Provision Of Empathy: Challenges Experienced By Psychotherapists In Cross-cultural Dyads

A Hermeneutic Literature Review

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Abstract

In relational and other humanistic psychotherapies, empathy is an integral part of the therapeutic relationship. Through the experience of empathy, clients gain insight into conscious and unconscious processes regarding self-perception, behaviours, and ways of relating with others. Therapists' provision of empathy strengthens the therapeutic relationship, building trust and improving positive outcomes for clients. Studies in human behaviour show that empathy is easier with people who share similar cultural beliefs, values, and worldviews. This hermeneutic literature review explores how therapists' cultural identities and worldview may affect the provision of empathy when working with clients from cultures with different worldviews. The findings show that empathy is defined, understood, and expressed differently across cultures and from differing worldview perspectives. Therapists are encouraged to understand their own cultural identities and worldview and to reflect on how this may affect their provision of empathy in clinical practice.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Madhu Chandra
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Chapter One - Introduction

Mark Twain observed that we only get to know and understand a mere fraction of a person's inner life and that much is hidden, through unconscious and conscious processes not only from themselves but also from others (Twain, 2010). In psychotherapy this may emerge in the form of defenses, transference, countertransference and behavioural patterns. When the therapist and client (dyad) have differing cultural beliefs and worldviews, can the therapist's empathy reach a close approximation of how the client experiences themselves? Can the therapist go beyond their own worldview to gain the perspective of the client? This dissertation is a hermeneutic literature review exploring the research question "What challenges do psychotherapists experience in the provision of empathy in cross-cultural dyads?"

In this chapter I describe my rationale for this research, then offer a preview of literature explaining the significance of empathy in psychotherapy, followed by definitions of the key terms related to the question, ending with an overview of the remaining chapters.

Rationale for this Research

Throughout my training as a psychotherapist, the topics of empathy and culture have been with me, albeit until recently quite unconsciously. Whilst writing an assignment on the cultural implications of working with Māori clients, I realised how complex and multi-layered culture is and how easy it can be to stereotype someone based on their ethnicity, race, and gender (to be inclusive of all genders I use the adjectives "them/their" instead of "he/she" or "his/her"). Furthermore, during my clinical training with a public mental health provider in Auckland, Aotearoa New Zealand, I noticed that most clients were from dominant, Pākehā (New Zealanders of European descent) ethnicities while very few clients were from minority ethnic groups. The main models of therapy used were Western based and included Dialectical Behaviour Therapy (DBT), Mentalisation Based Therapy (MBT), art therapy, and interpersonal therapy. I wondered if the models and treatments failed to resonate with people who may prefer holistic treatments. Finally, my psychotherapy training involved predominantly European and American psychodynamic and psychoanalytical theories and models which I sometimes struggled to resonate with, as they seemed reductionist and did not consider the whole person as a mind-body-spiritual being. When I was introduced to indigenous Māori models of hauora (wellbeing) and te ao Māori (Māori worldview), I felt immediate affinity towards their holistic approach to mental health. One such model

developed by Mason Durie (2011) called “Te Whare Tapa Wha” (p. 29) is applied within Aotearoa New Zealand’s public health system to treat Māori clients. Predominant Māori health values and concepts illustrate that illness is a result of a combination of mental, physical, spiritual, and environmental factors, therefore an integrated approach towards mind, body, spirit is incorporated into treating mental illness regardless of whether the symptoms are psychological or physical (Wratten-Stone, 2016). The client is considered part of a larger system therefore it is usual for family and members of the client’s community to be involved in the healing process (Edwards et al., 2007).

I began to explore my cultural beliefs and worldview, especially my understanding of empathy and how this impacted on my clinical practice. Empathy felt challenging as I engaged with clients from a wide range of cultural backgrounds. Being a non-white, Indian, female, and lesbian, I encounter many cross-cultural situations, where at times my world and that of my client appear very different. I notice that the empathy I have for clients differs in quality with each individual. I experience deeper and sustained empathy with some clients yet infrequently and inconsistently with others. At times I feel unable to empathise at all, thereby failing to forge a strong alliance or gain trust with these clients. In hindsight, the inability to empathise with this group of clients may have been due to a lack of understanding of their worldview and potentially a contributory factor in the early termination of therapy.

Therapists are encouraged to critically reflect and evaluate their clinical processes by recognising blind spots in order to improve the effectiveness of therapy. This includes therapists’ ability to look at their own cultural identities, worldview, beliefs, values and attitudes, and the effect these have on the intersubjective relationship with clients. As social and relational beings, cultural identities play a major role in self-identity, and are linked to our internalised view of the world. My hope is that through this hermeneutic research, I can better understand the challenges therapists’ cultural identities and worldviews have on the provision of empathy in cross-cultural situations. In chapter two, as part of the hermeneutic exploration and transparency as the researcher, I shall provide further details of my worldview and preconceptions regarding empathy.

Significance of Empathy in Psychotherapy

Relational and humanistic psychotherapies emphasise the correlation between the quality of the therapist-client alliance and positive outcomes for clients (as cited in Elliott et al., 2011a, p. 123). An integral component of this alliance is the practitioner’s empathic stance in understanding a client’s unique life experiences (Feller & Cottone, 2003; Greenberg & Elliott, 1997). When empathically attuned to the client, the therapist gets a better sense of the client’s “inner world and mental life” (Huprich, 2009, p. 95).

Understanding the inner world of clients provides therapists with an insight into their relational patterns, behaviours, use of psychic defenses and unconscious processes (Gabbard, 2010; Hertz et al., 2016). Heidegger (1996) proposed that understanding the individual requires understanding the worldview, for both are inexplicably intertwined while Sue et al. (2019) focus was on the significance of cultural influences on personal identity. These authors infer that self-identity is culturally bound and linked to peoples worldview. According to Pedersen et al. (2008) accurate empathic response depends on therapists understanding their own culturally bound beliefs and worldview, so that blind spots such as biases, stereotyping, cultural encapsulation and power dynamics can be recognised. Pedersen et al. (2008) suggest that blind spots can affect therapists' empathic responses to clients particularly in cross-cultural situations.

I found the idea compelling, that a person's worldview affects many aspects of their personality, and that cultural beliefs play a significant role in how a therapist empathises. If the way we, as humans, think, feel and behave, is linked to our cultural belief systems and how we view the world and others in it, then we, as therapists, will interact with our clients through the lens of our cultural beliefs. The notion that we potentially have unconscious biases and stereotype others due to our worldview and need to be aware of power dynamics and cultural encapsulation, is both confronting and comforting. Confronting, because if these issues remain unconscious then they may affect our relationship with clients unknowingly. It is comforting to know that as humans, universally we all have blind spots due to our belief systems and I find myself being more compassionate and therefore more empathic with clients who have different worldviews.

In the following sections I define key terms such as culture, worldview, empathy and cross-cultural that are the focus of this research.

Definitions of Culture

Marsella and Yamada (2010) posit that culture comprises of commonly shared behaviours and ideologies of social groups and are represented externally and internally in each person. Externally, culture is cultivated in areas such as family, food, art, clothes, music, education, and government institutions while internally culture pervades all aspects of the person and is embedded in self-perception, identity, and behaviours (Marsella & Yamada, 2010). Similarly Pedersen et al. (2008) claim that all human behaviour is a response to "culturally learned patterns" (p. 47) within an individual's environment and is complex and multi-layered. A person's worldview is shaped by cultural beliefs and influenced by nationality, ethnicity, race, socioeconomic

status, family, gender, sexuality, religion, spirituality, and affiliation to groups (Pedersen et al., 2008).

Chung and Bemak (2002) claim that there are two functions of culture. The first function is the integration of cultural beliefs and values into the self, providing a sense of identity. The second function is a sense of belonging and self-worth. The group has implicit and explicit codes of conduct to "maintain social and behavioral consistency so that the cultural patterns are recognizable and can facilitate social interaction and integration" (pp. 154-155) and can be distinguishable from other cultural groups. In clinical practice I see how clients' self-worth, self-identity and sense of belonging are affected, if they do not feel accepted by significant others or do not feel as though they belong to certain groups. Conflicts between cultural norms and personal wishes can cause inner conflict and dilemmas, destabilising the person's sense of self. For example, a person wishing to be in a same sex relationship who has been brought up with religious heterosexual values may be conflicted between a desire to adhere to religious cultural expectations and being happy living in a same-sex relationship. These types of conflict can be the difference between a sense of belonging or feeling an 'outcaste'. These factors create issues in relationships and affect social behaviours.

My understanding through these definitions is that cultures are created through people's shared beliefs and values. A culture cannot exist or be created by one person in isolation and involves at least two or more people with similar ideals. Self-identity and worldview are directly related to cultural values, beliefs, and attitudes. A person may have several cultural identities related to gender, sexuality, profession, stages of life, race, ethnicity, nationality, and other institutions. For example, I hold different cultural beliefs for each aspect of my self-identity as an Indian, female, lesbian, and a holistically minded psychotherapist. These beliefs dictate some of my behaviours and roles. As the eldest daughter, my responsibilities towards my parents and siblings are culturally bound through my Indian heritage and traditions. Yet my cultural attitude towards lesbian relationships is influenced by my experience of the predominantly tolerant and widely accepting New Zealanders attitude towards same sex relationships. The bicultural governing partnership between indigenous Māori and dominant colonial Pākehā places me on the outside, making me wonder about my place of belonging as a minority Indian 'other' in the country of my birthplace. Finally, as a holistic psychotherapist, the reductionist Western model of psychodynamic psychotherapy I have trained in feels incongruent to my worldview leaving me confused about how I wish to practice as a therapist. My Indian heritage and New Zealand upbringing have

conflicting belief systems and I find myself needing to make choices based on one or the other depending on the circumstances.

Definitions of Worldview

Koltko-Rivera (2004) describes worldview as “a set of assumptions about physical and social reality that may have powerful effects on cognition and behavior” (p. 3) and is a person’s overall perception of life, people, and the universe. Sue and Sue (2008) describe worldview as a person’s perception and relationship with the world which correlates with their “cultural upbringing and life experiences” (p. 293). Subjectivity is therefore present in the way humans feel, think, and behave, making therapists’ expression and communication of empathy a result of their worldview and various cultural influences (Chierchia & Singer, 2016; Watt & Panksepp, 2016). Historically worldview has been described as either ‘Western’ comprising of European and North American individualistic ideologies; or ‘non-Western’ comprising of Eastern and indigenous collectivist ideologies (Koltko-Rivera, 2004; Merriam & Kim, 2011). As a result of migration monocultural (single race or ethnicity) nations are no longer the norm with many countries having multicultural populations. Through acculturation between dominant and minority cultures, a person’s worldview may consist of a mixture of individualist and collectivist ideologies (Pedersen et al., 2015; Sue & Sue, 2008). In chapter five, I shall describe the difference in ideologies between individualist and collectivist cultures in detail.

Through my own upbringing between three cultures, as a New Zealand born Indian, having lived my childhood years in Fiji, the mixture of various cultural beliefs can be confusing and can cause internal conflict regarding self-identity. In clinical practice, the mix of cultural beliefs between the dyad and within each person can create additional intersubjective challenges.

Psychotherapeutic Definitions of Empathy

Psychotherapeutic literature has an overabundance of definitions for empathy. In this section I mention a few descriptions from seminal and contemporary authors to provide background understanding of the significance of empathy in psychotherapy. These descriptions are framed in general terms and do not specifically address empathy from a cultural perspective. In chapter three, I shall review literature that differentiates and distinguishes empathy in cultural and general terms.

Decety and Jackson (2004) state that humans are social beings and empathy is a naturally occurring phenomenon that helps us understand and relate to each other.

However, what constitutes empathy is difficult to define despite the many attempts by authors from multiple disciplines within the social and human sciences (Gibbons, 2011). During the literature search for this project, I found a plethora of literature that described empathy and its purpose or relevance in clinical practice. Hertz et al. (2016) and Clark (2007) agree that the concept of empathy is open to interpretation and is subjective. Historically, significant contributors to the field of psychotherapy, such as Sigmund Freud, Heinz Kohut and Carl Rogers had unique ways of defining empathy.

Freud, a psychoanalyst, mentions empathy in his earlier writing quite briefly and states that empathy is achieved through identification and imitation of another person's mental life (Freud, 1955a). Freud suggested that the person empathising can resonate with experiences or feelings of a similar nature to the person being empathised with. In addition, he posited that empathy could simulate what the client's internal world may look and feel like (Freud, 1955b). Freud's theory has some validity especially regarding the emotional resonance one may experience with a client, in light of more recent research into mirror neurons (Decety & Jackson, 2006). However, as Freud (as cited in Mitchell & Black, 2016) encouraged analysts to remain neutral, allowing the client to talk freely without the intrusion of the analyst's subjectivity, identifying with the client seems contradictory. Also similar experiences or identification with another person's internal world may lead to generalisations between the therapist and client that may devalue the uniqueness of the client's experiences.

Kohut (1959), another psychoanalyst within the same era as Freud, proposed that being empathic involved "vicarious introspection" (p. 461). Kohut claimed that the psychological functioning of a person can only be known indirectly (vicariously) by asking them. This involves dialogue and is open to interpretation by the therapist, making me question the accuracy of empathic understanding when words can be filled with nuanced meaning. However, what I was able to take away from Kohut's description, is that understanding a client's internal world is always second-hand, is open to interpretation and is subjective, therefore the therapist cannot remain neutral or bracket (put aside) their personal self.

Rogers (1975), a humanistic and person-centred psychologist, defined empathy as a process of entering into the client's "private perceptual world … and becoming thoroughly at home in it" (p. 4) suggesting that we put ourselves into the other person's shoes thereby perceiving their affects and experiences "as if" (Rogers, 1957, p. 99) we were them, whilst still maintaining our own separateness. I imagine that keeping boundaries between self and the client may be difficult if one is to become thoroughly

at home in someone else's world. In Rogers explanation there are two perceptions, the perception of the client of their own world, and the perception of the therapist of the client's world. These perceptions may not match, making the therapist's understanding of the client inaccurate.

Young-Bruehl (1988) disagrees that empathy is about putting one's self into the other's shoes either vicariously or through imitation and declares that "empathizing involves, rather, putting another person in yourself, becoming another person's habitat" (p. 22). However, she agrees with Rogers about being able to differentiate between self and the other when empathising so that personal boundaries and experiences of the therapist and client remain distinguishable. I do notice when empathising, I create a space within myself where I hold my client, their stories and my own thoughts and feelings about them. By being in relationship, the client has naturally entered and become part of my internal world.

All these authors hypothesise that either the therapist enters the client's world or the client enters the therapist's world, yet the therapist remains separate. Psychologically, this is quite a feat and being empathic seems fraught with challenges, that as an interpreter of another person's life, one may inadvertently misinterpret the experiences of the other quite easily. I, for example, as the interpreter of these authors descriptions of empathy, find myself trying to decipher the literal meaning of their words and also what may have been on their minds that has been left unsaid. I notice my resistance to such simple explanations of empathy, of a phenomenon that I believe cannot be explained in words. However, my understanding from these explanations, is that empathy involves the intersubjective interaction between the therapist and client, both collaborating to understand the world of the client.

More recently, Bolognini (1997b) found "true empathy" (p. 123) to be rare, noting the complexity that is involved in therapeutic empathy describing it as:

> a condition of conscious and preconscious contact characterized by separateness, complexity and linked structure, a wide perceptual spectrum including every colour in the emotional palette, from the lightest to the darkest; above all, it constitutes a progressive shared and deep contact with the complementarity of the object, with the other's defensive ego and split off parts no less than with his ego-syntonic subjectivity (as cited in Bolognini, 2010, p. 123)

Bolognini's definition suggests to me that empathy involves a complex process of sensing all manner of emotions, and deep connection with the pre-conscious and conscious psychological mind, ego, and parts of themselves that the client cannot see and is yet to see. The therapist then has to decipher all that is said, or remains unsaid, into some semblance of understanding that provides insights into the client's internal world.

De Waal (2009) viewed empathy "as an evolved response of approach and concern for others. The response begins with an emotional resonance between the potential empathizer and a fellow, followed by the empathizer's perspective taking on the other's situation." (as cited in Hollan, 2012, p. 72). The 'evolved response' refers to human behaviours that have evolved over time in the maintenance of relationships and social interactions (De Waal, 2009). This ties in with my experience in clinical practice of both the unconscious embodied emotional responses as well as cognitive thought processes involved in interpreting and understanding the client.

Definitions of Cross-cultural

Tsang and Bogo (1998) posit that cultural dynamics are complex and cultural identities are organised through family, individual, society and organisational structures and processes. The authors state that cultural identities are constantly adapting and evolving, as social behaviours change over time and through social change. In therapy, cultural identities intersect in the dyad through at least two or more cultural systems. Cross-cultural can therefore be described as two people with cultural identities that hold "different meaning contents and rules" (Tsang and Bogo, 1998, p. 75). A cross-cultural dyad is likely to have differing worldviews which may create challenges in understanding each other's point of view (Pedersen et al., 2008). This is relevant because verbal and non-verbal communication varies across cultures, including body language, mannerisms, and linguistic differences (Risser, 2019). In clinical practice, therapist and client may hold differing cultural beliefs and attitudes regarding gender, sexual orientation, race, ethnicity, socioeconomic status, age, and ability. These cross-cultural differences may create additional challenges in the provision of empathy.

Unless specified, when discussing the terms 'culture' or 'cultural', I shall be referring to groups that have common behaviours and ideologies, setting them apart from other cultures. The most common cultures discussed are race, ethnicity, gender, sexuality, stage of life, religion, spirituality, disability, sports and institutions.

Chapter Summary

In this chapter I outlined my interest in the research topic and provided a brief review of the significance of empathy within psychodynamic and humanistic psychotherapy. I then defined key terms related to the research question of ‘culture’, ‘worldview’, psychotherapeutic empathy and ‘cross-cultural’. This highlighted the complexity involved in the provision of empathy when factoring various cultural belief systems and worldviews.

Outline of Following Chapters

Chapter two discusses the methodology and method used to explore the research question and identify relevant literature. Chapters three to five are my findings of the reviewed literature, followed by chapter six, a discussion of those findings which includes my reflections, strengths and limitations of this study, implications for psychotherapy and further research.

Chapter two – Methodology and Method

This chapter provides rationale for the methodology and method used in this research, which is a hermeneutic literature review. I also outline my position as a hermeneutic researcher and describe the hermeneutic circle of inquiry model used in the search for relevant literature to conduct this study.

A Hermeneutics Interpretive Methodology

Hermeneutic methodology is situated within the qualitative interpretive research paradigm and has similarities to the way cultural empathy is conceptualised in psychotherapeutic terms, making the methodology appropriate. The researcher interprets literature through the context of their worldview, while the therapist interprets the client through empathy which is also contextualised through their worldview. Each dyad, whether they are the researcher/literature or therapist/client, has a unique intersubjective relationship; the results of which cannot be replicated by a differently configured dyad. Using a literature review as the method, I shall review existing psychotherapy, psychology and counselling text books, journal articles and empirical research. In the process I, the researcher, become the hermeneutic catalyst, interpreting the literature from my worldview and what I perceive as challenges in the provision of empathy within cross-cultural dyads.

Fossey et al. (2002) state qualitative research is aimed at “developing understanding of the meaning and experience dimensions of human lives and their social worlds” (p. 730). The authors posit there are three main qualitative research paradigms that have been developed for human and social studies: empirico-analytical, critical, and interpretive. Through a process of deduction, I have used an interpretive paradigm as it corresponds most closely to the purpose of this research. According to Fossey et al. (2002) empirico-analytical research is a scientific method which aims to be objective and logical, using observational and experimental studies in an attempt to generalise the phenomena being studied. This research will not involve human participants, experiments or observation of empathy in cross-cultural dyads therefore an empirico-analytical study design would be inappropriate.

Similarly, I found critical research inappropriate as it is designed to “uncover myths/hidden truths” (Fossey et al., 2002, p. 719) often regarding marginalised people, raising awareness of power differences between majority/minority groups. The agenda is often political, and goals of critical research are to proactively create radical social change. Blyler (1998) notes the primary goal is for emancipation and empowerment of

the marginalised, to free people from domination. Research questions are therefore more likely to review historical and social perspectives regarding power and ideology, in order to create political and social changes. Although the research question raises awareness and critically questions the provision of empathy in cross-cultural dyads, the purpose and intent of this research is to interpret and understand authors views regarding cross-cultural empathy, rather than to uncover injustices towards minority cultures. The research is not politically motivated, nor does it seek to actively create radical social change. For example, had my goal been to facilitate legal changes at a governing level, to ensure all mental health professionals complete cultural competency training prior to practising psychotherapy, then a critical research methodology may have been appropriate. Cultural inequities highlighted in this research are an indirect result of the challenges of cross-cultural empathy. I have therefore chosen an interpretive methodology that suits the purpose of this research.

Boell and Cecez-Kecmanovic (2014) state that hermeneutics research is a model used in qualitative, interpretive research. The aim is to interpret, understand, and describe phenomena. This methodology does not claim to be objective as the researcher is very much part of the study. This methodology aligns with my intention to describe and understand empathy and its impact within cross-cultural dyads. As a hermeneutic researcher, I acknowledge that the literature review is a matter of interpretation and understanding from my perspective, and that there is no definitive answer to the research question (Christopher, 2001). Another researcher may potentially come to a different conclusion using the same literature. In fact, the purpose for choosing hermeneutic as the methodology, is to stimulate thinking and discourse amongst psychotherapists about the challenges of working cross-culturally in a multicultural world. Boell and Cecez-Kecmanovic (2014) note hermeneutics research is interested in the process of understanding the phenomena being studied whilst recognising that a final or unified understanding may not be possible.

History of Hermeneutics

Originally hermeneutics was used to interpret the Bible and legal documents, which through the choice of syntax and linguistics, were open to interpretation (Sandage et al., 2008). In the 17th century, Schleiermacher (1768-1834) proposed a theory of hermeneutics as “an art of understanding” (as cited in Sandage et al., 2008, p. 345). He suggested that the interpreter empathically envisages the words and psychological intent of the author within the historical and social context in which it was written. Schleiermacher observed that understanding texts was difficult work, that

“misunderstanding occurs as a matter of course, and so understanding must be willed and sought at every point” (Schleiermacher, 1977, p. 110).

During the era of the 19th century romantics, hermeneutics was used to study history, aesthetics such as art and poetry, written and oral texts, and social sciences (Orange, 2011; Rennie, 2012). William Dilthey, who was influenced by Schleiermacher, believed that interpretation is subjective and comes from a person’s historical and cultural experiences (as cited in Sandage et al., 2008, p. 346). We could apply this to the researcher’s interpretation and understanding of literature, which is based on their subjectivity as a result of their experiences.

In turn, Dilthey influenced key phenomenologists such as Heidegger and Gadamer in the use of hermeneutics to think about and understand phenomena related to human social interactions. They veered away from the positivist and post-positivist paradigms used within the natural sciences, in which the researcher remained objective and detached from the research, aiming to generalise data. The qualitative interpretive model was created to better understand concepts within philosophy and the social sciences that are open to interpretation (Boell & Cecez-Kecmanovic, 2014).

When using hermeneutics as the methodology, I have been influenced by Gadamer’s philosophy that human experiences of being in and relating to the world are based on dialogical interpretation and understanding. He states:

> In reading a text, in wishing to understand it, what we always expect is that it will inform us of something. A consciousness formed by the authentic hermeneutical attitude will be receptive to the origins and entirely foreign features of that which comes to it from outside its own horizons. Yet this receptivity is not acquired with an objectivist “neutrality” … The hermeneutical attitude supposes only that we self-consciously designate our opinions and prejudices and qualify them as such, and in so doing strip them of their extreme character. In keeping to this attitude we grant the text [the other] … to manifest its own truth, over and against our own preconceived notions. (Gadamer, 1979, pp. 151-152)

The reference to ‘horizon’ in Gadamer’s writing refers to a person’s concept of the world based on their experiences bound within the period and cultures they live in. We can only know what we know from our own frame of reference. Gadamer (2013) believed that texts should be understood through the lens of the era and culture in which they were written. When a researcher is engaged with literature that has its own historical cultural topography, they need to keep in mind for whom and why the

literature was written, the significance of the text within the period, and the intention of the author. The researcher also needs to identify their beliefs, attitude, and preconceptions regarding the research topic to enable them to look beyond their own horizon, seeing the text in the context for which it was written. Gadamer describes this melding of the past and present relationship between researcher and author, as the "fusion of horizons" (2013, p. 264). Similarly, as a therapist, how I perceive empathy, requires me to understand my worldview and belief systems and that of the client. This, I believe is in essence, Gadamer's idea of 'fusion of horizons'. Later in this chapter, I outline how my worldview has been shaped and influences this research.

Link between Empathy and Hermeneutics

Gadamer et al. (2001) acknowledge that there is a hermeneutic philosophy in understanding people:

> the art of reaching an understanding … is not monological: rather, it has the character of a conversation. Our human form of life has an "I and thou" character and an "I and we" character… And reaching an understanding happens in conversation, in a dialogue. (p. 79)

Interpreting and understanding what is being expressed by the client requires two parts to the hermeneutic process. The first part is acknowledging that there are two people communicating from their own worldview (I and thou) and secondly knowing that the intersubjectivity involved in therapy has its own characteristics of a dyad (I and we). Communication of empathy involves verbal and non-verbal expression and is nuanced with different meanings and understanding for each person. There is a similarity in the hermeneutic principles of interpretation and understanding of clients as there is with texts. The difference in therapy is that through real-time dialogue the dyad can come to some form of mutual understanding of each other that is not available in the dyad interaction between texts and reader.

Grondin (1997) expands Gadamer's concept of requiring two or more people in dialogue to understand each other, by stating that we can open our horizon and worldview to that of the other through conversation, and suggests that "only in conversation, only in confrontation with another's thought that could also come to dwell within us, can we hope to get beyond the limits of our present horizon" (p. 124). Both Gadamer and Grondin recognise that understanding is reached only through dialogic engagement, whether reading a text or in therapy. Understanding our own worldview and horizon while being receptive to another person's worldview expands our horizon and opens us to accepting other worldviews. The dyad interprets, understands, and

communicates uniquely based on their respective worldviews. A different dyad and configuration of worldviews would result in a different interpretation. Similarly, the hermeneutic researcher reads and interprets literature according to their understanding of the content, contextualising the reading from the point of view of the research question. Therefore there are preconceptions and prejudices that the researcher inevitably brings to the topic. Psychotherapy is similar, as the main medium through which the therapist develops an understanding of the client's world is through dialogue.

Foregrounding my Position as the Researcher

At this stage I shall foreground my position as a hermeneutic researcher in relation to the topic, including discussing my cultural understanding of empathy, its place within psychotherapy and cross-cultural dyads, and any preconceptions and biases I have relating to the research question. This forms part of the research reflexivity and transparency that is required when conducting research (Creswell, 2003).

My complex cultural identities have consciously and unconsciously shaped my beliefs, values, life choices and relationships. In some ways and in some circumstances, I follow the norm of certain cultures and in other ways I am non-stereotypical. Therefore I am sometimes like others, sometimes like all and at other times like no one else as posited by Sue and Sue (2008) while explaining the "Tripartite Development of Personal Identity" (p. 34) model created by Sue (2001). My worldview is a blend of collectivist and individualist, Western and non-Western philosophies, and beliefs. I accept and reject parts of each culture's norms, forming biases and prejudices according to my values. As stated in the introductory chapter, my Indian ethnicity, female gender, sexuality as a lesbian woman, role as a daughter, country of birth, all play a part in forming cultural identities based on the values and beliefs I have been brought up with and introjected (internalised) as parts of my self-identity.

My non-Western holistic outlook regarding empathy means that I view the phenomena as an embodied and spiritual connection with fellow human beings that does not need to be categorised or viewed as a separate construct from my care and concern for clients for the purposes of therapy. It is a natural part of my interaction with others. I do not distinguish between empathy, love, compassion, sympathy as they are all intertwined in the way I experience the other. The provision of empathy requires me to be fully present for the client through constant attunement and engagement, this helps me to interpret and understand nuanced communication through my embodied experience of the client as well as a connection between our minds and souls. I believe there are instances when cultural beliefs may create a barrier to understanding clients. Currently an excellent example in differing beliefs systems is the divide amongst

people regarding Covid-19 vaccinations. Other issues such as abortion, suicide and arranged marriages may create conflict in the therapist based on their cultural values.

Sue et al. (2019) posit that being a culturally responsive therapist means looking at one's own "racial/cultural being" (p. 6), beliefs, values, and biases in order to understand how this affects one's relationship with clients. During this research I have been confronted with my own biases and stereotyping of races, genders and prejudices. My worldview and horizon will affect how I conduct this hermeneutic research and empathise with clients. I liken empathy to seeing colours. Is the green leaf I see exactly the same green to another person and how will we ever know? The fact is that we can never know, for one cannot see from another person's eyes. My experience of empathy in clinical practice is akin to watching a movie. As my client tells their story, I imagine myself in the movie walking, thinking, and seeing what the protagonist (client) is thinking and feeling as each part of their story is told. I see the other characters in their story and how each affects my client. As they describe an experience, I may feel sad or angry or happy. I look at the face of my client and see if they are feeling similarly. I look at their body and non-verbal language and imagine what may be going on, how they may be thinking and feeling and sometimes I walk alongside them as though I were there although a part of me knows that I am on the outside looking in. This is what I imagine Kohut meant by "vicarious introspection" (1959, p. 461).

To be able to understand people's experiences from different walks of life requires me to draw from my knowledge of similar life experiences and affects (feelings and emotions) and the customs, traditions, mannerisms of different cultures that I have been exposed to, whilst remaining open to the possibility that the knowledge I have may be inaccurate and unhelpful for the client. Schleiermacher's (1977) notion that misunderstandings are inevitable, makes sense to me, and highlights the importance of continuous dialogue between the dyad to ensure accurate understanding.

The following section describes the method and approach I used to find relevant material for this hermeneutic literature review.

Method

Applying the Hermeneutic Circle of Inquiry

Schleiermacher (1977) proposed a methodical approach to the hermeneutic interpretation of texts that involved moving back and forth between the whole and the parts of a text to give a clearer idea of the intention with which the text was written. A contemporary model for hermeneutic research involves the two-part hermeneutic circle of inquiry (Boell & Cecez-Kecmanovic, 2010). This approach enables researchers to search and filter literature on the topic, refining along the way so that the material gathered is relevant to the research question. The following process shows how a hermeneutic literature search is accomplished. This process can have several iterations before the final selection of literature is made.

Literature Review as Method for Hermeneutic Research

The method chosen for this research is a literature review conducted using the two-part process of the hermeneutic circle of inquiry developed by Boell & Cecez-Kecmanovic (2014). The authors illustrated that the first part is to search, sort, select, acquire, read, identify and refine existing literature. This process is repeated several times before data is ready to progress to the second part for analysis and interpretation which involves mapping, classifying, critically assessing, and developing an argument for the research question. The second circle can also be repeated and refined several times before final consolidation and write-up.

According to Grant and Booth (2009) there are several types of reviews that can be conducted for research, such as systematic, critical, literature, mapping, and meta-analysis. I have chosen a hermeneutic literature review as it allows flexibility in choosing a wide range of published material from books written by authors in the field, research studies, journal articles, and areas related to psychotherapy such as human sciences. This method aims to consolidate published material related to the research question as well as identifying omissions and areas for future research. A literature review is typically narrative in style and can be analysed thematically, conceptually, chronologically, or using other relatable forms of inquiry. In this research I shall be conceptualising my findings. A weakness of this type of review, as stated by these authors, is the subjectivity and bias of the researcher. This can lead to literature selection that inadvertently excludes potentially significant material. As this is a hermeneutic literature review, the subjectivity of the researcher is part of the research and therefore it is inevitable that the choice of literature included will be biased during

the selection process. Gadamer (2013) posited that impartiality is not possible in hermeneutic research, however when the interpreter is conscious of their prejudices and foregrounding, they are likely to be open to other points of view and others' horizons.

I have chosen to keep the focus of the research question relatively narrow to investigate challenges in the provision of empathy based on the therapist's cultural beliefs and worldview. Other inter-related areas such as cultural competency, training in cross-cultural practice and opposing views regarding whether empathy is a required condition for therapeutic change, are topics in their own right and have not been considered due to the time frame, scope, and limits of this research project. Within the epistemological traditions of interpretive research, knowledge is contextually and intersubjectively constituted. Aware of my bias that empathy is challenging in cross-cultural situations, I deliberately broadened my search to include many counselling related professions, the human and social sciences and anthropology. Broadening the search helped me remain open to authors who may oppose the idea that empathy is challenging in cross-cultural situations or that therapists' cultural beliefs and worldview do not influence the provision of empathy.

My initial search was to find keywords that explained empathy within dyads who have different cultural outlooks. The difficulty in sourcing literature came from the varied vocabulary and keywords used to describe the intersection of diverse cultures. 'Cross-cultural', 'multicultural', 'transcultural' and 'intercultural' were the main keywords describing interaction between people of different cultures. 'Multicultural' is a term used predominantly in American literature while 'transcultural' is more commonly used in Britain, to describe working with people from a wide range of cultures who may be of different cultures to the therapist (Lago, 2011). 'Intercultural' is described as the intersection between cultural groups that highlights significant differences between cultures and is used in social studies rather than psychotherapy literature (Koegeler-Abdi & Parncutt, 2013). Lee (2012) explains that the term 'cross-cultural' means that the dyad identifies with "an array of multiple diversity factors and create multiple cultural identities, some matched or mismatched between a client and clinician" (p. 24). I chose cross-cultural as the meaning that felt most closely aligned to the research topic. Keywords that described the second part of my research question regarding challenges varied with many authors using terms such as 'issues', 'challenges' and 'barriers' to identify challenges while working cross-culturally.

Initial Search

The aim of my initial search was to learn what had been previously written in the field of psychotherapy, on the topics of 'empathy' and 'culture'. The first part of the hermeneutic inquiry began with a general literature search starting with articles that had been part of my coursework readings and assignments. Once I became familiar with the common terminology used, I cast a wider net, searching through psychotherapy related databases, using Boolean and truncation methods where possible to narrow the search (Boell & Cecez-Kecmanovic, 2010). I used advanced search fields when available, limiting the search to peer-reviewed articles and text books. The following table denotes my initial keywords and search combinations.

Table 1 ***Initial database search***

Key search words	**Database**	**Total of peer-reviewed articles and text books**
Cross-cultur* OR intercultur* AND empath* AND psychotherapy* OR counsel*	Scopus	14
Psychotherapy AND empathy AND interculture OR multiculture OR cross-cultural	AUT library search	144
Cross-cultural OR intercultural OR transcultural AND emotion AND psychotherapy OR therapy OR counseling	AUT library search	47,629
Cultur* AND express* AND psychotherapy* OR counsel* OR psychology*	PsycINFO (Ovid)	5719
Cultur* AND express* AND psychotherapy* OR counsel* OR psychology* AND empath*	PsycINFO (Ovid)	208
Psychotherap* AND empath* AND cultur*	PsycINFO (Ovid)	8
Psychotherapy* AND cultur* AND negative*	PsycINFO (Ovid)	15
Cultur* AND empath*	AUT library	8 textbooks

By scanning the abstract and conclusion of articles, I was able to gather literature that included the general topic of cultural empathy. There were three main areas that emerged within the literature that covered challenges/issues, cultural competency, and general cultural characteristics or features of particular groups of people based on ethnicity, gender, age, disabilities, religions, sexuality. I also found that the majority of the literature was targeted towards European and American multicultural relationships.

Inclusion and Exclusion Criteria

From the initial search, I began the process of narrowing my selection using inclusion and exclusion criteria to those articles, books and book chapters that were directly relevant to my research question. I included empirical research, articles in published and peer-reviewed journals, and books written in English that were found in the Auckland University of Technology (AUT) library. I included seminal as well as contemporary literature within psychotherapy, psychology, counselling, anthropology, education, human, and social sciences. I excluded literature that discussed groups rather than dyads and ones that did not address challenges, issues, or barriers in cross-cultural empathy. I also excluded clients' experiences of empathy in cross-cultural situations, as the focus was on the therapist's provision of empathy. By including clients' experiences, I would have had to interpret the literature from both clients' and therapists' perspectives which would have been outside the scope of this research. Through this sifting process I was left with eight articles and eight books that related directly to my research question.

Refined Search

From the literature gathered in the initial search, I then used the snowballing technique recommended by Boell and Cecez-Kecmanovic (2010) to expand my literature base by using the references included in the journal articles and books I had already gathered. This is an easy technique that complemented my database searches and sped up the process. Once again I noticed that majority of literature related to European and American (Eurocentric) cross-cultural experiences. I was unable to locate much literature relating to empathy in cross-cultural dyad within Aotearoa New Zealand. It is possible that I have not been able to find such literature due to the limitations of the databases and snowballing confines of my search. Another possibility is that in non-Western cultures empathy is not separated from other feeling states and therefore not researched as a separate construct. A further possibility is that non-Western authors may have written in a language other than English, which I have not included.

The Eurocentric literature was specific to cross-cultural counselling within those regions. I found very little research had been conducted relating to multicultural populations within the South Pacific nations. Each country has its own cultural dynamics and the specific challenges experienced in America or Europe may not be relevant or transferable to cross-cultural dynamics of other countries. However, I was able to identify key challenges that can relate universally to the provision of cross-cultural empathy. These challenges relate to therapists' lack of awareness of their own

cultural attitudes and worldview potentially leading to biases, cultural encapsulation, stereotyping, racism, prejudices, power dynamics and language barriers when relating to those from other cultures.

Once the first circle of the hermeneutic process had been completed, I began the second part of the process by reading, interpreting, understanding, sorting, classifying, critiquing, and analysing. This constituted moving from the whole to parts and parts to the whole as endorsed by Schleiermacher (1977). The overview, abstract and conclusion of a whole article often gave me a general sense of the content whereas each paragraph or chapter provided me with details and examples that helped me understand the overall concepts. At times making sense was challenging and I would find myself resisting the viewpoint of authors, unable to see their horizon. When feeling stuck I would distance myself from the article, to provide space and time to grapple with their ideas until I was able to gain perspective from another's point of view.

As I delved deeper into the research topic, the literature led me in several directions that felt linked; I wanted to follow those directions to find out more and more, so that I could understand the topic deeply in all its entirety. Gadamer refers to this hermeneutic response in wanting to make everything knowable as an "un-ending dialogue" (Gadamer, 1984, as cited in Grondin, 1994). Boell and Cecez-Kecmanovic (2010) conclude that this never-ending process can make it challenging to exit the hermeneutic circle. The authors recommend remaining within the scope of the research and time constraints of the study. Reminding myself of the time limits and focus of the research helped me exit the hermeneutic circle once I felt that I had sufficient material to form a broad understanding of the research topic.

Chapter Summary

This chapter outlined the methodology and method involved in conducting a hermeneutic literature review and the validity for such an approach for my research question. In doing so, I discussed how the hermeneutic circle of inquiry helped identify relevant material that was used for this literature review. I also discussed my subjectivity and position as a hermeneutic researcher including any biases and preconceptions that were part of my worldview. Finally I described the process of exiting the hermeneutic circle of inquiry.

The following three chapters form the findings for my hermeneutic literature review. Chapter three addresses the conceptualisation of empathy in psychotherapy and human sciences, differentiating between empathy in general and from a cultural perspective. Chapter four addresses the effect therapists' worldview, cultural identities

and notions of ‘self’ have on the provision of empathy in cross-cultural situations. Chapter five addresses the specific issues arising from therapists’ worldview and cultural beliefs. My findings are discussed in chapter six pulling together the key points that were identified through the literature review, followed by what the findings mean for psychotherapy and the implication for psychotherapists as well as suggestions for further research.

Chapter 3 - Empathy

This chapter reviews literature that conceptualises and differentiates cultural empathy from general empathy, and the significance of this distinction when engaging cross-culturally with clients.

Carl Rogers on Empathy

Carl Rogers, a humanistic psychologist, is renowned for his development of client-centred or person-centred therapy and the role of empathy in facilitating positive therapeutic change in clients (Cohen, 1997). Rogers (1957) noted that empathy involved “understanding of the client's internal frame of reference” (p. 96) and was a core condition of therapy. He suggested that positive changes of behaviour in clients was partially a result of the therapist’s ability to communicate empathy effectively. Rogers (1957) claimed that “accurate empathy” (p. 99) involved a high degree of mutual understanding between the dyad of the client’s internal world. He intimated that when compatibility was low, empathy may not be accurate. Rogers (2012) acknowledge the importance of cultural influences in a person’s life. He compared empathy to culture suggesting that just as understanding the client’s internal frame of reference helps therapists to make sense of their behaviours, therapists also need to understand the cultural norms and behaviours that create the client’s internal world. Rogers (2012) claimed that individuals introject social values from cultures they are exposed to and these values are included as part of their self-identity. He posited that positive cultural introjections enhanced and maintained self-identity whereas negative perceptions de-stabilised the self. Rogers argued that failure to understand the psychology of a person’s behaviours occurs when the therapist generalised or applied their own personal values instead of the client’s. Rogers concluded that it is unrealistic and unachievable to empathise fully with all that the client has experienced in their “phenomenal field including both the conscious elements and also those experiences not brought to the conscious level” (2012, p. 701). He suggested that a sufficient amount of empathy over a long period of time is enough to provide the conditions for therapeutic change.

Rogers makes a valid observation that it is unlikely that therapists will reach a full understanding of the client’s psychological internal world through empathy. I link Rogers suggestion that good enough empathy over time is sufficient, to Winnicott’s idea of a “good-enough mother” (Winnicott, 1971, p.10). Just as an infant learns to tolerate inconsistencies in mothering with a mother that is good enough most of the

time, clients are likely to tolerate a therapist whose empathy is good enough most of the time.

Etic and Emic Cultural Approaches

Baruth and Manning (2016) identify two terms, “etic and emic” (p. 319) that are used in multicultural studies to address culturally general (etic) and culturally specific (emic) related theories. When applying this to psychotherapy, etic approaches can be applied universally across multiple cultures whereas an emic approach is tailored to a specific culture or one client. The authors express that an etic approach would include therapeutic interventions such as deep listening, expression of affects, or release of suppressed emotions as a form of catharsis that are universal human experiences. In contrast, an emic approach in psychotherapy may involve specific cultural customs. For example, Indo-Fijian and Māori people, in general, have a high regard for formal introductions and of reciprocal learning about one another at the beginning of relationships (Bowden, 2015; Wali, 2001). People who identify within these cultural groups may have expectations of a first meeting that includes name, place of origin/abode and family/clan or tribe details (Bowden, 2015; Wali, 2001). This helps to situate each person, providing a backdrop upon which the relationship and trust can be built. From this relational position, one can immediately acknowledge the more obvious similarities and differences in cultures. These may include ethnicity, first language, gender, country of origin, region and so on. Therapists who are informed by traditionally derived Western theoretical frameworks may find such self-disclosure uncomfortable or outside the bounds of their clinical practice. Constantine and Kwan (2003) advise therapists to adapt their theoretical standpoint when working with minority cultures as self-disclosure helps to develop and maintain therapeutic alliance. Applying etic and emic approaches in psychotherapy are equally important and allow therapists to understand clients from both universally human and culturally specific perspectives (Baruth & Manning, 2016).

Basic, Complex and Reenactive Empathy

Stueber (2006), a philosopher, and Hollan (2012), an anthropologist, who come from different disciplines had similar ideas of empathy. Both authors posited that there are two aspects to empathy, a basic form that is an unconscious embodied response of emotions, feelings and behaviours, and a conscious cognitive response. Stueber (2006) suggests that “basic empathy” (p. 170) is instinctive, non-verbal and has quicker response times. The unconscious response bypasses the pre-frontal cortex, an area of the brain that is responsible for cognition and processing of emotions (Decety &

Jackson, 2004). These researchers observed that basic or unconscious empathy is a result of instinctive mirroring and mimicking of gestures, mannerisms and facial expressions that is often a result of unconscious brain function and mirror neurons. In a literature review of cross-cultural empathy in various ethnic groups, Hollan (2012) concluded that perceptions of empathy vary in individual cultures. Hollan proposes that "complex empathy" (2012, p. 71) involves conscious awareness and understanding of the unique ways in which ethnic groups perceive and express empathy. In contrast, basic empathy is part of evolution to promote understanding and communication between humans, regardless of cultural background (Hollan, 2008, 2012). In social situations, the unconscious embodied empathic response is sufficient in connecting with others, however the psychotherapeutic relationship requires a more conscious and enhanced communication of empathy to be effective in letting the client know that they have been truly understood. Hollan argues that each ethnic group, has its own moral code regarding empathy. Some cultures see empathy as an altruistic concern for others while in other cultures, empathy is seen as an intrusion, used to cause harm or humiliation, therefore the result may be to suppress empathy. Hollan (2012) proposes that the expression of empathy can have consequences socially, politically, emotionally, and economically making it complicated and challenging in cross-cultural situations. The author provides an example of the difference between the two types of empathy suggesting that sensing when someone is angry is basic empathy and understanding the reason for the anger is complex empathy. Based on this, one could hypothesise that cultural norms which include specific behaviours and communication have coded messages that others of the same cultural background can decipher more readily than people from other cultures (Lee & Horvath, 2014). Metge & Kinloch (2014) noted that in various cultures a non-verbal communication such as a nod can hold different meanings, for example, 'yes' in agreement, or a mere acknowledgment that the listener has heard what was said, or as a greeting. The authors warn that verbal and non-verbal language construed differently across cultures can be misunderstood or misinterpreted by those unfamiliar with the cultural meaning behind such gestures.

Stueber (2006) describes the conscious aspect of empathy as "reenactive empathy" (p. 170). Stueber posits that the empathiser consciously re-enacts the experience of the other by contextualising the client's internal frame of mind through their own embodied and cognitive senses. This is similar to Kohut and Rogers notion of entering into the client's world and imagining vicariously their feelings and experiences (Kohut, 1982; Rogers, 1957). Both Stueber (2006) and Hollan (2012) noticed that conscious empathic response is complex and involves emotional, cognitive, and communicative processes. Hollan (2012) states that people feel, act, and think in specific ways that are "doubly

culturally- and historically-bound" (p. 71). My conclusion regarding these ideas of dual empathic responses is that as therapists, we are equally bound by our own historical and cultural identities and in clinical practice engage empathically in a complex manner that involves both unconscious and conscious processes to help us interpret and understand our clients.

Empathy - Shared Cultural Experiences

De Waal (2010), a biologist with an interest in the study of animal and human behaviour, claims that empathy has evolved as part of social interaction and helps in decoding others' emotions, feelings, and behaviours. De Waal observes that people identify with and are drawn towards those with similar attitudes, beliefs, and values. He suggests that it is easier to empathise with those belonging to cultural groups that have familiar beliefs and attitudes to one's own cultures compared to groups that are unfamiliar. I have noticed that at social gatherings, people are drawn towards those who share similar interests. Similarly, Pedersen et al. (2008) argue that cultures form due to geographical, racial and ethnic idiosyncrasies creating conditions and experiences that can only be shared and understood by people of those cultures.

General and Contextual Empathy

Ridley and Lingle (1996) advise therapists to identify when general or contextual empathy is appropriate so that responses and therapeutic interventions can be tailored accordingly. The authors claim that the more cultural similarities there are within the dyad, the easier it may be for the therapist to respond empathically, while the wider the cultural divide the more difficult accurate empathy becomes. According to Ridley and Lingle (1996), applying the same strategies to similar issues across cultures can lead to misunderstandings and failure in accomplishing positive outcomes for the client. Pedersen et al. (2008) suggest that empathy should always be understood within cultural context and seeking similarity in others based on race, ethnicity and other cultural factors may lead to stereotyping clients. The authors posit that by generalising or stereotyping our clients we may miss opportunities for accurate empathic understanding. An example of stereotyping was the perception a person had of same sex relationships, and their attempt to apply those to me, leading me to feel misunderstood.

Inclusive Cultural Empathy

Pedersen et al. (2008) propose an “inclusive cultural empathy” (p. 3) model for cross-cultural situations. The inclusive model emphasises the relationship between the dyad and suggests that therapists’ empathy includes awareness of their own and clients’ multiple cultural identities. The authors note that self-perception and identity constantly evolve and adapt to changes in cultural norms throughout a person’s life and is influenced by significant relationships. Pedersen et al. (2008) use the term “cultural teachers” (p. 20) for these relationships. Part of therapy for clients, may involve recognising their many cultural identities, the cultural roles they have adopted, and any conflicts that arise from these cultural identities. Conflicts regarding cultural identities may arise when the cultural norms and expectations are different from the individual’s own personal wishes. An example may be the cultural tradition of an arranged marriage and the individual’s preference to choose their own partner. Therapists who find themselves conflicted about their cultural identities, may need to process these issues so that conflicts do not interfere with the provision of empathy in the form of stereotyping or generalising, should the client have similar issues.

Pedersen et al. (2008) split empathy into emotional and cognitive processes, explaining that emotional empathy is the feeling or emotional response of the therapist, which includes their disposition and capacity for empathy, while cognitive empathy is a skill and active processing and communication of those emotional responses. Both are required for accurate understanding, the emotional component deepens the connection with clients while the cognitive aspect strengthens the therapeutic alliance (Pedersen et al., 2008). The authors suggest that as clients become conscious of their cultural identities, they also become aware of the cultural similarities and differences between themselves and the therapist. This relational model allows the client to see the therapist as a human being.

I found this model helpful, as it encouraged me to become aware of how my cultural identities affect my behaviours and relationships, particularly as I engage with clients. Those who teach us our cultural beliefs and values may not be physically present in the therapy room but are psychologically present in our attitudes and behaviour. This highlighted the cultural intersubjectivity within the dyad and how these may affect the therapeutic relationship.

Relationship between Personal Identity and Empathy

The “Tripartite Development of Personal Identity” by Sue (2001, p. 38) is another model that explains how personal identities are form through cultures. Sue declares that there are three contributory levels, universal, group and individual. At a universal level, identity is developed through shared human experiences such as birth, death, and use of language as a mode of interpersonal communication. At a group level, identity develops through particular group cultures including race, ethnicity, gender, sexuality, socioeconomic, political, religious affiliations, marital status, and ability. Finally at an individual level, each person’s identity is developed through unique non-shared experiences and genetic characteristics. Sue and Sue (2008) acknowledge that “all individuals, in many respects, are (a) like no other individuals, (b) like some individuals, and (c) like all other individuals” (p. 37). To understand clients, Sue (2001) states that therapists can draw upon some shared universal and group level cultures and experiences while still seeing the client as a unique individual. Sue et al. (2019) advise therapists to explore their own “racial/cultural being” (p. 6), to better understand the various cultural influences on their personal identity, and how they view the world.

This model helped me recognise that in some instances, empathy for clients can be experienced irrespective of cultural differences. Therapist and client may share common human experiences such as pain, suffering, happiness, anxiety, stress, relationships, life and death. The dichotomy that is often part of human nature, of generalisable and unique qualities of an individual, is also present in the provision of empathy and can be applied situationally to understand a client from a general or cultural position. Sue and Sue (2008) caution that therapists and clients may hold contradictory and ambiguous cultural beliefs depending on specific situations and circumstances, making self-identity ever-changing and dynamic. Empathising with clients becomes more complex and challenging when attempting to decipher clients’ contradictory concepts of themselves (Sue et al., 2019).

Chapter Summary

In this chapter, I reviewed literature that conceptualised empathy in general and cultural terms, through various theoretical standpoints and disciplines. I linked these to psychotherapy and clinical practice by providing examples of cross-cultural situations. I touched upon some of the challenges therapists experience in the provision of empathy and explore these in detail in chapter five.

The following chapter explores the concept that Western and non-Western, and individualist and collectivist cultural ideologies that influence peoples' worldviews and their perception of empathy. These ideologies may explain therapists empathic responses in cross-cultural situations.

Chapter 4 - Worldview Perspectives of Empathy

This chapter explores Western and non-Western, and individualist and collectivist cultural ideological perspectives towards peoples' worldviews. Worldviews are linked to perceptions of 'self' and the influence on therapists' view of empathy. Finally, I examine Gadamer's concept of 'horizon' and 'fusion of horizons', to explore how therapists reach beyond their own worldview to gain accurate empathic understanding of clients with different ideologies.

Concepts of Worldview

Worldview is a concept that has been used to understand social behaviours and how people relate to each other (Koltko-Rivera, 2004). The author claims that psychological insight of a person's view of the world is accomplished by understanding their cultural beliefs and values which affects how they think, feel and behave. To identify general behaviours of cultures based on how they socialise, some authors have categorised worldview into cultures that are either 'Western' or 'individualist'; and 'non-Western' or 'Eastern' or 'collectivist' (Hollan, 2012; Pedersen et al., 2008; Triandis, 1995). Pedersen et al. (2008) caution against stereotyping cultures based on Western and non-Western geographical locations, instead attributing cultural beliefs and values to individualist and collectivist ideologies. My preference has therefore been to use 'individualist' and 'collectivist' to explain differences in ideologies. However I have used 'Western', 'non-Western', 'Eastern' or 'indigenous' when authors have specified these terms in their literature.

Quinn (2006) breaks worldview down into individualist and collectivist ideologies to explain individual and group behaviours, including one's perception of "self" (p. 379) and self in relation to others (self-identity). Sue and Sue (2008) propose that self-identity incorporates many cultural identities that one is exposed to and introjects into the self. Cultural identities, self, and self-identity are therefore inextricably linked to one's worldview (Koltko-Rivera, 2004; Quinn, 2006). Quinn (2006) defines self "as the totality of what an organism is physically, biologically, psychologically, socially, and culturally" (p. 362). Markus and Kitayama (2010) distinguish 'self' from 'self-identity' explaining that "self is the ''me'' at the center of experience—a continually developing sense of awareness and agency that guides actions and takes shape as the individual" (p. 460), whereas 'self-identity' is related to how a person identifies themselves in relationship to others. An example for 'self' would be to say "I am kind" whereas "I am a lesbian" would be a self-identity based on how others differentiate or situate people of various cultures. Schwarzbaum and Thomas (2008) suggest that the 'self' develops

within multiple cultural, historical, and environmental contexts, and is constantly evolving, being created, and re-created throughout a person's developmental stages and lifespan. Markus and Kitayama (2010) and Triandis (1995) propose that psychological functioning, of thinking and feeling are part of 'self', 'self-identity' and worldview, and is a result of cultural conditioning. From this perspective, I assert that empathy, which is also a thinking and feeling phenomenon, is also subject to cultural conditioning. Therefore, in clinical practice, the worldview of the therapist is often unconsciously present in the provision of empathy.

The following section explores the distinguishing factors between individualist and collectivist attitudes and behaviours that influence the 'self' and interpersonal relationships.

Individualist and Collectivist Ideologies

Cultural groups often have rules of conduct based on individualism or collectivism, or a combination of both, and engage in particular ways depending on whether the person is part of the group (in-group) or outside the group (Heinke & Louis, 2009; Triandis, 1995). To have a sense of belonging within groups, individuals adjust their behaviours to conform to in-group beliefs and social attitudes (Koltko-Rivera, 2004). People tend to have complex patterns of individualist and collectivist dynamics and behaviours which are culturally bound and contextual (Heinke & Louis, 2009; Triandis, 1995). Gudykunst et al. (1996) identify three influences for behaviours and actions - cultural values, individual values, and "self-construal" (p. 516) meaning how one perceives oneself. Relating this to clinical practice, Pedersen et al. (2008) claim that worldviews will inevitably impact the dyad and the way therapists and clients relate to each other. Pedersen et al. (2008) add that traditional psychotherapy has followed a Western reductionist and individualistic perspective towards psychological issues, centring treatment around an individual as though they were separate from their environment and cultural influences. This is problematic for collectivist cultures whose worldviews are holistic, where there is a connection between the mind, body, spirit of the individual as well as other people, nature, and the universe (Di Stefano, 2006; Lees, 2016).

According to Koç and Kafa (2019) and Obasi et al. (2009) someone with individualistic values is motivated by self-interest and independence, whereas someone with collectivist values is motivated by interdependence and connection to others, often sacrificing their own needs for the best interest of the collective. Individualism promotes self-autonomy and self-reliance whereas collectivism promotes reliance on others and the belief that each person has a role within the group that supersedes personal

happiness (Pedersen, 2004; Triandis, 1995). In collectivist cultures individuals are not viewed in isolation but are interconnected socially, spiritually, and psychologically to family, community, and the universe (Hollan, 2012; Pedersen et al., 2008). Pedersen et al. (2008) describe Western and individualist cultures as “idiocentric” (p. 21), where emphasis is placed on individual’s freedom, self-confidence and competitiveness; and non-Western and collectivist cultures as “allocentric” (p. 21), where importance is placed on community responsibility, hierarchical authority and “social usefulness” (p. 21). Triandis (1995) states that people with individualist ideologies are motivated by personal goals, interests, and the pursuit of happiness, and are loosely connected to cultural groups such as family, work, tribe, and country. The author elaborates that individualists rationalise the benefits of associating with others and form agreements with other individuals regarding the nature of their relationship. For example, in a marriage there may be an agreement that each person contributes to household expenses equally, while keeping their finances separate. Individualists do not feel obligated to others nor do they conform to group expectations, maintaining internal validity regarding how they want to live their lives (Pedersen, 2004; Triandis, 1995). In contrast, collectivists are closely connected to group members and share commonly held beliefs and values, often sharing resources and allocating roles and duties within the group (Triandis, 1995). Triandis suggests that the group’s needs and goals are placed above personal goals, with external validity and approval of the group being important for cohesion and harmony.

In reality, people have a mixture of ideologies and may or may not conform to cultural norms. It is important, when understanding the views of these authors, that they are discussing general and overall characteristics of cultural groups based on stereotypical ideologies. In my opinion, having a basic knowledge of general characteristics of cultures is useful up to a certain point. However the unique personality and life experiences of the individual need to be factored in, when empathising using a cultural framework.

Another difference between Western and non-Western cultures is how illness is perceived. According to Pedersen et al. (2008) Western cultures have a reductionist perspective of illness, separating mind and body to treat psychological and physical symptoms respectively whereas non-Western cultures have a holistic concept of illness. Wratten-Stone (2016) argues that mainstream Western models of mental health care lack consideration of the spiritual aspect. In Aotearoa New Zealand, holistic Māori models of healthcare accommodate spiritual beliefs and Māori treatment practices when working with Māori clients (Durie, 1994; Wratten-Stone, 2016). Hollan’s cross-cultural ethnographic study notes that many non-Western cultures have spiritual

connections to non-human supernatural beings such as God and the spirit of those who have died (2012). For collectivist cultures such as Māori, Toraja Indonesians and native American Indians, seeing and talking to spirits of ancestors is considered normal (Dillon, 2008; Pedersen et al., 2008; Wratten-Stone, 2016). Wratten-Stone (2016) adds that interpretation of a person's spiritual experiences may lead Western therapists to incorrectly assess and diagnose non-Western clients as psychotic rather than attempting to understand the underlying meaning of the subjective experience. Literature shows that spirituality and relationship with non-human beings is not exclusive to non-Western cultures and must be understood from an individual's worldview (Pedersen et al., 2008; Schwarzbaum & Thomas, 2008).

Therapists' spiritual beliefs, in cross-cultural situations, may create challenges if they are unable to see the worldview or horizon of the client, and their spiritual beliefs. For example, if the therapist is an agnostic or atheist, then it may prevent them from understanding a client who believes in God.

The following section explores individualist, collectivist, Western, and non-Western cultural attitudes toward empathy.

Cultural Attitudes toward Empathy

I contend that cultural conditioning has a strong link to how a person empathises. Therapists, with either a predominantly collectivist or individualist belief system, are likely to hold different understandings of empathy, that will inadvertently be affected by cultural influences. Duan et al. (2008) and Pedersen et al. (2008) note that differing worldviews and cultural beliefs may create challenges in the provision of empathy and perspective-taking. Pedersen et al. (2008) states, and I agree, that all dyads are cross-cultural in some aspect or other, as differences will arise not only through ethnicity, but as a result of other cultural mismatches such as differences in gender, socioeconomic status, sexuality, ability/disability, religion, and spirituality. In traditional psychotherapy, individualist goals and interventions are directed towards ego-strengthening, self-empowerment, independence, and life choices based on self-interest (Gabbard, 2010; Pedersen et al., 2008; Sue et al., 2019). Understanding their own worldview may help therapists be aware of when they are interpreting issues from their own perspective rather than the client's (Koç & Kafa, 2019; Pedersen et al., 2008). Pedersen et al. (2008) caution that therapists who adhere to traditional Western or individualist models of therapy may impose individualist values on clients who are collectivist oriented. Rather than focusing on ego-strengthening and alleviating symptoms, empathic concern from a collectivist perspective may require reframing and acceptance of an issue rather than to 'fix' as individuals may not be able to choose their own happiness

over the group's (Pedersen et al., 2008). In Indian culture for example, an adult child may consider it their duty to have their parents living with them, overriding their own personal wish to live separately. How might a therapist with strong individualist beliefs, understand that the client's obligations outweigh their personal happiness and independence. The practicalities of the situation may not be able to be changed, however reframing the issue and empathising with the client's cultural dilemma may help the client see the situation from a different perspective. The therapist's cultural beliefs may prevent them from understanding that the client's goal may not be to live separately from their parents, but to find a more harmonious way to live together.

Duan et al. (2008) and Heinke and Louis (2009) report that empathy develops differently in individualist and collectivist cultures. A study conducted by Duan et al. (2008) showed that those with predominantly collectivist values are likely to have a disposition or propensity for empathy due to the outwardly oriented caring and concern for others, therefore people naturally develop empathy as part of their cultural norm. In contrast, the authors noted that those with predominantly individualist values tend to empathise situationally and disposition for empathy can be linked to the individual's learned behaviours from significant others. The study hypothesised that empathy in individualist cultures is more likely to be situational as the ego or 'self' driven interests compete with concern for others. However both collectivists and individualists empathise situationally with strangers or those outside their culture as the bond or connection with those outside the group is less so (Duan et al., 2008).

Gudykunst et al. (1996) comment that individualist and collectivist cultures communicate differently, which makes cross-cultural empathy particularly challenging as people receive, filter, and interpret messages in culturally nuanced ways. Individualist cultures communicate directly and explicitly using low context messaging, expressing openly how they feel while non-Western cultures tend to communicate indirectly using nuanced or high context implicit language and non-verbal messaging (Gudykunst et al., 1996). In a New Zealand study within the education sector, Metge and Kinloch (2014) found that even with the best of intentions people from different cultures tend to "talk past each other" (p. 9) often causing confusion, misinterpretations and conflict. The authors state that misunderstandings occur in cross-cultural situations when gestures and words have different connotations in different cultures. For example, teachers from Western cultures assumed that students from non-Western cultures were not listening, seeming disinterested or disrespectful if they did not answer the teacher. Whereas students' silence may have been due to a mark of respect for their elders or embarrassment and shame for not having understood the question. In these instances empathy regarding cultural differences may prevent misinterpretations.

Hollan (2012) ethnographic study concluded that Pacific cultures and in other parts of the world there is less distinction between empathy and other feeling states such as love, compassion, pity and sympathy. Hollan (2012) observes that empathy in such cultures is communicated differently, and it is common for Pacific cultures to empathise by demonstrating actively their care and concern through practical acts of service. When working with Māori, Pacific or Indian cultures, a more interpersonal and relational role is recommended (Boulton, 2006; Metge & Kinloch, 2014; Wali, 2001), rather than the neutral or passive show of empathy advocated in traditional Western psychotherapy practice. For example, therapy may be conducted at a client's home if the client is unable to come to a clinic, or a gift or monetary offering may be considered instead of a set fee (Boulton, 2006; Wali, 2001). Pedersen et al. (2008) posit that Western psychotherapy models encourage a passive or neutral role when empathising with clients however this approach may not be suitable with clients who have a non-Western view of empathy. The authors note that non-Western clients may expect therapists to provide advice and active participation in making decisions as part of an empathic response. In Western psychotherapy, advice, gift-giving and treatment outside the clinic space may pose ethical dilemmas of acceptable clinical protocols. Hollan (2012) states that therapists with Western views may find that boundaries between the self and other are likely to be blurred but would be necessary in forging a therapeutic alliance with clients from non-Western cultures. Hollan (2012) suggests that a non-Western client may misunderstand a therapist's neutral or passive communication of empathy as "a failure to understand the other's plight" (p. 72).

Another area of misunderstanding may occur due to the traditional psychotherapy notion that empathy is an altruistic and necessary condition of therapy (Kohut, 1959; Rogers, 1957). In some cultures intrusion into a person's internal world is mistrusted. For example, highland Mayans believe that empathy can be used against a person potentially causing embarrassment or harm (Hollan & Throop, 2008). The authors also reflect that in certain occupations such as hunting or the military, killing animals or humans is part of the job, therefore having empathy for the other could be detrimental to the goals or expected outcome of the task. These are extreme examples of why someone may not be able to empathise, however, learning about a client's occupational culture may help understand any inter-relational issues or behaviours that appear un-empathic. This could affect assessment and diagnosis. Someone who is un-empathic due to cultural influences, and someone who cannot empathise due to a personality disorder, may have different symptoms and require different treatment interventions. It may also be important to gauge how receptive a client is to the provision of empathy, that is, whether they view it as helpful or harmful.

Kakar (2003), an Indian psychoanalyst, believes that true empathy has a mystical and psychic quality that enables deep connection to humans, animals, art, and music without the need for verbal communication. Kakar argues that Western psychoanalytic empathy, which has a highly cognitive aspect, could possibly be enhanced by the Eastern healing practice of yogic meditation. Meditation involves stilling the mind of thoughts, memories, questions with no agenda or desire to know or fix anything. Kakar (2003) refers to Freud's notion of an "evenly suspended attention" (Freud, 1955b, p. 239), free from conscious thought allowing the analyst to access their own unconscious and that of the client. An example that readily comes to mind is the connection between a dog and their human. Our family dog, Ziya, could easily sense someone was feeling sad or needed comforting. Communication of this involved drawing closer to whoever needed comfort, following them around and giving a questioning look as though to say, "I can sense that you're upset, I am here for you". A deep connection between two humans does not require words, nor details about the cause. Kakar's theory leads me to question whether the provision of empathy in cross-cultural practice needs to be communicated verbally or can the unconscious psychic attunement of two minds be enough to facilitate understanding and therapeutic change?

I resonated with Kakar's view of empathy and wonder if this could be attributed to our shared Indian cultural beliefs. There is a comfort in knowing that unconscious empathy either through mirror neurons or a spiritual connection between two human beings is possible, without the need for cognition or verbal communication. For me, this also links to Rogers' (2012) idea of good enough empathy. If cultural beliefs prevent the therapist from being able to see the perspective of the client, then the emotional resonance between the dyad may suffice. Similar to Pedersen et al. (2008), I argue that cultural empathy is a skill that can be improved through practice.

Meditation and mindfulness are being incorporated into mainstream psychotherapy interventions, to combat anxiety and stress. During my clinical training, we often used mindfulness practice in group therapy. From my personal experience of yoga practice and mindfulness, I can see how useful these practices could be for opening our horizons to others' worldviews, by suspending our own cultural beliefs and values.

In the following section, I explore how therapists can go beyond their own worldview thereby extending their horizon to include other worldviews.

Worldviews and Horizons

My understanding of worldviews and horizons are that they are two different concepts. Worldview as Koltko-Rivera (2004) describes it, is limited to the person's subjective experience of the world. A horizon on the other hand involves an understanding of the world beyond the self-experiential aspect of a worldview (Gadamer, 2013). I interpret this to mean that a horizon is gained through acquired knowledge about the world we live in and share with other people, cultures, animals, nature, and the universe. In chapter two I discussed Gadamer's theory of horizons from a hermeneutic perspective. In this chapter I view 'horizon' from a psychotherapeutic standpoint. Gadamer refers to horizon as understanding text from the era (history) in which it was written and for whom (the context) it was written (Gadamer, 2013). He suggests that the reader recognises their own horizon, while also understanding the horizon of the text resulting in a "fusion of horizons" (p. 264). This hermeneutic method of interpretation and understanding through the discourse between the text and reader can be applied similarly to psychotherapy and empathy. To see the other person's worldview and horizon the therapist must open their mind beyond their subjective self-experience to understand the context of the other person's world as well as their horizon. In other words, how much of the client's affects, beliefs and behaviours are the result of personal experience and how much is through acquired understanding of the world they live in? There are two important reasons for understanding the client's worldview and horizon. Firstly, the therapist can acknowledge similarities and differences in both their worldviews bringing awareness to any biases in beliefs or values that may affect the relationship (Pedersen et al., 2008). Secondly, assessment, diagnosis and treatment interventions can be tailored specifically to match the client's cultural and personal values and goals.

Effectiveness of therapy can be compromised when therapists impose their own worldview through their empathic response to individuals with different attitudes towards mental illness and healing (Pedersen et al., 2015; Wratten-Stone, 2016). Pedersen et al. (2008) advise that accurate empathic responses in cross-cultural situations requires skill and practice through cultural competency training and more importantly from the client. Dyche and Zayas (2001) suggest therapists relinquish control of their own ego so that they can be receptive to learning from their clients, with openness and curiosity.

Chapter Summary

This chapter explored Western and non-Western, and individualist, collectivist ideologies regarding ‘self’, self-identity, and worldview. These concepts provide understanding of empathy from different cultural perspectives, and the influence cultural differences have on the perception and communication of empathy in cross-cultural dyads.

The following chapter identifies specific issues related to cultural beliefs and attitudes that may impact the provision of empathy.

Chapter 5 – Issues Preventing Accurate Empathy

This chapter identifies specific issues that may prevent accurate understanding and communication of empathy in cross-cultural dyads. Therapists may find the provision of empathy challenging due to issues such as conscious and unconscious biases, cultural encapsulation, stereotyping, power dynamics, incompatible communication styles and culturally inappropriate assessments and diagnosis. Being aware of these issues, which often arise through cultural conditioning, may help in overcoming barriers to accurate empathy. Although it may be argued that these issues are not directly linked to empathy, my view is that these factors are embedded in cultural beliefs and attitudes towards others. Therefore understanding the client, when these issues may inadvertently affect the provision of empathy, could prove challenging in cross-cultural situations. The findings from the previous chapter show that unconscious cultural beliefs affect behaviours. My rationale for including these specific issues is that therapists' behaviours and empathy towards their clients may be influenced by their cultural identities and worldview.

Biases

Governing organisations, education and healthcare systems are some areas that impose dominant cultural values on people of all cultures creating biases that prevent minority cultures from accessing services that fit their needs (Pedersen et al., 2015; Wratten-Stone, 2016). These biases tend to play out in cross-cultural dyads in therapeutic settings, often unconsciously (Reeves, 2018). Sue (2001) claims that biases are learned through social conditioning, and are bound by culture, class and gender therefore therapists' worldview will inadvertently affect their approach to therapy, how they empathise and their interaction with clients. Sue (2001) categorises biases into individual, professional, organisational, and societal levels stating that biases can have positive or negative effects on individuals or groups depending on inclusion or exclusion criteria. The author explains that at the individual level biases are formed through upbringing, social environment, and experiences with other cultures whereas professional biases occur due to learned behaviours through professional training, modelling and dominant cultural practices. For example, based on their training, a psychotherapist may have a bias towards or against a particular form of intervention, such as self-disclosure or countertransference. At the organisation level, organisations such as public mental health services may apply a 'one size fits all' dominant cultural treatment model. One such model, dialectical behaviour therapy (DBT), as noted in chapter one, is used to treat clients diagnosed with behavioural disorders and is a Western based model. At a societal level, biases favour dominant

cultural values and attitudes creating inequity, racism and prejudice towards minority groups or individuals, thereby promoting an 'otherness' of people who are culturally different (Sue, 2001). As socially conditioned individuals, therapists will inadvertently treat clients differently based on their biases and empathic understanding of clients' experiences may be coloured by such biases.

Cultural Encapsulation

Wrenn (1962) first applied the term "cultural encapsulation" (p. 445) to help counsellors and teachers adapt to the rapidly changing cultural environment in American schools. He suggested that, although inevitable, humans resist change finding it unsettling and view their reality through what is known or has been experienced from the past "seeing that which is as though it would always be" (ibid, p. 445). This gives a false reality of what might be occurring in the present. In psychotherapy, this may lead therapists to unconsciously have the notion that dominant cultural norms are how everyone lives, despite being from different cultures.

More recently, Pedersen et al. (2008) refer to therapists' cultural encapsulation as a set of cultural assumptions based on their own self-reference measures without evidence or proof of such assumptions. The authors maintain that encapsulation fosters moral inclusion and exclusion of people, creating 'in groups' and 'out groups' also known as 'othering' (Kirschner, 2012) or 'otherness' (Ivey, 1987). As a result, moral exclusion promotes antipathy and psychological distancing between cultures with extreme examples of moral exclusion being discrimination, ethnic cleansing, and genocide. More subtle expressions of cultural encapsulation are a lack of empathy and invisibility of other ethnic cultures and minority groups (Pedersen et al., 2008). Using own value systems and experiences as the only source of reference to interpret behaviour, thoughts and emotions of others is referred to as "ethnocentrism" (Pedersen et al., 2008, p. 94).

Thomas (2000) uses the term "cultural egocentrism" (p.153) instead of cultural encapsulation and state that cultural egocentrism is not limited to ethnicity but can be applied to other cultures such as countries, regions, gender, religion, language, sports, and occupation. For example a religion may assume superiority above other religions, or academics may consider themselves smarter than others. The culture has an ego that distinguishes itself more superior than others. Thomas describes cultural egocentrism as a failure to understand others' perspective, behaviours, and worldviews. In cross-cultural psychotherapy, cultural encapsulation or cultural egocentrism leads to a lack of empathy and understanding clients' experiences from

their perspective. This may reinforce feelings of oppression, shame, disempowerment, invisibility, being judged and stereotyped (Pedersen et al., 2008; Thomas, 2000). I agree that in clinical practice, cultural encapsulation may lead the therapist to think that they understand the client better than the client and make incorrect assumptions or judgments based on their own beliefs and values.

Although therapists are encouraged to bracket their subjectivity (Knight, 2020; Slochower, 2014), Pedersen et al. (2008) note that as humans we are all vulnerable to blind spots towards certain cultures and may inadvertently hold beliefs that impact on our empathic understanding of a client's cultures. Both Thomas (2000) and Pedersen et al. (2008) recommend sensitivity in cross-cultural situations, advocating an openness and curiosity in learning about other cultures. They suggest that the best means of understanding other worldviews is engaging in open dialogue with the client about their cultural identities and through cultural immersion and education.

Ivey (1987) declares that the nature of empathy requires the therapist to engage with the unique feelings and experiences of an 'other' therefore "otherness" (p. 198) is unavoidable. This form of 'otherness' appears to be different to cultural encapsulation as the therapist is aware of cultural differences of the client whereas encapsulation ignores the cultures of the other. Ivey urges therapists to address the cultural identities of the client as well as acknowledge their own cultural identities, accepting similarities and differences between the dyad as part of the relationship.

Seeing the client as the other, ties in with Rogers' and Young-Bruehl's notion that empathy means remembering that we, as therapists, are separate from our clients. What does this mean then, for the embodied emotional responses we have for our clients? Are these responses truly similar to what the client is experiencing? One explanation that may help understand the moments of deeper connection with our clients, when two 'others' bond spiritually or energetically, is Kaker's view of unexplainable mysticism that is the phenomenon of empathy (Kaker, 2003).

Stereotyping

Stereotyping differs from cultural encapsulation as the frame of reference is not from the therapist's cultural perspective, rather the assumption is that all people of a certain culture share the same traits and act or behave similarly (Sue & Sue, 2008). The predisposition in humans for group inclusion/exclusion has led to forming instinctive impressions when meeting someone new (De Waal, 2010). We use an internal frame of reference that incorporates previous exposure to experiences with people that are

similar or different to ourselves (Bošnjaković & Radionov, 2018). In social situations, people are drawn towards those with whom they share commonalities. In therapy, first impressions can be misleading and therapists who generalise or stereotype based on ethnicity, race or other cultural preconceptions are likely to misjudge the client and lack true empathy. Both Pedersen et al. (2008) and Sue and Sue (2008) warn against stereotyping clients based on race, ethnicity, gender, age, ability, religion, social status and sexual orientation as this will form a barrier to understanding the individual's worldview. On the other hand, therapists who believe that ethnicity and other cultural influences have no bearing in therapy or that everyone should be treated the same, fail to understand the effects of racism and treatment of minority cultures on their daily lives, and the impact on their worldview, cultural identities, and self-identity (Chung & Bemak, 2002).

For me, this research has highlighted that conscious and unconscious stereotyping is inevitable. Stereotyping comes from a human instinct to situate others into familiar categories. Therapists may find personal psychotherapy beneficial for discovering the origins of belief systems that underpin stereotyping. Understanding the reasons for such attitudes may help make sense of the dynamics that are created within the cross-cultural dyad and provide the opportunity to view client's unique experiences differently.

Power Dynamics in Dyads

Schwarzbaum and Thomas (2008) contend that minority cultures often experience power imbalances and oppression due to dominant cultural beliefs, practices, rules, and regulations. The authors state that power imbalances are often seen between dominant and minority cultures in areas related to race, ethnicity, socioeconomic status, gender, health and education. Nelson and Prilleltensky (2005) define oppression as the "asymmetrical power relationships between individuals, groups, communities and societies" (p. 5). Sue and Sue (2008) claim that therapists who do not view their clients as cultural beings or address cultural influences in relation to their issues may inadvertently oppress and disempower their clients.

Dyche and Zayas (2001) claim that historically psychotherapy has been practiced predominantly by European and American therapists, who generally have a higher socioeconomic status and can afford higher education. The authors suggest that clients from minority cultures who have been underprivileged, oppressed and disadvantaged due to racial and socioeconomic discrimination find themselves in a power imbalance when seeking psychotherapy. In order to rectify such imbalances, Pedersen et al. (2008) recommend therapists be mindful of power dynamics and the privileged position

they hold especially with clients from non-Western or collectivist cultures who may ‘look up’ to the therapist as the expert. Ivey (1987) recommends that therapists discuss any cultural similarities and differences, and how power imbalances may affect the therapeutic relationship, as these are likely to have been experienced outside in their lives by both parties and can facilitate deeper understanding of clients issues. Rather than being the expert, the therapist learns from the client and allows them to see the therapist as a human being.

I contend that power imbalances within the dyad, due to cultural inequities, will affect the therapist’s understanding of client’s experiences. An obvious power difference can be the colour of skin which privileges white dominant cultures. In some ways, the dynamics within the therapeutic setting, may mirror power dynamics in other areas of the dyad’s lives. Power imbalances in their daily environment may be subtle, therefore less accessible to the conscious mind. For example, the patriarch and matriarch roles men and women assume as part of their self-identity or cultural expectations, may be present and affect the dyadic relationship. These dynamics can be viewed as part of cultural norms, however, may potentially affect the individual’s sense of self and self-identity. The therapist-client relationship has its own cultural norms and power imbalances, due to the nature of the relationship. The therapist provides a service that requires certain expertise, that the client does not necessarily have. Mutual sharing of information is not present in therapy compared to a social relationship, as the client provides intimate details of their life, whereas the therapist does not. These imbalances are part of the working relationship and shows that similar to stereotyping, power dynamics are inevitable. Subtle and unconscious power differences may require the therapist to engage in personal psychotherapy to make sense of these, and to reflect on the unconscious meanings and dynamics that may arise for both the therapist and client.

Cross-cultural Communication

Risser (2019) declares that humans have multiple verbal and non-verbal modes of communication using poetry, art, facial expressions, body language and spoken language to express themselves. Each culture has its own communication style often with varied forms of explicit and implicit interactions that are easier to understand if one is part of that culture (Lee & Horvath, 2014). Pedersen et al. (2008) propose that many non-Western cultures use symbolic, indirect, or circular forms of communication therefore a client from these cultures may not respond or answer a therapist directly which could be misinterpreted if the therapist has a Western direct and explicit communication style. Hollan (2012) and Lee and Horvath (2014) state that for accurate

understanding of clients from other cultures, the way in which empathy is communicated is important if the client is to feel understood and benefit therapeutically. Pedersen et al. (2008) also argue that it is through empathy that clients learn to make sense of their emotional states and experiences, become conscious of the reason for their behaviours, relationship patterns and decision-making processes. Sue and Sue (2008) remark that cross-cultural misunderstandings and miscommunication can lead to a lack of trust in the therapeutic alliance and reinforces cultural oppression, reducing therapeutic benefits while increasing the likelihood of early termination of therapy.

Grondin (1997) proposed that:

> We come into contact with another mind not immediately but only by taking a detour through the objectivizations or meaning-bearing forms whereby it makes itself cognizable… The objectivizations to be interpreted (language, but also gestures, monuments, traces, tones of voice, and so on) represent or stand for the inner spirit or mind that one is trying to understand. (p. 126)

Grondin's words suggest that both parties introject the explicit and implicit meaning of what is being communicated by using one's embodied self, making meaning of what is expressed verbally and non-verbally, sifting through feelings, emotions, thoughts, previous reference points, facial expressions, and body language. These are all done consciously and unconsciously. A trembling voice, for example, suggests that the person is experiencing some emotion however unless the therapist is able to interpret accurately what those emotions are and the context of what was expressed, then empathy may not occur. How the therapist conveys empathy becomes more challenging in culturally diverse dyads when the communication style of the therapist does not match that of the client (Baruth & Manning, 2016). Semantics, syntax, and intonation become highly important if empathy is to be conveyed and experienced by the client in a manner they recognise and are accustomed to.

Schleiermacher et al. (1977) sum up the dance of interpretation and understanding between listener and speaker stating that "one cannot understand something spoken without having the most general knowledge of the language, and at the same time, an understanding of what is personally intended and uniquely expressed" (p. 374). Just as two dancers learn about the movement and rhythm of the other so that they may synchronise their steps, so do two people when attempting to understand each other. Pedersen et al. (2008) posit that accurate empathic responses are dependent on

correctly interpreting and understanding clients' use of verbal and non-verbal forms of communication from their cultural perspective.

Baruth and Manning (2016) claim that misunderstandings occur due to language barriers, especially when the spoken language in therapy is not the client's first language or when words are used differently by people of different ages, such as teenagers who often use slang or abbreviations while talking or texting (Metge & Kinloch, 2014). This led me to reflect on how other non-English cultures might define empathy. Hence I sought dictionary definitions of empathy in three languages to compare meanings. Table 2 shows the English definition as an example of a Western perspective. Table 3 shows the te reo Māori definition, and Table 4 shows the Hindi definition, both representing a non-Western perspective from different parts of the world. I chose English because this literature review is written in English; te reo Māori as it is a language from my country of birth; and Hindi as it is my first language.

I noticed that English was the only language that defined empathy explicitly going as far as specifying the difference between empathy and sympathy in their definition which I have included in Table 2. Hindi had five words for empathy, while te reo Māori had two words. I have presented the definitions below in table format to show the differences and similarities between the Western and non-Western understanding of empathy.

Table 2 ***English word and definition of empathy***

English	**Definition**
empathy	"The ability to understand and share the feelings of another."
	Usage: "People often confuse the words empathy and sympathy. Empathy means 'the ability to understand and share the feelings of another', … whereas sympathy means 'feelings of pity and sorrow for someone else's misfortune"

Note. Adapted from https://www.lexico.com/definition/empathy?locale=en. Copyright 2021 by Lexico.com.

Table 3 ***Te reo Māori words and definitions of empathy***

Te reo Māori word	**Definition**
aroha	"affection, sympathy, charity, compassion, love, empathy"
ngākau aroha	"empathy, sympathy, compassion, kindheartedness, kindness, consideration, caring, benevolence"

Note. Adapted from https://maoridictionary.co.nz/search?idiom=&phrase=&proverb=&loan=&histLoanWords=&keywords=empathy. Copyright 2003-2021 John C Moorfield, Te Aka Māori Dictionary

Table 4 ***Hindi words and definitions of empathy***

Anglicised word	Hindi word	Definition
samavēdanā	समवेदना	“commiseration, condolence, empathy, sympathy”
samānubhūti	समानुभूति	“empathy”
sahānubhūti	सहानुभूति	“commiseration, compassion, concern, condolence, empathy, feeling, fellow-feeling, mercifulness, mercy, shine, sympathy”
hamadardī	हमदर्दी	“commiseration, empathy, pity, shine, sympathy”
parānubhūti	परानुभूति	“empathy”

Note. Adapted from https://www.shabdkosh.com/dictionary/english-hindi/empathy/empathy-meaning-in-hindi. Copyright 2021 by Shabdkosh.com.

As shown, the English definition separated empathy from sympathy (Hollan, 2012; Pedersen et al., 2008), whereas the Hindi and Māori definitions suggest that empathy overlaps with other feeling states such as love, compassion, and sympathy. I know from personal experience, that the Hindi words are used differently depending on context. I noticed that Hindi and te reo Māori definitions did not describe the meaning of each word, merely stating other feelings or emotions, which I interpreted as an example of the explicit and implicit communication styles in Western and non-Western cultures. As explained by Lee & Horvath (2014), Western cultures prefer direct and clear communication that is unambiguous, hence the detailed explanation provided in English, with the additional description of sympathy in case there is any ambiguity in understanding. In contrast, non-Western languages such as Hindi hold contextual and nuanced meanings for individuals. For example, the words ‘samavēdanā’ and ‘hamadardī’ are used in different circumstances. The holistic nature of non-Western cultures is also I believe, embedded within language. Empathy, therefore in Hindi and te reo Māori has wider, inclusive and expansive meaning that encompasses other feelings and emotions. My understanding of empathy comes from a holistic perspective that evokes feelings and sensations that cannot be explained fully in words clearly, directly or unambiguously. Perhaps that is why there is no singular way of describing empathy, hence the reason for the various definitions of empathy by authors in this literature review. Each person is attempting to find words to describe empathy that language in itself cannot explain. My exploration of the three definitions in English, Hindi and te reo Māori highlighted the difference in language and communication styles of different cultures, and the importance of effective communication between therapist and client.

Culturally Appropriate Assessments

Leach and Aten (2010) caution that assessment, diagnosis and treatment strategies of non-Western clients using traditional Western diagnostic tools and methods may exclude cultural beliefs and attitudes towards mental health. Understanding how clients perceive illness and well-being is important so that treatment strategies can be tailored accordingly to achieve positive therapeutic outcomes. Diagnostic manuals, such as the DSM-V (American Psychiatric Association, 2013) and PDM-2 (Lingiardi & McWilliams, 2017) have made provision within their guidelines to ensure sensitivity and inclusion of cultural perspectives during assessment and diagnosis. In Aotearoa, the organisation for registered psychotherapists have also included cultural guidelines in their code of ethics (PBANZ, 2020) in an attempt to redress inequitable provision of mental health services for minority cultures.

I agree that without awareness of cultural beliefs and health practices, incorrect assessment and diagnosis may miss the true significance of the illness.

Chapter Summary

In this chapter I explored the specific issues that may affect the provision of empathy due to therapists' cultural identities and worldview. Biases, stereotyping, power dynamics, cultural encapsulation and communication styles are unconsciously part of the intersubjective relationship between cross-cultural dyads. Therapists' awareness of their own beliefs and values may help understand the ways in which they interact with clients and improve empathy in cross-culturally challenging situations.

In the following chapter, I discuss my findings and reflect on the implications for psychotherapy in general and particularly for psychotherapists in Aotearoa. Strengths and limitations of this research are identified with suggestions for further research, ending this dissertation with my conclusions.

Chapter 6 - Discussion

This hermeneutic literature review was conducted to research the question, " What challenges do psychotherapists experience in the provision of empathy in cross-cultural dyads?". I explored the interpretation and understanding of empathy within psychotherapy and related disciplines from general and cultural perspectives. I then investigated Western, non-Western, individualist, and collectivist ideologies that influence cultural beliefs and values and the effect their ideologies have on peoples' worldviews. Worldviews were linked to culturally bound perceptions of empathy and how this affects therapists' provision of empathy. Specific issues were identified that make empathy challenging for therapists within cross-cultural dyads. In this chapter, I discuss my findings and the implications for psychotherapy, particularly in Aotearoa New Zealand. I reflect on the strengths and limitations of this research and suggest areas for further research.

The findings show that authors in the field of psychotherapy have unique ways of describing what constitutes empathy. I believe that this is due to the intangible and uniquely experiential nature of empathy between two people. By attempting to explain in words what empathy means diminishes the whole experience, which is more than the sum of its emotional, cognitive and communicative parts. Some authors recommended that therapists reflect on their own worldview and cultural identities, so that they are conscious of the impact this has on empathy and the therapeutic relationship. Recognising their own beliefs and values, and how these create biases when working cross-culturally with clients, helps therapists become aware of the challenges that may be experienced in the provision of empathy. Cultural beliefs and values are embedded in our self-identity and view of self, which will inevitably influence therapists' expression and communication of empathy and how it is received by clients, who have their own cultural beliefs and values. My argument is that all dyads are cross-cultural, in at least one aspect or another therefore cultural similarities and differences will exist. The result of these similarities and differences will influence the dynamics of the relationship and impact on accurate understanding of clients.

A key point Gadamer makes is the notion of "I and thou … and … I and we" (Gadamer et al., 2001, p. 79) in relationships. Understanding another person's world through empathy will always be second-hand and is complex and multi-layered. The therapist remains a separate self and at the same time has a unique connection and bond with the client that is the 'we' together in relationship. I was particularly drawn to the idea that we are at times, like all others, at times, like some others and at times, like no one else (Sue & Sue, 2008). This highlighted the similarities and differences in people and

the contradictory uniqueness and generalisable qualities in each individual. Another theory that felt applicable to empathy is Sue's 'Tripartite Development of Personal Identity' (Sue, 2001). I was able to link the essence of the theory to empathy, by interpreting that sometimes empathy requires understanding of cultural identities; and at other times our basic human shared feelings, and similar life experiences are sufficient for the client to feel understood. At times, unconscious emotional attunement may be enough to understand how the other feels and at other times empathy may require conscious cognitive, emotional and communicative responses that reflect the uniqueness of the client. Therefore, empathy may be challenging at times and on other occasions relatively easy; with each client there will be varying degrees of challenge.

The literature outlined some of the issues that can be experienced due to differences in cultural beliefs. In humanistic and relational psychotherapies, this is particularly important as empathy is the means by which therapists learn about the client's psychological inner world which includes how they see themselves, how they relate to others and the effects of these on their behaviours. To provide appropriate assessment, diagnosis and treatment that provides the best outcomes for the client, therapists must be able to interpret accurately that which is communicated by the client verbally and non-verbally if they are to understand their clients.

Implications for Psychotherapy and Therapists

Through this research, I developed a deeper understanding of my cultural identities and how it affects my relationship with clients. This has changed the way I work and has broadened my ability to empathise with those from different cultures and worldviews. This literature review highlighted the importance for therapists to recognise and understand their own cultural belief systems and worldview and how this impacts their interpretation and understanding of clients' issues. Covering therapists' cultural belief systems within psychotherapy training may benefit the therapeutic alliance and improve outcomes for clients. I propose that cultural competency through the use of a cultural genogram to ascertain cultural beliefs and values may be helpful to include as part of an assessment process.

The dominant and minority cultures in each country have unique relationship dynamics. This fosters inequities and disparities for minority cultures to access equitable and culturally informed mental health services. Psychotherapy training that provides psychotherapists with skills to negotiate cross-cultural challenges would benefit both therapists and clients. An important aspect of cultural competency may include learning

how empathy is defined and understood in different languages, as this will affect interpretation and communication within cross-cultural dyads.

In Aotearoa New Zealand, it has been shown that Western mainstream mental health care models do not necessarily match the needs of Māori clients. Māori health models have been developed using a holistic approach that may benefit others from cultures whose worldviews are collectivist and holistic. An integrative approach that combines evidence-based mainstream therapies with culturally sensitive treatment strategies may improve therapeutic outcomes, not just for Māori but other cultures too.

Research Strengths

Using a qualitative methodology suited the research as the purpose was to explore a phenomena that is subjective and holds multiple realities. The hermeneutic methodology allowed me to interpret and understand the findings from my point of view as it recognises that reality is based on individual perceptions, that there are no definitive answers or a “single reality” (Davies & Fisher, 2018, p. 23). Using a literature review, as the method, enabled me to view a wide range of literature from various viewpoints. From the wide range of literature, I was able to make links between cultures and worldviews, and the impact of these on the provision of empathy.

The qualitative interpretive paradigm enabled me to immerse myself as ‘the therapist’, as well as the researcher. This created a strong dialectic connection to the literature, and the various theories and concepts addressed. I applied the hermeneutic circle of inquiry (Boell & Cecez-Kecmanovic, 2010) to sort, identify and assess how I formed my cultural identities, self, self-identity and worldview. I identified the influences of different collectivist, individualist, Western and non-Western cultures that have shaped my beliefs and values. Through this process, I became conscious of my biases and how these impact on my provision of empathy in clinical practice. I was able to reflect on the specific challenges I have when empathising with those who hold different worldviews. The immersion of myself into the hermeneutic process, highlighted blind spots in my practice as a therapist, of unconscious biases and attitudes towards clients of different cultures. This process has provided an opportunity to deepen my engagement with clients and improve my empathic responses.

Although the findings may be different, if other therapists were to use the same literature to understand the challenges they may have in the provision of empathy, the hermeneutic process itself is transferable. The application of interpreting and understanding can be applied by other therapists or researchers with no expectation of coming to the same conclusion as another person. Empathy, which is subjective and

open to interpretation linked perfectly with the hermeneutic interpretive research methodology.

Another strength of this research, I believe, is that the findings add to the limited understanding of empathy from a collective or non-Western perspective. My position as a minority, non-Western and holistic therapist and researcher, provides a fresh perspective that may help other therapists experiencing similar issues in Aotearoa New Zealand, which has a predominantly Western outlook towards mental health. My cultural identities gave me an inside view to the difficulties people from minority and non-Western cultures experience, when accessing psychotherapy. For me, this research validated my personal view of empathy, which felt different from the Western psychotherapeutic understanding of empathy. I have a better sense of the impact of cultures and worldviews on behaviours and relationships. The self-reflexivity involved, while conducting this research, has been invaluable in clinical practice, as I have a broader understanding of myself and my clients.

Research Limitations

A limitation of using a hermeneutic interpretive methodology is it's subjectivity and interpretive position, making it difficult to generalise data. My interpretation cannot be generalised by other researchers, who will interpret from their own perspective. Another limitation was that the majority of literature accessible and sourced for this review contained data pertinent to cross-cultural dynamics in America and Europe. Cross-cultural dynamics in other countries may experience different issues, therefore some of the findings may not apply universally, in other countries.

Each research paradigm and methodology has its own parameters that limits exploration of research topics. The structure of a hermeneutic literature review does not, for example, include human participants, which uses a different qualitative research methodology. Instead of a literature review, a different method, such as a survey or by interviewing therapists about their experience of empathy within cross-cultural dyads, would have provided different findings.

Due to time constraints and scope of the research study, the research question had to be limited to a particular area of focus. I chose to explore the challenges in the provision of empathy in cross-cultural dyads, as my work involves therapy for individuals rather than families, couples or groups. The findings may have shown different results when applied to other cross-cultural therapeutic relationships.

Suggestions for Future Research

During this research, I became aware of gaps in literature that could be explored in future research, especially for psychotherapists practising in the South Pacific region. One of the reasons for this research, was due to my personal observation during clinical training, showing that minority cultures utilised public mental health services less than Pākehā cultures. This observation was affirmed by Wratten-Stone (2016), in a review of Māori models of mental healthcare and the lack of use by Māori of mainstream mental health services. Research to understand the worldview of South Pacific cultures, including Māori, may help clients from these cultures feel safe and understood, through accurate empathy, when accessing treatment.

Majority of the literature focused mainly on the cross-cultural ethnic differences in dyads. It would be interesting to understand how cross-cultural differences due to gender, class, education, sports, occupation, spirituality and religion affect the provision of empathy, and whether the same issues such as biases and stereotypes apply.

There did not appear to be much research focusing on the experiences of therapists in the provision of empathy, in cross-cultural dyads. An empirical study using a questionnaire, interview process or survey, would provide valuable insight into psychotherapists clinical experiences. Similarly, studies to understand the experience of empathy from clients' perspectives would identify issues that contribute to misunderstandings and misinterpretations, due to cultural differences. These types of studies provide clinical data that may help improve empathic understanding of clients when working cross-culturally.

Another area for study could involve understanding the meaning of empathy in different South Pacific languages. My exploration of the definitions in English, Hindi and te reo Māori showed differences in the way empathy is defined. It would be interesting to see if there are similarities that link the definitions of empathy to worldview perspectives.

These suggestions for further research aim to provide a better understanding of empathy from a cultural perspective.

Conclusion

This literature review has highlighted that the concept of empathy is perceived differently across cultures. Therapists, at times, will find it challenging to empathise in cross-cultural dyads, when cultural beliefs and values of the therapist and client are different. These factors influence the therapist's provision of empathy in cross-cultural situations, as we strive to better understand our clients through deep empathic connection. Therapists may benefit from understanding their own cultural beliefs and values and how these affect the provision of empathy. Learning from clients, about their cultural beliefs and values may increase empathic understanding of the client's internal experiences and improve therapeutic outcomes. Treatment approaches that can be customised to accommodate different cultural beliefs regarding mental health, would reflect the cross-cultural nature of contemporary psychotherapy in multicultural South Pacific nations.

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