Culture and Psychotherapy: Review and Practical Guidelines
Wen-Shing Tseng
TRANSCULT PSYCHIATRY 1999; 36; 131
DOI: 10.1177/136346159903600201

The online version of this article can be found at:
http://tps.sagepub.com/cgi/content/abstract/36/2/131

Published by:
SAGE Publications
http://www.sagepublications.com

Additional services and information for Transcultural Psychiatry can be found at:

Email Alerts: http://tps.sagepub.com/cgi/alerts

Subscriptions: http://tps.sagepub.com/subscriptions

Reprints: http://www.sagepub.com/journalsReprints.nav

Permissions: http://www.sagepub.com/journalsPermissions.nav

Citations (this article cites 58 articles hosted on the SAGE Journals Online and HighWire Press platforms):
http://tps.sagepub.com/cgi/content/refs/36/2/131
Culture and Psychotherapy: Review and Practical Guidelines

WEN-SHING TSENG
University of Hawai‘i, USA

Abstract In this overview, the subject of culture and psychotherapy is considered broadly from five perspectives: (i) culture-embedded indigenous healing practices, (ii) culture-influenced ‘unique’ psychotherapies, (iii) cultural elements in ‘mainstream’ therapies, (iv) the practice of psychotherapy in different societies, and (v) intercultural psychotherapy. Various modes of therapy are compared with respect to their basic orientations, techniques and mechanisms of therapy. Culture-relevant psychotherapy requires technical adjustment, theoretical modifications and philosophical reconsideration. Practical suggestions are made regarding areas that need attention in order to conduct culturally appropriate psychotherapy.

Key words culture • ethnicity • indigenous healing • psychotherapy • practical guidelines

Contemporary mental health workers have come to realize that cultural dimensions can not be ignored in the practice of psychotherapy – a clinical process that is primarily focused on a person’s emotional life and utilizes psychological methods to resolve psychological problems and improve the quality of mental life (Abel & Metraux, 1974). How cultural factors affect psychotherapy and the kinds of cultural adjustments that are needed to provide effective therapy are common concerns that deserve attention, not
only from a scientific point of view, but also from a practical perspective (Tseng & McDermott, 1981).

Although psychotherapy can be defined as any psychological procedure that is aimed at relieving an individual’s psychological suffering, as pointed out by Prince (1980), such a definition can become problematic when psychotherapy is discussed from a cultural standpoint, particularly in reference to indigenous folk-healing practices. The emphasis on ‘talk’ and the gaining of ‘intellectual insight’ (Berelson & Steiner, 1964), or the establishment of a ‘personal relationship’ between therapist and client (Frank, 1961) as the core of the therapeutic procedure, become too narrow and restricted for the discussion of psychotherapy from a cross-cultural perspective. Clearly a broader definition of psychotherapy is needed.

In this overview, ‘psychotherapy’ will be defined broadly as a special practice involving a designated healer (or therapist) and an identified client (or patient), with the particular purpose of solving a problem from which the client is suffering or promoting the health of the client’s mind. The practice may take various forms, such as a religious healing ceremony, a special experience or professionally defined interaction between the healer and the client. The fundamental orientation may be supernatural, natural, biomedical, socio-philosophical or psychological. In folk therapy, healing practices, ceremonies or health-promoting exercises may be applied to resolve the problems, without being perceived as ‘psychological therapy.’ In contrast, in other practices, particularly professional psychotherapy, the therapist and the patient both recognize that the procedure is primarily for ‘treating or resolving a psychological problem’ and that they are engaged in an activity for that perceived purpose. Thus, there exists a broad spectrum of ‘psychotherapy,’ in terms of basic orientations, methods and goals to be achieved.

In order to comprehend the nature of psychotherapy broadly from a cultural perspective, this article divides different indigenous and modern therapeutic modes into three subgroups for review and comparison: (i) culture-embedded indigenous healing practices, (ii) culture-influenced unique therapies, and (iii) culture-related common therapies. The adjectives ‘culture-embedded,’ ‘culture-influenced’ and ‘culture-related’ are used to indicate the different natures and degrees of the relations of these therapies with culture – namely, from being ‘deeply embedded’ to ‘strongly influenced’ to ‘simply related.’ Several examples are presented in each of these three subgroups for comparison in the areas of therapeutic orientations, operations, mechanisms and goals of therapy (Table 1). The article then explores the professional practice of psychotherapy in different societies and the development of intercultural therapy. The review concludes with guidelines for the practice of culture-relevant psychotherapy.
CULTURE-EMBEDDED INDIGENOUS HEALING PRACTICES

Most early studies of indigenous or folk-healing practices were carried out by anthropologists as part of their field work. Since the 1950s, these practices have attracted a great deal of attention among clinicians as well. Among the well-known publications in this area are Jerome D. Frank’s *Persuasion and Healing* (1961), Ari Kiev’s *Magic, Faith, and Healing* (1964) and E. Fuller Torrey’s *Witchdoctors and Psychiatrists* (1986). An extensive review of religious healing appears in a recent issue of this journal (Csordas & Lewton, 1998).

As the terms were used by Jilek (1994: 221), ‘indigenous, folk, or traditional healing’ refers to ‘non-orthodox therapeutic practices based on indigenous cultural traditions and operating outside official health care systems.’ Although the practices serve to heal or resolve ‘problems,’ they are not normally considered by either the healer or the client to be ‘psychological therapy’ for the client’s mental problems. Instead, the practices are usually recognized as religious ceremonies or healing exercises related to supernatural or natural powers. However, from a mental health point of view, indigenous healing practices often provide psychotherapeutic effects for the client and can be studied as ‘folk psychotherapy.’

SPIRIT MEDIUMSHIP (TRANCE-BASED HEALING SYSTEMS)

Spirit mediumship refers broadly to a situation in which the healer or client, or both, experiences alternate states of consciousness in the form of dissociation or a possessed state at the time of the healing ritual. Three patterns of dissociation or possession are recognized. In shamanism, it is the healer who experiences the dissociation or possessed state. The healer is considered to be possessed by a supernatural being, which enables him to provide the service of healing. The proven authority of the healer with the supernatural power is the main force of the therapeutic mechanism. In contrast to this, in the zar ritual, both the healer and the client experience altered states of consciousness. With assistance from the healer, the client, in a dissociated state, will express his or her desire for fulfillment. Gratification of attention and wish-fulfillment are the essential mechanisms for healing. In a special religious healing practice observed in the Salvation Cult in Japan, it is only the clients (cult members) who are trained to experience altered states of consciousness. With the assistance of the healer, the client provides an explanation of the cause of the problem, as well as a suggestion for its resolution. From a psychotherapeutic point of view, it is important to distinguish which person is in an altered state of consciousness, as the mechanism of therapy differs depending on whether the healer or the client is dissociated.
<table>
<thead>
<tr>
<th>Examples of therapy</th>
<th>Orientation</th>
<th>Therapeutic operation</th>
<th>Special healing mechanism</th>
<th>Goals of therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture-embedded indigenous healing practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spirit mediumship</td>
<td>Supernatural</td>
<td>Altered state of consciousness</td>
<td>Belief in supernatural power, suggestions</td>
<td>Resolving ‘problems’</td>
</tr>
<tr>
<td>Shamanism</td>
<td>Symbolic interpretation</td>
<td>Revealing of wishes</td>
<td>Magical counteracting</td>
<td></td>
</tr>
<tr>
<td>Zor Ceremonies</td>
<td></td>
<td></td>
<td>Emotional catharsis</td>
<td></td>
</tr>
<tr>
<td>Religious healing ceremonies</td>
<td>Supernatural</td>
<td>Healing ceremony</td>
<td>Assuranse, suggestions</td>
<td>Restoring balance in life</td>
</tr>
<tr>
<td>Divination</td>
<td>Supernatural</td>
<td>Providing an ‘answer’</td>
<td>Finding a way to adjust ‘naming’ effects</td>
<td>Complying with divine instruction</td>
</tr>
<tr>
<td>Fortune-telling</td>
<td>Natural–supernatural</td>
<td>Providing guidance in making choices</td>
<td>Helping make decisions</td>
<td>Complying with rules of nature</td>
</tr>
<tr>
<td>Meditation</td>
<td>Somato-natural</td>
<td>Practice of meditation</td>
<td>Suggestion for counteracting</td>
<td></td>
</tr>
<tr>
<td>Yoga/Qigong</td>
<td></td>
<td></td>
<td>Tranquilizing effects</td>
<td>Harmonizing with nature</td>
</tr>
<tr>
<td>Culture-influenced unique therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatopsychotherapy</td>
<td>Somato-psychological</td>
<td>Supplementation</td>
<td>Suggestions</td>
<td>Restoring natural conditions</td>
</tr>
<tr>
<td>Mesmerism</td>
<td>Psychological</td>
<td>Recuperation</td>
<td>Legitimizing complaint</td>
<td></td>
</tr>
<tr>
<td>Rest therapy</td>
<td>Socio-religious</td>
<td>Group revealing and elaboration of conflict</td>
<td>Confession and apology</td>
<td>Restoring family–group relationships</td>
</tr>
<tr>
<td>Ho’oponopono</td>
<td>Psychological</td>
<td>Group confession and testimony</td>
<td>Group support and enforcement</td>
<td>Restoring normal life</td>
</tr>
<tr>
<td>A.A. group</td>
<td>Socio-psychological</td>
<td>Instruction and group activities</td>
<td>Sociopolitical sanction</td>
<td>Resuming status of normal member of society</td>
</tr>
<tr>
<td>Rapid integrated therapy</td>
<td>Socio-political</td>
<td>Self-examination</td>
<td>Group activation for recovery</td>
<td>Resuming ordinary family relationships</td>
</tr>
<tr>
<td>Naikan therapy</td>
<td>Philosophical-psychological</td>
<td>Programmed experience</td>
<td>Creating new life experiences</td>
<td></td>
</tr>
<tr>
<td>Morita therapy</td>
<td>Philosophical-psychological</td>
<td>Emphasis on confrontation</td>
<td>Change attitude and view</td>
<td>Fulfill self potentialities</td>
</tr>
<tr>
<td>Existential psychotherapy</td>
<td>Philosophical-psychological</td>
<td>Instruction and group enlightenment</td>
<td>Re-examination of self</td>
<td>Psychosocial change of self</td>
</tr>
<tr>
<td>Example of therapy</td>
<td>Orientation</td>
<td>Therapeutic operation</td>
<td>Special healing mechanism</td>
<td>Goals of therapy</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------</td>
<td>-----------------------</td>
<td>---------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Culture-related common therapy</td>
<td>Psychoanalysis</td>
<td>Psychological Listening with empathy</td>
<td>Transference</td>
<td>Resolving 'conflict'</td>
</tr>
<tr>
<td>Psychoanalytic therapy</td>
<td>Analytic interpretation</td>
<td>Psychological Insight</td>
<td>Striving for 'maturity'</td>
<td></td>
</tr>
<tr>
<td>Client-centered therapy</td>
<td>Psychological Self-actualization</td>
<td>Psychological Sanction of self-independence</td>
<td>Establishing self-independence</td>
<td></td>
</tr>
<tr>
<td>Behavior therapy</td>
<td>Psychological Behavior manipulation</td>
<td>Psychological Behavior manipulation</td>
<td>Establishing 'functional, adaptive' behavior</td>
<td></td>
</tr>
<tr>
<td>Family therapy</td>
<td>Psychological Working on family structure and Restoring family relations</td>
<td>Psychological Working on family structure and Restoring family relations</td>
<td>Establishing a functional family</td>
<td></td>
</tr>
<tr>
<td>Group therapy</td>
<td>Psychological Group learning and interaction</td>
<td>Psychological Group learning and interaction</td>
<td>Improving social relations</td>
<td></td>
</tr>
</tbody>
</table>
Shamanism

Shamanism is a particular form of spirit mediumship in which a specialist (the shaman), as a medium, is considered to be possessed by a spirit and to serve as a means of communication between human beings and the spirit world (Firth, 1964). The term 'shamanism' was initially used in a restricted sense, referring to a special kind of religious healing practice that originated and was prevalent in the north-east region of Asia; however, today, the term is used broadly, referring to any healing practice that involves spirit mediumship. Shamanism tends to predominate in food-gathering cultures, where the shaman most frequently performs a curing rite for the benefit of one or more patients (Lessa & Volt, 1965). Thus, shamanistic rites are not calendrical, but are contingent upon occasions of mishap or illness. Priests and priestly cult organizations, however, are characteristically found in the more structurally elaborate food-producing (agricultural) societies, where the common ceremony is a public rite performed for the benefit of a whole village or community. Such rites are often calendrical or performed at critical points in the ecological cycle (Turner, 1972). As part of the religious rite, a healing ceremony may be performed by the priest for members of the society who have need of it. Although typology for various practices can be made for the sake of discussion, in reality there is always some kind of transition or overlapping observed between shamanism and religious practices.

The geographic heartlands of shamanism were central and northern Eurasia, with widespread diffusion to southeast Asia and the Americas (Prince, 1980). Through a religious ceremony, a shaman can work himself into a trance state in which he is ‘possessed’ by a god. Rhythmic singing, dancing or praying (quiet meditation) seems to assist the self-induction of the trance state. Among native healers in North and South America, a psychedelic substance (such as cactus or peyote) is frequently used to induce an altered state of consciousness and a special psychic experience in a peyotism cult performance (Dobkin, 1968; La Barre, 1947). Whether the altered state of consciousness is substance- or self-induced, the healer is considered to be possessed by a supernatural power. The client can then consult the supernatural through the shaman for instructions on dealing with his or her problems.

The causes of problems are usually interpreted according to the folk concepts held by the culture – having to do with such things as loss of the soul, sorcery, spirit intrusion or violation of taboos. The disharmony with nature that is the basis of the concept of feng shui (geomantic belief) is often seen as the cause of problems by Chinese shamans. Although the interpretation is supernatural and symbolic in nature, it often projects and reflects an interpersonal causality that is perceived by the sensitive healer. The coping methods that are suggested are usually magical in nature, that is, prayer, the use of charms or the performance of a ritual ceremony for
extraction or exorcism. Utilizing supernatural powers, acting as an authority figure, making suggestions and providing hope are some of the shaman's main mechanisms for healing. The ultimate goal of the healing practice is to resolve the problems that the client is encountering.

**Zar Ceremonies**
The term *zar* refers to a ceremony as well as a class of spirits. According to reports, as pointed out by Prince (1980), *zar* ritual is observed mostly in Muslim societies in the Middle East, including Ethiopia, Egypt, Iraq, Kuwait, Sudan and Somaliland. *Zar* ritual is different from shamanism in that, in addition to the healer, the client also experiences a dissociated/possessed state.

Kennedy (1967) gave a clear picture of the *zar* ceremony practiced by Egyptian Nubians. The ceremony is essentially a means of dealing with the demonic power of evil (*zar* spirit) that may cause illness. The local people believe that a demon can indeed cause disorders and the patient becomes inextricably associated with that particular spirit for the rest of his life. Accordingly, the patient has the responsibility of satisfying this *zar* spirit with a special performance at least once a year, and incurs an obligation to attend the *zar* ceremonies of others.

The *zar* ceremony is primarily a female activity, reflecting Nubian social conditions of sex separation, low female status, restriction of women from religious participation, an unbalanced sex ratio, marital insecurity and relative isolation. All of those attending the ceremony wear new or clean clothing to please the spirits. The main patient usually wears a white gown, as much gold jewelry as possible and is heavily perfumed. The ceremony master begins the ceremony with a song and drumming. When a spirit associated with some person in the audience is called, that person begins to shake in her seat, dancing and trembling until she falls, exhausted, to the floor. Before the spirit consents to leave, it usually demands special favors, such as jewelry, new clothing or expensive foods. It is the duty of relatives and friends to gather around the prostrate woman and pacify the spirit. The whole tone of the ceremony is one of propitiation and persuasion, rather than coercion. The ceremony ends with an animal sacrifice and a feast.

The *zar* ceremony provides Nubian women with an ideal situation for the relief of persistent and regular anxieties and tensions arising from their life conditions. The goods demanded during the ceremony are all things that their husbands should provide. This fulfills a woman’s wish for attention and care. Emotional catharsis, revealing of concealed wishes, fulfillment of unsatisfied desires and compensation for the suppressed female role are some of the therapeutic mechanisms working in this therapeutic ritual. Restoring balance in real life is the hidden goal of the practice.
The Salvation Cult  A unique trance-based healing cult in Japan was reported by Lebra (1976). During the cult healing ceremony, it is the client (usually female), not the healer, who goes into a trance or possessed state, taking the role of a supernatural ‘other.’ During the altered state of consciousness, with close assistance or suggestions from the healer, the client reveals her problems and requests their resolution. It is interesting to note that it is the client, as a cult member, who is trained to perform self-analysis and provide suggestions for the resolution of her problems. The opportunity for catharsis, revealing internal conflicts and gratifying needs are some of the mechanisms operating in this form of trance-based healing. Again, this kind of healing cult works in a society in which the female members are unduly suppressed by the opposite sex. The goal of the practice is to restore balance in the client’s life through supernatural power.

Religious Healing Ceremonies

A distinction needs to be made between religion and a religious healing ceremony (Ponce, 1995). Religion refers to a system of belief in a divine or superhuman power or spiritual practice. As part of a religion, some people may perform special healing ceremonies to heal certain problems or disorders. There are various kinds of religious healing ceremonies observed in different societies that are considered by mental health workers to have therapeutic functions for participants. Csordas and Lewton (1998) have provided an extensive and up-to-date review in this journal.

E. E. H. Griffith and Mahy (1984) described the religious ceremony of ‘mourning’ practiced among members of the Spiritual Baptist Church in the West Indies. In a desire for spiritual strength and benefits, church members volunteer to participate. After ceremonial washing and anointing, the mourners are isolated in a small chamber at the back of the church and seclude themselves there for 7 days. During that time, each individual prays, fasts and experiences dreams and visions. The mourners claimed that they obtained many psychological benefits including a sense of relief in their moods, attainment of the ability to foresee and avoid danger, improvement in decision-making abilities, cures for physical illness, a heightened facility to communicate with God and to meditate, and promotion within the church hierarchy.

As pointed out by Hufford (1977), religion-related healing systems are rapidly increasing in popularity in the United States. In Christian religious healing, there is a broad spectrum of beliefs and activities, ranging from Christian Science to the fundamentalism of healers such as Oral Roberts to the Roman Catholic rite of anointing the sick. It is difficult to predict, on the basis of denomination, whether a religious patient is likely to be
significantly involved in a religious healing effort. As there is a great deal of variation among individual interpretations, as well as positions held by different denominations, specific features of a given patient’s system must be sought out.

In reviewing Christian religious rituals, E. E. H. Griffith and Young (1988) pointed out that a special style of prayer, testimony and spirit possession are integral parts of the service witnessed in the black church in the United States. These practices serve as a cohesive force binding blacks together. This form of service is particularly effective under the influence of the charisma of the black pastor and allows an oppressed minority to externalize its woes and obtain succor from a righteous God.

Among various forms of religious healing ceremonies, the therapeutic operation is carried out through the ritual of prayer, testimony, sacrifice, reliving experience or even spirit possession. Assurance, suggestions and the generation of conviction are some of the healing mechanisms utilized in the practices. The aims of the therapies are to resolve the client’s problems and to give certain moral and religious perspectives to the client’s life.

**Divination**

Divination refers to the act or practice of trying to foretell the future or the unknown by occult means. By definition, divination relies on divine instruction, thus, it has a supernatural orientation. In actuality, as the interpretation of divine instruction is usually provided by the diviner himself, or an interpreter, the interaction between the diviner/interpreter and the client becomes an important variable.

Divination methods vary in complexity. For example, in Nigeria, Africa, the divination practiced by Nsukka Ibo (called *Afa*) is carried out by casting four strings containing half-shells of the seeds of the bush mango (Shelton, 1965), and by the Yoruba people (known as *Ifá*), by tossing palm nuts (Prince, 1975). In divination practiced in other parts of Africa, the diviner himself presents the sign: for example, divination may occur while his hand is shaking, with the belief that he is guided by a supernatural power to give instructions.

In ancient China, turtle shells or the bones of large animals were burned during divination ceremonies and divine instruction was interpreted through the cracks made from the heat. An elaborate divination system called *chien* has been developed in China and a modified version is used in Japan and other parts of Asia. Some Chinese or Japanese visit temples for divination to obtain answers to questions they have about their lives. After a sincere prayer to the god of the temple, a person asks for divine instruction, which is provided through a fortune stick that he or she selects. Corresponding to the number on the stick, there is a fortune paper with an
answer written on it. This practice is called *chien* drawing in Chinese or *kujibiki* in Japanese. On the *chien* or *kuji* (divine instruction) there are predesigned answers for each category of issues about which clients may inquire, such as moving, changing jobs, marriage, family problems, treatment of an illness, interpersonal conflict and so on.

In order to understand the psychological effects operating in divination, J. Hsu (1976) studied the *chien* drawing practiced by the Chinese in Taiwan. Analyzing the preset answers to questions, she found that the answers reflected culturally sanctioned resolutions to problems. For instance, in an agricultural society, moving is usually discouraged. In the case of family or marital conflict, the client is often advised to be patient and try to solve the conflict with harmony; lawsuits are discouraged. If the patient is ill and current medical treatment is not satisfactory, it is suggested that the client seek other therapy. In other words, *chien* is designed as an institutional way of reinforcing culturally sanctioned coping methods. Because the divine answer is written in the format of an ancient poem or in language that is difficult for laymen to understand, the client must consult *chien* interpreters in the temple who are usually educated elders. Thus, a ‘counseling transaction’ actually takes place between the interpreters and the divining person.

The basic therapeutic operation in divination involves providing a clear-cut answer for the problems addressed. It is helpful psychologically for a client to find a definite way to adjust to his problems. Divination assumes that human life is under supernatural regulation. The basic goal is for the person to find the proper way to comply with the universe through ‘divine’ instruction.

*Fortune-Telling*

The system of reference shifts primarily from the supernatural to the natural in the practice of fortune-telling. Based on the concepts of microcosm and macrocosm, the nature of a person’s problems is usually explained in terms of an imbalance of vital forces or disharmony with the natural principles that rule the universe. Fortune-telling can be divided into several groups based on the sources of information used, e.g. astrology, oracles (such as the *I Ching*) and physiognomy. The objective is to help the client find out how to live compatibly with nature and adjust to the environment more harmoniously. Although the basic assumption underlying fortune-telling is that every person has a predetermined life course, this ‘fate’ is not absolutely unchangeable – it may be modified. Thus, fortune-telling does not dictate a completely passive acceptance of ‘fate,’ but allows for the adjustment of one’s fortune.

From the point of view of psychotherapy or counseling, it is important
to note that the interaction between the fortune-teller and the client is a significant variable in the effectiveness of the ‘therapy.’ Also, it is not so much what fortune is found from the available information, but how the information is interpreted and utilized by the fortune-teller in counseling the individual client that is most critical. Clearly, the fortune-teller can make a projective interpretation in order to ‘counsel’ the client. This phenomenon is similar to what is often observed in the practice of divination.

**Meditation**

The practice of meditation, in a strict sense, is not psychotherapeutic. But many people who practice meditation or meditation-related exercises claim that they obtain considerable benefits to their mental health. Meditation may therefore be considered a form of folk psychotherapy. The practice of meditation or meditation-related exercise aims to regulate the body–mind relation to obtain tranquility. The unspoken goal of the practice is harmony with nature or ultimate reality.

**Yoga**

Yoga originated in India. Yoga practitioners, or yogis, experience themselves as dual entities, that is, they have two co-conscious selves – a self participating in the world and an uninvolved, observing self. According to the yogis, meditation is the means by which the ‘participating self’ is controlled, allowing the ‘observing self’ to be uncovered or unassimilated from the activities of the participating self. A yogi who has accomplished this split in consciousness on a permanent basis is considered to have achieved liberation (Castillo, 1991). Hindu yoga is popular among some westerners today as a means to promote the health of the mind. Probably stimulated by this trend, some clinicians have begun to examine the relationship of meditation to psychotherapy, and explore its socio-cultural implications in contemporary industrialized societies (Engler, 1984; Hoehn-Saric, 1974). Based on his clinical experience in Europe, Nespor (1994) claimed that the use of yoga can relieve stress and anxiety, increase self-awareness, both on the mental and physical levels, and improve self-control. He considers yoga practice helpful for psychosomatic disorders and alcohol- and drug-related problems. Autogenic training is a related therapeutic practice, popular in Europe, that involves the patient in passive concentration on specific psychophysiological stimuli (Luthe, 1963).

**Qigong**

In Chinese Qigong literally means ‘the exercise of vitality’ (*qi*). It aims to regulate the force of vitality through the practice of meditation-related physical exercise. According to the clinical observations of Wu (1997), a psychiatrist who is also a qigong master, the practice of qigong can
help a person obtain tranquility of mind, diminish psychosomatic problems and improve psychological conditions, particularly problems of self-image and self-confidence. Wu speculates that the mechanisms of support, suggestions and provision of hope all work on the person. However, she also warns that some practitioners, particularly those who have premorbid personality traits of hysteria or borderline personality disorders, may develop complications from the practice of meditation. Mental complications reported include minor or major psychiatric disorders, as well as various forms of psychoses (Zhai & Zhang, 1985).

**Outcome Evaluation of Indigenous Healing**

In spite of a great deal of literature analyzing and emphasizing the effects of indigenous healing practices, there are only a few empirical studies that test the outcomes of folk-healing practices.

Finkler (1980) conducted follow-up studies of patients who visited a spiritualist temple for treatment of various disorders in a rural region of Mexico. Among 107 subjects who completed the investigation, 38 cases (35.5%) described their disorders as unresponsive to the treatment, while 27 cases (25.3%) reported that their disorders improved. Based on these data, Finkler concluded that spiritualist healers failed more often than they succeeded in treating their patients. Further analysis indicated that the therapeutic benefits of spiritualist healing tended to occur in four types of disorders: simple diarrheas, simple gynecological disorders, somatized syndromes and minor psychiatric disorders.

Ness (1980) studied two fundamentalist churches in a Newfoundland coastal community of Canada. The Cornell Medical Index (CMI), which includes problems of physical and psychological functioning, was administered to all church members after a year’s observation of their religious behavior. People who actively participated in religious ritual activities tended to report fewer symptoms of psychological distress than individuals who participated less. However, as no assessment was made prior to their participation in religious activities, it was difficult to determine whether the members had benefited from the religious activities or from some other correlate of religious attendance.

Kleinman and Gale (1982) compared patients treated by modern physicians and folk healers in Taiwan. Patients with various types of sickness, such as acute illness, somatization and chronic conditions, who were treated by local shamans, were followed up in their home settings 3–4 weeks after the initial assessment by public health nurses. Roughly comparable patients treated by modern physicians were also investigated for purposes of comparison. Counter to the hypothesis, a higher proportion of patients, whether their problems were acute, chronic or somatic, were
dissatisfied with shamanistic treatment compared with care tendered by modern physicians.

Using a questionnaire survey, Zuroff and Schwarz (1980) conducted a 2-year follow-up of a controlled experiment to measure the outcomes of subjects who practiced transcendental meditation versus muscle relaxation. From the results, the investigators concluded that, although some subjects (about 15–20%) enjoy and continue to practice transcendental meditation, it is not universally beneficial.

Comment

Comparative study of indigenous healing practices and modern psychotherapy has revealed the existence of universal elements of the healing process that are probably important factors whatever the form of therapy: the cultivation of hope, the activation of social support and the enhancement of culturally sanctioned coping (Frank, 1961; Kleinman & Sung, 1976; Torrey, 1986).

The joint declaration on primary health care made in 1978 by the World Health Organization and UNICEF at Alma Ata, Kazakhstan, for the first time gave international recognition to the positive role of traditional indigenous practitioners. The position was taken that any folk-healing practice that is proven (or at least considered) to be helpful to the client and useful to the community deserves the support and encouragement of clinicians as well as administrators. As an extension of this view, some have advocated that clinicians should collaborate with indigenous healers to provide optimal mental health services for the community. In attempts at such collaboration, several programs have tried to provide educational training for folk-healers. The establishment of a training program in a Navaho school for medicine men was reported by Bergman (1973). Koss (1980) described a project that attempts to integrate two healing systems by providing their practitioners with a means of continuous contact. Spiritual healers, mental health workers and medical professionals are able to meet on the neutral ground provided by the project. As a result, therapists and spiritual healers have begun to refer patients to each other.

In contrast to the usefulness of folk therapies, the potential ill effects have not been widely studied and reported. Yet, clinical observation has disclosed that some folk therapists may cause harm to the clients who seek their services through financial deceit or fraud, sexual involvement with a client, prescribing dangerous substances or physically injuring clients. Clearly there is a wide range of ‘professional’ quality among folk-healers and different motivations for practice. The major problem, from a public health point of view, is that in most societies there still are no formal
guidelines for regulating folk therapy. Folk therapy, whether it is shamanistic practice or faith healing, should be subject to periodic surveys and re-evaluation by the public health administration, as is modern clinical work, so that its benefits to clients can be protected and any potential malpractice can be prevented. If any folk therapist refuses to be examined and regulated, he or she should be discouraged or prevented from practicing.

**Culture-Influenced Unique Therapies**

The indigenous healing practices described above claim that healing occurs as a result of the power of a supernatural or natural being, rather than the psychological interaction between the healer and the client. In contrast, the psychotherapeutic exercises included in this section are recognized by both the healers and the clients as primarily mental practices whose purpose is healing the mind. Although any form of psychotherapy is more or less influenced by culture, the term ‘culture-influenced’ is used here to indicate therapy that is strongly colored by the philosophical concepts or value systems of the society in which it was developed. Therefore, such a therapy may be difficult to transplant to other cultures, or to practice in the same society in another era if significant cultural change has occurred. Since the therapeutic orientation and practice of this kind of therapy are so different and distinctive, compared with the so-called common or mainstream therapeutic modes, it is referred to here as a ‘unique’ therapy.

**Somato-psychotherapy**

These modes of therapy are characterized primarily by a biomedical, or somato-psychological, orientation. Even though the psychological aspects of the problems involved are recognized, it is intended that the problems will be resolved mainly through a somatic approach – at least from a conceptual point of view.

**Mesmerism** This mode of therapy was invented in the late eighteenth century by the Austrian physician Franz Anton Mesmer, and became popular in Paris (Alexander & Selesnick, 1966; Bloch, 1980). Mesmer subscribed to the theory that planets influence physiological and psychological phenomena of human beings. He hypothesized that man was endowed with a special animal magnetic force that, when liberated, could produce amazing healing effects. Based on this assumption, he developed a method for magnetizing neurotic patients in order to heal them. In treatment sessions, patients as a group were asked to hold hands in a circle around a baquet, a tub filled with ‘magnetized’ water. Mesmer, as the therapist, touched the patients, or simply gestured with his hands, to
transmit magnetic force from his body to his patients. Conceptually, the therapy was based on the somatic theory of the transmission and supplementation of an animal magnetic force. In practice, it was the psychological force (i.e. suggestions) of a charismatic therapist that worked for the patients.

**Rest Therapy** The rest cure was devised by a neurologist, Silas Weir Mitchell, in the late nineteenth century in the United States (Schneck, 1975). Based on the assumption that a neurotic patient's illness was caused by exhaustion of the nervous system or 'anemia of the brain,' a logical outgrowth of the concept of neurasthenia developed by George Beard in 1880, the ingredients of the therapy consisted of rest, proper food and isolation. Patients were prohibited contact with relatives and were separated completely from the setting in which the illness had developed. Mitchell considered rest therapy particularly beneficial in the treatment of neurotic women.

The likely therapeutic mechanisms of somatic therapies include expectancy effects, susceptibility to suggestion and the legitimizing of complaints. Restoration of natural conditions through supplementation or recuperation was the basic concept and aim of such therapeutic maneuvers. This notion is shared by currently popular homeopathic treatments.

**Ho`oponopono (Setting to right)**

Ho`oponopono is a Hawaiian term referring to an indigenous problem-solving practice that was developed and used by native Hawaiians to restore harmonious relations in the family (Shook, 1985). This folk family therapy was called upon whenever there was a serious conflict among extended family members or other members of the community and a need for setting right the relationships. A meeting was called for all family or community members involved, led by a senior family member or a respected outsider, such as a *kahuna* (healer). The meeting began by asking the members to pray sincerely for help from God to solve their problems. This was followed by a formal statement of the problem, discussion, confession of wrongdoing, restitution when necessary, forgiveness and release.

Culturally, native Hawaiians are discouraged from expressing negative emotions openly in daily life. Concealment of resentment and anger is sanctioned. During this traditional problem-solving rite, however, the person who has a complaint about his or her family or community life, or a relationship, is permitted to reveal the problem. After the problem is examined and elaborated by the group, the person causing the problem is expected to confess his or her wrongdoing, and his or her apology is accepted by the others. After the revelation and confession, all the
disclosures made in the meeting must be ‘returned to the sea’ – implying that people should forget or repress the uncomfortable issues explored before they return to their normal lives.

*Hoʻoponopono* offers a mechanism for setting interpersonal situations right according to the cultural system of Hawaii, an island society which emphasizes the group. A stylized procedure of group disclosure and elaboration of conflict is enforced in a cultural ‘time-out’ process. Sincerity is encouraged throughout the process as a condition for the success of the healing rite. Public confession and apology is the healing mechanism and the restoration of harmonious family and group relationships is the goal.

**Alcoholics Anonymous**

Alcoholics Anonymous (AA) started in the United States in 1935 as a self-help program designed to help alcoholics become sober. AA has since spread to all continents and, in 1990, had an estimated membership of 2 million worldwide. However, as of 1986, more than half of the members (53.8%) were from the United States and Canada, 34.5% from Latin America and the remaining 11.7% from countries in Europe. According to Makela (1993), the demographic composition of AA in many countries is a reflection of when and by whom AA was first founded in that country.

There is considerable variation in the format of AA meetings. For instance, in Austria, most meetings have circular seating arrangements, whereas audience-type seating is common in Mexico. There are also differences in turn-taking rules that impact the flow of discussion. In Finland, AA members usually speak in seating order, whereas in Switzerland, the chair selects the next speaker. There are also differences in interpretations of spirituality. The institutional 12-step treatment program emphasized in the United States is not necessarily considered important in many other countries, including Austria, Sweden, Finland and Poland.

Western-style Alcoholics Anonymous has not been successful among North American Indian populations. However, by omitting certain features of philosophy and practice, and incorporating important indigenous cultural elements, transformed ‘AA’ groups have been quite successful in attracting and rehabilitating alcohol-abusing persons among native populations (Jilek-Aall, 1981). Native American AA groups reject the concept of anonymity. Instead, open identification of participants is practiced and family members, including children, are invited to the open meetings. A formal set of rules and procedures, including a time frame, is abandoned. Instead, more traditional ways of congregating, without predetermined times of arrival or departure of participants, are practiced (Jilek, 1994). These culturally transformed ‘AA’ groups are becoming widely accepted among the Native American population.
Although the method of practice in AA may vary in different societies, group confession and testimony are the basic operations, while group support and enforcement are among the healing mechanisms.

**Rapid Integrated Therapy**

Rapid integrated therapy was invented by Chinese psychiatrists as a specific mode of treatment for neurasthenic patients in China during the 1960s. At that time, China was in the midst of vigorously pursuing the ‘Great Leap Forward.’ Under Chairman Mao’s political ideology, people were encouraged to utilize all means, including traditional or indigenous methods, to obtain rapid economic expansion and improvement. In response to political demand, rapid integrated therapy was developed for neurasthenic patients who were identified nationally as one of the major patient populations that was unable to participate fully in social production.

The therapy was characterized by a combination of educational group therapy coupled with individual counseling, physical exercises (including qigong), and somatic treatment, such as acupuncture, herbal or drug therapy. Patients, in small organized groups, were treated in a short-term course of out-patient therapy (usually 4 weeks). It was claimed that the therapy was useful for treating neurasthenic patients, and the program grew throughout the nation.

According to Chinese psychiatrists (C. P. Li, 1997), this form of therapy was effective for several reasons. Neurasthenia was originally considered by patients to be a chronic disorder. This pessimistic view was corrected through instruction; the nature of the disorder was explained and the possibility for improvement was emphasized, so that patients were motivated and activated for recovery. Many neurasthenic patients (mostly students and intellectuals) tended to lack adequate physical activity in their daily lives. By participating in the therapy, which emphasized a balance of mental and physical activities, they normalized their life patterns. Group activation and regulation of daily life activity of the mentally exhausted person were recognized as the mechanisms of the therapy.

Rapid integrated therapy was a product of its time, and the prevailing social atmosphere and political ideology functioned as the main force behind its effectiveness. When the Cultural Revolution started in 1966, creating extensive social turmoil, this therapy was discontinued and no one was interested in reviving the method after the Cultural Revolution was over.

**Naikan Therapy**

Naikan therapy was invented by a Japanese monk, Yoshimoto Ishin, five decades ago for the purpose of treating juvenile delinquency and other
problems. In Japanese naikan literally means ‘introspection.’ According to Reynolds (1977), the roots of Naikan lie in the Jodo Shinsu sect of Japanese Buddhism. The founder of the sect, Shinran, promised 10 kinds of profit to those who believed – among them, ‘joyful acceptance of any hardship’ and ‘the desire to repay others with a joyful heart.’ These two benefits are common results of Naikan meditation. Yoshimoto discovered the usefulness of Naikan during his own search for enlightenment. He eased the physical restrictions and modified the procedure somewhat for laypeople. Interestingly, as noted by Reynolds, Yoshimoto now maintains that there is no real relationship between Naikan therapy and the Jodo’s religious concepts, other than a historical one.

The core of Naikan practice involves clients carrying out self-inspection of their own life in the past, with a particular focus on the kind of relationships they have had with significant persons, usually parents. Clients are instructed to review the things their parents did for them, and what they did in return. Through the process of self-inspection, clients may obtain insight into their attitudes and learn not to complain and cause trouble for others, but to repay others with appreciation and a joyful heart. The change in one’s attitude toward others and one’s view of life are the core of the therapy.

The Japanese cultural psychologist Murase (1984) commented that the goal of Naikan therapy is to assist the client in obtaining the psychological state of sunao, a unique Japanese term and value system. Sunao is derived from the Japanese character meaning things in their original state without any transformation. It implies a harmonious and natural state of mind directly associated with honesty, humility, docility and simplicity. Murase pointed out that the concept of sunao does not belong to the ‘imported’ religions of Buddha, but is essentially derived from ancient Shintoism, a value system that remains a strong undercurrent of Japanese culture. Thus, in his analysis, the emphasis of Naikan therapy is to search for the culturally sanctioned state of mind of sunao.

The basic therapeutic mechanisms of Naikan therapy involve reappraising primary interpersonal relations within the family and discouraging a narcissistic view of the world by learning appreciation of others, rather than making demands for the self. The aim of the practice is to restore family relations by making use of a culturally sanctioned value system relating to the parent–child relationship.

Originally, the practice of Naikan therapy was supported by a millionaire who offered its benefits to prisoners. In addition to a major center in Nara, there are only a few religious institutions that offer this therapy. The practice is gradually fading away, but, due to its uniqueness, has attracted the attention of scholars as well as the interest of some Westerners. An American psychologist, Reynolds, who participated in Naikan therapy in
Japan, has reported that the few Americans who tried Naikan therapy in Japan shared some characteristic difficulties. According to Reynolds (1983), Japanese tend to believe that if they receive some kind of benefit or favor from others, it is their moral duty to repay at least as much as they received. However, Americans tend to see social relations as being among equals, with shared responsibilities and faults and so it is difficult for Americans to benefit from Naikan therapy.

**Morita Therapy**

Morita therapy was originally developed by a Japanese psychiatrist, Shoma Morita, in 1919, primarily for the treatment of anthropophobia, a common social phobia recognized in Japan (Iwai & Reynolds, 1970; A. Kondo, 1953; K. Kondo, 1976). Associated with rapid social change in Japan around the turn of the century, many neurotic patients with diagnoses of 'neurasthenia' appeared in clinics without any relevant therapy. Morita himself had been troubled by the fear of death and neurasthenia since his childhood, and had overcome the problems on his own. Based on his personal experience, Morita was very much interested in the treatment of patients diagnosed with neurasthenia, shinkeishitsu (nervous temperament) and taijinkyofusho (interpersonal relation phobia). According to Kitanishi and Mori (1995), Morita tried to replicate Silas Weir Mitchell's 'rest therapy,' Otto Binswanger's method of 'life normalization' and Dubois's 'persuasion method,' but did not obtain favorable results. After attempting a variety of treatment methods, he created a new therapy of his own, which he called 'experiential therapy.'

In experiential therapy, Morita treated patients in his own home, letting them go through different stages, including rest, life renormalization and rehabilitation. Through all the stages of therapy, patients were discouraged from talking about their problems and complaining about their symptoms. An atmosphere was set up to encourage the patient to learn to accept the self 'as it is' (arugamama in Japanese, literally 'thing-as-it-isness') and to concentrate on enjoying his or her own life as it is. Perhaps because Japanese patients were not used to talking about their internal emotional lives in face-to-face situations with others, each patient was asked to write a daily diary in which various therapeutic comments were made by a therapist. Arugamama, shizen-fukuzui (being obedient to nature), kodo-honi (action-orientation), ichi-nichi kore kōji ('every day is a good day') and heijosin kore michi ('keeping an ordinary mind is the way of life') are examples of comments used as slogans in the patient's daily life, with the intention of changing his or her basic life attitude (the latter two comments are direct quotations from Zen teachings) (Ohara & Ohara, 1993).

Morita theorized that shinkeishitsu was a result of a hypochondriacal
temperament, exposure to internal or external mental stimulation and the patient’s own emotional response. The patient sees his or her ‘natural’ emotional reaction toward stress as a negative one and gives it excessive attention. Symptoms are formed and fixated through this negative interaction between sensation and attention. The core of the therapy is to help the patient accept the self and ignore the symptoms, in order to resolve the excessive awareness (toraware) resulting from this negative psychic interaction. The change of attitude is achieved through actual life experience with the therapist.

Although Morita himself denied that he was influenced directly by Zen philosophy, many scholars have pointed out that his therapeutic principles were very much rooted in Oriental philosophical concepts (Miura & Usa, 1970). To learn through life experience with a master is a common practice in Japanese traditional life. In general, people in Japan do not feel comfortable communicating personal feelings toward others. Instead, communication through writing a diary is comfortable and acceptable to ordinary Japanese.

During the past 75 years, there have been many changes in the practice of Morita therapy (Ohara & Ohara, 1993). The original target population, diagnosed with shinkeishitsu, has declined, and now more patients with obsessions are treated with the therapy. All therapy now takes place in hospitals, not at a therapist’s personal residence, as was originally done by Morita. The 2-week complete rest therapy is less tolerated by young, contemporary Japanese patients and is not strictly observed. Drug therapy is frequently combined with work and recreational therapy. One of Morita’s major successors, Kenjiro Ohara, has pointed out that the core of the therapy that remains is the emphasis on creating a new life experience. Thus, he prefers to call it ‘creative experiential therapy.’

While the practice of Morita therapy is gradually declining in Japan (Kitanishi & Mori, 1995), a new Morita therapy movement has been observed recently in mainland China. According to Chinese psychiatrists, Morita therapy has become popular for various reasons: an eagerness to develop psychotherapy after its period of absence following the Cultural Revolution; availability of funding from the Morita Foundation; and the relative ease of mastering the techniques of Morita therapy. Most important, according to Cui (1997), is that the basic therapeutic attitude and ideology emphasized in Morita therapy are related to the teaching of Zen Buddhism, which originated in China. This therapeutic ideology is very easy for patients in China to understand and accept.

There have been several attempts to conduct Morita therapy in western societies. According to Iwai and Reynolds (1970: 158), Leonhard tried the therapy in East Germany and reported in 1965 that ‘it was almost impossible for the neurotic European patient to undergo the stage of absolute bed
rest for therapy; besides, recreational activities rather than work activities were more effective for anxiety reduction in his patients.’ According to Reynolds and Kiefer (1977), several therapists implemented Morita therapy in West Coast areas of the United States with reasonable success for certain populations of clients. It is worth examining the kinds of modifications needed for this imported Japanese culture-related therapy to work for American patients.

**Existential Psychotherapy**

Existential psychotherapy is a general term used to refer to the basic approach of understanding the client as he exists in his world. The incorporation of an existential approach in psychotherapy was developed independently in various parts of Europe around the 1960s by a group of trained psychoanalysts and scholars, including Binswanger, Boss, Frankl, Marcel and Sonneman (Patterson, 1966).

Existential psychotherapy is based on existential philosophy, which holds that man is responsible for his own existence. From an operational perspective, the therapy emphasizes confrontation, primarily in here-and-now interactions, and feeling experiences. The therapeutic relationship is regarded as an encounter, a new relationship, opening up new horizons. The goal of therapy is to encourage the client to actualize himself and to fulfill his inner potential.

Kelman (1960) claimed that the existential psychotherapy orientation is a phenomenon of the West. He explained that the East is characterized by a subjectifying attitude, the West by an objectifying one. Eastern cognition is interested in consciousness itself. Western cognition is interested in the objects of consciousness. According to Kelman, existentialism is the formulated awareness of Westerners’ estrangement and alienation from their roots and from all otherness. He regards the emergence of and interest in existentialism as evidence that western man is aware that his philosophic roots are inadequate.

**est (Erhard Seminars Training)**

Founded by Werner Erhard, a layman whose formal education only included high school, est was fashionable among well-educated adults in the United States during the 1970s. It consisted of a structured, two-weekend (60-hour) program for self-improvement. As a program, est is concerned primarily with a philosophy of life and self. The seminar was designed to help participants recognize that life is only what it is, not the way it used to be, ought to be or might be. As its founder recognized, est has philosophical views similar to the Zen attitude toward life.
Coupled with its philosophical views, the purpose of EST training was to transform a person’s ability to experience, to expand his or her experience of aliveness and full self-expression, to intensify a person’s awareness that an individual ‘runs his own show,’ whatever he chooses it to be. The ultimate goal was for the participants to gain the sense that: ‘I have total responsibility for my life – all of it, the happiness and the sorrow.’ As interpreted by Torrey (1986), EST tends to make a person believe that he has the power to handle his own life, a value that fits with the rugged individualism of American society.

**Comment**

From a clinical point of view, a culture-influenced unique therapy usually shows certain characteristics. First, the therapy is often applicable only to clients with a specific type of pathology. Second, the therapy is often useful clinically only in a particular socio-cultural environment in a given era. Third, the therapy is often atheoretical, without a comprehensive theory of psychopathology or healing. However, these unique forms of psychotherapy provide opportunities to examine the kinds of cultural factors that can be utilized to promote psychological change. There is a great need to investigate the actual factors that may contribute to the effectiveness of these therapies, if they are, indeed, effective.

**Culture-Related Common Therapies**

Culture-related common therapies are a group of psychologically oriented therapeutic modes that were originally developed and continue to be widely practiced in Euro-American societies where they are regarded as ‘mainstream’ or conventional. The distinction between ‘unique’ therapies and ‘common’ therapies is arbitrary and depends on who is viewing the phenomena. Every kind of psychotherapy, whether it is considered mainstream or not, is subject to the influence of culture and the adjective ‘culture-related’ is used to stress the fact that common therapies are, in ways both subtle and explicit, still related to culture. Therefore, when the common therapies are applied to a different cultural context, modification becomes necessary. This review will focus on several common therapies that have received extensive discussion of their cultural aspects in the literature.

**Psychoanalysis**

Although many psychoanalysts hold the view that psychoanalysis deals with basic aspects of the human mind and is universally applicable, clinicians from various societies do not agree. Scholars have pointed out that
the theory and practice of psychoanalysis are very much culturally influenced, both by the background of its founder, Sigmund Freud, and the environment of fin-de-siècle Vienna, where the practice originated.

For instance, Meadow and Vetter (1959) indicated how the Judaic cultural value system influenced the Freudian theory of psychotherapy. In contrast to Christianity, Judaism maintains that the ultimate goal of human happiness is attainable in the real world (not in heaven), and any unhappiness in the real world is regarded as evil and needs to be fixed; this basic attitude is reflected in psychoanalytic theory. While psychoanalytic therapy upholds the view that heterosexual relationships constitute a *sine qua non* for happiness, it is the aim of psychoanalysis to aid the individual in establishing rational control over his sexual drive. This affirmation of rational control is consistent with a major emphasis in Judaism. There is also a similarity between Talmudic and psychoanalytic attitudes toward the meaning of words; to the Talmudic scholar, a word is presumed to possess a special hidden significance in addition to its simple and direct meaning. Finally, the Freudian concept of family relations and the development of the Oedipus complex are closely related to the typical family pattern in Jewish culture; the mother–son relationship is more intense and complete than the relationship between husband and wife; and the ideal marital relationship is one in which the wife treats her husband as a child.

Pande (1968) pointed out that in eastern, relationship-oriented societies, no formal agenda is necessary for the cultivation of a relationship; however, in western work- and activity-oriented societies, the absence of an agenda would be disturbing. Although the explicit language of psychodynamic practice is of understanding and insight, the metalanguage of psychoanalysis is of love and human involvement in an activity-oriented society. In addition, there is a general tendency in western societies to rush a person from infancy into adulthood. This leaves much unfinished business, and the ‘working through’ of childhood experiences in psychotherapy, particularly in psychoanalysis, becomes a meaningful and worthwhile experience for patients in this regard. Thus, the institution of psychotherapy may be viewed as a symbolic and substantive cultural undertaking to meet the deficits of western societies.

**Client-Centered Psychotherapy**

In the 1940s, Carl R. Rogers, a psychologist with a Freudian background, developed a method of counseling he originally called ‘nondirective’ and, later, ‘client-centered.’ In marked contrast to the orientations of classic psychoanalysis that were most influential at the time in the United States, the cornerstones of Rogers’ method were the basic knowableness and
trustworthiness of one's own inner awareness, and an individual's ability to accurately symbolize these inner data, and use them to reorganize and make choices (Wexler & Rice, 1974). The fundamental assumption of the therapy was that a person's basic motivation was toward growth and differentiation. Thus, the therapy focused on the enormous potential of the individual and on freeing the client for normal growth and development (Rogers, 1974). Facilitating self-actualization is the basic operation of psychotherapy. The sanction of independence is considered the major force in the therapy and improvement of the self is its goal.

Meadow (1964) pointed out that client-centered therapy is an expression of the fundamental 'distrust of the expert' theme in American culture. Reflecting the tendency of American culture to de-emphasize the past, client-centered therapy places greater stress upon the immediate situation. Client-centered therapy is closely related to the American ethos that not only seeks independence for oneself, but holds it a moral duty to make others independent. Such a therapeutic approach is not particularly welcomed by clients in cultural settings where dependence on authority is expected and personal autonomy is less emphasized.

**Behavior Therapy**

The origins of behavior therapy can be traced to the animal-learning laboratories of Pavlov (1927), yet it is only during the past quarter of a century that behavior therapy has emerged as a comprehensive approach to clinical problems. The basic operation of behavior therapy is the systematic application of principles of learning theory to the analysis and treatment of behavior disorders. The mechanisms of therapy are perceived as the extinction (or unlearning) of dysfunctional or non-adaptive behavior and relearning new adaptive behavior. The concrete goal of therapy is to develop 'functional' and 'adaptive' behavior.

As behavior therapy is based primarily on psychological theory, manipulating behavior through the mechanisms of reward or punishment, it seems to be culture-related. As part of behavior analysis, the basic procedure of behavior therapy, attention is focused on the socio-cultural determinants of behavior. The emphasis on action, which is basic to behavior therapy, in contrast to verbal interaction, may be perceived and accepted more favorably in certain cultures than in others.

**Family Therapy**

During World War II, to make up for the shortage of psychiatrists in the United States, families were encouraged to get involved in the care of mental patients, and social workers were created as new professionals to
assist families in this service. It was in this social context that a psycho-analyst, Nathan Ackerman, published a book (1958) encouraging therapists to shift their focus to the family as a whole. Family therapy is primarily focused on interpersonal issues within a family group in terms of family structure and process. The restoration of adaptive family relations is encouraged as the main mechanism in therapy, while working toward a ‘functional’ family is conceived as the goal of therapy.

**Group Therapy**

It was not a mental health worker, but an internist, J. Pratt, who began the first group therapy. While practicing in Boston, he noticed that many socially stigmatized tuberculosis patients suffered from isolation and depression. In an attempt to improve their situation, he started periodic group meetings for the patients in 1905. Following Pratt’s approach, in 1919, a psychiatrist and priest, L. Marsh, conducted group meetings for hospitalized psychiatric patients. In 1925, a psychoanalyst, T. Burrow, attempted the practice of ‘group analysis’ for a group of out-patients, and initiated the modern mode of psychodynamic group therapy.

Group therapy is similar to family therapy in that it is oriented to the psychological aspects of human relations. Group sessions focus on interaction among group members and with the group leader. Learning through group experience is the fundamental mechanism by which therapy leads to the improvement of social relations, the identified goal of therapy.

**The Practice of Psychotherapy in Different Societies**

Many clinicians have begun to call attention to the kinds of considerations and modifications that are needed when psychotherapy is practiced for a particular ethnocultural group, especially in their own societies or countries. The ethnocultural background of the patient population, the sociocultural environment in which therapy takes place and the general attitude people have toward psychotherapy, all significantly affect the nature and process of therapy. Information on this subject is still very limited and lacks systematic evaluation. Based on the literature available, the situation in several societies will be reviewed here.

**Psychotherapy in Japan**

Although knowledge of psychoanalysis was introduced as early as 1912, two different translations of Freud’s selected papers were published in 1929 and a branch of the International Psychoanalytic Association was
established in 1934, the psychoanalytic and psychotherapy movements never became popular in Japan (Doi, 1964). As pointed out by Kato (1959), then head of the National Institute of Mental Health in Japan, Japanese psychiatrists’ strong orientation toward Kraepelinian psychiatry and patients’ requests for somatic treatment were among the main reasons for this lack of popularity. In Japan, as in many other Asian countries, physicians in private practice customarily charge the patient primarily for medicines prescribed and dispensed. Patients are not used to paying for talk therapy on an hourly base. Therefore, very few Japanese psychiatrists are interested in the practice of psychotherapy.

Beyond such practical reasons, many scholars have pointed out psychological and cultural reasons that make psychoanalysis less popular than other forms of psychotherapy in Japan. For instance, Tatara (1982), a psychoanalyst practicing in Japan, indicated that the typical Japanese psychotherapy patient is action oriented, seeking direct guidance from the therapist, rather than oriented toward introspection. Furthermore, based on culturally patterned expectations, Japanese patients tend to assume a ‘pathological’ dependent role, and do not appreciate the goal of autonomy or independence emphasized in psychotherapy. Doi (1962) indicated that ‘benevolent dependency’ (amae) – a key concept of Japanese personality structure – is very much valued in Japanese society in interpersonal relationships. Based on long-term observation in Japan, DeVos (1980) claimed that psychoanalysis is emotionally impossible for the Japanese, who live in a culture that is concerned with hierarchy and obligation to society and that does not value the concept of individual autonomy.

Psychotherapy in China

Owing to political ideology, psychotherapy was severely suppressed in China during the Cultural Revolution. Individually focused psychotherapy was considered the product of capitalism and was criticized as unsuitable in a socialistic country. Since the end of the Cultural Revolution, China has opened itself to western influence and ideas, including those of psychotherapeutic theory and practice. As pointed out by M. G. Li and colleagues (1994), there is a great need for psychotherapy, yet there is currently a lack of psychotherapy skills within the Chinese medical profession.

Despite the shortage of well-trained clinicians, enthusiasm for psychotherapy is increasing in China. For instance, in the Chinese Mental Health Journal, one of the leading journals on mental health and psychiatry, more than one-tenth of the articles were psychotherapy related, a phenomenon rather unusual in an era in which biological psychiatry is overemphasized in other parts of the globe (Tseng, 1997).
Psychotherapy in India

Varma (1982), an Indian psychiatrist trained in the West, pointed out that the major factors influencing the practice of psychotherapy in India are the fundamental philosophico-religious beliefs of the culture, represented by the doctrine of karma and the concept of reincarnation. Psychotherapy has a limited role for a fatalistic people who believe that their present sufferings are the result of sins committed in earlier incarnations. Varma's view was echoed by a psychiatrist from Switzerland, Hoch (1990), who argued, based on three decades of psychiatric activity in India, that the basic obstacle to psychotherapy in India was traditional Hindu philosophy. Hindu life lacks an anthropocentric orientation, and discourages egoistic and individualistic striving, leaving very little that can be done with the tools and methods of western psychotherapy.

Desai (1982) listed several cultural issues that need to be addressed for the practice of psychotherapy in India. The basic unit of Hindu society is the family, rather than the individual. Thus, individual growth is subordinated to family integrity. The matter of collaboration versus individuation needs to be handled carefully. The Hindu family strives to maintain integrity by prohibiting expressions of anger and hostility. The balance of suppression versus expression of emotion thus requires delicate management in therapeutic situations.

Psychotherapy in Africa

As pointed out by a pioneer psychiatrist, Lambo (1982), it is impossible to speak of a single African situation, as the continent contains a broad range of cultures. Yet the basis of most African value systems is the concept of the ‘unity’ of life and time. African thought draws no sharp distinction between animate and inanimate, natural and supernatural, material and mental. Furthermore, there is continuous communication between the dead and the living. In working with African patients, it is important to understand this world-view.

A psychiatrist from Nigeria, Asuni (1967), pointed out that the situation in sub-Saharan Africa is the result of colonial domination in the past. The continuing colonial influence is manifested by the extreme shortage of trained indigenous personnel in all fields, especially psychiatry. Limited manpower is available to focus on minor psychiatric disturbances, particularly in the format of psychotherapy. Reflecting this reality, psychiatry in Africa is the psychiatry of psychosis.

Based on clinical experiences with Tanzanians over a number of years, Neki and his colleagues (1985) pointed out that the central notion that talk therapy is ‘good for you’ is undoubtedly a product of western culture.
A Western-trained Nigerian psychiatrist, Oyewumi (1986), reviewed the difficulties encountered in practicing psychotherapy in his home country, including the tendency to externalize and an apparent lack of introspection. Based on his traditional orientation, the Nigerian patient expects benevolent authoritarian treatment and is confused by a therapeutic endeavor that leaves him to decide what he should do next. Uzoka (1983) conducted clinical experiments in Nigeria, and found that when the therapist spoke a lot, the patients attended more and made substantially more self-disclosures. Based on such findings, Uzoka concludes that, for African patients, the therapist needs to appear actively involved if therapy is to be credible. Recently, Ilechukwu (1989) pointed out that many generalizations made in the past about psychotherapy in Africa were misguided and must be challenged lest they discourage attempts at psychotherapy.

Psychotherapy in Muslim Societies

As pointed out by El-Islam (1982), the characteristics of Arabs vary greatly from one community to another. Nevertheless, there are certain widely shared features of general relevance to psychiatry that can be recognized, such as traditional beliefs regarding spirits and the evil eye, family structure and relationships, particularly regarding the status of women, and traditional healing practices. Concerning psychotherapy, El-Islam pointed out that Arab patients may not accept ‘talking’ as a treatment that can replace a prescription. Most Arab patients have a dependent attitude toward doctors and are not interested in active participation in their own treatment.

Referring to the situation in the Eastern Province of Saudi Arabia, West (1987) suggested that the Islamic influence on Arab psychology is revealed in the conviction that the future is in the hands of Allah. Many patients believe that the therapist is hakeem (wise man and healer), through whom Allah works. Patients tend to expect an active, authoritarian role on the part of the therapist. Thus, therapy must be directive if it is to be effective.

Psychotherapy in Russia

An article written jointly by an American psychologist and a Russian psychologist (Gilbert & Shiryaev, 1992), provides insightful comments about the practice of psychotherapy in Russia. Psychoanalysis was considered ideologically unacceptable prior to glasnost, but there is considerable interest among clinicians now. Surprisingly, in the nation where Pavlov discovered classical conditioning, behavior therapy is not very popular. Instead, humanistic–existential approaches are more
common, consistent with the prominent role that existential thought plays in Russian culture as a whole.

Group therapy is far more popular than individual approaches and is widely practiced in Russia. There are practical reasons for this trend. It is estimated that there are approximately 2000 practicing psychotherapists in all of Russia, and the majority of these began their clinical work after glasnost. Few of them have had the opportunity to be trained in individual therapy. Group therapy is less expensive than individual treatment. Russia, especially during the years dominated by the Soviet state, has been a group-oriented society and the forces of social influence that are present in group therapy can exert a powerful effect on behavior or attitudes.

Regarding individual therapy, it is noted that the therapist–patient relationship is very much shaped by Russian culture. For centuries, Russia has been highly paternalistic and authoritarian. Therefore, it was adaptive for the individual to exhibit an attitude of deference to authority and to hope and expect that this deference would be rewarded by the authority’s taking care of the individual. This cultural legacy of authoritarianism has an important influence on patients’ expectations of psychotherapy. Many patients approach the therapist as a figure of authority with the implicit expectation that the therapist will intervene on their behalf or provide them with solutions. It is interesting to note, in this context, that hypnosis is one of the most desired methods of treatment for Russian patients.

**Comment**

From the above review of psychotherapy practiced in different societies, it becomes clear that there are many reasons why modifications and adjustments in psychotherapy may be needed, including: the basic personality or ethnic character of the population concerned (Doi, 1964); commonly shared belief and value systems (Hoch, 1990); basic philosophical attitudes (Rhee, 1990; Varma, 1982); and orientations toward, and expectations of, psychotherapy (Neki et al., 1985; Ng, 1985; Tseng, 1995). Beyond this, it is also obvious that the practice of psychotherapy is profoundly influenced by socio-cultural factors and political ideology. In particular, medical–economic systems have a direct impact on the movement and practice of psychotherapy. This is illustrated by medical insurance systems that impose their effects on the practice of psychotherapy in many societies.

**Intercultural Psychotherapy**

Associated with the clinical experiences of working with patients in foreign societies, or with minority groups, literature on intercultural psychotherapy began to appear in the 1960s (Bishop & Winokur, 1956; Bolman, 1968; Carstairs, 1961). J. Hsu and Tseng (1972) pointed out the influence
of cultural factors on the process of intercultural psychotherapy broadly in
the areas of communication, assessment, therapist–patient relationship,
interpretation, advice giving and treatment goals. Kinzie (1972) emphasized
that an open system model is important when a therapist is engaged
in cross-cultural psychotherapy.

Closely related to the emerging human rights movement in the United
States, as well as the growing migration of non-European minority groups
into European countries, there was increased concern in the 1970s and 1980s
with how to deliver mental health counseling for minorities, migrants,
refugees, sojourners and foreign students. The monograph Transcultural
Counseling, by Walz and Benjamin, appeared in 1978, suggesting ways to
provide counseling for various minority groups in the United States. The
book Counseling Across Cultures, by Pedersen, Lonner, and Draguns (1976),
followed by several revisions (Pedersen, Draguns, Lonner, & Trimble, 1989;
Pedersen, Draguns, & Lonner, 1996), is another example of the work that
has been carried out in this area. Numerous books have appeared recently
that focus on intercultural therapy among particular groups, such as
refugees (van der Veer, 1992) and minorities (Aponte, Rivers, & Wohl, 1995),
indicating greater awareness of, and experience with, this subject.

Clinical experience in intercultural psychotherapy raises many issues,
including: the need to examine the congruence and incongruence of
cultural backgrounds between therapist and patient; how to communicate
with patients on verbal, as well as nonverbal, levels (Wolfgang, 1985); how
racism may affect interracial counseling (Burke, 1986; Geller, 1988); the
problem of ethnic or cultural identification with the therapist; the manage-
ment of culture transference and countertransference; how to deal with a
therapist’s cultural rigidity or cultural scotoma; how to provide appropri-
ate therapy for patients who are refugees (van der Veer, 1992); and how to
provide culture-fair, -matched, -sensitive or -relevant therapy.

From the early 1980s, many writings have appeared that offer specific
suggestions on how to provide psychotherapy for patients of particular
ethnocultural backgrounds (Kinzie, Tron, Breckenridge, & Bloom, 1980;
Marcos, 1988; Sanchez & Mohl, 1992; Tseng, McDermott, & Maretzki,
1974; Walz & Benjamin, 1978). Generally, it has been suggested that, in
addition to concern about how cultural factors may influence the process
of therapy, the therapist should be equipped with knowledge about the
culture of his patients, and that certain issues require special care in
treating each particular cultural group.

**Cultural Transference and Countertransference**

The cultural transference and countertransference that are observed in
intercultural psychotherapy have attracted the attention of therapists for
some time (J. Hsu & Tseng, 1972; Schachter & Butts, 1968). Cultural transference refers to a patient developing a certain relationship, feeling or attitude toward the therapist because of the therapist’s ethnocultural background; cultural countertransference implies the reverse phenomenon, namely, a therapist developing a certain relationship with the patient mainly because of the patient’s ethnocultural background. Transference or countertransference is primarily based on the previous knowledge, impression, bias or experience of a therapist or a patient in relation to a particular ethnocultural group. In the same way as personal transference or countertransference, cultural transference or countertransference can be positive or negative, profoundly influencing the process of therapy, and, therefore, needing prompt attention and management.

Comas-Diaz and Jacobsen (1991) indicated that cultural transference may be manifested in a variety of ways, including: denial of ethnicity and culture; mistrust, suspicion and hostility; ambivalence toward the therapist; or overcompliance and friendliness. Likewise, countertransference can be shown as denial of ethnocultural differences, being overly curious about the patient’s ethnocultural background, or demonstrating excessive feelings of guilt, anger or ambivalence toward the patient.

**Racism and Ethnic Matching**

The possible negative impact or obstacle of racism on psychotherapy has received a great deal of attention. The difficulty of psychotherapy involving racial factors has been demonstrated by extreme circumstances. For example, in South Africa, as pointed out by Lambley and Cooper (1975), individual contacts between a white therapist and a black client contained elements of the overall relationship between blacks and whites in an apartheid society that severely affected the therapeutic relationship. Psychotherapy of an Arab patient by a Jewish therapist in Israel during the Intifada provides another example of how political reality may intrude into psychotherapy and interfere with the therapist–patient relationship (Bizi-Nathaniel, Granek, & Golomb, 1991). To address these issues, being open with patients at an early stage of therapy about the possible effects of race and ethnic difference is encouraged (Brantly, 1983).

Griffith (1977) addressed issues of concern in certain racial matches between therapist and patients in the United States. He pointed out, for instance, that the main issue in the white therapist–black client relationship is ‘trust’, in the black therapist–black client relationship is ‘identity’, and in the black therapist–white client relationship is ‘status contradiction.’ Resolving these special issues in each different racial match presents a challenge of a different nature.
Probably influenced by the minority and human rights movements, some groups have stressed the importance of having ethnic/culture-matched therapy. The usual assumption is that, in order to obtain effective therapy, every client is better treated by a therapist of the same ethnic-cultural background who applies culture-relevant models of therapy (Sue & Morishima, 1982).

There is no doubt that congruence of ethnocultural background between therapist and patient can benefit the therapy process, particularly during the initial stage, making engagement and meaningful communication easier. Yet, from a clinical point of view, it has been shown that congruence of background alone is not sufficient. In fact, as argued by Kareem and Littlewood (1992), ethnic matching of client and therapist is not the solution to improving intercultural therapy, since it imprisons the professional and the client in their own racial and cultural identities and diminishes the human element.

Based on their clinical work, Sue and Zane (1987) emphasized that, in transcultural psychotherapy, it is not enough for the therapist to merely have cultural sensitivity to, and knowledge of, the cultural background of the client. Cultural knowledge and culture-consistent strategies must be linked to two basic processes—credibility and giving—to make the therapy successful.

It is seldom pointed out in the literature that there are negative factors associated with the treatment of minority patients by therapists of the same minority background. Confidentiality becomes a real concern if the minority population in the community is relatively small. Patients from a minority background may prefer to be treated by a therapist from outside of their own group. Negative ethnic transference may also occur. The patient may not trust a therapist of his own kind, with a minority or disadvantaged background, and may prefer to be treated by a therapist from a majority group.

In an interesting reversal, Cheng and Lo (1991) have pointed out the advantages of cross-cultural psychotherapy when the therapist is from a minority group. As an outsider from the mainstream, the minority therapist may provide cultural objectivity and neutrality for the patient in coping with the stresses of life.

From a practical point of view, there will always be too few therapists of various ethnic-cultural backgrounds to match that of the patient in every case. This is particularly true in relation to minority groups, for whom it is more important than ever to provide training and consultation to enable the therapist to carry out intercultural therapy. Therapists who are clinically well trained and sensitive to their patients’ cultural background can provide successful treatment even though their ethnic-cultural background may differ from that of the patient.
Working with Families

Cultural aspects of family therapy have been discussed from several perspectives (McGoldrick, Giordano, & Pierce, 1996). Regarding the applicability of family therapy, the question has been raised whether ethnic-cultural groups that give greater importance to the family in their lives (such as Italians, Portuguese or Chinese) are better suited for family therapy. However, this is not consistently borne out by clinical experience. For instance, Moitoza (1982) pointed out that Portuguese families’ closed family systems prevent them from actively seeking family therapy; instead, they attempt to solve their problems via their own family resources and support systems. Chinese families are concerned that ‘internal disgrace’ should not be known by outsiders; thus, until a family trusts a therapist, it is relatively difficult to work on their family ‘secret’ (J. Hsu, 1983).

It is widely acknowledged that it is desirable for the therapist to respect and utilize the culturally defined and sanctioned family hierarchy and relations that already exist within the family, and constantly evaluate the cultural transference that may occur in family therapy. For instance, McGoldrick and Pearce (1981) pointed out that the cultural attitude toward authority figures will often lead members of an Irish family to show extreme loyalty and willingness to follow through on therapeutic suggestions. J. Hsu (1983) suggested that, based on the concept of extended family social relationships, the members of a Chinese family may feel more comfortable if they are allowed to address the therapist by a kin term (e.g. if the therapist is a woman close to the mother’s age, she may be referred to as ‘auntie’).

Therapeutic strategies are also influenced by culture. In working with Japanese families, it is necessary to deal with family matters according to cultural priorities, that is, to work on parent-child relations before beginning on husband-wife issues (Suzuki, 1987). Working with Chicano families, several clinicians (Falicov, 1982; Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967) have proposed that it is better to follow a structural family therapy approach to meet the cultural emphasis on hierarchies within families. McGoldrick and Pearce (1981) have pointed out that Irish patients are apt to feel threatened by therapy directed at uncovering hostile or erotic feelings and may respond better to the positive reframing of strategic therapy. Regarding Jewish families, Herz and Rosen (1982) mentioned that, closely related to the tendency to recognize suffering as a shared value, the verbal expression of feelings in family therapy can be emphasized.

In sum, the family therapist needs to be familiar with cultural variations in family systems, structures and interactional patterns, including role-playing, communication and value systems. The therapist must also know
how to select culturally suitable interventions, so that specific types of family therapy can be applied for families of different cultural backgrounds (Tseng & Hsu, 1991). As stressed by Ho (1987), in working with ethnic minorities, the role of the therapist is to serve as a ‘culture broker’ rather than an intruder, to facilitate negotiation between systems, and, usually, to work closely with the more acculturated member to promote adjustment to the host society for the whole family. A similar view has been presented by Jalali (1988), who pointed out that, in treating ethnic families, the therapist is often confronted with a clash of two cultures, two generations and problems in acculturation. The therapist explains and teaches both sides of values and norms, and actually acts as a cultural mediator, encouraging all to become multicultural, or to have a foot in both cultures. Thus, it is clearly recognized that family therapy is very much focused on the matter of cultural adjustment both within the family and between family members and the wider social world.

**Working with Groups**

Group therapy has been widely applied in different cultural settings. In addition to the basic factors relating to group composition, including age, gender, personality and the psychopathology of the group members, the group transactions will obviously be influenced by the ethnic and cultural backgrounds of the members and the therapist.

Working with Greek immigrants in group therapy, Dunkas and Nikelly (1975) commented that their patients were more attuned to group goals rather than individual fulfillment. They tended to do what the group expected, receiving cues through its tacit or obvious approval. Instead of self-actualization and personal happiness, Greek culture encourages the pursuit of the love, esteem and admiration of members of the group. As a result, the group members tended to maintain an attitude of servility and passivity; they looked up to the therapist and expected the therapist to do the work.

Based on his experience working with Orthodox Jewish patients in New York, Shapiro (1996) raised issues that are pertinent to treating this population in group therapy. Owing to a small and closely knit community, individual anonymity was almost impossible to maintain. The mixture of gender in the group was quite untraditional and culturally unfamiliar, and resulted in heightened resistance to therapy. Verbal propriety is a cultural requirement, so group members were restricted in their language, verbal style and the topics that they were willing to discuss.

Leading group therapy for Chicanos in Texas, Martinez (1977) pointed out that there is a Mexican tradition of not opening up to others (*no te rajes*). This tradition works against communication and expression of
feelings in group situations. Also, there is a built-in formality in interpersonal relations as reflected in language usage. This greater formality makes it difficult for group members to relate to one another candidly as equals, and inhibits the voicing of negative feelings toward the therapist.

Based on group therapy experiences with Chinese clients in Canada, Chen (1995) noted that the Chinese tended to expect the therapist to maintain the image of an authority figure with expertise, to educate the group members and to provide structure for the group process. It was also better for the therapist to define rules and boundaries for the members to follow.

All of the examples raised above suggest that the behavior of group members will be very much influenced by their cultural backgrounds in the areas of communication style, relational patterns and interaction with the therapist, all of which, in turn, affect the process of group therapy. Since group psychotherapy deals primarily with interpersonal issues there is a great need to understand the impact of culture on interactional behavior.

**Comment**

Working with patients from diverse ethnocultural groups, particularly minorities and immigrants, clinicians have begun to accumulate more experience of issues relating to ethnic identity confusion, transcultural migration adjustment problems, and intercultural marital adjustment problems, all primarily cultural issues. Associated with these clinical experiences, clinicians have begun to provide some therapeutic suggestions on how to deal with such issues.

There have been few studies on how cultural factors actually affect the process of psychotherapy. Sundberg and Sue (1989) proposed many research hypotheses on the effectiveness of intercultural counseling that need to be tested, including: the influence of the degree of cultural congruence between counselor and client in their orientation toward therapy and expectation of therapy; the counselor’s knowledge about socialization in the client’s culture; and the counselor’s sensitivity toward cultural patterns of communication, relationships, etc. The fundamental question of whether culture-specific modes of counseling are more effective with certain cultural and ethnic groups than with others remains to be addressed.

Although cultural issues tend to be noticed only when cultural differences between patient and therapist are clearly evident, all psychotherapy is cross-cultural in that no two people have internalized identical constructions of their cultural worlds (Wohl, 1989). Even if the therapist is treating someone from a similar cultural background, there are always communication problems to overcome and differences in values to be negotiated.
Thus, there is no sharp distinction between intercultural and intracultural psychotherapy, which represents situations located on a continuum of cultural encounter.

**INTEGRATION AND CLINICAL GUIDELINES**

**COMMON ELEMENTS IN FOLK AND PROFESSIONAL PSYCHOTHERAPIES**

Despite major differences in orientation, therapeutic operations and healing mechanisms among the various forms of psychotherapy reviewed, there are common elements (Tseng & Hsu, 1979). These are summarized in Table 1 (pp. 134–5) and below.

*Provision of a Culturally Permitted Channel for Revealing Wishes or Desires* In many societies, it is difficult for some of the members, particularly those who are in underprivileged or culturally suppressed subgroups, to voice their unsatisfied needs or desires. Healing ceremonies or therapies become channels for them to reveal their unexpressed wishes. The practice of the *zar* ceremony illustrates this point. Since revelations are made through possessing spirits, rather than directly by the clients, there is no concern about being criticized. The practice of free association in psychoanalysis is another example in which clients are given the opportunity to express their inner thoughts or desires without social inhibition.

*Reinforcement of Culturally Sanctioned Coping Patterns* One of the functions of psychotherapy is to reinforce culturally sanctioned coping patterns. This is exemplified by the Chinese *chien* divination practice, in which the traditional Chinese way of remaining ‘patient’, ‘unaggressive’, and ‘accepting’ of the situation is emphasized for coping with problems encountered in daily life (J. Hsu, 1976). In contrast to this, Alcoholics Anonymous, which originated in the United States, encourages members to reveal and face their problems, to work out the problems through concretely defined ‘steps’ – a reflection of coping patterns sanctioned in a society that emphasizes openness, action and dealing with things through a ‘program’.

*Affirmation of Central Cultural Values* Psychotherapy provides an institution through which the basic philosophy or value system emphasized by a culture is affirmed and implanted in the clients. The emphasis on the *arugamama* (‘as it is’) attitude toward life and illness in Morita therapy and on becoming *sunao* in Naikan therapy in Japan, the regaining of self-confidence and becoming socially productive members to comply with the politics of the Great Leap Forward in integrated rapid therapy in China, all
illustrate this point. Client-centered therapy emphasizes a non-directive counseling approach to reinforce an independent coping style valued in American culture (Meadow, 1964).

**Permission for Cultural ‘Time Out’** Therapy may offer a cultural ‘time out’ for clients. For example, in the Hawaiian folk-healing practice, *ho`oponopono*, family members who have concerns are permitted to express their anger or resentment during the healing meeting. In this therapeutically protected circumstance, the clients are allowed to temporarily ignore the ordinary cultural emphasis on harmony and not expressing negative feelings in public. Once the therapy session is over, the patient represses the uncomfortable issues and returns to normal life.

**Exploration of Alternative Approaches for Problem Resolution** Instead of enforcing culturally valued traditional coping, therapy may urge the clients to explore alternative approaches. To encourage a culturally sanctioned ‘submissive’ wife to become ‘assertive’ and seek her own rights in her relationship with her husband is an example of searching for alternative resolutions. To guide a man to becoming relaxed and not overconcerned with his success in an achievement-oriented society, is another example of finding balance and resolution against the mainstream cultural trend.

**Incorporation of ‘New’ Culture Systems** Psychotherapy can be viewed as the interaction of two value systems: the client’s and the therapist’s. Through the process of therapy, a client is exposed to the therapist’s way of viewing things, which is supposedly more healthy and functional than the client’s. Through a process of interaction and exchange, the client gradually incorporates the ‘healthier’ value system.

**Adjustments Needed for Culture-Relevant Therapy**

The cultural adjustment of psychotherapy needs to be approached from at least three levels, namely, technical, theoretical and philosophical (Tseng, 1994).

**Technical Adjustments** Technical adjustments refer to the skills and considerations that must be used and manipulated by the therapist to fit the background of the patient, which includes the patient’s age, gender, personality, pathology or motivation for therapy. For instance, adjustments are needed: in the way in which therapy is initiated, based on the patient’s orientation toward and understanding of therapy; in forming a culturally appropriate therapist–patient relationship; in managing cultural transference and countertransference; in performing culturally
suitable communication and interpretation; and in selecting culturally relevant models for therapy.

**Conceptual and Theoretical Modifications** Beyond technical adjustments, it is also necessary to make conceptual or theoretical modifications to fit the patient’s cultural background. At present, several theories, particularly psychoanalytic ones, are utilized by the therapist to understand the patient’s personality and behavior. However, such theories are subject to cross-cultural modifications if they are to be used for people living in different socio-cultural settings. Ethnicity and culture must be recognized as significant parameters in understanding psychological processes [American Psychological Association (APA), 1993] including: concepts of self and ego boundaries (F. L. K. Hsu, 1985; Kirmayer, 1989; Marsella, DeVos, & Hsu, 1985; Roland, 1991); theories of personality development (Abel & Metraux, 1974; Erikson, 1963; F. L. K. Hsu, 1981; Malinowski, 1953; Tseng & Hsu, 1972; Whiting & Whiting, 1975); the theory of defense mechanisms (Cheung, Zhang, & Song, 1996; Vaillant, 1986); and therapeutic mechanisms (Kirmayer, 1989; Marsella et al., 1985; Roland, 1991).

**Philosophical Considerations** It is becoming clear to cultural psychiatrists that in the practice of psychotherapy, the therapist needs to take into consideration the patient’s philosophical orientation. A patient’s basic view of, and attitude toward, human beings, society and life, closely related to concepts of normality, maturity and health, will have an obvious impact on the patient in his search for improvement.

**Guidelines for ‘Culturally Relevant Psychotherapy’**

Culturally relevant, compatible or sensitive therapy requires attention to the areas discussed below.

**The Socio-cultural Setting of Therapy** The socio-cultural environment within which the therapy takes place includes the basic philosophical orientation held by the society and the individual toward nature and the meaning of life. This fundamental philosophical orientation may affect the nature and goal of the therapy as a whole. Attention is also needed to people’s common behavior patterns, beliefs, customs and daily practices. Furthermore, the social structure, family system, political ideology, economic conditions, medical system, history of medicine and psychiatry, and the population’s general understanding and attitude toward mental illness and emotional problems, may all influence the practice of psychotherapy.

**The Patient’s Expectations of Psychotherapy** Familiarity with, and attitudes toward, psychotherapy vary from society to society, as well as from
individual to individual, based on the general attitude toward mental illness or emotional problems and medical knowledge. Psychotherapists develop rules for patients to follow and establish certain agreements for patients to observe in order to facilitate the process of therapy. However, many patients are unfamiliar with such rules, in which case they need to be explained and discussed. Similarly, the purpose of specific therapeutic techniques (e.g. dream analysis, free association or interpretation of unconscious dynamics in psychoanalysis; reframing or paradoxical suggestions in family therapy; and positive reinforcement or punishment in behavior therapy) must be carefully explained and guidance on how to follow them is always needed.

Culturally Suitable Therapist–Patient Relations The desirable ‘therapeutic’ relationship is defined differently in different therapeutic modes. However, it is generally considered that the relationship needs to fit the individual patient’s condition to be ‘effective.’ The relationship also should be culturally relevant and this requires consideration of how the patient views and relates to authority in his society, and what kind of therapist is expected according to his cultural perspectives. For some patients, the therapist is expected to take an authoritative, active and giving role; while for others, the therapist is expected to relate in an egalitarian way, without interfering with the patient’s autonomy and independence.

In addition to personal transference and countertransference, it is necessary to note that there is additional ethnocultural transference and countertransference, particularly if the therapist and patient belong to different ethnic or cultural backgrounds. Such ethnocultural transference and countertransference can be manifested in various ways and need proper management from the very beginning of therapy. This is particularly true when there is a preexisting negative relation between the therapist and the patient due to ethnic or racial background.

Communication Style The patient’s style of problem presentation, complaint and suffering will be shaped by cultural factors. Special attention and consideration need to be given to the nature of communication between the therapist and the patient. This includes the content, level of sophistication and focus of communication. It is particularly important when a therapist is going to provide explanations, interpretations and suggestions that such communication fit the culture of the patient and his family.

Culturally Adjusted Theories of Psychopathology For in-depth understanding of the patient’s behavior, personality and coping patterns, clinicians make use of available theories regarding the basic nature of the
human mind, personality development, coping mechanisms and so on. These theories need adjustment to be applied to people from different cultural backgrounds. From a practical point of view, it is impossible for clinicians to possess full knowledge about all the cultural systems and behavior patterns they encounter. However, there is one shortcut to learning about the culture of the patient, and that is learning from the patient. If necessary, it is useful to consult resource people, such as cultural or medical anthropologists.

**Therapeutic Models** There is much debate as to what therapeutic models are best suited for patients with certain types of psychopathology or personality traits. As an extension of this, there is room for clinicians to consider which therapeutic models are better suited for patients of specific ethnic or cultural backgrounds. For instance, is directive therapy better than non-directive therapy for people who culturally tend to view the therapist as an authoritative figure who offers suggestions and makes decisions for the patient? Is family-oriented therapy better suited than individual therapy for people who are strongly influenced by close family relations and who emphasize the family as a whole in their behavior? Does it make any difference if analytic therapy or behavior therapy is used, depending on culturally patterned preferences for introspection or action-oriented approaches to solving problems? These questions need further investigation.

**Universal Therapeutic Mechanisms and Culture-specific Coping Patterns** Therapists need to pay attention to universal therapeutic mechanisms and make good use of them, rather than merely being concerned with specific therapeutic mechanisms favored by a particular school of therapy. In addition, various styles of coping are strategically enhanced in therapy. For example, for an internal emotional conflict, the patient might be assisted to ‘uncover’ or encouraged to ‘suppress’ the conflict. This is not merely a matter of clinical judgment, but also involves cultural considerations depending on the kinds of coping mechanisms that are sanctioned and function better within the patient’s cultural setting. ‘Seeking harmony’ with others or ‘resolving conflicts’ are other examples of patterns that may be thought of differently in different socio-cultural settings, depending on the extent to which social harmony is emphasized and active solutions of identified problems are favored.

**The Potential Impact of the Therapist’s Value System** In addition to a therapist’s medical knowledge, psychotherapeutic orientation, personal view and clinical experience, his or her value system will have a direct or indirect impact on the practice of psychotherapy. In general, it may be
assumed that the value system of the therapist is healthy and functional, so that it will be useful for the patient to adopt that view or value system. Yet, the therapist’s view is not always relevant or useful from the standpoint of the patient’s cultural background. A clinician needs to be aware of the possible irrelevant or even negative impact of his personal cultural orientation, and constantly reassess and regulate the therapy to maintain its relevance to the patient from a cultural point of view.

The Goals of Therapy Finally, it is important to recognize that the goals of psychotherapy need to be evaluated from a cultural, as well as a clinical, point of view. The concept of ‘normality’ may be approached by definition of a professional expert, evaluation from a statistical standpoint, judgment from a functional perspective or from a socio-cultural point of view (Offer & Sabshin, 1975). Clearly, the definition of a ‘healthy,’ ‘mature,’ ‘adaptive’ person is very different depending on the value system held by a group of people in a particular cultural setting. A therapist needs to take into consideration the socio-cultural environment in which the patient is living and the kind of person it is desirable for the patient to become in order that he or she can function as a ‘healthy’ and ‘mature’ person in his or her socio-cultural setting.

Conclusion

This article has attempted to show that there are different degrees of cultural influence on various modes of therapy. Using the adjectives ‘culture-embedded,’ ‘culture-influenced’ or ‘culture-related’ in grouping therapies assists us in recognizing that cultural impact on therapeutic modes varies in nature and degree. Some therapies, such as the zar ceremony, are so deeply embedded in their particular cultural settings that it is almost impossible to transplant them to other cultures; some, such as Morita therapy, need considerable modification; while others, such as psychoanalysis, although their relation to culture may not be as obvious, still require cultural adjustments in both theory and technique for transcultural application.

This understanding is particularly important when we are attempting to apply therapy interculturally for an individual or to transplant therapy across societies – something that is happening more often than in the past, creating new challenges for modern therapists. In dealing with the contemporary world, it is desirable for therapists to examine and understand psychotherapy broadly, not only vertically across time, but horizontally across cultures, in order to grasp the overall experience of human beings with regard to the theories, knowledge and practices involved in the healing of the mind.
References


Tseng: Culture and Psychotherapy


Koss, J. D. (1980). The therapist–spiritualist training project in Puerto Rico: An experiment to relate the traditional healing system to the public health system. *Social Science and Medicine, 14B,* 255–266.


Tseng: Culture and Psychotherapy


Tseng: Culture and Psychotherapy


**Wen-Shing Tseng, MD**, is Professor of Psychiatry at the University of Hawai‘i School of Medicine and Guest Professor at the Institute of Mental Health, Beijing Medical University. He has travelled throughout Asia and the Pacific for teaching and research, and as a consultant to the World Health Organization. He served two terms as Chair of the Transcultural Psychiatric Section of the World Psychiatric Association. Dr Tseng has authored or edited numerous books, including: *Psychotherapy: Theory and analysis* (Beijing Medical University Press, 1994), *Chinese societies and mental health* (Oxford University Press, 1995) and *Culture and psychopathology: A guide to clinical assessments* (Brunner/Mazel, 1997). *Address*: University of Hawai‘i at Mānoa, John A. Burns School of Medicine, Department of Psychiatry, 1356 Lusitana Street, Honolulu, HI, 96813, USA.