When we travel abroad, we have to take a power adaptor with us if we want our electrical appliances to work. Extending the analogy, shouldn't we also remember to adapt our Eurocentric psychological theories when we work with clients from non-Western cultures?

Adapting to difference: the hairdryer theory

by Meera Kapadia

I am an Asian counsellor and psychotherapist interested in how (North) European/American psychological therapy can be adapted for people from collective cultures. The most prevalent and privileged psychological theories from Freud onwards are based on a set of social (middle class) and cultural values (individualism) of their time. However, they are presented as if they are universally applicable truths. There is a two-fold problem with this. Firstly, the implicit assumption is that Europe and America are the world (colonial attitude) – i.e. that there is no geographical boundary between these countries and the rest of the world. Secondly, it is assumed that all the world's cultures and religions belong to a homogenized, 'I-self', individualistic culture. This is despite the fact that the

majority of the world's population actually comes from collective cultures.

Crossing boundaries

Having studied social constructionist theory[1] during my psychology degree, I was empowered to critique and challenge the 'colonial' aspects of European theories. So when I was asked to facilitate a workshop at the 2007 BACP Annual Conference on 'Crossing Boundaries', I did just that. The boundaries being referred to are Eurocentric theory boundaries, yet they are spoken of as if they are universal. I therefore turned the title on its head: 'Has European psychological theory crossed its boundaries? The hairdryer theory'. When we talk of crossing boundaries, whose boundaries are we crossing, and from which historical period or cultural standpoint?

When we travel across geographical boundaries to go abroad, we need to take an adaptor to use electrical items like hairdryers. Yet when it comes to psychological theory, many of us expect that we can apply it across the world without an adaptor. Hence, the title the 'hairdryer theory' – to remember to use an adaptor.

Individualism versus collectivism

Individualistic cultural boundaries are placed around the 'I' like a psychological skin. These boundaries are often firm, even rigid around privacy of the individual and different selves (e.g. the professional self and personal self). This may extend to the couple relationship (based in itself on the two 'I' selves), or the nuclear family. Collective cultures function from a psychosocial self where the other is not separate from the self, but rather the self-identity is a 'We'. In collective cultures this psychosocial skin is firm, even rigid around the family unit, and concepts of duty, obligation, and the maintaining of family honour. In contrast to individualistic cultures, where privacy is about threat to self-image, in collective cultures privacy is about threat to the family honour and reputation. These are maintained by not speaking to 'outsiders' about 'family business'. Hence the reluctance, particularly from first generation 'We-self' culture individuals, towards therapy.

Figure and ground

The Gestalt notion of a figure/ground relationship[2] is a useful one to consider in this context. For example, an individual from a collective culture may have a 'We-self' in the figure the majority of the time, and the 'I-self' in the background. Yet this would shift according to the role and context she is in (i.e. home, work), and there will be individual differences about where each person is on the individualist/collectivist continuum. In individualistic cultures, the 'I-self' may be in the foreground most of the time, yet Christmas is a time when the 'We-self' often comes into the foreground.

Thus, I acknowledge that this is a complex multi-layered phenomenon and intra-cultural differences can be huge, as they will interact with other variables such as geographical area, season, socio-economic class, education, gender, and personality. So perhaps individuals are on a continuum of individualism/collectivism in each culture.

Fifty years ago Britain also had the 'We-self' in the foreground and the 'I-self' in the background. Perhaps this is also linked to resources and necessity – there has to be a very strong 'We' when the resources and finances of a society are in short supply, and people are the main resource. For example, in Victorian Britain, except for the upper classes, people could not afford to live independently nor afford to promote the 'I-self', so a 'We-self' culture in which the individual's needs were sacrificed for the greater good of society was promoted. Whereas in post-industrialised capitalist societies, the 'I' reigns supreme. So the very fabric of society and its beliefs and values are geared around economic necessities.

My experience in a collective culture

During my psychotherapy training in the UK, I was aware of being trained to work within a Western model, which discounted my collective cultural experience. Soon after finishing my training, I went to India to see how therapy was done in a culture with a different view of the self to the Western model*.

My most profound experience was with earthquake survivors in my ancestral state, Gujarat[3]. The earthquake took place in January 2001 and killed around 30,000 people. Most of my work was in rural villages in the epicentre of the earthquake region. I worked with an NGO? to recruit and train volunteers from 20 villages so they could provide psychosocial support on an ongoing basis.

While interviewing potential volunteers, a common theme emerged: they denied that the earthquake affected them mentally, yet described difficulties in sleeping, loss of appetite, and reduced enthusiasm for life. This could be because they didn't recognise these (often) physical symptoms of distress as being psychological in nature. Perhaps they were reluctant to admit they were affected mentally, because it might bring about not only individual but family shame, if this information became public knowledge. Either way, it seems evident that they had a different language to describe emotional distress.

As therapists we are trained to interpret physical symptoms as being linked to psychological distress, yet why should non-professionals do the same? In the UK therapy services are geared to accept referrals from people who use psychological labels, such as depression or anxiety. Where does that leave people who have different languages for expressing emotional distress?

The Gujarat volunteers were trained in a key working model, with counselling skills as the main component, and training was also given on legal aid, physiotherapy and psychiatric illnesses. This is a holistic model as compared to the Cartesian mind/body split still generally adopted in the West. The therapist becomes an advocate for the client's mental, emotional, social and physical wellbeing and partakes in psychosocial rehabilitation, rather than compartmentalising his or her needs.

Implications for UK service provision

It is interesting that many black and minority ethnic (BME) organisations in the UK offer a holistic model of care, so that clients can enter therapy through different gateways. Many people from collective cultures – for example asylum seekers and Asian people – present to GP services with aches and pains, and GPs are unable to recognise the psychosomatic nature of the illnesses[4]. It is well known that black and Asian clients[5] are more likely to be offered medication than therapy, and that it is a Department of Health Delivering Race Equality (DRE) target to provide more equitable provision of counselling and psychotherapy by 2010. Perhaps this involves listening to different languages of psychological distress to our own.

Hierarchy, status and gender boundaries

In Asian, African and other collective cultures, social boundaries demarcate status and encapsulate codes of behaviour. These include gender appropriateness and morally acceptable behaviour. Boundaries between self and other, professional and personal, extended family and community, are much more fluid. The boundaries of caste, gender roles (based on patriarchal rules) and respect for elders, are applied as rigidly or more rigidly than some boundaries in Western cultures. Adhering to these boundaries is the responsibility of all members, in order to preserve the family name, and is often linked to marriage-ability and social standing in the community.

In collective cultures patriarchy is often more overt, and pressure on women to carry the family 'honour' can be very strong. For example, if one woman within the family transgresses sexual boundaries, the honour of the whole family is seen to be tainted. In extremely patriarchal collective cultures like Saudi Arabia, women who dress 'inappropriately' or commit adultery are subjected to severe state-sanctioned punishments.

Taking a solely individualistic stance, collective clinical issues become invisible. These issues may include Hikikomori, a Japanese illness in adolescence, and female infanticide. To look at this from a clinical stance, a study by Patel[6] stated that Hindu women in Goa, India who already had one living female child, were 25 per cent more likely to develop postnatal depression if the new baby was a girl, but the risks were not increased if the new baby was a boy. Yet these issues do not come to the attention of mental health professionals, as only 'I-self' clinical issues are recognised and highlighted in psychological literature.

Universal therapy boundaries?

In the therapy field perhaps there are some universal boundaries we need to adhere to. But are we making false gods of the notion of boundaries per se? Freud and Klein analysed their children; Winnicott's patients were made hot chocolate and driven home if they were too distressed; Masud Khan played chess with his patients; and Brian Thorne had the naked embrace with his client. These masters crossed boundaries – were these abuses? Were these appropriate boundaries for the age of the clients or for the historical period? Can you be a pioneer without crossing boundaries?

Assessment and boundaries

The assessment process aids therapists in judging normality and pathology from a seemingly objective standpoint. Yet, from Freud onwards to Mahler, Jung, Rogers and Perls [7, 8, 9, 10], psychological theories

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emphasise increasing separation and autonomy as a goal of therapy. In fact Maslow's hierarchy of needs[11] is based on self-actualisation of the 'I'. How does assessment of psychological health from this perspective affect people who come from collective cultures, where the model of health is of interdependence and interconnectedness? I would hypothesise that people from collective cultures may be pathologised, and seen as 'symbiotic', 'enmeshed' or not psychologically mature.

Suman Fernando refers to the assessment process as colour- and culture-blind[12]. Assessment tools also need to be validated for the local population. I attended a lecture where Professor Bhugra[13] spoke about his own experience of creating a diagnostic tool for assessing eating disorders in the UK, and then applied it to an Indian cultural context. He found that there was an abnormally high level of eating disorders in the Indian population according to this research study. He pinpointed the statement that brought about this result: 'I am preoccupied with food.' It is culturally normative to be preoccupied with food in the Indian culture, some people would argue! Also, some of the people in the study, were starving, and so would be preoccupied with food.

National suicide statistics state that white men under 35 yrs old[14], are at highest risk of suicide. Yet on doing an ethnic breakdown, Asian women have suicide rates three times that of the national average[15]. It is easy to see from these two examples, that we can either over pathologise people from minority cultures as in the Bhugra study, or make their mental distress invisible as in the suicide statistics.

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Assessment adaptor

How can one create an assessment and treatment adaptor that does not become prescriptive and self-limiting? I believe the answer lies in asking the right questions and bearing certain concepts in mind. 'We-self' issues and the experience of being a BME person in the UK are key here. It is important to understand the reasons for the client's migration to the UK, the method by which they came to arrive in the UK, and also to know their residency status. It will also be useful to know how many times have they migrated across cultures/countries before, and their relationship to their mother country.

For example, an African man who has come as a student will have a different relationship to UK culture to an Asian woman who came as a result of marriage, or a Serbian asylum seeker. This information will tell us a great deal about their sense of belonging, psychological rootedness, and cultural transference to the UK culture. An example of cultural transference is when I saw a Serbian client who was reluctant to tell me her ethnic origin for fear I may judge her at a time in which Serbians were being demonised in the media.

Focusing more on the individual client's background, it's crucial to ascertain whether he/she is from a rural or urban background, what their educational and employment background is, language issues, and how they define their religious or spiritual identity. Someone from a rural background is likely to have a more dominant 'We-self' than someone from an urban background, where there is more of a dismantling of the extended family system. It will also be useful to explore what their attitude towards their mother country is. Do they experience cultural shame? Or do they idealise their country of origin? This is likely to be different in different generations of migrants.

For example, a first generation Indian man is more likely to feel cultural pride, and perhaps hold on too tightly to his cultural identity as a result of not returning to his mother country for many years due to financial constraints, so he may not see how his country has progressed since his departure. This may lead to intergenerational conflict, which may be more complicated for a family from a rural background,

Collective cultures	Individualistic cultures
Connectedness	Boundary/separateness Privacy
Honour/shame, family reputation	Egalitarian society
Hierarchical and patriarchal Society	Personal/professional Autonomy ('I' focus)
Gender roles	Privileges the psychological self
Duty and obligation ('we' focus)	Cost is Psychosocial self
Privileges the psychosocial self	
Collective superego – cost is psychological self	

due to the more dominant 'We-self' culture, being a stark contrast with the individualistic culture of the UK. The second and third generations of the family will experience this sharp contrast, living in both extremes of the collectivist/individualist continuum, and this intergenerational conflict then becomes intercultural conflict with their parents.

As a therapist it is also important to pay close attention to one's own feelings and prejudices and consider what the prevailing media stereotypes of the particular client group are, as these are bound to have some effect on us. This is not an exhaustive list, but hopefully gives a sense of the complexity involved in assessment of people from collective cultures.

Treatment adaptor

What may happen during treatment to clients whose 'We-self' is excluded from the therapy? The 'I-self' therapy is useful and important, yet I would suggest that it may lead to an internal cultural split, where the 'I-self' part of the psyche 'colonises' the 'We-self' part, and there may be cultural shame about the collective self.

The treatment adaptor may include consideration of the client's concept of counselling and relationship to authority. It will also be important to consider their cultural, gender and family scripts and projections. A person from a collective culture does not 'leave home' psychologically, rather, the collective identity remains a big part of their identity, so they may continue to have powerful family scripts and projections replaying throughout the lifespan. This may not be the case for someone from an individualistic culture, and if it is, it would not be enacted so powerfully, due to the relationships with the extended family being less intense.

It is important to explore the person's racial identity in order to be able to use culturally appropriate metaphors. For example, a culturally appropriate metaphor for psychological distress for first generation Asian women could be a pressure cooker. During some mental health awareness raising for a group of first generation Asian female carers, rather than telling them about counselling, I explored their cultural scripts of being carers. They compared the cultural script of being a carer in the Indian subcontinent, with that of being a carer in the UK. The majority said they had far more state and financial support in the UK but far less extended family and community support, which led to more isolation and depression. Then I asked them to define depression and used the metaphor of a pressure cooker. I drew the parallel in terms of them bottling up their distress, which leads to depression. The entry point is the client's frame of reference, that of their cultural self. This also helped them to frame their distress as isolation through migration, and gain social support without losing 'honour'.

To conclude, I hope that clients can be seen in their 'I-self' and 'We-self' contexts Psychological theory is a powerful tool or weapon depending on its usage. It can either minimise the distress of people who fit the theory, or it can inflate the distress and pathology of those who don't. As I often wondered during my psychotherapy training: are black and Asian trainees less able to fulfill the requirements of psychotherapy trainings, or is it that the lens is contaminated? Having gained my status as a psychotherapist, perhaps I have more permission to verbalise this dynamic and be true to my bicultural therapeutic self.

Meera Kapadia is an integrative psychotherapist, trainer and supervisor. She works at TLZ Young People's Counselling Service, within CAMHS, in the NHS, and is a Visiting Lecturer at Regents College. Email meerakapadia@hotmail.com, www.meerakapadia.moonfruit.com

*I use the term Western as a global term, and am aware of the vast cultural range within this, and how the Western culture of today is relative, as it is not the same as the Western culture of 30 to 50 years ago. I use the term Western to denote the predominant culture of today.

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