Ethical Issues in Cross-Cultural Psychotherapy

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Ethical cross-cultural psychotherapy practice requires the therapist to be open in every aspect of the psychotherapeutic relationship to all the dimensions of culture, both in the client and in oneself. Ideas about culture, 'ethical toleration', 'culture-centred counselling' and 'cultural safety' are examined here as a backdrop to a discussion of ethical issues, psychotherapy and culture. This discussion is drawn from twenty-four years of experience working with refugees at the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS). Themes include the diversity and fluidity of cultural identity, boundary and role issues, and the possibility of cultural issues acting as a smokescreen for minor enactments. Also addressed is the need in cross-cultural therapy for development of a capacity to tolerate difference and psychological separateness as part of the work, for both the therapist and the client.

Drozdek (2007) writes that there are hundreds of definitions of culture. As a psychotherapist, the dimension of culture in psychotherapy work is a complex, fluid notion that changes over time and intersects every layer of our identity, feelings, thoughts, language, and relationships.

Tension infuses how we think about culture in psychotherapeutic practice. One theme in the multicultural counselling literature acknowledges the complexity and fluidity of cultural identity in Western society, and urges us to avoid stereotyping, and to recognise the uniqueness of each individual. Many people are either bicultural or multicultural and cultural identity is not fixed. Other dimensions such as gender, sexual identity and disability can intersect with racial or ethnic identity (Pack-Brown & Williams 2003). Even though it is hard to define distinct 'cultures', it is still possible to experience different 'cultural realities', and it is useful to talk about a particular culture in relation to psychotherapy with refugees from a particular group (Nguyen & Bowles 1998). A political perspective recognises issues affecting people from minority groups who may be 'falling through the net', because so-called Western interventions may not be suitable for them.

Rowson (2001) uses the words 'ethical' and 'moral' interchangeably, to refer to general ideas of right and wrong behaviour. Bowles W et al. (2006) define ethical practice as being "concerned with making decisions or judgements about how to act or what to do, and being able to justify those actions and behaviours within some kind of philosophical framework". They distinguish between 'values'—which are general, personal and professional ideals—and 'principles', which are like guides for how to operationalise the more general values. "Values do not tell us what to do, they tell us what is good. A number of principles may come out of one value" (2006:55).

Holmes (2001) points out that while codes of ethics for psychotherapists appear straightforward, in fact, the actual work of psychotherapy is full of uncertainties and challenges. We try to have clear goals for therapy work, yet we should not be controlling or imposing these on our clients. We try to be accepting and open, yet we constantly reveal our own values, for example, in our speech patterns, dress and facial responses. We may consciously believe that we are acting in a certain way, yet we may be re-enacting other dynamics of which we are not aware.

Barnes and Murdin (2001) point out that every theory about psychosocial development implies a particular view about human nature and values certain kinds of behaviours, states of mind, and personality development as being desirable or better than others. The issue is who decides which are better? We respect the value of autonomy and believe that clients should be developing their own ideas of what is better or good, but the reality is that clients are vulnerable and everything that we do or say as therapists is influential. Our own value system is constantly being communicated to our clients. Barnes and Murdin (also Pack-Brown & Williams 2003, Pedersen 2007, Sue et al. 2009) point out how critical it is for psychotherapists to become aware of their own values. Much of the time, we are not aware of the values by which either we or our clients live.

When we are working with clients from other cultures, these issues become heightened. The first fundamental principle in the CAPA Code of Ethics, for example, is Autonomy and Self Determination, which is defined as "respect[ing] the dignity and worth of each person, their culture and context" (CAPA:7). How can we ensure that we are respecting culture in our work? Do our codes of ethics themselves contain cultural biases?

Relativism, Absolutism and Ethical Toleration

Central questions underlying the subject of cross-cultural psychotherapy and ethics include whether there are any universal ethical standards or values which exist across cultures. How do we understand the relationship between culture and ethics? Are ethics objective moral truths or personal opinions and social/cultural attitudes (Rowson 2001)? The historical debate surrounding 'relativism' or 'absolutism' has probably been considered by scholars from many cultures, but we do know for certain that versions of it were outlined by Aristotle in Ancient Greece (Bowles W et al. 2006).

'Cultural relativism' posits the existence of neither fixed personality characteristics of a universal human nature nor universal ethical standards. This position holds that all cultures—along with the ethical standards within different cultures—are equally valuable. Spiro (1978), for example, pointed out that relativism undermines racist notions and the idea of a 'primitive mentality'.

Related to cultural relativism is the post-modern lens that views the existence of no single 'truth' but, instead, multiple realities and discourses and ways of understanding the world. This idea calls into question the authority and absolute standards of codes of ethics. For example, what kinds of dominant discourses have influenced their making and do they ignore the views of cultural minorities (Bowles W et al. 2006, Pedersen 2007, Pack-Brown and Williams 2003)?

It could be argued that because no culture agrees universally about its own values, relativism is not a coherent position (Bowles W et al. 2006). A response to this argument holds that while people may be part of many cultures, that doesn't mean morality is not relative to culture (Rowson 2001).

Understanding something about relativism, including its complexities and limitations, can be useful for grappling with ethical situations that arise in everyday cross-cultural psychotherapeutic situations. This includes developing a capacity for tolerating different ethical and cultural viewpoints simultaneously. However, intellectual reasoning, as will be discussed later, is only one aspect of this process, which involves the ability to balance alternative values and cultural perspectives and to cope with difference.

Bowles W et al. (2006) describe the three possible responses of a social worker to a client advocating female genital mutilation (FGM). A 'relativistic response' accepts FGM without judgement, because it is from another culture. The 'absolutist response', immediately rejects the notion of FGM in accordance with the social worker's cultural/moral principles. The third response embodies both simultaneously. It is best, however, to avoid either extreme and instead opt for an ethical position between the two (Bowles W et al. 2006). This middle ground involves respectfully trying to understand the client's cultural and ethical perspectives while working through the issue with the client to reach some point of mutual agreement where neither the client's nor the therapist's values are sacrificed. The sophisticated discussion by Bowles W et al. includes detailed philosophical arguments, which promote a style of working together that the authors term 'ethical toleration'. While there are core elements in the authors' approach that are relevant for psychotherapists, the ethical dilemma described is based in a welfare counselling context and includes community levels of intervention, rather than focussing on more internal, subjective psychotherapeutic processes.

Codes of Ethics and Culture, Culture-Centred Counselling and Cultural Safety

Authors (Pack-Brown & Williams 2003, Pedersen 2007, Barnett & Bivings) from the literature on multicultural counselling and ethics point out that ethical guidelines inevitably contain the cultural values of the group who wrote them. They further claim that sometimes multicultural counsellors can either follow culture-bound ethical guidelines, which will lead them to act towards their clients in inappropriate ways, or act appropriately but end up transgressing or bending the guidelines.

Pack-Brown & Williams (2003) describe cultural issues in existing codes of ethics for counsellors and advocate culturally appropriate ways of interpreting existing codes. They also describe working through different ethical dilemmas in multicultural counselling situations. A central issue is the individualistic bias in ethical codes and practices, compared with the values and behaviours derived from a more collective culture. Their general goal is to encourage ethical thinking and behaviour in accordance with primary values, rather than 'rule-following'.

Pack-Williams & Brown (2003), Pedersen (2007), Sue et al. (2009) describe how to develop 'cultural competency' or to become a 'culture-centred counsellor' or 'multicultural counsellor'. Their different training programs broadly include three categories: becoming aware of one's own cultural values, developing knowledge, and practising skills. This framework of 'cultural competency' has become widely recognised and includes the kind of person the professional is, the interventions and skills used, and the processes followed (Sue et al. 2009).

The related notion of 'cultural safety' was originally developed in New Zealand by Maori nurses and was first adopted by indigenous people in Australia in the 1980s, as a way forward for their empowerment. Williams (1999) defines cultural safety as:

> *[A]n environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together* (Bin-Sallik 2003).

Williams points out that cultural safety does not connote special treatment for indigenous people but, rather, all cultural groups can relate to it. She describes two processes to develop cultural safety amongst health professionals: the development of 'cultural awareness' of cultural differences and histories, and the development of 'cultural sensitivity' about oneself and others.

Clinical Observations from a Cross-Cultural Psychotherapy Practice

A good proportion of the staff at STARTTS come from refugee or refugee-like backgrounds, and this has been an important factor in our attempts to develop culturally sensitive interventions. The service operates on a 'bio psycho social' model, which integrates community development and clinical approaches. Since 1988, we have worked with refugees from over 150 countries. The different cross-cultural counselling models with which we have worked have included the bicultural counsellor model (working in co-therapy with bicultural colleagues), psychotherapy with interpreters, and working in English with clients who are from diverse cultures.

The opinions expressed in this article are my own, and are not made on behalf of STARTTS. Any references to 'my clients' are not based on particular people but are general descriptions of commonly occurring situations.

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When I first started working at STARTTS in 1988, I was unsure about whether Western models of psychotherapy and counselling would be helpful to our refugee clients. Would we be 'imposing' a 'Western' model of working and did Western forms of psychotherapy have any relevance?

Our way of working in psychotherapy at STARTTS has evolved organically over the years, from the grass roots upwards, in close collaboration with colleagues who were themselves from refugee backgrounds. We have tried to create what Pedersen (2007) describes as 'culture-centred' approaches to counselling where culture takes a central place in our interventions. We have tried to establish what Williams describes as 'cultural safety', providing structures for counsellors to have a safe place for working through and adapting various approaches for working with traumatised clients from their own countries. These structures include working in co-therapy with a cross-cultural colleague and receiving regular supervision and training. (For related publications please view our STARTTS website.)

Many therapists may have clients from the same broad cultural background as their own, yet still experience ethical conflicts with their clients regarding cultural values and practices. The same beliefs are not shared by everyone from the same ethnic background. The social worker and the client in the example about FGM could have been from the same broad culture but from different groups within it.

A point relevant to subjective experiences in psychotherapy is that many people have a multicultural identity. Therapists and clients may have a mixture of values, identities and relationship styles, all of which may not be integrated in a consistent, conscious framework. For example, people may belong to a family or a group that has a collective orientation, in which they place the values of the group as primary, and yet also have more separate, autonomous ways of functioning elsewhere.

It is possible to have a fluid kind of cultural identity that changes over time, and both therapist and client may alternate between different cultural value-positions in their minds during a single psychotherapy session. Subjective phenomena can be experienced to some degree by both therapist and client in the 'play area' (using Winnicott's concept) of a psychotherapeutic relationship.

While some major ethical dilemmas can arise (for example, the situation involving FGM) many everyday ethical issues in cross-cultural psychotherapy work are related to subtle and multi-faceted ways of respecting and being open to a different culture. It could be argued that these issues could occur with any client; whenever two people are in a therapy relationship, they are in a sense opening themselves up to the internal world of the other, including the cultures which helped form the other person. When the cultural differences are marked, the issues of 'the other' are heightened, with an awareness that a different world view, history, language, and cultural milieu has formed this person. Ethical practice includes developing an awareness of how culture can influence the dimensions of identity, relationships, feelings and expressions—the entire reality. The challenge is to open oneself as deeply as possible to the other, while also maintaining a sense of self.

There are interesting ethical issues relating to the subtle aspects of relationships formed between people who share aspects of a 'collective' sense of self. What are the ethical professional boundaries, appropriate roles and behaviour for a therapist in this situation? Consider this example.

An elderly grandmother from a traditional Asian family, newly arrived in Australia, having lost her daughter in a civil war, starts to feel as though her younger therapist is, or is becoming, a replacement daughter. (This is in addition to the myriad unconscious projections, which occur all the time between client, therapist, and interpreter.) The interpreter is respectful to the grandmother in both verbal and nonverbal ways, always deferring politely to her. The interpreter does not know what words to use in their language to frame their relationships properly, particularly when the elderly grandmother starts to feel affectionately towards them, using words that suggest she feels the therapist is 'her daughter'.

(For a discussion regarding ethics and psychotherapy with interpreters, please see Becker & Bowles 1991.)

The therapist experiences a subtle shift in the boundaries of their relationship, or in the feeling in the room, as if she, the interpreter, and the client are all closer emotionally, having somehow 'let each other in'. A kind of merging with the client at times occurs or a kind of valency towards the group forms comprising the interpreter, client, and therapist as if they were a family. The therapist is aware, to some degree, of how to behave respectfully with elderly people in this culture. She tries not to 'put the client off' for example, by speaking quietly and respectfully. Eye contact is a confusing issue for the therapist, because neither the interpreter nor the grandmother may wish to look at the therapist when speaking, feeling more comfortable to look away. The grandmother expresses deep feelings of grief but in understated, restrained ways.

The therapist, at times, finds her client's pain unbearable and allows herself to escape momentarily, removing herself in her mind from her position as therapist. For a few seconds she instead feels sort of 'merged' with her client in a kind of mother-daughter feeling, which has interesting cultural nuances that are difficult to pinpoint. A few moments later, the therapist struggles to return to the reality of the situation, to regain her mental position as the therapist. To do this, she must allow the pain that she and the client have been working through back into her mind while trying to also think about the confusing cultural dimensions of the situation.

How do we understand what is happening here? Is the psychotherapy a 'culture-centred' style of working that fits the collective style of relationship and unconscious internal object relations inside the three women? Or is the therapist not maintaining enough professional distance and not setting appropriate emotional boundaries? Do the 'cultural' aspects of this relationship interfere with the psychotherapy work momentarily, acting as a defensive manoeuvre to avoid the pain of losing the real daughter? Or is the therapist allowing herself to experience the countertransference as fully as she can, in all the cultural and emotional aspects? In trying to be open to the client's culture, does the therapist lose her own sometimes?

All these ideas are useful to think about. The critical point is to try not to avoid the complexity and fluidity of the situation. Pedersen suggests thinking of complexity as 'your friend', rather your enemy, when coping with a complex multicultural world (Pack-Brown & Williams 2003). It is important to have a reflective space in supervision to think through what could be happening.

Many ethical issues in cross-cultural psychotherapy work (as in all psychotherapy work) can relate to avoiding the pain of the work, for both the therapist and the client. Sometimes we can use culture as a kind of smokescreen for enactments, although this may only be one dimension of what is occurring. This is discussed in the following example.

Colleagues from STARTTS are often invited by colleagues to attend family events. I remember attending a funeral ceremony. Unexpectedly (I did not consider this beforehand, although it should have occurred to me), I realised that some of my clients were there as well. I worried that my clients might feel embarrassed, seeing me there in a public gathering of their community, and I suddenly realised that I might inadvertently be socialising with my clients and transgressing an ethical guideline.

Another secret dimension was that the experience enacted briefly some kind of fantasy—and perhaps for the clients as well—that I could actually be in their community as a kind of relative, rather than being separate as their therapist. I experienced an emotional 'collective pull'. I felt confused and guilty, and I worried that I was suddenly escaping into a fantasy to avoid the pain and boundaries of the work. In reality, we were actually joining together in experiencing real grief in a communal, religious setting, which had its own boundaries. The experience gave me a better understanding of their community and culture and probably further developed the attachment between us. Several processes were occurring at once, and it can take time to work through what is happening.

The toleration of difference and pain requires a level of separation, healthy boundaries and balanced, emotional maturity. Melanie Klein described this developmental movement as progressing from the paranoid-schizoid position to the depressive position in our minds, and this movement is, to some degree, occurring every day in our thinking. Many of my clients, at times, cannot cope with any separation or difference between themselves and myself. In parts of our sessions I have received political or religious lectures from my clients asserting their views as 'right' and all others as 'wrong', enlisting me to somehow merge with them. Another version of this kind of black and white thinking or 'split' mental organisation typical of the paranoid-schizoid position is a situation where clients feel that they are worthless and their culture 'second rate'. Clients may try to take on my culture instead, as if I have all the good aspects and the client all the bad. These feelings of inadequacy are reinforced by parts of their environment which validate the dominant culture.

In both of these seemingly opposite situations, the work in psychotherapy attempts to assist the client (and myself) to move to a more balanced position where we can tolerate differences in each other, diversity in different cultures, and sit with each other as separate people. This is not only an intellectual exercise but also an emotional one. The therapist must tolerate intrusive projections and contain the client's intense emotional experiences in order to help the client develop a more separate and balanced way of operating. The work involves constant backwards and forwards movement towards a more balanced view. Developing an ability to tolerate difference and 'other' cultures is more than a philosophical discussion—although this is one aspect of it. Tolerance depends much on the therapist's ability to contain clients' intense projections and—using Bion's notion of 'containment'—which assists them to attain a more integrated state of mind and to cope with ambiguity and different realities (1984). (A discussion of the application of psychodynamic concepts across cultures is beyond the scope of this paper.)

Conclusion

In summary, while the possibility of a universal code of ethics or morality remains unresolved, we can still follow general professional values and guidelines, but with awareness of the cultural biases in our codes and in ourselves. Ideas about ethical tolerance, cultural safety and culture-centred counselling are useful for developing ethical thinking and practice which respect culture. Ethical cross-cultural psychotherapy is about respect and understanding. It requires the therapist to be as open as possible to clients' internal worlds, including the cultural worlds that have shaped and continue to shape them. The challenge is to balance this openness with an awareness of our own developing values and sense of self. It is important to open oneself to the subtle, fluid presence of culture in all the dimensions of a psychotherapeutic relationship, including thoughts, feelings, behaviour, identity, and unconscious processes.

It is also necessary to ensure reliable supervision in which we, as therapists, can sort through complex questions about culture and ethical practice as they arise. Being able to tolerate difference and 'otherness' is a developmental, psychological process with which we all struggle.

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