Therapy Across Cultures: A Clinical Round Table discussion about working with people from cultures other than your own.
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The "Clinical Round Table" is a conference session in which an invited panel of discussants with relevant expertise discuss a particular issue amongst themselves and with input from the audience. At the 2006 NZCCP Conference a Clinical Round Table was held to discuss the topic of **Therapy Across Cultures**. The goal of this was to identify practical aspects of working therapeutically with people from cultures other than your own. The panel consisted of:

- Clive Banks - a clinical psychologist of Maori and Pakeha descent.
- Chaykham Choummanivong - a clinical psychologist of Laotian descent
- Jennifer Hauraki - a clinical psychologist of Chinese and Maori descent
- Malcolm Stewart (Convener)- a clinical psychologist of Pakeha descent
- Pauline Taufa - a clinical psychologist of Tongan descent
- Samson Tse - an occupational therapist of Chinese descent and Director of the Centre for Asian Health Research and Evaluation (CAHRE) at the University of Auckland.

This paper was prepared from notes taken by Malcolm Stewart and Nik Kazantzis. The paper was then fed back to the panelists so that they could correct, modify, or expand on any of the material reported. These modifications were incorporated into the paper and it was then fed back to the panelists again for their approval. This paper is therefore based on, and expands, the content of the Clinical Round Table session.

It was identified in the session that subcultures are not defined just by ethnicity. There are a broad range of subcultures within any ethnic group. These may be defined on the basis of variables such as age, gender, shared lifestyle or interests, or degree of acculturation to their own and other cultures. However, culture defined through ethnicity was the primary consideration in the discussion at the Clinical Round Table.

A major issue addressed at the Clinical Round Table was how to establish and maintain effective therapeutic engagement with people from diverse cultural backgrounds. Another major focus was information about cultural patterns that panelists believed would be helpful for psychologists to understand when they work with people from particular cultural groups. The following explores these issues and associated topics.

Working With Maori
Working across cultures involves more than knowledge about the other culture. For example, too often clinicians deem themselves to be culturally competent to work with Maori if they have completed a course in Te Tiriti O Waitangi or if they can sing waiata (songs), say a mihimihi (welcoming ritual) or say karakia (prayers) in te reo Maori. However, being competent in these activities does not ensure the ability to work effectively with Maori.

Engagement with Maori was seen as requiring the development of confidence and trust of the service user and the whanau (family) first. It is only once this is established that you have a chance of "doing your psychology". Related to developing this trust was the importance of the concept of Manaakitanga (hospitality and caring). Displaying Manaakitanga is likely to prepare the way for, and underpin, the development of a therapeutic relationship that can work.

Clive discussed how the whanau may want to be closely involved and have significant influence in the care process. When working with the family it is important to look and see who steps forward, and/or who is waiting to step forward, to take the leadership. When available, a cultural advisor may also be able to clarify who the influential leaders within the family are.

The importance of ensuring that the therapeutic approach is consistent with the client's world view was also seen as important. In the case of Maori, weaving elements of the Maori world view into the presentation of psychological concepts and work was seen as an appropriate and helpful approach. Jennifer described using a whakapapa (ancestry and family/whanau inter-connections and history) exercise to initially engage a child or young person and their whanau,. This exercise not only starts the crucial process of whakawhanaungatanga (relationship development), but will also help the clinician to understand the various relationships and dynamics within the whanau. The principles discussed by Pita Sharples (side bar) can, if incorporated in and used to guide the development of therapy, assist with making the therapy both consistent with a Maori world view, and make it feel safer and more acceptable for Maori service users. However, caution must be taken to not assume that all Maori are comfortable with or have an affinity to *te ao* Maori (the Maori world or world view).

Working with Pacific Island People

It is important to remember that the Pacific People do not have one culture and that, in Pauline's words, "Pacific Islands is only a term used when we come to New Zealand" - people define themselves by their own island or island group.

For Pacific Island people, issues of stigma. shame, and distrust about involvement with mental health services are highly significant. Distrust left over from the time when the "Dawn Raids" happened in New

Zealand, and similar injustices, have contributed to this distrust of Palangi institutions including the mental health system There may also be current concerns for Pacific people that may inhibit a trusting relationship with health professionals, for example if there are "overstayers" in the household, or concerns that involvement with authorities may lead to police involvement. For all these reasons there is often a strong reluctance to be involved with "Palangi" health services.

Work done by health professionals and health organisations to build the relationship with the Pacific communities may be an important component in developing the trust of members of that community. Persistence and an ongoing presence within the community were seen as very helpful for building trust from Pacific communities. Clive described work that his service is doing to engage with the strong Pacific community in their area as being "Hanging around until the community finds a use for us" - contributing and attempting to be helpful when asked as a way of building trust. It may be important that this trust-building occurs if Pacific peoples are to be effectively engaged in therapy. Similarly, for good engagement with Pacific Island people it will be necessary to go out to them - they will frequently be unlikely to keep clinic appointments.

Pauline described how, if at all possible, when working with Pacific Island people, it is helpful to involve a Matua (Elder) - and if possible be introduced to the family by that person, as a way of helping to build the trust from the initial point. Whether an elder can be engaged or not, it is helpful to seek consultation from a cultural advisor from the same island group to assist with understanding the cultural patterns and dynamics that may be important in the situation. In Pacific Island culture "Clout comes with gray hair, not with degrees". Highly qualified health professionals, particularly younger clinicians, will not necessarily be highly influential within the Pacific community, even if they are of Pacific ethnicity.

Pacific Island people typically have tight-knit family structures with very clear hierarchies and roles within the family, and it is important that the impact of this on the client is recognized. If the client does not follow this authority then they risk being ostracised from the family or face other severe sanctions. Psychologists must be very mindful of this when using western psychological approaches with Pacific people as some of the assumptions and goals of western psychological approaches may be at significant variance to Pacific cultural values and this clash could cause significant problems for the client.

Within a Pacific context it is important to go out to the family and make space for the key decision makers in the family to assume a strong role in the therapy. As described for working with Maori, when working with a Pacific Island family it is important to look and see who steps forward and/or who is waiting to step forward to take the leadership. Making an alliance with this person will often be important. A key person within the family structure is often the paternal aunt of the family - this is the person who will often "call the shots". A similar pattern of the paternal aunt being the most influential person is also seen in some African tribes. In many Pacific cultures, the role of the family in being the primary decision maker remains as long as the person is unmarried even through to when they are in their 40s. The exercising of this decision making power by elders is usually in an island context regulated by the broader family structures. However, in the New Zealand context these family structures sometimes get distorted and this can lead to distortions in these family power structures.

Working With East Asian People
Samson, drawing on recent research about therapeutic effectiveness with Chinese experiencing problem gambling reported that key components for success were:
• the therapeutic relationship and conveying real empathy
• delivering therapeutic interventions in a structured way

- being prepared to engage on assisting with other post-migration adjustment difficulties (eg employment, budgeting, relationships, housing, income support etc), in addition to the index problem (problem gambling)
- enhancing social connectedness was seen as an important goal and an important therapeutic intervention

Keeping in mind the wider context in which people live was seen as important. The church was seen as a significant part of social connectedness for many Asian people, particularly Korean people. In this case, Samson identified that it is often useful to have a Korean person who supports the service contact the church and establish a relationship with the church community prior to working with any church community members to pave the way for mental health professionals when needed. Similarly, making connections with community leaders in the Chinese community is another useful strategy that can be attended to. However, it was also reported that in the New Zealand context the notion of community leaders in the Chinese society is not well defined as yet, with some self-appointed leaders not really representing a constituency, so finding the right person can be quite challenging at times. .

A major problem in engaging with Chinese people, particularly youth, is when they feel as if they are being treated as the stereotype: hard working, high-achievers. From her doctoral research on barriers to mental health service use by Chinese youth and their families, Jennifer reflected on the comment of a young Chinese adult who said "The thing that failed for me was that all they saw was the Chinese face [and all the stereotypes and assumptions followed]".

Engaging in Any Cross-Cultural Situation
The Clinical Round Table participants agreed that an important part of engaging cross-culturally is to be flexible. It is important to ask early on in contact how the person chooses to define themselves rather than making assumptions on the basis of cultural group. Be prepared to ask and learn from you clients rather than just assuming. Jennifer described how in her CYF team they have found it more valuable to deal cross-culturally with such flexibility rather than rigid protocols. Chaykham also discussed the importance of taking extra care in discussing the referral questions or goals, and how these are perceived from the person or family's perspective. Chaykham also suggested asking the family directly what the therapist needs to keep in mind from a cultural perspective to assist the individual or family with their recovery. This respectful, empathetic inquisitiveness and the psychologist's awareness of their own cultural issues, processes, expectations, and assumptions is immensely important in helping to strengthen the therapeutic relationship and engagement.

For many small migrant groups there is a major concern regarding disclosure and trust when exposed to health services in general. For Pacific Islands, Laotian, and Chinese clients, or those from a relatively small ethnic community concentrated in a small geographical location, it was identified that there was a significant concern that if a member of their own culture was involved there was a risk of breach of confidentiality or other social embarrassment, and trust would need to be built with any people involved. The Laotian community in New Zealand includes only 2000 people and is relatively close-knit, so there was a high level of concern of embarrassment if offered the prospect of working with a Laotian psychologist. For Asian clients in particular, avoiding "airing dirty laundry in public" or "losing face" is seen as a very powerful cultural imperative.

In some cases this concern would lead people to refuse or avoid working with people of their own culture. The panel described that this causes some frustration for the clinician who often have at least in part trained so they are able to bring the psychological skills for the benefit of their own communities, but then find their communities putting up barriers to their contributing in this way. A practical implication of this

are that the same staff (eg the same translator) should be involved repeatedly or else the trust is unlikely to ever be built up enough to allow effective working. Another implication of this is that it cannot be assumed that a person will wish to work with someone of their own cultural background even if such a person is available. Similarly, panelists also made the point that being tangata whenua or being a member of another ethnic minority group does not necessarily make it easier to develop a strong relationship and engagement with members of a minority group other than their own.

Samson discussed a recent project on interpreters in health. This research found that it is important to "work with" the interpreter (ie have them as part of the team) rather than "use" an interpreter. In line with comments above about the need to establish and maintain trust, it was seen as important to repeatedly involve the same interpreter so a trusting relationship can develop. It was also seen as important to ensure that the interpreter stuck to the interpretation role, and did not stray into working as a consultant or co-therapist. Professional interpreters were seen as advantageous because they are more likely to be able to offer accuracy and consistency in their translation, especially around technical matters, and may be less impacted on by family or social dynamics than if a family member does the translation. The issue of having family members translate for clients was discussed. While in some ways this may be less than ideal (eg, the family members may not be as capable of translating specific health concepts as professional translators, may not translate accurately for cultural, family, or personal reasons, and may restrict the opportunity of the client to discuss particular taboo subjects), translation by family members was seen as essential (sometimes the only option) and valuable in some instances.

There was also some discussion of a recent trial in one DHB of telephone based translation in which the translation is undertaken via telephone and never meets either the client, the family, or the clinician. While this approach may need to be trialed and evaluated, concerns were raised about its likely acceptability to families and clients, particularly given the concerns above about privacy, and perhaps particularly if working with paranoid clients. There were also some concerns regarding the impact on the translators of translating traumatic material without access to a support network of other people to assist with debriefing or buffering.

Developing skills at working across cultures was seen as an ongoing learning task for all clinicians. Jennifer described how her CYF team has developed a weekly Cultural Hour where staff meet and share information about cultural patterns and cultural interactions, so that everyone's skills in this area can be enhanced. The Cultural Hour arose from the observation that team members often "filed away" knowledge and skills gained from liaisons with cultural consultants, only drawing upon this information when they encountered barriers in their work. An individual's culture follows them everywhere and is as inherent as gender or age. Culture can not be separated and "filed" to be considered at a later stage, and therefore, there was a need for ongoing consideration about the world that ethic minorities live in everyday. Cultural Hour served as a small step towards this ideal and she has found that exploring the experiences of various clinicians in their daily work with children and families of different cultures has enabled a more practical application of cultural knowledge and principles for the team.

As discussed earlier, there is often a range of cultural practices and beliefs within families, which lead to significant conflict within the family. One cause of this can be that some members of the family (eg young people) may acculturate to New Zealand society faster than other family members. It was also identified that fear of losing their culture and cultural identity is a major concern for many family members, and sometimes migrant families end up maintaining a form of cultural practice (often through generations) that stays static and does not evolve to the extent that the cultural practice in their country of origin does. One implication of this is that newer migrants may have cultural practices from their own country which are more similar to mainstream New Zealand/western cultural practices than people from the same culture who migrated to New Zealand in earlier times. This can challenge the assumption that migrants who

arrived in New Zealand longer ago will necessarily be more acculturated to New Zealand than more recent migrants.

Perhaps related to this. adolescents of many cultures may question their culture, and possibly identify more overtly with other sub-cultures such as a strand of youth culture vastly different from their parent's culture. This questioning of their own culture is age-appropriate across many cultures. However, how this is perceived and responded to by, for instance, family members and other members of their own ethnic group may vary widely in part depending on culture, and this may need to be taken into account in understanding the adolescent in their context.

Conclusion
This Clinical Round Table lasted for ninety minutes but it was clear that at the end of this time a further ninety minutes could easily have been spent exploring this complicated, fascinating, and important topic. Much of the above relates to the initial but very important stage of ensuring a strong therapeutic relationship and engagement of the person of another culture into the therapeutic process. Being prepared to adopt a position of respectful curiosity, being prepared to ask questions about culture and its meaning in the situation, and not making assumptions about this person on the basis of their cultural group, were seen as important factors in all the cultural groups represented. Building the trust and collaboration of people around the identified client is always important in therapy, but it seems to be particularly important, and perhaps particularly challenging, when working across cultures. Also, being prepared to identify that some cultural patterns or beliefs may make some of the assumptions and goals of western-based psychotherapies at least counterproductive and at worst quite destructive for the client in their natural context is clearly another theme that ran through this Clinical Round Table. Issues of how to undertake western psychological therapies in ways that are compatible with the world views of people from different cultures could also clearly have been another whole Clinical Round Table discussion.

Our thanks to the participants, both on the panel and in the audience, who contributed to the discussion that has been reported above.