IFP
international federation
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Zurich, March 2011

EDITORIAL

Some new faces, some well-known faces..
The new IFB-Board is in charge...

In this first Newsletter in 2011 the new IFP board wants to introduce themselves to the IFP members. Some of us are longstanding IFP members involved in the IFP for many years; some of us are rather new to the IFP community. It is certainly not by chance that the IFP-board members come from a different background, ranging from clinical psychology to psychiatry and psychosomatic medicine. Beyond this interdisciplinary background, we come from different countries with different health care systems and thus covering different approaches to research and practice in psychotherapy. In addition every board member has a different scientific expertise in the field of psychotherapy covering a wide spectrum of psychological disorders (e.g. personality disorders, post traumatic stress disorder, eating disorders) and in addition a certain spectrum of psychotherapeutic approaches (e.g. cognitive behavioral therapy, psychodynamic psychotherapy, systemic psychotherapy). However this variety of approaches represents scientifically sound, evidence based psychotherapy.

Our future aim for the IFP Newsletter is to expand and intensify this medium as a communication and information tool and platform. Therefore, we would like to invite all IFP members from different countries and cultures around the globe to exchange their experience and views on the history and potential future of psychotherapy. Besides providing you with information from the IFP board we would like to invite you to send us articles which might be of interest for the whole IFP community. In addition to the established Newsletter format we would like to implement a section "Letters to the Editor" in which you are invited to share your thoughts e.g. on published papers. Please continue to send us announcements of psychotherapeutic meetings, conferences and workshops, which might be of relevance and interest for the IFP-community. At this point we want particularly thank Dr. Längle for developing an attractive IFP Newsletter format and for secretarial assistance by Ms Erpenbeck in the past and future. The IFP board wishes all of you an excellent start in the year 2011 and please feel free to contact us (stephan.zipfel@med.uni-tuebingen.de). For more information, please visit our IFP News Section in the Journal of Psychotherapy and Psychosomatics (http://content.karger.com/ProdukteDB/produkte.asp DOI=10.1159/000323944).

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Dr. David Orlinsky is a professor in the Department of Comparative Human Development at the University of Chicago, where he has taught since 1960. He is the principal author of two research-based volumes, Varieties of Psychotherapeutic Experience (1975, with K.I. Howard), and How Psychotherapists Develop (2005, with M.H. Rønnestad), and he is currently working on two other research book projects on "the psychotherapist's work" and on "the personal and spiritual lives of psychotherapists." He also co-edited and contributed to The Psychotherapist's Own Psychotherapy: Patient and Clinician Perspectives (2005, with J.D. Geller and J.C. Norcross). He has published more than 100 articles and book chapters, including frequently cited chapters on the relation of therapeutic process to outcome in four successive editions of the Bergin & Garfield Handbook of Psychotherapy and Behavior Change (1978, 1986, 1994, 2004).

In 1968-69, Orlinsky and his colleague Kenneth Howard organized the international Society for Psychotherapy Research (SPR), which David served as its first president-elect and subsequently in other capacities (e.g., as founding president of the SPR North American Regional Chapter). In 1989, he co-founded and led the SPR Collaborative Research Network, which for the past 20 years has continuously conducted research the characteristics, experiences, and development of psychotherapists of varied professions and orientations, at all career levels, in many countries.

Orlinsky has received awards for distinguished scientific and professional contributions from the American Psychological Association Division of Psychotherapy (Division 29), the Illinois Psychological Association, and the international Society for Psychotherapy Research, as well as an award for teaching excellence at the University of Chicago. A chapter on him and his was included in a recent volume on leading clinical researchers, published by the American Psychological Association: L.G. Castonguay et al., Eds. (2010), Bringing Psychotherapy Research to Life. In 2011, Orlinsky will be awarded an honorary doctorate by the University of Oslo. In addition to teaching and research, he practiced psychotherapy in Chicago for many years. He is married, has two children, seven grandchildren, and four great-grandchildren.

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Prof. Herpertz is member of the board, in charge of psychotherapy, within the German Association for Psychiatry and Psychotherapy (DGPPN) and chair of the section "personality disorders" within the European Psychiatric Association (EPA) and member of the board within the International Society for the Study of Personality Disorders (ISSPD) and member of its research committee.

She is editor of several textbooks in the field of psychotherapy and personality disorders and champions an integrative approach to psychotherapy. Concerning medical journals she is member of the board of editors responsible for Psychopathology and she is member of the editorial boards of *Journal of Behavior Therapy and Experimental Psychiatry, Verhaltenstherapie, and Persönlichkeitsstörungen, Theorie und Therapie* (PTT).

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He has passed his clinical training in internal medicine as well as psychosomatic medicine and psychotherapy at the universities of Heidelberg, Germany and Sydney, Australia. His major research interests are psychotherapeutical and psychobiological aspects of eating disorders (including obesity) and somatoform disorders. He is founding and board member of the German Eating Disorder Research Society, PI of the ANTOP-study (Anorexia Nervosa Treatment of outpatients), the largest outpatient psychotherapeutic RCT in anorexia nervosa. He is editor of several textbooks in eating disorders and psychosomatic medicine and member of the editorial board of the Journal Psychotherapie, Psychosomatik, Medizinische Psychologie and the European Eating Disorders Review.

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Culture and Psychotherapy:

Clinical, Theoretical, and Philosophical Explorations from A World Perspective

Keynote Presentation
20th World Congress of Psychotherapy, Lucerne, Switzerland
June 16-19, 2010

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[I] Introduction

It is common knowledge that contemporary psychotherapists need to be culturally competent, namely: to be equipped with cultural sensitivity, knowledge, and empathy; to be able to perform culture-relevant interactions with patients and to provide culturally suitable guidance for patients. These qualities and skills are needed particularly when working with patients from different ethnic-cultural backgrounds, but even from the same cultural group as well. After all, each person is different, with a different way of thinking, beliefs and value system, which needs special attention.

To be able to provide culture-competent psychotherapy, considerations need to be emphasized at multiple levels, namely: clinical, theoretical, and philosophical dimensions. This will be attempted by reviewing the information available around the world to ensure exploration can be made from a world perspective.

[II] Clinical Explorations -- Culture and Different Modes of Therapy

This refers to the professional clinical knowledge, experiences, and adjustment that are needed to provide culturally-competent care. This involves: understanding of cultural influence on psychological problems and manifestation of psychopathology; culturally-proper clinical assessment; selection and suitable modification of proper modes of treatment; engaging the client, reaching the family and helping them to utilizing available support resources; offering flexible, effective clinical care that considers the patient's cultural background as well as the therapist's own cultural values system; and to manage and minimize the therapist's own cultural ignorance and bias.

Based on the culture-influenced help-seeking behavior, many patients receive various modes of therapy as an alternative or simultaneously. Thus, it is important for therapists to be aware of the existence of such various modes of care that may exist in society and utilized by the patients. It is also important for the therapist to realize that the healing practices offered by the therapists, no matter which mode of therapy, are subject to cultural factors beyond professional knowledge and reasoning. Because of this, it is necessary for us to examine various healing practices that have existed in the past as well as the present. If the psychotherapy is defined broadly, they can be grouped into: indigenous, unique, and common healing practices that exist in various societies (Tseng, 2001, pp.515-561).

The brilliant Iranian medical doctor, laureate of the German Federal Cross of Merit, and Nobel Prize candidate, Professor Nossrat Peseschkian, M.D., passed away on April 27, 2010.

(A) Culture-Embedded "Indigenous" Healing Practices:

Indigenous or folk healing practices refers to non-orthodox therapeutic practices based on local cultural traditions and operating outside official health-care systems. While indigenous healing practices function in general as healing methods for "problems," they are not usually considered by either the healer or the clients to be "psychological therapy" for the clients' emotional or psychological problems. Rather, they are recognized as religious ceremonies or healing exercises related to supernatural powers. Thus, such healing practices are very much supernaturally-oriented.

Shamanism

Spirit mediumship broadly refers to a situation in which the healer experiences alternate states of consciousness in the form of dissociation or a possessed state at the time of the healing ritual. Shamanism is historically believed to be prevalent in the Siberia region, but the term of shamanism is used broadly for any spirit mediumship observed around the world. Through a religious ceremony, a shaman can

work himself into a trance state in which he is "possessed" by a god. The causes of problems are usually interpreted according to the folk concepts held by the culture -- involving such things as loss of the soul, sorcery, spirit intrusion, or violation of taboos.

Coping methods suggested are usually magical in nature, that is, prayer, the use of charms, or the performance of a ritual ceremony for extraction or exorcism. Utilizing supernatural powers, acting as an authority figure, making suggestions, and providing hope are some of the main mechanisms for healing provided by the shaman. Familiarity and belief of the practice is another important psychological aspect associated with this healing practice.

Zar Ceremony

Zar refers to a class of spirit believed by people in many Muslim societies. Zar ceremonies are different from shamanism in that, in addition to the healer, the client also experiences the dissociated or possessed state. The female clients, during the ceremony will become dissociated, possessed, dancing, trembling, and (before the possessing Zar consents to leave), make demands for special favors. It is primarily an adult female activity reflecting social conditions of sex separation and low female status. The ceremony usually ends with an animal sacrifice and a feast. It is the husband who should satisfy the demands made by the female client during their possessed state. Thus, the ceremony not only provides women an ideal situation for relief of anxiety and tensions arising from their life condition, but also fulfills a women's wish for attention and care. Therefore, it may be said that it is a culture-designed mechanism for catharsis and fulfillment of unsatisfied desires for the suppressed female.

Religious Healing Ceremony

A distinction needs to be made between religion and a religious healing ceremony. Religion refers to a system of beliefs in a divine or superhuman power or spiritual practice. As part of a religion, some people may perform special ceremonies for the purpose of healing certain problems or disorders.

There are various kinds of religious healing ceremonies observed in different societies that are considered by mental health workers to serve a therapeutic function for their participants. It is important to know that religious healing ceremonies are not only observed in primitive societies or among uncivilized populations, but are quite common in many industrialized societies, as well. An extremely different form of religious ritual was a snake-handling cult in the southern United States. By handling a poisonous snake during the trance state, the clients were blessed for their courageous behavior and belief in God. In spite of the practice being dangerous with a possible fatal accident, and forbidden by the government, such ceremony is still occurring secretly.

In Thailand, people suffering from substance abuse were treated by the monks in the temple. After the intake of an abusing substance, a certain herb was given at the same time to promote vomiting, establishing a negative condition for taking an abusing substance. Then, the patients, as a group, were given instructions by the monk on how to change their behavior and lifestyle. Because the therapeutic instruction is given by the monk, the religious leader, it enhances the power of the therapeutic effect.

Divination

Divination refers to the act or practice of trying to foretell the future or the unknown by occult means. It relies on mysterious, magic, or religious methods. Since the interpretation of divine instruction is usually provided by the diviner or an interpreter, the interaction between the diviner/interpreter and the client becomes an important variable.

An elaborate divination system called chien has been developed in China. To obtain answers to questions about their lives, some Chinese will visit temples for divination. After a sincere prayer to the god of the temple, the person will ask for divine instruction, which is provided through a fortune stick that the person selects. Corresponding to the number on the stick, there is a fortune paper with an answer written on it. It is interesting to notice that there are a certain set of replies provided for certain items consulted. Such as:

Social achievement -- discourage too much ambition.
Lawsuits -- suggestion for negotiation.
Traveling -- prohibiting moving and traveling.
Marriage -- favorable arrangement.
Attitude toward life – be conservative, patient, acceptance.

Thus, it clearly indicates that culturally-sanctioned coping is reinforced through this folk counseling (Hsu, 1976).

(B) Culture-Influenced "Unique" Psychotherapies:

Culture-influenced unique psychotherapies are therapeutic modes that are biological-psychologically-philosophically oriented. They are very much culture flavored and characteristically "unique," being different from the "common" or "mainstream" modes of psychotherapy that are currently practiced in Euro-American societies. These unique therapies were developed either by laymen or professionals.

Mesmerism

Mesmerism was invented by Austrian physician, Dr. F. A. Mesmer in the late 18th century. Emotional disorders were interpreted as the result of improper balance of "magnetic" force within the body, and the proper adjustment of the magnetic force is the main approach for therapy. Thus, a special instrument was invented for the exchange of the "magnetic" force. This mode of therapy has been popular in the late 18th century in Paris, France. Most of the clients were affluent women, looking for treatment by the charismatic healer, being touched physically by him to balance the magnetic force. When the founder-healer was not available no one was able to continue the therapy and it faded away.

Alcoholics Anonymous (AA)

Alcoholics Anonymous (AA) started in the United States in 1935 as a self-help program designed to help alcoholics become sober. It has since spread to all continents – but mainly in the United States, Canada, Latin America and some from countries in Europe.

The interesting point is that the Western-style Alcoholics Anonymous has not been successful among North American Indian populations. However, by omitting certain Western features of philosophy and practice, and incorporating important indigenous cultural elements, the transformed "AA" groups have been quite successful in attracting and rehabilitating alcohol-abusing individuals among native populations (Jilek-Aall, 1981). The Amerindian AA groups reject the concept of anonymity. Instead, open identification of participants is practiced and family members, including adolescent children, are invited to the open meetings. This revision of the program, skipping the emphasis of "anonymous," works well for clients living in a small community in which every person knows each other and makes it almost impossible to keep things secret from the members of the community.

Erhard Seminars Training (EST)

Founded by Werner Erhard, a layman, EST was fashionable among well-educated adults in the United States during the 1970s. It consisted of a structured, two weekend (60-hour) program for self-improvement. The program was organized with certain rules, including a strict seven hours between bathroom breaks -- thus it was nicknamed "no-piss training."

Coupled with its philosophical attitude, the purpose of the training is to transform a person's ability to experience -- to expand his or her experience of aliveness and full self-expression. It is aimed at intensifying a person's own awareness that an individual runs his own show, whatever he chooses it to be. The ultimate goal is for the participants to get the sense that: "I had total responsibility for my life -- all of it, the happiness and the sorrow." From a cultural perspective, EST appealed to well-educated adults during the 1970s because it provided an alternate philosophy of life that was radically different from the beliefs of the society then. The therapy tends to effect the participant through the "superman syndrome," i.e., to make a person believe that he has the power to handle his own life. In spite of its popularity for a decade, the program terminated when the founder encountered finance-related legal problems.

Morita Therapy

Morita therapy was originally founded by a Japanese psychiatrist, Shoma Morita, in 1919, primarily for the treatment of neurasthenia and/or anthrophobia (interpersonal relation phobia). Associated with rapid social change, many neurotic patients with diagnoses of "neurasthenia" appeared in clinics without any relevant therapy. Morita treated patients by letting them go through different stages of experience, including rest, life renormalization, and life rehabili-

tation. Most important is that, through all stages of therapy, patients were discouraged from talking about their problems and complaining about their symptoms. A life atmosphere was set up to encourage the patient to learn to accept self "as it is" (arugamama in Japanese, which literally means: thing-as-it-is-ness) and to concentrate on enjoying his own life as it is.

Thus, the therapy is to help the clients to: re-experience life through social deprivation; conversion of perception and attitude toward illness; adoption of life attitude – "accept things as it is"; resolving ego-centric love and suffering caused by unwarranted attachment and craving; and discovering a new self and moving forward with life (Kitanishi, 2005). Although the mode has caught the attention of scholars and has been discussed often in literature from a cultural perspective, in reality, such a mode of therapy is practiced only by few psychiatrists in Japan.

Naikan Therapy

Naikan therapy was invented by a Japanese civilian, Yoshimoto Ishin, in Japan five decades ago for the initial purpose of treating juvenile delinquency and other problems. Naikan in Japanese literally means intra-inspection. The core of the Naikan practice is the client carrying out self-inspection about past experiences in his own life, with a particular focus on the kind of relationships he/she has had with significant people in his/her life -- usually his parents. The client is instructed to review the kinds of things his parents did for him, and what he did in return. Through the process of self-inspection, the client may obtain insight about his attitudes and learn not to complain and cause trouble for others, but to repay others with appreciation and a joyful heart. The change in the patient's attitude toward others and his view of life are the core of the therapy. Facilitating guilt-consciousness by reinforcing the sense of obligation (on) toward others is the core of the treatment (Kawahara, 2005). It utilizes the culture emphasis of obligation (on) toward others in a collective society.

Daoistic Cognitive Therapy

It was rather recent that a special form of cognitive therapy emerged in China that specifically utilized Daoistic thought in the treatment of neurotic patients. The main thrust of the therapy is to help the patient obtain cognitive insight and become "detached" (or relieved) from his excessive desires or expectations. The therapy is called *chaotuo xinlizhiliao* in Chinese (literally, "detachment psychotherapy"). After studying Daoist (or Taoist) thought carefully, the team identified eight phrases (or slogans) in four categories that form the basis for their cognitive therapy (Young et al., 2005). They are:

Benefit without harm to your self as well as to others.
Do your best without competition with others.
Moderate desires and limit selfishness.
Know when to stop and know how to be satisfied.
Know harmony and put oneself on a humble position.
Hold softness to defeat the hardness.
Return to the initial purity and back to the original innocence.
Follow the rule of nature.

Clinical experiences indicated that such therapy is beneficial for: the aged patients with higher education, suffering from a minor emotional disorder, particularly for patients with type A personality and suffering from coronary heart diseases (Zhu, 2007).

Client-Centered psychotherapy

This therapy was developed in the 1940s by Carl R. Rogers with several emphases. The cornerstones of his method were the basic knowableness and trustworthiness of one's own inner awareness, and an individual's ability to accurately symbolize this inner data to be used to reorganize and make choices. The fundamental assumption of the therapy was a person's basic motivation toward growth and differentiation. Thus, the therapy focused on the enormous potential of the individual and freeing the client to allow normal growth and development.

From a cultural point of view, it is interesting to note that client-centered therapy is related to the basic American ethos – with expression of the fundamental individual "distrust of the expert" theme in American culture. The therapy gives particular attention to the autonomy need, or the need of the personality for independence. No wonder such a therapeutic approach is not particularly welcomed by

clients in other cultural settings, where dependence on authority is expected and personal autonomy is less emphasized.

Existential Therapy

Developed in various parts of Europe around the 1960s by a group of trained analysts (Frankle, Binswanger, Boss, and others.), existential therapy refers to the basic approach concerned with understanding the client as he exists in his world. It is not a particular type of therapy with a special theory, method, or technique. Rather, it focus mainly on the attitude and approach to human being. It is based on existential philosophy, which holds a man responsible for his own existence. It has been pointed out that the orientation of existential psychotherapy is a phenomenon of the West.

(C) Culture-Related "Common" Psychotherapies:

This refers to ordinary, mainstream therapies that are recognized by contemporary professionals in European-American societies. It is entirely psychologically-oriented and regarded as professional activities with scientific nature. However, the culture impact of such therapies can not be denied or ignored.

Psychoanalysis

Even though many psychoanalysts tend to take the view that psychoanalysis deals with the basic aspects of the human mind and is universally applicable, clinicians from various societies do not agree. Some scholars have pointed out that the theory and practice of psychoanalysis are very much culturally influenced -- by the ethnic cultural background of their founder (Sigmund Freud) and the sociocultural environment of Vienna then, where the practice originated. Furthermore, the Judaic cultural value system influenced the Freudian theory of psychotherapy. In contrast to Christianity, as with many other religions, Judaism maintains that the ultimate goal of human happiness is attainable in the real world (not in heaven), and any unhappiness in the real world is regarded as evil, and needs to be fixed. This is the basic attitude reflected in psychoanalytic theory -- and the purpose of therapy.

Behavior Therapy

Among the different kinds of individual psychotherapies, behavior therapy is most heavily oriented toward the pure psychological aspects of behavioral change, and is less colored by cultural elements. In Russia, behavior therapy is called "condition-reflex therapy," implying that it is embedded in the biological-behavioral nature of therapy. Yet, by examining the cultural dimensions of therapy models, one recognizes that behavior therapy is also not immune from cultural impact. Contemporary behavior therapists have discovered that the application of the principles of learning theory requires attention to the sociocultural determinants of behavior as part of behavior assessment and treatment planning. The practitioner needs to understand the norms of behavior in the patient's sociocultural milieu. Also, the culture implication for the choice of reward and punishment for the purpose of conditioning needs careful consideration.

Cognitive Therapy

Cognitive therapy has been developed with an emphasis in working on therapeutic issues mainly at the level of cognition. It is considered more beneficial to people who are oriented toward reviewing and discussing psychological issues at a cognitive rather than an emotional level. The so called distorted-dysfunctional (automatic) thought possessed by the patient or functional thought suggested by the therapist subjects greatly to the individuals cultural value system. Namely, the so called functional thought to be suggested by the therapist, subjects to cultural evaluation and judgment.

Marital Therapy

In marital therapy, the therapist usually works on the married partners' expectations of and commitment to marriage, division of roles between husband and wife, ways of rearing children, relationships with families of origin, communication and sharing between partners, and methods of coping when problems arise. Obviously, all of these issues are related to interpersonal issues (rather than psychiatric disorders) and subject greatly to a psychological matter as well as cultural factors. Thus, there is a great need for cultural consid-

eration when conducting marital therapy.

The marital therapist needs to pay attention to the culturally defined roles of man and woman, husband and wife, or father and mother. These roles vary greatly in different cultural groups. The acceptable and effective ways of dealing with marital problems vary from culture to culture. For instance, openly acknowledging and facing problems and actively -- even aggressively -- dealing with problems to resolve them, are coping patterns favored in some cultures; whereas, passively enduring and concealing problems to maintain harmony may be considered virtues in other cultures. It is the therapist's job to consider and check with the partner-clients to learn the nature and direction of their cultural coping patterns. The goal and outcome of therapy needs to be clarified with the clients from the very beginning of therapy and throughout the course of treatment.

In general, cultural issues will become more explicit if therapy is undertaken for problems related to intercultural marriage (Tseng et al., 1977). In therapy for intercultural marriage-related problems, the therapeutic maneuver should be focused on the promotion of awareness and understanding of differences in values between the partners; encouragement of negotiation and compromise for resolution of differences; allowing time for gradual change of culture-related emotions; and permitting a cultural holiday for both partners as needed.

Family Therapy

A family is the basic social unit in life. Family life is characterized by an interpersonal relationship and subject to psychological and culture factors. Cultural aspects of family therapy have been discussed from several perspectives. Regarding the applicability of family therapy, the question has been raised whether ethnic-cultural groups that give greater importance to the family (such as Italian, Portuguese, or Chinese) are better suited for family therapy. Based on clinical experience, it has been pointed out that an emphasis on close family interrelations does not necessarily favor the family therapy approach. For instance, Moitoza (1982) pointed out that Portuguese families' closed family system prevents them from actively seeking family therapy; instead, they attempt to solve their problems via their own family resources and support systems. Chinese families are concerned with "internal disgrace not to be known by outsiders"; thus, until a family trusts a therapist (whom is considered as an outsider by the family members), it is relatively difficult to work on their family "secret" (Hsu, 1983; 1995). Also, for a family with culturally fixed, preexisting behavior patterns, it usually takes considerable effort to help the family to unlearn its way of dealing with problems (Tseng & Hsu, 1991).

Concerning the therapist-family relationship, it has been pointed out that it is desirable for the therapist to respect and utilize the culturally defined and sanctioned family hierarchy and relations that already exist within the family, and constantly evaluate the cultural transference that could occur in family therapy. For instance, McGoldrick and Pearce (1981) pointed out that the Irish cultural attitude toward authority figures will often lead members of an Irish family to show extreme loyalty and willingness to follow through on therapeutic suggestions. In Chinese families, Hsu (1983) suggested that, based on the concept of extended family social relationships, members may feel more comfortable if they are allowed to address the therapist by a pseudokin term (e.g. if the therapist is a woman close to the mother's age, she may be referred to as "auntie" for the children receiving therapy).

Directly relating to the matter of therapeutic strategies, there are numerous points made by various clinicians concerning cultural aspects. In working with Japanese families, it is necessary to deal with family matters according to cultural priorities, that is, to work on parent-child relations before beginning work on husband-wife issues, according to the Japanese cultural priority of dyad within a family (Suzuki, 1987). Working with Chicano families, several clinicians (Minuchin et al., 1967; Falicov, 1982) have proposed that it is better to use a structural family therapy approach to meet the cultural emphasis on hierarchies within families. For Irish families, McGoldrick and Pearce (1981) have pointed out that the Irish are apt to be threatened by therapy directed at uncovering hostile or erotic feelings and may respond better to a positive reframing of the strategic therapy model. Regarding Jewish families, Herz and Rosen (1982) mentioned that, closely related to the cultural tendency of treasuring suffering as a shared value, the verbal expression of feelings in family therapy can be emphasized.

In sum, a family therapist needs to be familiar with cultural variations of family systems, structures, and

interactional patterns, including role playing, communication, and value systems that are emphasized. The therapist also needs to know how to select culturally suitable intervention techniques, so that culturally relevant family therapies can be applied for families of different cultural backgrounds (Tseng & Hsu, 1991). If the therapist is working with ethnic minorities, as stressed by Ho (1987), the role of the therapist is to serve as a "culture broker" rather than an intruder; to facilitate negotiation between systems; and, usually, to work closely with the more acculturated member to promote change within the whole family, facilitating its adjustment to the host society. A similar view has been raised by Jalali (1988), who pointed out that, in treating ethnically-minority (or immigrated) families, the therapist is often confronted with a clash of two cultures (of the majority and the minority), two generations, and problems in acculturation or adjustment to the hosting society. The therapist, at the time of the conflict, explains and teaches both sides of values and norms, and actually acts as a cultural mediator, encouraging all to become multicultural, or to have a foot in both cultures. Thus, it is clearly indicated that family therapy is very much focused on the matter of cultural adjustment within the family or among family members.

Group therapy

The behavior of group members will be very much influenced by their cultural backgrounds in the areas of communication style, relational patterns, and interaction with the therapist, all of which, in turn, impact the process of group therapy.

If the group therapy is for multi-ethnic group members, special attention is needed on how cultural values will influence group dynamic, such as: mutuality vs. individualism, social role and hierarchy, ethnic identity and transference (Matsukawa, 2001).

(D) Summary Comments

Healing practices or psychotherapies are cultural product. In addition to professional knowledge and experiences, psychotherapies subject to cultural influence. Although the mode of practice, basic theory and techniques may varies, there are universal elements which work for the clients. At the same time, cultural considerations are necessary for any form of psychotherapy.

From a historical point of view, it is found that healing practices without an underlying theory and well defined method, relying solely on the charismatic personality of the therapist, tend not to survive long (exemplified by Mesrism or EST). Also, therapies that are too culture-specific (such as Morita therapy or Naikan therapy) tend to be difficult for transcultural application and fail to prevail across cultures. As well as therapy that is too rigid to follow its theory and to keep its method, ignoring social-cultural variation or change, tends not to last over time.

From a clinical perspective, it may be said that each therapy may be useful for certain groups of patients, but not necessary applicable to others; may be suitable for patients of a particular cultural group, but may not for other cultural groups, needing substantial modification at the level of technique, theory, and philosophy.

[III] Theoretical Explorations – Focusing on Culture and Personality

Theoretical consideration refers to the need for careful examination of the theories upon which mental health knowledge and practice is built. This may include the theory of personality, behavior, pathology, coping, and therapy. It is necessary to be aware that: theory developed for a particular ethnic-cultural group may not be applicable to other groups without proper modification or expansion. Let us examine some examples, which are more concerned about the basic nature of the human mind:

(A) Self and Ego Boundary

As early as the 1970s, Chinese-American cultural anthropologist, Frank H. L. Hsu (1973), has challenged the concept of "self" and personality as defined by Western scholars. He pointed out that the boundaries of the ego are different between people of the East and the West. Namely, the ego boundary is clearly defined in individual-oriented societies (mainly in the West), while the boundary is blurred in situation-oriented societies (mostly in the East).

(B) Attachment vs. Independence

Japanese cultural psychiatrist, Takeo Doi (1973), also pointed out in the 1970s that a child's benevolent dependence on his parents (amae in Japanese) is valued and extended into adulthood in Japanese society. He indicated that maintaining certain mutual dependent relationships among adults is considered desirable or, at least, acceptable in Eastern cultures. This is in contrast to Western cultures that value

independence.

(C) Parent-Child Triangular Emotional Complex

In Western psychoanalysis, the Oedipus complex is considered a basic developmental task that each child must experience and resolve. Many Oedipus-like children or folk stories are noticed throughout different societies. However, if we studied carefully, from a cross-cultural perspective, we will realize that the classic Oedipus complex derived from Greek mythology is only one type of parent-child complex that occurs and needs to be resolved (Tseng et al., 2005). From India, the story of Ganesha ended the parent-child triangular complex by the father defeating the son. A similar ending of complex is noted in the Chinese opera story of Xue Ren-gui in which a famous general killed his own son by mistake. Thus, the triangular conflict among father, mother, and son ended with the son being killed by the competitive father in a society which stresses the importance of the authority figure. For the popular folk story of Monkey, there are only father-like figures (the Jade Emperor, the monk) and son-like figures (the monkey) without mother or other female figures to form a triangular complex. In such bilateral parent-child relations the defining child-figure was punished by the authority figures but given the opportunity to make up his misbehavior and to become mature. For the folk story of India, Ajase, the main conflict is between the queen and the prince (Ajase), emphasizing the important relationship between mother and son rather than father and son.

Thus, the figures involved in the parent-child complex may vary in different cultures. Also, it leads us to theorize that parent-child complexes become triangular ones in cultures that tend to sexualize interpersonal relations; and parent-child complexes exist merely as bilateral without becoming triangular in cultures that desexualize interpersonal relations. Also, a young child who is allowed to defeat a parental figure exists in cultures that value individuality and youth; whereas, parents who defeat their child occurs in cultures that value authority and age over the younger generation. It illustrates that the parent-child complex needs considerable expansion and modification from a cultural perspective.

(D) Culture-Shaped Personality: Comparison of East and West

From various studies, it can be summarized that there are characteristic differences of personality observed among people in the East and West (Tseng, 2007). Namely:

East	West
Blurred ego boundary	Clear ego boundary
Suppression and regulation valued	Expression and gratification stressed
Situation-oriented	Individual-oriented
Vertical, hierarchical relations	Horizontal, egalitarian relations
Emphasis of family	Emphasis of individual
Harmonious resolution	Confrontation & challenge
Synthetic integration	Dichotomatization
Comply with nature	Conquer the nature

Exemplified by the discussions above, it is indicated that, there is a need for theoretical consideration regarding the concept of personality cross-culturally. From a clinical point of view, it will help us to define what is normal, what is desirable interpersonal relations, and what will be the possible parent-child complex to be encountered and the culturally prescribed resolution for it. This is useful background information and knowledge to have for carrying out culturally proper psychotherapy.

[IV] Philosophical Explorations – Concerning A Healthy Mind

Philosophical consideration is necessary when the therapist is going to provide culture-competent psychotherapy, particularly for clients of diversified ethnic-cultural backgrounds. The consideration includes the comprehension of: underlying set of philosophy and faith shared by people of different ethnic-cultural groups; and the meaning of life, maturity, or a healthy mind stressed by the people. This is simply due to the fact that the direction and goal of therapy tends to be guided explicitly or implicitly by the basic philosophy held by the client and the therapist both, which mutually interact in the process of intercultural therapy.

(A) Examination of Major Religions

Philosophy that is held by people of different cultural backgrounds is rather abstract and not easy to examine. However, an attempt can be made by examining the basic book of various major regional philosophies such as: Judaism, Christianity (from the

West), Muslim (of Mid-East) or Buddhism (from East), as well as the traditional thought of Confucius and Daoism from the East and the thought of philosophy from the West. For the sake of comparison, the examination can be carried out by analysing and examining certain items or categories, such as: basic attitude toward the world and life, self subjective-experience, interpersonal relations, forbidden behaviour, coping ability, and idealized mature personality.

JUDAISM: Guide from The Old Testimony

The books making up the Jewish Scriptures are called the Hebrew Bible (also known as The Old Testimony). It is believed that Moses wrote the first five books – which covers the creation of the world, humankind's early history and the emergence of ancient Israel's ancestor (Geoghega & Homan, 2003). The books served as a guide for believers to follow the religious life.

Attitude toward the world and life – The world created by God has order and purpose.
Self Subjective-Experience – Trusting in God and doing what is right.
Interpersonal Relations – Do not take revenge but love your neighbor.
Forbidden Behavior – Murder, adultery
Coping Ability – To make distinction between good and bad.
Mature Personality – To be wise and make good decisions.

CHRISTIANITY: Guide from The New Testimony

The Christian Bible consists of histories of the life of Jesus, history of the early church, and letters written by leaders of the early church (Geoghega & Homan, 2003). There are some guides, moral teachings or philosophy suggested, emphasizing how Christians are to live their lives.

Attitude toward the world and life – All believers are to live together in unity and in love.
Self Subjective-Experience – A heartfelt benevolence toward others.
Interpersonal Relations – Do to others what you want them to do to you.
Forbidden Behavior – Murder, lusty desire.
Coping Ability – Turn the other cheek; overcome evil with good.
Mature Personality – To be perfect with "universal love," to love every person.

MUSLIM: Guide from Koran

The Koran (or Qur'an) is the supreme authority in Islam. It is the fundamental and paramount source of the creed, rituals, ethics and laws of the Islamic religion. The Koran has been at the heart of Muslim life and culture (Haleem, 2004; Sultan, 2004).
Attitude toward the World and Life – Life is for a person to be a complete believer.
Self Subjective-Experience – To worship God and to follow God's guide.
Interpersonal Relations – Be good to your parents, children, orphans, migrants.
Forbidden Behavior – Murder, intoxicants.
Coping Ability – To believe that God is always with you and cares for you.
Mature Personality – Believe in God and His message.

BUDDHISM: Philosophical enlightenment

Buddhism was found by the teachings given by the originator, Shakyamuni Buddha, the awakened sage (Landaw& Bodian, 2003). In a strict sense Buddhism is not a religion. Buddhism is an experience-based teaching of life, a means of release from suffering, and a way of healing (Chang & Rhee, 2005).

Attitude toward the World and Life – Based on illusion and desire the world is full of suffering.
Self Subjective-Experience – Peaceful mind, to let things be, without trying to control.
Interpersonal Relations – Loving and kind relations with others.
Forbidden Behavior – Murder, intoxicants.
Coping Ability – Inner investigation and experience for self-enlightenment.
Mature Personality – Cultivate insightful wisdom.

(B) Analysis of Traditional Thoughts and Contemporary Philosophy

Confucian Thought

Confucian thought is the core for the traditional thought shared by the Chinese and many other people in Asia. It deals with a general philosophy of life, ethics, and education (Tseng, 1973; Yan, 2005). The Confucian thought is very much concerned with humanity.

Attitude toward the World and Life – A life is full of potential for development and maturity through self-cultivation.
Self Subjective-Experience – In the joy of the attainment of knowledge, forgets the sorrows.
Interpersonal Relations – Proper relationship between persons in all aspects of life.
Forbidden Behavior – Being malicious, greedy.
Coping Ability – Introspection of self.
Mature Personality – The heart is rectified, and expresses emotion with harmony.

Daoistic Philosophy

Daoism (or Taoism) is an ancient school of Chinese philosophical thought, founded by a legendary person, Lao-zi. The primary emphasis is to follow the Dao (the way of nature and universe). In contrast to Confucian thought which emphasize social order, Daoism is in favor of nature and intuition.

Attitude toward the World and Life – Practice non-action; work without doing.
Self Subjective-Experience – Empty yourself of everything, let the mind rest at peace.
Interpersonal Relations – Yielding is the way of Dao.
Forbidden Behavior – Indulged in power and success.
Coping Ability – Soft will overcome hard; let things take their course.
Mature Personality – Being able to cast off selfishness and temper desire.

Western Philosophy

There is an endless list of famous philosophers in the West, such as Socrates, Plato from the ancient time to Descartes, Rousseau, Kant in the later history. However, it needs to be pointed out that, in contrast to ancient philosophers in the East, who were more concerned about human nature and the meaning of life, ancient philosophers in the West are more concerned about the nature of the world (such as how things are made and the rule of phenomena). It is more characterized by abstract issues about the world in which we are living. Fore example, as the philosophers of the Greeks, Empedocles was concerned about the dualisms of good and evil, truth and falsehood, or two sets of opposites; Pythagoras considered the soul as an attunement of the body.

During the medieval times, philosophy became the handmaiden of theology. The existence and power of God became the center of the philosophical thought. Christians, who took hold of the West, regarded earthly life as a preparation for a greater life to come, and the miseries of human existence as trials imposed on him to cleanse him from the congenital burden of sin in which he was heir (Russell, 1959. pp. 164 &168). Dante, in his Divine Comedy, describing a journey through hell, purgatory and into heaven, summarized the thought of the medieval era.

After the Italian renaissance of the 15th and 16th centuries, came modern philosophy, which became interested in man, under the movement of humanism. Associated with the improvement of physical and mathematical sciences, there was technical development, which modified the human thought – there is literally nothing man might not achieve if only his efforts are suitably directed and applied (Russell, 1959. pp.170 & 172). More from England, wrote his "Utopia" – a piece of speculative, social and political theory (inspired by Plato's "Republic") emphasized that all men should be equal. Descrates indicated his famous saying that: "I think therefore I am (exist)," indicating that he is a thinking thing, quiet independent of natural substances, and therefore likewise independent for the body. It implies that the mental and the physical are separate.

In general, it is difficult to make comparisons between Eastern and Western philosophy by items or categories. However, we can point out several issues concerned by Western philosophers, which is relevant to our discussion. A philosophical movement goes hand in hand with a scientific tradition during the period of civilization in Greek. Although the philosophy was under the influence of theology during the medieval age, after the renaissance, an individual person was greatly liberated and became independent. Overall, we may say that dualism (and conflict) is emphasized in the West while monolism (and harmony) in the East.

(C) Summary:
Comparison between East and West

Based on the examination of major regional philosophy and traditional thoughts observed around the world, it can be summarized that there are basic differences that exist in the East and West (Tseng, 2007). Namely:

East	West
Attitude toward the World and the Life:	
Comply to nature	Devotion to God
Recognize that life is unpredictable and full of suffering	Search for happiness and enjoyment in life
Self Subject Experience:	
Internal satisfaction to achieve happiness in life	Perceived self-efficacy and well-being.
Peaceful mind – to let things be	Sense of autonomy and competence
Interpersonal relations:	
Mutual benevolence with love	Mutual respect for self-autonomy
Proper hierarchical relations with others	Every person is brother and sister
Harmony, empathy, and yielding	
Forbidden Behavior:	
Kill, steal, sexual misconduct	Murder, steal, adultery, take revenge
Misbehavior against authority	Intoxication, gambling
Management of Primary Desire:	
Sexual desire is nature	Sexual desires related to Original Sin
Be natural and proper	Proper management and expression
Regulate aggression	Overcome aggression
Emotional complex: Comply toward authority	Emotional complex: Conquer the authority
Coping Ability:	
Inner investigation for self-enlightenment	To face and resolve the problems
Obtain suitable help from others	Actualization of one's potential
Letting things take their course	
Mature Personality:	
Cultivation of personality	Effective dealing of reality

Although the summary above is simplified, polarizing the potential differences of philosophy between the East and West, does indicate how we view the world, the meaning of life, and how an ideal mature person could be subject to great variation among people (including client and the therapist) of different cultural backgrounds. This is very important to keep in mind when we are going to provide mental health care particularly for transcultural situations.

[V] Closure – Integration and Summary

(A) Healing Practice – Universal Elements and Cultural Variations

By reviewing the different groups of healing practices, we can point out that they share common or universal elements for therapeutic effectiveness. They are: a supportive healing relationship with the therapist; the opportunity to express one's own thoughts and emotion; and the opportunity to gain better self-understanding (Luborskey et al., 1999). The cultivation of hope is also very significant (Frank, 1961). The Provision of culture-relevant and a useful guide for improvement is critical as well (Tseng & Hsu, 1979)

Cultural variations among different modes of healing practices are: the basic orientation of practice from the supernatural, natural, psychological, to philosophical; the relationship between the client and the therapist (from authoritative to egalitarian); the basic theory, emphasis, and method utilized for healing; and finally, the goal of therapy.

(B) Cultural Implication of Psychotherapy

After reviewing all of the different modes of therapy and what mental health care can provide, including the super-nature-oriented indigenous healing practices, culture-unique therapies, or common therapies, we can summarized that the implication of therapy from a cultural point of view are (Tseng & Hsu, 1979):

To define norms, values and maturity for the client;
To reinforce a culturally-sanctioned coping mechanism;
To provide culture "time out" – temporary relief from the culture restriction;
To explore culture-alternative resolutions;
To expose, exchange and incorporate a new culture system for a better adjustment in life.

(C) Quality Needed for Culture-Competent Therapist and Service Provided

In order to provide culture-competent care and therapy, the therapist needs to be equipped with the following qualities (Tseng, 2001, pp. 796-801; Tseng, 2003, pp. 219-225):

Cultural sensitivities -- the clinician needs to be able to sense cultural differences among people, and know how to appreciate them without ignorance, bias, or prejudice.

Culture knowledge -- a clinician needs to have a certain base of cultural knowledge about humankind as a whole and of the particular patient and family concerned.

Culture empathy -- being able to feel and to understand at an emotional level from the patient's own cultural perspective.

Culture-relevant interaction with clients and families -- the relation and interaction between the therapist and the patient needs to take into consideration the cultural background of the patient, the therapist, and the setting in which the therapy takes place.

Culture-suitable mode of care and therapy -- to be able to select clinically suitable and culturally relevant ways of treatment that will work best for the patient.

Culture-effective guidance – to be able to provide a therapeutic guide for the patient to deal with the problems encountered. It takes not only clinical judgment, but cultural insight to find relevant and optimal solutions for the patient being treated.

Beyond the individual therapist, for the mental health service, it has been stressed that, mental health service, in general, needs to pay attention to: involvement of a family beyond an individual; provision of care and support beyond therapy; innovative but clinically competent approaches; and broad and comprehensive approaches to meet the clients' culture and clinical needs.

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www.psychiatrie.usz.ch

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Information: Internationale Gesellschaft für Logotherapie und Existenzanalyse (GLE-International) Wien, Tel.: +43-1-9859566
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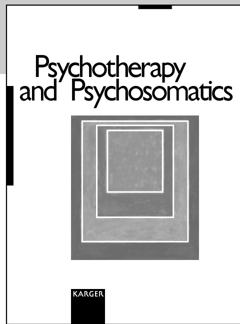

Psychotherapy and Psychosomatics

Current Impact Factor: 5.022

Official Journal of the International College of Psychosomatic Medicine (ICPM)

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Psychotherapy and Psychosomatics
2009: Volume 78, 6 issues per volume
Language: English
ISSN 0033–3190 (print), ISSN 1423–0348 (online)

Listed in bibliographic services, *including Current Contents®, MEDLINE, Biological Abstracts, Science Citation Index.*

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Agoraphobia and Panic. Prospective-Longitudinal Relations Suggest a Rethinking of Diagnostic Concepts: **Wittchen, H.-U.** (Dresden/Munich); **Nocon, A.** (Munich); **Beesdo, K.** (Dresden); **Pine, D.S.** (Bethesda Md.); **Höfler, M.** (Dresden); **Lieb, R.** (Munich/Basel); **Gloster, A.T.** (Dresden)

Current Status of Augmentation and Combination Treatments for Major Depressive Disorder: A Literature Review and a Proposal for a Novel Approach to Improve Practice: **Fava, M.** (Boston, Mass.); **Rush, A.J.** (Dallas, Tex.)

Financial Ties between DSM-IV Panel Members and the Pharmaceutical Industry: **Cosgrove, L.** (Boston, Mass.); **Krimsky, S.** (Medford, Mass.); **Vijayaraghavan, M.; Schneider, L.** (Boston, Mass.)

Psychotherapy of Childhood Anxiety Disorders: A Meta-Analysis: **In-Albon, T.; Schneider, S.** (Basel)

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