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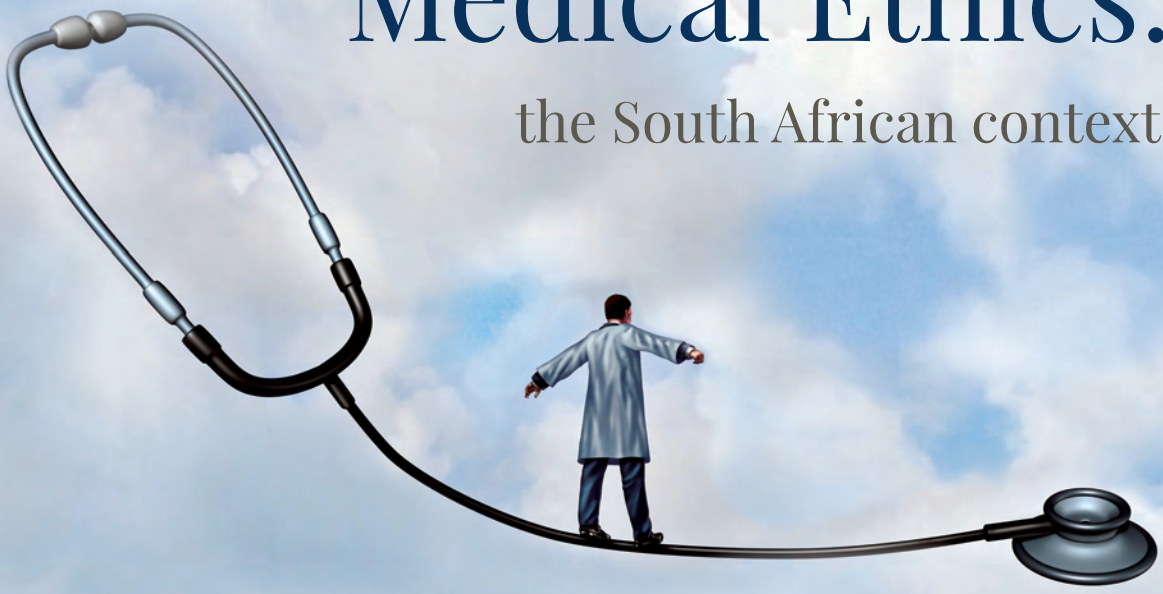
Challenges in Medical Ethics:

the South African context



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8

The Ethics of Mental Health Service Delivery in a Multicultural Setting

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Keywords: cultural competence; culture; ethics; language; logic; multiculturalism; psychology; psychotherapy

8.1 INTRODUCTION

The problems posed by multiculturalism are typically encountered and discussed in the political sphere. However, the harm pertinent to multicultural situations is primarily psychological in nature (which in no way diminishes such harm) and the inequalities that authors such as Will Kymlicka (1989:175) highlight are the result of expending energy and resources to avoid psychological harm. As such, it would be worth investigating to what extent the political dilemmas of multiculturalism translate to obligations/responsibilities of practitioners, particularly in mental health service delivery. In this chapter we discuss some of these obligations, all of which can be summarised under the heading of cultural competence. Cultural competence, however, comes in many shapes and sizes. We will discuss cultural competence in terms of: (1) the obligations of larger structures, including policymakers, educators, and selectors to create structures for cultural equality; and (2) the obligations of practitioners and theorists to practice an approach characterised by (a) an awareness of the cultural conditioning involved in their existing models and (b) a willingness to understand models with different cultural origins as if from the inside, and not as so-called neutral observers. In this regard, we also pay special attention to criticisms aimed at the scientific method as practiced by mainstream or 'Western' psychology.

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The various challenges will be discussed with reference only to the Rules of Conduct Pertaining Specifically to the Profession of Psychology, henceforth refer to as the Rules of Conduct (RSA DoH, 2004:15-47), but the pertinent sections are present in other codes as well, such as the Ethical guidelines for Good Practice in Health Care Professions (HPCSA, 2008).

8.2 DEFINITION OF CULTURE

To gain a conceptual grasp on the challenges of mental health in a multicultural setting, the concept of culture requires a sharper definition. Culture is defined here as a system that is constituted by the communicative relationships between people. Communicative relationships are therefore the elements of the cultural system. In turn, a communicative relationship between two people may simply be defined as the pattern of agreement and disagreement between them, or put differently, which meanings they share and which they do not. These communicative relationships shape the way people process meanings (and are in turn shaped by the meanings people continually process). Because they play a part in our processing of meaning, they are involved in how we fundamentally make sense of the world. They therefore make significant contributions to the norms and values we hold.

It is important to note that, so far, our definition of culture requires us to think of it as a broad and amorphous system that is shared (in principle) by all of humanity (and one could plausibly claim that there is strictly speaking only one 'culture' as opposed to various different 'cultures'). Conversely, the communicative relationships that any given person has been embedded in during his lifetime is unique to that person (so that one could plausibly claim that there are as many 'cultures' as there are people). This poses a problem, as it is exactly this idea of 'cultures' as discrete entities or groups of people that is referred to in the Rules of Conduct (RSA DoH, 2004:15-47).

This problem can be solved if we conceive of distinct cultures as being delineated by historical conflicts (Niemand, 2015:255).[1] In multicultural society, we see that the minority groups or, more pertinent to the South African context, previously disadvantaged groups, ceded their sovereignty involuntarily, through conquest or colonisation. These conflicts create a delineation between the conquerors and the conquered, so that a definition of the group can take the form of 'those people who were forced to cede sovereignty' in various conflicts, avoiding formulations

1 The notion of delineation through conflict relies to some extent on Henri Tajfel's Social Identity Theory, which has considerable empirical, experimental support (Tajfel, Billig, Bundy & Flament, 1971:149; Diehl, 1990:263, 292; Tajfel, 1982:39).

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that require that they share certain characteristics. In this regard, one can also think of various 'colonisations' and conquests, a group need not have been involved in only one conflict and could also have been the conqueror in some of them.

The *internal* disunities between the group's members prior to that moment of conflict do not disappear but are moved thoroughly to the background. One could compare this to the respective supporters of two opposing *provincial* sport teams defining themselves in terms of their common *national* team when the contest is with an international competitor. Furthermore, unlike the sports allegory we just used, societal conflicts have long-term or even permanent effects when they continue to maintain the conquered group's marginalisation, thereby arresting an otherwise fluid and dynamic group identification. As such, defining cultures in terms of historical conflicts allows delineation of the culture without needing to claim a common essence that characterises the whole culture or all of its members.

Assuming such homogeneity is, of course, inaccurate. A wide variety of different beliefs, values, and practices may occur inside a so-called culture. Nevertheless, the delineation via historical conflict allows one to think of cultural differences as occurring where two people or two parties differ; where the difference appears to be related to the different communicative relationships they have been imbedded in, and the difference is characterised by originating from opposing sides of a historical conflict to which cultural difference is a shorthand reference.

8.3 MULTICULTURAL ISSUES

The aforementioned conflicts also plot the landscape of what we would refer to as multicultural or intercultural issues. The first relates to multicultural or intercultural inequalities. These issues can be characterised by concerns or conflicts about the fair distribution of goods. Where the members of the dominant culture can pursue their goals without needing to expend any energy or resources to maintain that culture, members of a previously disadvantaged culture have to expend effort and resources to maintain their culture, leaving them little energy or few resources to pursue the life goals they would want to (cf. Kymlicka, 1989:189). They are thus disadvantaged, not as a result of their choices, but as a result of something they had no control over, e.g., having been born into that culture. Furthermore, if members from a previously disadvantaged culture then choose to relinquish their culture, and assimilate into the dominant culture, this comes at an expense, at least of energy and resources and at worst at the loss of an important attachment, as Kymlicka argues (1989:175). The examples we discuss below of what we term 'simple multicultural issues' mainly pertain to addressing these inequalities.

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A second pertinent aspect of multicultural issues relates to the imposition of Western values or norms onto other cultures. In political matters, this leads to particularly tricky dilemmas, due to the question whether the liberal response to cultural differences may in itself represent Western norms that are unfairly applied to other cultures. Accordingly, the neutrality of the public sphere becomes a problematic notion in multicultural affairs (Niemand, 2013:23-32).

In the field of mental health, the problem is not so much with classical liberal ideas such as those pertaining to tolerance, procedural rights, and autonomy. Rather, the imposition would be in the form of Western theories imposing their world view on patients from other cultures. Psychology as a discipline fundamentally deals with meanings. All the phenomena we usually term 'psychological' can be understood in terms of meaning. For instance, all our thoughts about the world carry with them the relevance these facts may have in our lives. The same is true of our experience of emotions. Emotions are always already *interpreted* emotion. If not, they are merely instinctive, bodily reactions. Furthermore, emotions serve to orientate us in the world, they prime us for what we need to do next and as such, they are answers to the question of meaning (Niemand, 2013:84). In dealing with meanings, as opposed to objective fact (in as much as that is ever possible), psychological theories would always reflect, or be suspected of reflecting, the cultural background or their authors'. As such, they may not be applicable to people of other cultures.

One may object that this may not represent such a tricky dilemma. One can for instance say: "let us be careful to validate our theories on other cultures before we assume them to be universally valid." However, the problem potentially runs deeper. Some critics we discuss below even reject the very method of studying psychological phenomena, including such fundamental notions as requiring theories to be based on empirical evidence and avoiding metaphysical explanations for (psychological) phenomena. With these criticisms, we arrive at an impasse similar to the ones we encounter in political matters.

It is important to note that in these multicultural issues, some values, beliefs, principles, and practices two parties may disagree on are so basic that they are to be considered *axiomatic*. They cannot be proven by reason or science, because they are the suppositions from which we reason and that underlie our scientific endeavours. They themselves cannot be proven; we can only believe in them. This means that any two people could have been embedded in communicative relationships that are so different that they have differences that are axiomatic and upon which they cannot agree, despite their utmost willingness and ability to reason.

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In this regard, the challenges we outline below may be divided into two types of problems. The first we will call simple multicultural challenges, which do not pose difficult theoretical conundrums and do not represent any real clash between different sets of values. Rather, the differences at play represent the unfamiliarity that different cultures may have with regard to each other. Furthermore, they may also pertain to certain intercultural inequalities, created by the historical conflicts that simultaneously served to delineate the cultures in question. Though these problems may not involve insurmountable or axiomatic differences, they are nonetheless very important to address. They set goals that may be very difficult to achieve practically and would also require the political will to take multiculturalism seriously.

The second type of problem we will call complex multicultural problems. In these cases, axiomatic differences may be at play, where no neutral Archimedean point is possible. We will address these below.

We discuss these different types of problems with reference to the Rules of Conduct (RSA DoH, 2004:15-47). Furthermore, the rules we discuss may all be regarded as extensions of a master requirement, in Rule 12 (RSA DoH, 2004:20), that prohibits unfair discrimination based on race, gender, and religious belief. Discrimination based on cultural beliefs is also not allowed and the practitioner may not force his opinions/beliefs on the patient.

8.3.1 Language and multiculturalism

According to rule 9 of the Rules of Conduct (RSA DoH, 2004:18), practitioners are to make sure that, where language is an issue, suitable interpreters are used. These should be suitably qualified, maintain confidentiality, and should not be in multiple relationships with the patient. The content of this rule does not appear problematic at first glance. However, it glosses over an important challenge for intercultural fairness we face due to the linguistic landscape of the country. We face an important question: how do we assure non-discrimination based on linguistic background in the delivery of mental health services? Rule 9 stipulates requirements for the use of interpreters, but anyone who has ever been in a psychotherapy session requiring an interpreter would attest to the extreme frustration involved in the process. Sessions such as these are at best suboptimal in quality. In this regard, the more general stipulation in rule 12(3) (RSA DoH, 2004:20), which requires appropriate services to be made available and appropriate standards of language proficiency to be met, is more suitable.

Psychotherapy requires a human response when revealing, for example, an intimate fear. Revealing an intimate fear and then having to wait to see your therapist's

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response, diminishes the human quality of the interaction.[2] Building rapport and containing emotions require interaction, uninterrupted, even when some pauses may be tense.

The optimal solution to the challenges posed by the reality of language differences in South Africa lies with greater linguistic competence among mental health practitioners. We need therapists who can speak to their patients in their mother tongue, be able to do so fluently, and be able to convey sometimes quite complex ideas in that language. While some patients may be able to express themselves in their second language, nevertheless, one's most intimate thoughts and feelings often require the safety of one's mother tongue.

In this context, therapists who are practically monolingual are simply not acceptable. This would mean that the roughly 10% of English mother tongue speakers in the country have full access to therapy in their first language, while the remainder of the population, the majority of which would be considered previously disadvantaged, do not. This situation clearly represents an unfair distribution of goods, and the skew distribution is based entirely on the language group a person has been born into. This clearly does not pass the test of non-discrimination. Accordingly, the selection of monolingual therapists is already an act of discrimination perpetrated by selection panels. Conversely, bilingual or multilingual abilities should be considered an *operational requirement*, not just a nice-to-have. Likewise, therapists posted in areas where the population is predominantly non-English speaking should be required to be fluent in at least the dominant language of that region. Moreover, if certain linguistic groups are found to be underrepresented in the pool from which selected, progressive steps need to be taken to correct the under-representation.

8.4 CULTURALLY FAIR ASSESSMENTS

Next, we turn to rule 48 (RSA DoH, 2004:31). This rule pertains to the administration of culturally fair assessments. Practitioners are to make sure that assessment methods are valid and reliable for the designated population and should make sure that the assessments used are culturally fair. As with the case of language differences discussed above, the contravention of this rule is a clear case of discrimination and poses no theoretical dilemma.

2 Many people have by now experienced something similar to this due to the Covid-19 pandemic and concomitant lockdown regulations, where psychotherapy sessions are conducted online with poor Wi-Fi connections. The same lack of fluency described above applies here.

https://doi.org/10.52779/9781991201959/08

Accordingly, personality tests should at least be validated on local populations. Ideally, local personality tests should be developed from the ground up using local data (as opposed to using international, possibly Western concepts and dichotomies that may not apply to the local populations.) In this regard, recent developments in the South African Personality Inventory are promising, but also indicate that full cultural validation has not yet been achieved (Hill, Hlahleni & Legodi, 2021).

Aptitude and cognitive tests should naturally be available in all local languages. Moreover, certain items and subtests of existing tests can be considered unfair as they rely on background knowledge a person not born into Western culture may not have. The true aim of these assessments should be to assess intellectual capacity, not cultural knowledge. Intellectual capacity, in turn, should be thought of as the ability to master cognitive tasks on exposure to them. Maintaining a cultural disadvantage would have the effect of excluding intellectual gifted, potentially good candidates from competition for no reason other than the cultural group they were born into. This is the opposite of meritocracy and clearly a form of discrimination. In this regard, learning potential assessments such as the APIL ([Conceptual] Ability, Processing of Information, and Learning), TRAM-2 and TRAM-1 (Transfer, Automatisation, and Memory) appear to hold promise in that they purposefully avoid measuring already acquired knowledge, which may be cultural in origin (Taylor, 2013:166-168).

While the challenges outlined above do not pose particularly thorny theoretical dilemmas, they nonetheless pose practical challenges. Consequently, because they are difficult to achieve in practice, they result in dilemmas on ground level. How does one, for instance, do an assessment if, perhaps due to lack of resources, the required culture fair assessment is not available, or the necessary linguistic capacities are not present? In the case of assessments, one may consider not administering the assessment at all, as the results may simply not be valid. In contrast, practising psychotherapy in suboptimal linguistic conditions may be necessary. In this regard, one may spare a thought for the under-resourced practitioner, who, most often through no fault of their own, may be required to render suboptimal services. The true failing in such cases lie not with the practitioner, but with the larger structures that shape mental health service delivery in South Africa.

8.5 DIAGNOSIS

Diagnosis is complex in multicultural environments due to the fact that the practitioner must be able to discern between (a) universal pathology that is just expressed differently – e.g., somatisation of depression in certain societies (cf.

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Swartz, 1998:121-139), (b) culture specific illnesses, and (c) normal cultural practices. Of course, the correct diagnosis has a very important bearing on treatment. Moreover, especially in serious cases, the practitioner's assessment can lead to suspend the person's right to autonomy (e.g., in cases of involuntary admission), which the practitioner will need to justify.

Now, part of the problem is already adequately covered by the Rules of Conduct's prescription against cultural discrimination (RSA DoH, 2004:20) and training on cultural illnesses is already part of most curricula. However, this does not yet go far enough. Recall from our earlier definition of culture that it resists any essentialist definitions. This means that our competence needs to be practised in *particular cases*. The practitioner can expand his ability with knowledge from comparative studies, but, crucially, these rely on the construct of 'cultures' that does not do justice to the full diversity one might possibly find in practice. This requires one to choose a *hermeneutical approach* as supplement to one's existing knowledge. This means that one has to justify one's diagnosis based on existing knowledge and supplement it with considering what the symptoms/signs would *mean* for this *particular* person, within his/her *particular* background.

8.6 BEST PRACTICE

Where the previous rules we discussed may by typified as simple (but nonetheless challenging) multicultural problems, the issue of best practice has aspects to it that are decidedly complex. Where issues around diagnosis may still be regarded as simple (but difficult) problems, requiring great competence in cultural matters, the questions around treatment introduce some complex issues.

The concept of best practice has been intimately connected with evidence-based treatment and more specifically to quantitative empirical studies. What complicates the matter is the centrality of meaning in psychology, as discussed above. While other fields medicine can agree on, for instance, a virus under the microscope, even while justifiably situating their fields within biopsychosocial model, the problem to be addressed in psychotherapy cannot be conceptualised at all without reference to some idea of the good life or some orientations to the world. Moreover, the value system thus constituted to understand and address problems in psychology is culturally conditioned. It has been arrived at via the communicative relationships within which the authors of the various theories are situated. Likewise, within any practitioner's cultural framework, their clinical judgement about whether some behaviour is interpretable, that is, whether it constitutes a sign of some underlying pathology, may be culturally conditioned.

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What is considered assertive from one vantage point may be considered aggressive, even anti-social, from another. Even fundamental concepts, like psyche, are not free from cultural conditioning. For instance, Baloyi and Ramose (2016) argue for the use of the term *moya* instead of *psyche* when creating African theories of psychology. They also show convincingly what is lost in translation between the two terms.

What is the psychological damage caused by being incorrectly pathologised? Incorrect judgements such as these can most accurately be understood as a form of violence because they are not supported by evidence and reason, but represent the suppositions from which evidence was gathered, and from which deductions and inferences are made. They are judgements that therefore are not strictly speaking rational, that need to be *enforced* either by convention, tradition, or the authority bestowed upon a medical professional. Furthermore, it goes without saying that patients in a mental health service setting tend to be emotionally vulnerable and a message conveying that certain thoughts and behaviours are signs of insanity (to put it harshly) – while they themselves have not been convinced properly of this judgement – can cause considerable emotional distress and may have a lasting impact on their self-image. Given the power dynamic between a professional and lay person, a professional opinion may be especially damaging, as it tends to be harder to shrug off as 'just someone's opinion'.

It is for this reason that the inappropriate application of Western concepts may be regarded as offensive. Moreover, one should be wary of generalising from gold-standard treatment efficacy studies. They still only present evidence that a certain treatment does well on average, compared either to other treatments or to placebos. It simply does not follow that such treatments are universally applicable to all mental health patients in all situations.

Once again, as with linguistic capacity and culturally fair assessments, practitioners can become more skilled in adopting an approach in which they collaborate with their patients and humbly gain understanding from an initial point of ignorance, instead of going in guns blazing, armed with their existing conceptual framework. Yet, the aforementioned ignorance can of course never be a blank slate. Practitioners have been trained in models that explain, at least to some extent, human behaviour and psychopathology. In this regard, the skill required would involve being well versed in as many models as possible (for no model offers a complete understanding of the human condition) and to be open to the possibility that the patient may introduce new perspectives that may require the practitioner to adapt and/or refute some of their current understandings of psychology.

https://doi.org/10.52779/9781991201959/08

It is worth noting that not all psychotherapy necessarily requires confrontations about conceptual *content*. On the contrary, many psychotherapy approaches can be of great benefit in addressing the problems with *form* of thought, such as over-generalisations, attribution errors, miscounting positive evidence, etc. Furthermore, many behavioural approaches also aim to address operant and classical conditioning that led to distress or psychopathology, and therefore avoid to a large extent the biases associated with ideas, beliefs, values, and norms that could be culturally conditioned. Therefore, in practice, cross cultural psychotherapy is less of an intercultural conflict than one might expect, notwithstanding that there are pitfalls that are to be avoided, as discussed above.

A theoretically interesting, but perhaps practically less pertinent question, is whether the openness and collaborative approach required from a practitioner in a multicultural setting itself represents a Western norm that is being imposed on patients from other cultures. We would argue that, if it is indeed Western in origin, it nevertheless does not represent an imposition. A value like openness, when practised in a situation, may threaten other values, but has the benefit of doing so not by use of force, but by being convincing. It therefore represents an exit possibility. An exit possibility in multicultural settings refers to arranging the situation in such a way that members of a cultural group can freely relinquish a cultural value, so that, if they continue to adhere to that value, they do so not due to force, but due to conviction (Niemand, 2013:191). Put differently, being exposed to openness does not force anyone to become a convert to Western values.

Perhaps a more difficult problem arises when critics of Western psychology take issue with the scientific method it uses in studying psychological phenomena. Nwoye (2015) for instance, takes issue with Western psychology's insistence on using only empirical evidence in its theories. Likewise, she argues that the Aristotelian logic typically employed in Western thought, where a statement is either true or false, with no third option, excludes other possible logics, where contradictions are more acceptable. She argues that "under the Aristotelian binary logic of the excluded middle, one is either tall or short; and not tall AND short at the same time" and that "we can call somebody 'mom' even-though she is not directly our mom but is related to our mom or plays the role of mom in our lives" (Nwoye, 2015:108). Similarly, Adésínà (2002) argues for the use of Ti'bi-t'ire logic, where contradictory forces are allowed to cohere and where these are understood to already have their contradictions embedded in them.

If these criticisms hold, they represent a deeper problem than merely navigating different conceptual frameworks. Rather, they would explode any notion of common preconceptions and rules of engagement by which consensus about

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an argument or a state of affairs may be achieved. We do not, however, think these criticisms are fully tenable. Firstly, the inclusion of evidence other than empirical evidence is problematic. We would agree that metaphysics may be valuable, perhaps even indispensable in providing *meaning* to phenomena, and as such, *understanding* a patient may very well require one to understand their metaphysical framework. However, when *researchers* use metaphysics to *explain* behaviour or other psychological phenomena (e.g., "this mystical force caused him to do x"), it becomes problematic. What happens in a case where two people do not share the same metaphysical conceptions? Can only researchers who share the metaphysics of those they study be engaged in a psychology of those people? If so, to what extent can one still call it science? We would argue that the possibility of criticism and refutation is central to the scientific endeavour, and as such, being able to confirm or disconfirm something is crucial to the scientific process. Likewise, theory must go further than tradition – as valuable as tradition may be in terms of providing insight into the human condition – in that it should be able to revise, question, and even refute some of what is held in that tradition.

As is often the case with multicultural matters, the manner or process in which something is refuted is important. For instance, the Freudian approach to religions[3] is condescending and offensive, mainly because it does not take religion seriously *ab initio* and consequently forces its concepts onto something that is not understood from the inside. This is similar to an anthropologist simply judging a different society from their own colonial perspective. In contrast, when the revision comes from *within* the perspective of another culture, taking experiences and concepts seriously and then proceeding from there, the revisions are less easily dismissed as condescending and arrogant.

We therefore hold that psychologists and theorists in the field should not be dismissive of others' beliefs. Moreover, these beliefs should not be rejected as irrational and indiscriminately (and often condescendingly) be reduced to materialist explanations. However, one can take such beliefs seriously *and* study empirically the results of those beliefs among people. Put differently, while the objects of belief may not be accessible to empirical study, these beliefs are held by certain people and the role those beliefs play, among other things in providing meaning to those who hold them, are phenomena that are empirically observable. Furthermore, given the cultural conditioning inherent in psychological theorising and the clear overrepresentation of European and Anglo-American theorists in

3 In these examples, religion is also considered cultural. This does not represent a reductionist view of religion. However, the aspect of religion pertinent to a conflict is that which it shares with culture. In this regard, it is a system of beliefs and concepts that to some extent demands collective observance and action (Niemand, 2013:13).

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mainstream curricula, calls for representation of a wider variety of theorists are clearly justified.

The second type of criticism, aimed at Aristotelian logic, is not tenable. Firstly, the examples Nwoye (2015) mentions do not pose a serious challenge to the excluded middle, as is alleged. To say that John is tall (with the added context: "for a 9-year-old") and saying John is not tall (with the added context: "for a rugby player") clearly does not constitute a contradiction and in a real-world situation, the context would clearly be added if one ever needed to *argue from that premise*. Likewise, that somebody can be both a mother and an aunt to the same person can easily be non-contradictory, if one admits varying definitions of motherhood. If the definition is stricter, e.g., the person who was pregnant with you and who raised you after birth, the aunt is clearly excluded. Furthermore, in cases where a continuum between two poles exists, another logic complementary to Aristotelian logic (e.g., fuzzy logic) exists and implicitly assumes that contradiction is not allowed (cf. Pelletier, 2004). If contradictions were allowed, it would render the logic worthless, as one would not be able to move forward and make inferences from premises, given that any conclusion, even a flat-out contradiction, is permitted. In making an argument with concepts that have degrees, one would, for instance, need to be able to say definitively that x is taller than y.

Furthermore, Adésínà (2002), in arguing for the use of Ti'bi-t'ire logic, where contradictions cohere and statements have their opposites embedded in them, then goes to great lengths to position this type of logic as the opposite of Aristotelian logic, the former being valid while the latter is not. This of course at once confirms and refutes his argument. However, we would argue that the opposition of the two (and the paradox it creates) is already unnecessary. The two modes of thinking are clearly complementary, and the full weight and clarity of insight gained by understanding how contradictory concepts are embedded in each other is only fully understood on the basis of understanding their binary opposition.

In other examples of logics that permit other options beyond a statement being true or false, such as the tetralemma in Buddhist thought, the concepts involved all aim to denote the ineffable, a limit of thought as it were.[4] These concepts are perhaps best elucidated by poetry, symbolism and/or ritual, and the result of engagement in these activities is not *knowledge* but *meaning*. In sum, for all except the ineffable concepts, rules exist to which all interlocutors can agree,

4 Being confronted with a limit of thought may in turn be very valuable in psychotherapy. It may for instance, signify that the patient is asking the wrong type of questions, barking up the wrong tree, so to speak. It is useful in this manner precisely because it does not permit an argument to proceed from there onwards.

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and those from different cultural background need not withdraw themselves into windowless monads from which no dialogue is possible. The aim of such a dialogue would indeed be to widen the array of perspectives involved in our growing understanding of psychological phenomena. The criticisms often laid against Western perspectives, e.g., that they are not holistic enough or that they do not give enough weight to context (Nwoye, 2015), should all be taken seriously and should be addressed by gathering evidence from a wider variety of sources and making sound inferences from these findings, not by discarding logic and evidence in one fell swoop.

The possibility of *dialogue* has interesting implications for psychotherapy in a multicultural situation. Given that dialogue does not equate with either a mere repetition of traditional understanding, or a simple imposition of existing models on new phenomena and given that any meaningful dialogue (with the possibility of transcending existing understandings of phenomena) would always require some difference in perspectives, we suggest that a true blank slate for practitioners is not simply unattainable, but a logical impossibility. Some threat to the patient's cultural perspective is always present. Unlike the case of simple multicultural problems, which at least have a more or less objective end state to be striven for, which is at least achievable in theory, the dilemma attached to best practice does not have a satisfactory end state. Instead of being obligated to solve this problem, the obligation that rests with practitioners lies in their attitude, in the manner in which they approach these matters.

8.6.1 Children: An added complication

The case of treatment for children adds further complexity to the above dilemma. In the case of treatment for adults, their consent acts as a type of escape from what the patient may perceive as a discriminatory or offensive practice. This means that continuing something like psychotherapy is also tacit consent for the difficult process of putting one's cultural framework – indeed many of one's central meanings – on the table, with the risk of having to let go of some of it. However, as we argued above, the therapeutic setting does represent an imbalance of power and as such consent is not always as perfectly free as one would like. Evening out this power balance requires some innovative thinking. Perhaps one option would be to have more traditional options available to the patient, to which they can escape without foregoing treatment altogether.

However difficult it would be to achieve a free consent with an adult patient, the case becomes markedly more difficult with children. In cases with minors, their assent is sought, as well as the consent of the parents, and yet South African law requires practitioners to act in the best interest of the child and not allow cultural

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norms to interfere with what would be the best interest (RSA, 2005). How would the best interest be determined? By existing scientific knowledge. And so, we return to the above dilemma, only this time, parents would not technically be able to withdraw their consent if, e.g., non-treatment is not in the best interest of the child.

8.7 PROCESS MODEL OF JUSTIFICATION

The great difficulty with a multicultural setting is that it casts profound doubt on any form of alleged neutral or objective judgement, especially in matters where meaning is involved. As argued above, practitioners and theorists may not be able to achieve such neutrality in mental health service delivery. Instead, they would have to justify their judgement on the process by which they arrived at it. How would such a process look? The practitioner/theorist would need to display self-reflectivity: they would need to show that they have reflected on their own background and how it may colour their perceptions of a case. They would also need to try actively to understand the other culture's values from *within* and not as if they are a neutral observer, studying rituals in a far-off tribe as if it were a lab experiment. If the practitioner then, after this process of self-reference, still holds their view, it has the character of an authentic decision: they have not followed their cultural background blindly, but have argued from axiomatic fundamentals, knowing that they could be wrong, but believing, as a leap of faith, that they hold those fundamentals true not because they were culturally socialised into it, but because it does in fact represent a valuable idea.

While not escaping the charges of discrimination, decisions that have a self-referential quality serve to diminish the offence. Where enforcing one's culture on others implies an arrogant approach, which constitutes most of the offence caused by ethnocentrism, self-referential decisions represent an authentic response. We would argue that this serves to draw attention away from a response's cultural origin and may instead draw attention to the claim regarding the value of an idea, regardless of its cultural origin. This is the basis upon which dialogue can continue with the aim of a mutual understanding. One may point out, of course, that this process could also be construed as carrying certain values/norms. This is a valid point. We would point out, however, that rejecting it simply due to its origin does very little to advance dialogue. One may, of course, reject it on other grounds, which would be a very valuable conversation in search of the optimal way to deal with differences in norms. However, such criticism would be aimed at the ideas, not their origin.

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8.8 CONCLUSION

In this chapter, we have set out some of the obligations of institutions like the Department of Health, training institutions, selection panels, as well as the obligations of practitioners and academics. The progressive equality to be striven for, particularly by larger structures, represents a solution to simple (but practically difficult to achieve) multicultural problems. In contrast, the freedom from bias that is to be achieved, particularly by practitioners and academics, is a logical impossibility. The obligation that rests with practitioners and academics lies in their attitude, in the process in which they approach these matters.

In both the simple and complex cases, what lies at the heart of cultural competence is a healthy doubt, by politicians, academics, and practitioners alike, of anything that appears to be neutral. It is through this healthy doubt that dialogue becomes possible and a retreat to impenetrable laagers avoided.

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Bibliography

Adésínà, J.O. 2002. Sociology and Yorùbá studies: epistemic intervention or doing sociologyin the 'vernacular'? *African Sociological Review*, 6(1):91-114. https://doi.org/10.4314/asr.v6i1.23204

Baloyi, L. & Ramose, M. 2016. Psychology and psychotherapy redefined from the viewpoint of the African experience. *Alternation Journal*, 18:12-35. https://bit.ly/3Vjsgh8

Diehl, M. 1990. The minimal group paradigm: theoretical explanations and empirical findings. *European Review of Social Psychology*, 1:263-292. https://doi.org/10.1080/14792779108401864

Hill, C., Hlahleni, M. & Legodi, L. 2021. Validating indigenous versions of the South African Personality Inventory. *Frontiers in Psychology*, 20 May:1-13. https://doi.org/10.3389/fpsyg.2021.556565

HPCSA (Health Professions Council of South Africa). 2008. *Ethical guidelines for good practice in the health care professions*. Pretoria: HPCSA. https://bit.ly/3U2M0V2 [Accessed 5 May 2022].

Kymlicka, W. 1989. *Liberalism, community and culture*. Oxford: Clarendon Press.

Niemand, J.R. 2013. The autonomy of culture: a cultural-philosophical analysis. PhD thesis. Stellenbosch: Stellenbosch University.

Niemand, J.R. 2015. 'Cultures' and cultural protection. *Human Affairs*, 25:251-260. https://doi.org/10.1515/humaff-2015-0021

Nwoye, A. 2015. What is African Psychology the psychology of? *Theory & Psychology*, 25(1):96-116. https://doi.org/10.1177/0959354314565116

Pelletier, F.J. 2004. On some alleged misconceptions about fuzzy logic. *Artificial Intelligence Review*, 22:71-82. https://doi.org/10.1023/B:AIRE.0000044308.48654.c1

RSA (Republic of South Africa). 1996. *Constitution of the Republic of South Africa*. Pretoria: Government Printing Works.

RSA (Republic of South Africa). 2005. *Children's Act 38 of 2005*. Pretoria: Government Printing Works.

RSA DoH (Republic of South Africa. Department of Health). 2006. Rules of conduct pertaining specifically to the profession of psychology. *Government Gazette*, No. 29079 of 4 August. https://bit.ly/3ia2ihW

Swartz, L. 1998. *Culture and mental health: A southern African view*. Oxford: Oxford University Press. https://doi.org/10.4102/hsag.v4i1.7

Tajfel, H. 1982. Social psychology of intergroup relations. *Annual Review of Social Psychology*, 33:1-39. https://doi.org/10.1146/annurev.ps.33.020182.000245

Tajfel, H., Billig, M., Bundy, R.P. & Flament, C. 1971. Social categorisation and intergroup behaviour. *European Journal of Social Psychology*, 1:149-177. https://doi.org/10.1002/ejsp.2420010202

Taylor, T. 2013. APIL and TRAM learning potential assessment instruments. In: S. Laher, K. Cockcroft, Z. Amod, K. Bain, F. Bhabha, M. Brink, et al. *Psychological assessment in South Africa: research and applications*. Johannesburg: Wits University Press. 158-168. https://doi.org/10.18772/22013015782.16

https://doi.org/10.52779/9781991201959/08