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 tolerance’, ‘cultural safety’, ‘cultural 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 multicultural elements. 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 in a particular situation, 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 behave in particular situations and 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 or unconsciously tell the client that we are acting in a certain way, yet we may be re-creating other dynamics of which we are not aware.

Barnes and Murnin (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 personal and professional 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 Murnin (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 Tolerance

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 there 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 personal ethical character nor universal standards of ethics. This position holds that all cultures—along with the ethical standards within different cultures—are equally valid. Spino (1978), for example, pointed out that relativism undermines the ‘moral order of society’. Relativism is the idea that there is no universal or objective standard of right and wrong.

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 their values are not relative to culture (Rowson 2001).

Understanding something about relativism, including its complexities and limitations, can be useful for grasping 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 focusing on more internal, subjective psychotherapeutic processes.

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

Authors (Pack-Brown & Williams 2003, Pedersen 2007, Burnett & Williams 2007, Sue et al. 2009) state that the codes of ethics 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 ‘[An 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, 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 STARiTS 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 a variety of cultural and ethnic backgrounds.

The different cross-cultural counselling models with which we have worked have included the bicultural counsellor model (working in co-therapy with bicultural colleagues), psychotherapists with interpreters, and working in English with clients who are from diverse cultural backgrounds.

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

Robin Bowles

(continued on Page 30)
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 our clients, themselves from refugee background. 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 William 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 our own countries.

Many structures include working in co-therapy with a client or a co-worker, regular supervision and training. (For related publications please view our STARTTS website.)

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