Culture and Psychotherapy: A Psychosocial Framework for Analysis

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ABSTRACT

Culture possesses multiple functions in psychotherapeutic processes: (1) it creates specific sources of stress, (2) it provides specific modes of coping with distress, (3) it governs social responses to distress and disability, (4) it defines the symptoms of distress and psychopathology, (5) it determines the interpretation of symptoms and their subsequent biological, psychological, and social impacts, (6) it guides help-seeking and the response to treatment, and (7) it shapes the meaning of the illness experience. Psychotherapy, therefore, involves processes that are informed by the patient's culture. Indigenous psychotherapies could be found in many societies and they may be used alone or in conjunction with Western modalities of treatment. In the Philippines, psychotherapists largely employ Western models of psychotherapy.

This paper describes some indigenous healing rituals and discusses the psychosocial framework that lends efficacy in the treatment modalities for psychological problems. Furthermore, this paper also aims to integrate this framework into the current practice of psychotherapy in the Philippines and provide recommendations vis-a-vis training, service, and research in the field of psychotherapy.

Key Words: culture, psychotherapy, worldview, indigenous healing rituals, collectivism, individualism, psychotherapy training, psychotherapy research

In every culture, a triangular relationship between the client, the therapist, and society exists. Cultural beliefs and practices are part of the definitions and understanding of a psychological problem and are, thus, part of psychotherapeutic processes.[1] This psychological problem is often given the labels *disease* or *illness*. *Disease* is conceptualized as having "a typical course and characteristic features that are independent of the setting." Illness, on the other hand, is "usually understood in a specific context of symbolic meanings, social interactions, and labeling." Labels serve to socially construct symptoms and shape the quality of the experience of psychopathology. This process of social construction of symptoms gives way to distinctive illness experiences that involves expectations of how individuals are supposed to feel and behave when suffering from a particular psychopathological condition. Thus, the major mechanism by which culture affects the individual and his or her psychopathology is portrayed in these illness categories and experiences. Consequently, health care systems are also socially and culturally constructed.[2] Kleinman notes, however, that the impact of culture on psychopathology is not fully appreciated. Few practitioners believe that cultural competence is needed in treatment and there is little research demonstrating that culturally informed approaches affect outcomes of treatment.[3]

Western concepts of psychopathology and psychotherapy pervade the training of psychiatrists in the Philippines. Such concepts may be valid but the extent to which they are applicable in the Philippine setting remains largely an unexplored territory. Most Western-oriented psychotherapeutic modalities may be suitable to highly educated people and those living in cosmopolitan areas but not to the majority of patients. Manickam pointed out the same dilemma in India where the socio-cultural milieu contradicted the principles of psychotherapy.[4] Varma posited that Western forms of psychotherapy could not be made applicable in India because of the following characteristics of the Indian people: (1) dependence/interdependence, (2) lack of psychological sophistication, (3) social distance between the doctor and the patient, (4) religious belief in rebirth and fatalism, and (5) guilt attributed to misdeeds in past life. He added that in Indian culture, the patient had to accept what was considered as "truth" by the therapist.[5] In the Indian language, Neki noted that the terms confidentiality and privacy did not exist and he opined that at least a couple of sessions with family members should complement dyadic therapy for psychotherapy to progress.[6]

Western models of treatment are "saturated with a particular theoretical orientation that have no means of taking into account patient and lay perspectives on a given sickness episode." Oftentimes, these points of view "strip away what is most unique to the experiences they constitute and express."[2] This practice is tenuous given the culture-specific nature of psychopathology and psychotherapy. Psychotherapeutic interventions must, therefore, be attuned to the cultural needs of patients. Such interventions have

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been found in many societies and are called indigenous psychotherapies. They are used alone or in conjunction with Western techniques. Among the common indigenous forms of psychotherapy that are cited in literature are those rooted in Japanese and Haitian cultures. Morita and naikan therapies are Japanese forms of psychotherapy and voodoo is considered as Haitian psychotherapy.[1] Morita therapy is based on the acceptance of reality as it is (*arugamama*) and it aims to make patients reach a state of mind that will allow them to carry on with life even while they experience anxiety, depression, or somatic symptoms. This form of therapy engages the patient in assuming an outward perspective of life and increasing his social functioning. One basic methodology of this therapy is treating the patient in the therapist's home.[7,8] Naikan therapy allows the individual to explore himself in the context of relationships with important persons in his life. The three themes or questions that must guide the patient through therapy are: (1) what did you receive from a specific person?, (2) what did you do to that person in return?, and (3) what troubles, worries, and difficulties have you caused that person?[9] Voodoo, which is basically a form of religion, is based on a belief that spirits reside not only in humans but also in animals and such things as food. The practitioner of voodoo utilizes trees and other plants to create a "root" that will accomplish either good or evil. The evil root produces a hex that can cause weakness, suffering, pain, sickness, and death. The good root produces attraction, potency, success, recovery, and protection. Voodoo is essentially a reflection of how the "root doctor" is able to establish a strong alliance with his patient through the use of empathy.[10]

The Philippines is rich with what may be classified as indigenous forms of psychotherapy but they are not formally integrated in the practice of psychotherapy of mental health professionals. It is in this light that this paper aims to tackle the influence of culture on Filipino psychotherapy. It describes some indigenous healing rituals and discusses the psychosocial framework that lends efficacy in the treatment of psychological problems. Furthermore, this paper also integrates this framework into the current practice of psychotherapy in the Philippines and provides recommendations vis-a-vis training, service, and research in psychotherapy.

The question of how far Western concepts of psychotherapy can be applied in the Philippine setting has been present since the 1970's. Filipino psychologists clamored for the modification of Western psychological models. Church and Salazar-Clemena cited the works of Enriquez that sparked the movement against "intellectual dependence and academic imperialism" in the Philippines.[11,12] These works became the driving force behind the development of Filipino theories, concepts, and methods in psychology. In the area of psychopathology, Siason and Go supported the belief that this phenomenon "should be studied from an indigenous Filipino point of view by identifying concepts that truly arise from experience within the culture."[13]

Salazar-Clemena pointed out that the orientation of counseling psychology in the Philippines has largely been American. Thus, she called for the "reexamination of counseling practice in the context of Philippine cultural realities" and the development and identification of counseling techniques that were applicable to Filipinos. She proposed four cultural variables pertinent to counseling, namely Filipino worldviews, conceptions of self and mental health, peace and harmony, and expectations about counseling. The Filipino counselor, according to her, must be able to combine and integrate aspects of each worldview into a harmonious union in order to maximize the client's "effectiveness and psychological well-being."[12]

Tanalega proposed the Solution-Focused Brief Therapy for Filipinos. He argued that the overall positive outlook and affirming stance of this approach accommodated the *hiya* (shame), *amor propio* (self love), and the revulsion for *pintas* (negative criticism) that was possessed by Filipinos. This form of psychotherapy utilized questions that implied a lot of hidden meanings that, in turn, led to change. The co-creation or the constructivist approach of this form of therapy and its non-adversarial stance made it appropriate to Filipinos.[14]

Bulatao described the indigenous process of treating psychological disturbances in the Philippines as essentially exorcistic in nature. This healing process is derived from the transpersonal view of the Filipino that is characterized by animism. Bulatao asserted that the Filipino's world is made up of a material world that is "peopled" by a variety of spirits. Such spirits are believed to be "living normal, earthly lives of their own as if they were a race of humans." In essence, the Filipino conceived of the "earth as peopled by two kinds of beings, the seen and the unseen, occupying the same plots of ground, bathing in the same stream, moving through the same fields and forests." A well-known strategy of exorcism is the Charismatic approach.

> *Following biblical injunctions, the exorcism is preceded by prayer and fasting. Then the possessing spirit is addressed and commanded to depart from the ailing man's body. Indigenous healers abound in rural areas and many gain footholds in urban centers. Indigenous approaches involve a process of diagnosis and treatment. To diagnose whether a patient is possessed or not, there are various tests that can be performed, usually by an arbularyo or mangtatawas. One diagnostic test is to place the two hands side by side, palms up, with the little fingers touching. If one finger is longer than the other, the patient is believed to be possessed. Another test is to apply a short stem of the pandakaki plant to the crown of the patient's head. He is diagnosed as possessed if he feels*

unbearable heat. In the absence of pandakaki, three matchsticks are used. Another test is to place a piece of wood or a pencil between two toes and to press the two toes together. The patient, in pain, will cry out the name of the possessing spirit. The most common test is the use of tawas (alum). Either alum or melted candle is poured in a basin of water. The alum or candle then forms the shape of the possessing spirit or of the person who is employing kulam against the patient.[15]

It is clear that culture influences the process of psychotherapy. In the Philippine setting, how can one fully appreciate this relationship? What framework or frameworks may be used in order to understand it? What do indigenous rituals say about the Filipino's worldview? One perspective of understanding the influence of culture on psychological phenomena is the concept of individualism (IND) and collectivism (COL). Many psychologists have embraced this perspective since it emerged from the works of Geert Hofstede and have studied the relationship of culture and psychology in this light.[16] Hofstede claimed that IND and COL were two poles of one dimension, and western countries such as those in Western Europe, North America, Australia and New Zealand can be categorized as individualistic societies whereas societies from Africa, Middle East (excluding Israel), East Asia and South America can be categorized as collectivist societies.[17]

The implication of the IND-COL construct on the construal of the self has informed the practice of psychotherapy. Markus and Kitayama argued that the concept of one's self and of others and the relationship between one's self and of others strongly influence or determine individual experiences including cognition, emotion, and motivation.[18] Such construals vary among cultures. Western societies view the individual as independent, self-contained, autonomous, and detached from context. Western thinking, therefore, emphasizes that the individual behaves primarily as a consequence of his or her unique internal attributes such as traits, abilities, motives, and values. Non-Western notions, on the other hand, view the self as interdependent with the surrounding context and it is the "other" or the "self-in-relation-to-other" that is the focus in individual experience. The reactions of other people significantly shape and govern the experience and expression of emotions and motives of the individual.

Markus and Kitayama proposed that a sense of autonomy, personal accomplishment, and agency give rise to positive feelings in individualist cultures. Positive feelings in collectivist cultures, on the other hand, arise from a sense of interpersonal connectedness and of fulfilling one's obligations.[18] Several studies tend to support these notions. Stewart et al. showed that a sense of personal worth, efficacy and control may be less salient in Asian cultures. In their comparison of Hong Kong Chinese and American adolescents, self-efficacy was not associated with the concept of depression among Hong Kong youths.[19] This observation may be explained by the fact that the Chinese culture gives less value to individual autonomy but it emphasizes the reliance on other people. Marsella noted the same scenario in Indonesian society. Among Indonesians, a person's worth or value is not determined by his or her achievement and it is perfectly acceptable that one can do nothing for months. Thus, deterioration in achievement does not need to cause guilt and feelings of inadequacy.[20] Tsai et al. argued that emotions play a major role in achieving a sense of connection with others.[21] Taking the Latino culture as an example, they pointed out how this culture valued emotional responses that promoted social relations and de-emphasized responses that reflected internal emotional experience.

Hall indicated that the challenges in psychotherapy are markedly different in individualist and collectivist contexts.[22] Oftentimes, the task of the therapist in individualist contexts is to "determine the idiosyncratic processes that determine behavior." The fact that few others engage in the behavior or that most others disapprove of the behavior is unlikely to be a compelling reason to change the behavior. The therapist in individualist contexts must tailor each intervention to fit the individual, even if two individuals have the same disorder. Attributing a problem to a context may be viewed by many individualist therapists as a projection or excuse on the part of the client and a failure to assume personal responsibility for behavior. In collectivist contexts, on the other hand, the task of the therapist is to integrate the individual into the group. The negative impact of the individual's behavior on the group could provide an incentive for a change in behavior. In situations where groups hold values that may not be prosocial or health enhancing, the task is made more difficult. The scenario becomes even more complicated when the client is bicultural. Individualist and collectivist influences shape the behavior of a person who is bicultural, thus he deals with issues that are both intrapersonal and contextual in nature. In this era of multiculturalism, it is unlikely that an exclusively individualist or collectivist therapeutic approach would be effective.

Hall asserted that "traditional American psychotherapy, with its emphasis on individualism, is most likely to be effective for persons of color who are already the most acculturated or who seek to become acculturated."[22] He, however, wondered what culturally sensitive approaches existed. He cited the work of Sue et al. that identified "various forms of indigenous healing and support systems that may be more culturally consistent for some Americans of color." He proposed that Western psychotherapists could make referrals to these sources or even work collaboratively. On the whole, he saw the need for an integrative approach that would address collectivist and individualist issues. He

cited Sato who proposed an integration of collectivist principles into Western approaches in response to the "rapidly changing ethnic/cultural composition of American culture."

In the past twenty years, the influence of culture on psychological phenomena has been studied using the IND-COL dichotomy. This position has been met with many criticisms. Oyserman and her colleagues conducted a meta-analysis of studies that were done on IND-COL and they noted three main dilemmas arising from such studies.[23] First, confusion in the current literature abounds because authors commonly describe their research in cross-national terms although their data are at the individual level. Second, the narrow focus on differences between European American undergraduates and undergraduates from either a single East Asian country or a single American racial or ethnic minority groups limits generalizability to other countries, racial groups or ethnic groups. Third, there is enormous heterogeneity in how researchers conceptualize and operationalize IND-COL. Oyserman pointed out that the terms IND and COL have become "too broadly construed and are often used to explain almost any cultural or cross-cultural difference."[12] Although they recognized that the IND-COL construct is helpful in describing particular ways in which cultures differ systematically, it should not replace the study of culture. They proposed a new framework that integrates process and level of analysis in the study of culture and psychology (Appendix A). According to this model, the influence of culture on psychological phenomena is situated in the subjective construals of the social situations in which such phenomena emanate. These social situations are influenced by three levels of cultural variables namely, societal-level, social institution-level and individual-level variables. The societal-level variables include language, history and religious and philosophical traditions (and this is where the various Filipino healing rituals may be significant). The social institution-level variables include parenting and child-rearing systems and educational, legal, and economic systems. The individual-level variables include values, attitudes, scripts and norms. In this model, the cultural variables are not viewed as either individualist or collectivist. Instead, they are seen as an integration of both IND and COL.

The model of Oyserman and her colleagues appears to provide a tenable framework in the study and practice of psychotherapy in the Philippine context (Appendix B). Psychopathology could be viewed as a manifestation of construals of various social situations. In this light, psychotherapy must be informed not by social situations alone but also by patients' construals of such situations. An appreciation of these construals necessitates an evaluation of the societal-level, social institution-level, and individual-level factors that influence them. Indigenous rituals of healing in the Philippines reflect various construals of psychological problems across the three levels of cultural variables that have been proposed by Oyserman. Furthermore, such rituals portray the collectivist concept of interdependence among Filipinos. Interdependence is expressed in these rituals not only as the close interaction and alliance of an individual with others but also with his or her spiritual world. This is consistent with Bulatao's description of the world of the Filipino that is populated by the seen and the unseen.[15] Such rituals are often performed on the sick person in the presence of loved ones and other important members of the family and community. This stresses the belief that, in order for the identified patient to get well, other people who are closely linked with him must partake in the healing process. In essence, the patient will only experience healing if those with whom he is bonded also participate in the process and experience "healing" as well. This collectivist phenomenon behooves the psychotherapist to reconsider the strict application of Western principles of psychotherapy for his Filipino patients. Neki's recommendation to conduct the initial stage of therapy with the patient and his family all in attendance in the sessions may be an acceptable strategy that will enhance the healing process for Filipino patients.[6] In this manner, psychotherapy is not strictly dyadic but one that involves the interactions of various individuals including the patient and the therapist throughout the therapeutic process.

Tanalega's non-adversarial stance in his Solution-Focused Brief Therapy depicts the importance of other people's reactions in shaping and governing one's experience and expression of emotions and motivations. His assertion that Solution-Focused Brief Therapy is effective for Filipinos may be valid because it underscores the construct of collectivism and the concept of locus of control that is not entirely internal. Filipinos rely to a large extent on other people, the environment, or their spiritual world for guidance. Alvidrez and her colleagues point out that socioeconomic status greatly influence perceived control over life circumstances. They argue that locus of control may differ between the rich and the poor.[24] In developing psychotherapeutic interventions, Filipino psychotherapists should take heed of the fact that majority of Filipinos belong to the low socioeconomic strata of society.

Leong hypothesized that Filipinos are inclined to participate in therapy when the therapist is directive rather than collaborative. This is believed to be in keeping with the cultural value of deference to and respect for authority.[25] Varma's observation of Indian patients may be similar to this situation.[5] Again, we see here a reflection of a collectivistic recognition of the other person as an important component of one's worldview and concept of self. The Filipino operates in a world of interlocking relationships that define and govern his sense of self or *loob*. The therapist may become a vital part of the Filipino patient's *loob* and, as such, is given great authority to influence his healing process.

Other significant persons in the Filipino individual's *loob* should also become involved in the therapeutic process because of the assumption that if the individual's *loob* is psychologically disturbed, those people who are part of his *loob* must be experiencing the same state.

The concept of psychotherapy in the Philippines needs to be clearly defined and Oyserman's model may provide the template by which to achieve this task. This model may be an oversimplification of a very complex issue but it is not being proposed as a definitive guide to the study of culture and psychotherapy. It is conceived as a starting point in facilitating the integration of cultural processes in the practice of psychotherapy in the Philippines. Assuming, for instance, that both collectivist and individualist contexts inform psychopathological conditions, the clinician's task is to determine which particular conditions arise from each context and, subsequently, which appropriate therapeutic measures to employ.

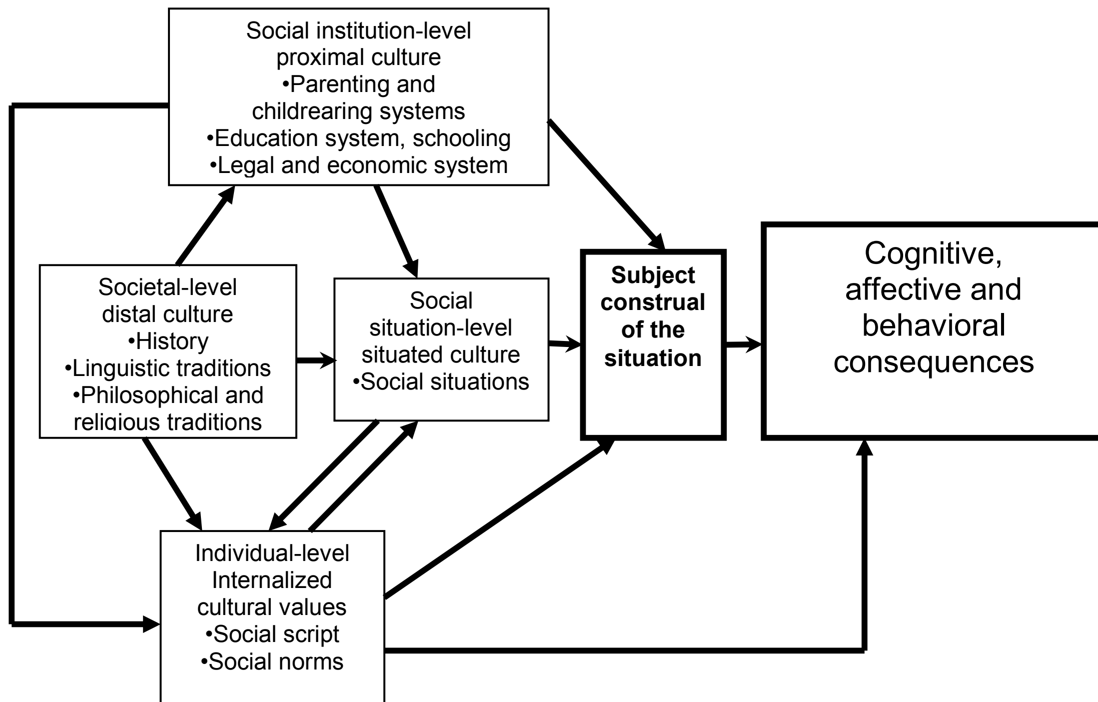
Western modalities of psychotherapy may be useful but Filipino clinicians must recognize and integrate more culturally sensitive healing processes in their work, be it in research, training, or service. Psychiatrists, psychologists, sociologists, social workers, and anthropologists must create a strong alliance in the pursuit of this endeavor. Qualitative and quantitative methods of research may be employed. Ethnographic and linguistic approaches to research will provide a rich pool of data that could be gathered through focus group discussions of indigenous healers and key informants. The Filipino indigenous approach to the focus group discussion, *kolektibong katutubong talakayan* or *ginabayang talakayan*,[26] will be a meaningful tool to explore the relationship between Filipino culture and psychotherapy. Quantitative measurements of dependent and independent variables will also increase this body of knowledge. This process can be daunting given the current Western inclination of psychotherapy training in the Philippines but it is an undertaking that will certainly help improve the practice of psychotherapy in the country.

References

1. Berry JW, Poortinga YH, Segall MH, Dasen PR. Cross-Cultural Psychology: Research and Applications. Cambridge, United Kingdom: The Press Syndicate of the University of Cambridge; 2003.
2. Morico MAL. Nuances of the cultural language of depression: a pilot study. Paper presented during the Annual Convention of the Philippine Psychiatric Association, Inc., 28 January 2004.
3. Kleinman A. Culture and depression. N Engl J Med. 2004; 351(10):951-3.
4. Manickam LS. Psychotherapy in India. Indian J Psychiatry. 2010; 52(Suppl 1):S366-70.
5. Varma VK. Present state of psychotherapy in India. Indian J Psychiatry. 1982; 24(3):209-26.
6. Neki JS. Confidentiality, secrecy and privacy in psychotherapy: sociodynamic considerations. Indian J Psychiatry. 1992; 34(3):171–3.
7. Kurokawa N. Morita therapy in psychosomatic medicine. International Congress Series. 2006; 1287:313-5.
8. Li C, He Y. Morita therapy in schizophrenia. Schizophr Bull. 2008; 34(6):1021-3.
9. Maeshiro T. Naikan therapy in Japan: Introspection as a way of healing (Introduction to Naikan Therapy). World Cultural Psychiatry Research Review. 2009; 4(1):33-8.
10. Stitt VJ Jr. Root doctors as providers of primary care. J Natl Med Assoc. 1983; 75(7):719-21.
11. Church T. Indigenous Philippine Psychology: Methodological Considerations. In: Enriquez VG, ed. Indigenous Psychology: A Book of Readings. Quezon City, Philippines: New Horizons Press; 1990. pp. 173-209.
12. Salazar-Clemena RM. Understanding the Filipino Client: Towards a Culture-Sensitive Counseling Model. In: Bernardo ABI, Dayan NA, Tan AA, eds. Understanding Behavior Bridging Cultures: Readings on an Emerging Global Psychology. Manila, Philippines: De La Salle University, Inc.; 1998. pp. 213-226.
13. Siason IM, Go J. Mental health-seeking behavior and perceptions of mental illness in Western Visayas. In: Bernardo ABI, Dayan NA, Tan AA, eds. Understanding Behavior Bridging Cultures: Readings on an Emerging Global Psychology. Manila, Philippines: De La Salle University, Inc.; 1998. pp. 169-174
14. Tanalega NE. Solution-Focused Brief Therapy Model from a Humanistic Perspective: Its Applicability in the Philippine Setting. In: Bernardo ABI, Dayan NA, Tan AA, eds. Understanding Behavior Bridging Cultures: Readings on an Emerging Global Psychology. Manila, Philippines: De La Salle University, Inc.; 1998. pp. 194-200.
15. Bulatao JC. Phenomena and their Interpretation: Landmark Essays 1957-1989. Quezon City, Philippines: Ateneo De Manila University Press; 1992.
16. Oyserman D, Kemmelmeier M, Coon HM. Cultural psychology, a new look: reply to Bond (2002), Fiske (2002), Kitayama (2002) and Miller (2002). Psychol Bull. 2002; 128(1):110-7.
17. Shulruf B, Hattie J, Dixon R. Development of a New Measurement Tool for Individualism and Collectivism. J Psychoeduc Assess. 2007; 25(4): 385-401.
18. Markus HR, Kitayama S. Culture and the self: implications for cognition, emotion and motivation. Psychological Review. 1991; 98(2):224-53.
19. Stewart SM, Kennard BD, Lee PWH, Hughes CW, Mayes TL, Emslie GJ, Lewinsohn PM. A Cross-cultural investigation of cognitions and depressive symptoms in adolescents. J Abnorm Psychol. 2004; 113(2):248-57.
20. Marsella AJ. Depressive Experience and Disorder across Cultures. In: Berry JW, Poortinga YH, Pandey J, eds. Handbook of Cross-Cultural Psychology. Massachussetts: Allyn and Bacon; 1997. pp. 237-289.
21. Tsai JL, Pole N, Levenson RW, Munoz RF. The effects of depression on the emotional responses of Spanish-speaking Latinas. Cultur Divers Ethnic Minor Psychol. 2003; 9(1):49-63.
22. Hall GCN. The self in context: implications for psychopathology and psychotherapy. J Psychother Integr. 2003; 13(1):66-82.
23. Oyserman D, Coon HM, Kemmelmeier M. Rethinking individualism and collectivism: Evaluation of theoretical assumptions and meta-analyses. Psychol Bull. 2002; 128(1):3-72.
24. Alvidrez J, Azocar F, Miranda J. Demystifying the concept of ethnicity for psychotherapy researchers. J Consult Clin Psychol. 1996; 64(5):903-8.
25. Leong FT. Counseling and psychotherapy with Asian-Americans: Review of the literature. J Couns Psychol. 1986; 33(2):196-206.
26. Pe-Pua R. Kros-Katutubong Perspektibo sa Metodolohiya: Ang Karanasan ng Pilipinas. Quezon City, Philippines: Pambansang Samahan sa Sikolohiyang Pilipino; 2005.

APPENDIX A

SOCIALLY CONTEXTUALIZED MODEL of CULTURAL INFLUENCES[23]



APPENDIX B

CONCEPTUAL FRAMEWORK on the RELATIONSHIP of CULTURE and PSYCHOTHERAPY in the FILIPINO CONTEXT

(Adapted from Oyserman, Coon & Kemmelmeier)[23]