part of the study. Consequently, there was a bias with regards to those who self-selected to participate. A convenient sample such as this reflects the experiences of predominately white, well-educated, middle-class individuals predominately from Europe and Australia. In order to collect the diaries of individuals in the earliest days of the pandemic, a convenience sample was used to necessarily respond to the urgency of the situation at the cost of a larger or more diverse sample. As such, the results of the study should not be generalised to other populations (e.g. lower-class, materially disadvantaged, non-dominant racial or ethnic groups). There were no formal limitations on who could/could not participate.

Participants were asked to submit one diary entry per week for four weeks and send these via email to the study authors. Single diary entries ranged from a few paragraphs to several pages in length. Participants were told that *“The simple task is to write about your personal experience during the period of emergency. You can write about your feelings, thoughts, actions, using text or also using images. You are requested to send once per week your messages beginning on the week of the 13th of March 2020.”* This start-date was approximately two days after the Italian government imposed a national lockdown in response to COVID-19 (Pepe et al., 2020) and about one and a half weeks before most Australian states imposed severe restrictions for all citizens not engaged essential work (Chow et al., 2020).

All participants were provided with the rational for the study (see Appendix) and gave implicit consent by providing their diaries to author three by email. Ethics approval for the study was granted by the University of Oslo (ref: 585083). Overall, 29 participants submitted diaries to the study. Participants were instructed to provide one diary entry per week for four weeks, though the number of entries submitted ranged from one to six, with the modal number being four diary entries and the mean number of entries being 3.2.

Overall, given that two of the researchers reside in Australia and two in Italy, participants predominately resided in Australia (17), Italy (9), Denmark (2) and the USA (1). Those diaries written in Italian were translated into English by researcher three before analysis. Overall, 24 participants self-identified as female and five as male. The study authors did not attempt to gather formal quantitative demographic data, given the urgency with which events were unfolding and the use of a convenience sample. That said, qualitative reading of the diaries suggested that most diarists appeared to be well-educated, middle-class professionals, ages ranging from young adults (mid-twenties) to older adults (sixties). No children, adolescents, or seniors took-part in this study. Most participants lived alone or with a partner, and only a very small minority lived with their children or elderly parents.

Analysis:

The method of analysis is largely consistent with a social constructionist paradigm (e.g. Gergen, 1985) that argues that persons actively construct their realities by accessing meanings and discourses that are available in a community of speakers. As such, the researchers understand that when the participants write their diaries they are performing ‘acts of meaning’ (Bruner, 1990) which they intend to be understood as significant by the reader.

The qualitative data in the diaries were thematically analysed (Braun & Clarke, 2006, 2012), specifically guided by principles of constructionist epistemology. A brief overview of these theoretical orientations is given below.

a. **Thematic analysis informed by a constructionist epistemology**: Thematic analysis involves “thematising meanings” (Holloway & Todres, 2003) that arise in a given text, however these meanings are configured by the participants. An appropriately broad definition of a theme being ‘. . . patterned response or meaning within the dataset’ (Braun and Clark, 2006, p. 82). Here, the data are scoured for ‘themes’, ‘meanings’ and ‘discourses’ that participants use to interpret and construct reality, with particular interest paid to the experience of temporality. Epistemologically, these themes and meanings are constructed by the participants and, therefore, could have been constructed differently if social, material, political and cultural contingencies had prevailed.[9] These themes are then grouped into higher order representations that collectively characterise participants’ lived experience of distress, adjustment and time. The results generated from this step were then interpreted by the researchers through a specific theoretic lens:

b. **Interpretative analysis through the lens of cultural semiotics**: This step involved understanding ‘themes’ and ‘meanings’ to be semiotic resources that are culturally constituted. Using a theory-driven approach from the field of the psychology of cultural semiotics (Valsiner, 2014; Salvatore, 2016), the authors explored and interpreted the emergent meanings in terms of semiotic devices, drawn from the larger cultural

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[9] That said, this analysis requires us to acknowledge a social-constructionist epistemology with consideration to both participants’ constructions of their distress, and the researchers’ constructions of ‘themes’. On this latter point, we much acknowledge that themes are not passively found in data, but that they are identified and configured somewhat by the researchers’ interests (Ely et al., 1997)

> space, that affect phenomenological experience. Using a theory-driven approach, the researchers aim to make explicit the model of knowledge that is used to make-sense of the data. In doing so, the researchers highlight that their own interpretive and sense-making process (i.e. of data analysis) also occurs within a field and is contingent upon the researchers' own semiotic universe.

In step a), the first-author researcher read and re-read all diary entries, becoming familiar with the data and searching for ways that participants made meaning of their experience. The first step in analysis involved open coding, wherein all data are coded according to the meanings and themes that the participants used to record their experience. In this step, the researcher coded in a line-by-line manner, "naming segments of data with a label that simultaneously categorizes, summarizes, and accounts for each piece of data" (Charmaz, 2006, p.43). Open coding was undertaken by the first-author and partially coded by the second-author to support trustworthiness. After this, the researcher selected the most significant, salient and frequent codes (focussed coding). These significant codes are then grouped together into over-arching super-themes, which represented an abstracted similarity between the themes subsumed within it (axial coding). After this step, researchers reread all diary entries searching for further instances of the themes that were identified in the previous steps.

The super-ordinate themes generated from this part of the analysis represented both participants' unique phenomenological experience (Corbin & Strauss, 1990) while also giving insight into how each of the participant's unique experience draws more generally on culturally available meanings. The interpretive analysis (step b) then involved discussing the themes between the four researchers, wherein the living theory (Whitehead, 1989) of the researchers and their influences in clinical and cultural psychology further informed the interpretation of these themes as semiotic resources that regulate affect in some way.

The researchers aimed to identify how participants operationalised their affective reactions to the transition to life under COVID, under the presumption that this transition would be affectively charged (Pfefferbaum & North, 2020; Qiu et al., 2020). As noted above, this effort to ‘identify’ the way participants operationalised their distress is as much informed by the researchers’ construction of this theme as it was by the participants’ construction. In truth, the data presented below represents a co-construction of the themes as it was informed by both these perspectives.

Results

The results of this study are organised into analytic themes which represent repeated efforts of multiple diarists to understand the pandemic and cope with the global and local uncertainty resultant from it. These themes represent widely available cultural narratives within this group, given that they were evident in multiple diarist’s entries. The themes detail the ways that multiple diarists made sense of their own personal experience through discourses and narratives that are culturally available to them. These themes are:

1. Distressful psychological disequilibrium:

    a. The recognition of non-normality: Participants notice the strangeness of their local and global situation. Such strangeness is accompanied by self-reported distress.
    b. Temporalities slow: participants notice that time is not experienced in the linear, forward-moving way that it was before. Time appears to slow or stop as material and social conditions of living through a pandemic are experienced. Time becomes ‘suspended’ while the diarists wait for ‘normal’ life to resume.

2. A semiotic transformation occurs in the way that this new time is experienced. Participants use several familiar cultural narratives to transform ‘suspended time’ to regulate their affect:
    a. Return to ‘normal time’: the strange is assimilated into the ‘normal’ by re-coding novel activities (e.g. zoom calls to celebrate St Patrick’s Day) into, in fact, normal activities (socialising, celebrating).
    b. A transformation into productive time: the extra-curricular activities that are peppered through the day are semiotically transformed into productive enterprises. Cooking, cleaning, watching webinars, yoga etc. are made valuable by their assimilation into the realm of work.
    c. Transformational time: the experience of ‘waiting to return to normal’ is replaced with ‘metamorphosis into something new’. The slowness of suspended temporality is individually experienced as a personal reflective space, and collectively as a necessary global re-prioritization of values.

Distress as experienced by the participants

a. ***Situating shattered temporalities in the time of COVID - The recognition of non-normality***

One of the more evident initial consequences of the pandemic was the sudden change to everyday routines of work and socialising. The diarists describe becoming estranged from normality either through lockdown (i.e. mandated social distancing in their home) or by strangely reduced contact with others (transitioning exclusively to 'Zoom meetings', keeping distance from others in public, etc):

- *It took me years to learn to be alone, but never like now I realize that I need human contact. I need to hear from a friend and say "let's drink it's been a hard week I need alcohol" or the "come on let's go out tonight".* – Female, Italy, week 1.

- *I felt really lonely during the first few days. I tried to make the house lively by playing music loudly and keeping all light on. And when I was out for walking, it seemed that everyone wanted to keep away from others, which is totally right to protect people from the virus, but still, I miss days that people can smile and say hello to strangers.* – Male, Denmark, week 1.

Prominent characteristics of these changes are reduced physical contact with others, changed routines of work and socialising, and a keen awareness of the disruptions to local, national and global life. Not all participants explicitly express that these changes initially caused distress. Indeed, some participants express some satisfaction (at least, initially) that they can cut out daily commutes or spend more time with their children at home.

b. **Stretched temporalities and time: Living in suspended time - 'Dead time', 'wasted time'**

As the distressing effects of the pandemic started to amass during the first weeks of lockdown, diarists increasingly began to note a new and perhaps unexpected source of distress: time was no longer flowing the way it normally had. Diarists struggled to find an appropriate way to make sense of temporality whilst within the liminal ‘in-between’ period of pre- and post-covid existence. Many of the participants express that their time, once so meaningful and productive, starts to become “wasted” and “dead.”

- *I am simply wasting my time waiting that all this will be over. I am fluctuating into time. Not really using it, not really wasting it, but not able to make it better.* – Female, Italy, week 4.
- *I can't handle it. And so I live by two hours in two hours, no longer. Waiting for a time that doesn't pass and I'm afraid of.* – Female, Italy, week 1.
- *This week I reckon I have lost cognition of the time passing by. Yesterday I thought it was Tuesday: nope! Thursday. I don't know if this is good or bad. Thing is I feel like the time is passing more slowly than before.*– Female, Italy, week 2.
- “*Sometimes it feels very hard to be "human" in the isolation period, not to mention being productive”* – Male, Denmark, week 2

Diarists noted how they found it difficult to make plans and extend their lives into the future. Instead, they are simply stuck ‘waiting’. In the liminal space between life as it normally was and life as it will be after COVID, the participants are forced to relinquish future-planning and live in a suspended ‘now’. The only time that matters is the present and how to deal with what one can do on a day-to-day basis whilst the world sorts itself out.

Phenomenologically, the diarists characterise suspended time by an inability to plan, a lack of social and work activity, and a general angst which does not allow for such idle time to be restful. Generally, the participants are unable to live satisfactorily in this suspended time as they complain of not feeling “human” within it and unable to live forwards through it. The sudden arrival of suspended time prompts a way of understanding and making meaning of it. The following are examples of attempts the diarists make to restore meaning to time:

Semiotic resources to regulate distress

The seemingly undesirable experience of living suspended time prompts an effortful meaning construction process by searching the semiotic universe for answers. The Semiotic Cultural Psychosocial Theory posits that the mediating role of cultural representations gives meaning to one’s experience, thereby altering it (Valsiner, 2007). The affective dimension of this theory further suggests that affect can be regulated through successful use of particular representations (Salvatore & Freda, 2011) that are available in a particular semiotic universe (Lotman, 2005). Below we document the representations/meaning that participants use to achieve affective regulation.

A) Returning to “normal” time

One way that participants attempt to escape suspended waiting time is by re-engaging in culturally significant activities that connect isolated individuals with others. In this way, the lost temporality marked by ‘waiting’ is returned to ‘normal’ by re-connecting the personal and the collective through culturally universal activities. For example, participants were able to achieve this through connecting with culturally significant event such as Easter and St Patricks day:

- *Then on March 17th with a group of friends scattered around the world we decided to celebrate St. Patrick via Skype and it was a wave of positive energy that accompanied me all week.* – Female, Italy, week 2.

- *On St. Patrick's evening, the first time we celebrate it at home and that Skype call that brought me back in the world, for smiles, for laughter, the mess and the fact* *of being there, we were there together, far, but close Like never before* – Female, Italy, week 2.

The restoration of the meaningfulness of time is achieved by the return of the grounded events that populate our calendars and give social life meaning. The excerpts above reference one such cultural event (St Patrick's day) which effectively brings isolated individual into the social fold. However, many such events occurred over the course of our data collection including larger events (e.g. Easter) and smaller events (e.g. daily coronavirus update made by the government/media).

B) The management of suspended time – affect regulation through 'productive time' and 'transformational time'

Whilst dwelling in suspended time, the diarists become anxious, despairing, and frustrated. Their efforts are therefore directed towards regulating their states via activities that are not only, in and of themselves, enjoyable, but also qualitatively change the nature of time itself. The participants attempt to connect their experience with a cultural meaning that is considered worthy, legitimate and commendable: productivity. Indeed, the participants imply that for time to be meaningful, it must be productive in some way. This includes cooking and cleaning, exercise, yoga, attending webinars, calling friends on Zoom etc.

- *I am trying to cope with this forced quarantine doing my best: webinairs, cooking, cleaning, decluttering, calling people I know are alone in their houses… I try not be too exposed to the news or my panic will devour me.* – Female, Italy, week 3.

- *I rejoice in modern technology; embrace online yoga classes, live streamed gigs and trivia, speaking with friends and family more, playing games with my friend's children online. There's time for cooking, art, reading, thinking, watching, listening, quiet; just so much more time.* – Female, Australian, week 3.

- *Everyday I exercise. Everyday I call someone or I keep myself busy with a project: a baking project, a reading project, a dubbing project (I am a dubber as a hobby)…* – Female, Italy, week 3.

In these examples, we see our participants attempt to neutralise the threat of suspended time by imposing a familiar order upon it. This is primarily via personally meaningful and collectively legitimated activities that restore a sense of productivity and structure. Time is therefore restored from ‘suspended’ into ‘personally meaningful’, mediated by activities that are culturally significant as being productive. These include those listed in the quotations above, but also include the ‘smart working’ activities of those who are either forced to work from home or adjust to new office life. What we might otherwise call ‘leisure time’ (if it were not for the pandemic unfolding in the background) is being made to increasingly resemble work-time. This is achieved by attempts to mirror the structure of work-time (the importance of creating a ‘routine’), needing to upgrade one’s skills (baking, webinars, home work-outs), making ‘appointments’ for calls to friends or online classes, coping with ongoing delays and adjustments (attempting to ‘work around’ the pandemic), the need for time to be ‘used’ in the pursuit of some ends (e.g. having a ‘pandemic project’), and the overt appreciation of having work to do.

C) ‘Waiting time’ becomes ‘transformational time’:

Another way diarists attempt to disavow the uncertainty generated by the pandemic is by attempting to transform suspended time into ‘transformational time’. Transformational time may be defined as the gestational, incubational period that precedes social or personal metamorphosis. In this narrative, a new world is created through the necessary destruction of the old world. The pandemic acts to correct the course of society which hitherto has been sailing in the wrong direction. The diarists make sense of their waiting as if it is a necessary, though uncomfortable, event which ought to remind each of us individually not to take the world for granted. The affective consequence of such a semiotic transformation is that the previously nervous and uncomfortable ‘waiting time’ begins to feel hopeful and catalytic.

- *I had come to think that the Planet needed to breathe: we were acting like we were its virus. High temperatures, forests burning like our lungs are burning now … Nature has its way to make us listen to her. Or maybe this had to happen, no other hidden meaning. I'd like to think of this as a lesson to learn: take back our time, stop running, listen to ourselves, take care of our loved ones. We were so loud that we couldn't listen to this scream, and now we MUST stop.* - Female, Italy, week 2.

- *I start to feel more like it is possible that we’ll come out the other side of this somehow and establish a new normal. There will always be both tragic and wonderful things about change. I try to remind myself about this on a daily basis. I plan to write again next week.* – Female, Australia, week 4.

- *All we can do is to take care of the "here and now". So maybe the lesson is: life is really 'here and now', keep it simple. Do the things we love to do, stay with the people we love, care about the people we love, give time a value.* – Female, Italy, week 2.

Diarists make reference to the potential for the event to be transformational in a collective sense (i.e. to change social and institutional arrangements) and in an individual sense (e.g. as a reminder to one’s self not to take for granted time with loved ones etc.). Such a semiotic move allows participants to experience time not as suspended (e.g. ‘waiting in vain’), but as a necessary recovery that will restore health to the world and to the individual.

Discussion:

The results here indicate that the participants are immediately affected by the strange conditions brought about by the COVID pandemic. In many cases, contact with others is suddenly removed or drastically changed by the pandemic. Early clinical research, predominately measured by questionnaire and other quantitative methods, suggest that the anxiety-inducing effect of the pandemic was moderated by persons felt sense of alienation (Zhu et al., 2021) and loneliness (Robb et al., 2020). Not only were the diarists dealing with the distress generated by the consequences of the pandemic, but there were fewer people physically around to provide validation and comfort when they are feeling distressed.

The diarists are quick to point out that they feel immediately affected by a feeling of non-normality from the first days of the pandemic. The theory of Cultural psychology of Semiotic Dynamics suggests that affect and perception go hand-in-hand (Branco & Valsiner, 2010; Tateo, 2019). The environment exerts an influence on an individual such that it affects him/her, and such affect foregrounds or backgrounds certain elements of perception that thereby give the individual his/her perceived reality (Salvatore et al., 2019). These diaries reveal the immediate affective force of the pandemic and how this thereby shapes diarists' perception of time. In this case, aspects of temporality are suddenly foregrounded during a distressing pandemic.

Such a finding highlights the social dimension of time. Henri Hubert, in his study on religious life and its assimilation into the social (1904), suggests that collective life segments time *qualitatively*. Time is tied intimately to social and collective life, such that it is the rhythms of life that give each hour, day, week etc, it's qualitative feeling (see also Lefebvre, 2004). Hubert contends that it is the 'things' of social life, the objective activities with all their intensities and particularities, that give segments of time qualitative feelings (see Munn, 1992, p.52 for brief overview of Hubert's anthropology). For the diarists of this study, the rhythms of social and collective life are disturbed by the infection control measures. It is therefore no surprise that the participants describe a phenomena where the passage of time no longer ‘feels’ the same.

For many in the study, this initial temporal change is characterised as ‘suspended time’, where the clock ticks over from one hour to the next, though there is little feeling that time is moving forward. For the middle-class working participants in this study time is most ardently fixed to activities that are “productive”. ‘Suspended time’ is felt most strikingly in contrast to feelings of productivity and social activity, the cultural forces that often imbue time with significance. Nowotny (1994) suggests that in the period of late modernity that we now find ourselves, time is experienced in budgetary terms, such that it is something to be used, consumed, and exploited. Zerubavel (1987) points out that our culture has many ways of symbolically assigning importance to durations that are spent productively. For instance, expressions (in English) suggest that one can “spend” their time well or “waste” it by being idle, and points to modern “schedule” as an obsession with the correct use of every particle of time (Zerubavel, 1985).

Suspending normal time causes a reaction in the opposite direction. We see as an effort to restore some sense of normality by connecting the experience of lockdown with the culturally admirable duty to be busy, working, and always improving. As such, through engaging in otherwise banal everyday activities such as cleaning or watching webinars, the participants’ experience of time passed through the filter of the cultural sign ‘productivity’. Such a semiotic transformation has the affective consequence of regulating distress and is used (either intentionally or unconsciously) to return a feeling of normality. In this sense, by re-establishing the normality of full daily routines, the diarists can heal the semiotic rupture brought about by ‘suspended time’.

This effort at the construction of ‘productive time’ links personal tasks with the culturally prized value of industriousness. The historical roots of such might be linked back to the industrial ethics of Calvinsim and Taylorism, and cultural ideologies such as the protestant work ethic (Mudrack, 1999) and newer forms of neo-liberal capitalism (Sugarman & Thrift, 2020). The long history that links feelings of worthiness to time management routines and the mandate to ‘keep busy’ is beyond the scope of this paper, but can be found elsewhere (Sugarman & Thrift, 2020). What is notable from the data in this study is that time is conceived as something that can be spent in the purchase of achievement, self-growth, and creativity.

It is notable that affect is managed through demarcating time into separable units that take their form from the duration of certain activities. The seemingly unending time of the outside world continues indefinitely (when can we return to work? When will the vaccine be available? When will the curve flatten?). Nevertheless, it is possible to regain personal control of time by creating micro-temporalities that structure the days, weeks and months. These temporalities are created by populating time with activities that effectively create separatable units (the time of the activity itself, the time between activities, the regularity with which an activity needs to be done). As such, new temporalities are created that have divisible units, thereby creating an affectively pleasant quality of experience.

It must be noted, at this point, that the vast majority of the pariticpants in this study were female and we cannot ignore the role that gender plays in influencing how time is experienced in family and individual life. Davies (1989) described feminine time as being more “relationally oriented”, partly due differences in child-rearing time commitments and available career options (e.g. higher representation in nursing, teaching, lower in construction and agriculture). This refers to the relatively greater focus that women are expected to have in ensuring that relationships are nurtured and maintained. Predominately, women also tend to be the keepers of family schedules and exert more control over the organisation of time in the household (Daly, 2002; Deem, 1996). The combination of a relational orientation to time, mixed with the responsibility to take on extra domestic duties can lead to womens time being less linear and more cyclical.

The diaries point to some differences in the domestic schedules and social routines of the participants and their experience of disrupted time. Historically, gendered dvisisions in the labour market and in the household have meant that representations of the ideal female identity is suited to acquiesing the needs of others (Odih, 1998, 1999). The women in this study would often regard the loss of embodied relational time (i.e. time physically spent with others) as one to the most stark consequences of their experience of suspended time. As such the loss of embodied relational time came to be a characteristic of suspended time in the highly gendered cohort participating in this study.

Whilst ‘feminine time’ is structured (relative to ‘masculine time’) more around the duties of caregiving than bread-winning (Daly, 2002), both genders live under the constraints of modern capitalism. The time discipline of capitalism is imposed on all equally (and therefore unfairly), and the demands to be productive are felt by all (Bryson, 2007). There are some differences in the way that professional productivity (paid work) and household productivity (unpaid work) transform time.

The majority female diarists in this study place an emphasis on time becoming productive when it is used to connect with others. Women perform greater amounts of invisible, affective connective labour (Boler et al., 2014), which involves tending to the social bonds that enable individuals to work harmoniously together. The semiotic transformation into ‘productive time’ is therefore particularly influenced by gendered cultural narratives, as well as by wider cultural narratives around industriousness.

Another temporal semiotic transformation involved understanding suspended time as ‘transformational time’. ‘Transformational time’ is long and arduous, and it does not have the industrious character of ‘productive time’. Instead, it is an opportunity to make a lesson of the situation; to make sense of the senseless experience by seeing it as an opportunity to learn or transform in some way. Indeed, in his holocaust memoir and treatise on coping with trauma, Viktor Frankl artfully describes how suffering (in his case, in a prisoner of war camp) is much more difficult to bear when such suffering is deemed meaningless (Frankl, 1985). Similarly, the painful and uncomfortable experience of the pandemic is experienced as the painful growth that follows a trauma. For the individual, this involves ‘slowing down’ and taking time attending to the ‘important things.’ Similarly, for the collective, it becomes Noah’s-ark-type re-boot of society, which was somehow always needed, but only just arrived at.

In another study aimed at exploring meaning-making during the pandemic, Venuleo et al. (2020) found that persons often made sense of the pandemic as a prompt to ‘reconsider social priorities’ and ‘reconsider personal priorities’. They found that persons often understood the pandemic as a ‘turning point’; a generative event that, by its consequences, has made us see the folly of our pre-covid existence. The event is marked as the point when the world could no longer sustain the damage being done to it and forced us to stand-back and return to proper living. This idyllic ‘proper living’ involves spending more time with family, treating the earth more kindly, and ‘slowing down’.

Indeed, it may be that it is because of such collective transformation that an individual transformation becomes possible. The transformation of suspended time in the collective sense prompts a need to reconsider the currency given to one’s own personal time. Indeed, popular idioms in health messaging such as “We are all in this together” and “Stay at home. Protect the NHS. Save Lives” aim to emphasise the inseparable nature of the individual and the collective. The damage that the pandemic inflicts upon macro structures such as the economy and the NHS are composite effects of multiple micro effects on individuals. Similarly, it is through micro-revolutions in priorities such as ‘slowing down’ and ‘caring for those around us’ that the world will be able to heal from the pandemic. In this sense, psychological transformations such as slowing down and giving time more “value” are the result of real, material, systemic changes in the way that social bonds are created and maintained.

It must be re-iterated that this sample is largely homogenous with regards to gender, social class and education and any generalisation beyond such a group must be done with caution. A limitation of the study is that there was no formal demographics data obtained which specifies the age of the participants. As such, despite age being an important moderator of meaning-making, no such comment here can be made regarding such. The study is also somewhat limited by the narrow class range (middle class) of the participants, as well as higher representation of women. However, the study aims not at generalisability nor representativeness, but aims to understand how diarists made sense of a novel experience through the use of cultural signs familiar to them. While a different population may have yielded different insight, contingent on the different cultural spaces they inhabit, a population such as this give insight.

Time in this sense is qualitatively transformed by connecting the unusual experience of the pandemic with other unusual experiences (such as traumatic personal injuries, justifiable wars) which are necessary but uncomfortable, and require anxious waiting in order for recovery to take place. This allows for the slowness experienced in time to be understandable and calm. It is in this sense that it allows for affect management.

Conclusion:

The guiding theme of the analysis was the experience of time. Culture connects the unknown to the known; the world of personal experience with the world of meaning. While each diarist experiences temporality in a unique way, such experience must pass through the mediating layer of culture to gain meaning, thereby gaining a collective quality through its communicability. This analysis showed what diarists made sense of the foreign phenomena of suspended time through commonly available cultural narratives.

The analysis begins by explicating the ways that participants experience and construct their distressing “shattered” temporality. The diarists wrote of a disruption to the taken-for-granted notion of time flowing normally from one hour, day and week to the next. The social ‘things’ that make up life (such as work, socialising, planning etc.) are interrupted and a keen awareness of such a disruption sets-in. Diarists then find themselves in a liminal zone between pre- and post-covid existence. The automatic sensemaking processes are no longer able to regulate inter- and intra-subjective domains of experience. Affectively, time takes on a different quality. Temporalities slow or stop, and feelings of strangeness, fear, anxiety, loneliness, and disquiet are amplified. Time is ‘suspended’; diarists complain of waiting for a future that might not come.

This is followed by diarists’ attempts to reconstruct normality through management of temporalities. To neutralise the threat of suspended time, new ways of making meaning of the experience of the pandemic are discovered. What is interesting is that the affective management of temporalities occurs through the recruitment of semiotic resources that are contingent upon the cultural semiospheres that participants exist within. Temporality is rescued from strangeness by returning to the normalness of pre-pandemic times. What is novel about such an affective regulation strategy is that it is guided by temporal ‘formatting guidelines’ or cultural codes that existed in pre-covid cultural awareness. The new application and reformulation of these cultural codes in turn changes their cultural meaning while re-inscribing them into the semiosphere.

The diarists used the following cultural codes to make sense of their pandemic time. Firstly, in a reaction to the suspension of normality, diarists attempt to re-normalise their lives by returning to pre-covid celebrations. An attempt to assert upon time that it is no different now than before; that the essence of our sociality has not changed. Secondly, there are efforts to make pandemic time feel useful and productive. Specific activities and structures are created that resemble work-time. The allure of being productive, upgrading one’s skills and creating ‘projects’ to fill one’s time promises to offer relief to suspended time. Lastly, the slowed temporarily is made-sense-of as a meditative, reflective time. It is a liminal re-organising period which, while uncomfortable, is necessary to metamorphosis into a new personal and collective reality.

The study was able to show that diarists were able to make sense of their experience by integrating their unique phenomenological experience of time into the already-established semiotic universe of meaning. The experience of time is made subjectively meaningful by the interactive use of cultural signs that characterise the experience of time *as* meaningful. What is more, the meaning of the experience of time modulates its affective feel. While slowed time spent anxiously ‘waiting’ is distressing, slow reflective or transformative time is palatable. The global and local contexts furnish the environment with possible meanings and the individual has at her disposal the propensity to use these meanings to regulate affect. To this end, we have shown here that cultural devices exist that are able to constitute the affective reactions to the pandemic.

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Chapter 3: Left to their own devices: The significance of mental health apps on the construction of therapy and care

Mental health (MH) mobile apps offer convenient, low/no-cost automated psychological support. Little is known about what this technology does to the very definition of MH care. Looking through a post-phenomenological lens (Idhe, 1991), we examine how the app's materiality mediates the construction of psychological care. Through interviews with MH app users, analysis revealed that users experienced a detached and abstract kind of care, which ignored their real-life circumstances and particulars, and was not sensitive to the complex, context-dependent nature of their problems. Instead, the apps amplified a mechanistic and individualistic idea of psychological wellbeing. Meanwhile, the apps concealed the importance of interpersonal understanding, healing spaces, and sharing as meaningful parts of care. Some found this to be an impersonal and inappropriate way to deal with emotional problems, while others lamented their own inability to conform to the app’s ideals.

Introduction

Mental health (MH) care involves the treatment of mental disorders, including anxiety and depressive disorders. It also involves treatment that aims to reduce risk factors for developing these disorders, such as stress, overwhelm, or substance use (McGorry, 2011). While MH care is most explicitly delivered by clinicians, such as GPs and psychologists, increasingly MH care services are being integrated into non-clinical institutions. Schools offer counselling to students (Manthei et al. 2020), human resources teams offer mental health first aid to employees (Kitchener & Jorm, 2004), and amateur football coaches facilitate deliberate conversations about feelings with their players (Breslin et al. 2017). Another emerging site for MH care has become the smartphone. A question remains: How do digital mental health tools redefine the meaning of MH care? This is the question that will be addressed in this paper.

App-delivered psychological therapy

As of 2017, more than 10,000 different digital mental health smartphone apps were available for download in the app store (Torous & Roberts, 2017). MH apps received approximately $400 million (US) in venture capital funding in 2019 and over 112 mental-health app studies were funded by the U.S National Institute of Health in 2018 alone (as quoted in Connolly et al., 2021). These apps offer various psychological therapies and activities, such as psycho-education, behaviour tracking, guided psychological therapies such as cognitive-behavioural therapy (CBT), and mindfulness/relaxation techniques. Some governments are optimistic about the prospect of digitalising MH, with the Australian government including the role out of Internet-delivered cognitive behavioural therapy (iCBT) as a key policy agenda for improving population MH (Titov et al., 2018). Responses to some small surveys suggest that the general public also has a favourable opinion of internet-/app-delivered therapies (Linardon et al., 2020; Wetterlin et al., 2014).

There has been a wealth of research investigating whether these technologies 'work', in some narrowly defined sense (e.g. Andersson, 2016). These research studies often take the form of 'does app x produce a difference in responses on outcome y', where y usually consists of a battery of clinical symptom measures. The results of such studies are mixed. Some meta-analyses show that smartphone interventions have a small but significant positive effect on measures of wellbeing (Linardon et al., 2019). Other meta-analyses suggest that these effect sizes diminish or disappear when smartphone interventions are compared with more rigorous control groups (Goldberg et al., 2022). Smartphone MH app studies generally suffer from high attrition and low retention rates, where a significant proportion of study participants discontinue using the app during the study (Perugi et al., 2019). This is also the case outside of controlled clinical trials, too, where engagement with these apps after initial uptake is often very low (Eysenbach, 2005; Fleming et al., 2016).

Beyond clinical outcomes, sociologists have developed several more critical explorations of digital MH apps. Lupton (2016, 2014) has explored the cultures of self-surveillance that these apps facilitate. She details the proliferation of digital self-tracking practices for productivity enhancement and health monitoring, describing the ‘quantified self’ that is constructed with these technologies. Research has also investigated the ideologies that are baked into digital mental health tools (Crosby & Bonnington, 2020; Fullagar et al., 2017; Maturo et al., 2016). Within a culture of “proactive and dutiful self-improvement” (Crosby & Bonnington, 2020, p. 935), these apps can function as convenient vehicles of self-discipline via playful gamification. Moreover, technological solutions that medicalise and individualise distress risk obscuring complex social arrangements that lead to mental ill-health and glamorising self-care over collective action (Fullagar et al., 2017; Maturo et al., 2016).

Moving beyond clinical efficacy studies and rich sociological analysis, we wish to explore how the MH app shapes the experience of MH care. Health technologies have the potential to change the way patients think about and perceive their health (Hofmann & Svenaeus, 2018). For those with diabetes, for example, glucose monitoring devices can “shift people’s attention away from their physical sensations towards the numbers measured” (Mol, 2000, p. 9). In pregnancy, imaging technologies (x-rays, MRIs, etc) can “create a straightforward sense of reality and visual pleasure”

(Georges, 1996, p. 157). The present study aims to investigate how the socio-technical properties of the therapy app shape the meaning and experience of MH care.

A common refrain from therapists, as noted by Neiman (2021), is that computer-based MH interventions turn “a two-player game into a single-player one”, thereby taking “the essential “spark” out of therapy, perverting or removing the interpersonal rapport that allows for an effective clinical encounter.” (Neiman, 2021) p. 2). Therefore, throughout this paper, traditional (human) talk-therapy is used as a helpful comparison with app-based MH care. This exploration will be guided by a key source in the philosophy of technology, Gunther Anders.

The Antiquatedness of humankind

Philosopher Gunther Anders wrote extensively on how technology affects our existence in the world (Anders, 1956a). Technology, Anders suggests, offers us the opportunity to operate on the world more seamlessly and efficiently in some way. However, this is a conditional offer; in order to achieve some increased flow, we must accept the demands of the technology. Technology demands something of us by its form, not just its content (see also McLuhan, 1994). For example, in order to get news of the world, we accede to technology’s demands via its content (by submitting to political persuasion of the TV news programme), but also via the form of the technology itself (its demand for us to stay home in front of the TV, engaging with it passively (Anders, 1956b)). We restructure our lives, physically and psychologically, to be able to use technology.

We can consider two types of demands on users: practical demands and epistemological demands. Practical demands involve the way technology requires certain behaviours from the user (e.g. sitting in front of the TV passively). Epistemological demands, on the other hand, are the demands the technology makes on how knowledge is structured. An example from the field of education illustrates this point. Adams (2010) studied the demands of PowerPoint slideshow software (a digital teaching tool) on the lecturer. Practically, the technology demands that the lecturer move through their lesson in a pre-determined sequence by making it difficult and clunky to deviate from the slideshow’s fixed order. Epistemologically, PowerPoint demands that knowledge is commodified in consumable bullet points and subpoints, thereby making it difficult for learners to experience teaching as dialogical and responsive. In such a way, the experience of 'teaching' and 'learning' are configured in a certain way, which they might not have been without the demands of technology.

The emphasis on 'demands' highlights the non-neutral and non-passive characterisation of technology (see also Schraube, 2005). On this view, the MH app is not merely a *means* that agentic users use for their already-determined *ends*. Rather, just as the user demands some outcome from the app, the app demands something of the user in return. By focusing on the MH apps' practical and epistemological demands rather than their content, we may be able to uncover how MH care is configured by the technology and how users experience this type of MH care.

Theoretical framing: Post-phenomenology

To investigate both MH apps' demands and the user's experience requires a theoretical tool that is sensitive to the effects of technological mediation on subjective experience. Post-phenomenology (PP) (Ihde, 1990) is a philosophy and empirical research tradition which has been used as a powerful tool for investigating the socio-technical use of technologies (e.g. Lynch et al., 2022; Moerenhout et al., 2020). PP studies are indebted to the careful description of subjective experience as it is explored through traditional phenomenological analysis (Giorgi, 2009) whilst focusing specifically on the relations between humans and technology (Rosenberger & Verbeek, 2015).

A key tenet taken from PP is the idea that technologies actively shape experience by *amplifying* some part of the experience by simultaneously *downplaying* other aspects (Kiran, 2015). It draws attention to the two-sidedness of technology's mediating effect: every moment of amplification is always also a moment of reduction. In a practical sense, technologies *enable* some behaviours by *constraining* other behaviours. For example, within hospitals, computers on wheels (COWs; computers that are attached to stands that can be wheeled from bedside to bedside) enable instant charting of medications and care at the patient's bedside. Simultaneously, they constrain eye-contact and patient-perceived care during a consult (Anderson & Robey, 2017). Epistemologically, technologies *magnify* some aspects of experience by *reducing* other aspects. For a dentist examining a patient's teeth, for example, the sickle-probe magnifies the dentist's experience of the texture and hardness of the teeth, while reducing the experience of the temperature and moisture of the surface (Ihde, 2008).

Within this study, we will consider how MH apps demand a restructuring of experience by amplifying aspects of care that fit the digital format, while downplaying or hiding those elements that are beyond its capabilities. Furthermore, we explore how users interpret, accept, or resist these demands and the subjectivity they insist upon.

Method:

This study aims to investigate the mediating effect that the MH app has on the experience of MH care. Guided by PP, we understand that the MH app should be understood in terms of the relation a user has with it, rather than an entity with a fixed essence in and of itself. That is to say, we assert that it is impossible to know the true/objective demands of the app separate from the user's experience of these demands (Rosenberger & Verbeek, 2015). This study therefore investigates the users' real-world experiences of MH apps in their everyday lives. In doing so, we hope to highlight the distinct construction of the notion of mental health care experienced in response to the MH app.

Sample

In this qualitative study, 21 university students were interviewed by first author. Participants were recruited to the study via an advertisement to undergraduate students at a university in Sydney, a major metropolitan city of Australia. This research gained ethics approval from the host University. Given the subject matter, efforts were made to safeguard the participants from harmful distress whilst also avoiding unnecessarily fragilizing them (Schubert, et al. 2023). Students were given research credit as compensation for their time. The majority of students were studying psychology degrees, and no students were taught by any of the authors. These interviews were conducted between January and June of 2022. Interviews lasted between 45 and 60 minutes each. Informed consent was sought and given by the participants. Of the 21 participants, 16 identified as female and five as male. Participants were aged between 18 and 45, with a mean age of 23.47 years. No information was captured regarding formal psychiatric diagnoses of any of the participants, and no participant disclosed this information unprompted.

To be eligible to participate in the study, each participant must have used a MH app on at least a few occasions, though they did not have to have sustained their use of it for any minimum amount of time. Participants varied in the duration which they used the apps, with most participants reporting having used an app for 3-4 months. Some, however, used an app for much longer (up to 20 months) and some much shorter (less than a week). Most participants reported having used a MH app in the last few months. Some participants reported having used several different apps, though many had used just one.

Table 1 gives an overview of the apps used. These apps included a variety of elements, such as psychoeducation, self-guided cognitive behavioural therapy, mindfulness and relaxation practices, and symptom tracking. No participant noted any experience of using an artificial intelligence chatbot or similar. Looking over the apps, we see that all apps explicitly emphasise their benefit to mental health. Those iCBT programs offered by ThisWayUp offer “practical online tools to help you manage your mental health” (St VIncentes Hospital Limited, 2023). The WorryTime app aims to “helps you to control everyday stress and anxiety by acting as a place to store your daily worries” (ReachOut, 2023). The Smiling Mind app offers “evidence-based tools to support people to learn the skills to maintain their mental health in fun and interactive ways.” (SmilingMind, 2024). There is, therefore, good reason to believe that users were using these apps for appropriate reasons. Namely, to better their mental health.

Almost all participants also reported having done other forms of psychological therapy. Most reported having done some form of traditional face-to-face counselling or therapy. Others reported having connected with a psychologist online via programs such as BetterHelp or TalkSpace (online therapy platform that uses video-, telephone-, and text based-counselling). One participant had joined a group-based treatment program. In addition to formal MH support, all participants reported

Table 1:

The mental health apps or programs that the participants in this study reported using.

No. of participants	MH App or program	No. of Participants	MH App or program
2	Coping with Stress Course by This Way Up	1	Daybreak
1	GAD Online program by Mental Health Online	1	MyCompass by Blackdog institute
1	Healthy Mind by Black Dog Institute	1	Headspace
1	Managing Insomnia Course by This Way Up	1	WorryDolls app
1	Mixed Depression and Anxiety Course by This Way Up	1	Ten Percent Happier
1	MoodGYM cognitive behaviour training by ANU	1	Dare Anxiety
4	Smiling Mind app by Smiling Mind	1	Bloom
1	The Check-in app by Beyond Blue	3	Betterhelp
1	WorryTime app by ReachOut	2	Talksapce
1	Stress Management Program by This Way Up	1	Sonder

that they had addressed their mental health by various other means (exercising, talking with friends, engaging in creative pursuits, etc.).

Interview and analysis:

The first author interviewed the study participants, aiming to understand the users' lives and how their problems came to be. We conducted semi-structured interviews, eliciting a discussion about participants' hopes for, and experiences of, the MH app they used. These questions were followed by open-ended discussions that explored how the app fit into the participants' lives. These interviews were recorded and transcribed. The analysis was carried out by researcher one, who is himself a clinical psychologist in a state youth MH clinic. We agree with Finlay (2008, 2012) that it is neither desirable nor possible to bracket-off the researcher's own experience and understanding. Instead, we aim to both enter the subjective world of the informant, while using our own reflexivity as a world of insight.

Formally, the analysis was conducted with reference to a method exemplified in Guest et al.'s (2011) applied thematic analysis. This involved becoming familiar with the transcripts; reading and re-reading them, and looking for the contingent ways that participants' discourse on MH was shaped by the technology. This involved reading each account idiographically, then identifying general themes. These themes relate to the aspects of care that were amplified or hidden by the technology. The transcripts were thematically analysed through a PP lens, attempting to see the two-sided nature of each aspect of care. That is to say, each theme attended to “not only to what [these technologies] do, but what they may undo; to what they say, and what they cannot say.” (Adams & Thompson, 2011. p 746). Initial themes were generated, the transcripts were further reviewed, and modifications to these themes were made.

Findings:

The interviews would often begin with participants sharing the story of how they came to see the app as a possible option for therapeutic input in their lives. One participant detailed her experience leaving her home country, which was in a politically unstable state, to come to Australia, where she subsequently felt isolated and anxious. Another discussed her experience of being kicked-out of home after a disagreement with her mother, and then having to live with her father whom she had not had a relationship with for many years. Another was grieving her recently deceased father and had begun eating and drinking excessively during this period. Yet another discussed his problems with alcohol use, which had persisted for years, and the birth of his first child which led to further attempts to quit. All participants had complex and context-dependant problems which often arose at the intersection of numerous interpersonal, psychological, and cultural factors. The stress, frustration, anxiety, sadness, and grief led these participants to MH apps.

The participants used a variety of apps, as detailed above. By way of example, a quintessential experience of app-use is given by a participant in the following example:

> So you jump into the app. And then there's a check-in with faces, and you pick your happy or sad face on a scale of probably five or six faces. And then it goes more specifically into words. So then you can pick words from a list, or, you know, how you're feeling with words, or you can write your own words. And then that kind of stems into a journal. So then you

> could write how you’re feeling that day. And then, on the back of that, you have the option of going on to like programmes of CBT programmes. So then it will say like, for example, you might want to do like ‘building relationships programme’. And then there’s a 10-minute session. You sit there and they talk to you and they'll teach you a bit about something and then they'll be like "right, tell me something that you could do or a person that you want to build a relationship with." Then you write it in and then they come back and it's pre-recorded, like "okay, that sounds great." And then they tell you a little bit more and then fill in this thing about this. [Female, 27].

Themes:

The interviews revealed a subtle process of amplification and reduction which shaped the construction of a de-contextualised and abstracted version of MH. We briefly detail these amplification/reduction and enabling/constraining processes here before moving on to examine them in more detail.

Firstly, users’ found that their distress was abstracted and then categorised by the app. This simultaneously diminished emphasis on the context and content of their suffering. This occurred when users felt that the app was unable to fully capture the historical, situational, and interpersonal *reasons* why certain psychological problems arose for them. Secondly, users also experienced amplified privacy and ‘anonymisation’ of care, while the experience of sharing distress interpersonally was constrained by the app. Thirdly, users reported that the app afforded them a flexible type of care that could be achieved in any place or at any time, which simultaneously forced their care into the banal, emotionally closed-off places such as the bedroom and dining table. Finally, the therapy app implicitly amplified ideals of self-reliance and independence, which users felt gave them greater responsibility for the success or failure of the therapy process. This simultaneously hid the possibility that the app itself might be problematic. Partly as a consequence of these processes, some users were left feeling deficient and shameful when they did not suit the app’s style of care.

By highlighting these particular processes, we wish to draw attention to the non-dominant, and perhaps unintended, effects of the technology. It is not the case that every process was evident in every participant's account. Some participants touched on multiple processes, while others reported none. Therefore, the list of amplification/reduction processes listed here does not exhaust the entirety of possible themes that might be extracted. Rather, these themes show a perspective on these technologies that is taken when engaging with certain theory (e.g. Anders' moral philosophy, post-phenomenological epistemology, etc). Each process of amplification and reduction will be discussed below and exemplified with quotes from participants in the study.

Amplification of generalisation, reduction of clarification

The MH apps amplified abstract concepts over concrete and specific problems. The abstraction process can be explained as such: a problem is always a problem *of* something. That is to say, anxiety (for example) is always anxiety *of something happening* (e.g. anxiety that I'll get sick, anxiety that I will lose my job, anxiety that my partner will leave me). In addition to there always being a context to suffering, there is also always 'content' of which suffering is *about*.[10]

Users felt that the apps did not have the capacity to understand exactly these concrete particulars. To compensate for this fact, the app worked with broader, abstracted concepts. For instance, the user might be asked to identify 'negative thoughts' or engage in 'meaningful activities', without being specific to the user herself. The app must present content that is applicable to many different users, all of whom have unique particulars to their problems. The app, therefore, operates at an abstract level in order to solve problems regardless of specific content. It is then up to the user to adapt the app's solution to their specific situation. While this provides the advantage of having a broader application, informants discussed how they thought the app necessarily missed some important aspect that they were expecting from therapy:

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[10] This is not so much an empirical claim, as much as an ontological one. For there to be a conscious state, there must be a consciousness of *something.* In phenomenological parlance, we might say that suffering has the character of 'intentionality' (Jacob, 2003)*;* it is always suffering *about something*. Insofar as there are psychopathologies, (e.g. paranoia, anxiety, depression, anger), there are always intentional characteristics to such disorder such as specific thoughts, beliefs, desires, memories etc. (Heinrichs, 2020).

> *Like, I don't know, and it's not exactly just techniques that I'm looking for. I mean, I'm looking to apply them to my specific situations. And I guess I want to clarify some of the things that are happening with me. So it's nice to have someone on the other end that can actually listen. I don't know. It just feels a bit silly. Just talking to no one.* [Female, 21]
>
> *[When I was using the app] it's like, "oh, that's nice." But then, when it comes to applying it to real life, I guess with all these apps, it's really difficult. Like even with mindfulness. I don't even think like I reached mindfulness because it's very hard to like, adapt it to your own life.* [Female, 20 years]

This was sometimes experienced as impersonal. Rather than learn about abstract MH concepts, informants spoke of wanting to "clarify" things, "iron out" details of their lives, "talk about [their] struggles," and be "given an allowance to express" their feelings and thoughts.[11] The users were interested in discussing the specific details of *their* lives and problems and wanting to be 'understood'. Not only abstractly and anonymously, but also concretely and in a deeply personal way. It was often this aspect of therapy that the informants spoke of as being helpful and lamented the app's inability to do.

Amplification of categorisation, reduction in personalisation

In addition to the problem of users not being able to "clarify" the specifics of their presenting problem, users also felt the app missed contextual features that made their lives *their* lives. In addition to the app downplaying the importance of the 'depth' of their problems, they also concealed the importance of the breadth of the user's lived experience. Consequently, informants reported that aspects which they thought ought to be quite important to care, such as the reasons and context of their suffering, were ignored:

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[11] These are quotes from various informants, discussing what they had instead wanted from the app, but it could not offer.

> *With an app, I guess they sort of, like, they fit your experiences into these boxes. But it's like they never address, and they can't address, why you're fitting into this box, because of your experience, because an app can't tell you that. Whereas a psychologist can kind of go through everything that you've personally gone through. Like, for example, when I went to therapy, like I had to the whole first session just explained my whole life story, essentially. And then from there, he would sort of like, give me sort of techniques on how to overcome my anxiety, but in terms of what I experienced.*
>
> *Internet therapy was a little bit harder only because I feel like it was very generalised. Like, it's a bit harder to get a response out of like an app as opposed to like a human interacting with you. And it was like I had to sort of fit myself into a box, like into these standards of like 'this is what you have' because these are the boxes that you've ticked off, and stuff like that. And I feel like there was nothing that could really cover everything that I had been through over that time.* [Female, 20 years]

As encapsulated in the quote above, users often felt that the app demanded that their problems fit into fairly neat ‘boxes’ and measurable units. This resulted in users' problems being standardised despite important contextual differences. Even when users agreed with the app’s identification of their symptoms, they suggested that the treatment they were receiving from the app was not sensitive to the nuanced particulars of their lives. One informant reported that such decontextualization felt like a “one-size-fits-all” approach to psychological therapy. The social realities of the users, in all their richness, were left unexplored by the app, which could not account for subtle differences (e.g. in demographic, in style, in history) between users. This generalised approach was experienced as an inappropriate or ineffective way to get help with the problems they were facing.

Enabled privacy, constrained connection:

One aspect of the app that some informants often preferred was the way that it allowed them to privately address their issues without the need for other humans to be involved. In such a way, the apps generally promoted the practice of private reflection, simultaneously downplaying the importance of connecting with others in distress. User's were able to work through their problems privately, without having to involve friends, partners, parents, or teachers in their struggles.

> *I don't think I want to be weak. But, also, like, I know my friends wouldn't care either. Like, they wouldn't be like "Oh, fuck this guy." I don't know… It felt like it was a process, like a really proper process. Like, to go see [the school counsellor], I'd have to tell my house-master and tutor. And it'd just be this whole thing. And I just didn't like… I think that's the beauty of the apps and stuff. It's not like, huge. It's like anonymous and stuff. It's not this whole thing. [With apps] you don't have to explain something uncomfortable 50 times. [Male, 18 years]*

> *[With the app] it's just me helping myself. I think psychology is, like, all about yourself. You can talk to someone, and someone will listen to you, but they cannot fix your problem. Only, like, the only thing that helps you is your own thoughts. If you can get through those problems, and you can think through, you will be better. If you cannot, you will just be miserable all the time. [Female, 19 years]*

Some informants found the privatising aspect of the therapy app appealing (exemplified in the quotes above). They preferred being able to avoid the messy awkwardness of small talk, re-explaining their problems, and others haphazardly knowing about their suffering. The promise of being able to change one's feelings without having to involve an 'other' was often appreciated by users. It made it possible to avoid having the vulnerable experience of having another person know that there was a problem. Users reported feeling like the app promised them sole responsibility for the therapy process.

Enabled flexible care, constrained healing spaces

Most users reported using the app at home in their bedroom or other private space. This seemed unproblematic given that the context of the suffering (in this case, the physical space the person was in) was not considered to be significant to the functioning of therapy. For some this was experienced as unproblematic or even beneficial, given that they could do therapy in any space and at any time. However, some users found that they missed the deliberate spaces often used in traditional therapy:

> *I feel kind of embarrassed because there's a difference when you go into a professional setting. Like, sitting in your bed doesn't feel the same as going and sitting and talking to someone and actually getting it off your chest. […] I literally once went to a park and I started crying. I'm like 'I'm fucking crying in a park!?' I'm embarrassed. And it's like, other people have their own rooms or their own luxury or their own time. Like people who have their shit together aren't going to go online to ask for help, right? [Female, 20 years]*

> *I don't know how to explain it. Like right now I'm sitting at my dining table. And it's not a place that I normally open-up. On the other hand, I know when I go to the [psychology clinic] and I sit on the couch, and I hold the cushion, and I have the tissues next to me and the cup of tea is there. I know that I'm about to get fucked up* [i.e. emotional and tearful]. *And that's why I'm there.* [Female, 30]

In these examples, the informants discussed how using the app in certain spaces felt inappropriate. At worst, it created situations where they felt ashamed of being alone or emotionally constricted by their physical environment. While the app could be used in a more therapeutic environment, users in this study did not report finding or making such spaces to use their apps. As such, in effect, the app constrained the creation of a dedicated space for MH care.

Unintended consequences: feelings of inferiority and shame

Sometimes, users were able to suit the app's demands successfully and were grateful for what they were able to achieve when they did so. Other times, the user would feel inferior when compared to what the app expected of them. Despite many of the informants being disappointed by their experience using the apps, many of them did not blame the app’s capabilities for failing them. Instead, they suggested that they themselves were deficient or lacking in some way:

> *I kind of, like, know* what *I should be doing. And so I like, yeah… Whenever I do something like that* [use the app]*, where I get coaching, I just think, well, it kind of comes down to, well, I know what I need to do. I'm just not doing it. Because there's, you know, yeah, because… there's something wrong with me. So it comes back to that again.* [Male, 45]

> *I feel like maybe if I did all the modules, it'd be more ingrained in my head. But, like, I started out and then I couldn't commit to keep doing it. […] I think I have to be, like, maybe more open minded, more committed. [More] focused, I think. This is already, like, an internal problem for me. Because I'm not really… I can't really focus on things easily. And then when [the app] is trying to like educate you on these things, I get distracted. And then leave it and then I forget about it. [Female, 18]*

> *If I was more self-aware, I think that [the app] would really help. But I'm not a self-aware person. I just, I tend to just like… My own feelings and thoughts, they come second to other people that I care about. […] If I was someone who was self-aware, and I knew that I had anxiety, and knew all of my symptoms, I could list them off. And I wasn't lying to myself like “this is a panic attack!” If I had all of these things, then I think the app could actually read me a lot better.* [Female, 20]

Often users viewed the app as an unproblematic vehicle of legitimate self-improvement. Therefore, if the user is unable to suit what the app is offering, the user must conceive of themselves as deficient in some respect; lacking self-awareness, self-control, or the ability to sustain focus. If the user could not conceive of their problems in a quantified way, if they could not de-contextualise their problems, and if they could not work through the linear ‘modules’ of the therapy, then their problems remained unresolved. In some of these cases, the users reported feeling like there is something wrong with them.

Discussion:

Gunther Anders (1956a) suggests that by accommodating technology into our lives, we submit to what technology demands of our subjectivity. There was some evidence that the users shaped their understanding of MH to accommodate the app’s affordances. Informants discussed using apps that operated only on abstract information, in an a-contextual way, and were blind to embodied activity and social reciprocity. In order to use the app, user’s reduced their experience of suffering into something that the app could understand. Eager to take advantage of this type of support, users decontextualised their problems, quantified their symptoms, and dealt with their suffering in private. For some, this understanding of suffering felt inadequate, over-simplified or detached. Users often reported wanting something more emotional and personal from their experience of care.

The app-based therapy required the user to fit their experience into “boxes”, as one informant put it. The abstract and decontextualised conceptualisation of users' problems meant that these problems became amenable to change through psycho-technical praxis. The app is configured as a “psychotechnician” who is a “dispenser of a predetermined set of technical manoeuvres” (Cushman & Gilford, 2000, p. 989). The promise of scientific controllability relied on the user reducing their experiences into units of meaning that the app could deal with. In theory, this meant that the user could then easily control these amplified concepts.

The amplification of technical praxis came at the expense of dialogical exploration of real, concrete problems. The users’ real lives were often messy and nuanced, requiring thoughtful disentanglement and exploration. Yet, informants felt that the apps’ abstract and anonymous concepts were unable to capture some important aspects of their suffering. Informants in this study discussed a desire to ‘express’ some feeling and ‘go deeper’ into the reasons that underlay their distress. They yearned for something more from their experience of care. This desire was expressed in interpersonal terms, such as the desire to be 'listened to' or 'understood'.

The type of care that emerged from the use of the MH apps was one that relied on categorisation. Users felt that the app was good at listing symptoms, making diagnoses, and suggesting which of the pre-determined clinical categories the user fit into. This understanding was then re-affirmed by the users, who described their problems as bundles of discreet clinical symptoms. While definitely not unique to digital MH care alone, such 'psychocentrism' (Rimke & Brock, 2012) suggests that at the root of all problems lies a psychological deficiency or psychiatric disorder. This formulation subtly hides the reality that most psychiatric problems are responses to social and relational adversities (Johnstone & Boyle, 2018; Kessler et al., 2010).

The psychocentric orientation of the apps has the potential to further lead to a 'medicalisation' and 'psychiatrisation' (Rose, 2018) of suffering. Maturo and colleagues (2016) studied the discursive formations of six highly popular MH apps available in 2016. They found that these apps all had in-common a theme of 'quantification' of the self, 'medicalisation' of suffering, and 'gamification' of self-management. One consequence of such is that suffering is often individualised. In this sense, the responsibility for positive MH is left to the individual, marginalising alternative discourses on suffering, such as the social justice perspective (Rimke, 2016). When problems are individualised, it is much easier to see the solution as a retreat into the private sphere of computerised therapy which requires input only from the affected help-seeking individual.

One of the defining features of the MH-app is that it promises the user independence from relying on others, such as therapists, parents, friends, or strangers. Such self-reliance is often culturally valued in individualistic societies. Peacock et al. (2014) have dubbed this the 'no legitimate dependency' discourse: the internalised neoliberal conviction that turning to others is weak, and one should instead assume personal responsibility for one's problems. Yet, such a discourse has the potential to conflict with another cultural demand metonymized in 'therapy culture': the obligation to explore one’s emotional interiority and engage in secular confessional practices with a ‘professional’ (Furedi, 2004; Illouz, 2008). Indeed, young people in particular (of whom there were many in this study) are caught between these two messages. They are increasingly exposed to mental health awareness campaigns and school-based mental health interventions (Sampogna et al., 2017; Werner-Seidler et al., 2017) whilst also still caught in the zeitgeist of the ‘age of personal responsibility’ (Mounk, 2017). The MH app offers a possible solution to this sociocultural double-bind: engaging in therapeutic self-enhancement and risk-reduction, whilst still curtailing the need to ask for interpersonal support.

By shutting-out others, app-based MH care insulated the user from the relational aspects of psychological healing. Findings in psychotherapy research suggest that it is the therapeutic alliance, empathy, and “the real relationship” between client and clinician that accounts for most of the positive outcomes in psychotherapy (Wampold, 2015, p.270. See also Horvath & Luborsky, 1993). We agree with Greenhalgh et al. (2013) when they state “[w]hen we are seriously ill, we yearn for human contact and for someone with symbolic power to witness our suffering and take responsibility for decisions that may have grave consequences” (p. 87). With automated computerised therapy, the social aspects of psychological therapy are inhibited, concealed, and reduced. Rather than MH care fulfilling a need for connection in a time of alienation and suffering, the app demanded that the user (quietly) denounce or forget the importance of these elements.

When improved MH is restricted to those who can successfully de-contextualise their suffering and solve their problems in private, then app-users may only see decontextualised symptoms and may only consider private solutions as appropriate. When the app demands that only the aspects of care that can be replicated by a computer are considered essential for mental wellbeing, then the individual may strive to become more like a computer. The user pre-reflectively abandons the possibility of personalised and contextualised care, and instead tries to adapt their needs to what the app can offer. However, some participants expressed that they were just not organised enough, not motivated enough, not able to keep free from distraction, or not self-aware enough for the app to help them. When the type of care that the app offers doesn't match the user's needs, it is often the user who feels inadequate for not being able to meet the app's demands.

To reduce this feeling of inadequacy, Anders (1956a) warns that we fashion ourselves into something resembling the machine. As it relates to mental health apps, the app-user must become app-like. The benefits of using the app (i.e. improved mental health) are only available to those who can mimic the working properties of the app itself. The app is impervious to changes in the physical environment. The app operates the same way no matter when or under what circumstances it is being used. It can completely replicate the information and operation of its therapy from one user to the next without error. It does not need to adjust its style or content from one user to the next given that it speaks in broad, abstracted, non-specific language. It operates algorithmically, working on the logical execution of its pre-determined set of rules. The representation of progress (or lack thereof) is made using quantitative language and is solely reliant on the individual using the app. The app is abstract, precise, and impersonal. This is what the user comes to expect from herself.

Conclusion

This study conceptualised MH apps as active constructors of the experience of MH care, rather than merely passive conduits of clinical knowledge. Using concepts borrowed from post-phenomenology, the two-sidedness of the digital MH app was exposed: by offering greater privacy, users got less connection; by increasing generalisability, users felt less understood; and by giving users more control, they felt more blameworthy.

Users came to the app with suffering resulting from complex human problems. They experienced a type of care that encouraged them to view problems through abstract decontextualised MH categories and required them to work through solutions in private. Some users adopted this ideal, discussing their real-life troubles as the result of individual psychological deficits and relished the opportunity to ‘help themselves’ in the privacy of their own home. For these individuals, the MH app provided a positive experience of care that allowed them convenience and control over their suffering in the short-term.

Others, however, felt that this experience of care was lacking. By concealing certain elements of care, such as connection and dialogue, these users felt there was limited therapeutic benefit to their experience. These users wanted to feel listened to and understood. The promise of efficient and private MH support ended up disappointing those who were unable to operate in the way the app required. Feeling like they lacked motivation, self-awareness, or self-control, some users abandoned the app altogether. Others felt inadequate; unable to live-up to the implicit requirements of the self-help ideal.

This analysis revealed a tendency for idealised MH care to be aligned with what the app can offer. Due to its inability to offer relational, embodied, contextualising, and socially-aware care, the importance of these elements is discounted. Instead, care is constructed as a-contextual and private. Those discounted elements are hidden and obscured and, in some cases, the individual blames themselves for being unable to successfully adapt themselves to the app's demands. In those instances where the individual does adapt, their subjectivity is shaped by the app such that they view their problems as reflections of decontextualised, individual psychopathology.

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Chapter 4: ADHD in ecosocial niches: an exploration of Adult ADHD in-context:

Against a backdrop of dramatically rising adult ADHD diagnoses in recent decades, this article advances a cultural eco-social niche theory of adult ADHD, proposing that symptoms emerge within specific cultural and social contexts rather than solely from neurobiological differences. Through in-depth interviews with seven Australian women recently diagnosed with adult ADHD, complemented by photo-voice methodology, we demonstrate how ADHD symptoms fluctuated markedly across different social interactions—often disappearing in certain contexts while intensifying in others, challenging static neurochemical explanations. Our findings reveal how participants often reframed their histories of social isolation through a neurochemical lens—attributing it to brain-based differences rather than recognising patterns of social ostracization. We examine how settings scaffolded with salient social cues can contain ADHD symptoms, while settings absent of interactions can lead to disorganisation and distraction. Intra-individual conceptualisations of the disorder obscure structural factors, while simultaneously enabling participants' aspirations for independence. We argue that intra-individual theories of ADHD resonate powerfully within neoliberal societies that emphasize personal responsibility and merit-based achievement. Emerging beliefs about neurodiversity provide access to collective support and identity. These findings illuminate the complex ways socio-cultural settings can both constrain and empower, while highlighting implications for how we conceptualise and address adult ADHD in an era of increasing diagnosis.

Introduction:

Attention Deficit hyperactivity disorder (ADHD) is a psychiatric neurodevelopmental disorder where individuals display symptoms of impulsivity, hyperactivity, and/or inattention, with the latter being the most common in adults (Wilens et al., 2009). ADHD is primarily diagnosed based on reports of behavioural and cognitive 'symptoms' and their effect on meaningful activities (functioning). The most widely used criteria for diagnosing ADHD is found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA Taskforce, 2013). The DSM-5 states that individuals meet the criteria for diagnosis if they display several symptoms of inattentiveness and hyperactivity, which must've been present since before age 12, and cause impairment in social and occupational functioning.

ADHD was once considered exclusively a childhood disorder, however, it is increasingly diagnosed in adulthood (Fairman et al., 2020). In the early 1990's ADHD was considered a relatively rare condition in adults, with global epidemiological estimates ranging from between 1-2% of the adult population (Bellak & Black, 1992). By 2010, these estimates had more than doubled to 2 -5% of the adult population (Kooij et al., 2010). In the USA, adult ADHD diagnoses have consistently continued to increase into the present (Chung et al., 2019; Danielson, 2023). This is likely true in Australia, too, where rates of ADHD medication prescriptions have risen steadily over the past few decades (Bruno et al., 2023). The rate of diagnosis in girls and women has grown at three times the rate of boys and men over the past two decades (Fairman et al., 2020).

A large proportion of children diagnosed with ADHD seemingly 'grow out' of the disorder, with up to 80% of childhood cases remitting in adulthood (Sudre et al., 2018). Meanwhile, another group of individuals seemingly develop the disorder (to the diagnostic extent) only later in adulthood. Those with 'late-onset' or 'adult-emergent' ADHD form a distinct group in the ADHD population; compared to those who were diagnosed in childhood, they are more likely to be female, less likely to have low IQ scores, and less likely to exhibit 'externalising behaviours' (Agnew-Blais et al., 2016; Hartung et al., 2022; Moffitt et al., 2015). While the genetic heritability in childhood ADHD is relatively high, for those diagnosed in adulthood the largest influence appears to be non-genetic (i.e. environmental;

Brikell et al., 2015). Some suggest that late-onset (adult) ADHD may be a distinct sub-type of the disorder, where symptoms are clearly observable in adulthood but not saliant in childhood (Caye et al., 2016).

The problem: reductionist conceptualisation of Adult ADHD

Intra-individual theories seek to explain ADHD via neurobiological mechanisms, which are mediated through cognitive capacities, and manifest in behavioural symptoms (e.g. Alexander & Farrelly, 2018). These types of explanations have strongly influenced psychiatric treatments for the disorder, which have focussed predominately on pharmacotherapy and, to a lesser extent, cognitive-behavioural interventions (Weiss & Weiss, 2004). However, despite extensive research, the search for distinctive biological correlates of ADHD is ongoing (Thome et al., 2012). The phenomenon of ADHD is likely to have multiple etiological and neurobiological pathways and the line between normal and pathological has been described as a "moving target" (Michelini et al., 2022, p. 1). Regardless, even when symptomology is reflected in neurobiology, this is not to say it is caused by neurobiology (Kirmayer & Gold, 2011).

Explanations that narrowly focus on the intra-individual level of analysis offer a relatively thin description of the disorder (Geertz, 2008). These explanations fit a certain technological paradigm in psychiatry, which sees disorder as i) arising from faulty mechanisms in the individual, ii) context-independent, and iii) independent of relationships and values (Bracken et al., 2012). The technological paradigm obscures the role of the social environment, the place where people live, become disordered, and cope. Furthermore, it hides the fact that individuals are socially tethered to others to whom they respond (Di Nicola, 2019). An alternative perspective views cognition as socially 'situated' (Smith & Semin, 2004). Mental processes are situated such that they are constantly shaped by the social and environmental contexts to which they are oriented and that provide them with background meaning. A situated account of adult ADHD could highlight the full range of social resources and adaptive strategies to cope with it.

Previous studies, particularly in the medical anthropology literature, have explored the phenomena of Adult ADHD from a cultural perspective (Brinkmann, 2014; Tal & Goodman, 2023) and from a critical perspective (Davies & Horton-Salway, 2016; Hinshaw & Scheffler, 2014; Stenner et al., 2019; Winter et al., 2015). Of particular note is Tal and Goodman's (2023) study with Israeli adults diagnosed with ADHD later in life. Participants in their study challenged the dominant cultural belief in their context, which frames late diagnosis as problematic. Instead, they framed the time of their diagnosis as beneficial, given that it helped develop various coping strategies, thereby challenging the dominant psychiatric discourse. We wish to explore the cultural and social forces that interact in the Australian context which might help to understand the recent increase in adult-ADHD diagnoses.

Alternative: ADHD in context

Material, social and cultural contexts shape the brains, symptoms and persons within them (Occhipinti et al., 2024; Patel et al., 2010; Rutter, 1985). Kiymayer and colleagues describe psychiatric disorders as existing in 'cultural-ecosocial niches' (Gómez-Carrillo & Kirmayer, 2023; Kirmayer, 2005, 2019). The term 'niche', borrowed from ecology, refers to the environmental conditions in which a certain species, organism or behaviour can survive (Chase, 2011). For humans, these conditions are not only material but also cultural and social. A niche occurs when an organism and environment mould each other to fit together.

Niche theory suggests that the social environment affects mental processes, while at the same time, these mental processes can bring about change in the social environment. Psychiatric processes (the deleterious mental processes that cause distress and create problems in functioning) are partly caused by an adaptation to a hostile social environment (Patel et al., 2010). However, humans can also re-shape the environment through their actions (Odling-Smee et al., 2013), thereby mediating its effects. Mental processes, including psychiatric ones, are therefore, both a cause and effect with respect to what constitutes a niche (Kirmayer, 2015). The process by which niches are constructed is interactive and dynamic, whereby individuals adapt to the social environment, whilst also altering it to make it more suitable.

ADHD consists of sets of behaviours (symptoms) which allow or interfere with the achievement of some objectives (functioning) which indicate something about the person and the nature of the world (meaning). All these units rely somewhat on processes outside of the brain. Behaviours, such as conversing, problem-solving, organising etc, are not enacted alone but are instead mediated through interaction with objects and people in the environment. Whether these actions are 'functional' depends on the environment in which they occur. And this behaviour and functioning must be explainable via the stories, symbols and language that are available in a given culture. Niching therefore occurs at various levels, mapping roughly onto the domains of symptoms, functioning and meaning.

To categorise the contextual forces that affect ADHD, we chose to use a taxonomy of micro-, meso-, and macro-social levels, following (Gómez-Carrillo & Kirmayer, 2023). This categorisation differentiates between the timescale and social-coverage (size) of these contexts. Larger (macro) cultural niches might be available to entire societies and sustain for long periods of time (encapsulated in cultural stories and beliefs). Likewise, an individual might construct a more local (micro) niche that serves their personal needs and exists only within the confines of a single relationship or interaction. Below, we define the meaning of these terms and provide evidence of the effects of these forces on adults with ADHD.

Three levels of context:

At the micro-social level are the most proximate material and interpersonal interactions that influence psychiatric symptoms. Here, we refer to the interactions that individuals have with people and objects that mediate the expression of symptoms and provide resources for coping. We largely rely on others to regulate our mood (Marroquín, 2011) and achieve complex tasks (Billings & Moos, 1982). Schilbach (2016) convincingly argues that many, if not all, psychiatric diagnoses involve a failure of reciprocal social feedback loops, wherein symptoms are the result, and cause, of poor social interactions. A lack of interaction with others, or interactions of a problematic type, may result in individuals using other means to address their needs, some of which might be maladaptive or ‘symptomatic’. Evidence from family studies indicate that ADHD is associated with stressful family interactions such as when there is a difficult attachment between parent and child (Erlandsson et al., 2022). Meanwhile, warm ‘authoritative’ parenting protects against ADHD (Modesto-Lowe et al., 2008). Similarly, having a supportive social group appears to buffer against the expression of more severe ADHD symptoms in adulthood (Lan et al., 2023).

At the meso-social level, the unit of interest is the group. At this level, forces emerge from social structures and are given expression in the way that groups promote or inhibit certain actions. Within a certain social or demographic group, one might be exposed to greater stressors, or be inhibited from pursuing some course of action, or gain access to greater resources. As stated in the preceding section, adult women represent the fastest-growing group of ADHD diagnoses in Western countries (Simon et al., 2009). Once in adulthood, women who are exposed to the gendered expectation to balance work, household, and family demands (the impossible ‘superwoman ideal’) can experience a splintering of attention and difficulty functioning relative to these high expectations (Winter et al., 2015). Meanwhile, adults with ADHD who are situated in workplaces that afford more hands-on and fast-paced tasks can work efficiently and productively, functioning to a high standard (Lasky et al., 2016).

Lastly, at the macro-social level, global and national social conditions give phenomena meaning. Macro-social conditions, such as political and economic arrangements, become active social forces when distilled into cultural beliefs and customs (Kirmayer & Bhugra, 2009). Cultural beliefs are the systems of meaning through which the world is conceived and perceived. We focus here on how culture provides causal explanations of behaviour and pathology. The availability of meanings for psychiatric phenomena change relative to moral and ethical dimensions (e.g. the pathologisation of homosexuality; Bayer, 1987), political situations (e.g. drapetomania; Szasz, 1971), and financial incentives (e.g. the chemical imbalance theory of depression; Lacasse & Leo, 2015).With regard to adults with ADHD, the diagnosis has been associated with low-income groups in precarious living situations (De Zwaan et al., 2012; Spencer et al., 2022). Cross-culturally, however, adult ADHD is less prevalent in low-income countries than in high-income countries (Fayyad et al., 2007)[12]. One interpretation of this finding is that certain diagnoses arise in response to the types of healthcare that are available to treat them (Conrad & Bergey, 2014).

Research Aims:

This study aims to provide empirical evidence for the cultural eco-social niche perspective concerning adult ADHD. We aim to highlight instances of niching that influence the symptoms, functioning and understanding of adults with ADHD. To do this, we aim to map the cultural ecosocial niches where ADHD occurs, showing how cultural and social contexts contribute to and alleviate the disorder. A secondary aim was to highlight how this perspective might enable individuals to access emancipatory resources to alleviate distress associated with ADHD. We aim to highlight the niche construction process; the ways that the environment is manipulated to be more enabling to those living with ADHD.

Methods:

Participants

The participants were six adult Australian women who had been diagnosed with ADHD in the previous 12 months. Participants self-reported their ADHD diagnosis and any co-morbid psychiatric diagnoses they had been given. Participants were recruited via a Facebook post on the group ‘Adult ADHD Australia’. The advertisement asked for anyone over the age of 18 who would like to participate in a study exploring how context affects ADHD. A total of 20 people replied to the advertisement, ten of whom returned the participant questionnaire that was attached to the information and consent form. Of those, seven made a time for the initial interview. One participant did not return for the second interview. The internal ethics committee of the host university approved the study (HREC 2023/388).

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[12] This is the case even when non-referred (random) individuals are sampled, suggesting that this is not merely a case of misdiagnosis (Farrad et al., 2007).

This sample, recruited via convenient means, was demographically characteristic of the rise in new adult ADHD diagnoses in Australia (see introduction). All participants were female, though this was not a requirement for participation. All participants were working in professional jobs, though one was semi-retired. Information regarding participants' socio-economic status was not recorded, though all appeared middle-class, as was partially indicated by their ability to obtain a diagnosis for ADHD (in Australia, where individuals self-fund their assessment). Moreover, all women appeared to have high 'health literacy' (Berkman et al., 2010), again, partially indicated by their ability to navigate the health system and seek a diagnosis. The Facebook-recruited sample exhibited comfort with social media, possibly indicating a preference for this medium as a means of connection and communication. Some participants identified as being in relationships, some with children, while others did not. These demographic details contextualise the findings. Participant characteristics can be seen in table 1.

Participants were interviewed twice by a member of the research team (first author), both times via online video-call. The first interview was semi-structured. Participants were asked about their lives outside of ADHD (including their work, relationships and living situation), about the period preceding their diagnosis, and about their life following diagnosis. Particular attention was paid to how ADHD fit into the wider context of their lives, both before it was labelled as such and after understanding it as such. Participants were then asked to keep a photo diary for the next four weeks, taking photos of situations where they felt ADHD showed up for them and times when their lives felt unaffected by ADHD. This prompt was deliberately ambiguous, to allow participants' own conceptualisation of what terms like 'ADHD' and 'show-up' mean to them. The second interview involved reviewing these photos together. Most participants had fewer than a dozen photos from the month, although one had over 50. The interviewer prompted the interviewee to explain each photo to them, dialogically exploring the context of the situation together. The interviewer's prompts were vague, such as "tell me what's going on here" and "Can you explain this photo to me?", wherein the interviewee would then tie the photo back to ADHD in a personally meaningful way.

This established method, sometimes called photo voice, has been used to deepen and extend participant narratives by providing reminders of their experience that can be explored in interview (Han & Oliffe, 2016; (Thompson et al., 2008). This is perhaps particularly important for those with ADHD who are able to overcome memory deficits when aided by visual prompts (Skodzik et al., 2017). Moreover, we agree with Thompson et al. (2008, p. 15) who suggest that "photo-voice enlarges the perimeters of health from the strictly medical to the psychological, economic and social conditions". The interviewer aimed to draw participants' attention to elements within the photo (people, places, things) that they were interacting with and what meaning they made of these things. In doing so, the participants shared multiple contexts of their lives over a time-period (1 month) that would have been unachievable by interview alone.

Interpretative Analysis

Qualitative data were analysed to examine the fit between the individual and the social, material, and cultural environments. The fit was examined by exploring the interactions between the individual and the environment as they manifest in participants' behaviours, emotions and cognitions. In fitting with the ecological perspective, these interactions were considered to be bi-directional. Participants' emotions, for example, were conceptualised as being caused by contextual factors while simultaneously causing changes in the contextual environment (Krueger, 2014). Cultural beliefs were conceptualised as forces that affect participants' interpretation of the world, but were also considered as 'resources' that could be used to justify or negate some course of action (Laland & O'Brien, 2011). Rather than being conceived of as internal states, participants' thoughts and feelings were viewed as emergent properties of the ongoing process of niching – active processes that are adaptations to, and shaping of, the environment.

With this perspective in mind, analysis of the interviews followed a reflexive thematic analysis approach (Braun & Clarke, 2006). Transcripts were analysed on a line-by-line basis, coded regarding smaller units of meaning, and these codes were then sorted into emerging themes concerning the interaction between the person and the environment. This process was iterative, resulting in further themes being added and transcript segments re-sorted with respect to these new themes. The analysis was reflexive, such that the themes were generated from within a certain perspective, one that considered psychopathology to be connected to social and cultural forces.

Findings:

Our analysis found that macro-level cultural beliefs, meso-social group dynamics, and micro-social interactions acted together to create a niche for ADHD to emerge. Together, these illustrate how ADHD symptoms become intelligible through culture, are shaped by group belonging, and emerge within specific interpersonal contexts.

Macro-level cultural beliefs

At this broadest level, participants' experiences were shaped by cultural meanings concerning identity, causation, and diversity. These frameworks provided meanings for ADHD to become intelligible and had downstream effects on group-dynamics and interpersonal interactions.

Brain-based personhood

Participants consistently framed their actions and identities as partially determined by brain chemistry. They frequently attributed both positive and negative behaviours to their dopamine levels or neural wiring. Brain chemistry was overwhelmingly cited as the fundamental cause of ADHD. This biological framing positioned certain tendencies as somewhat beyond conscious control. This provided justification for departures from dominant cultural norms—such as remaining quiet in meetings or showing deference to authorities.

I try to explain it that my brain is just seeking dopamine. So I like I like to do things that are interesting and exciting. So if I'm doing a job, I'm now looking for a job where I'm not going to be doing repetitive stuff, stuck at a desk. And, sorry, sometimes the filter goes off in social situations. So if I say something that you find offensive, just let me know. And I'm comfortable saying that. And that I'm gonna forget stuff. So, you know, it's not that I don't care, I'm just going to forget things. So apologies. I'm doing my best but I'm just... these things aren't going to happen [Participant 2]

Diagnostic causal attributions

Within the broader category of brain-based explanations, participants frequently used psychiatric diagnostic frameworks to explain and justify life trajectories. This was particularly the case when they diverged from conventional expectations. One participant attributed her exploration of multiple university degrees and professions in her twenties to ADHD, noting this differed from the expected path of early professional specialization and linear career advancement. Participants would suggest that their life trajectories, particularly when they deviated from unrealistic career and relationship expectations, must be viewed through the lens of psychiatric diagnoses. Psychiatric language was used to deviate from normative expectations without directly challenging those norms.

This diagnostic framing created a niche that provided relief from certain expectations while avoiding direct criticism of social pressures. For example, when asked about contextual factors influencing her life, one participant positioned her diagnoses as mediating influences:

[Interviewer]: *You said that you believe that when people grow up and go through adolescence, society and culture start to have a bigger impact on people. I think you said society can be "oppressive" sometimes? Did you feel that that was the case for yourself growing up?*

[Participant 2]: *Yeah, I think so. I have always put a lot of pressure on myself. And I think that comes back to my diagnoses* [OCPD and ADHD]*. There's this expectation of being perfect. Doing well in school, having a good job, having good friends, acting a certain way, being a certain way. And when you're not able to do that, well, then that makes you weird. You're different. You're an outsider. And I definitely felt that growing up. And it's taken me probably early in the last few years to, sort of, to break out of that*

Neurodiverse identity

While participants often used diagnostic language, they also showed strong affinity for the emerging "neurodiversity" discourse, particularly when constructing their social identities. They frequently spoke of *being* neurodiverse rather than *having* ADHD—a subtle but significant distinction. One participant explicitly rejected pathologizing language when asked about ADHD "symptoms":

It's not symptoms of a disorder, it's just traits of a neurotype. That just means it's the kind of brain that I have. Because I've never felt like I have a disorder. It's a neurobiological condition, is what I understand now. But that just means it's the kind of brain that I have. And I hate [the term] "symptoms". I say "traits". So, things that make life difficult for me and things that make life easy for me, just like any other brain. But you can group certain types of brains into different areas, and ADHD is one of those groupings. So yeah, I don't I don't see 'symptoms'. I see 'things that work for me things that don't work for me.' Things I do well, things I can't do well. Just like a normal person. [Participant 5]

This construction of ADHD maintains the neurobiological foundation of the medical model while rejecting its moral associations with disorder and illness. Participants found a more affirming identity niche using the emerging cultural script of "neurodiversity" - where conditions like ADHD and autism are positioned as natural biological variations rather than inherent problems. They emphasized the "natural" diversity of neurotypes and advocated for acceptance of non-dominant cognitive profiles, often explicitly rejecting terms like "disorder" and "symptoms" while still advocating for necessary accommodations.

Unlike psychiatric disorders, participants positioned neurotypes as immutable aspects of identity. This immutability supported advocacy for social acceptance rather than personal change. Attempts to conceal one's neurotype—described as "masking"—were framed as potentially psychologically harmful. The neurodiversity paradigm thus created space for positive social identity construction whilst maintain an acknowledgment of difficulties and advocating for accomodation.

Meso-social level

These broader cultural frameworks affected, and were affected by, how participants navigated social groups. These social groups influenced participants' sense of belonging and group identification, and produced repertoires of behaviour that would also influence interpersonal interactions.

Isolation

At the group level, participants described significant challenges fitting into social collectives. This seemed particularly true in those groups with gendered expectations for agreeableness, amiability, politeness, and emotional labour. Instead of conforming to these expectations, participants often challenged social hierarchies and norms, both deliberately and not. This nonconformity appeared to produce a sense of social isolation.

This social isolation was evident when participants reported a fundamental lack of "relatability" with peers. One attributed this to missing the "social rule book" that would have enabled group acceptance. Three of the six participants spontaneously mentioned feeling more comfortable in male-dominated groups than female ones. Over time, these experiences led to a sense of social alienation, expressed by one participant as feeling "separate from mainstream society" throughout her entire life.

I think having ADHD, I always just miss out. So there's always something that I'm blaming ADHD because I'm not a 'yes person.' I have a real sense of justice. So if something's not right, I'll speak up. I call people out on stuff. That's seen as being difficult. When actually I'm not, I'm just trying to share knowledge. And it doesn't have to be something that impacts me, it could be something that impacts someone else [...] so I don't have a lot of female friends I've always gotten along better with guys. I do have some close female friends but I don't have a group of girls, that like, go drinking. You know how people have a girl gang, I don't have that. And the females that I am friends with a little bit different. [Participant 6]

Self-sufficiency

Together with experiences of social marginalization, participants developed and often reframed their independence as a strength. The same attributes that had marked them as different became valuable assets in contexts where independent functioning was prized. At work, several enjoyed engaging in autonomous research or technical tasks separate from collaborative teamwork. Many described periods of intense "hyperfocus"—pursuing activities with concentrated enthusiasm free from external interruptions. They discussed their favoured activities as often involving a lot of autonomy, including woodworking, crafts, independent research, solo physical exercise, musical instrument learning, and entrepreneurship.

Moreover, they discussed their robust capacities for self-entertainment and self-soothing. Even in roles requiring social presence, participants gravitated toward groups that valued self-sufficiency and practical competence over social conformity. One participant described finding her place in volunteer firefighting:

I'm a volunteer firefighter. Have been for 10 years now. I've been to some big bushfires up in Sydney. Being a female in a very male-dominated environment... Like, I turn up, I had pink hair and sparkly long sparkling acrylics on, they're like 'What the hell's this?' I didn't do as much as the boys. That course I was on there [showing me a picture of a fire-training course]*, I was the only female. I actually lead one of the captains of the other brigade through the assessment, to get through the little house on our hands and knees. That morning there, they made us climb a big flight of stairs to get our physical activity up. They made me do that and I freaked out. I wanted to take the* [oxygen] *mask off. I had to say to myself 'You've got this. You'd look like a dickhead If you take it off. You're the only female here, you've got to do it. Do it for yourself. But you really need to do it for the other girls.'* [Participant 1].

Neuro-social grouping

Whilst finding ways to function autonomously, participants also described finding meaningful belonging through identification with the "neurodiverse" social category. They reported positive connections with others who identified as neurodivergent. In some cases, these connections formed after discovering a shared neurodiverse identity; in others, participants retroactively applied the "neurodiverse" label to explain pre-existing positive connections:

So I went to visit some friends on their farm on the weekend, and that was just delightful. [Pointing to the picture] *This was someone I went to school with, who, I can see now, definitely has ADHD. When she actually heard about it, she's like 'yep!'. Her daughter's been diagnosed, and I was like, 'Oh, I wonder where she gets that from.' So, we've been really good friends for a very long time and hadn't seen them in years. We went to this farm with them and the conversation just flowed. We laughed a lot. It was just fantastic. So I guess that's just a picture of neurodivergent people getting along well [...] I've never had trouble finding neurodivergent people to become friends with. Most of my friends, I think, they either know or they don't know [they are neurodivergent]. But I think most of them are neurodivergent spirits. Certainly the ones I'm closest to. In the process of my own self-diagnosis, I worked out that my husband is autistic, which he has confirmed. As we have grown to learn more and more about neuro-divergence he has confirmed that 'yeah, that that does sound right.'* [Participant 5]

By linking relationships through the shared sign of "neurodiverse," participants would describe shared eclectic behaviours or interests as to why some social arrangement (with a friend, or spouse, or group) worked. The neurodiversity framework provided a basis for understanding these connections not as random but as grounded in neurobiological commonality, allowing participants to construct a social niche through inclusion in this emerging category.

Neuro-social distancing

Complementing neuro-social grouping, the opposite category of "neurotypical" was helpful for understanding challenging social relationships that were challenging. Rather than attributing difficulties to malice or personal failing, participants could explain them as resulting from fundamental neurological differences. This reframing transformed potentially hurtful interactions into understandable mismatches:

My dad visited over the weekend. And we went to we went to the races yesterday, and, like, I wanted to be there. Like, obviously, I had a choice whether I went along. There was extended family and that. But there were moments that, you know, I was on my phone. And I wasn't on my phone the whole time. Like, I was talking to people and taking in what was around me. But, he's like "God, you're on your phone a lot". But it's like, if only you knew the effort it took me to come out today. And, my phone, I'm not like, I wouldn't say I'm addicted to it. But it definitely does give me a bit of a reset and a moment to just totally hone the focus on one thing as opposed to being overstimulated by everything else around me. [Participant 6]

In this example, the participant reframes her phone use not as rudeness or addiction, but as a necessary coping strategy for overstimulation—drawing on a neuropsychologically-based explanation. This allowed her to carve out a social niche where she could occasionally distance herself from family interactions while maintaining relationships and avoiding distress. The neurodiversity framework provided a language for justifiable difference without implying rejection or dysfunction.

Micro-social level

At the most proximate social level, ADHD symptoms fluctuated based on interpersonal context and environmental features. These interactions were also affected by, and affected, cultural frameworks and group dynamics. The ongoing interactions with the world (including other people) were the site where behavioural ‘symptoms’ of ADHD could be identified.

Peer interactions

Within their immediate social circles, participants frequently described a relative lack of enriching social interactions throughout their lives. As discussed above, this was sometimes characterised by periods of loneliness and isolation, particularly in adolescence. In adulthood, interactions were often characterised by misunderstanding or misattunement. This appeared to lead to avoidance of interactions, or rushed social encounters that felt confusing or awkward. Notably, participants typically attributed these difficulties to personal deficiencies rather than social dynamics, citing tendencies to "overthink" interactions, be "over-empathetic," or simply "forgetting" to respond to correspondence.

Like, as a young person, I didn't have many friends. I didn't quite know how to make friends. I didn't know how to talk to people. Because small talk is just not my jam. Do you just go up and say hello to someone? What if they don't want you to say hello to them? [...] It's hard not having any friends as a kid and wondering why people won't talk to you. I didn't like sitting alone. Because I felt like everyone was staring at me because I was sitting alone, which made me more of an outcast [Participant 2]

Attempting tasks solo

Participants' ADHD symptoms often intensified when they attempted to complete complex tasks without interpersonal resources (i.e. other people). Tasks requiring emotional support or logistical organization proved particularly challenging when undertaken alone. Participants described symptoms like "dysregulation," "disorganisation" or "inattention" emerging specifically when they lacked the collaborative resources to handle all aspects of complex tasks. One participant described feeling overwhelmed when inheriting her late mother's belongings and trying to manage the sorting and selling process solo. Another described the emotionally charged task of taking her children to swim school:

I took my two kids to swimming school. And they used to scream the house down. I've got a child who's ASD and both have an ADHD diagnosis. My younger one really struggles with emotional dysregulation You give them a pep talk and you're there to support them and you explain to them that stuff's safe, but there's still screaming. And the swimming teacher we had didn't handle that. Every time it ends with them in tears, me in tears, my husband is angry at me for him being distressed. [...] Yeah, it's been a learning experience for my husband too. So, the way my ADHD shows up in these situations is anxiety. Overthinking. You know, trying to control everything. [Participant 1]

Conversely, symptoms often diminished significantly when participants were surrounded themselves with others. A participant who struggled with messiness and disorganization reported cleaning her house when by inviting over housemates or guests. Another found she could concentrate more effectively when working alongside a peer, even on different tasks (a practice sometimes called "body-doubling"). Several described improved learning and consistency in the presence of others, for example mastering an online course in a group setting or maintaining a Pilates practice by attending classes rather than practicing alone.

Occupational interactions

While general social interactions often presented challenges, participants thrived in contexts requiring brief but intense interpersonal engagement. These situations, which demanded novelty and responsiveness, seemed to accommodate their cognitive profile particularly well. Their occupational choices reflected this preference for dynamic interactions. For example, a number of participants worked with young children and enjoyed their unpredictable movements and conversations.

Participants engaged in work that was typically hands-on and fast-paced. Among those in the study were a gymnastics coach, bush regenerator, call centre operator, child-protection officer, kitchenhand, disability support coordinator, and emergency services coordinator. Most reported juggling multiple roles simultaneously, and some combined paid work with volunteering, parenting, or full-time study. These environments, structured by brief, intense and variable social demands, provided a functional niche for their attentional patterns.

Okay, this is a photo of my cousin. And he has a very rare disability. And the reason I've put this [photo] *in is he has very high needs and is very unpredictable. And I think that I'm quite suited to something like this. You know, this high-paced environment, because I have the ability to think so quickly, and react really quickly as well. Like, if he falls, and you know, he's bleeding or you know, he's having a seizure, I think that in really high-stress situations I have the ability to be calm. I think, day-*

to-day, my brain is moving so fast. And when something crazy is happening, it's almost as if, like, I am calm. [Participant 6]

Salient work reminders

Often these brief, fast-paced and intense social interactions were removed when participants were forced to work from home (e.g. due the COVID pandemic). In previous work settings, salient social cues provided structure, accountability, and efficiency. When forced to work from home, many found themselves in environments lacking these important social scaffolds. Without conspicuous social cues directing attention to appropriate activities, participants often struggled to maintain focus:

I was working at home on a Thursday and at 10am during my workday, I said 'I'm gonna cook a lentil dal.' And so this [showing me a picture of the dal] *represents my inability to concentrate. So yeah, here I am. I've got so much to do at work. But I decided to take an hour out of my workday to cook a lentil dal that I was going to eat later on [...] so I literally had to ban myself from working from home because I'm so unproductive. Because I just want to do other things. Like whatever is interesting to me at the moment in time. No one's there to hold you accountable. So, I still allow myself to work from home, but I make it a priority to go into the office. So that I don't have the temptation to do something else. But it still that happens. But, yeah, like you're kind of reminded that you're at work and you're like 'ok, pull it back'* [Participant 6].

Digital mediation

Digital technologies provided an important domain where participants could adaptively engage with others and information. This appeared to be the case bothduring, before, and after the pandemic. Participants used digital media for business, news, entertainment, relationships, and research. These platforms, which often required short bursts of attention and facilitated frequent task-switching, aligned well with their attentional patterns. Most participants discussed using social media platforms like Instagram and TikTok for both work and entertainment, navigating these spaces with a functional attentional style suited to the hyperlinked digital environment.

> *I have, like, reached out to like, different Facebook communities and, it's really funny, because I'd post and say to 'anyone in [suburb] want to meet up?' And like, 20 people would be like 'Yeah, I'm here. Let's all hang out'. But because we all have ADHD, like, we haven't organised anything. [...] I think that I get bored of people as well. And that's like the same with like relationships as well. Like talking to people on dating apps or whatever I'm, like, could be really interested in you in two weeks, when I'm feeling really good. And then that just goes through and I think that you're the most boring person in the world* [laughing]*. Yeah, just horrible to say, but you know.* [Participant 6]

Through digital engagement, participants effectively conditioned their attentional patterns to leverage these platforms productively. Several described using social media entrepreneurially—managing family business pages, promoting professional services, or running promotional accounts for workplaces. Within digital environments, particularly social media, participants found niches where they could successfully work, study, socialize, and relax.

Discussion:

Following Kirmayer (2024), we conceived of diagnoses as existing at the intersection of multiple social and cultural forces, deemed cultural ecosocial niches. The findings highlighted relevant factors at each level of analysis. In their micro-social environment, participants tended to miss out on rich social interactions through misstatement or exclusion. They therefore attempted to do complex tasks without help, leading to disorganisation and procrastination. Yet, with the aid of others, in the form of highly variable social interactions or digitally mediated platforms, their attention was guided back to relevant activities. At the meso-social level, participants were often able to find and create occupational environments that were rich in just these types of tasks. Yet, their way of relating to others stood in contrast to social norms, often of a gendered nature, which demanded a kind of etiquette and comportment that they eschewed. Despite feeling different from their peers, they adapted to this by pursuing independent activities, hyper-focussing on solo tasks, and finding refuge in groups that prized self-sufficiency. At the macro-social level, there was a niche for this way of being in a culture that allows for 'difference' based on biological and neurological grounds. Hence, participants found identity and inclusion through the neuro-diagnostic paradigm.

Participants were situated within a national context where diagnostic labels were pre-legitimised by the mental health industry, which has reasonable standing in Australian society (Brauer et al., 2021). Progressive health media campaigns in Australia have aimed to destigmatise mental health conditions (Hickie, 2004). There has been a particular emphasis on identifying and intervening for those who are 'at risk' of disorder, even if they do not meet full criteria for a diagnosis (McGorry et al., 2014). Emily Martin (2007, Chapter 8), in her analysis of depression and mania, suggests that diagnostic labels can shrink and expand particularly when they are tied to economic outcomes, thereby allowing more or fewer people into the diagnostic category. In Australia, recent expansion of most psychiatric labels, including ADHD, has effectively allowed for a larger portion of the population to engage with the psychiatry industry.[13] It was not surprising, therefore, that participants often conceptualised their suffering as a form of psychiatric disorder and used diagnostic labels endorsed by authoritative psychiatric institutions.

In particular, participants often had a form of self-understanding epitomised by belief in the "neuro-chemical self" (Rose, 2003). Rose argues that cultural and economic forces have promoted an agenda that locates psychopathology within the brain. Indeed, popular representations of ADHD often characterise the disorder as a "problem of the brain" (Horton-Salway & Davies, 2018). Following this, individuals re-code their own behaviours as being neurochemically caused (see also Vidal & Ortega, 2020). There was evidence in this study that participants tended to perceive their thoughts, actions, feelings, and identities as somewhat mediated neuro-diagnosis. Brinkmann (2016) describes a cultural phenomenon of "psychiatrisation from the ground up", whereby individuals apply diagnostic labels to themselves and readily urge others, including psychiatrists and psychologists, to do the same. This was highlighted by the fact that all participants voluntarily and enthusiastically pursued diagnosis, despite the burdensome costs associated with getting a psychiatric assessment. Indeed, some of the participants described having to ardently advocate for their ‘right’ to be diagnosed to sceptical medical professionals.

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[13] There is some evidence that newer ADHD diagnoses in Australian children are statistically more likely to be milder, "leading to diagnostic inflation by widening the definition to include ambiguous or mild symptoms" (Kazda et al., 2021).

A psychiatric diagnosis, and a neurochemical one in particular, provided some refuge to those who felt “separate from mainstream society” (as one participant put it). Participants described experiencing confusing social interactions and, at times, blatant ostracization. Participants could justify their actions by their diagnosis and thereby gain some allowance to follow a non-dominant path through life. This was particularly true in a society such as Australia, where there has been a continuous push towards neoliberal social policy that values ‘blind’ meritocracy (Western et al., 2007). In such a culture, there are few remaining ways to validly justify non-achievement in education, career, and social life. Most described feeling greatly relieved to get a diagnosis of ADHD. Participants found a niche within a culture where psychiatric diagnoses are legitimate reasons for alternative ways of achieving.

This kind of understanding, however, also divorced participants from their social environment. When human actions appeared neuro-chemically caused, the emphasis on change lay within the brain, not outside in the social environment. This was highlighted by another finding in the study: Participants ‘symptoms’ were sometimes the result of trying to do complex tasks without help from others. By understanding their own behaviour through a neurochemical or neurophysiological perspective, the socially-contingent variation of their symptoms was obscured from view. Internal shortcomings, such “dopamine seeking” tendencies, were often blamed for challenging experiences (like stressful outings with children, struggles in adapting to new work methods, or failing to complete college degrees). Yet many of these tasks required the cooperation or emotionally soothing interpersonal influence of others.

Grange Isaacson (2020) describes a mixture of cultural and social forces that obligate ‘hyper-independence’, using the paradigmatic example of her native Usonian context. She describes problems that develop when people can’t rely on others, resulting in the development of pathological tendencies to cope with forced independence (see also Peacock et al., 2014). A mix of social preference for independence, plus a lack of interpersonal resources, led some participants to struggle to complete actions that, in different circumstances, might’ve been completed cooperatively with others.

The findings from this study suggest that there is also a comfortable and functional niche for such independence. Not only did diagnosis provide a coherent cultural logic for their suffering, but it validated a different way of being. Participants developed ways to entertain themselves, learn by themselves, and soothe themselves. In their relationships, they could eschew implicit demands for harmonious and implicit communication, and instead be brazen and explicit about their views. They pursued solo hobbies, such as woodworking, sewing, and martial arts. In their jobs, they excelled in areas where they could make use of their ‘hyper-focus’; the ability to ignore social interferences and deep-dive into solo work. By creating a justifiable reason for separation from others, participants were vindicated in their preference to be self-sufficient and shamelessly individualistic.

Participants often reported ‘feeling different’, which is consistently reported in adults with ADHD across the lifespan (Brod et al., 2012; Ginapp et al., 2023; Nyström et al., 2020). The findings from this study are conducive with research that suggests that adult ADHD and loneliness are connected (Stickley et al., 2017). Participants described not feeling accepted in peer groups or included in activities with others. They somewhat attributed this to quasi-psychological social deficits (e.g. being an overthinker, over-sensitive, lacking ‘communication skills’). Finding inclusion was perhaps particularly important to those in this study who appeared to experience subtle social rejection, particularly in their adolescent years. This niche of independence, perhaps promoted by cultural normative ideals, was challenged somewhat by the neurodiversity paradigm.

Despite the discursive transformation brought about by the destigmatisation movement (Angermeyer et al., 2017), a completely psychiatrized identity was neither affirming nor emancipating. The metaphor of mental *illness* is still rooted in a disease paradigm. The 'deficit model' of mental illness culturally denies the possibility of celebrating such conditions. Moreover, when one's actions are seen as symptoms of potential sickness, the afflicted individual is potentially sapped of political power. Instead, the neurodiversity paradigm uses the ecological metaphor of biodiversity to describe ADHD. 'Biodiversity' was a term used to advocate for the conservation of all species, following from the understanding that variability in living things is desirable for a thriving ecosystem.

The concept of 'neurodiversity' has biological undertones and fits well within a society that values secular and scientific belief systems. It also fits alongside other modern Western cultural movements that promote acceptance over assimilation, such as multiculturalism and LGBTQIA+ rights movements. Being a particular 'neurotype' meant having a hard-wired, natural and informative identity. The neurodiversity model shifted the focus from trying to find a 'cure' to helping facilitate social- and self-acceptance. Participants could understand their place in the world via a belief system that didn't relegate their status to something deficient. Participants' struggles resulted from being 'out of place', rather than 'broken'. Effectively, this created the conditions in which participants could find a positive identity and could be accepted and appreciated.

The social category of 'neurodiverse' allowed for the creation of a social identity within an 'in-group' (Tajfel & Turner, 1986). Having an 'in-group' made it possible to find solidarity by drawing attention to the similarities, and away from the differences, between participants and their friends. Similarly, it helped them reconcile differences between themselves and 'neurotypical' others. By neuro-categorising others, participants modulated the social environment by pulling some people in closer while pushing others (e.g. 'neurotypicals') away. The neurodiversity paradigm also provided for the community through its symbolic power to connect. When participants perceived a relationship as being neurodiverse, they could enact their preferred social style with less hesitation and assume a greater level of familiarity with their interlocutor. It imbued certain social interactions with extra meaning and thereby made these relationships stronger. Participants were able to find, and create, a social niche with others whom they felt understood by and comfortable with.

Online social media was one way that social interaction was preferable for those in this study. Digital media use (in particular, on smartphones) appears to be connected to self-reported ADHD symptoms (Kushlev et al., 2016; Ra et al., 2018). Internet use is associated with a type of attentional regime that favours short attentional bursts with frequent switching between online media content (Firth et al., 2019). This differs significantly from pre-digital written and oral traditions, where a premium is placed on sustained attention on a singular media. The functional use of modern media technology can represent an adaptation to an environment that places a premium on attentional agility. Australian psychiatrist Gordon Parker has suggested that "digital pre-occupation and increasing pressures for a 24/7 online presence may be setting a variant trap and springing a new variant of ADD/ADHD [adult onset ADHD] into existence" (2024, p. 9). The findings from this analysis are somewhat less alarming. While it did appear that participants engaged with digital media, it is unclear whether this was unambiguously dysfunctional. They used social media technologies to socialise, dating apps for relationships, internet sources to research, and gaming platforms for leisure. Meanwhile, digital technology conditioned attention to be agile, so that it could be functional for continued technology use. Agility in attention could either be functional or dysfunctional depending on the demands of the environment.

Participants found their cognitive profile allowed them to excel in work that was high-pressured and unpredictable. They were able to split their time over several different tasks, such as when they switched back and forth between jobs or between paid and unpaid labour. These findings are consistent with (Lasky, 2015; Lasky et al., 2016) who found that adults with ADHD could engage their symptoms in positive ways when they engaged in work that was challenging, required multi-tasking, and was fast-paced. In the pandemic years, when they were mandated to work from home, their proximate work environment changed such there were less salient social reminders to orient them to work activities. When separated from their work colleagues, they lost the implicit and explicit social prompts to remain on-task. In this study, participants' formal workplaces were furnished with objects and other people that directed attention to work-related activities. A call centre operator was constantly answering new calls, a childcare worker followed erratic children around, and a bush regenerator was moved along by a moving working troupe.

Summary and Conclusion:

In this discussion, we explored evidence for a holistic, ecological model of ADHD, guided by the understanding that cultural and social forces create constraints and opportunities. This model highlights how constraints at one analytic level (e.g. macro-social level) modify other contexts (e.g. interpersonal interactions), leading to re-enforcing feedback loops in multiple directions. For example, Cultural beliefs about neuro-chemical identities modulated the social environment (via neuro-connecting and -distancing) where participants emphasised the similarities between themselves and their neurodiverse interlocutor, thereby re-enforcing the validity of these cultural categories. Similarly, feedback loops can begin at the micro-social level. For example, participants had histories of difficult social interactions, which lead to engaging in jobs that required independence and autonomy, which contributes to cultures of individualism and self-sufficiency, which leads to individuals missing out on rich social interactions.

The findings from this study challenge the perspective that ADHD develops from the 'inside-out' - where naturalistic internal causes indeterminately produce behavioural symptoms, leading inevitably to outside (dys)functioning, which is then interpreted via cultural meanings. Instead, an ecosocial theory conceptualises health condition (such as ADHD) as an emergent property of multiple, overlapping contexts. Not only does it eschew a reductionist account of ADHD as being merely an internally-caused (i.e. neurobiological) condition. It also rejects the possibility of reducing it to merely external factors (e.g. merely a social/cultural construction).

By mapping the cultural-ecosocial niches of adults with ADHD, we were able to highlight the multiple and overlapping influences on disorder and coping. By looking beyond intra-individual factors, such as psychological or neurochemical mechanisms, we are able to identify how the social world gets 'under the skin' and comes to be disorder. This view has consequences for the assessment, formulation and intervention of those with ADHD. Just as the causes of disorder may expand into the social world, so may the resources for coping.

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Chapter 5: conclusion and discussion

This chapter begins by re-posing the research questions that this thesis aims to address. I then summarise the findings of the three case studies in relation to how they address these research questions. This involved exploring meaning-making during the COVID-19 pandemic, the ideological underpinnings of e-therapy applications, and the socio-cultural construction of adult ADHD diagnoses. The summary focuses on how these studies demonstrate that clinical phenomena, such as distress, therapy, and diagnoses, are intricately tied to and shaped by cultural forces. I argue that these studies reveal that Western psychological experiences are as culturally specific as any other, challenging the idea that clinical psychology is based on a-contextual and ahistorical norms. I then go on to suggest that a non-reflexive clinical psychology has made the discipline blind to its inherent biases, including individualism, internalism, and the subtle infusion of neoliberal values.

I then move on to discuss the implications these findings might have on clinical theory and practice. I first argue that understanding distress in clinical psychology requires a case-formulation approach that moves beyond purely internal explanations. It involves recognising how cultural narratives, material objects, and prevailing discourses actively influence subjective experience. Instead, a more culturally informed, critically self-reflexive clinical psychology would acknowledge the interaction between individual agency and broader socio-cultural forces. I then examine what the implications might be for psychological therapy. I argue that an awareness of the Western-biased concepts used to make sense of the world, such as individualism and internalism, play an important role in therapy. They make the therapeutic endeavour intelligible as such, and act as foundations of common understanding. Conscious, ethical and strategic use of these concepts (in the right contexts) can have benefits for the therapeutic encounter. I finish by detailing some limitations of this research and give some concluding remarks.

Central argument, research gap and research question:

I began this thesis by arguing that clinical psychology, in its pursuit of universal truths, overlooks the role of culture in providing a complete picture of an individual's psychology. (Schwartz, 1992). I suggested that clinical psychology, originating in Western Europe and the USA, has primarily focused on and been practised by individuals from Western, educated, White ethnic backgrounds. This wouldn't be an issue if it acknowledged itself as just another cultural healing practice (Kirmayer, 2007). However, it often presents itself as a universally applicable science, like physics, thereby overlooking its cultural relativity. As such, it tends to seek timeless laws of human nature and suffering, and ignore how social, political and historical contexts shape individuals (Boyle, 2011; Coles & Mannion, 2017). Furthermore, the positivist and realist assumptions that this kind of psychological science operates within leave little room for understanding the construction of meaning, which is important to many areas of clinical psychology. I then argued that this blindness to culture might be an artefact of the understanding of culture that operates within clinical psychology. Often, I suggested, culture is understood as merely synonymous with ethnicity or geography or as something only non-Western people have. Moreover, some theories construct culture as an all-determining force, leaving no conceptual room for the individual and her creativity, while others consider that inherent psychological processes determine various forms of suffering and relief, relegating culture to a mere superficial expression.

Having identified this gap, I posed the following research questions:

- A) How do the biases inherent in a scientific and universalist conceptualisation of psychology miss the ways the psychological suffering and relief are intertwined with local social, historical and political issues? And,
- B) Can clinical psychology borrow from cultural psychology to more meaningfully understand psychological suffering and relief as socially, politically and historically co-constructed?

I proposed that I could explore these questions using a series of case studies that engaged with emerging issues confronting the understanding of distress, diagnosis and psychological intervention. The issues that emerged during this time were the distress created by the COVID lockdown, the explosion in newly identified ADHD diagnoses in adults, and the digitalisation of psychological therapy and intervention.

Summary of case studies in response to research questions

The findings from these three case studies highlight the ways that clinical psychological phenomena are deeply embedded in and co-constructed by cultural, social, and historical contexts. These case studies showed how the dynamics of psychological suffering and relief in Western contexts are just as ‘cultural’ as those in ‘Other’ contexts. In each case study, I incorporated different aspects of culture (the historical, the ideological, and the macro-social) into modern problems confronting clinical psychology (COVID-19 distress, online therapy, growing ADHD diagnoses). These cases provided critical and novel insights into each of these areas:

- The first study of participants in the COVID lockdown showed the usefulness of understanding history and how it shapes narrative and distress. This appeared in the ‘formatting guidelines’ utilised by participants to construct the meaning of time. The experience of time and distress was connected to cultural legacies such as work, gender, and spirituality.
- The second case study examined the ideologies present in online mental health interventions and how this is embedded in a modern cultural artefact (the digital mental health app). It further highlighted the impact this had on the therapeutic process. This orientation was able to reveal how mental health apps don't simply deliver therapy but actively transform it by amplifying certain aspects (privacy, abstraction, self-reliance) while

reducing others (interpersonal connection, contextual understanding) in accordance with cultural demands.

- The final case study explored the rising number of ADHD diagnoses from a socio-cultural perspective, paying particular attention to the interaction between macro-social beliefs and micro-social interpersonal interactions. This study framed culture as an ecological environment that both constrains and enables individual functioning and distress.

Before examining the themes that emerged from these studies, it's worth reflecting on how the chosen methodologies enabled a nuanced exploration of the meaning-making process.

Methodological Discussion: a means to explore meaning

In this section, I reflect on how the specific analytic methods chosen (semiotic analysis, postphenomenology, cultural eco-social niche analysis) allowed me to capture the nuanced, contextual, and meaning-based aspects of the phenomena under investigation. I contrast this with the limitations of the quantitative or purely positivist methods critiqued in my introduction. I briefly discuss the different cultural frameworks explored (temporal narratives, technological demands, diagnostic/neurodiversity discourses) and how they function in meaning-making.

As I argued in the introduction, conventional psychological research, which takes its ideal from the physical sciences, seeks universal and unchanging laws and principles to model the world. In doing so, it operates with what Kull (2009) calls a monist ontology, i.e. is interested in only one ‘true’ reality. Cultural psychology, on the other hand, allows for meanings to be ‘plural’ depending on context, time, social position, interpretation, construction, etc. A central aim of this thesis was to examine how psychological *meanings*—what something implies or signifies to someone – are constructed with culture. Cultural psychologists contend that humans do not merely *have cognitions*; instead, they actively *engage in thinking* (Zadeh et al., 2022). Cognition refers to the process of finding truth, while thinking encompasses active tasks such as interpreting and creating, which involve the quest for making meaning. This thesis explored what conventional clinical psychology may gain by examining how meaning is created, interpreted, and experienced in ways that purely scientific paradigms struggle to capture.

Study 1: Meaning-making and time during the pandemic

The first study explored how individuals experience the flow of time during the COVID-19 pandemic. A quantitative positivist perspective on lived temporality might use clock time as the universal measure, and then seek to find the association between this objective measure (days spent in lockdown) and the psychological construct (perceived time) to assess the effects of the pandemic on time distortion. In contrast, my study applied Lotman's concept of the Semiosphere (Lotman, 2005) to investigate how meaning is derived from lived experiences of time. The semiosphere refers to the conceptual environment encompassing the entire range of texts, languages, arts, rituals, and other sign systems that shape a culture. This perspective enabled an investigation of how cultural narratives and frameworks structure the meaning and experience of time.

Initially, people experienced time as frozen or slowed down, disrupting the Western concept of time as linear and purposeful. The meaning of time was then reorganised through cultural scripts. Those who emulated "work-time" during lockdown regained meaning through productivity. Others who interpreted time through religious narratives (like a "Noah's Ark reboot") found redemptive meaning in the slowness. This semiotic approach captured nuances of experience that would be difficult to quantify in traditional quantitative models.

Study 2: The materiality of meaning in e-therapy apps

The second study contrasted how creators of mobile-based therapy apps constructed "therapy" versus the meaning that participants made of these interventions. In doing so, this study challenged modernist assumptions that content matters more than medium (cf. (McLuhan, 2017), i.e. that the app is merely a neutral conduit of clinical information. Instead, following Anders (Müller & Anders, 2016), this study started from the premise that the medium of the technology demands something from the user through its use. By viewing the phenomena through the post-phenomenological lens, I suggested that the meaning of the therapy was constructed *with* and *through* the app. Instead of viewing technologies as neutral tools, post-phenomenology perceives them as active intermediaries linking humans to the world in some specific way. Technologies, such as apps, do not merely function within the world; they also construct the phenomenological world as they go.

The study found that while apps were intended to be analogous to talk therapy, users interpreted these apps quite differently. When the apps delivered a decontextualised and abstract form of therapy, this challenged the very meaning of therapy as 'care'. They foreground certain elements of experience while backgrounding others, proposing value systems about what matters for wellbeing. This mechanistic construction of care fit within other cultural beliefs about identity (glorifying individualism) and the nature of the self (as an information processing entity).

Study 3: Adult ADHD diagnosis – co-constructed by the social environment.

The third study examined how adult ADHD diagnoses emerge at the intersection of multiple overlapping contexts and timescales. Typically, research on the phenomena of increasing ADHD diagnoses presupposes that the meaning of 'symptoms' and 'functioning' are unambiguous and objectively observable. In this study, rather than starting from the internal neurochemical level and working outwards to the behavioural level, I approached the diagnosis by conceptualising it first from the social level and followed these effects inwards to the level of individual behaviour and interactions. By combining semi-structured interviews with participant-generated photographs, the study captured rich, contextualised narratives of how individuals actively construct and navigate their environments. This method allowed me to look outward into the participants' world and then hear how this world was made meaningful in their narration of it. The meaning of adult ADHD emerged within a "niche" of overlapping historical and social contexts (medicalisation narratives, neurodiversity identity, solo hobbies, fast-paced work environments, etc).

ADHD was seen as a manifestation of biodiversity via a neurochemical pathway. It was able to explain both social exclusion and in-group acceptance, dynamically observed in particular professional and personal situations. This niche enabled them to blend essentialising psychiatric labels with emancipating beliefs in diversity. It accommodated the pursuit of achievement whilst allowing the exploration of alternative life paths. And it maintained participants' inclination towards asociality whilst allowing them to connect with others. Participants constructed the niche which constructed them. They modified their social environment to encourage particular types of interactions, which subsequently impacted their likelihood of exhibiting certain social behaviours. They recognised themselves through specific socially accepted psychiatric labels, which further reinforced the legitimacy of these labels. Consequently, the ecosocial niche theory sidestepped both deterministic and overly individualistic views of psychopathology.

"Culturizing" Western Subjectivity: a discussion

In this section, I first recap findings from the three case studies. I do so to highlight the cultural co-constitution of these phenomena. I then reflect on certain themes that cut-across all three of the case studies and therefore reveal something interesting about clinical psychology's cultural orientation. These themes, I argue, are a helpful way to highlight the cultural relativity of the approach that clinical psychology takes to suffering. In doing so, I hope to draw attention to aspects of experience that mainstream clinical psychology, shaped by its particular socio-cultural history, tends to overlook.

In the introduction, I proposed that an aim of this thesis was to examine Western psychological experience as culturally specific, rather than a universal form from which other psychologies occasionally differ. The subsequent studies explored how new and emerging issues in clinical psychology could be understood culturally, rather than exclusively scientifically. By way of reminder, the findings showed how:

- The experience of time among Europeans and Australians during lockdown was constituted by culturally specific narrative structures (e.g., "productive time," "transformational time").

- The therapeutic value of mental health apps, often presented as universal and neutral technologies of change, were constituted by Western cultural values such as privacy and self-reliance, via quantification, in both their conceptual design and practical application.
- The emergence of psychiatric diagnosis, exemplified here by ADHD, could be located in space and culture, at the intersection of overlapping discourses and social patterns. These include the notion of the "neuro-chemical self," contemporary societal demands for particular attentional regimes, and the ethical acceptance of diversity.

These three studies collectively demonstrate that contemporary Western social, political, and historical contexts constitute psychological phenomena. More than being a disparate set of studies, I believe that there are several interconnected themes that they each share with one another. By culturalising these phenomena, it became easier to see that these three ethnocentric assumptions are pervasive in clinical psychology.

The first is the assumption that the *individual* is the most pertinent unit of analysis for understanding the construction of their psychological reality. This assumption is premised on the belief that the individual operates independently of their surroundings. The second unacknowledged assumption is that *neoliberal* values like independence, self-determination, and productivity are positive, while dependency and reliance on others are inherently negative. From such values, it follows that work is positioned as the principal means to achieve satisfaction and achievement. The final assumption concerns the value attributed to *interiority*, the private inner space of the individual, which is believed to hold the key to understanding psychological experience. Consequently, introspection and insight are promoted as the optimal methods for achieving emancipation from suffering.

It is important to clarify at the outset that this is not an attempt to distil the very essence of Western subjectivity. Such an endeavour would be a self-contradiction, given that I argue in the introduction that cross-cultural psychology falters when it presumes abstract ethno-geographical contexts can adequately capture the nuances of highly contextualised psychological experience. Therefore, any effort to distil these findings into conclusive ‘results’ risks undermining this core argument by essentialising Western subjectivity.

It is also worth noting that the themes discussed here are not entirely novel; they resonate with established scholarship in anthropology, critical psychology, and cross-cultural psychiatry. On individualism, anthropologist Clifford Geertz notes that “The Western conception of the person [is of a] bounded, unique, more or less integrated motivational and cognitive universe; a dynamic centre of awareness, emotion, judgment, and action organised into a distinctive whole and set contrastively both against other such wholes and against a social and natural background” (Geertz, 1974, p. 31). Regarding neoliberalism, critical psychologist Thomas Teo observes that Western subjectivity is largely influenced by a neoliberal outlook, emphasising self-control, wherein “agency should focus on overcoming [reliance on others] both, through working on oneself and one’s skills.” (Teo, 2018, p. 593). Meanwhile, cultural psychiatrist (Kirmayer, 2007) highlights the interiority bias, pointing out that Western psychotherapy relies on "the creation of a ‘deep’ narrative [which] depends on a sense of interiority or hidden motives, which can be invoked to make the narrative advance through layers of progressively more difficult self-revelation” (p. 235). Therefore, the aim of this discussion is to situate the findings of my studies within these broader intellectual currents.

Socially Situated Psychological Experience: Western Individualism and Distress

The three studies in this thesis highlight how psychological reality is constructed within social context. Across all three studies, it was notable how psychological experience was consistently framed within an individualistic worldview. ‘Individualism’ may indicate a specific moral-political stance (prioritising individual freedom and autonomy over collective well-being) or a particular perspective on personhood (wherein individual autonomy and identity are independent from the influence of others). Here I am referring to this latter use of the term; the worldview that persons are “bounded unique wholes […] set contrastively against both others and against a social and natural background" (Geertz, 1974, p. 31). This perspective "implies that judgment, reasoning, and causal inference are generally oriented toward the person rather than the situation or social context because the decontextualised self is assumed to be a stable, causal nexus" (Oyserman et al., 2002, p. 5). This perspective was evident in the distress caused by the loss of individual control in the pandemic lockdown. It also helps explain the appeal of diminished relationality facilitated by digital platforms and why participants overlooked the influence of social interactions on ADHD symptoms.

The COVID pandemic highlighted a form of forced isolation that was emblematic of the lockdown experience. Separation from others under lockdown led the participants to search for ways to continue exercising their independence, even while collectively conforming to government mandates. Indeed, a significant alleviator of distress was the degree of individual control that the participants felt they had over their lives. Participants who adjusted their work schedules or reevaluated their personal values experienced the satisfaction of control over their distress. This was the case even within the broader context of dependence on others. It was frequently the extent to which participants could separate themselves from their surroundings and recognise the outline of their individual selves that coherent meaning was returned to psychological experience.

The therapy app's promise to relieve psychological suffering rested upon the assumption that suffering itself was a reflection of personal attributes (thinking styles, behavioural patterns etc). The therapy app, devoid of relationality and a contextual understanding of users' problems, promised freedom from social circumstances. Its mechanism of action denied the possibility of seeing connection as a possible antidote to suffering. Instead, it appealed to the ideal of self-determination; that one's psychological destiny lay within one's own control. The culture of individualism was reflected in both the apps' design, which ignored the possibility that relational factors might influence therapy, and in the way participants valued it, appreciating its ability to provide privacy and personal convenience.

The ADHD study revealed that individualism shaped the diagnosis process. Although the study's findings highlighted the significance of social factors in understanding ADHD, the participants rarely discussed it in these terms. Instead, they discussed non-relational conceptualisations, often rooted in personal neuropsychological differences, as the basis for their challenges. However, it was this individualised framing of their issues (as neurobiological differences) that arguably enabled them to better grasp their problems. The very act of getting a diagnosis (i.e. legitimising their neurobiological difference) enabled them to accept their identity and engage preferentially with others in their lives. Similarly, participants needed to embrace the individualised perspective of the disorder to find empowerment in it. If they could be held somewhat accountable for their behaviours, they could also receive recognition for creativity, quick thinking and entrepreneurial spirit.

The individualistic-collectivistic dialectic has long been a fascination of cross-cultural psychology (see Oyserman et al., 2002, for a review). Findings from such studies suggest that the extent to which one holds an individualistic worldview is somewhat dependent on the region of the world one lives in (Oyserman et al., 2002), pointing to the socially contingent nature of such a worldview. The three studies within this thesis added to this literature, showing the particular ways that this socially situated worldview affects modern clinical phenomena in psychology.

Politically situated psychological experience: Neoliberal values (and resistance)

The three studies also aimed to highlight how psychological phenomena are co-constructed within an ideological context. The clearest ideological backdrop across these three studies was that of Neoliberalism. Neoliberalism is a political and economic philosophy defined by a “free market ideology based on individual liberty and limited government” (Clegg & Lansdall-Welfare, 2020). Neoliberal subjectivity is oriented towards enhancing individual competitiveness and efficiency within the existing system, rather than exploring collective solutions or critiquing structural inequalities (Teo, 2018).

Each study critically explored the ways that neoliberal value systems characteristic of modern Western societies interact with clinical phenomena. The COVID study highlighted how the imperative to transform "suspended time" into "productive time" reflects neoliberal values of efficiency and productivity, even during a global crisis. During lockdown, the value of work, even work on oneself through productive enterprise, was seen as the path to wellbeing. The study of e-therapy apps showed how values such as individual privacy and self-reliance enabled the app to appeal to users, even when its use and benefit were limited. The app was viewed mainly as a 'tool' for enhancing one's self-reliance in a hostile world, safeguarding the self from dependency on others in times of distress. By its design, rather than its content, the app denied that others might have responsibility for our wellbeing, instead suggesting that 'work' on oneself was key to relief. The ADHD study demonstrated how individualised neurochemical explanations overshadowed socio-structural explanations for the disorder. Despite expressing that interactions with others greatly influenced their symptomology, participants appeared to require a 'disorder' to justify their disengagement from non-normative life choices.

These studies also identify emergent frameworks that challenged these values. In the COVID study, "transformational time" emerged when neither productive time nor normal time properly made sense. In the second study, participants sensed that something was missing from the app's version of therapy, which I identified as connection and understanding, despite the app suggesting it was unimportant. In the ADHD study, the neurodiverse identity acted as a buffer against the pathologising and commodifying identity of psychiatric illness. The studies highlighted how alternative frameworks of value emerge precisely at points where neoliberal subjectivity fails to account for lived experience adequately.

Significant attention has been given to examining how clinical psychology can become infused with neoliberal ideology by promoting an individualistic perspective on psychological suffering and its alleviation (Adams et al., 2019; Bettache & Chiu, 2019; Esposito & Perez, 2014). With regard to psychological suffering, this framework emphasises personal responsibility, self-entrepreneurship, and adaptation to market-driven demands, while de-emphasising socio-structural determinants of mental health (Esposito & Perez, 2014). An uncritical clinical psychology might unintentionally conform to neoliberal principles by packaging therapy as a marketable commodity that can be used to enhance one's individual self-management and construct the individual as a consumer responsible for cultivating their own psychological resources. (Beattie, 2019; Teo, 2018).

The studies in this thesis paint a more nuanced picture. They suggest that clinical phenomena, such as therapy and diagnoses, can also be seen as responses to neoliberal imperatives. Indeed, Pande (1968) suggests that psychotherapy is an "undertaking to meet the deficits in the Western way of life" (p. 432), which demands self-reliance and independence.[14] It is no surprise, therefore, when the interdependent relationship in psychotherapy was taken away, as with automated online therapies, that this was unsatisfying. Similarly, just like the ADHD label pathologises inefficiency and unproductivity, it also provides a means to handle these pressures by presenting a validated escape route. As such, these studies add nuance to the ways that clinical psychology is entangled with neoliberalism.

Historically-situated psychological experience: Internalism - the 'psychologization' of subjectivity

These studies highlight how modern Western subjectivity is typified by a certain 'internalised' psychological perspective on suffering. Participants' understanding of distress and disability was often referenced through a form of self-reflection on internal states, such as 'emotions', 'moods', 'motivations', 'desires', 'thoughts', etc. Such language, influenced by theories from psychiatry, psychoanalysis, and psychology, emphasises the critical distinction between internal and external processes for individuals. This internalist psychologised perspective has developed over history. While today life is increasingly understood through the internal perspective, this rarely appeared in older literature. Erik Hoel (2024, Chapter 2) studied the progression of classic literature over time, starting from ancient Egyptian writings, moving through classical Greek philosophy, Roman literature, the Bible, medieval works, and romanticism, all the way to contemporary texts. He argues that the older the text, the less it tends to elaborate on mental states, thoughts, and inner experiences.[15] Over time, however, these texts display an increasingly psychological vocabulary and introspective language. This cultural-historical co-construction of life as something lived internally was reflected in our studies.

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[14] Pande goes further, suggesting that psychotherapy is a "magnificent ruse for fostering long-term and intimate relationships" which is less needed in "other societies that are oriented towards inter-dependence" (p. 426)

The lockdown study focused on how cultural narratives could act as historical roadmaps that help navigate novel experiences of time and, consequently, distress. However, the diarists frequently identify the source of their issues (distress, altered time perception) within themselves, believing that introspection and personal transformation could yield control over these problems. The findings from the app study were similar, highlighting how these apps encouraged users to deconstruct their internal worlds rather than the specific contexts and connections in their lives. Then, when the app failed to have any effect on their suffering, participants in the study blamed themselves for not being ‘self-aware’ or lacking greater ‘insight’. Lastly, in the ADHD study, participants described their faults as primarily psychological, such as their tendency to overthink or be overly empathetic. It was telling that some participants suggested that much of their social and occupational life could be attributed to the workings of one internal organ, the brain, rather than to the many social influences throughout their lives. Taken together, these studies suggest that this internalistic perspective represents a culturally significant modern way of understanding suffering.

The use of internalistic psychological language represented significant way of making sense of distress. However, it must be said that this is a historically situated way of making meaning. Hsu notes that *“*while the need to share distress may be universal, the 'psychologising of distress' appears to be a relatively recent Western phenomenon" (Hsu, 2004, p. 5). What's more, it appears to be socially normative. Generally, processes occurring internally (e.g., deep within one's mind) are deemed more significant than those that can be readily seen on the 'surface'. Clinical psychology also promotes this normative ideal, assuming that gaining a greater understanding of life rests on the individual's propensity for introspection. Berrios & Markova (2003), in their conceptual analysis of the Western 'self', argue that the modern subject is constructed in such a way that allows for it to be a thing that psycho-pathologies and psychological disease can afflict.[16] This ideal suggests that a greater understanding of suffering is associated with going beneath the 'surface' and penetrating deeper layers of consciousness. The studies within this thesis further highlight the ways that "art of introspection in psychology, turning inwards [and] slowing down" (Rhodes, 2019, p. 24) represents a culturally important way of making meaning, particularly in times of distress.

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[15] Hoel takes a normative stance of this, suggesting that individuals from earlier times had a deficit in their ability to articulate their internal mental life and that the increasing ability to discuss ‘inner’ life represents our evolution as a species.

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If mainstream clinical psychology fails to critically explore these underlying cultural assumptions, it may inadvertently remain blind to the culturally constituted nature of the experiences it seeks to understand. Recognising these deeply embedded cultural assumptions and their resultant biases can help keep clinical psychology ethically attuned. I believe there are several responses to this cultural relativisation of clinical psychology, each of which has both a theoretical and practical component. The first response concerns clinical formulation, and is to resist the prevailing bias in clinical psychology to look inwards, and instead look out into the cultural environment. The second response concerns psychological therapy and involves consciously working *within* the relativistic cultural frameworks to achieve the goal of alleviating suffering.

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[16] The also offer a cultural-historical hypothesis for the emergence of this type of Self: "Originally meant by St Augustine to be just a metaphorical or virtual space within which theological models of responsibility, guilt and sin could be played out, The Self regained importance in the hands of Luther who stated it's reification as a private cave where God and man would regularly meet to sort our their differences. During the seventeenth century the metaphors of the Reformation became secularised and built into liberalism and capitalism. The Self survived by becoming a conceptual prop for bourgeois notions such as individual ownership, natural rights and democracy." (Berrios & Markova, 2003) p.9).

Implications for Clinical Psychology Theory and Practice:

The findings of this thesis, which highlight the cultural co-constitution of psychological phenomena, have implications for both how clinical psychology understands distress and how it engages in the therapeutic process. This section will examine these implications by first looking at how clinical formulation might change when incorporating a cultural perspective. Secondly, I consider how therapeutic practice might be transformed by acknowledging the inherently cultural nature of the clinical encounter.

Implication 1: Looking outwards: counteracting internalism in clinical formulation.

Case formulation is a fundamental practice in clinical psychology. A case formulation is a "'a hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal and behavioural problems" (Eells, 2022, p. 4) informed by theory of psychological processes. Such a case formulation helps clinicians and clients understand the nature of their predicament and guide decisions about what might be helpful (Persons et al., 2006). Formulation effectively bridges the gap between clinical theory and practice, providing both an ideographic approach whilst maintaining its status as 'empirically supported'. Clinical formulation offers a more personalised construction of psychiatric diagnosis (Coles & Mannion, 2017; Johnstone, 2018). Despite being ideographic, formulation relies on 'nomothetic templates', which explain psychopathologies by a number of 'evidence-supported theories': "e.g., views of depression as because of negative cognitions, as because of loss of positive reinforcers, and as because of problem-solving deficits, among others" (Persons et al., 2006, p. 168).

As discussed above, I found that there was a prevalent Western cultural bias favouring 'internal' over 'external' understandings of suffering. Furthermore, clinical psychology itself was somewhat implicated in this bias. For example, I demonstrated that certain mental health interventions and devices encourage users to identify the abstract, underlying causes of their distress rather than the contextualised factors of their outer reality. And, that diagnostic categorisation of distress can sometimes foster the belief that identity is based on inherent traits rather than social circumstances, a point underscored by the recent phenomenon of Adult ADHD diagnoses. This thesis, however, opens the door to an alternative way for clinical psychology.

The studies in this thesis demonstrate that psychological experience cannot be understood through individual introspection alone, but also requires an understanding of the culturally available materials and discourses within the environment. By viewing psychological experience as a cultural co-construction (Shweder, 1990), psychologists can focus on surveying the cultural materials available in the client's environment. Understanding emerging trends in clinical psychology, such as diagnosis, therapy, or distress, can be achieved by looking outward, rather than inward. The ingredients for constructing these phenomena can be found in the socio-cultural environment, including semiotic signs, material constructions, and cultural discourses. The clinical implications of outward turn for clinical formulation are significant.

By looking outward, both clinicians and clients can gain a richer, more contextualised understanding that moves beyond introspection towards a more holistic and culturally relative conceptualisation of well-being. This shift towards a critically self-reflexive clinical psychology, one that actively strives to identify and counteract its internalist, individualistic, and other culturally specific biases, is an important implication of this thesis. Like the fish that doesn’t see the water that ubiquitously surrounds it (Wallace, 2009), clinical psychology can sometimes miss the cultural biases that sustain it. I believe these studies made it easier to see the cultural waters in which the discipline swims.

For the clinical psychologist, it means that understanding a client's distress or behaviour requires more than just an exploration of their internal world. It also necessitates a curiosity about the cultural worlds they inhabit. This includes the myths and narratives they are exposed to, the identity categories available to them, and the culturally sanctioned ways of expressing or understanding suffering. This perspective can help clinicians understand how experience becomes intelligible. It encourages a shift from an exclusively individual and intra-psychic focus to one that considers the interplay between the individual and broader socio-cultural forces.

The case studies presented in this thesis offer strong empirical support for the principles of the Power Threat Meaning Framework (PTMF) by demonstrating how distress is shaped by the meaning of time, technological affordances, and diagnostic niches. There are significant consensual grounds between the 'outward gaze' proposed here and the PTMF’s focus on ideological power; the power to control language, meaning, and agendas (Johnstone & Boyle, 2018). For instance, my analysis of Adult ADHD (Chapter 4) illustrates how a diagnostic label acts as a form of ideological power, offering a specific meaning that shapes the individual's identity. Similarly, the analysis of mental health apps (Chapter 3) highlights how Economic and Technological Power can strip care of its relational context, reducing complex suffering to data points.

A recent empirical scoping review of the PTMF (Gallagher et al., 2024) indicates that when clinicians move beyond diagnostic labels to explore these 'macro' narratives, they open new avenues for therapeutic change. By integrating the PTMF’s questions into the case formulation process, clinical psychology can formally adopt the interactionist ontology I have argued for. It allows the clinician to validate the 'vitality' of the non-human environment—whether it be a virus, an algorithm, or a cultural narrative—recognising these not as background noise, but as active co-authors of the client’s distress."

For clients of clinical psychology, this approach encourages examination of how their experiences are influenced by their cultural contexts, rather than getting caught in a solitary internal quest to identify personal factors. Clients can gain a critical perspective on their personal struggles by learning to “read” the cultural landscape, allowing their individual problems to connect to broader contexts. Their suffering may be illuminated by identifying which cultural narratives (about distress, mental health, identity) might be contributing to their struggles. It can also open new avenues for agency. Clients may begin to see possibilities for re-negotiating their relationship with dominant cultural artefacts (as they did in the MH apps study). Or, by drawing from alternative discourses that offer more empowering ways of being (as in the ADHD study).

However, this critical awareness cannot lead to further attempts to operate *outside* of culture. Clinical psychology is itself a cultural practice that inevitably takes place within a culturally constituted reality. While there is room to challenge limiting cultural assumptions, clients are always-already deeply embedded within, and making sense of their lives through, these very cultural frameworks. Both clinicians and clients must use shared cultural narratives, symbols, and discourses to communicate. Therefore, engaging with these existing cultural frameworks is not optional; it is an intrinsic part of all clinical practice. The critical self-reflexivity advocated here is not about seeking an impossible a-cultural stance, but to acknowledge the relativity of the field. Given this inevitability, the question becomes how to do this using the critical insights discussed. Rather than attempting to transcend culture, clinicians might focus on how to engage *with* cultural elements.

Implication 2: Acknowledging and engaging with cultural biases in therapy

Along with formulation, therapeutic practices also undergo transformation when recognised as inherently cultural activities. Recognising that cultural artefacts construct clinical psychology brings about a second implication: the need to actively engage with these cultural artefacts in therapy. Rather than trying to transcend broad social, historical, and political currents and their attendant biases, clinicians might consciously flow *within* them. Rather than seek an elusive, bias-free high ground, clinical psychology could develop practices that critically utilise these culturally biased discourses, artefacts and constructions for therapeutic benefit.

As the case studies demonstrated, individuals are always-already actively using available cultural resources: temporal narratives to make sense of lockdown, the features of mental health apps to construct their emotional suffering, or diagnostic labels like ADHD to construct their identity and navigate social worlds. These are the languages and resources that make suffering intelligible and facilitate certain actions in response.

Therefore, a key component of a culturally attuned clinical psychology involves skilfully operating within these cultural assumptions. This can be achieved in therapy through the thoughtful use of familiar, albeit biased, cultural artefacts and discourses. This is not an endorsement of the biases themselves, nor is it about uncritically reinforcing potentially limiting assumptions. Rather, it is a pragmatic recognition that these assumptions can lead to a variety of different outcomes. Clinicians might use these assumptions to help with relational connection, improve interpersonal understanding, and contribute to emancipatory change.

First, connection often begins within shared understandings: To meet clients in their lived reality, clinicians must often first engage with the narratives clients themselves use. This might involve, for example, framing an intervention in a way that resonates with dominant cultural values (like the "psycho-technical" aspect of an app appealing to problem-solving ideals). Or, by using common narrative formats to engage in an inter-subjective storytelling (like the story of metamorphosis that came with ‘transformational time’ in the pandemic). These shared understandings foster initial engagement and can help clinical psychology feel acceptable and accessible to the client.

Furthermore, meaning in therapy is co-constructed with whatever conceptual tools are at the individual's disposal. Employing understandable concepts, even if they carry historical or cultural baggage (such as the 'internalistic' construction of distress), builds an intersubjective bridge and ensures that client and clinician can communicate. These shared concepts enable dialogical meaning-making and communication. Making meaning within a therapeutic encounter, for example, requires the shared use of common comprehensible concepts. It is through the competent use of such concepts that change is possible.

Finally, this autonomy can be created through these limiting cultural concepts. Individuals can enact agency by actively repurposing cultural constructs, as demonstrated by participants who used ADHD labels for empowerment and identity re-negotiation. This capacity for creative reinterpretation enables therapeutic meaning-making to foster emancipatory change, as when established cultural concepts are applied creatively in new contexts to challenge novel pressures. For example, essentialised and biologised psychiatric labels, while limiting of identity, can be used to rebuff the demands of late-stage capitalism.

Therapeutic practice, then, is one of conscious choice and ethical navigation *within* the inevitable cultural encounter. It requires the clinician to utilise shared meanings to build rapport and foster an intersubjective reality, while simultaneously remaining critically aware that these meanings are culturally situated, relative, and partial. This method enables the therapeutic relationship to serve as a space where current cultural understandings can be utilised for both connection and transformation. Whilst also, when suitable, be softly examined, deconstructed, or broadened, to empower different ways of being.

Limitations and Future Research:

I will outline a number of limitations of this research. The first is a broad theoretical critique of the obscuration that happens when one view of reality is taken necessarily at the expense of others. In this research, I viewed certain problems as cultural co-constructions, which means that any intra-personal or individual aspects of these problems, for example, are obscured. I then detail a few limitations with regard to the methodological choices. And finish by highlighting a potential moral limitation relating to my positionality as a researcher.

First, however, I must make a brief note about the limitations of this research in general. This research is purposefully limited in its scope. I set-out to show that research that might present itself as universally generalisable ought to be more modest. This thesis argues that the world can be constructed in multiple ways through research, and the story told might be just one of many ways to tell it. When I highlight the limitations of this research, I hope it's acknowledged that these limitations are inherent in the process of taking some perspective, which in turn enables such a perspective to exist as such.

Theoretical limitation:

Following this, there is a theoretical limitation to this study. It constructs emerging problems in clinical psychology, such as e-therapy and ADHD, as being inherently cultural in nature. Or, at the very least, it gives culture a very prominent role in the construction of phenomena. By taking such an approach, there is a possibility that problems become over-culturalized. That is to say, other aspects of these problems are ignored. Di Nicola (following Friedman, 1982) suggests that, in therapy, culture can be a shared language and ritual that a family uses to express themselves and make sense of the world (1986). He calls this the family's cultural costume. However, families can also use 'cultural camouflage'. In this sense, families use this cultural costume to hide problems that are interpersonal or individual in nature. "When culture is invoked as a smokescreen to obscure individual states of mind or patterns of interaction in the family, the cultural costume becomes camouflage." (DiNicola, 1986, p. 183).

I believe that there is a possibility that these studies provide cultural camouflage, hiding other ways of conceptualising things. As with all research, by illuminating one way of seeing the world, other ways are obscured. By taking a social constructionist ontology, this obscures a realist ontology. Viewing distress as culturally co-constructed obscures the understanding of distress as biologically or existentially universal. By considering diagnoses as existing and promoting of a certain habitat, it obscures seeing it as a purely genetic condition, or an evolutionary trait unaffected by micro-social environments. Conceptualising e-mental health technologies as constructors of mental health concepts obscures seeing these technologies as instructional devices which change MH purely through the explicit 'knowledge transfer'.

Limitations related to my positionality

Another limitation is me and my position in the world. I am positioned in a certain way. My own perspective is necessarily limited, and while the methods help to expand this perspective, they do not provide an omniscient viewpoint. This research is conducted from my perspective at this time and in this place. No doubt the choice of what to study, the choice of method, and a certain interpretation of the data are reflections of my particular socio-cultural positioning. My worldview shaped all interpretations. It is neither possible nor preferable to have research that encapsulates all perspectives on a certain phenomenon. That said, my position as a white male researcher in a privileged environment must be acknowledged. Raymond Williams stated that culture is that which seems most normal to those who inhabit it, but foreign to others. As such, I may be most blind to the culture that I live and work in (as a Westerner, a clinical psychologist, a male, and someone with many forms of privilege and power). Those things that I miss are likely those things that, like the fish in water, are most pervasive.

Limitations related to methods and choices of the case studies

Another limitation involves the choice of studies themselves. I focused on new and emerging phenomena in clinical psychology. In 2020, this was the effect of the pandemic lockdown. In 2022, this was the emerging use of digital mental health apps in Australia, and in 2024, this was the increase in ADHD diagnoses in middle-class adults. I chose studies that I believed were limited by the hegemonic theory that clinical psychology used to understand the phenomenon. Nevertheless, other cultural-clinical issues could have been investigated, and these choices would have led to different outcomes.

Another methodological limitation is that all studies used convenience-based samples. The COVID lockdown study used a ‘sample’ of diarists who were recruited via convenient means, and the ADHD study used participants recruited through Facebook. The e-therapy study found participants through an undergraduate psychology course at a prestigious Australian university. All these samples represent a somewhat slim sliver of Western modern society. Despite warnings that the findings of these studies should not be uncritically generalised to other populations, there remains the possibility that these findings from predominantly white, Western and privileged samples might further privilege this worldview. The extent to which these sample characteristics perpetuate psychology's tradition of extrapolating from narrow samples to make broader claims about humanity warrants careful consideration by the reader. Regardless, this possibility cannot be ignored.

Limitations related to critical perspective

Moreover, the critiques I make of mainstream clinical psychology could be considered somewhat one-sided. Researchers with a more positivist, realist, or scientific orientation might rightly seek their 'right of reply' to the critiques presented. I admit that there is less engagement with potential counterarguments from within mainstream psychology on how cultural insights are already being integrated in some mainstream practices. Critical psychology is sometimes integrated into clinical psychology indirectly via the psychoanalytic tradition (Parker, 2015). Narrative therapies have, for some time now, embraced a social constructionist and relativist approach to therapy (White & Epston, 1990). Ryder and colleagues (2011) introduced the concept of cultural-clinical psychology over a decade ago, urging clinicians and researchers to examine and loosen their grip on predominantly Western cultural assumptions. All these show that clinical psychology has, and most likely will continue to, seek ways of challenging mainstream cultural assumptions in the field.

In response to these limitations, further research may continue to explore clinical issues in various contexts. Clinical psychology still confronts issues that were almost non-existent in the field a decade or two ago. Future research could further explore the cultural embeddedness of these clinical phenomena from other theoretically diverse viewpoints. These could use different methods, examine other cultural contexts, and investigate other clinical issues through an interactionist lens.

Conclusion:

This thesis undertook a critical examination of clinical psychology, challenging its often-unacknowledged cultural relativity and alignment with a purportedly universal, scientific paradigm. I argued that clinical psychology tends to overlook social, political, and historical contexts that shape individual psychology. Such an oversight is aided by its reliance on positivist assumptions, which limit an exploration of meaning-making. This hinders mainstream clinical psychology and makes it blind to Western cultural biases such as individualism, internalism, and an uncritical infusion of neoliberal values. The central contention is that psychological suffering and relief are not timeless, a-contextual human universals; rather, they are profoundly and dynamically co-constructed through cultural processes. Furthermore, many emerging phenomena in clinical psychology could benefit from an analysis based on these premises.

To show how such an approach might be applied, I chose to explore three distinct and emerging phenomena in clinical psychology. These case studies were chosen because they represented contemporaneous issues that I, as a clinician, was confronted with in my clinical work. These issues were: the construction of time and distress during the COVID pandemic lockdown; the ideological underpinnings of digital mental health apps; and an exploration of the socio-cultural contexts where adult ADHD emerges from. The COVID study, guided by a focus on narrative, found that cultural ‘formatting guidelines’ contributed to how distress and time were experienced. These narrative structures existed within an interconnected semiosphere and were linked to ideals surrounding work, gender, and spirituality. The examination of digital mental-health apps showed how these technologies are more than mere conduits of pre-established clinical knowledge. Instead, they were mediators of experience, amplifying some cultural values (abstraction, privacy and self-reliance) whilst obscuring the therapeutic role of interpersonal connection. Finally, the ADHD study explored how macro- and micro-social conditions can create ‘niches’ that both enable and restrain symptoms, functioning, and identity. There existed a niche where cultural frameworks that conceptualised the self as neurochemical and agency as psychiatrically limited, when facilitated by specific social conditions, ADHD could emerge. Taken together, these studies brought the cultural co-construction of psychological phenomena into focus.

These case studies employed constructionist qualitative methods to give a deeper and more nuanced appreciation of each topic. Each study was guided by theoretical perspectives that are not often used when investigating clinical subjects, such as semiotic analysis, postphenomenology and eco-social analysis. These theoretical lenses captured aspects of meaning-making that positivist approaches frequently miss. As such, when taken in combination, these studies highlighted that suffering and adjustment are not just phenomena to be predicted and controlled with science, but also made-sense-of with the humanities.

I explored a few different ways that clinical psychology could respond to the integration of cultural- and clinical-psychology. One such way could be by integrating a culturally oriented ‘outward gaze’ in case formulation. This would mean moving beyond the internalistic focus on mental mechanisms to also include the ways that cultural narratives, the values embedded within technologies, and macro-social structures might contribute to suffering and relief. Not only would this make clinical psychology more comprehensive, but it would also highlight the ways in which it, too, fits within the wider cultural environment. Another response could take place in psychological therapy. This would mean that clinicians become aware of cultural tendencies, such as individualism or internalism, and acknowledge the ways these are utilised in therapeutic encounters. Conscious and ethical utilisation of these tendencies can enable communication, help aid understanding and facilitate change. In this way, therapy can continue to be acceptable and culturally intelligible whilst not succumbing to the essentialising outcomes that might result from a non-critical stance.

This research also has its limitations. It may focus too sharply on cultural co-construction of phenomena, and thereby give the impression that other paradigms for understanding psychology are wrong. It may also have suffered from the use of small and narrow samples (people), as well as from my own positionality as a researcher, which may have led to some potential interpretations being missed. However, overall, this thesis has shown how psychological suffering and relief can be understood as relative and contextual within specific local contexts, while also being deeply intertwined with broader social, political, and historical contexts. Clinical psychology as a practical and research endeavour can benefit from the perspectives that cultural psychology brings. By viewing itself as a cultural practice situated within various contexts, it can shed its ethically dubious, universalising claims and be free to embrace multiple dynamic and diverse realities.

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Appendix 1: Advertisement for participants in study 1

The advertisement for participation in the current study made and disseminated by researcher three:

"I am a professor at the University of Oslo. This is a study about the experience of people in a time of anxiety and preoccupation.
People are facing a moment of concern and an exceptional experience, due to the spreading of the COVID-19 epidemy. Some people are affected, some other are in quarantine. Some people in different countries are simply requested to stay home.
I ask whoever is willing to share his/her experience of these days to join a qualitative international diary-study.
The simple task is to write about your personal experience during the period of emergency. You can write about your feelings, thoughts, actions, using text or also using images. You are requested to send once per week your messages.
I will collect your diaries and analyse them in order to understand what we share as human beings facing such difficulties. All your diaries will be treated anonymously and no personal information except your age, gender, town and job will be retained or disseminated. You can withdraw at any time from the study. Only a summary of results will be published, without individual information. At the end of the study, I will tell you about the findings.
If you want to participate and you give your consent to the terms above, just post here writing accept, and I will include you in a private group where you can write your posts for a period of 1 month. You can also invite other persons who can be interested in participating.

Informazioni sullo studio
Sono un professore dell'Università di Oslo. Questo è uno studio sull'esperienza delle persone in un momento di incertezza e ansia.
Le persone stanno affrontando un momento di preoccupazione e un'esperienza eccezionale, a causa della diffusione dell'epidemia di COVID-19. Alcune persone ne sono colpite, altre sono in quarantena. Ad alcune persone in diversi paesi viene semplicemente richiesto di rimanere a casa.
Chiedo a chiunque sia disposto a condividere la propria esperienza di questi giorni di partecipare a uno studio-diario internazionale qualitativo.
Il semplice compito è scrivere sulla tua esperienza personale durante il periodo di emergenza. Puoi scrivere dei tuoi sentimenti, pensieri, azioni, usando il testo o anche usando le immagini. Si richiede di inviare i messaggi una volta alla settimana.
Raccoglierò i tuoi diari e li analizzerò per capire cosa condividiamo come esseri umani che affrontano tali difficoltà. Tutti i tuoi diari saranno trattati in modo anonimo e nessuna informazione personale esclude la tua età, sesso, città e

lavoro sarà conservata o divulgata. Puoi ritirarti in qualsiasi momento dallo studio. Verrà pubblicato solo un riepilogo dei risultati, senza informazioni individuali. Alla fine dello studio, ti parlerò dei risultati.
Se vuoi partecipare e dai il tuo consenso ai termini di cui sopra, pubblica semplicemente qui scrivendo accetta e ti includerò in un gruppo privato in cui puoi scrivere i tuoi messaggi per un period”

Appendix 2: Ethics approvals

NSD NORSK SENTER FOR FORSKNINGSDATA

Notification Form 585083

Last updated

07.05.2020

Which personal data will be processed?

- Name (also with signature/written consent)
- Email address, IP address or other online identifier
- Background data that can identify a person
- Other data that can identify a person

Type of data

You have indicated that you will be processing background data that can identify individual persons, describe which

Participants will write personal diaries using Facebook posts on closed group. They are identified by their FB profile names. They can talk about themselves and other persons (but they are explicitly required not to use real names).

You have indicated that you will be processing other data that can identify individual persons, describe which

I am not sure what kind of information people can provide in their diaries.

Will you be processing special categories of personal data or personal data relating to criminal convictions and offences?

No

Project information

Project title

Life with COVID19

If the collected personal data will be used for other purposes, please describe

n/a

Explain why the processing of personal data is necessary
It can be necessary to provide some description of the person in the qualitative analysis of the results (e.g. telling where the person lives or the job or the family structure) if it is relvant in the diary. However, I will never use real names.

External funding

Type of project

Research Project

Sample 1

Describe the sample

Adults in different countries

Recruitment or selection of the sample

Subjects are recruited through an event page on facebook and disseminated through friends lists.

Age

18 - 90

Will you include adults (18 years and over) who do not have the capacity to consent?

No

Personal data relating to sample 1

- Name (also with signature/written consent)
- Email address, IP address or other online identifier
- Background data that can identify a person
- Other data that can identify a person

How will you collect data relating to sample 1?

Online survey

Data controller

Data controller (institution responsible for the project)

Universitetet i Oslo / Det utdanningsvitenskapelige fakultet / Institutt for spesialpedagogikk

Project leader (academic employee/supervisor or PhD candidate)

Luca Tateo, luca.tateoisp.uio.no, tlf: 393925178418

Will the responsibility of the data controller be shared with other institutions (joint data controllers)?

No

Legal basis for processing general categories of personal data

Consent (art. 6 nr. 1 a)

Information for sample 1

Will you inform the sample about the processing of their personal data?

Yes

How?

Written information (on paper or electronically)

Third Persons

Will you be processing data relating to third persons?

No

Processing

Documentation

How will consent be documented?

- Electronically (email, e-form, digital signature)

How can consent be withdrawn?

just writing to me

How can data subjects get access to their personal data or have their personal data corrected or deleted?

they have access to the facebook group and can visualize or delete their posts until the completion of the data collection. After, I will save the data on UiO computer and deleted the FB group. Participants cna write to me for asking cancellation or changes.

Total number of data subjects in the project

1-99

Approvals

Will you obtain any of the following approvals or permits for the project?

Where will the personal data be processed?

- Computer belonging to the data controller
- External service or network (data processor)

Who will be processing/have access to the collected personal data?

- Project leader
- Data processor

Which data processor will be processing/have access to the collected personal data?

TSD

Will the collected personal data be transferred/made available to a third country or international organisation outside the EU/EEA?

No

Additional information

Information Security

Will directly identifiable data be stored separately from the rest of the collected data (e.g. in a scrambling key)?

No

Explain why directly identifiable data will be stored together with the rest of the collected data

the data consists of text files conaining the diaries, the participants sign the diaries with a nickname of their choice. This is the only kind of data that will be stored.

Which technical and practical measures will be used to secure the personal data?

- Personal data will be anonymised as soon as no longer needed
- Restricted access

Duration of processing

Project period

17.03.2020 - 01.12.2021

Will personal data be stored after the end of the project?

No, all collected data will be deleted at the end of the project

Will the data subjects be identifiable (directly or indirectly) in the thesis/publications from the project?

No
Dear sirs,
I have hopefully implemented the requested changes.

1. I have posted in the group a new constent information letter (see examle uploaded) following NSD list of requirements and template
2. Facebook is the best tool I have for this kind of data, and participants are all already in my friends' list and they are all adults. I will delete the group as soon as the data collection ends. The group is closed and I am the only administrator. After the study, I will formally ak FB to permanently delete all the information, too

3. I have asked participants not to write sensitive information in the presentation letter. In case this information is present, I will delete it.

I have updated the processing procedure:
1) participants have been invited
2) Participants are writing their diaries and will send it to me via mail, choosing a nickname
3) I will archive the data on TSD
4) Participants have received the addendum to consent in which they are informed of the participation of the colleagues from Sydney University
5) I will share anonymized data with the Sydney colleagues by granting them access via TSD

Research Integrity & Ethics Administration
HUMAN RESEARCH ETHICS COMMITTEE

Thursday, 25 November 2021

Assoc Prof Paul Rhodes

Psychology; Faculty of Science

Email: p.rhodes@sydney.edu.au

Dear Paul,

The University of Sydney Human Research Ethics Committee (HREC) has considered your application.

I am pleased to inform you that after consideration of your response, your project has been approved.

Details of the approval are as follows:

Project No.:	**2021/709**
Project Title:	**An investigation into the realities of cyber-therapy users.**
Authorised Personnel:	**Rhodes Paul; Ruse Jesse; Schraube Ernst;**
Approval Period:	**25/11/2021** to **25/11/2025**
First Annual Report Due:	**25/11/2022**

Documents Approved:

Date Uploaded	**Version Number**	**Document Name**
19/11/2021	Version 1.1	Survey questions (for qualtrics) - updated
08/10/2021	Version 1.2	Participant consent form - Questionnaire survey
08/10/2021	Version 1.2	Participant consent form - interview
08/10/2021	Version 1.2	Participant Information statement- updated
06/09/2021	Version 1	SONA advertisements v1
09/08/2021	Version 1	Interview Prompts
09/08/2021	Version 1	Appendix - Potential apps/programs used by participants

Condition/s of Approval

- Research must be conducted according to the approved proposal.

- An annual progress report must be submitted to the Ethics Office on or before the anniversary of approval and on completion of the project.

- You must report as soon as practicable anything that might warrant review of ethical approval of the project including:
  - ○ Serious or unexpected adverse events (which should be reported within 72 hours).
  - ○ Unforeseen events that might affect continued ethical acceptability of the project.

- Any changes to the proposal must be approved prior to their implementation (except where an amendment is undertaken to eliminate *immediate* risk to participants).

esearch Integrity & Ethics Administration
Research Portfolio
Level 3, F23 Administration Building
The University of Sydney
NSW 2006 Australia

T +61 2 9036 9161
E human.ethics@sydney.edu.au
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ABN 15 211 513
464 CRICOS
00026A

- Personnel working on this project must be sufficiently qualified by education, training and experience for their role, or adequately supervised. Changes to personnel must be reported and approved.

- Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, as relevant to this project.

- Data and primary materials must be retained and stored in accordance with the relevant legislation and University guidelines.

- Ethics approval is dependent upon ongoing compliance of the research with the *National Statement on Ethical Conduct in Human Research*, the *Australian Code for the Responsible Conduct of Research*, applicable legal requirements, and with University policies, procedures and governance requirements.

- The Ethics Office may conduct audits on approved projects.

- The Chief Investigator has ultimate responsibility for the conduct of the research and is responsible for ensuring all others involved will conduct the research in accordance with the above.

This letter constitutes ethical approval only.

Please contact the Ethics Office should you require further information or clarification.

Sincerely,

Associate Professor Mark Arnold
Chair, Human Research Ethics Committee (HREC 2)

The University of Sydney of Sydney HRECs are constituted and operate in accordance with the

National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2018) and the NHMRC's Australian Code for the Responsible Conduct of Research (2018)

Research Integrity & Ethics Administration
Human Research Ethics Committee

Friday, 7 July 2023

Assoc Prof Paul Rhodes

Psychology; Faculty of Science

Email: p.rhodes@sydney.edu.au

Dear Paul,

The University of Sydney Human Research Ethics Committee (HREC) has considered your application.

After consideration of your response to the comments raised your project has been approved.

Approval is granted for a period of four years from **7/72023 to 7/72027**

Project No.: **2023/388**

Project Title: **ADHD in ecosocial niches**

Authorised Personnel: **Rhodes Paul; Ruse Jesse;**

First Annual Report due: 7/72024

Documents Approved:

Date Uploaded	Version number	Document Name
29/05/2023	Version 1	pcf_mar-2023_Ethics application_ADHD in ecosocial niches
29/05/2023	Version 1	Interview prompts_ADHD in ecosocial niches
29/05/2023	Version 1	poster v2_ADHD in ecosocial niches
03/07/2023	Version 2	PIS - v2 - final
03/07/2023	Version 1	Advertisement v2

Condition/s of Approval

- Research must be conducted according to the approved proposal.
- An annual progress report must be submitted to the Ethics Office on or before the anniversary of approval and on completion of the project.
- You must report as soon as practicable anything that might warrant review of ethical approval of the project including:
  - Serious or unexpected adverse events (which should be reported within 72 hours).
  - Unforeseen events that might affect continued ethical acceptability of the project.

- Any changes to the proposal must be approved prior to their implementation (except where an amendment is undertaken to eliminate *immediate* risk to participants).
- Personnel working on this project must be sufficiently qualified by education, training and experience for their role, or adequately supervised. Changes to personnel must be reported and approved.
- Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, as relevant to this project.
- Data and primary materials must be retained and stored in accordance with the relevant legislation and University guidelines.
- Ethics approval is dependent upon ongoing compliance of the research with the *National Statement on Ethical Conduct in Human Research*, the *Australian Code for the Responsible Conduct of Research*, applicable legal requirements, and with University policies, procedures and governance requirements.
- The Ethics Office may conduct audits on approved projects.
- The Chief Investigator has ultimate responsibility for the conduct of the research and is responsible for ensuring all others involved will conduct the research in accordance with the above.

- The Clinical Trials Support Office has been notified as outlined in the University's Clinical Trials Policy where a clinical trial is being undertaken.

This letter constitutes ethical approval only.

Please contact the Ethics Office should you require further information or clarification.

Sincerely,

Associate Professor Stephen Fuller
Chair
Human Research Ethics Committee (HREC 2)

The University of Sydney HRECs are constituted and operate in accordance with the National

Health and Medical Research Council's (NHMRC) current National Statement on Ethical Conduct in Human Research (2018) and the NHMRC's current Australian Code for the Responsible Conduct of Research (2018).