

## INTERCULTURAL THERAPY AND ETHNOPSICHOANALYSIS: ARE THEY BOTH 'POSSESSION'?'<sup>1</sup>

By Francesca Zanatta

The assumption that such a delicate practice as therapy is universal is a fault belonging to the past. The universality of therapy has been questioned for a long time without any consistent or final answer. The biggest contribution of Anthropology to therapy has been to open up new approaches to and points of view about therapy. Therefore the problems linked to assumptions about therapy's universality have been overcome partially through the analysis and the understanding of differences and peculiarities of cultures. Ethnopsychanalysis and Intercultural Therapy are two approaches to therapy that have been developed in response to the Anthropological critique and its identification of cultural variance. They both give effect to Littlewood's suggestion (1990), which was developed in his article that promoted the rise of a *new cross-cultural psychiatry*: According to Littlewood, 'we need to take into account the whole context of a particular experience and its personal meaning even if it leads us to such areas as local politics or social structure'. Each of the new therapies referred to above give effect to Littlewood's suggestion in different ways. On the one hand, Intercultural Therapy, starting from the Western traditional theories, has been modeled on other cultures; on the other hand, Ethnopsychiatry has been based on traditional therapy belonging to non-Western cultures, with some help from psychoanalytic theories. Both these therapies are an attempt to overcome the problems caused by the assumption of universality. A question still remains: is this effort just another way to make therapy fit into non-Western cultures? Is this effort simply another way to 'possess' cultures?

### The origin of Ethnopsychiatry

The pioneering work of Emile Kraepelin in comparative cultural psychiatry, a contribution less known than the theories on the etiology and diagnosis of psychiatric disorders which have influenced modern psychiatry, is considered to be the foundation of a new form of psychiatry (Littlewood, 1996) (Jilek, 1995). Kraepelin wanted to identify and analyze the influence of cultural factors in psychopathology among the non-European

population. During his studies in comparative psychiatry, he drew attention to the fact that modern civilization has had negative consequences. In fact, he argued, the mental health situation was better in preindustrial traditional societies. His research about the differences in psychiatric illnesses among the various Germanic tribes led him to the conclusion that culture not only influenced behavior but also created different forms of illness. Consequently he developed a theory regarding the presence of specific disorders for specific cultures: the 'culture-bound' disorders.

Kraepelin's sudden and unexpected death did not allow him to continue his project of comparing mental health in various countries in order to reveal differences. His students continued his work by creating three different sub-categories of research (Jilek, 1995): comparative psychiatry, transcultural psychiatry and ethnopsychiatry. The last discipline's name derived from a footnote of a book of the Haitian psychiatrist Louis Mars. As Devereux (1982) indicated 'as far as I know, it was the eminent Haitian psychiatrist Dr Louis Mars who invented the term ethnopsychiatry'. This expression, originally used by its creator to refer to the study of local mental illnesses (Littlewood, 1996), would have been adopted with different meanings. As used by Kraepelin's students, it came to mean the study of cultural factors in mental health.

### Ethnopsychanalysis: a de-colonialised therapy

In order to understand ethnopsychanalysis, it is essential to analyze the context and the process that lead to its development.

While William H.R. Rivers was among the first anthropologists to propose and conduct a debate between anthropology and psychoanalysis, George Devereux has been the first to use Freudian theories developed in 'Totem und Taboo'. Devereux's real name is Gyorgy Dobo, which, besides revealing his Hungarian origins, embowers the history and the context from which he writes. Jewish, and an escapee from Hungary after the suicide of his younger brother, Devereux arrived in Paris where he became quickly part of the vivid intellectual life of the city. He soon left his own identity behind, changing his name (a few times) and being baptised<sup>2</sup>. Underlining Devereux's incredible interest in the concept of identity, Roudinesco (2005) argues that Devereux was always searching for his own place, his own identity but was also scared by this need; Devereux thought that the only way to 'survive' was to deny or fake identity,

<sup>1</sup> This expression is taken from Littlewood (chapter 3 Kareem J., R. Littlewood 2000).

<sup>2</sup> This happened around the 30's before the Second World War and was thus a free decision.

since a person whose identity is known is easily subjugated.

The 'new-born' social-anthropology fascinated Devereux quickly and introduced him to his bigger interest: the Native Americans. His studies then moved to the research of a model through which to understand the mental organization and functioning of a 'native' person in his cultural context, analysed from the perspective of social anthropology. First, he studied Kraepelin's theories, and then moved his attention to Freud's work. His relationship with psychoanalysis has been quite controversial. Devereux has never been completely accepted by the Psychoanalytical Society, never really considered a real psychoanalyst<sup>3</sup> but has always been close to the psychoanalytical context, even if he criticised some of its features.

Devereux has never really been part of something, not of an association, not of a place, not of a discipline. Maybe for this reason, he conceived of psychoanalysis as a process that would allow the person to recreate 'connections' with personal insight, not simply as a way to heal a person but also in order to get back into or adjust to society. From his point of view, the psychoanalytical movement was becoming too focused on the scientifically rigorous side of modern medicine instead of following Freud's theories. Although all these changes were happening around him, he remained conservative and loyal to Freudian psychoanalysis. In fact, Devereux's aim was to apply psychoanalytical theories to non-Western population as well, in order to understand and explain not only the mental disorders influenced by cultural factors, but also the way in which the culture understands and represents those pathologies. However, he never discussed the existence of ethnic differences, in the sense that he never allowed ethnic variety to overcome the universalism in which he believed. Devereux was sure that psychoanalysis was universal and so would work in every cultural context.

Devereux' thought has been interpreted in a very personal and particular way by his student Tobie Nathan, one of the most relevant and known exponents of modern ethnopsychanalysis.

Nathan's ethnopsychanalysis differs from that of Devereux regarding two main issues:

- The distance from Freud's theories; even though Nathan's foundation is the psychoanalytical context and he maintains the basic lines of that discipline, he has refused the 'dogma' imposed by Freud and his students. In the first chapter of his 'Principles d'ethnopsychanalyse', he claims, referring to the influence of Freud, that

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<sup>3</sup> Devereux did not have a degree in Medicine and so was not qualified to practice psychoanalysis, only psychotherapy.

'people still endure the conflicts due to the power of his clergy' (Nathan, 1993).

- The validity and the value of traditional healers, whom Nathan perceives as 'therapists'. Devereux was afraid and scared that 'magicians, healer and quack doctors' (Roudinesco, 2005) would have had the possibility to practice. He accused *licit clinical* psychiatry of losing time with bureaucracy and trying to be a dogmatic science, giving traditional healer the space to emerge. In contrast, Nathan critiques the derision, evident in the Western medicine, for traditional healers.

In modern ethnopsychanalysis, the first aim is to escape from the Western attempt to create a rigid and coherent theory that ignores cultural differences and perceives those differences as phenomena without any relevance in the field of mental health.

The innovation therefore has to derive from the practice, from experiencing problems in the relationship with the patient and from that experience, discerning the necessity of moving to something different. The substance is in the practical awareness, not in the theoretical knowledge. In this way, the issues and the features of Western psychiatry/therapy will not suffocate therapeutic practice. As Nathan writes, 'for every immigrant patient, every therapeutic act deriving from scientific causality represents a further psychological traumatic experience' (Nathan, 2004). Moving away from the Lévi-Strauss' concept of the 'naked man' separated from his cultural context, Nathan proposes three postulates that should form the theoretical background to the practice of ethnopsychanalysis, but also to the practice of any discipline related to culture (Nathan, 1993):

- The mind, which Freud called 'psychic system', cannot be considered independent and isolated from the rest of the body and the person; it is an apparatus guided by the culture.
- The value of traditional therapies has to be recognised in their rationality, even when it is hard to perceive their efficacy.
- Psychotherapy is actually an auto-therapy induced and guided by *operators*.

Basing his interpretation of the discipline on these points, Nathan clarifies that ethnopsychanalysis is not 'un-ruled', is not an orphan without any kind of theoretical background. On the contrary, this method is based on a variety of theories from which it is possible to extract the help needed in every peculiar therapeutic experience.

Every therapeutic session becomes an experience promoted by the relationship between the therapist and the patient. This relationship is not exclusive, in the sense that this method contemplates the presence of a group of co-therapists that helps the development of this interaction. The other functions of the group are to create a context of interculturality in which the patient will not feel as the 'other' but will feel as part of a 'community' on which the patient can rely; the group will also promote a feeling of shared experiences, knowledge and habits or beliefs. The interaction will then be more vivid and not statically focused on the pathology. Besides this, the group, which is usually composed of fifteen therapists from different cultural backgrounds, facilitate and eliminate the possible issue with language. Frequently, immigrant patients cannot speak fluently in the adopted language. Also, when discussing such delicate and personal issues, it is better to be able to express the situation in the mother tongue (Nathan, 1993).

### **Intercultural Therapy: an acculturated therapy**

As pointed out by Littlewood (Kareem J., R. Littlewood 2000), the first approach to the adoption of socio-cultural factors in the therapeutic field has happened quite late in Britain. While in other countries this phenomenon was already quite developed and experienced, the U.K. seemed to be indifferent to the need for a discipline suitable for ethnic minorities. The first attempt to develop such a discipline was made by W.H.R. Rivers, an anthropologist, psychiatrist and author of *Medicine, Magic and Religion*, who tried to use psychoanalytic theories with non-Western populations. The reasons for this non-interest are grounded in the fact that therapy in Britain has always been seen as a service allocated for a certain component of the society. Health care in general has been a good reserved to particular groups of people, and definitely not to immigrants (Ibid, 2000). The idea of trans-cultural psychotherapy in a country where practice is directed to the needs of non-immigrants, and where doctors from a non-Western background are not favored in their job (Littlewood and Lipsedge, 1997), sounds quite strange and revolutionary. However, the high presence of ethnic minorities in Britain suggests that a transcultural therapy is extremely necessary. Nowadays, British society is composed of a variety of ethnicities that enrich the country with new meanings and which propose new cultures. This change has, however, created new necessities, like an answer to the increasing rates of diagnosis of mental disorders among the ethnic minority population.

Intercultural therapy is basically the practice of psychotherapy among people from different cultures. It involves adapting Western theories to a new context with new meanings and beliefs. This actually does not correspond to the attempt made by Devereux, who thought those theories were suitable universally to every culture. The British effort is different. The therapist's knowledge derives from Western theories but their application has to be enriched by the awareness of cultural differences, which have to be clear and respected through the entire session.

Kareem's words may be useful in explaining the method of intercultural therapy: it is 'a form of dynamic psychotherapy which is not necessarily tied to one theoretical orientation but which derives its strength from various analytical, sociological and medical formulations' (Kareem J., R. Littlewood 2000). The bigger contribution derives from psychodynamic theories. These theories suggest that the primary tools required by the therapist are the abilities to create and interpret transference and counter-transference (Ibid, 2000) and to explore dreams, whose relevance is emphasized by Ilechukwu (1989). The relationship has to be balanced, considering the fact that it is an intervention in an inter-racial context where the risk of racism and 'colonialism' is high. This especially means that the situation must not take the form of a relationship of power in which the therapist embodies an authoritarian role and the client a submitted one. In order to achieve this, the therapist will have to be aware of the variety of understandings of concepts such as the person itself, the body, the pain, the illness. Basically his/her aim is to have clearly in mind the fact that every factor related with the *psyche* has a value to it and has to be considered through the patient's experience. An example may be the role of the community in a person's life; in some societies, the community supplies the need of reliance of a person, thus the interaction between the community and the person is very relevant in the therapy (Kareem J., R. Littlewood 2000).

Since the patient has to be considered as part of a context and the experience of illness as part of a wider experience, the therapist will need to have a wider narration from the patient, not only regarding the disorder itself. This particular point appears quite difficult to develop since the intercultural therapy seems to be more effective if short. Kareem suggests twelve sessions, primarily because of the evidence of better efficacy rather than as a means of making therapy more affordable<sup>4</sup>. This point may be

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<sup>4</sup>The affordability of therapy is a major concern in practice. At the Nafsiyat Centre, short-term psychotherapy is largely practised. The principal benefit of this particular approach is economic. Some patients may not be able to afford the expense of long-term

perceived as problematic by the majority of the therapists, who are used to a different approach to therapy. Short therapy may cause, through the lack of time, problems with the necessity of a wider narrative process. The therapist needs to be able to detect the events that appear more relevant and, if required, to request a consultation in order to have easier access to some specific cultural meanings. Again, the most important feature of the intercultural therapy is the awareness of difference and the respect of it. Besides this, it is very relevant to remember that the external context influences a person's process of internalising the environment; quoting Kareem (Kareem J., R. Littlewood 2000) it is necessary to remember 'the universality in the diversity'.

### Comparing the two experiences

Littlewood (Kareem J., R. Littlewood 2000) suggests the existence of three possible approaches to intercultural work:

- Maintaining traditional healing;
- Imposing Western psychiatry;
- Reconciling the first two approaches to produce a therapy that incorporates the possibilities of each.

The first approach seems very close to the kind of therapy offered in France, while the third approach is closest to the one offered in Britain. However, through the analysis of these two approaches to intercultural work with ethnic minorities, some points may be found to be quite similar to each other.

First of all, both disciplines are based on psychodynamic theories, and therefore share a similar background and a similar approach; both aim to avoid a situation where parity of roles between therapist and client is absent. In ethnopschoanalysis, this problem of parity is circumvented by the presence of a group which should represent a community of parts, where everyone is different and no one embodies the role of the 'other'. While this strategy evokes the tradition of many ethnicities, the method used in intercultural psychotherapy is based on the image of the therapist. He/she has to be aware of the differences between him/her and the patient, and this point, instead of being a problem, should be a factor that enriches the session.

In both, the narrative is supposed to be wider than in 'normal' therapy. Again, this point has two different interpretations. On the one hand, in France the patient is not just someone with a disorder; the session is not focused only on that issue but is

open to every kind of argument proposed by the patient or by a member of the therapeutic group. On the other hand, in Britain the narration has to be wider in order to include all the possible influencing factors and external events that have been internalized by the patient.

A correspondent to the ethnopschoanalytical group may be the idea of inter-professional consultation. Steinberg (Kareem and Littlewood, 2000) recommends the use of this technique in order to provide the patient with a relief based on different ideas and opinion, one that is not only circumscribed to the therapist's experience but also enriched by others' points of view. In this sense, an example may be the consultation of a culture broker, who can be helpful in avoiding misunderstandings or problems linked with cultural diversity.

The two approaches appear quite similar, or at least have many congruencies, even if they have developed differently. This last statement leads to the analysis of the primary difference between the two therapies. Ethnopschoanalysis is characterized mainly by the rejection of the use of Western practice among immigrants. Nathan claims that the 'healer' has more value than the medical doctor: the imposition of thought is reversed. The culture that was once subjugated, is here the dominant one. Western psychiatry, psychotherapy and medicine in general lose their power and strength in the face of the potency of traditional therapy. This situation almost reminds one of a 'colonialist' movement to take back the identity that a population has lost in the process of acculturation.

On the other hand, intercultural therapy seems to try to be de-colonialized by itself. It is almost reminiscent of the title of Mannoni's work *The Decolonization of Myself*. Fanon criticized that book because it seemed to reduce the relationship between black and white to the point where there is no possibility for the black population not to be colonized (Roudinesco, 2005).

This situation reflects the suggestion made by Littlewood (Kareem J., R. Littlewood 2000) in the conclusion to the first chapter of 'Intercultural Therapy': 'We cannot assume that an adequate or appropriate goal is simply to provide "therapy". Psychotherapy is perhaps less innocent and less free of social and political ideologies than is biomedicine; it is potentially far more insidious an agent of social control than is the Mental Health Act itself.'

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therapy; therefore the Centre provides initial free help for residents of the area funded by the Trust and cheap sessions for non-eligible patients. The reduction in fees and sessions facilitates access by low-income patients and requires a shorter term commitment from the patient.

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