# Professional closeness: cultural empathy as the quintessence of psychotherapeutic treatment for ethnically diverse patients

Mario H. Braakman

**Abstract: Professional closeness: cultural empathy as the quintessence of psychotherapeutic treatment for ethnically diverse patients**

Due to globalization and increasing mobility, western-educated psychotherapists in Europe are progressively confronted with ethnically diverse patients. Since these patients also take their cultural background into the psychotherapist's office, the therapist has an additional challenge to master. Empathy is a fundamental aspect of successful psychotherapeutic engagement. An adequate empathic understanding is challenging if the cultural roots of patient and therapist are different. The more diverse these cultural differences are the more difficult it is for the therapist to grasp adequate empathy. Cultural empathy is the ability to sufficiently experience the cultural context of a patient. In this paper the most important competencies to achieve cultural empathy by the therapist are explained, both technical skills which can be learned as well as intra-psychic adaptations by the therapist himself or herself.

**Keywords:** Empathy, psychotherapy, ethnicity, cultural competency

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## Introduction

Empathy is the ability "to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person without ever losing the as if condition" (Rogers, 1959, cited by Pedersen, Crethar & Carlson, 2008, p. 9). Empathy is considered to be an essential ingredient of adequate and effective psychotherapy (Elliott, Bohart, Watson & Greenberg, 2011). Empathic understanding is positively related to clinical improvement and shows stronger associations with improvement compared to specific therapeutic techniques (Chu, Leino, Pflum & Sue, 2017). Empathy comprises two aspects: *conceptual or cognitive* empathy by which a therapist tries to understand a patient's thoughts, feelings and behavior, and emotional or affective empathy by which we feel and experience the emotions and intentions of the patient straightaway (*Einfühlung*). Cultural empathy is the same as empathy, but stresses the fact that in addition to overcoming differences between therapist and patient an additional challenge has to be overcome if these two subjects have different cultural backgrounds. Culture is a complex concept which led to a myriad of definitions by anthropologists and other scientists. As far back as 1952 Kroeber and Kluckhohn published a monograph in which they already accumulated about 150 different definitions of the concept. For present purposes the following definition of Keesing and Strathern (1998) is quite useful: Culture comprises "systems of shared ideas, systems of concepts and rules and meanings that underlie and are expressed in the ways that human beings live" (cited by Helman, 2007, p. 12). Within the context of psychotherapy the therapist must "ascertain how cultural values and assumptions influence the client's personal experience" (Chung & Bemak, 2002, p. 156-157). When patient and therapist differ in cultural background/upbringing an additional challenge emerges: the greater the otherness of the patient the larger the effort to bridge the gap between patient and therapist. The more cultures differ the more is the risk of misunderstandings and bad therapy outcomes. How to bridge these differences is the question this paper wants to answer. How to become culturally empathic? A lot of issues are involved in establishing a culturally empathetic relationship with an ethnically diverse patient. In this paper, space is limited, we focus on a few key-issues which are essential in improving cultural empathy.

## Ethnic matching

One way to increase cultural empathy between patient and therapist is to select a therapist with the same cultural background as the patient. Ethnic matching between patient and therapist is a common practice. Ethnic matching offers the advantage of having a lot of cultural knowledge, feelings and experiences which are similar to that of the patient. Often, but not always, an interpreter is not necessary. However a therapist with the same cultural roots as the patient is not equivalent to being a cross-culturally skilled therapist. Therapists who are culturally close

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can become too close for a patient in cases in which cultural taboos or issues concerning "family honor" or political differences are at stake. Patients are more reluctant to disclose these issues in therapy. In addition cultural closeness meant to increase the empathic understanding of the patient can easily lead to not exploring "culturally related issues" because the therapist is convinced he/she understands what a patient means. But skipping those questions can lead to misunderstandings. Being possessed by "Djinns" could have very different meaning for a patient and his therapist and always needs to be explored.

The therapist him-/herself can feel a negative impact: being selected by mental health institutions or teams because of similarities in cultural background and not based on a therapist's skills. In a treatment team it can lead to an overloaded ethnic specialist who has to deal with oftentimes complex patients and by segregating ethnicity it hampers the growth of cross-cultural expertise of the team as a whole. Patients often prefer ethnic matching and ethnic dissimilarity is associated with reduced therapy uptake, increased premature dropout and reduced treatment (Farsimadan, Khan & Draghi-Lorenz, 2011). Although ethnic matching is slightly preferred by patients it does not lead to better treatment outcomes (Cabral & Smith, 2011; Knipscheer & Kleber, 2004).

Finally, ethnic matching is not always available, accessible nor desirable. In a globalizing world with increased world-wide migration all psychotherapists should possess some basic cross-cultural skills. So attention for basic aspects like cultural empathy is necessity for all therapists. In the following paragraphs we will discuss some essential techniques which can be applied to bridge the cultural gap between patient and therapist in ethnically diverse psychotherapeutic encounters by increasing cultural empathy in the therapist. This is mainly done by strengthening the cognitive parts of empathy in the therapist.

**Basic cultural empathy: constructing cultural context**

Being able to interpret patients' complaints, problems and, potential therapeutic resources within its cultural context is of considerable importance for psychotherapy. Therapists cannot have profound culturally informed knowledge of all possible cultural backgrounds of their potential patients. Neither is it necessary. There are means to construct this cultural context by using the patient as the key-informant. This enables the therapist to construct the most important aspects for assessment as well as treatment. The most sophisticated way of mapping this cultural context is the *Outline Cultural Formulation* (OCF), published in the DSM-IV, and its successor the *Cultural Formulation Interview* (CFI), published in the DSM-5. The forerunner of the CFI, the OCF, is nothing more than a short checklist with core cultural aspects that should be mapped before and/or during psychotherapeutic treatment. These aspects are (Lewis-Fernandez, 1996; Lewis-Fernandez & Diaz, 2002):

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1. Cultural identity of the patient
   (including the cultural reference group, degree of involvement in the host culture and language preferences)
2. Culture-specific explanations of the patient's illness
   (including idioms of distress, local illness categories used, and perceived causes and explanatory models)
3. Culturally relevant interpretations of social stressors and social support
   (including local stresses, perceived discrimination, as well as religious and social support systems)
4. Individual differences in culture and social status between patient and therapist
5. Overall cultural assessment for diagnosis and care
   (summarizing how cultural factors could influence diagnosis and therapy)

Despite of its importance the therapist needs training and experience to construct the patient's cultural context by this method. In order to simplify and improve its clinical usefulness cross-cultural psychiatrists and anthropologists created an OCF-derived semi-structured interview with specific questions the therapist can ask his patient (Lewis-Fernandez et al., 2014). It consists of a *Core Cultural Formulation Interview* (CFI) with 16 questions and twelve supplementary modules (each with additional question) of which the therapist can choose as many as he or she wishes in order to construct and clarify the cultural context [1]. This method is nowadays the best available technique to improve cultural empathy by constructing the relevant cultural roots of the patient.

*An example of cultural identity* [1]

A 24-year old refugee who fled from Sri Lanka to the Netherlands was referred to me by a colleague who suspected a manic episode. Besides a lot of other symptoms the patient persisted in his opinion that he had 50 brothers and 60 sisters. My colleague knew that, in the country of origin, men are allowed to have four wives. However this patient had a father who had only one wife and was not married previously nor were there other non-official relationships with women involved. Despite this the patient persisted in his estimation. After conducting an OCF it became clear that this patient was a Tamil from Sri Lanka and that he was raised in a patrilineal cross-cousin marriage system in which cross-cousins are differentiated from parallel cousins. Cross-cousins are a parent's opposite-sexed siblings (the children of the brothers of someone's mother and the children of the sisters of someone's father) and parallel-cousins are a parent's same sex siblings (the children of the brothers of someone's father and the children of the sisters of someone's mother. A cross-cousin marriage system requires that a man marries one of his cross-cousins while marrying a parallel-cousin is considered taboo and incest.

So for men, females classified as cross-cousins are marriageable, however parallel-cousins are labeled by the kinship term "sister". Also male parallel-cousins are labeled as "brothers".

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So in fact what this patient meant was that his biological brothers and half of all his cousins are "brothers" and his biological sisters, including his female parallel-cousins are all called "sister". Based on this information we can conclude that this patient was telling the truth and was not suffering from a (grandiose) delusion. Moreover this patient just arrived in the Netherlands and came from a small village from the interior of Sri Lanka. Although he spoke English quite well he has had no school-education. Thus, this patient had very few notions of western culture, and certainly not what the western kinship terminology means. He knew only his own. To be able to assess the postmigration context both the OCF as well as the CFI offer help. The exact acculturation process of this and other patients can be mapped according to figure 1.
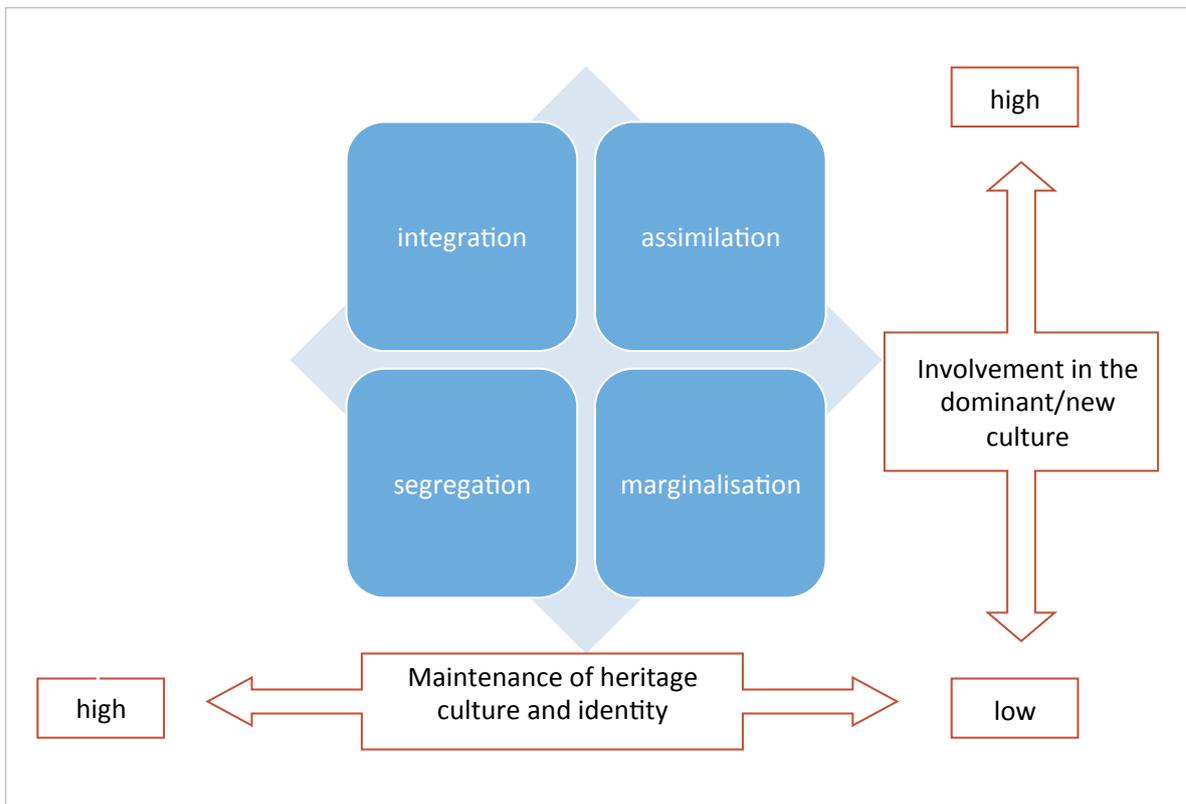


Figure 1[2]: Acculturation strategies by Berry (2008)

If this patient would have been acculturated he would have known what western therapists mean by the term "brother" and "sister" and he would have supplied an answer according to the concepts of the therapist in this regard. He would have known that the word "brother" and "sister" have different meanings in the west compared to his village. Plotting patients somewhere in the map of figure 1 is very clarifying and helps to reach a better form of cultural empathy.

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Hence, a culturally empathetic therapeutic assessment takes into consideration the patient's cultural beliefs and customs (in particular in this case his kinship terminology) and evaluates the actual position of the patient in his acculturation process. This increases the comprehension and leads to better treatment outcomes. A therapeutic assessment that is not culturally empathetic would not explore, and thus not be aware of the tribal kinship terms which are ubiquitous in the patient's culture of origin but would assess the expression "I have 50 brothers and 60 sisters" only from his or her own western cultural framework and unjustly conclude that this expression should be regarded as pathological. Also a non-culturally empathetic assessment does not consider extensively the patient's acculturation status. Not plotting the phase of a patient's acculturation status into Berry's scheme would decrease the understanding of the actual sociocultural position of the patient in the host culture.

*An example of social stressors and social support* [3]

After conducting a cultural formulation interview with a 29 year old Palestinian Sunni woman, it became clear that she was suffering from a Dostoyevsky-complex, a family disorder typically found among refugees, in which social stressors and social support come from the same source. A Dostoyevsky-complex is a secondary symbiotic relationship between a husband and his spouse (but can also be seen between other members of a family, e. g. mother and son). Symbiotic means that both partners feel they cannot exist without each other nor without their mutual help and interaction. By secondary I mean that initially this relationship was normal and not symbiotic but symbiosis arose later during the relationship. In refugees this symbiosis arises regularly after traumatic experiences. Let us explain this by first giving some more details of the Palestinian woman. She suffered from a paralysis of her right leg, no somatic explanation was found by her doctors. She also was depressed and had a full-blown posttraumatic stress disorder. She could not walk and her husband carried her where ever she had to go. Her husband also took care of the household and went shopping and did the laundry. She was totally dependent on him. In the past, in their country of origin, her husband took part in political activism without her consent. He came into conflict with the authorities and had to hide for the police to avoid an arrest. The police tried to track him down and visited his house. His wife opened the door and after she said she did not know where he was she was beaten up and raped by the police-officers. Some months after this incident both managed to escape to the Netherlands. There the symbiotic relationship started. She was feeling very angry at him: because of his political actions she had to leave the country and her family and because of him she was severely traumatized. She couldn't express her anger however, so she let him suffer and punished him by letting him take care of her basic needs and forced him to do activities that in her country were chores for women. He, on the other hand, felt guilty and deserving blame, since it was due to his political activities that his wife has been traumatized. So he willingly accepted his joke and served his wife in whatever way he could. This secondary symbiotic relationship, often seen in traumatized refugees, I call Dostoyevsky-complex after a novel written by Fyodor Mikhailovich Dostoyevsky, titled "Crime and

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Punishment" (in Dutch also translated with an alternative title "Guilt and Punishment"). Women who experience a lot of anger and not able to express that anger (because of intrapsychic processes or because of cultural restriction preventing to express those feeling openly), take on the role of the sick patient and consciously or unconsciously let their husbands suffer and punish them for years to come. On the other hand the husbands accept punishment and deserve blame and in order not to feel those feelings of guilt and culpability, they put their whole life in serving and helping their wives.

Conditions like these are difficult to treat: most of these symbiotic relationships try to avoid getting help from outside, since the feeble, but pathological, balance is then threatened to be disturbed. In case therapy can no longer be avoided three therapists are needed: one family therapist and two individual therapists. The first one to take step-by-step actions to separate the symbiosis, the other two for both spouses individually to contain, assist and handle the emotions which arise quickly.

Hence, a culturally empathetic psychotherapy is much more ecological and focusses much more on interpersonal factors. In a non-culturally sensitive psychotherapy there is an increased risk that the therapist would focus exclusively on intra-psychic mechanisms and restricts him- or herself to labels like conversion and posttraumatic stress and fails to perceive the causal and perpetuating interpersonal factors.

### An example of differences in culture and social status [4]

A 32-year old Tunisian illiterate asylum seeker, who his whole life devoted to herding goats was an inpatient and treated for his posttraumatic stress disorder. Hospitals also express a subculture, they uphold a cultural healing environment. In western-style mental hospitals patients are often structured in space and time. So having lunch at 12.00 AM is considered to be healthy and if a patient arrives twenty minutes too late it is considered "healthy" to inform him or her that he/she is too late and that having lunch is no longer an option. Patients are then advised to come back for dinner at 6.00 PM. But how to take care of that herder of goats who has a completely different conception of time: he felt asleep when his herd was grazing, he woke up when the herd started to move. He was a Muslim, therapy schedules in hospital were from Monday till Friday, so what to do with his request that on Fridays he wanted to visit the mosque. What to do with the therapy program and the fact that Friday is the holy day for Muslims and are expected to come together to pray in the mosque? On one day he made a request: he was sleeping badly because of his nightmares and he wanted to sleep outside the hospital-building on the lawn in the park next door. His whole life he slept a lot outside and looking at the stars above him made him feel at ease and at home, a good manner to fall asleep. The nurses of the hospital were aroused: it is a hospital rule to go to bed in your own bedroom and stay there till morning. Sleeping outside was, according to the nurses, out of the question, since they were no longer capable of monitoring the

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patient and could not take care of their responsibilities. After long deliberations the team chose not to give him medicines to sleep but to accept his wish and allowed him to sleep outside. Hospital rules are part of our cultural environment and cultural clashes are ubiquitous. The CFI can elucidate a lot of these conflicts and opening up discussions and accepting to willingness to change cultural norms, on both sides, can resolve most of them.

The OCF and CFI are very valuable tools for (re-)constructing the cultural context around our ethnically diverse patients. It usually takes 90 minutes of extra time to administer an OCF and 20 to 50 minutes to perform a CFI. Assessing these cultural issues is not only of importance for adequate culture-sensitive diagnosis and therapy but it often creates (in an instant) a strong working alliance of which any kind of psychotherapy will benefit. Patients sense a kind of respect and attention and feel noticed as a person.

Hence a culturally empathetic psychotherapy inserts time to explore culture-specific issues and by doing so helps to create in the patient an intrapersonal feeling of being understood. The therapist reflects contiguously on the impact of one's own values and biases on the therapeutic process and is willing to adapt core treatment components, both in content as well as in structure. In a non-culturally empathetic psychotherapy a therapist lacks cultural self-awareness and fails to overcome the natural tendency to view one's own beliefs, values, and worldview as superior which has a negative impact on treatment outcomes (Chu, Leino, Pflum & Sue, 2016).

**Internet resources**

In addition to (and in combination with) the CFI, internet resources can be used to improve empathic understanding of ethnically diverse patients. Information on the cultural context of patients from diverse ethnic backgrounds can be found on the internet. However not all sources are reliable and therapists should be wary of stereotyping dangers when consulting these sources. As a supplement of the CFI, however, certain websites can be very beneficial. A therapist seeing a patient for the first time and just a few minutes to prepare could consult the *World Factbook* [2] providing reliable and short pieces of information of all countries in the world, including what languages are spoken, the most important ethnic groups and the major religious affiliations. Therapists who can spend more time could consult the *Library of Congress Country Studies* [3], a database maintained by social scientists and containing detailed information about many countries in the world.

Of particular interest for psychotherapists is the *World Values Survey site* [4] *w*hich supplies scientific data collected by a network of social scientists studying values and their impact on social and political life in more than 100 countries. Very detailed information can be found

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about topics which can be very relevant for psychotherapy. Except for assessing background information about patients this site can also be used to evaluate the cultural and social distance in values between patient and therapist.

**Culturally adapted psychotherapeutic techniques**

There are a lot of different approaches in psychotherapy and associated theories and techniques. Does psychotherapeutic techniques and theories matter? Should they be adapted? Cross-cultural studies focusing on which psychotherapeutic theory or what techniques are preferred when treating ethnically diverse patients are still quite uncommon. Only recently, the first review of studies of culturally adapted mental health interventions has been published (Rathod et al., 2017).

What has been known for a long time is that if the basic conditions of all psychotherapies are met, the theoretic orientation is secondary importance. Comparative studies of psychotherapy show that there are four basic conditions, called "common factors" or "universal therapy-factors" which are effective features shared by all types of psychotherapies (Frank & Frank, 1961):

1. offering a therapeutic relationship with a helping therapist which is emotionally charged;
2. a healing setting, in western based psychotherapies usually an office or a hospital;
3. a rationale to explain the condition and how to resolve it;
4. a therapeutic procedure (or ritual) in which both patient and therapist actively participate.

Most meta-analyses show a moderate to large effect for culturally adapted interventions compared to care as usual. "The overall approach in the studies of cultural adaptation appears to be western versus non-western cultures, without realizing the diversity in non-western cultures" (Rathod et al., 2017, p. 14). Adaptations were made in the "dimensions of language, context, concepts, family, communication, content, cultural norms and practices, context and delivery, therapeutic alliance, and treatment goals" (Rathod et al., 2017, p. 12) but "current evidence does not offer a solution to the issue of which components of cultural adaptation are effective" (Rathod et al., 2017, p. 16). Adapting psychotherapeutic techniques in order to increase professional closeness proves valuable but just started recently and needs to be explored a lot more in the future.

**Interpreters**

While the scalpel is the most important instrument for a surgeon, for psychotherapists it is language. Adequate verbal (and non-verbal) communication is a requirement for any verbal psychotherapy. Language is also an essential part of a patient's cultural background. Language

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differences are an important barrier that needs to be overcome in verbal therapies in which patient and therapist cannot communicate in one shared language. To increase cultural empathy it is necessary to work with interpreters unless the mastery of the language used in therapy is high. Certain aspects, especially connotations of verbal expressions, are inevitably and easily lost in translations. A question like "Are you married?", will be translated in Dutch as "Bent u getrouwd?" (literally meaning: are you faithful or loyal to your spouse?), in Spanish it is "Esta casada?" (literally meaning: are you housed?) and in Yucatec Maya it is "Tsoka'an a beel?" (literally meaning is: has your way been completed?). It is evident that these questions which are all translated as "Are you married?" have different connotations. However many other aspects can be saved and transmitted if the interpreter is instructed by the therapist. Important for an interpreter is to know that unlike encounters with medical doctors in diagnostic assessments we do not have an interview first and after that we conduct a physical examination. In mental health settings we do both things at the same time. Interpreters have to be informed about this. During diagnostic interviews the content of what the patient says is only half the message. Equally important is the detailed way people express themselves, otherwise aspects like subtle formal thought disorders are missed (like increased associative thinking or neologisms). During psychotherapy it is important to instruct the interpreter where he or she should wait for their appointment: in the same waiting area as the patient which leads within a few consecutive sessions to a lively talk between interpreter and patient before the session starts. This could be desirable in supportive forms of psychotherapy but should be avoided in psychodynamic therapies. Of equal importance is to ask for consecutive sequential translations or for simultaneous translation techniques. Also the positioning of the interpreter in the therapy-room is a way to foster empathy. The usual position is triangular, however positioning the interpreter closely alongside the patient, without the possibility of eye-contact between interpreter and patient can increase feelings of transference. Interpreters can also be asked to transmit the emotional intonations and non-verbal behavior. Finally, it is worth to spend a few minutes after the treatment session to explore additional observations in a debriefing of the interpreter by the therapist.

**Perspective suppression**

The topics described in the preceding paragraphs all deal with decreasing cultural bias and increasing cultural empathy by what can be called patient-related *perspective production*: creating cultural context around the patient and improving interpretation and cross-cultural communication by actions and skills of the therapist, focusing on the patient. However, there is another set of actions to be taken to improve professional closeness and those are focused on the therapist and his or her intrapsychic biosphere. Following Pedersen we call this *perspective suppression* (Pedersen, Crethar & Carlson, 2008). See figure 2 for a comprehensive overview.
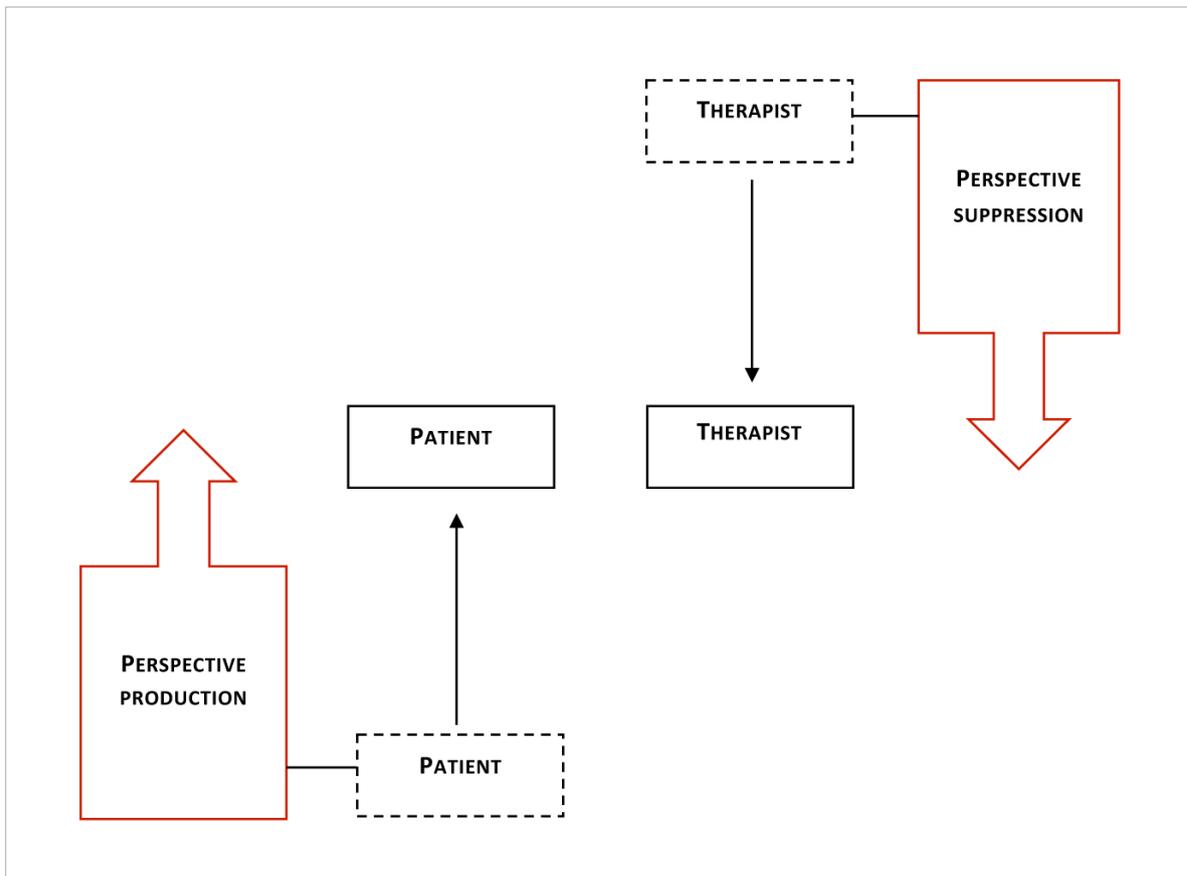
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Figure 2[5]: Perspective production and perspective suppression

What people think, do and feel is profoundly influenced by their cultural upbringing and context. Psychotherapists themselves are no exception. Cultural determination of the way therapists think and act in psychotherapeutic situations can impede the empathic understanding of the cultural other. In order to decrease cultural bias from the therapist perspective it is crucial to be aware of the fact that a lot of cultural hallmarks and central values serve unconsciously as a (moral) judgement of patients from other cultures. Prejudice, stereotyping, ingroup-bias and ethnocentrism are not processes to be ashamed of, but have to be acknowledged and faced in order to surmount them. "Thus, empathy further requires regulation of one's own idiosyncratic associations to stay on track with those most pertinent to mirroring the other and, especially, tolerating negative affect and discomfort and regulating its intensity to continue to track the other person" (Kirmayer, 2008, p. 460).

In fact cultural empathy starts in ourselves, as therapists. The therapists introspective abilities of observing the self, and self-reflection on feelings and thoughts are established skills, so should observing the cultural self be and a cultural relativistic self-reflection in which

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cultural countertransference can be noticed and acted upon. Especially issues related to the individualism-collectivism dimension are frequently missed as a core issue for therapists. Western therapists are educated and trained in a highly individualistic context and achieving self-reliance or autonomy for patients is much sought-after in therapies. However, patient from much more collectivistic cultures have very different aspirations or treatment goals. For example, in situations in which the therapist is enculturated in a culture exclusively composed of images of romantic marriages (marriages resulting from feelings of love and the wish to be emotionally involved with one another for the rest of their lives), it can invoke feelings of disgust, anger and other negative feelings in the therapist when encountering patients who are subject to forced types of marriages, spouses chosen by parents for economic or political reasons and not based on loving relationships. It is difficult not to have moral objections to these issues. Judging the patient and his cultural context by the values of the therapist who considers his or her values to be superior is called ethnocentrism and is imminent. It disturbs cultural empathy, cannot always be avoided, but should be recognized by the therapist as much as possible. Noticing these aspects and recognizing them as being culturally determined opens the way to perspective suppression and increases professional closeness.

Cultural empathy can best be seen not as a goal that can be achieved easily but as a continuous process, an unceasing thrive toward understanding the culturally diverse Other.

**Notes**
[1]  AI CFI's are available for free online: www.psychiatry.org
[2   https://www.cia.gov/library/publications/the-world-factbook/
[3]  https://www.loc.gov/collections/country-studies/about-this-collection/
[4]  http://www.worldvaluessurvey.org/wvs.jsp
[5]  ????

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