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CULTURAL CONDITIONS OF THERAPY

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ABSTRACT. *Drawing on the relevant literature and the authors' own experience and work, this article discusses therapy in the context of culture. Culture is defined and distinguished from race and the implications of cultural variables discussed in relation to the practice of therapy as well as the training of therapists. Rogers's (1957/1990b, 1959) six conditions of therapeutic personality change are developed from a cultural perspective.*

INTRODUCTION

Race and culture have not been seen as necessary subjects for investigation in psychology and its application in the field of counselling and psychotherapy. Moreover, until recently, few professional training courses in these fields have encouraged sufficient study of these issues. From a person-centered perspective, we consider culture and cultural variables to be both necessary and sufficient conditions which affect the therapeutic relationship and which require further development and study. Rogers himself identified experiential knowledge of cultural setting and influence as important preparation for the training therapist (Rogers, 1951).

There are many reasons for this lacuna in the therapeutic literature, theory, training and practice, reasons which depend on the different underlying assumptions of the theoretician, trainer and therapist. For some it is due to a (false) premise of (Western) cultural neutrality; for others it is another example of cultural imperialism. From our different backgrounds, experiences and involvements we are aware of differing political perspectives and different psychological traditions which elaborate understandings of race and culture in society. In this article, however, we are concerned to discuss our contribution from *within* the person-centered approach (PCA), thereby developing the PCA as well as its application to this developing field. In doing so we are responding to criticisms of Western psychology in general and of the PCA in particular as being individualistic. Whilst some of these criticisms are misrepresentative (e.g., Ho, 1985) and, whilst Rogers himself, particularly in his later years, became more interested in larger, social issues (see Rogers, 1978), Holdstock (1990) observes that the point of departure of the PCA has remained embedded in empowering the individual as the ideal means of accomplishing societal change' (p.112). Patterson (1995) argues, from a person-centered perspective and counter to current perspectives on cross-cultural therapy, that concepts such as those of the fully functioning person (Rogers, 1963) and self-actualization (Maslow, 1956) are ultimate -- and universal -- goals in psychotherapy. This article is thus written from the perspective of cultural psychology in which culture is made explicit rather than remaining implicit and made intentional rather than remaining unintentional or accidental (Shweder, 1990).

One reason for the lack of a wider cultural consideration in therapy has been the growth in Western cultures over the last 100 years of various 'helping' professions (see Hillman & Ventura, 1992). In Protestant Christian cultures particularly, the professional is invisible, shut with their

client behind closed doors and closed codes, defining themselves in terms of their job, status and qualifications instead of as a person who is part of a community. Tudor (in press) identifies community as one of the parameters of integral (integrative) counselling. Thus our race and culture become personal rather than public matters, lying behind our 'colour-blind' professional persona and the perceptions and assumptions of others. Given this attitude, the client has difficulties in creating a point of reference for the professional therapist. Time is spent in guesswork: who is this human being? what is their frame of reference? - and this detracts from the creation of the (pre-)condition of psychological contact. Informal research conducted by one of the authors (JS) amongst 1,000 General Practitioners (GPs) and 3,000 of their patients revealed that whilst the GPs defined themselves in terms of their qualifications, status and specialization their patients viewed them in terms of their culture, gender, age, idiosyncratic behaviours and attitudes to life (see Figure 1).

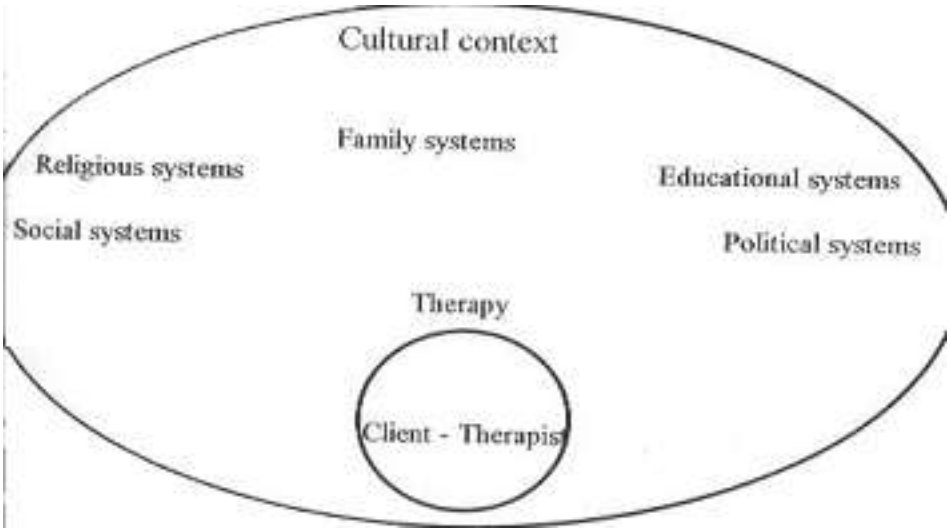

Figure 1. The cultural context of therapy.

This reflects that whereas clients are generally more interested in the *conceptual* level of the therapeutic relationship, which, according to Paniagua (1994), includes the client's and therapist's perceptions of sincerity, openness, empathy, motivation, etc., doctors/(therapists) appear more concerned about the *behavioural* level of relationship which includes the client's perception of the doctor's/(therapist's) competence in their profession.

In their multicultural perspective on counselling and psychotherapy, Ivey, Ivey & Simek-Morgan (1993) suggest that there are four key concepts in the construction of counselling and psychotherapy: our worldview, our cultural intentionality, the concept of the scientist-practitioner, and ethics. Here, we discuss worldview as an aspect of empathy and cultural intentionality as part of congruence (see subsections below); throughout our discussion and following in the Rogerian tradition we draw on scientific study and research to inform our practice, practice which is also informed by a moral base on which rests codes of ethics and professional practice (e.g., BAC, 1992/1993, also see Bond, 1993).

Before elaborating our perspective on cultural aspects of therapy we consider some definitions of relevant terms.

DEFINITIONS: RACE, CULTURE AND ETHNICITY

Influenced by Darwin, race used to be defined in terms of genetic characteristics, for instance, by skin colours, facial features, hair texture and blood grouping, leading to the identification of four races: Arian (of which Caucasian is a European sub-division), Negroid, Dravidian and Mongolian. This anthropological tradition with its arbitrary divisions has been challenged by social scientists to include social, political and cultural factors. We consider a more useful definition of race as: 'a category of persons who are related by common heredity or ancestry and who are perceived and responded to in terms of external features or traits' (Wilkinson, 1993, p.19). Most dictionaries define culture in terms of biology - 'the artificial development of macroscopic organisms' (Onions, 1933/1973, p.47 1) - and intelligence -'the intellectual side of civilization' (Ibid., p.47 1). Wider definitions include ethnographic variables (nationality, ethnicity, language, religion), demographic variables (such as age, gender, place of residence), status variables (social, economic, educational) and affiliation variables (formal as well as informal). Another term in this field - ethnic - strictly refers to nations (Onions, 1933/1973); however, Wilkinson (1993) refers to ethnicity as 'a shared culture and lifestyles' (p.19). The significance of such distinctions is thus that an individual may belong to or identify with a race without sharing culture or ethnic identity associated with that race -- which difference may be explained in terms of the process of acculturation. In terms of therapeutic relationships a common assumption that a black client should work with a black therapist may, therefore, be seen to be at best a generalization or at worst patronizing and not relevant. A more sophisticated approach must take account of race, culture and ethnicity. Using these terms, the authors may identify and be identified as follows:

Table 1. A comparison of race, culture and ethnicity.

Race	**Culture**	**Ethnicity**	
JS	Arian	British Asian	Asian (Sikh)
KT	Arian (Caucasian)	British	English

However, if we consider culture in its widest sense (as above), ethnicity becomes only one aspect of culture and we may elaborate a more comprehensive and useful schema (Table 2).

We have not included colour as a part of culture as it is more properly an aspect of race, both in the anthropological traditional and, more recently, as a political factor by which, for instance, 'black' is seen as a political statement of identity and solidarity. It is also used as a distinguishing term which highlights that black people in society are discriminated against on a wide range of socio-economic issues.

CULTURE AND THERAPY

These variables are conscious – or, perhaps more commonly, subconscious –filters through which the therapeutic relationship is medicated. The issue is not *whether* they exist but *how* they affect the relationship and how they may be brought into consciousness or awareness and made accessible in a therapeutic process in and by which both therapist and client may examine how such variables affect the therapeutic relationship. This presupposes that the therapiat is conscious, clear and intentional about their own cultural filters – and hence this becomes a key issue in the training of therapists.

Table 2. An elaboration of cultural variables.

Culture	**JS**	**KT**
Ethnographic variables		
Nationality	British	British
Ethnicity	Asian (Sikh)	English
Language	Punjabi	English
Religion (family)	Sikhism	Non conformist Christian
Demographic variables		
Age	Middle-aged	Middle-aged
Gender	Male	Male
Place of residence	Midlands	North
Status variables		
Social	Middle class	Middle class
Economic	Self-employed	Self-employed
Educational	Private school	Comprehensive
University	(not completed)	University (twice)
Political	Conservative	Socialist
Affiliation variables	A family man	--

In recent years there has been a considerable debate that therapists and therapy are essentially middle-class phenomena. The debate posits that therapists from well-educated, middle-class backgrounds are not equipped to deal with people from different social classes or cultures; similarly, 'talking therapy', a therapeutic tool which relies on the verbalization of feelings, is more suitable to clients who are also from middle-class backgrounds (who are often pejoratively referred to as 'the chattering classes'). This has led to therapy being examined from feminist (e.g., Chaplin, 1988), black (e.g., Speigilt, Myers, Cox & Highlen, 1991), cultural (e.g., Kareem & Littlewood, 1992), and gay perspectives (e.g., Davies & Neal, 1996). This has led to the polarization of views about client: therapist choice. These views may be summarized as those of *cultural compatibility* in which racial, cultural and ethnic (and other) barriers are minimized, usually by the 'matching' of therapist to client; and a *universalistic approach* in which theories about human beings, their nature and development and therapy are viewed as universally applicable and therapeutic skills as universally transferable.

The integrity of the therapeutic alliance may be strengthened by matching clients to therapists with similar demographic backgrounds (Beutier, 1981, 1989). One problem with the cultural compatibility argument, however, is the question of limits to that compatibility. One women's therapy center, which, by virtue of its existence, made only women therapists available to women decided to extend their notion of compatibility to the provision of black women therapists for black clients but, at the same time, argued against lesbian clients having access to lesbian therapists (on the inconsistent basis of a universalistic argument: that all their therapists were sensitive to issues of female sexuality). On a conceptual level, compatibility involves the exploration of whether a particular theory, rooted in one particular culture, is compatible with or transferable to other cultures - for a discussion of which as regards the PCA, see Prasad (1984), Williams de Couderc (I 984) and Holdstock (I 990).

At best, the universalistic approach means that what is relevant in the assessment and treatment of clients from multicultural groups may be taken as evidence of the therapist's cultural sensitivity

and cultural competence (see Paniagua, 1994). However, a problem with the universalistic approach is that it is based on assumptions about the nature and range of the training of therapists which in practice may not necessarily equip them to deal with issues of culture -or assessment. Also, particular orientations or 'schools' of or approaches to psychology and therapy need to argue their applicability across cultures. Patterson (1995), for instance, argues that the core conditions, together with what he refers to as 'concreteness or specificity' in responding to the client, may be summarized as love in the sense of agape (self-giving) and that these conditions 'are part of all the great world religions and philosophies'(p.60) (see Purton, 1994; Brazier, 1995). Linking the critique of individualism to the universality of psychotherapy, Littlewood (1992) argues that historically psychotherapy became accepted precisely because it 'was able to ignore social contexts in favour of intrapsychic factors ... [which] helped establish psychoanalysis as a universal (and thus a 'scientific') process' (p.8).

Our belief is that there is a middle ground between cultural comparability and universalism: namely that, from a cultural perspective, all the factors in Table 2 (above) are important in any therapeutic relationship. This analysis, however, prioritises the *therapeutic relationship in context* (as outlined in the next section) (see Tdor, in press) rather than any crude 'matching' of client with therapist on the basis of race, gender, sexuality or disability alone. This is not incompatible with support for client choice.

Rogers (1957/1990b, 1959) identified six conditions of therapy and maintained that these -and not the 'core conditions' alone (as is commonly misunderstood) -- are both necessary and sufficient conditions for therapeutic personality change. A belief in the necessity and sufficiency of these conditions distinguishes the person-centred therapist from those of other orientations. These six conditions thus represent a universal and integrative approach to therapy (Rogers, 1957; see Bozarth, 1996). However, there is a danger that these conditions are viewed somewhat simplistically and outside of cultural contexts. Using the six conditions as an integrative and organizing framework, we elaborate each one, taking account of cultural variables, settings and influences. In doing so, we are concerned to *describe* cultural conditions for therapeutic change rather than *prescribe* certain actions, behaviours, feelings, thoughts, etc. - a common approach to theory and practice in cross-cultural or trans-cultural therapy (see, for instance, d'Ardenne & Mahtani, 1989).

THE CULTURAL CONDITIONS FOR THERAPEUTIC CHANGE

Psychological contact

This first condition specifies ‘that a minimal relationship, a psychological contact, must exist ... [and] that each [person] makes some perceived difference in the experiential field of the other’ (Rogers, 1957/1990b, p.221). Rogers suggests that it is probably sufficient if each person in the relationship makes some '*sub*ceived' difference, i.e., a difference the impact of which the person concerned may not be consciously aware. We consider this hypothesis by elaborating the notion *of subception* in relation to three areas: pre meeting, the development of psychological contact, and the cultural impact of the therapeutic environment.

Psychological contact between client and therapist begins before their personal meeting i.e., through the therapist's presentation of themselves in the world, by reputation, by word-of-mouth as well as through more formal publicity. It is common in Western Protestant cultures that therapist use some formal publicity (business cards, adverts, etc.) and, indeed, many clients expect this. In other cultures people rely on word-of-mouth and the therapist may be reluctant to publicize themselves formally: 'Whoever needs me finds me' (African/Asian saying); indeed in many cultures there are important myths about the journey to find wisdom. There is also a belief that both guide and pilgrim (client) will seek each other out when the time is right for each one

of them (see, for instance, Kopp, 1974). If we are to be more explicit about our culture -- which is what we propose - it is important for the therapist to be visible in terms of their value system or'world view', beliefs and standing in the community. This then allows us to be clear in and about our relationship with clients and offers the client the safety that the therapist is not a detached, remote or mystical figure but an accountable member of the community. This is reflected in how the authors are viewed differently. JS is known locally as being a member of the community, the Chair of a local Family Service Unit, and married, living with his wife and mother and therefore fulfilling traditional Asian requirements of an eldest son. He is called upon to mediate between different communities and is treated as an elder. He is known as a therapist and he is visible as such. He is invited to functions by clients especially the blessing of babies, marriages and funerals: the rites of passage. By contrast KT is known as a professional with degrees, qualifications and professional affiliations, specialising in certain areas of work. He has written a book and a number of articles. Having been active in a number of communities, he now moves more in professional circles. Despite this polarity, due to our influence on each other over nearly ten years of friendship, there is a certain cross fertilisation of ideas and practice -- which this article represents.

Face to face meeting is also influenced by cultural variables. A Hindu client who was nervous about meeting his new Sikh therapist felt affected and reassured on hearing 'arti', Hindu welcoming music, a tape of which had been accidentally left on by the therapist's wife -- a Christian! This is an example of the establishment of psychological contact (probably at a subceived level) through a cultural frame of reference. Through the 'contact' of the tape the therapist's culture was made visible, including (in this example), the fact of his 'mixed' marriage -- which was a pertinent issue for the client. In making contact with clients, many beginning therapists will rely either on 'intuition' or procedures -- a polarity reminiscent of the dangers in resolving the developmental crisis of industry vs. inferiority (Erikson, 1951/1977, 1968). Others believe that they have to be able to work with any client or 'presenting problem'. For us this is not only not true but is also dangerous. Developing our capacity for and awareness in making psychological contact with others is a process which integrates both intuition and procedure through experience and training. At the beginning of an initial session a client started the conversation by saying that she had few days to live and then proceeded to talk quite lightly about her recent sexual exploits. The therapist responded by saying that she was deeply touched by the client's impending death. After a few minutes of deep silence, the client left looking touched and thoughtful. The therapist experienced this contact as 'many lifetimes of relationship' and as a moment of genuine and profound contact between herself and the client. What is most important is the therapist's awareness of their own culture and how they make psychological contact with people in this example about death and sex -- both evocative subjects. Also therapists need to be aware of how they make contact procedurally as well as any issues they may have with this, such as having a rigid position about never or always shaking hands with clients or making them a cup of tea. It seems to us that such cultural considerations about psychological contact are more important than prescriptions about learning about other cultural traditions about 'meeting, greeting and seating'.

This said, it is also important to know that clients will assess or even judge the therapist from their working environment. One therapist who conducted his therapy in a book-lined room learned later that this engendered for some of his clients a perception (and, probably a subception) that he was highly knowledgeable and, furthermore, a fear that they would be considered ignorant. This is not to say that therapists should not practice in such rooms (which would be prescriptive) but to note the possible impact of such variables, often at a subceived level (-- a descriptive observation). In this example, psychological contact was established by one client

on seeing the therapist in a local supermarket for, as he later commented, he then saw the ordinariness of the therapist.

A further point of contact is the view, common in both Africa and Asia, that both the therapist and the client are on the journey of discovery:

'Who, then is the therapist, and who is the patient? In the end, everyone is both. He who needs healing must heal. Physician, heal thyself. Who else is there to heal? And who else is in the need of healing? Each patient who comes to a therapist offers him a chance to heal himself. He is therefore his therapist. And every therapist must learn to heal from each patient who comes to him. He thus becomes his patient. God does not know of separation (Foundation for Inner Peace, 1976, p. 16).

(Client) incongruence

For Rogers, incongruence refers to the discrepancy between the actual experience of the organism and the self picture or self-concept of the individual as they represent – literally, *re-present* -- that experience and others to themselves and others. Thus, someone telling a joke against themselves and their culture, from one perspective an example of self-oppression or internalized oppression, may, within the PCA, be viewed as an incongruence between that person's genuine or congruent experience of themselves and an introjected view of themselves as-others-see-them which is part of their self-concept as a result of their distortion of social experiences and denial of sensory and visceral experiences. Rogers's (1951) theory of personality is a sophisticated framework within which we can describe people's experiences and development and the relation between the two. Although this notion of the self-concept is based on an 'I' self-concept it is equally applicable to a 'we' concept (Nobles, 1973), a concept which is a more relevant notion in many cultures.

Rogers describes three (process) elements of incongruence: vulnerability, anxiety and awareness. Firstly, 'when the individual has no awareness of such incongruence in himself [sic], then he is merely vulnerable to possibility of anxiety and disorganization' (Rogers, 1957/1990b, p.223). Secondly, if the individual dimly perceives -- or subceives -- some incongruence then they develop a tension or anxiety. The third process is when the individual is aware of his or her incongruence e.g., 'some element of their experience which is in sharp contradiction to his self-concept' (lbid, p.233). Self-concept in the PCA is not only a problem or incongruence with self but also may be understood as incongruence with self-in-context, in relation to family, environment and culture.

The following case example reflects these three elements of incongruence. One particular client initially hid his Moslem faith from his therapist (vulnerability). Later, when he discussed this, he 'admitted' that he was scared that his therapist was going to 'tell him off because he was not being 'a good Moslem' (anxiety). Rather than challenging the client's frame of reference (in which he was 'guilty'), the therapist firstly reflected on this issue in terms of his own cultural references about 'being good', forgiveness for making mistakes, and reparation and absolution. From this the therapist and client identified the client's incongruence which, it emerged, was based on his being selective about an aspect of Moslem faith (i.e., his culture). The therapist and client then explored the client's perception of Islam, following which the client did what was required to seek and achieve forgiveness. This reflected the client's awareness of his incongruence and his achievement of congruence with himself-in-his-cultural-context.

Client incongruence is experienced by the client; it may only be perceived and assessed by the therapist. In terms of visibility - and visible pedagogy -- therapists need to acknowledge the basis of their assessment of client incongruence. Different underlying assumptions about person-centred assessment or, for instance, psychiatric diagnosis affect the way we view the world,

ourselves, our role/s, our clients and their 'presenting problems.' An ability to assess people taking account of cultural variables is not only an issue of competence but also one of ethical principle (see Paniagua, 1994). This is also crucial in being aware of our own incongruence as well as that in our practice which may limit the range of clients we may attract and/or with whom we work.

Often the context in which we live is incongruent and generates incongruence:

> 'We have been unwittingly trained to worry, trained to struggle by a society that thinks it is teaching us well but that doesn't understand the very fundamentals of a life well lived. And so we end up worrying and struggling. Many of us go to therapy ... it may teach us to adjust to this world, it too often doesn't teach us how to rise above the clouds' (Jeffers, 1996, p. 10).

Therapy too, and in particular 'talking therapies', may exacerbate incongruence. The accumulation of knowledge and 'awareness' can become another form of materialism -in a 'banking' concept of education and training - which may block an inner and deeper understanding of life. Instead of become truly autonomous, the client takes on the received wisdom. Kabir, a saint who lived in India five centuries ago, one day offered an axe to those passing in the marketplace and cried, "Chop off and cast away your head if you'd walk by my side". Similarly, Kopp (1974) suggests in the title of his book that *if you mieet the Bhuddha on the road, kill him! !* This has major implications in the field of cross cultural therapy when clients may adopt the predominant cultural norm about therapy and (exeternal) authority. An Asian client had been seeing a white English therapist and had been comfortable in talking about her family problems and her cultural dilemmas. She then began to see an Asian therapist from the same culture and became uncomfortable in talking about these same issues and, later, challenged the Asian therapist for being incompetent. What the client was really saying was that an Asian could not be a competent professional: she was assessing the therapist from an English frame of reference.

Congruence

Rogers's third condition of therapeutic personality change (and the first of the 'core conditions') is that 'the therapist should be, within the confines of this relationship, a congruent, genuine, integrated person' (Rogers, 1957/1990b, pp.223-4). Later he defined therapist congruence thus: 'by this we mean that the feelings the therapist is experiencing are available to him, available to his awareness, and he is able to live these feelings, be them, and able to communicate them if appropriate' (Rogers, 1961, p.61). From this, Tudor and Woffall (1994) identify four elements of congruence: awareness, awareness in action, communication, and appropriateness - which we elaborate here as regards their cultural context.

Awareness involves the therapist's awareness of their own culture and themselves in relation to it and, indeed, the world. Esterson (1970) observes that consciousness is a self-consciousness-in-context: 'oriented to knowing simultaneously the world, which is other than itself, and itself, human consciousness is an explicit consciousness of the world' (p.240). This has implications for the training of counsellors and psychotherapists. The universalistic approach emphasizes the universality of the method or the way rather than the specificity of culture. The cultural compatibility approach tends to lead to an emphasis on consciousness-raising, multicultural awareness and even anti-racist training (often based on the assumption that white people are inevitably or even inherently racist and oppressive). Both these approaches miss the point of congruence. Our middle position requires the therapist to journey to come to terms with their position in their society and the predicaments of life in relation to culture. As a black person living in Britain, JS from time to time experiences racial abuse. All abuse may damage a person's self worth (and commonly leads to distortion/s of perception and denial of experience) and may

damage their relationship with their culture, however this is defined. Therefore, just as in the field of child protection it is argued that all physical abuse may be seen as sexual abuse, all abuse may be viewed as cultural abuse as it leads to the loss of self worth and, more profoundly, the loss of cultural worth and identity. Discrimination is an aspect of every society; the challenge for person-centred therapists is to be aware of discrimination -including their own -- but not to lose their cultural identity or self worth.

The second element of awareness in action is reflected in Rogers's linking congruence and trust in the helping relationship:'l have come to recognise that being trustworthy does not demand that I be rigidly consistent but that I be dependably real' (Rogers, 1958/1990a, p. 1 19). In response to the predominant emphasis on the development of therapeutic techniques at the time, Rogers described his approach in general and the core conditions in particular *as a way of being* (Rogers, 1980); more recently, Brazier (1994) emphasises this existential attitude: 'congruence is not something that one can use. It is something that, at a given moment, one either is or is not'(p.4). Dhiravamsa (1984) discusses this in terms of challenging external authority (locus of evaluation): 'The freedom to be is the most important of all. This is the freedom to be free, without any authority, beliefs, traditions, knowledge, logic, opinions, teachers of books. You are really yourself at that moment.' (p.98). Congruence is thus a lifelong journey for the therapist. It also means that the therapist is active about living their awareness not only for themselves but also by being involved in their community where they illustrate their congruence in dealing with their everyday business transactions in the community and, for instance, in challenging incongruence. This perspective is not unusual in African, Asian and Oriental societies in which the therapist/healer/shaman/wise woman/man is both a part of and separate from their society: an accepted and respected outsider. In Britain, this perspective of living one's awareness and involvement has been developed through the concept and practice of social action psychotherapy (Holland, 1988, 1990). This approach has serious implications for therapists:

> 'This kind of therapeutic method demands ... that therapists ... be immersed in the same milieu as their clients. If therapists and clients truly form an endogamous community, then the boundaries between personal problems and social problems vanish; the personal and social become merely polar points on a spectrum, and therapy can deal with the whole spectrum by working to transform the individual and his surroundings at the same time' (Castel, Castel & Lovell, 1982, pp. 160- 1).

This is the intentional therapist: the therapist who is aware, conscious and intentional about their culture, their world and their participation in it.

> 'The principle of intentional (or constituted) worlds asserts that subjects and objects, practitioners and practices, human beings and sociocultural environments interpenetrate each other's identity and cannot be analytically disjoined into independent and dependent variables. Their identities are interdependent; neither side of the supposed contrast can be defined without borrowing from the specifications of the other' (Sweder, 1990, pp. 1-2).

This kind of involvement and visibility means that our communication as therapists (the third element of congruence) extends to behaviour, conduct, dress, language, how we deal with boundaries (see Embleton Tudor, 1997) and disputes, where we shop, etc. In short, it means living and communicating this (person-centred) approach in daily life. It also means that therapy itself becomes more a part of community life rather than a secretive activity; this, in turn, encourages an open rather than closed approach to therapy and to communication between

people. The cultural context of this element of congruence places a demand and a kind of accountability on the therapist: to be congruent in their communication both in the therapy setting and in their social communications outside therapy.

Appropriateness is concerned with the appropriate communication of congruence. Mearns and Thome (1988) offer guidelines for the therapeutic use of congruence. They suggest sharing feelings or sensations which are a *response, relevant* and relatively *persistent* or particularly *striking*. To these we would add *context and timing***.** The logic of living *being* a therapist, as distinct from living *as* a therapist, is that appropriate communication may take place inside or outside the therapeutic setting e.g., in the waiting area or in the supermarket. This has profound implications for the concept of contracting (see Embleton Tudor, 1997). For instance, as an Asian male therapist it is more appropriate for JS to comment on a female client's dress outside the immediate context of therapy and with his wife present than to do so in the therapy session. It is important to recognze that, culturally, therapy takes place not only within certain ethical and professional codes and organizational contexts but also within wider social mores.

Finally, a point about awareness. Much of the Western literature on awareness is written in terms of cognition and understanding. A study of other traditions gives us a wider experiential 'understanding 'of the concept and process of congruence, wisdom often couched in the form of paradox.

> The power lies neither in speaking nor in silence;
>
> The power lies neither in asking nor in giving**;**
>
> The power lies neither in living nor dying;
>
> The power lies neither in the wealth of kingdoms nor in the resolve of the mind;
>
> The power lies neither in remembrance nor in knowledge of the divine;
>
> The power lies neither in the world nor in the devices to be rid of samsara[4] (Osho, 1996, p. 175).

"I have not done anything. I could not do anything. I am helpless to do anything. It is the miracle of God that I have become Kabir." (Moraribapu, 1987, p.176). As with the other core conditions, congruence has its roots and equivalence in other cultural traditions as wisdom, mindfulness, active surrender, etc. (also see Purton, 1994; Brazier, 1995).

Unconditional positive regard

Rogers describes this condition variously as unconditional acceptance, prizing, non possessive love and warmth. Developmentally, as humans, we have a need for unconditional positive regard and to have an internal self-regard (Rogers, 1959). Again, criticism has been levelled at this individualistic perspective on love, self development and self-actualization (e.g., Rigney, 1981) and, indeed, some 'me' cultures, reflecting a political ideology, are concerned -- even obsessed -- with the self and self-development. Nevertheless, individual self-actualization as a concept is culturally specific and needs to be mediated by the concept of relatedness. Fromm (1956) refers to relatedness (along with transcendence, rootedness and the need for a sense of identity) as a specific human need. Barrett-Aranui (1989) describes the Maori sense of and words for related-ness: 'whanau means family, whanaunga means a relative, and whanaungatanga means the relatedness of people, one with another' (p.99). In an article on spirituality and the PCA, Villas-Boas Bowen (1984) discusses a wider interconnectedness -- with the universe. In developing perspectives on unconditional positive regard, then, we need to consider regard for self, others and the culture itself. Here, we focus particularly on the culture of the self as other texts in the field tend to focus on the culture of others (e.g., d'Ardenne & Mahtani, 1989; Paniagua.

The manifestation of such regard is different in different cultures. A client may be silent, withdrawn or downcast and it is important that during this the therapist maintains a positive regard for themselves (rather than, say, worrying about the perceived incongruence in the client). This provides the client with a *temenos* -- a space set aside from common purposes; a sacred space (see Tudor, in press; Embleton Tudor & Tudor, 1997). For example, a therapist challenged a working-class client on their lack of self-worth, following which the client became engrossed in deep thought. The therapist was considering whether to challenge the client's silence but felt on balance that this would be inappropriate -- which involved a reflection on her own predominantly verbal culture. In the next session the client appeared more smartly dressed. Reflecting on this, the therapist speculated that by staying with the silence and by not intervening verbally, she had shown her client unconditional positive regard and that she trusted the client's own process. The client, in turn, reflected positive intemalised self-regard through his appearance. A few sessions later the client verbalised this positive self-regard.

This also shows how important it is for therapists to be clear about their own culture --both their culture of origin and their present culture -- and to be aware of the positive messages about their culture, especially if the therapist has themselves had problems in growing and developing within their own culture. They may feel or believe that their culture is imperialistic or they may have been abused as a child. For instance, it took a year of living in another country for KT, having firstly denied that he had a culture and then seeing it only as negative, to become aware of his own culture (origins, history, moral values, class, accent, etc.) and to see its positive value both for himself and for others. Therapy which is intentional and positive about culture needs to provide such regard even and especially when the client feels negative about themselves and their culture, primarily through a positive self-regard and a separateness on the part of the therapist (Rogers, 1957/1990b) -- without necessarily needing to live abroad! In a culturally mixed men's group, comprising Africans, Asians and English, the English clients could not identify a positive role model within their own culture. This resulted in a search for older English people who would come to the group to talk about their fulfilment and satisfaction in life as well as how they had coped with predicaments and crises in their life. Furthermore, what was interesting and saddening was that the older people who were identified and contacted did not see themselves in a positive light; indeed, some were highly negative. This lack of elders with positive self-worth is a significant phenomenon for people in increasingly dispersed and relocated communities and for young people.

In training therapists, we invite them to identify their own culture of origin (i.e., their family culture) and, within that, three positive elements. In a British context, this is often a difficult exercise, especially with people from English cultures, who have rarely been encouraged through their development and formative years to examine English culture and what it means to them personally. The result is that most middle class people equate looking at English culture with xenophobia. Following on from this we ask therapists to address three questions:

Who am I as an individual?

Who am I in relationship with others?

Who am I -- in my culture?

For other exercises on this and other issues in race, culture and counselling, see Lago (1990) and Lago and Thompson (1996).

Empathic understanding

Empathy - or empathic understanding as Rogers mostly referred to it -- is 'to sense the client's private world as if it were your own, but without ever losing the "as if" quality' (Rogers, 1957/1990b, p.226). Our ability to have and develop this empathic understanding or 'felt sense'

(Gendlin, 1981) is, of course, affected by our own ways of understanding or framing our world. Kelly's (1955) concept of personal constructs (the borrowing of which Rogers acknowledged), based as they are on the construing of reality, is a useful reminder that both the client's understanding and the therapist's empathic understanding are cultural understandings (see also Ivey, Ivey & Simek-Morgan, 1993).

> My eye conversed while my tongue gazed.
> My ear spoke
> and my hand listened.
> And while my ear was an eye
> to behold everything visible,
> my eye was an ear listening to song
> (Ibn-ul-Farid, quoted in Reps, 1982, p. 1)

Within the humanistic/existential worldview, and consistent with the focus (above) on self, others and culture, individuals are seen in terms of the *umwelt* (the physical dimension, our immediate and wider environment including our own bodies), the *mitwelt* (the social dimension, how we relate to other people in the world), the *eigenwelt* (the psychological dimension, our personal world) and the *ueberwelt* (the spiritual dimension, our ideological and spiritual outlook). In training therapists we have found this to be a useful way of elaborating and extending the concept of empathy. Usually we elicit a scenario, for example:

> Client: 'My partner just doesn't understand me. I've sacrificed my integrity for him, for our relationship. And that's most important to me: that public commitment. He keeps talking about responsibility and finding one's own way. I can't find my own way. We're very close. I don't want to be separate from him: we are -- or were -- as one. I can see he's hurt and angry and I want to help. How can I find my own way if he's not OK? I just want to hide and don't even feel like going out.'

We then ask the trainees to write down a response and then discuss these in terms of the focus on the *umwelt*, the *mitwlt*. the *eigenwelt* and the *ueberwelt*. Exampled of responses are

Therapist (focusing on *umwelt):* 'The *public* nature of your commitment to your partner is important to you -- and you're concerned that *people* might see the loss of your integrity.'

> Therapist (focusing on *mitiwelt): 'Your partner's* very important to you. Your *relationship* is the most important thing in your life right now. You sound as if you really want to help *him* and resolve this difficulty *betvveen you.'*

> Therapist (focusing on *eigenwelt): 'You're* feeling lost and ashamed. *You* don't know what to do and *you* feel like hiding.'

> Therapist (focusing on *ueberwelt):* 'You clearly *value* the closeness you and your partner experience with each other. You want to work out a way of your current difficulties -- together.'

Being empathic is an attempt to understand the other. Sometimes the therapist listens so intensively to the client that they forget their own separateness and become merged with the

client. Rogers (1958/1990a) highlights this issue when he asks, "Can I be strong enough as a person to be separate from the other? Can I be a sturdy respecter of my own feelings, my own needs, as well as his?. . . Am I secure enough within myself to permit him his separateness?" (p. 121). Eastern philosophies meet and at the same time avoid the whole issue by acknowledging that we cannot understand the other: we can hardly understand ourselves. This is summed up by a quote from Bhagvad-gita: "When I don't know who I am, I serve you. When I know who I am, I am you."

The client's perception of the therapist

'The final condition as stated is that the client perceives, to a minimal degree, the acceptance and empathy which the therapist experiences for him. Unless some communication of these attitudes has been achieved, then such attitudes do not exist in the relationship as far as the client is concerned' (Rogers, 1957/1990b, p.227). As we have shown (above), such perception is not only based on the words (language) and actions (behaviour) in therapy but is also about the person of the therapist and the therapeutic relationship. A therapist had a large plate of sweets on a table to which people could help themselves. At the end of one session a new client put a large quantity of sweets in his bag. The therapist's initial inclination was to challenge this behaviour but on reflection he decided to observe what happened. The client continued to help himself to sweets at the end of each session for three months. On Christmas Day the client turned up with his family to thank the therapist for what he had done during the year -- with twenty boxes of chocolates and sweets. This behaviour could be analyzed, from within an individualistic culture (and a medical/psychological model) as pathological; however, it emerged that the client had been taking sweets for his children and family which represented his way of sharing with them his therapeutic journey which he then re-presented back to his therapist by 'sharing' his family – an analysis from a collectivist cultural worldview.

CONCLUSION

In many ways the philosophical roots of the PCA are universal: it echoes and has echoes in many cultural traditions -- Brazier (1995) explores this in relation to Buddhist thought, Miller (1996) compares person-centred therapy and Taoism. The concepts, language, practice and attitudes of the PCA are familiar in many cultures. In this sense, we have no doubt in affirming that Rogers's six conditions are necessary and sufficient - if necessarily and sufficiently studiedin cultural contexts

NOTES

[1] In this article 'therapy' and 'therapist' are used to stand, respectively, for counselling and psychotherapy and practitioners in these fields.

[2] For some this would include sexuality and sexual orientation such as identifying with the gay community', for other disability such as 'disabled' or 'persons' disabilities.'

[3] Even when he rebelled against authority and his own culture, JS ultimately found peace and· a place in his own culture

[4] Sanskrit word for journeying.

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