Working with Cultural Difference: Implications for Psychosexual and Relationship Therapy

Sarah Collings

Psychosexual therapy is sometimes seen as a very 'fix-it' behavioural model by people who are unaware of the developments in the field. My training was grounded in a humanistic-integrative theoretical model, and while I do sometimes, though not always, set exercises for people suffering from sexual dysfunction, I work from a more holistic approach. Physiological symptoms may be the somatic response of an otherwise healthy person to emotional and psychological difficulties. My work therefore attempts an integration of the psychosexual with the psychotherapeutic.

Having worked for two years in a dedicated NHS clinic in south-east London and for over a year in a GP practice in another inner-city area, many of my clients have been from cultural and ethnic minorities. I believe it is imperative therefore to develop cultural sensitivity when working with clients whose cultural or ethnic backgrounds may differ from those of the average white therapist (the word I shall use for clarity) in Britain.

As we live in an increasingly multicultural world, it seems of vital importance to have a profound awareness of the need to take cultural dimensions into account. If a therapist does not do this, they are not reaching out to meet the client, the client's world, and the client's needs.

Although most training now includes a consideration of cross-cultural issues, and pays respect to the sexual orientation of people which differs from our own, or from the heterosexual majority, I believe that there is still not enough emphasis on working with difference being an integral part of training courses. Too often any consideration of difference seems to be regarded as a separate issue, rather than as part of the very fabric.

It is vital in today's world that therapists have given enough thought to their own cultural heritage, and how it affects their sexuality and attitudes towards the sexual behaviour of others. Thus a therapist needs to be able to see contextually their own psychosocial and psychosexual development and its place in their social construction, both in the here and now, and as far as any of us are able to, recognise the less conscious aspects.

Cultural sensitivity may be of particular importance when working with sexual issues, since the erotic as well as the relational mores of one society may be very different from those of another. As Brauner reminds us, 'We need to acknowledge that psychotherapists and counsellors in Britain are mostly from the white racial majority, middle class and heterosexual'. (Brauner, 2000.11) However from a more ontological perspective it is equally important to consider that sexuality might be considered a 'given' of human existence. Merleau-Ponty posits that 'sexuality, without being the object of any intended act of consciousness, can underlie and guide specified forms of...existence. Taken in this way, as an ambiguous atmosphere, sexuality is co-extensive with life.' (Merleau-Ponty, 1962.169) Coming from this outlook, while being conscious of the dangers in being 'colour blind' and 'colour deaf', it may also be important to consider the commonality of human sexuality, while recognising its permutations.

Another of Merleau-Ponty's concepts is that 'Man is a historical idea and not a natural species', (Merleau-Ponty, 1962.170) This 'idea' might therefore be considered to have evolved differently in non-western cultures, and as Brauner once again points out, have 'radically different ... social, historic, economic and political contexts.' (Brauner, 2000.11)

Culture and the internalisation of the self as 'bad'

Culture is constantly evolving, and as the world is 'shrunk' by television, the internet, mobile telephones and satellite communication, people may lose some of their sharper cultural definitions. As the twenty-first century progresses and processes there may be less emphasis on the physical appearance of people playing such a large part in cultural and ethnic differentiation as it has done historically. However, as Fernando points out, (1991.12) 'The classification of people into racial types on the basis of physical appearance has a long history in Western culture.' We have only to consider that the arrest rate for white people in Britain is 34 per 1000, for Asians 47 per 1000, and for black people 155 per 1000 (Panesar, 1999.11) in order to have some understanding of how a black client's self concept and experience may differ hugely from that of someone from the majority white culture.

This process can start at a very early age. As Jane Rogers Clay puts it, 'I ... knew that I was wrong to be black and I was sorry that I was black. I knew that black children were not as good as white children, or as smart, or as pretty.' (1963.12) The therapeutic implication here is that it is important to remember that in Britain white people do not necessarily learn to see themselves as white, rather as heterosexual people do not have to consider their sexuality. This could be

considered the 'majoritarian privilege of never noticing oneself', and the 'beginning of an imbalance from which so much, so much else' flows. (Williams, 1997.18) The lifelong introject of internalised racism, similar to that of internalised homophobia, starts early.

Weeks (1995,90) puts forward the view that 'All cultures seem to depend on a secure sense of self, and a placing in the order of things'. Each culture may therefore have 'its own guidelines on what is normal or abnormal', how to interpret reality and what 'standards and conduct have to be followed'. (Eleftheriadou, 1994.16) This might seem to apply to sexual behaviour as equally as to any other form of conduct, and is something that a psychosexual and relationship therapist needs to be vigilant about, in order that the client is not presumed to be resistant to certain forms of sexual therapy, such as masturbatory exercises for premature ejaculation. It is also important to remember that much of modern sex therapy has originated from the United States of America, the prime example of the individualistic society, and may not sit so easily in the framework of a more collectively oriented culture.

There may therefore be a rather insecure sense of self for some people from ethnic and cultural minorities, and a confusion regarding behavioural expectations, since these may differ inside a client's community from that of their peer group in the outside world of the majority population. I believe it is therapeutically of great importance to be aware constantly of a client's possible introjected sense of being 'less' due to internalised racism. Therapists from the white majority need to be aware that 'The legacy of slavery...ever present in the United States,' (Pigler-Christensen, 1988.192) is as true in Britain, and along with colonialism has left an imprint in institutionalised racism among such bodies of authority as the police, the judiciary and the armed forces, even though there has been a movement recently to address this issue.

Cross cultural psychosexual therapy: the importance of assessment

The place of assessment in psychosexual work is of attempting not only to ascertain a client's sexual and relationship problems, but also to place them contextually in a client's life. This involves understanding a client's psychosocial construction, both at a personal and at a public level. Binswanger's 'map' of the three dimensions of human experience, consisting of the natural, social and private worlds, may be of help here, along with van Deurzen's later addition of a spiritual dimension. (Eleftheriadou, 1994.6-9) Whether a client is from a western individualistic cultural background, or from a more collectively oriented society, understanding a client's mode of relation to the world will hopefully always be underpinned by a recognition that each person's subjective interpretation will be unique, despite similarities between themselves and others. It is also important to recognise the identity problems and frustration that may be experienced by some clients whose cultural background may be traditional within the family, but who have assimilated the values of the majority culture in their life outside. The dual

or plural cultural implications here may create feelings of 'ongoing confusion with feelings of not belonging to any one culture.' (Eleftheriadou, 1994. 70-71) Using Binswanger's & van Deurzen's models here may facilitate a deeper understanding of the cultural splitting a client may experience in relation to their own self construction, and especially in regard to the very sensitive area of sexuality.

Taking a psychosexual and psychosocial history with clients from a non-British ethnic background will also involve the necessity of the therapist being aware of how they may be perceived by the client. The client from an ethnic minority will carry their own, possibly unrecognised, feelings regarding those from the majority culture. A therapist from the majority culture may be perceived as 'having a certain power that the client cannot have.' (Eleftheriadou,1994.44) It is from this 'perspective of power' that the 'combination of white counsellor with black client has a potential danger, namely the perpetuation of white superiority'. (Lago and Thompson,1996.27) Equally it may be important for some clients to feel that they are safely held in the hands of an expert. Eleftheriadou reports that the psychiatrist Sushrut Jadhav 'found that Asians have a preference for professionals who present themselves as experts, are more directive and provide more structure and guidance, because this is culturally familiar and acceptable.' (Eleftheriadou, 1994.42)

In addition there may be very real fears regarding the stigma of being labelled mentally ill, as there has been a history of racism within western psychiatric diagnosis. Therefore coming for therapy, which can provoke a state of anxiety in any new client, may be accentuated for people to whom talking about problems with anyone who is not a family member may seem an alien act. This may be exacerbated by the deeply personal nature of sexual problems, and only desperation might lead a client to seek therapeutic help. I believe that while this is not necessarily limited to clients from ethnic minority backgrounds, it may be increased by the very nature of therapy being a eurocentric concept.

Historically the African and African-Caribbean immigrant has been for many 'a socially approved scapegoat for, among other things, sexual frustrations, fears and fantasies.' (Hernton, 1973.158) Hernton describes '*the racism of sex*' in the language of that time, in how 'coloured men and women become the objects onto which all kinds of sexual derangements of the culture, as well as those of individual whites, are projected.' (Hernton, 1973.12) Nearly thirty years later, despite the efforts of many to implement equal opportunities into being an integral part of society, this may still hold true. Agoro (1998.16) seems to illustrate the continuing relevance of Hernton's concepts when he talks of black people manifesting internalised racism and 'acting out of white stereotypes of blackness' the 'black stud/black whore ... black mama /superwoman.'

Therefore any psychosexual work, but in particular the first assessment session, must be able to 'recognise and assess factors relating to racism, intertwined with sexual problems'. (Pigler-Christensen,1998.197) Thomas puts forward the idea of a black child, as early as three years old,

developing protective antennae as a defence mechanism to keep safe from prejudice and racism. He suggests that these children may therefore show 'a proxy or pretend self' somewhat akin to Winnicott's concept of a 'false self', and posits that the professional working with these children 'needs to be keenly attuned...in order to help them through this protective barrier so that real communication can take place.' (Thomas, 1999.22-23) The psychosexual therapist should possibly be encouraged to extend this concept to adult clients who present from an ethnic minority background, and to be aware that 'we need to have an understanding of what the whole unconscious storehouse might contain in relation to blackness...race...and gender.' (Thomas,1999.25) This 'storehouse' may generate cultural typecasting by both or all parties which impedes the relational aspect of the therapeutic encounter.

Assessment sessions might be a way of bridging the cultural gap through taking a very detailed psychosocial history in order to facilitate an understanding of the client's own self construct, in relation to family and the world in general. Equally through asking generalised questions about familial history past and present, and including what type of housing, education, employment, and interests the client has, there may be a normalising of therapy. Most people are used to health and social professionals asking such questions, and by doing the same hopefully some of the fears of therapy being autonomous with mental health problems may be reduced. At the same time it helps the therapist gain an understanding of how the client operates in their world, as well as whether they are suited for the 'talking cure', or might respond better with a more medical and physical intervention. If a healthy man really can not see that there may be any connection between erectile dysfunction and his emotional being,

he may benefit more from Viagra at this point in his life. Equally for some people the idea of undertaking masturbatory exercises may really impinge on their religious views to exclude any non-medical intervention.

Religious and cultural implications

As human beings we live a multiplicity of lives: we are partners, parents, children, friends, colleagues, employers or employees. Our lives will encompass how we think about our environment, our social world, our personal selves and often include our spiritual beliefs, values and philosophy. Our sexuality, whether active or celibate, will be an integral part of our being human. Psychosexual therapists need to be aware of how religion may play an active part. Eleftheriadou posits that clients who are Evangelical Christians or Orthodox Jews may benefit more by working with 'a counsellor who shares their religious beliefs'. (Eleftheriadou, 1994.43) Muslim men may seek help from a psychosexual

therapist, as erectile dysfunction can mean that they are unable to fulfil their marital duty, and premature ejaculation may signify for them the idea of 'wasted seed'. Sungur suggests that 'when religious people attempt to seek help, it indicates that they are strongly motivated to change'. (Sungur, 1999.168) However masturbation is proscribed by Islamic law, so compliance with psychologically motivated treatment strategies may prove difficult, particularly if 'the cause of the problems is attributed to ... the notion of physical causation'. (Sungur, 1999.166) For some such clients this belief leads on to thinking 'that treatment should also be physical' (Sungur, 1999. 166) and referral of such clients to a medic specialising in this area may be the most culturally appropriate and empathic action, although others respond well to psychological intervention and behavioural exercises.

It cannot be over-stressed that any female therapist needs to be very sensitive to this type of client. The very way in which a client sees a therapist alone in a room may carry pejorative cultural implications; it may be the first time that a client has ever been alone with a woman who is not a close family member. It may also be the first time that they have ever talked about sex. When taking a history it may be very important to bear in mind that masturbation may never have been practised, that the client may have very little sex education, and even talking to peers about sex may have been frowned on in his society. Working phenomenologically may be the most appropriate way of trying to ascertain a client's feelings, through inquiry as to how he feels about being asked these questions. It is also important to bear in mind that the client may perceive you as a member of the medical rather than therapeutic world, particularly if he is seeing you in a medical setting such a NHS or private clinic, or in a GP's surgery. My belief that it is always important to check whether they would prefer to see a man, and if this is so, to refer on.

According to Pigler-Christensen (1988.197) 'women from certain ethnic and racial backgrounds seldom present...asking for help'. They may be referred for psychosexual therapy 'when they seek help with concerns around contraception or birth, gynaecological or other medical problems'. The reason for their seeming reluctance may be due to a cultural belief that seeking help outside the family, especially for matters of such intimacy as sexual and relationship issues, may be perceived as shameful, even taboo. In many cases such women will feel happier to see a female therapist, and therefore a male therapist might do well to ask them if this is the case, and to refer them on if so.

Some women, particularly in certain African communities, may have experienced various forms of female circumcision, with the result that some of their problems may also have a very real physical causation.

Some women, particularly in certain African communities, may have

experienced various forms of female circumcision, with the result that some of their problems may also have a very real physical causation. In this case referral for a medical examination, as with any other reported physical problem, is important, unless the therapist is also a medic. There are other issues to consider here in that while a western viewpoint may consider female circumcision as genital and psychological mutilation – fundamentally a form of ritual abuse – the client, despite pain and sexual problems, may not consider it as this, but rather as the lot of women. It may be very difficult to remain congruent with a client by respecting her cultural and personal values in this instance, but in trying to listen to the client's interpretation of what they mean to her, a therapist may find it possible to bracket her own feelings.

Building up trust may take longer with a culturally 'different' client, because in addition to the previously mentioned possibility of feelings of embarrassment and shame at discussing highly private and intimate matters with a stranger, an alien act in itself, there may also be memories of previous negative experiences with other white or eurocentric helping professionals. There may be client fears that their background, with its customs and mores, will not be fully understood or respected by the therapist. I believe that it is important to remember that the therapist can achieve a therapeutic relationship through 'accurate reflection of the client's experience'. (Eleftheriadou, 1994.44-46)

Some clients may prefer a therapist from the majority culture in the belief that talking to someone from their own background would be less appropriate. This may be so particularly if the client is in the process of acculturation, and might wish to talk about her mixed, or even negative feelings towards aspects of her own culture in relation to the new society in which she now seeks to find herself. There may be a hope that a western therapist may be more open and receptive to ideas that clash with a client's traditional value system. It is

A therapist needs to be open to her own society's failings and to accept the adverse aspects of it in relation to people from ethnic and cultural minorities

therefore important that a therapist does not culturally stereotype clients, but is open to the presence of the individual. While it would be impossible to be entirely bias and prejudice free, when working cross-culturally a therapist must use her 'internal supervisor' constantly in order to check out assumptions and her own internalised racism.

A therapist needs to be open to her own society's failings and to accept the adverse aspects of it in relation to people from ethnic and cultural minorities; the racial prejudice that is still endemic, the draconian immigration laws, the difficulties facing many asylum seekers regarding housing, benefits, and other such considerations. A therapist needs to be aware of the impact of trauma being replayed in the guise of the officials from the Home Office, that a policeman may recall memories of torture, or of a relative who 'disappeared'. We need to be wary of

repeating any former abusive practices by being open to our own inner-perpetrator. I also believe that we need to be available for our clients, in the manner of an emotionally present parent who is able to contain the nightmares, the fears and anxieties. Conversely, I believe that while respecting the ever-present inequality of the therapeutic relationship, there is also potential for repairing some of the indignity society can inflict on those who are not indigenous to the UK, or who despite being here for several generations, due to the physical difference of skin, are not treated as though they were.

Conclusion

Working as a psychosexual therapist with ethnic minority clients from a humanistic integrative perspective therefore necessitates constant contact with the therapist's 'internal supervisor'. Phenomenological awareness of what is happening in the room can be enhanced if the therapist has an understanding of the client's social self construct, and belief and value system. It is also important to consider the clients from white ethnic minorities, who may equally suffer from racism, language difficulties, trauma, and isolation, in addition to feeling invisible.

A therapist may feel overwhelmed at times when trying to establish a relationship with a client where the cultural difference feels too wide a divide, so at those times I believe it may be important to remember that we are all linked by the common bond of being human. Our lives are open to potentiality, we all 'represent searching in opposition to finding.' (Jaspers, 1953.42) as we remain constantly in process on our journey.

Further Reading

Agoro, O. (1998). 'Black Therapy Defined: Delusion of Reality' *RACE Multi-Cultural Journal no.18 (pg 16-18).*

Brauner, Rita (2000). 'Embracing Difference: Addressing Race, Culture & Sexuality' (Pink Therapy 3 Ed. Charles Neal & Dominic Davies). Open University Press, UK.

Clay, Jane R. (1963). 'Goodbye America'. *Negro Digest (pg.12).*

Eleftheriadou, Zack (1994). *'Transcultural Counselling'.* Central Book Publishing, UK.

Fernando, Sunan 1991 *'Mental health, Race and Culture'* Macmillan, UK.

Hernton, Calvin C. (1973). *'Sex and Racism'.* Paladin, UK.

Jaspers, Karl (1963). *'General Psychopathology'.* Manchester University Press, UK.

Lago, Colin & Thompson, Joyce. (1996). *'Race, Culture and Counselling'.* Open University Press, UK.

Merleau-Ponty, Maurice. (1962). *'Phenomenology of Perception'.* Routledge, UK.

Panesar, P. (1999). 'Options & Opportunities for Ethnic Minority Young People' *RACE Multi-Cultural Journal no.19 (pg.9-1.2).*

Pigler-Christensen, Carole. (1988). 'Issues in Sex Therapy with Ethnic and Racial Minority Women' (*Women & Sex Therapy.* Ed. E.Cole & E.D. Rothblum) Harrington Park Press, USA.

Sungur, Mehmet Z. (1999). 'Cultural Factors in Sex Therapy: the Turkish Experience' *Sexual & Marital Therapy,* Vol.14 No.2).

Williams, Patricia J. (1997). 'The Emperor's New Clothes' *RACE Multi-Cultural Journal No.15 (pg.17-19)*

Sarah Collings MAHPP, is a qualified and accredited psychosexual & relationship therapist as well as working as a humanistic-integrative psychotherapist, counsellor and supervisor. She works in private practice, a GP surgery, and with a voluntary counselling organisation in West London. Until April 2001 Sarah worked in a dedicated psychosexual NHS clinic. At present Sarah is on the Middlesex University doctoral programme at Metanoia Institute.