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# Culture as a Variable in Psychotherapy

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## Abstract

This paper reviews the impact of culture on the therapeutic relationship. It suggests that difficulties often arise within the inter-subjective milieu when the therapist fails to maintain an attentional stance with regard to their own values, beliefs and world-views and the way these contrast with those of the client in cross-cultural psychotherapy.

## Introduction

The essentially bicultural society of New Zealand is becoming increasingly multicultural. Immigrants from other parts of the world are faced with the severe stress of acculturation here. They may also be suffering from the aftermath of trauma endured in their own country. Psychotherapy with these clients of varying cultural background is extremely complex.

Literature on psychotherapy rarely explores matters concerning culture. This may be due to the fact that psychotherapy evolved in the West and therapy often occurs in a monocultural setting. However, when psychotherapy happens in a cross-cultural setting, culture furnishes an undeniable variable. It has a profound impact on the process.

This paper undertakes to explore the answer to the question: *What are the effects of culture in psychotherapy in a cross-cultural setting?*

## Definition of cross-cultural therapy

Cross-cultural psychotherapy is a therapy relationship in which two or more of the participants differ with respect to cultural background, values and life-style (Sue, & Sue: 1990).

### *Culture and social constructionism*

A culture is a community of individuals who perceive their world in a particular manner, and who share a common meaning and value system (Howard: 1991). Social constructionism describes the process of coming to know the world

through a socially negotiated construction. The social constructionist view emphasises the ways in which people collectively perceive, interpret and construct experience in order to make meaning of it and thereby shape their world.

The semantic dimension of social constructionism focuses on the relationship between language and culture. It also emphasises the intersubjective nature of knowledge. Social constructionism is not concerned with ontology and considers objective knowledge of reality as unattainable. The reality referred to is a consensual reality where meaning is communally constructed through dialogue (de Shazer and Berg: 1992). Knowledge is located neither in the observed nor in the observer but in the intermediate space, in the sociocultural arena. When knowledge is constructed as embedded in culture, notions of health and psychopathology become arbitrary. No particular conceptualisation can claim universal relevance. Concepts of the child, of mother's love, of the self and other constructs remain essentially culture-bound (Gergen: 1985).

This is relevant to the practice of psychotherapy because the process is concerned with the creation of meaning. In a cross-cultural setting, where the client's and therapist's world-views differ, the intersubjective milieu is permeated with "unthought" forces. If the therapist fails to recognise and accept the world-view of the clients, there can be detrimental consequences.

#### *Culturally mediated notions of wellness and illness and approaches to healing*

In the development of psychoanalytic theory, culture is not regarded as primary. Many phenomena viewed as pathological in psychoanalytic terms can be seen as social realities in an anthropological view. Psychopathology can be seen as the individual's representations of symbolic themes concerning social relations (Lewis, Balla, & Shanok: 1979). Subjective experience of distress is not the same in all cultures and different cultural groups experience different emotions. Affective experience of any kind includes not only what is happening but also what the person makes of it. The phenomenon of depression in the Western world provides a useful illustration. What is experienced is not just depression but the subject's own interpretation of it. I have observed that depressed clients carry the added burden of guilt about being depressed due to the Western world-view that negative emotional states are objectionable. This culture-bound response is an indication of the social construction of meaning.

Psychoanalysis has a model of human personality centred around biography and the individual's unconscious. Early childhood experiences and relationship with parents are seen as shaping the personality. Psychosexual and interpersonal traumas are seen as affecting the healthy development of personality in the child. The healing process in psychoanalysis is through self-exploration which may lead to personality transformation. This model of healing is inadequate for some other cultures.

Jung (1964) stated that it is presumptuous to claim that we understand the human psyche. For him, healing comes from the collective unconscious which has the wisdom of the ages, beyond the wisdom and knowledge of any therapist or any school of psychotherapy. Jung's notion of healing parallels the concepts of healing in Eastern cultures, which incorporate faith and religion.

Between the West and the East there are stark differences in the goals and objectives of psychotherapy. The Western concept of mental health involves a search for intrapsychic integration and attainment of autonomy. This is at variance with Eastern concepts where therapy is focused on reintegration of the individual into their familial and social matrix.

### *Culture-bound issues in psychotherapy*

A culture consists of explicit and implicit behaviour patterns acquired and transmitted through symbols. A culture exists at two levels, the observable phenomena and the realm of ideas. At the first level the pattern of life within the respective cultural group is clearly visible. At the second level there is the subtly organised system of knowledge and beliefs that allows a cultural group to structure its experience.

The second realm of culture furnishes a challenge in cross-cultural therapy. In a given culture an individual acquires systems of values, beliefs and meaning, learns a particular language and acquires norms of behaviour and patterns of experiencing the environment. By habitually thinking in a particular language or in a set of beliefs, these forms of thought become structured in the biology of the individual of a particular culture. (Thompson, Donegan, & Lavond: 1986). In other words, the sociocultural environment has a physical dimension for the individual. The culture specific neural organisations influence most aspects of cognitive processing by individuals, forming cognitive schemas and structuring their experience of the world. In a cross-cultural therapy context, each member of the therapeutic dyad carries unique vehicles of thought, conceptual structures of space, time and of the natural world.

Psychotherapy presupposes certain innate qualities in the persons concerned. The capacity for listening and empathic appreciation for another's experience is paramount. In the therapeutic relationship, there is an ongoing trial identification (Casement: 1985). The therapist attempts to place herself in the exact spot where the client is. How is this possible in the cross-cultural context? Do cultural differences between the dyads impede trial-identification? Does the cultural contrast in their life experience curtail empathic immersion in the psychological experience of the other? Where there are few resonating experiences in the therapist and the client, how do they maintain attunement with the other? These are important questions in cross-cultural therapy.

### **Attitudes, beliefs and behaviours of therapists and supervisors**

Rosen and Frank (1962) studied therapeutic encounters between black clients and white therapists. They recognised that the inter-racial situations embodied deeply rooted racial beliefs and attitudes. They observed that pairing in individual therapy or even in group therapy was determined by the cultural attitudes of whites and blacks towards each other. The authors noticed that black clients bring predisposing attitudes of resentful anxiety and distrust to the therapeutic relationship. The therapists revealed unconscious prejudice which manifested through behaviours such as insecurity, reaction formation, guilt feelings and rejection. On the other hand, if the therapist was black, over-identification with the black patient was the consequence.

Grier (1967) has stressed the role of race in the transference process. It was observed that the therapist's race from the outset evoked certain unconscious dynamics in clients from other races. Gardner (1971) studied therapeutic encounters under two racial situations, white therapist–black client and black therapist–white client. He observed several countertransference patterns which include racial guilt on the part of the white therapist, the need for a dominant role and the desire for a broadening of social experiences.

Inter-racial psychotherapy studies conclude that psychotherapists carry the attitudes, values and biases of the culture of which they are a part and therefore are not immune to cultural conditioning. Therefore therapists need to be concerned about the potential influence their cultural conditioning exerts on the intersubjective context.

## Transference and countertransference

To illustrate culture-bound countertransference, I shall describe an actual therapy situation from my practice. Hema, a twenty-three year old Indian woman, was referred to me after a failed suicide attempt. The clinicians who assessed her at the hospital were from another culture. In their contact with Hema, they experienced her as polite but reluctant to engage. They felt very concerned for her safety.

In my initial session with Hema, I experienced her as candid and co-operative. I was struck by her ready trust. As I became aware of my countertransference, I was able to identify the cultural variables operating between us. I recognised that Hema was perceiving me as an older, trust-worthy relative who would give her spiritual advice and even act on her behalf. I also realised that Hema was not seeking transformative insight into emotional conflicts. She wanted a spiritual resolution to her problems. She was also concerned with restoring harmony within her immediate and extended family.

The fundamental questions I had to address in working with Hema were related to the meaning of healing and the role of religion and spirituality in the process. This led to questions concerning the nature of self and the nature of client -therapist relationship.

The cultural, ethnic and religious elements of cross-cultural therapy engender characteristic issues. External reality may intrude into the therapeutic space and may appear in the manifest and latent content of therapeutic interaction. In an initial session a Caucasian male client commented on my idiosyncratic use of English. I perceived this as a transference interaction coloured by cultural differences, which I raised with the client.

I am also aware that cultural differences can be used by the client in the service of resistance. A female Caucasian client, very early on in therapy began to project her racism on to the cultural symbols in my office. When I interpreted this, she was able to get in touch with her racial prejudices against me.

I have strong countertransference responses in these clinical situations. I am aware of the potential for projection of my impulses onto the client. I could also fall into over-identification with the client's devaluation of me. I manage these countertransference responses by addressing cultural, ethnic and religious differences in therapy. At times cultural attack can temporarily impair my technical skills, empathy and diagnostic acumen. It can affect the stability of my self-esteem. When I am under attack from clients on ethnic or cultural

lines, the therapeutic path lies in the exploration of the meaning of cultural and racial differences. Internally, I am deeply wounded by the attack but am able to sublimate and create meaning out of this emotional pain. I also explore whether the client's attack on me is an avoidance of their psychological pain. Cross-cultural therapy requires me to explore my internalised rules of racial categorisation and ethnic stereotypes. I have been able to differentiate a self from the culture of origin with enough space for thinking and reflecting.

Working with clients from non-Western cultures has exerted profound influence on how I work with Western clients. My Indian supervisee discusses in supervision a Caucasian client who is married to a Pacific Islander. The client brings to therapy the conflict regarding the husband's extended family. In her view the husband's priority is his extended family, not wife and children. The client's conflict indicates a clash between world-views. The main supervisory issue is the possibility of the Indian supervisee's identification with the husband because of similarity in their world-views.

Being aware of the impact of cultural variables in therapy has influenced my practice. When I assess a new client I am interested in knowing about as many of the members of their families as possible including grandparents and great grandparents. I enquire about how long people lived in a particular place and why they moved. If clients do not remember, I wonder how these events were erased from their memory. A lack of connection with family histories and myths seems to be an important part of the alienation felt by so many clients.

Hearing non-Western clients' relational narrative alerts me to the Western paradigm of the individual. Western clients want to move away from home in search of autonomy. I hold their aloneness—which is due to the break from significant relationships, places and historical roots—and work with it. Working with cultures where family and community still have great importance for the person reminds me of the psychoanalytic schools where self-in-relation is emphasised (Mitchell: 1988).

## **Conclusion**

I have lived in cross-cultural settings over the past 22 years. In the last 10 years I have worked psychotherapeutically with clients of different cultural and ethnic backgrounds. My supervisees also come from various cultures. From my clinical experience and through research I have drawn the following conclusions.

Postmodern philosophies see reality as a by-product of human interaction, a social construction mediated by language and contextualised by culture. Psychotherapy is influenced by postmodern thinking. Within the field of psychoanalysis, postmodern dialogue is evident between intrapsychic schools and experiential schools (Mitchell: 1988). The outcome of this dialogue is an evolution towards a more relational perspective.

Levinas proposed the concept of heteronomy where one shares the phenomenal world with others, allowing others to limit one's autonomy (Matthews: 1996). The fundamental otherness of the culturally and racially different other must not be made 'the same' through a process of assimilation.

Therapists need to remain alert to the pitfalls of applying theory to fit the culturally other into their world-view. The therapist's awareness of her own assumptions, values and biases will alert her to the client's world-view. The movement from being culturally unaware to being aware of one's own cultural matrix opens the way to valuing and respecting cultural difference in the other. It is evident that a culturally blind psychotherapist is likely to impose her world-picture onto a client from another culture. Consequently the therapist may unwittingly engage in an act of cultural oppression. A culture-sensitive psychotherapist is willing to acknowledge her own racist attitudes, beliefs and feelings. Preconceived notions of psychopathology are suspect because cultures are too complex to fit universal descriptions of mental health or illness.

The integral part of being human is our capacity for imagination. Without imaginative expansion, human life becomes a dull animal existence. It could be argued that in psychotherapy across cultures, it is the human person's capacity for imagination that spans the space between separate cultures. Also, for human beings, experiencing is primary. In the course of cross-cultural therapy, the client's capacity to attend to and find ways of articulating the felt sense of her being can bring about the narrowing of the cultural gap.

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