

CHAPTER THREE: CROSS-CULTURAL PSYCHOTHERAPY

Culture and Psychological Treatment

3.1: Psychological Treatment Approaches and Culture

When discussing the applicability of psychoanalysis across culture it is necessary to understand that culture itself is inextricably linked to the psychological processes of the individual. These processes are embodied in the concept of “self”. Just as language is an innate human capacity, which is configured differently in accordance with the particular social context of the developing individual, so can the self be considered as an innate capacity, which is manifested and organised differently depending on the individual’s social milieu. As recognised by William James in 1890, organisation of the self is strongly shaped through socio-cultural factors (cited in Owusu-Bempah & Howitt, 2000). Jungian analyst Vera Buhrmann (1984) in her work with the Nguni people of South Africa makes reference to the impact of culture on shaping the self. From a Jungian perspective she outlines an alternative dimension to the mind, which she believes is of great importance for a better understanding of other cultures. She refers to this dimension as the “cultural layer”. She situates this cultural layer in the Jungian topography of universal unconscious, personal unconscious and ego-consciousness and states that it is shaped and determined by the norms and value systems of the culture that one grows up in and like the ego, is partly conscious and partly unconscious (ibid).

It is important to recognise, when considering psychological treatment approaches, that all approaches for psychological healing and treatment are based on culturally defined conceptualisations of self. The following section therefore places culture and self as central to the discussion of cross-cultural psychotherapy and emphasises the often neglected point that the concept of self differs according to culture, and theoretical approaches adapted from one cultural expression of self may not be readily transferable to a different culture.

This section gives a detailed account of how the principles of psychological practice and psychoanalytic theory have been applied across cultural boundaries both historically and contemporaneously. Western notions of self have been very strongly informed by the Cartesian concept of dualism, which has strongly informed the Western individualised self. There has been an historical trend whereby the concept of the individualised self was held as an ideal standard, which could be imposed as a universal rule holding true for understanding the formation of self in all cultures; more recently post-positivistic stances have understood the need to examine the self

from within its specific cultural context and allow for differences in self-formation to emerge from this context (a relativist as opposed to a universalist approach).

If psychoanalysis is constantly evolving to reflect the changes of the society it represents, then it is feasible that such theories can be reformulated to accommodate the nuances of different cultural groups in South Africa. Whilst it is not the aim of this study to revise the core concepts of psychoanalysis, it should highlight the fact that such concepts need to be de-contextualised from their western position and then re-contextualised in a different cultural milieu. All Black South Africans have been exposed to Western influences and ideologies. It would be just as short sighted to speak of a traditional African self as it would be to speak of an ideal Western self. No society is static and this is especially visible in South Africa. This study takes into account the fact that whilst Black English-speaking South Africans may have taken on many of the values and beliefs of the Western system through their education, they also rely strongly on their traditional belief systems. These beliefs show themselves most clearly in times of emotional distress (Pretorius, 1995). Such beliefs are highly personal, comprising symbolic understandings that are often culture specific (ibid). In the words of Buhrmann many South Africans are:

Living in two worlds... the Western world, which is primarily scientific, rational and ego-oriented, and the world of the Black healer and his people, which is primarily intuitive, non-rational [and] oriented towards the inner world of symbols and images of the collective unconscious (1984, p. 15).

It is a part of a colonialist mind-set that believes one system is superior to another and can be transposed and will be suitable. All too often clinicians are faced with great confusion when working cross-culturally. In some cases clinicians and hospital staff may label a patient as 'cultural' rather than 'psychiatric' implying that a more effective treatment solution lies outside the boundaries of biomedicine. This re-labelling may have positive and negative impacts for individuals with serious mental illness (Swartz, L., 1998). In other cases clinicians may compensate by referring the patient for pharmacological intervention or for the use of suggestive, short term or cognitive forms of therapy. Pelzer (1996) points out that medical and psychiatric services in Africa are prescribing psychotropic medication for an increasing number of patients with psychological illness. In short, treatment interventions often reflect western views and in South Africa such views have been further complicated by colonialist and Apartheid ideologies. This research study aims to explore ways of thinking about such patients that are psychoanalytically based. It does not pre-suppose a specific outcome but rather hopes to contribute by allowing these changes and adaptations to emerge out of the therapeutic encounters that comprise the three case studies of this research.

It can be reasonably assumed that the primary tools of psychoanalysis, classical and contemporary, are imbued with the dualistic stance of western culture. Whilst contemporary psychoanalysis attempts to overcome the subject/object dichotomy the essence of dualism is still present to a greater or lesser degree depending on the approach used. In accordance with the classical model the patient engages in free association saying whatever comes to mind whilst the quiet and listening therapist attempts to maintain a neutral stance. This neutrality requires the therapist to reveal little about himself. The expected aim of withholding such information is to inspire transference reactions from the patient that reflect inner conflicts. This relationship is artificial by nature and often evokes anxiety responses. The tension that may arise in these interactions is expected to bring to the fore fantasy material to be interpreted, thereby transforming the unconscious wishes and desires into the conscious life of the person. A patient in this relationship is required to be active and willing to co-operate in a stylised interaction. Patients vary in their willingness and in their capacity to engage in such a relationship. With regard to working in the transference they may experience difficulty in putting aside their immediate feelings, such as anger, and reconsidering how such feelings towards the therapist may illuminate conflicts with others in the patient's current and past life. Individuals who are well acquainted with the discourse of psychotherapy and the nuances of western style communication do best in this relationship. Individuals from non-western cultural groups may not respond as favourably and often experience the relationship as unnatural and anxiety provoking (Levenson, H., Butler, S. & Beitman, B., 1997). They are already confronted with the challenges of communication and trust. They may often experience difficulty verbalising emotions and may be unused to the notion of introspection and articulation of the individual self. This is especially pertinent for individuals who come from a cultural background that places a strong emphasis on a community rather than an individual sense of self. To expect such individuals to conform to a model of psychoanalysis that relies on the classical use of abstinence, non-interference and objectivity is presumptuous and needs to be re-thought. It is likely that contemporary models of psychoanalysis that adopt an interactive here-and-now approach will be more suitable to cross-cultural work.

The developmental and intrapsychic models that are fundamental to psychoanalytic treatment are based on the belief that the individual can be empowered to overcome his own internal conflicts. Such a belief cannot be assumed for non-western cultures where the source of conflict is often understood to be located outside the individual, who considers himself far less empowered to bring about personal change. As Buhrmann states, "treatment, [in traditional African cultures] especially for any mental dysfunction, is not individual but requires the co-operation of the

family and at times the active treatment of others in the family” (1984, p. 25). She goes on to point out that “certain healing ceremonies cannot be done without some relatives of the patient being available to fulfil certain obligations. In addition to the living, no ceremony can hope to succeed without the guidance and co-operation of the ‘living dead’ kin – the ancestors”.

3.2: Defining Culture

In order to understand how we can use psychoanalytic psychotherapy in a different cultural milieu, we need to have a better understanding of what culture is and how it informs the concept of self. Most elements of a culture are intangible and include: beliefs, values and ideas which its members incorporate into their selfhood and which become important motivating factors in moulding and shaping (conscious) dreams, aspirations and conduct. An individual’s cultural background therefore becomes inseparable from his psychological processes (Owusu-Bempah & Howitt, 2000). Gonzalez, Griffiths and Ruiz (2001) describe culture as a set of meanings, behavioural norms, values, practices and beliefs used by members of a given group in society as a way of conceptualising their views of the world and their interactions with the environment. In this respect, language, religion and social relationships are manifestations of one’s own culture. This definition implies that culture is a composite structure of the corporeal, the symbolic and the mythical: objects, institutions, artefacts, beliefs, ideas, mythology, religion and rituals transmitted and internalised in varying degrees by members of that culture. The culture of a given group is the sum of the shared ways of thought, reactions, rituals, customs and habits or behaviour acquired directly or vicariously by its members. It includes child rearing practices, kinship patterns, marriage rites, diet, dress, music and art; it also includes interpersonal relationships (Owusu-Bempah & Howitt, 2000).

3.3: Western Culture and the Foundations of the Western Self

3.3.1: Dualism

The social structures of any culture are based on “myths” which interpret the perceived realities of a society; in the case of western culture dualism is a central “myth” around which social structures and social interactions are built. The foundations are derived from Cartesian dualistic understandings of the world as delineated in terms such as self/other; subject/object. Western culture is constructed around an understanding of the world based on these dualistic principles; each individual is orientated into this understanding from birth. Given that the self emerges out of interactions with others and cultural symbols, the western self clearly incorporates dualistic notions of functioning.

The majority of western concepts of mind and its consequences for the self are encapsulated in Descartes' writing (Stanley Messer & Seth Warren, in Muran, 2001). The Cartesian approach to self includes the following features. The mind is a separate individual self, which can be known in isolation, independent of other human beings. Knowledge of the essential self (which is regarded as a separate thinking entity) comes from observation and analysis. The mind – the thinking thing (*res cogitans*) – can be more aware of the reality of itself than the reality of anything else. Consequently knowledge of one's self as a separate, distinct being is the starting point of Descartes' philosophy. The mind's existence or knowledge of the mind is not dependent on or related to the existence of the body. There is thus a separation of the mind from the body in his philosophy.

Descartes' philosophy splits the experienced world into the subjective (inner) and objective (outer) worlds. The mind is pictured as an objective entity that exists amongst other objects in the world, it is a "thinking thing" that looks out on an external world from which it is essentially estranged. In this way the mind is seen as separate from all experience and separate from all other minds. The mind is the subject separate from the external world of objects. The culture of individualism - and in psychological terms the individual self – emerges out of the Cartesian dualistic perspective.

Postmodern developments in philosophy have had a strong impact on psychoanalysis and psychotherapy (Gabbard & Westen, 2003). The shift away from the subject/object dichotomy towards a more constructivist understanding of the nature of reality is at the centre of these developments. This study acknowledges that postmodern epistemology represents a powerful revisionary force in the social sciences however, it also accepts that this revision is still in transition. In spite of the developments that have occurred, western philosophy still reflects a dualistic explanation of human nature and development. Theories of psychology that emerge out of a particular culture will reflect that culture's understandings of self; dualism is therefore an integral part of western psychologies, including psychoanalysis. The very fact that psychoanalytic theory often refers to internal objects and external objects is reflective of dualistic thinking patterns.

The ideological and methodological tools which psychoanalysis has created to bring about the desired therapeutic outcome in its subjects are therefore based strongly on the dualistic myth. Theories of psychological development and intra-psychic theories are the product of the values, norms and beliefs of the culture of individualism in which they were developed (Muran, 2001). Individuals are seen as separate from the world and as mechanics of their own destiny. Implicit in

psychoanalysis is the notion that all individuals have the capacity to do exactly this: manufacture their own destiny as autonomous entities. Therapists trained within this system will enter the therapeutic encounter with a set of assumptions about the nature of the individual and human development. These assumptions are supported and reinforced by psychoanalytic theory.

3.3.2: The Influence of Dualism on Western Psychology

George Kunz (1998) states that modern psychology is founded upon the philosophical and cultural tradition of individualism. He states that psychology has moved the ego to the heart of its philosophical assumptions about the nature of the human. Modern psychology has shifted in its capacity to study the human psyche's ability to transcend its needs to find a deeper desire, rather it has become a science of the ego, an *egology* or an egocentric psychology. The *psyche* of modern psychology is the *ego* establishing itself in the centre of the individual personality, constructing its own identity through self-development, manipulating its environment to meet its needs, and enjoying the pleasure of satisfying those needs. The meaning of the word *psyche* in psychology has therefore been altered to justify the dominant ideology of individualism and self-reliance. In making such a shift psychology has defied the self, paradoxically by reifying it as a natural force. As a result self-interest acts as a core principle upon which much of the social sciences are founded.

Individuals in western society hold a view of themselves as separate from the community and the environment. Success is generally viewed in terms of individual rather than collective achievement. Competency in western society is seen as obtaining, exercising and utilising control over resources. Individuals are encouraged towards self-development and urged to develop skills that empower them to be self-sufficient (Kunz, 1998). Self-identity has as a result taken on supreme importance for the individual. Operating from the position of the ego as the centre, the western individual takes up a particular position in relation to the world. This position is exemplified in the following description:

As an ego-centred self I define myself as the *subject*, the one who acts upon all that is not me as subject, that is, *objects*. I, the *subject*, know manipulate, and enjoy those things that are other than me. I define all others (things and persons) as *objects* available to my understanding, effort and satisfaction. Claiming my power to myself, I totalise (objectify) others. I claim others to be *nothing-more-than* what I make them to be. As an ego-centred self I try to *comprehend* (totally grasp in understanding), I try to *control* (totally dominate by my own effort), and I try to *consume* (satisfy my needs...) (Kunz, 1998, p. 108).

Messer and Warren cited in Muran (2001) reinforce the point that western psychology is structured around dualisms that are absent from non-western thought. These include dualisms of

the self and other, mind and body, the theoretical and the applied, the subjective and the objective and most importantly religion and science. In western thought psychology and religion are independent. Western psychology evolved out of science and medicine and is fundamentally isolated from religion. In the East as well as in Africa psychology, religion and philosophy are united. Thorpe (1991) established that in Zulu thought the material (or the organic) and the spiritual are almost indistinguishable. “No fundamental distinction is made between a person’s visible, physical being and his invisible spirit being” (Thorpe, 1991, p. 36). In many African cultures there is no separation between issues of magic, religion, health and disease. Western philosophy tends to dichotomise and polarise aspects of human experience. This is particularly evident in the way that western biomedicine emphasises a division between the psychological and the physical. In this framework mental and physical states are thus seen as separate.

The attempt to divide illness into areas of speciality is not only losing some of its impact within western biomedical thought itself, but is largely untenable in other systems of thought. In many non-western societies it does not make sense to separate the physical from the mental and many forms of healing do not make this distinction (Swartz L., 1998). This point is further emphasised by Buhrmann who states “Western medicine divides illness into the different categories of somatic, psychological and psychosomatic; the Black people do not: they say that ‘when part of me is ill, the whole of me is ill’, irrespective of what the illness is” (1984, p. 26).

Cultural Foundations of the Self

3.4: Understanding the Concept of Self

The self is understood as emerging out of a process through which “social relationships and cultural symbols are filtered through and internalised into the psyche in affect-laden inner images of self and other(s) in complex inter-relationships” (Roland, 1988, p. 5)³. Roland draws on anthropological and sociological perspectives and categorises the self as encompassing three aspects. He states “[there are] three overarching or supra-ordinate organisations of the self: the *familial self*, the *individualised self* and the *spiritual self*, as well as an *expanding self* [my italics]”. He makes the important point that different cultures emphasise different aspects of the self and integrate them differently (Roland, 1988, p. 6). The “expanding self” represents a

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Roland’s terms for discussing “self” are derived from object-relations theory and owe much to the works of Grinaker (1957), Jakobson (1964), Kahn (1974), Kernberg (1975), Segal (1964) and Winnicott (1965). The work of Klein (1976) and Gedo (Gedo & Goldberg 1973; Gedo 1979, 1981) describes the self as having its own organisational schema or sub-organisations.

growing individuation of the self, arising out of cross-cultural influences on the existing construct of the primary self.

3.4.1: The Familial Self

The familial self refers to a basic inner psychological organisation that allows the individual to function with the hierarchical relationships of extended family and community kinship structures. This familial self is generally characteristic of strongly relationship-centred cultures, such as is the case in India and Africa. Central to the functioning of the familial self is an emphasis on certain sub-organisations. These involve *symbiosis-reciprocity*, which refers to intensely intimate relationships which are strongly inter-connected and inter-dependent and in which there is a constant affective exchange through permeable outer-ego boundaries. High levels of empathy and receptivity to others are an essential part of this sub-organisation, where sense of self is experienced as highly relational in different social contexts. The term “we-self” has been used to describe this experience of self (contrasting with the “I-self” implicit in the Western framework of self (Collins & Desai, cited by Roland, 1988). *Self-regard* is based on a self-esteem derived from strong identification with familial rather than individual reputation and honour, and culturally encouraged idealisation of elders.

For the familial self the *ego ideal* is very much a socially contextualised entity in which social responsibilities, obligations and hierarchical relationships are scrupulously observed and form the structural basis for ego aspirations. The *superego* is largely constructed through the requirements of the hierarchical extended family. Modes of cognition and ego function and communication adhere strongly to context, and place overt emphasis on a shared understanding of symbols, signs and influences (whereas in the individualised self symbols and signs are far more covert and individually interpreted) (Roland, 1988).

Buhrmann (1984) shows that the Xhosa and Nguni people of South Africa place particular importance on the role and place of the individual in the community. The importance of the individual rests largely in his usefulness to the group; for the most part personal achievements are secondary. This results considerable interdependence within the family group.

3.4.2: The Individualised Self

Development in a western society emphasises a conceptualisation of self in terms of individual autonomy and self-responsibility which is well adapted to functioning in a highly dynamic society. The individual is compelled to choose from a variety of social options in contractual, egalitarian relationships governed by the dominant cultural principle of individualism. The

individualised self is characterised by inner representational sub-organisations that emphasise an individualistic “I”-ness with relatively self-contained ego-boundaries, sharp differentiation between inner images of self and other, and considerable social individuation.

In the individualised self the *ego ideal* is orientated to functioning as an autonomous unit in a great number of extra-familial groups. Aspirations are organised around competitive individualism and self-actualisation. *Self-regard* is self-contained and self-derived and is relatively independent of mirroring. The *superego* is orientated around abstract principles of behaviour that are separated from contextuality and familial organisation and are appropriate in a large variety of situations. *Modes of ego functioning and cognition* are adjusted to self-reflection and rationalisation, and also have considerable mobility and adaptability to the different situations confronting the individual (Roland, 1988). The sub-organisations of the individualised self are structured in accordance with “the ongoing self-creation of one’s own self-identity through the realisation of one’s inner potentials” (ibid, p. 9).

Owusu-Bempah and Howitt (2000) suggest that the attainment of a “fulfilled self” in western society is synonymous with individual autonomy. Psychoanalytic theories of human development that have gained prominence in western thought reflect these values in that they present human development as a pathway to the idealised state of autonomy from others. Foster (1998) describes how children are construed as being in a struggle for liberation from their mothers. Adolescence is a period of independent identity formation, through which the individual achieves separation from a family that would otherwise impede growth towards independent adulthood. The healthy outcome is perceived to be individuals able to function as independent adults who have a mind of their own and are prepared to speak their mind. Whilst this may be considered normal development in western society it becomes problematic when transferred universally to non-western cultures.

3.4.3: The Spiritual Self

The spiritual self is the inner spiritual reality that transcends the ego and ego aspirations. As with the other two notions of self, it is an inherent capacity in all individuals and is experienced and expressed to a varying degree; however, unlike the familial self or the individualised self, it rarely becomes the dominant organising self. It is manifested differently by the familial self and by the individualised self. In the latter it is more often an individual spiritual endeavour; in the former it tends to be manifest through overt symbol and ritualised religious practices.

3.4.4: The Expanding Self

The expanding self is the term devised by Roland to describe the process whereby the basic sub-organisations of self developed through a primary context, while remaining intact, are able to assimilate new sub-organisations when confronted by a different culture with its attendant standards and expectations (1988). This is particularly relevant to many urbanised Black South Africans who often experience conflict between their traditional social structures and the expectations of a westernised society.

3.4.5: Changing Conceptions of Self in Western Society

The modernist view of self is encapsulated in the notion of self as self-contained individualism with a rich conscious and unconscious life, “as an autonomous entity, not subject to continuous change and reformation, but a stable and rational being: *res cogitans*, in Cartesian terms” (White & Hellerich, 1998, p.3). In this study the African notion of self is sharply contrasted with the classical concept of self as unified, firmly bounded and highly individuated. However, there is no single definition for the so called western self, in fact it is true to say that on the level of theory, the modern search for self has failed to yield a universal truth. There is no one discourse that can unify all theories of self in psychotherapy but rather there are multiple discourses that are not mutually reducible to one another (Muran, 2001).

In the process of re-defining clinical conceptions of the self it was the prominent theorists Harry Stack Sullivan, Ronald Fairbairn and John Bowlby who rejected the ego psychology focus of the self as subordinate and representational. They elevated the self, claiming that it was primary and functional. Sullivan (1953, 1964) outlined the self in the context of interpersonal processes, claiming that self should not be considered in isolation but in relation to others. This notion was developed further by the object relations theorists who extended the idea of self as a process. Fairbairn (1952) initiated this turn of thought when he provided a dramatic revision to the Freudian model, in claiming that the libido was object seeking. This fundamental need to seek others was placed into a biological frame by Bowlby (1988) who considered ‘attachment’ as part of survival. These changing trends in the understanding of self were recognised by Greenberg and Mitchell (1983) who identified a movement away from the *drive model* particularly evident in the ego psychology, towards the *relational model*. In their own words this represented a movement in psychoanalysis from solitary reflection to relational struggle (ibid). In the relational model the analytic situation is seen as inherently dyadic. This train of thought was supported most strongly by the interpersonal, object relational, and self-psychology orientations (Muran, 2001). In the relational model we see a postmodern trend away from understanding the self as ‘autonomous’

towards seeing it as 'expressive'. This perspective on self does not contrast as sharply with African theories of self as does the modernist perspective.

In recent years there has been numerous postmodern challenges to the way that self is understood. In the clinical setting there are several overlapping trends in the consideration of self. These include (a) *contextualism*: the recognition that we are intrinsically embedded in context; (b) *multiplicity*: the idea that we are composed of multiple selves; (c) *intersubjectivity*: the appreciation of subjective relations in our interpersonal encounters; (d) *social constructionism*: the understanding of our selves as social and historical constructions; and (e) *deconstruction*: the process of decentering from such identities as gender and race in our self constructions (Muran, 2001).

Theoretical conceptions of self are constantly being revised; however, there still exists a plurality of perspectives on a concept that is central to understanding the human condition and its possibilities for change. These new developments in theories of self have strong implications for the practice of psychoanalysis across culture. The movement away from a modernist position means that issues such as abstinence and neutrality are not important in the analytic situation. This allows for greater technical flexibility as well as a constructive relational experience, which is more able to accommodate difference, diversity, symbol and metaphor.

3.5: Structure of Self in Traditional African Society

The concept of self in traditional African society is predominantly organised around the familial self as described by Roland (1988). Mason, Rubenstein and Shuda (1989) state that a deep sense of kinship is one of the strongest forces in traditional African life. Kinship controls social relationships between people in a given community, it binds together the entire life of the tribe, and is even extended to cover animals, plants and non-living objects through a totemic system. The concept of family is not limited to father, mother and children but includes an entire network of members bound by blood and betrothal ties. In this system the individual does not exist alone but rather corporately, whereby he is defined in terms of both contemporary members and past generations or ancestors. The individual is part of the whole. It is through other people - that is, through relational responsibilities, duties and privileges - that the individual consciously defines his being. Individual aspirations are subsumed to familial and community aspirations.

In this framework the individual perceives all natural occurrences in terms of the entire group. Whatever happens to the individual happens to the group and whatever happens to the group happens to the individual. The individual therefore implicitly views his relationship to others in

terms of “since we are, therefore I am”: the Cartesian dictum “I think therefore I am” becomes “I am because we are” (Owusu-Bempah & Howitt, 2000). Similarly disease, illness and treatment in this context are generally understood in terms of the relational context and not as being located in the individual alone (Mason et al, 1989). Jagers and Mock (1993, p. 394) emphasise that in African traditions one’s “identity is tied to group membership rather than to individual status and possessions”. Sharing as opposed to self-centeredness is promoted because it confirms the importance of social interconnectedness. “The centrality of human connectedness in the African conception of self gives rise to the moral obligations of communalism, mutual support, collectivism and co-operativeness, with one of the highest values being positive interpersonal relationships” (Myers, 1993, p. 13).

Buhrmann in her seminal work *Living in two worlds* (1984) documents her experiences in South Africa with the Nguni and Xhosa people. Through this work she clearly illustrates that any understanding of the self in such communities that does not incorporate the “living dead” or the ancestors would be incomplete. Ancestor communication and obligation are an integral part of communal and individual life. In fact ancestors are often conceived of as “living in one’s body”, communicating through dreams, somatic symptoms, and other signs. She shows how the traditional structure of self in such communities engages with unconscious dynamics through relating to ancestors as literal beings in the objective world. The western notion of the “individualised self” sees the unconscious rather as a subjective internal phenomenon. However, the relationship between the ego and unconscious in the western mind is not dissimilar to the relationship between the family and the ancestors in traditional communities. Just as the personality of the western individual needs to negotiate, engage and respect the manifestations of the unconscious through dreams, visions and fantasies in order to remain healthy, so the traditional community needs to engage with the wishes and demands of the ancestors in order to maintain an equilibrium.

Buhrmann states “I perceive the fantasies about and images of the ancestors and *abathakathi* (witches and sorcerers) as expressed in Xhosa cosmology as projections from their unconscious, especially the cultural and collective layers. The ancestor and witch concepts are therefore archetypal” (1984, p. 21). She suggests these groups are in touch with the archaic levels of the psyche in ways generally not available to the western mind. During healing ceremonies symbols from the unconscious are brought to the fore, these symbols are worked with ritually and carry powerful transformative properties. In western society the ego has developed at the expense of the unconscious matrix from which it was born. An over-emphasis on the rational, logical and intellectual properties of the ego has served to distance the western individual from the deeper

resources of the psyche. Buhrmann believes that what the “modern” individual thinks and talks about is in traditional cultures acted out through dancing, singing, ritual and ceremony.

In illness and healing the ancestors play a pivotal role. The purpose of such ritual and ceremony is often to decipher the wishes of the ancestors (generally transmitted through dreams), to be guided by their wisdom and to have communion with them. Clan Ancestors are omniscient and play an ever-present role in the day-to-day lives of the family and clan. They represent protection and guidance and are consulted in times of difficulty and illness. If customs are not kept or not regularly performed the ancestors can withdraw their protection and expose the individual or clan to evil powers and bewitchment. Many healing ceremonies aim therefore to restore the broken connection with withdrawn ancestors, thus restoring physical and psychological health.

The sharp divisions in terms of subject-object duality, which are characteristic of the western concept of the individualised self, are virtually absent in traditional African culture, which is based rather on subject-object unity. Jung himself found during his travels that “in Africa the ‘without’ and ‘within’ were so interdependent that he spoke of it and remembered it all to the end of his days with astonishing detail” (Van Der Post, 1975, p. 89).

Interpretation of Psychological Meanings across Culture

3.6: Theoretical Approaches

When considering psychoanalysis as a form of treatment across cultures, it must be constantly borne in mind that psychoanalytic schemata have been developed in a western cultural setting and are therefore strongly bound to western values and notions of self. Concepts which western psychoanalysis takes for granted as universals holding true in all analytic circumstances may need to be reformulated in different cultural settings. As pointed out by Kim and Berry (1993), a relativist approach affords a partial means of overcoming the likelihood of misinterpretations and misunderstanding arising from the top-down universalist approach.

The relativist standpoint attempts to understand “self” from the patient’s own perspective, including cultural, social or psychological factors. By adopting a relativist approach it becomes easier to understand the patient in his own context. The relativist approach allows for the emergence of *derived etics*. Kim and Berry use the terms “etic” and “emic” as substitutions for “universalism” and “relativism” respectively. “Derived etic” is their phrase for describing the process of identifying the universal components across cultural groups that are not imposed from

the outside but arise as emics from within. These derived etics can form the basis for a more indigenous psychoanalysis. This is not suggesting that psychoanalytic universals must be dismissed, but rather that derived etics in the process of recontextualisation should be integrated into modified universals of psychoanalytic belief.

Psychoanalysis is known as the “Talking Cure”. With increased migration in the western world it is becoming more frequent for practitioners to be confronted with issues relating to language in psychotherapy. It follows therefore that language plays an important role when interpreting psychological meanings across culture. In any discussion of cross-cultural psychotherapy these issues relating to language must be addressed.

3.6.1: Theoretical Approaches to Language

An area in which psychoanalytic practice comes into apparent conflict in cross-cultural settings is with language. An important concept to consider when practicing psychotherapy across language divides is the fact that language reflects a world-view. The hermeneutic/constructionist approach maintains that language creates its own reality and reality is negotiated through language (Swartz, S., 1998). This is an extension of the well-established Sapir-Whorf hypothesis (Crystal, 1998) which maintains: “language creates world” and vice versa. That is to say a language will develop to express the world-view of its users; a changing worldview will lead to a change in the language. Language thus reflects the symbolic structure inherent in a group culture. For instance in Xhosa culture in South Africa the question “How are you?” often elicits a response of “We are fine”. The plural form in this case reflects the subject/object unity inherent in the collective self (Ulmer, 2003).

Language is thus a reflection of cultural world-view; however, just as culture is not a static entity, nor is language: it adapts to express changes in world-view. An individual from one culture attending psychoanalytic psychotherapy with an individual from another culture and language is expressing an already present and existing change in his world-view. It can be postulated that although his mother-tongue language may not have the means to express this changing world-view there exist a series of “vacuums” awaiting new terms. These new terms for expressing new concepts may be supplied by the analyst or may be provided by the patient himself: this word or term will not have the same meaning when used by the patient as it would when used by the analyst, but it reflects a changing world-view which the analyst will have access to through paying close attention to the context in which the word is being used. Individuals adopting western value structures are simultaneously searching for new words to express and define their changing world-view.

The only means that the analyst has of understanding his patients' psyche is by listening to what they say, what they do not say and how they say it. The empiricist view of language regards words as labels, with each word having a set meaning readily available to speaker and listener and by extension readily amenable to translation. More recent theories of language understand that this is an over-simplification of an extremely complex framework of interactions between world, language and the individual (Crystal, 1998). Postmodern/deconstructionist philosophers such as Derrida (1989) have postulated the concept of the word as not only a denoting device but also a connoting device. The word chosen generates a series of meanings and excludes other word choices and thus other meanings. There is no one-to-one relationship between word and entity, but rather an endless deferment of meanings, which are strictly speaking only available to the speaker and not necessarily to the listener. This has implications for psychoanalytic psychotherapy in that the analyst is constantly required to focus on the patient's potential meanings rather than his own suppositions, and further, on how the patient uses the word, this includes tone, body language and combinations with other words.

Given this understanding of language as a dynamic, rather than a static process it follows that meaning in the therapeutic dyad can be generated through negotiation and attention to context. From this perspective different language bases do not represent an insurmountable obstacle in psychoanalytic psychotherapy. To this end Amati-Mehler (1990) makes the point that psychoanalysis was born out of linguistic and cultural multiplicity. Referring to the cosmopolitan atmosphere of Freud's Vienna she emphasises that hardly any analysis was conducted in the mother tongue of either analysand or analyst.

3.6.2: Universalism

The fundamental assumption of *Universalism* is that there are natural laws that govern all humanity. It is further assumed that human psychological development and mental illness can be understood by universal natural laws and "our job in looking cross-culturally is to find evidence for these universals" (Swartz, L., 1998, p. 12). Owusu-Bempah and Howitt (2000) state that cross-cultural psychology as it is generally understood involves testing theories and concepts that have been developed in the west on cultures outside of western perspectives in order to form a picture of the generalisability of these theories. The search is for cross-cultural universals, which are presumed to be much the same in all populations. Universalism as practiced in western psychiatry tends to use diagnostic systems that claim to identify core syndromes universally applicable, albeit with different manifestations in different parts of the world.

The universalist tradition has given rise to major studies, such as the International Pilot study on Schizophrenia conducted by the World Health Organisation (WHO, 1973, 1979). The assumption of this study was that the disorder was the same across all cultures (Swartz, L., 1998). A main criticism of this approach is that it does not give attention to the fact that “our ways of seeing the world, and our assumptions, help shape how we see the world” (p. 13). Furthermore it is argued that universalist psychiatry, far from being truly universalist, simply imposes western psychiatric models on the world and does not take sufficient account of the actual experience of the sufferer (Eagle, 2005). These models tend to reify psychological illness as static and fixed, thereby failing to take account of illness within the context of social relationships.

The dominant theories which constitute psychoanalytic thinking generally include Drive Theory and Structural Theory (often referred to as Classical psychoanalysis), Ego Psychology, Object Relations theories, Self Psychology and various forms of developmental psychology. Major proponents of these theories include psychosocial theorists such as Erik Erikson (1950) and Margaret Mahler (Mahler, M. S., Pine, F., & Bergman, A., 1975); Object Relations theorist Melanie Klein (1957); Otto Kernberg (1976) whose views included a development from both ego psychology and Melanie Klein and developmental theorists such as Winnicott (1969), and Kohut (1971) who was a proponent of Self Psychology. It can be argued that all these theorists adhere to the philosophical stance of the individualised self. As the very names of these theories suggest, the movement of the individual from dependence towards autonomy is fundamental to most psychoanalytic approaches. Central to psychoanalytic theory are developmental schema that trace psychological growth from infancy through childhood, adolescence and adulthood in accordance with certain stages of development. These theories began with Freud’s psychosexual stages and were expanded by Melanie Klein’s concepts of object-relations development in early childhood and Winnicott’s theory of transitional objects. This was followed in turn by Erikson’s and later Mahler’s stages of psychosocial development. More recently Kohut’s Self Psychology proposes notions of developmental needs and deficits involving narcissism.

The schemata inherent in these theories form the basis of psychoanalytic interpretation when considering how a patient’s current symptoms derive from past conflicts and deficits in the developmental process. Psychoanalysis has generally operated on the explicit assumption that these schemata hold true universally, regardless of culture or background, and that they may be used in any context to judge normality and mental health.

However, western perspectives embodied in psychoanalytic theory are not directly applicable to other cultures. For instance, child-rearing practices clearly vary from culture to culture. Any

attempt to apply the theoretical perspectives of “normal child-rearing practice” grounded in a western value system will inevitably fail when attempting to interpret such practices in non-western cultures. Roland (1988) describes childrearing practices in India that are significantly different from the accepted western norm. Unlike the norm in western society, weaning does not take place until the second or third year. Similarly, a young child may remain in the maternal bed until being displaced by the next sibling or until several years old, in some cases well into adolescence or until ready for marriage. Often the child will exchange the maternal bed for that of a sibling, aunt or uncle, but rarely sleeps alone. Using schemata from Western developmental theories, such a relationship between mother and child would be construed as a pathological narcissistic involvement. For a child being prepared for an individualised self with strong interpersonal boundaries and values of independence, such a scenario would be untenable. However, for a child being prepared for a collective and familial self with values of connectedness and more fluid interpersonal boundaries, such a scenario is fitting. The central schema of separation-individuation therefore cannot be taken for granted across all groups and needs to be revised.

The process of enculturation is not confined solely to the interactions of the parents. The seminal work of Abel, Metraux and Roll (1987) point out that the very architecture of the home environment gives the child cues about the ordering of life, not only in the home but also within the self and in the community. The whole setting of the home environment, what it incorporates of the wider world and what it excludes, enters into the child’s experience from an early age and sets up complex expectations of the larger world. The use of space and time, the assignment of certain activities to certain parts of the house, the parts of the house to which only certain individuals are allowed full access - these clear limits of time and privacy all contribute to the enculturation of the child into the acceptable cultural norms and values of larger society.

Roland gives a vivid example of the western psychoanalyst recognising the limitations of his pre-conceived universals in his book *In search of self in India and Japan* (1988). He describes his experience:

What I had originally thought would be an interesting journey in clinical psychoanalytic research in India and Japan turned out to be a much longer odyssey with a far greater re-thinking of psychoanalysis and myself than I had anticipated. ... As I wrestled with psychoanalytic formulations that would capture the make-up of the Indian self as I was observing it, I began an increasingly searching re-examination of the theoretical models of psychoanalysis I carried with me. From my reflections on the current psychoanalytic theories. ... I realized that the whole elaboration of the psychoanalytic theory of

personality in its many variations is Western-centric. Much of it is clearly related to the clinical data of Western personality in societies emphasising individualism. Although psychoanalysis repeatedly claims to deal with the universals of psychological make-up and ideal norms of mature human functioning, yet these universals, ideals and norms were frequently contradicted in India and Japan (1988, pp. xiv-xv).

Buhrmann in her work with the Xhosa people of South Africa states that whilst there are universal psychic similarities these universals are expressed in unique ways by different cultural groups: “The basic content is similar, but the forms in which this is experienced are different, much like different musical variations on one theme” (1984, p. 31).

3.6.3: Relativism

Fundamental to the *Relativist* approach is to be as true to the context as possible. In order to understand illness in different contexts the relativist approach attempts to gain as comprehensive a picture as is possible of the meaning of the illness to the sufferer in the context of the family, community and spiritual background. In so doing the relativist endeavours to enter into the *explanatory models* (emotional worlds) of those people being studied or treated. “Explanatory models” refers to the ways in which all individuals understand their own illness. Many of the beliefs that individuals hold with regard to illness often appear strange to western mental health workers; however, these beliefs have a valid internal logic. In this approach it is the responsibility of the clinician to attempt to understand the individual’s explanatory model and to negotiate these understandings with understandings drawn from a professional explanatory model so that there is some common ground for treatment acceptable to both parties (Gilbert, 1999). Negotiating between the individual’s and the professional’s explanatory models increases compliance; in other words a patient is more likely to participate in a treatment plan if there is some common understanding of the illness. Even in the physical biomedical framework practitioners are often faced with situations where a patient complains of illness without any obvious sign of disease. In such cases adopting a universalist approach may give rise to much frustration; however, from a relativist standpoint it becomes possible to understand that for cultural, social or psychological reasons the patient is in fact experiencing illness. By adopting a relativist approach it becomes easier to understand the patient and therefore easier to consider other possibilities for treatment beyond western biomedicine (Swartz, L., 1998).

3.7: Psychoanalysis: Universalism versus Relativism

Both the Universalist and Relativist approaches have their limitations with regard to understanding psychological development and illness across culture. The universalist perspective

often gives rise to distortions in understanding internal processes; whereas the relativist runs the risk of missing the larger picture. Kim and Berry (1993) suggest that relativism may be used to consider universals in a different way. The terms *etic* and *emic* are substituted for universalism and relativism respectively. They believe that it is possible to conduct a series of *emic* studies in different cultures and then to explore the commonalities that exist between these cultures. In this way it should be possible to establish universalist trends across these cultures referred to as a *derived etic*. With a *derived etic* the universals emerge from a series of local observations and not from a set of a priori assumptions held by the practitioner - an *imposed etic* (*ibid*). This latter term refers to the imposition of one set of cultural and philosophical norms on an alternate culture.

The theoretical structure of psychoanalysis is based on Western-centric thought. Postmodernism has taken a critical stance towards deconstructing the positivist tendency to maintain clear boundaries between subject and object. However, the fundamental split between self and object and between self-representation and object-representation based on Cartesian dualistic assumptions is deeply embedded in western understanding of human nature. Moreover there is a tendency to universalise these understandings and to assume that that everyone has essentially the same nature (Rubin, 1997). Alan Roland states:

I found that psychoanalytic theory was indeed helpful to my Indian patients, that the various dimensions of human nature that psychoanalytic theory addresses were all relevant... [however,] the content of these dimensions as spelled out in psychoanalytic theory is western-centric (1988).

Roland offers a more postmodern position towards the use of psychoanalytic theory across culture. He believes it is possible to develop a theoretical strategy to integrate both western universalising and Indian contextualising modes of thinking whereby broad psychoanalytic categories from the major models of Freudian psychoanalysis are used as universals, but are elaborated upon contextually from the actual observations of clinical psychoanalytic work with Indians and Japanese rather than from their present content in psychoanalysis. He shows how it is necessary to de-contextualise various psychoanalytic categories of their Western content before re-contextualising them with clinical data from Indian and Japanese patients. Roland's theoretical strategy of integrating psychoanalytic universals with actual contextual phenomena parallels Kim and Berry's proposals of developing *derived etics* from *emic* data – in other words recontextualising the data to create (new) universals. In a similar vein Gilbert, (1999) points to the necessity to develop a working synthesis between western and traditional approaches to understanding mental illness in Africa. She emphasises the importance of overcoming the cultural

imperialism of psychiatry in Africa that ignores cultural understandings of illness and health. In her effort to establish a culturally appropriate ideology for teaching psychiatry in Africa, one that draws on both western and traditional belief systems, she emphasises the need for: “listening, recognising, and valuing difference and diversity, seeking parallels and similarities across different methods of healing, and actively working to establish cooperative, culturally appropriate, mutually respectful ways of collaborative working “ (p. 293-294). In essence Gilbert proposes a similar framework to the ‘derived etic’ of Kim and Berry and the notion of re-contextualising proposed by Roland. Berg, (2003) captures the spirit of this exercise by pointing out that psychiatry and psychology in South Africa must work towards building bridges between cultures and world-views. Its aim should not be to colonise African concepts , nor to clothe them in Western psychological language, but rather to see, understand and describe what lies on the other side of the bridge.

3.8: Psychoanalytic Universals to Reconsider in Cross-Cultural Settings

A predominant universal in psychoanalysis is the oedipal complex. The oedipus complex forms the central core of psychoanalytic theory. Freud defined the oedipal struggle as a universal phenomenon. Much research at the interface of psychoanalysis and anthropology has been conducted in this regard. It is generally accepted that the Freudian understanding of this complex arose at a time when patterns of authority were strongly delineated. However, contemporary patterns of authority within western culture have changed. For instance in American and Southern Italian families it is largely the mother who sets the tone of the home and establishes the ethical standards and rules of conduct. She defines the circumstances in which her son should stand up for himself and fight as well as the situations in which he should refrain from sex, alcohol and other unacceptable behaviours. She expects him to succeed and often defines his success in terms of excelling his father. Fathers themselves also expect their children to surpass them financially, educationally, socially and occupationally. These expectations are very different to the expectations of society at the time of Freud’s writing. At Freud’s time the authority of the Emperor, the father, the Priest and other authority figures was absolute; the position of the mother was subordinate and submissive (Abel et al., 1987).

It is therefore clear that the oedipal struggle differs not only across culture but also within western culture itself. These differences depend on the cultural patterns of approved behaviour inculcated by parents as well as by other significant persons in a society at a given historical period. Devereaux (1985) has reiterated that oedipal impulses are not universally identical and are highly responsive to familial and cultural patterns. However, the different patterns can all be considered to be variations of the oedipal struggle through which a male or female child learns to give up the

pre-genital sex object (the mother) and the genital sex object (the parent of the opposite sex) and to identify more rather than less with the parent of the same sex. In many cases the parent may be a parent surrogate or a series of parent displacements, as among the Chinese (Abel et al., 1987).

Psychoanalytic theory has undergone many revisions, the most notable of which is the shift from the “topographical position” as outlined by Freud in *The interpretation of dreams* (1900) to the “structural theory” he presented in 1923 in *The Ego and the Id*. In the topographical model the mind or mental apparatus is divided into unconscious, preconscious and conscious; in structural theory the mind is divided into the Id, Ego and Superego. It is this latter which has been expanded and become strongly incorporated into general theory relating to the ego, its defences and the concept of instinctual drives. Structural theory has been used in those formulations of infant development that emphasise the formation of the ego and the superego and the relations of these structures to the id and to each other as the child gradually enters into object relations and begins to relate differentially to significant persons in his life. The superego, an introject from parental pressures based on concepts of right and wrong, is strongly affected by the cultural values upheld by parents. Similarly ego functions - integrated beliefs, values, modes of thought and behaviour - reflect cultural patterning.

Roland (1988) states that different superego manifestations are generated by different cultural codes and family structures. In close-knit hierarchically oriented families there is a strong necessity for the containment of unacceptable aggressive and sexual feelings and impulses, which often results in specific symptomatology. Such was the case in the Vienna that Freud grew up in and is the case in contemporary India and Japan. In traditional societies where inter-relational and dependency needs are intensified a high degree of anger and ambivalence can be generated through disappointed expectations and a perceived lack of reciprocity, a strong superego response to contain or often repress such reactions may give rise to compulsive symptoms, amnesias, somatisation or physical ailments. The superego exercises control and containment over these angry feelings for the purpose of maintaining familial hierarchical relationships and the harmony of emotional connectedness that exists between family members. This contrasts with the contemporary western superego where internalised cultural values allow for a much freer expression of anger and sexuality in the more mobile nuclear family (Roland, 1988, p. 255).

Identity formation.

Another universal in psychoanalysis relates to identity formation. Erickson (1950, cited in Roland, 1988) introduced his seminal concept of identity formation which involved both **self-identity** and **ego identity**. Self-identity refers to the contents and self-experience of identity and

ego identity refers to the process of identity formation. Erickson essentially viewed identity as the major organizer of the psyche (Roland, 1988, p. 4). It has been argued that whilst Erickson's concept of self-identity focuses on self-experience and successfully links the intra-psyche with the social, cultural and historical, it is nonetheless rooted in western individualism and does not provide an accurate representation of identity formation in many non-western cultures. Erickson's theory places a strong emphasis on the notion of self-creation that is central to western personality (Roland, 1988, p. 20). Western culture grants the individual an enormous degree of autonomy in adolescence and young adulthood. Individuals are free to choose love and marriage partners, their educational and vocational direction, their social affiliations, their work, where to live and what kind of ideology or value system to develop and to become affiliated to. This process of self-creating requires integrating adult role commitments with the intrapsychic identifications and self-images developed within the family. Successful negotiations of earlier psychosocial stages - such as autonomy and initiative - impact strongly on the adolescent's struggle for a self-created identity.

Whilst Erikson's (1950) understanding of identity formation may provide a highly accurate description of psychological development in western society, it does not reflect well on the experience of childhood, youth and young adulthood in non-western society. Buhrmann (1984) points out that western culture encourages the individual to strive towards personal achievement and face the loss and relinquishment of primary dependency. However, in African tradition individual fulfilment largely coincides with being integrated into the community (ibid). Traditional and even urbanised non-western cultures that are family and community centred do therefore not allow the same degree of autonomy to the individual nor do they offer such a vast range of social and cultural options to the person. Marriages are often arranged, educational and occupational choices are made in collaboration with parents and elders, social affiliations and friends are often absorbed into the extended family and spiritual and religious choices are often taken for granted rather than chosen. It follows therefore that in these communal cultures the pressures and conflicts of identity formation are not present in the same form as they are in the western society. That is not to say that identity formation is conflict free in non-western culture but rather that the schemata proposed by Erickson need to be reformulated to incorporate the nuances of each cultural group.

Formation of conscience: superego versus ego ideal.

The conscience as understood universally in psychoanalysis comprises two inner organisations: the superego and the ego ideal. The superego is frequently unconscious and is orientated towards regulating drives and affects, whereas the ego ideal is oriented around the conscious inner effort

to live up to certain ideals and also idealised images of oneself (Roland, 1988, p. 250). Muensterberger's 1969 paper on psychoanalytic anthropology supports the view that "conscience" in Asian and African societies lacks the internalised psychological structures of the western superego, and is essentially dependent on external controls and guides such as family elders. This point of view is typical of the universalist stance that has prevailed in writings on this topic. In fact the conscience in such societies is profoundly internalised into psychic structures that develop and function significantly differently from those of individuals with a different value orientation (ibid). In family and community based culture the ego ideal is a social-contextual ideal. Reciprocities and ways of relating in varied hierarchical relationships influences conduct. What is correct conduct in one situation or relationship is not necessarily correct in another. Thus what is said on a particular topic to one person in a given situation and time may be quite different from what is given to another person in another situation, with both statements being quite appropriate to their contexts. It is this socially contextual way of functioning which often appears unprincipled or hypocritical to a western individual. Western ethical decrees, which are incorporated into the ego ideal, tend to be universal such as "thou shalt not kill". In non-western culture the ethic is not a universalist ethic but is rather a context-oriented ethic (ibid). For instance in India each class or "jati" has his own laws and ethic. Roland (1988) suggests that in the western conscience it is generally the unconscious superego that regulates behaviour whereas in non-western culture it is often the ego ideal that determines correct conduct in specific contexts.

3.9: Indigenous Theories of Illness: Causation and Cure

The way in which any society understands illness is completely embedded in that society's way of making sense of the world. While some types of illness appear to have similar symptoms across cultures others are culture bound. However, even if symptoms appear similar, how they are understood is totally dependent on the context in which they emerge. For people in developing countries illness and healing most commonly involve beliefs concerning supernatural powers, ancestors, or being bewitched (Gilbert, 1999). Psychiatry and psychology in Southern Africa has in the past concerned itself with trying to develop taxonomies of indigenous illnesses similar to the DSM-IV. Swartz, L., (1998) suggests that diagnosis in African indigenous healing may be better understood through theories of causation. Diagnosis of illness is inextricably related to causation, including natural, social, personal, spiritual and political issues. By using this system it is possible for two individuals to receive the same diagnosis, such as bewitchment, but to exhibit different symptom patterns. Illness may be related to ecological imbalance, pollution, impaired social relationships, bewitchment, sorcery or disturbed relations with the

spiritual world (such as not complying with the wishes of the ancestors) (ibid). In such systems a strong emphasis is placed on contextual information to make sense of the illness.

In African medicine a distinction is often made between illness and disease. In her book on healing amongst the Zulu people Ngubane (1977) draws a distinction between *umkhuhlane* and *ukufa kwabantu*. The latter refers to ‘African illnesses’, which are generally treated in a ritualised way. The former refers to illnesses that are universal, such as influenza that can be treated biomedically. Two well researched ‘African illnesses’ or Culture Bound Syndromes in South Africa are *amafufunyana* and *ukuthwasa*. The former is generally viewed as a negative spirit possession state and is commonly associated with mental disorder, the latter is seen as a positive state of emotional turmoil experienced by a person on the path to becoming an indigenous healer. However, Swartz, L., (1998) notes that these illnesses do not have one single meaning. The meaning shifts according to different contexts and different accounts from healers. Similarly whilst depression in Africa is on the increase, the way in which it is understood presents some difficulty for professional health services that rely on a high degree of differentiation of emotional states for diagnosis and treatment. For instance the word *khatazekile* in Xhosa can be translated as either ‘sad’ or as ‘worried’. These terms are confusing for biomedical forms of diagnosis and treatment as one term suggests anxiety and the other depression. Swartz, L., (1998) suggests that the first step towards developing a culturally informed view of depression is to recognise the diversity of emotional experience in different contexts.

Diagnosis and treatment in a western system relies on the careful differentiation and grouping of symptoms. In indigenous systems the approach is different. Most African conceptualisations of health and illness arise out of two fundamental philosophical concepts, Ubuntu (humanity and compassion) and Ancestor reverence (Berg, 2003). From this perspective, illness is better understood through a hermeneutic rather than an empiricist view of science. It is important therefore to note that indigenous systems of healing differ not only in terms of actual labels and diagnoses but also in terms of how diagnostic systems are constructed (ibid). The process of healing itself - which may for example involve dancing and drumming - will provide more information about the problem as the treatment proceeds (Buhrmann, 1984). This position is not unlike certain branches of psychotherapy, which emphasise the healing relationship above the diagnostic abilities of the therapist (Swartz, L., 1998). Similarly, the capacity to put aside overt symptoms and to focus rather on aetiology is reflective of the psychoanalytic position in western society.

In African indigenous healing there exists wide variety of healers. These healers are highly trained therapists who undergo extensive training, sometimes lasting several years (Berg, 2003). These include an *inyanga* (doctor) and an *isangoma* (diviner). The *inyanga* is generally a man who learns through apprenticeship to dispense herbal treatments. The *isangoma* is often a woman who has been chosen by the ancestors to be a healer (Ngubane, 1977). Pelzer (1996) states that most healing methods focus on psychosocial problems and disorders. This view is supported by Hewson (1998) who states that traditional healers work most successfully with psychological and psychosomatic illnesses. Ritual and herbal remedies, dance, dream interpretation and co-habiting with the healer may form part of a treatment process. Healing takes place either on an inpatient basis with the inclusion of family members or on an outpatient basis with the inclusion of the community (Pelzer, 1996). During treatment the healer may make direct statements to the patient and others present. By monitoring the reaction of the group, new interpretations and understandings of the patient's problem emerge. Healing is therefore not only about the individual but also about maintaining the norms of the particular community. The emphasis on non-rational procedures in indigenous healing can give the mistaken impression that there are no rules or rational codes of practice. In fact rationality does play an important part in these healing processes (Reynolds, 1996). This is exemplified by Sinzingre and Zemleni (1992) who show that in African medicine there are four key questions that are generally asked. These are: Which sickness is it? How has it happened? Who or what produced it? Why did it occur at this moment in this individual? Rather than following pre-determined rules, the healing procedure flows on from the meaningful logic that emerges out of these questions.

In most African cosmologies disconnectedness can cause profound suffering (Hewson, 1998). Traditional healing rituals are generally aimed at restoring connectedness and therefore restoring psychological health to the individual or community. The efficacy of this process lies in the fact that it addresses the fundamental human need of establishing links. Through ritual, connectedness is re-established and concrete links are made between the individual, the family, the community and the ancestors. Such links simultaneously serve to re-connect body and mind, the conscious and the unconscious. This process occurs in a ritualised space, presided over by a trained healer who acts on behalf of the ancestors (Berg, 2003).

In spite of enormous cultural differences, there are certain characteristics of healing that are common to all societies. Frank and Frank (1991) outline some of these features:

- 1) An emotionally charged, confiding relationship with a helping person (often with the participation of a group).
- 2) A healing setting.

- 3) A rationale, conceptual scheme or myth that provides an explanation for the patient's symptoms and prescribes a ritual or procedure for resolving them.
- 4) A ritual or procedure that requires the active participation of both patient and therapist, and that is believed by both parties to be a means of restoring the patient's health.

Western individualised forms of therapy and indigenous collective approaches to healing are therefore in essence not entirely different. The challenge for biomedicine and African medicine is similar to the challenge for psychoanalytic psychotherapy and traditional healing practices. It is not a case of romanticising indigenous practices and seeing them as better, neither is it acceptable to elevate western-based systems of healing. As stated by Swartz, L., (1998.), "Much more work needs to be done which critically examines the interface between indigenous healing and professional mental health care, so that the best can be gained from both approaches, in the interests of the users of these services" (p. 254).

Cross-Cultural Psychotherapy in Africa and South Africa

3.10: Cross-Cultural Psychotherapy in Africa

The most dominant form of psychotherapeutic care in most African countries is provided through traditional forms of practice. Traditional healing rituals are culturally organised, symbolically meaningful events which provide standardised therapeutic experiences aimed at reducing anxiety and emotional distress in individuals suffering from a variety of mental illnesses (Kiev, 1989). Research shows that traditional and religious faith healers attend to approximately 80% of mental cases in Africa (Madu, S., Baguma, P. & Pritz, A., 1999). Whilst these traditional healing methods are highly appropriate to the vast majority of individuals, such methods are becoming increasingly unable to deal with the newly structured psychopathologies that appear with modernisation, urbanisation, economic and political instability. As a result the demand for psychotherapy is increasing, particularly in urban areas (Peltzer, 1995), and psychological disorders now account for approximately one fifth of all contact with health services in Africa, with the majority of mental health problems being psycho-social rather than psychiatric (Madu et al., 1999). The need for increased psychotherapeutic intervention in Africa having been established, the question has been raised as to how to proceed. It was in the spirit of these questions that a forum for cross-cultural dialogue was established by the World Council for Psychotherapy. At the First World Congress for Psychotherapy (Vienna, 1996) specific questions relating to "psychotherapy in Africa" were raised. This was followed by the First African Conference on Psychotherapy in Kampala (Uganda, 1997) and the second African Conference on

Psychotherapy in Sovenga (South Africa, 1998). This debate has been continued at further conferences and meetings. In South Africa the following statement encapsulated the spirit of the Sovenga conference:

Psychotherapy as it should apply to (Black) Africa is yet to be well defined. The right attitude towards the western forms of psychotherapy, the appropriate ways for adapting them for use in Africa, the right attitude towards African traditional and religious ways of healing, how to relate them to modern methods of treatment of emotional problems of Africans, and what psychotherapy-related areas should draw the attention of researchers: these are some of the questions that have generated dialogue among psychotherapists (Madu et al., 1999, p. 270).

Discussion arising from this conference established that the interest in and the need for psychotherapy in Africa are indisputable (ibid). The World Council for Psycho-therapy initiative requires ongoing dialogue and research to ascertain how different forms of therapy, both indigenous and western-based, can be developed into meaningful structures for general use. The question of how psychoanalytic psychotherapy, which is a particular form of therapy, can be adapted to a South African context is one of the goals of this thesis. It is important therefore to consider how this form of therapy has been adapted in other countries.

3.11: Adaptations of Psychoanalytic Concepts for Treatment and Research in South Africa and other Non-Western Cultures

Psychoanalysis in Africa has been largely confined to ethnopsychanalytic studies, which utilise psychoanalytic research methods to understand different cultural dynamics. Whilst psychoanalytic thinking has been used in various African countries for a number of decades there are no references in the literature that discuss in detail the use of psychoanalysis as a treatment strategy with Black Africans. In some instances, particularly South Africa, various forms of psychoanalytic treatment have been used, however the use of this treatment has been confined to patients of western culture: mostly White South Africans. On the whole psychoanalytic psychotherapy has not established itself firmly as a treatment approach in Africa.

Peltzer (1995) states that as a treatment method in the third world psychoanalysis needs to undergo certain modifications and adaptations to technique. However, in certain non-western cultures psychoanalysis has been adapted to the needs of the cultural milieu. This is particularly evident in Latin America where Rabanal (1990) practised psychoanalytic work with patients living in a slum in Lima, Peru. He adapted his treatment strategy to the context by conducting sessions with patients in their home environment. Similarly, Devereaux in his work with an American Plains Indian adapted his technique to “expressive-supportive therapy” (1985, p. 207),

which did not attempt to change the cultural values of the patient but rather adapted the goal of treatment to the external cultural conditions. These successful uses of psychoanalysis in a cross-cultural environment suggest that psychoanalytic psychotherapy should also be capable of adaptation to an African context.

In South Africa psychoanalytically informed thinking has been integrated into various programmes to good effect. The Kathorus Parent and Child Counselling Centre was established in 1995 and grew out of what was previously the Johannesburg Child Guidance Clinic, which was founded in 1946 during the time of Wulf Sachs. A strong psychoanalytic orientation has been maintained at this centre since its inception, throughout Apartheid and into its current transformation as an appropriate resource, which is strongly based in the community. Other programmes, mostly coordinated through universities, have shown how psychoanalytic thinking can be used in different cultural settings. For example, Dr Astrid Berg started the Infant Mental Health service in the community of Khayelitsha in 1995. This is a clinical service that has a psychiatric and psychotherapeutic focus. It is a culturally sensitive programme that takes account of traditional healing practices (Berg, 2003). Van Breda (1997) explored the possibility of using Jungian dream analysis as a psychotherapeutic framework for White therapists working with Black patients. In this essay Van Breda concludes that the Jungian understanding of the psyche, particularly the universal unconscious, offers a promising framework for working across culture in South Africa. The concepts of the universal unconscious, the archetypes and images are well suited to the cosmology of indigenous healing practices, particularly with regard to understanding the role of ancestors in such communities (ibid). Other examples are the psychodynamic outreach work of Valerie Sinason (1998) in Cape Town with traumatised communities and the work of Anne Mckay in Durban with deprived and delinquent youth (Mckay, 1996), which are further testimony to the effectiveness of psychoanalytic thinking across culture.

3.12: Psychoanalytic Psychotherapy in the South African Context

When discussing the evolution of psychoanalytic thought in South Africa it is important to contextualise these developments in the historical and socio-political past. Prior to the institutionalisation of Apartheid in 1948 attitudes towards mental health were directed by the Mental disorders Act No. 38 of 1916. This act declared the superiority of Whites and popularised a Eurocentric view of mental health. This mindset flowed out of European imperial notions of the presumed superiority of Western culture, and the universal application of western norms (Sadowsky, 2003). Cultural stereotypes equating primitive society with degeneration, disruption and pathogenesis were readily adopted and woven into Apartheid ideology. As a result in the early years of Apartheid, psychology and psychiatry acted largely in the political interest of the

white minority (Vontress & Naiker, 1995). In later years these disciplines moved towards a more neutral position, largely dissociating themselves from political systems and in some cases leaning more towards the provision of appropriate social services. There is no doubt that the Apartheid system and its predecessor the colonial system caused untold harm to the people of South Africa. The systematic disruption of Black families and communities created social and psychological problems that are likely to linger for many generations. Furthermore this system was responsible for skewing and retarding the development of a mental health service that takes account of cultural difference and the needs of the general population at large. It is no wonder that white psychologists and other mental health professionals who work in African contexts stand accused of oppression, irrelevance, elitism, Eurocentricism, and neo-colonialism (Bakker & Snyders, 1999). The practice of psychology and psychiatry in South Africa has undergone significant change in recent years (Swartz, 1999) these efforts have focused on overcoming the racial and cultural barriers that were defined and upheld by the Apartheid system. As Berg (2003) states: “In South Africa western-trained health professionals can no longer ignore the needs of the majority culture. As professionals we have to move out into communities of need” (p. 276).

Despite the academic isolation of the Apartheid years there has been a long tradition of psychoanalytic thinking in South Africa. This started most definitively with Wulf Sachs, a psychoanalyst who liased closely with Ernest Jones in attempting to establish a South African branch of the International Psychoanalytic Association (IPA). This did not materialise as Sachs died in 1949 before it could be firmly established. As a pioneer of psychoanalysis in South Africa, Sach’s work is well documented in his book *Black Hamlet* (1947). This work was the first attempt at cross-cultural psychoanalysis in South Africa. The subject of this book was a biography of his client, the Black traditional healer John Chavafambira (Madu et al., 1999). After Sachs’ death the further institutionalisation of psychoanalysis was prevented largely through the installation of Apartheid. In 1972 the South African Institute for Psychotherapy (SAIP) was established by Dreyer Kruger in collaboration with senior psychiatrists and psychologists. This institute carried a strong psychoanalytic emphasis. In 1979 a psychoanalytic study group was founded in Johannesburg and in 1984 a similar group was established in Cape Town (Gillespie, 1992; Hamburger, 1992). In January 1987 the Centre for Jungian Studies was inaugurated by Sir Laurens Van Der Post, Vera Buhrmann and others. This centre continues to offer postgraduate training in advanced psychotherapeutic techniques and is affiliated to the International Association of Analytical Psychology. Strong connections are maintained with the international psychoanalytic community and psychoanalytic theory continues to play an important part in the training and practice of therapy in this country.

There have been no co-ordinated programmes but there have been a number of individual and local initiatives looking at the practice of psychoanalytic psychotherapy in the South African context. Becker and Isaacs (1993) found from interviews with 29 clinicians working in Cape Town that 48% practised brief dynamic psychotherapy and 72% had a psychodynamic orientation. However, questions about the relevancy of psychoanalysis in post apartheid South Africa are continuously raised. This was particularly evident at the International psychoanalytic Conference in 1998, held in Cape Town. This conference attracted a large number of South African delegates, many of whom took the opportunity to question the appropriateness of psychoanalytic understanding to communities beyond the western ethnic minority. Despite this controversy it is clear that, as Sally Swartz (1998) points out, “In a sense we do not have a choice about whether or not psychoanalytic theory is a feature of the landscape: it is a part of the landscape” (p. 1). She further notes that psychoanalytic thinking has been a strong feature of the psychological training in most South African universities as far back as the 1920s and 1930s.

Two threads of argument emerge from the controversial position of psychoanalysis in South Africa today. The first relates to the appropriacy of imposing a western conceptual framework on a non-western setting. The second relates to the fact that there is, strictly speaking, no choice as to whether psychoanalytic thinking should be used or discarded as it is indelibly an ongoing part of South Africa’s psychological evolution. It follows therefore that research is required to determine ways of bridging the gap between the present use of psychoanalysis and the appropriate use of psychoanalysis in South Africa. Sheila Miller, an English psychoanalyst working in Johannesburg, gives an interesting cross-cultural example of culturally different analyses of the same symbol. When a child’s drawing of an elephant was presented to her she offered an interpretation which derived from her own cultural association of “elephant” with “memory”; her non-western colleagues pointed out that many of the indigenous South African cultures would associate an elephant with power (1999). This simple point raises the important issue of allowing the individual to express his own associations and interpretations of a particular symbol rather than the clinician imposing culturally derived assumptions. This requires a relativist stance such as is expressed through Kim and Berry’s notion of the derived etic (1993). This is precisely the challenge that the whole of psychoanalysis needs to meet in South Africa.

3.13. Interracial and Cross-Cultural Concerns in the Practice of Psychotherapy in South Africa.

During the decade from 1970-1980 Black students in South Africa received only 2% of the degrees in psychology (Vontress et al, 1995). These numbers have been steadily increasing with most universities placing a strong emphasis on restoring this imbalance. In spite of this most psychologists in South Africa are White. Such individuals are well aware of the legacy of

Apartheid and the associations that still exist when attempting to work across culture. White therapists working with Black patients need to contend with issues of power emanating from a legacy of segregation and racial discrimination. Other factors that may impact on the process include patient mistrust, lack of awareness and education about the effectiveness of psychotherapeutic interventions and limited financial resources. Therapist bias and gender issues are also concerns that need to be taken account of. Therapists are required to be aware of their own cultural values and biases and simultaneously need to develop culturally sensitive attitudes and skills towards their patients' cultural difference (Wilson & Stith, 1991).

Apart from these factors the fundamental issue highlighted in this study is to what extent are psychodynamic and other psychological models of treatment are appropriate across racial and cultural divides. Jackson and Greene (2000) consider psychodynamic theory in a cross-cultural context to be ethnocentric, perpetuating sex role stereotypes, pathologising difference, and failing to provide an in-depth understanding of the experience of the other. They state that the real task for psychodynamic work across culture is to train clinicians towards expanding theoretical paradigms and therapeutic methods of enquiry that take into account the historical, political and real life experiences of Black people. In doing so a better understanding of the psychodynamic underpinnings of these individuals' psychological experience can be gained.

White therapists working with Black patients in a South African context are confronted not only with the recent socio-historical factors but also with more general issues pertaining to cross-cultural work. Most studies agree on several critical points that culturally-sensitive therapists need to consider when working across culture. Berg (2003) highlights the fact that the archetypal presence of ancestors in African culture is a reality that cannot be ignored in the consulting room. Dupont-Joshua (2003) extends this argument and points out that when the African individual walks into the therapy room he may often bring with him his entire family, both alive and dead. Therapists are therefore compelled to look beyond the therapeutic dyad in order to understand their patients.

This view is supported by Peavey and Li (2003) who argue that successful intercultural counselling depends on the extent to which the therapist understands the socially contextual factors surrounding the interaction. Secondly they argue that intercultural counselling is a collaborative process, the success of which depends on how well the therapist and the client coordinate their communication on process and content issues. Therapists that have an understanding of their client's social and cultural contextual variables are more likely to establish a working alliance. Ruiz, Bland, Pi and Zulueta (2005) support the notion that no successful

intervention can occur without the engagement and establishment of a therapeutic alliance. A strong alliance requires that therapists openly acknowledge potential impediments to the process in order to gain credibility with the client. They need to acknowledge that their racial difference may create an experience of social distance for both patient and therapist. Also, that this distance may mobilise anxiety and mistrust thereby decreasing self-disclosure on the part of the patient. These open acknowledgements can only serve to increase the empathic bonding that is necessary for a successful treatment outcome. Most studies agree that the therapist needs to know the cultural rules of conversation, other than language, that may hinder communication. An attitude of reciprocity, negotiation, humility and respect, together with a reverent attitude towards difference is necessary to facilitate successful outcomes in cross-cultural therapy.

White therapists working with Black patients in South Africa cannot divorce the consulting room from the larger socio-cultural and political context. Race relations, the exercise of power, stereotyping, discrimination and issues of gender inequality that exist in the broader context will be reflected in the therapeutic encounter (Palmer, 2002). Given that the relationship between Black and White individuals has always been typified by conquest, oppression, exploitation and discrimination, it is paramount to develop models of practice that can overcome these issues of dominance, rather than perpetuating old themes of White authority and superiority that may cause further damage. One aspect of conditioning established through colonialism and Apartheid is the perception that White people are knowledgeable, powerful, wealthy and intelligent. For this reason Black patients may have more confidence in a White therapist than a Black therapist. Conversely they may also harbour deep feeling of resentment (Palmer, 2002).

Furthermore, therapists need to understand similarities and dissimilarities between their own cultural values and the values of their Black patients (Wilson et al, 1991). Sharing, obedience to authority, respect for elders, and values associated with patriarchal dominance may differ markedly to the value system of the therapist. The position of women in most African value systems is largely subordinate. For a White male therapist working with Black female patients an understanding of the impact of, not only his Whiteness but also his maleness, must be acknowledged from the position of the patient's own cultural patterns. Similarly, the therapist needs to be aware of his own cultural stereotypes concerning gender inequality.

A postmodern constructivist orientation as opposed to a rationalist style of intervention has been recommended for cross-cultural and interracial work (Eagle, 2005). This approach is a form of discourse located in a particular cultural context. It embodies a style of working that encourages sensibility in the culturally mediated communication of the participants (Peavey et al, 2003).

Peavey et al state that constructivist counselling is premised on multiple realities and is receptive to myth, symbol and metaphor. It focuses more on the dictates of cultural knowledge than on the claims of universal scientific knowledge and “it eschews the ‘authoritative’ voices and vocabularies of professional and academic psychology, as well as the pathologising vocabularies of psychiatry and psychotherapy” (2003, p.189). Eagle (2005) emphasises that it would be impossible to fully engage with African clients holding to traditional world-views by using a model of understanding that does not encompass subjectivity, alternative logics and content that the therapist might consider to be non-rational or irrational.

Peavey et al outline the main features of a constructivist approach for cross-cultural counselling. These include:

- 1) Respect for difference and diversity.
- 2) Openness to a range of possible ways of interpreting reality.
- 3) Encouragement of creativity, inventiveness and cultural resonance.
- 4) A sense of real-life engagement.
- 5) Resistance to the negative effects of classification or categorisation.
- 6) Helping based more on cultural rather than psychological hypotheses.
- 7) Direct use of language tools and social artefacts.
- 8) Cooperation and consensus rather than authority and imposition.
- 9) Help construed as emancipatory and capacity-building in intention (2003, p.189).

The constructivist approach to counselling across culture and race is in keeping with the relativist position outlined in 3.6.3 above which aims to remain as true to context as possible. From this position meanings are constructed collaboratively and are viewed as interactional achievements in the therapeutic encounter. In this process the therapist gives prominence to the patient’s explanatory system of cultural meanings. By listening, responding and re-contextualising these meanings, rather than imposing universals, the constructivist approach allows for the emergence of a therapeutic framework that is, in principle, similar to the concept of a derived etic suggested by Kim and Berry (1993).

3.14: Summary

There is no universal model of self. The western individualised self, arranged around the core concept of dualism, is deeply entrenched in the theory and practice of psychotherapy. This theoretical mindset is inappropriate for understanding the life experience of those individuals whose sense of personhood is socially constructed. Treatment approaches that base themselves on western-centric ideas of health, illness and cure are therefore counter-therapeutic in cross-cultural

work. For psychotherapy to be practicable in South Africa it is necessary to acknowledge the fundamental differences in the arrangement of self that exist across culture. It is important to note that the construction of self reflects the cultural system from which it emerges. Family structures, child-rearing practices, education, obligations to the community, social hierarchy, morality and spiritual beliefs are some of the constructs that inform the development of self in all cultures. When considering how to work across culture it is clear that a model of practice is needed that can assimilate these different perspectives of self and can integrate different cultural patterns. Such a model needs to free itself from dominant western assumptions and values such as self-reliance, self-control and autonomy. Furthermore, such a model needs to acknowledge the damaging effect that universalist assumptions - entrenched through colonialism and Apartheid – have had on Black South Africans.

Psychoanalytic thinking has a long tradition in South Africa. If this discipline is to continue to meet the challenges of its context and to develop into an appropriate tool it must incorporate models of practice that are based on the concept of an *expanding self* rather than an *individualised self*. Such a model needs to be critical of past inadequacies and develop new ways of interpreting psychological meanings that replace the positivist and modernist epistemologies. It needs to adopt a relativist position that is culturally sensitive and allows for meaning to be constructed rather than imposed. White therapists working with Black patients need to be culturally sensitive to indigenous cosmologies and need to be acutely aware of their own personal beliefs and prejudices as well as the associations and negative transferences attached to them by their patients. In order to make sense of the life experience and life difficulties of Black South Africans it is necessary for therapists to understand their patients not only from an emotional perspective but also from within their cultural and social context. Prejudice, racism, poverty and social disadvantage form part of the total life experience of most people in South Africa. White therapists also need to consider their own negative countertransferences, recognising that they belong to a society that has always projected negative images of Black people (Dupont-Joshua, 2003). Those therapists who remain unconscious of their own understanding of race are more likely to experience negative reactions and outcomes, often indicated through early termination (Palmer, 2002).

Contemporary psychoanalytic models of practice that have moved beyond the constraints of the classical determinist model are more able to accommodate the therapeutic needs of Black South Africans in transition. The intersubjective relational quality that is inherent to these approaches allows for an easier assimilation of diverse cultural configurations of self that include both collective/traditional and individualised/ western values.