Addressing Cultural Differences in the Psychotherapeutic Process

It's time for parents to teach young people early on that in diversity there is a beauty and there is a strength.

—Maya Angelou

The United States is quickly becoming the home for individuals from all corners of the world. Throughout most of its history, the United States has experienced a vast influx of immigrants from different races, religions, and ethnicities. As a result many different generations of diverse clients are visiting our psychotherapy offices in increasing numbers. As the diversity of our clients grows, two important psychotherapeutic questions arise. First, should cultural differences be addressed in psychological treatment? And second, if cultural differences are addressed, then when and how should these differences be addressed? This chapter discusses these two questions and further elaborates my work with Aprile Maxie, entitled, "Ten Considerations in Addressing Cultural Differences in Psychotherapy" (La Roche & Maxie, 2003). In contrast to previous work, however, this chapter takes a more systematic and thorough approach to the matter. The 10 clinical recommendations are described in more detail and integrated with the three-phased cultural psychotherapeutic model. Thus, each of the 10 recommendations is introduced in relation to one of the three phases. Any of these recommendations could have been placed within any of the three treatment phases of cultural psychotherapy. That is, any one of these recommendations can be beneficial during any phase of cultural therapy. However, each is described within a particular phase for practical and theoretical reasons. Each recommendation is discussed in the phase where it is best conceptualized and/or can be of most utility.

Before describing the 10 clinical recommendations, it is important to clarify some key terms. After these terms are defined, a general description of the three prevalent clinical perspectives to address cultural differences in psychotherapy is presented, followed by the 10 clinical recommendations to address cultural differences.

UNDERSTANDING AND DEFINING KEY TERMS

Cultural Differences

When we think about cultural differences, most of us immediately imagine people who are from a different ethnic or racial background. In our culture, race and ethnicity have become the main standards to define the "we/us," and "others/them" (Sue & Sue, 2008). Our culture emphasizes an understanding of who we are and who others are based on skin color and place of birth. Unfortunately, these differences often end up separating and segregating people rather than promoting dialogue and growth. Furthermore, through explicit and implicit messages, cultural differences are consistently undervalued by the dominant culture (Dovidio, 2009; Weisbuch, Pauker, & Ambady, 2009). Cultural psychotherapy attempts to go beyond racial and ethnic stereotypes and seeks a more accurate understanding of who we are. To accomplish this goal, however, it is first necessary to define racial, ethnic, and cultural differences. These terms are distinct and are often used interchangeably in the psychotherapeutic literature, generating confusion and misunderstanding. The manner in which the concepts of race, ethnicity, and culture are understood has direct implications for the way cultural difference is defined. For this reason, I start by briefly defining each of these terms.

Race

Race is often defined in terms of selected physical characteristics, criteria, or permanent attributes (Betancourt & Lopez, 1993). Historically, skin color and facial characteristics are used to define racial groupings (e.g., Landrine & Klonoff, 1996). A racial difference occurs when people have different racial characteristics. In addition, these differences are considered permanent.

Ethnicity

Although many equate race with ethnicity, these are two distinct terms. Ethnicity is broader than race, as it relates to the shared nationality, language, common values, beliefs, and/or customs of an identifiable group of people (Betancourt & Lopez, 1993). Ethnicity includes a person's identification with their ethnic group, which may be determined by genealogical ties or geographical origins (e.g., born in the same country) or other socially related factors (Alvidrez, Azocar, & Miranda, 1996). For example, an ethnic difference would exist between individuals who are born in different geographical areas. Although these differences are permanent, they are more complex, requiring some level of flexibility. For example, a woman who has lived all her life in the United States and whose father was Filipino and mother Latino could identify herself as "Filipino American," or "Latino-Filipino" or other combinations at different times. It is also important to note that a person can identify him- or herself as Latino (ethnically), but be perceived as black because of her or his skin color (racially).

Culture

Culture has been understood in multiple ways; however, Geertz's (1973) definition of culture is particularly applicable to the discussion of cultural differences in psychotherapy. Geertz (1973) defined culture as

> a historically transmitted pattern of meanings embodied in symbols; a system of inherited conceptions expressed in symbolic forms by means of which people communicate, perpetuate, and develop their knowledge about their attitudes toward life. (p. 89)

Consequently, culture is understood as an interrelated web of meanings that are *dynamic, complex,* and *representative of a multifaceted experience,* in which a person is understood first and foremost as *homo symbolicus,* or meaning maker. This definition of culture suggests a broader and more inclusive understanding of culture, cultural variables and cultural differences not limited to ethnic or racial minorities. For this reason, when I talk about cultural variables or differences in this chapter, I am including not only racial and ethnic differences, but also sexual orientation, socioeconomic status (SES), religion, and language, just to name a few possibilities. Although in general individuals within a cultural group may share some meanings, people construe meanings in many diverse, complex, and changing manners. In addition to this conceptual reason to broaden our cultural understanding, it is suggested that addressing multiple cultural differences has significant clinical value. The first clinical recommendation proposed in this chapter, that *"cultural differences should be viewed as subjective, complex, and dynamic,"* is a direct result of this conceptualization of culture.

THEORETICAL PERSPECTIVES TO ADDRESS CULTURAL DIFFERENCES

Another result of this broad understanding of culture is that differences (e.g., skin color, religion, SES, gender orientation) are not only likely, but inevitable in the psychotherapeutic encounter (Cardemil & Battle, 2003; Davies, 2011; Gonzalez, Biever, & Gardner, 1994; Hays, 2008). However, the theoretical importance of cultural differences and the subsequent ways in which they are (or are not) considered and used in psychotherapy vary. Despite the enormous diversity of approaches, cultural differences have traditionally been understood and categorized through three distinct perspectives: universalism, particularism, and transcendism (Segall, Lonner, & Berry, 1998; Tyler, Brome, & Williams, 1991). Researchers have used different names to refer to each of these three perspectives, and although the labels may vary, the main underlying theoretical ideas are similar. There are no clinicians, however, who would label themselves using these categories; nevertheless, I have found these terms useful to identify and clarify clinicians' cultural assumptions. As clinicians become increasingly aware of their cultural assumptions, they can become more effective in designing culturally sensitive interventions. Below, each of these approaches is briefly described, as means for clinicians to further explore their cultural assumptions.

Universalist Clinicians

The common denominator of universalist clinicians is that they underscore similarities, not differences. Universalist clinicians do not believe cultural differences should be highlighted in psychotherapy. In support of this view, they argue that general factors such as the therapeutic alliance, degree of warmth, and empathy are necessary to facilitate any type of successful psychotherapy (Kaduchin, 1972). They believe that if general treatment factors are present, psychotherapy will have a favorable outcome irrespective of race, ethnicity, or context. Consequently, therapists who endorse these assumptions prioritize the need to foster these universal treatment ingredients and overlook cultural differences.

Many clinicians argue that if addressing cultural differences is an intervention that has rarely been theorized to be therapeutic or currently lacks evidence to support its usefulness, then, why should it be considered? Similarly, most clinicians would argue that it is impossible to accomplish all treatment interventions in one hour of therapy and that it is necessary to prioritize and focus on treatments theorized to be therapeutic (e.g., eradicating irrational beliefs, understanding the oedipal complex).

The emergence and development of empirically supported treatments (ESTs; Chambless, 1996; Chambless et al., 1998) is a movement highly influenced by universalist conceptualizations. In support of this statement, most EST manuals[1] do not include strategies to address cultural differences and many cultural variables are often not explored sufficiently. Many ESTs have yet to be validated with different ethnic minority samples. To be fair, most EST authors note these limitations (e.g., Chambless et al., 1996); however, only a few (although the number is growing rapidly) do in fact undertake their validation projects with culturally diverse groups. The main aim of most ESTs is the refinement of specific psychotherapeutic ingredients to ameliorate a certain constellation of symptoms as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-4;* American Psychiatric Association, 1994). These specific therapeutic ingredients are assumed to be effective independently of the therapeutic relationship or cultural context (e.g., Chambless et al., 1996; Chambless et al., 1998). It is almost suggested that these therapeutic ingredients have a universal effect. However, more recently a growing number of landmark EST studies have emphasized the importance of including both the cultural context and the therapeutic relationship (e.g., Hinton et al., 2005; Rosselló, Bernal, & Rivera-Medina, 2008) and started to develop important psychotherapeutic adaptations for different cultural groups.

Particularist Clinicians

In sharp contrast to universalists, the particularist perspective contends that ethnicity and race have a decisive and unavoidable impact on an individual's experience. Race, ethnicity, and/or culture powerfully determine the way in which people define themselves and relate to others. Given these fundamental racial and ethnic differences, it is difficult, if not impossible, for individuals from different backgrounds to understand each other (Dixon, 1976; Jackson, 1976; White, 1970). In partial support of this approach, most studies show that

clients prefer therapists matched to their race, ethnicity, and native language (Coleman, Wampold, & Casali, 1995). From a particularist approach, racial/ethnic differences are insurmountable barriers that make it unlikely that clients and therapists from different backgrounds can work together successfully. Thus, the basic clinical recommendation that stems from this perspective is that clinicians of a specific background should only work with clients from that same background.

In reality, although it is possible to create some level of ethnic or racial match, it is very difficult to create multiple cultural matches. It is nearly impossible to find a clinician that shares most or even many of the cultural characteristics (e.g., sexual orientation, religion, socioeconomic status) of a client. Also, the number of clinicians from different backgrounds remains limited. For example, in a survey of psychologists, only 12 % reported speaking a language other than English well enough to provide services in that language (American Psychological Association, 2010). Despite these significant practical limitations, it is important to note that partly as a result of this particularist conceptualization, many mental health associations (e.g., psychology, social work, and psychiatry) have underscored the need to train providers from a variety of racial and ethnic backgrounds.

Transcendist Clinicians

Last, the transcendist perspective affirms the importance of addressing cultural differences and designing strategies to do so. Despite the differences between individuals from different ethnic/racial backgrounds, therapists from this perspective believe these differences can be transcended. That is, clinicians can learn cultural competencies that will allow them to effectively treat clients from backgrounds different from their own.

Perhaps no one has done more to support the need to develop cultural competencies than the Sue brothers (David, Derald, and Stanley), who have worked tirelessly in developing cultural guidelines (e.g., Sue, Arredondo, & McDavis, 1992; Sue, Ivey, & Pedersen, 1996; Sue & Sue, 2008). Many of the clinical recommendations proposed in this chapter, and in this book, are influenced by their important contributions. The basic idea is that cultural competencies can be learned and that the effectiveness of psychotherapy with diverse clients increases as we develop our cultural competencies. There is an important difference between their work and mine, however. Their ideas seem to have emerged from university counseling sessions, while many of the ideas proposed in this book have originated from clinical settings. Clients seen in clinical settings have more severe mental health problems than the ones encountered in the counseling offices of universities. For this reason, I consistently talk about psychotherapy, while the Sues mostly talk about counseling.

Proponents of the common factor model (e.g., Norcross, 2002, 2010; Wampold, 2001, 2010) could be included in the transcendist group. They argue that although the therapeutic relationship is a necessary and common factor for favorable outcomes in psychotherapy, it has different meanings for each individual (Norcross, 2002, 2010; Wampold, 2001, 2010).

Segall et al. (1998) reported that most clinicians seem to subscribe to a transcendist model, thereby locating themselves theoretically somewhere between the universalist and particularistic perspectives in terms of their views on the importance of addressing

cultural differences in psychotherapy. Nevertheless, the lack of mention of cultural differences in many psychotherapeutic theories indicates the prevalence of universalist assumptions. This suggestion is supported by a study conducted by Aprile Maxie and colleagues (Maxie, Arnold, & Stephenson, 2006), in which the authors found that only 43% of their sample of licensed psychologists ever had conversations with their clients about cultural differences.

Perhaps it goes without saying that cultural psychotherapy adheres to a transcendist stance and emphasizes the importance of discussing cultural differences when appropriate. Having an open conversation with diverse clients presents an opportunity to discover one's self, the client, and our contexts through the dialectic of sameness and difference. Cultural psychotherapy suggests that our desire to know and grow is fueled by both our differences and similarities (Davies, 2011). Although there is a growing and increasingly sophisticated literature that proposes various strategies to address cultural differences (e.g., Cardemil & Battle, 2003; Hays, 2008), in this chapter the goal is to integrate these recommendations with the three-phased cultural psychotherapeutic model. Unfortunately, the empirical research on the effectiveness of addressing cultural differences in psychotherapy remains limited and is supported only through clinical cases (Hays, 2008); thus, these recommendations must be viewed as tentative clinical considerations to be tested through further research and practice.

TEN CLINICAL CONSIDERATIONS IN ADDRESSING CULTURAL DIFFERENCES

The 10 clinical recommendations suggested and described in this section are designed to help determine how and under what circumstances we should discuss cultural differences in psychotherapy. The primary goal is to help clinicians intervene in a therapeutic manner when working with clients whose racial, ethnic, and/or cultural backgrounds are different from their own. Given that cultural psychotherapy defines cultural differences broadly, these recommendations should be applicable to most clinical encounters. These are guidelines only and not meant to be used in a cookbook approach. Clearly, these considerations should be adapted to the specific characteristics of each client, therapeutic relationship, and context. Under no circumstances is there an adequate substitute for good clinical judgment and an understanding of the unique requirements of the psychotherapeutic process. Moreover, it is important to appraise all 10 clinical recommendations simultaneously rather than embracing one without regard to the others. Finally, these recommendations are grouped in accordance to the clinical phase they best underscore.

Addressing Cultural Differences During Phase I

4.1   Cultural differences should be viewed as subjective, complex, and dynamic.

4.2   The most salient cultural differences should be addressed first.

4.3   Similarities should be addressed as a prelude to discussions of cultural differences.

4.4   The client's level of distress and presenting problem often determine when and if cultural differences are discussed.

4.5   Cultural differences are addressed as assets.

4.6   It is necessary to consider the client's cultural past and racial identity development.

Addressing Cultural Differences During Phase II

4.7   Meanings and cultural differences are influenced by the psychotherapeutic relationship.

4.8   The clinician's cultural competence has an impact on the way differences are addressed.

Addressing Cultural Differences During Phase III

4.9   Cultural contexts affect the therapeutic relationship.

4.10   Dialogues about cultural differences can impact the cultural context.

4.1 Cultural Differences Should Be Viewed as Subjective, Complex, and Dynamic

First, there may be some agreement in any psychotherapeutic relationship on what constitutes a cultural difference (e.g., ethnicity, religion, and race) between client and therapist. For example, there are some obvious characteristics such as skin color, accents, or socioeconomic status that are immediately categorized as a cultural difference. However, the interpretations or meanings of these differences are subjective. Clients understand these dissimilarities according to their own set of experiences, and these subjective meanings are often more relevant than the "objective" differences themselves. Therefore, therapists could benefit if they suspended their preconceptions about the meaning of cultural differences (Cardemil & Battle, 2003; Helms, Jernigan, & Macher, 2005) and allowed themselves to know their clients free from stereotypical racial/ethnic assumptions. This recommendation challenges the notion that there is one standard way to treat individuals of a specific race or ethnicity. This conceptualization dashes the belief that "one size fits all individuals" of a certain cultural group. Rather, it emphasizes the need to explore the meanings that clients ascribe to cultural differences.

   Second, beyond the subjective differences that naturally exist, it is argued that cultural differences are multiple and complex (Bingham, Porché-Burke, James, Sue, & Vasquez, 2002; Hays, 2008). As previously stated, cultural differences may include multiple variables (e.g., gender, sexual orientation, socioeconomic status, age, educational level, language, and religion). It is crucial to consider all possible differences and to identify how these differences come together in defining an individual's identity and experience. For example, it might be more effective therapeutically to understand the multiple and interacting experiences of being a young second-generation Muslim Japanese American man than to focus solely on his ethnicity. Moreover, each of these characteristics is complex and includes several possible meanings within different contexts. What type of Islam does he embrace? From which town in Japan do his parents come? Furthermore, the meanings of each of

these differences can vary according to contexts. For example, being a devoted Muslim may be acceptable in his family setting but a painful secret at work.

Third, the perceptions on the part of clients and therapists as to what constitutes cultural differences are dynamic, not static. At different points in the therapeutic process, what is construed as a cultural difference may shift into the background, and other factors may come to the forefront. Therefore, therapists are encouraged to engage in ongoing exploration of changing meanings rather than to assume that once cultural differences have been understood, it is no longer necessary to continue exploring. Meanings are always in flux, and it is important to explore these as well as the factors influencing them (White & Epston, 1990). For example, a dark-skinned African American female physician started to change her acquiescent attitude toward her lighter-skinned African American female therapist. The client had angrily questioned her therapist's ability to understand her. There had been no such questions during the first year of psychotherapy. In exploring this change, the client explained that she recently had been subject to discrimination at work. Her colleagues had jokingly hinted, but repeatedly, that she had obtained her medical degree because of affirmative action preferences, and she feared that her lighter-skinned therapist might also think that she had achieved her position as a physician because of something other than merit. This case also illustrates the multiple shades of "one race," which also calls into question the usefulness of classifications such as race.

4.2 The Most Salient Cultural Differences Should Be Addressed First

This consideration is based on two clinical assumptions: first, that cultural differences have varied levels of significance, and second, that it is often beneficial for clinicians to directly address cultural differences. With regard to the first assumption, cultural differences are construed in many ways and have different ascribed levels of relevance. Not all differences have the same relative value in the therapeutic relationship. Clinicians should explore these meanings and consider addressing first what is most salient. It may be possible, for example, that dissimilarities in race between client and therapist may not hold the same weight as differences in marital status. Cultural psychotherapy argues that the saliency of the difference is influenced by the histories of the therapist and client, their interpersonal history, and the cultural context in which the differences are embedded.

The second assumption of this clinical recommendation is that clinicians should directly address cultural differences. Given the power differential in the therapeutic relationship (La Roche, 1999; Pinderhughes, 1989; Sue & Sue, 2008), which may be particularly noticeable in the first phase of cultural psychotherapy, the majority of clients do not initiate discussions of cultural difference. Clients and therapists alike often feel they must tread lightly when it comes to cultural differences. Hence, the therapist may need to communicate openness and comfort in understanding the client's unique experiences, including cultural perspectives (Sue & Sue, 2008; Whaley, 2001). A therapist who directly acknowledges a difference with a client takes the first step in exploring the meaning of the difference and whether the client views the difference as important. This is particularly relevant during the second phase of cultural psychotherapy. In addition, addressing client-therapist differences opens up a dialogue about the meaning of difference within the

therapeutic relationship. Although clients may choose not to immediately address these differences, having this conversation conveys the message that cultural differences are important and can be addressed at any time during the psychological process.

Many clinicians believe it is more appropriate to wait until clients bring up the issue of cultural differences. Cultural psychotherapy, however, maintains that at the very least a conversation needs to be had to let the client know it is all right to address cultural differences, if not going further and actually addressing them right away. Although in certain situations it is still recommended that the client initiate the discussion, a therapist should seriously consider that when salient differences or multiple cultural dissimilarities exist, it is important for the therapist to take the initiative. Some theorists have even suggested that the therapist routinely address differences in the first session (e.g., Gopaul-McNeil & Brice-Baker, 1998; Paniagua, 1998). Cultural psychotherapy, in contrast, argues that the decision to address differences depends on several factors. One such factor is the degree of saliency of the cultural difference between client and therapist. The clinical recommendation is that the more salient the cultural difference is, the sooner it should be addressed.

The following example illustrates this point. Eddie, an 18-year-old Puerto Rican male, was mandated to start counseling through the court system. He met with a middle-aged, White European American female therapist. From the onset of treatment, it was obvious that Eddie was reluctant to speak. He appeared very guarded, and the therapist sensed his intense anger over having to attend the counseling session. The therapist therefore stated, "It must make you angry to be forced to talk with a White female therapist." Eddie defiantly responded, "We live in different worlds." The therapist validated Eddie's point, and during the session she determined that he did not like to communicate with White people, particularly women. Therefore, she had to address the meaning of their differences. Without an explicit discussion of these differences, it would have been difficult to bridge the cultural gap that existed between them. Six months later, Eddie reported that this discussion helped him to open up slowly and talk more about his experiences. Many clinicians may believe that as they discuss differences with their clients, they are diminishing their ability to use the commonality of human experience in their therapeutic work. Nevertheless, it should be kept in mind that therapists can effectively use both client-therapist differences and similarities in their work with culturally diverse clients.

4.3 Similarities Should Be Addressed as a Prelude to Discussions of Cultural Differences

As previously noted, therapists and clients may not only differ on a number of cultural attributes; they may also share cultural characteristics (Hays, 2008; Speight & Vera, 1997). One approach that may be useful is to explicitly share commonalities before fully exploring cultural differences. A client may benefit from the therapist's acknowledgment of certain similarities between them, and addressing commonalities may serve to reduce the client's ambivalence or increase the therapist's perceived credibility (Speight & Vera, 1997). The acknowledgment of similarities may also assist therapists in establishing initial rapport, which may allow the client to experience more comfort, security, and acceptance. This strategy may also serve to reduce apprehensions about treatment, especially in the

presence of significant cultural differences between therapist and client. For example, during the early stages of treatment or during stressful periods (i.e., when clients are presenting with high anxiety or depression levels), the therapist's highlighting of similarities may make clients feel more respected and accepted. As a consequence, during these times emphasizing commonalities can assist the client in engaging more successfully in psychotherapy. An initial emphasis on similarities, however, does not negate the need to address differences.

The following example illustrates a situation in which the therapist addressed similarities with a new client through self-disclosure. A Korean woman was disappointed that she was not assigned to the Asian therapist who had been recommended by her friend. The Asian therapist she wanted to see had no available openings and she disappointedly had to settle for a Latino therapist. The clinician sensed his client's ambivalence in working with someone from a different cultural background and he feared that she would drop out of treatment. Thus, the clinician decided to share in the first few sessions several commonalities: first, that they were both ethnic minorities, and second, they had both lost their fathers. After a few months of psychotherapy, the client relayed that discussing these commonalities initially had helped her to bond with the therapist and to begin to trust him. Focusing on these similarities also opened the door to examination of cultural differences in later sessions. Nevertheless, it is again important to underscore the need to use caution when and if clinicians decide to disclose personal information. Clinicians should only disclose information that furthers the therapeutic process. The decision to share personal information must be a result of careful analyses of its benefits and disadvantages, and the information disclosed must also be information that the therapist feels comfortable sharing (see recommendation 2.5: Continue to develop a culturally sensitive therapeutic relationship)..

4.4 The Client's Level of Distress and Presenting Problem Often Determine When and If Cultural Differences Are Discussed

As emphasized in Chapter 1, it is crucial to assess the degree of emotional distress and the severity of the client's chief complaint (Lopez, 1997). The more stable (optimal levels of affect regulation) a client is, the more likely it is that he or she will benefit from a discussion of cultural differences. In contrast, the frailer and less stable clients are (e.g., extremely anxious, severely depressed, delusional, or severe substance abusers), the more likely it is that they will benefit from this dialogue. Moreover, the issue of differences should not be brought up during a crisis intervention, regardless of saliency. Concerns for safety, focusing on mental status, and working toward improved functioning are paramount in working with any client. While some counseling approaches (e.g., Gopaul-McNeil & Brice-Baker, 1998; Paniagua, 1998) argue that it is beneficial to address cultural differences in the first session, cultural psychotherapy holds that this is not recommended when clients are unstable (e.g., suicidal, experiencing domestic violence).

Additionally, it is important to keep in mind that it can be detrimental to the therapeutic relationship to repeatedly address these differences when clients are pressed by other concerns. For example, many of my students, after hearing me talk about the importance of addressing cultural difference, start initiating discussions of cultural differences when

clients are clearly not interested or ready to engage in such dialogues. As a result, clients may perceive therapists as not being sensitive to their concerns. This has sometimes prompted clients to drop out of treatment and underscores the risks of addressing cultural differences. Sometimes working with similarities in these circumstances may be more productive (Speight & Vera, 1997). Nevertheless, therapists should still seriously consider how cultural factors influence the severely distressed and how further treatment should incorporate addressing cultural issues.

4.5 Cultural Differences Are Addressed as Assets

Many culturally diverse clients have repeatedly experienced how the majority group construes their cultural differences as deficits (Steele & Aronson, 1995; Sue, 1998). In the United States, being a member of a nondominant group (e.g., not Caucasian, female, homosexual, non-Christian, disabled, etc.) is viewed as a deficiency, whereas persons who are White, male, Christian, and heterosexual are viewed as better. It is often helpful to suggest how these assumed "deficiencies" are fabricated by explicit and implicit messages held by mainstream culture rather than limitations that reside within clients (Zimbardo, 2008). However, efforts to discuss these differences should proceed gradually, gently, and carefully. They should always follow the client's lead. Moreover, whenever possible, clinicians should attempt to examine how differences are related to a client's strengths rather than viewing them as weaknesses. For example, one of my White psychology students stated to her Latino client, "Feel free to ask me any questions if you don't understand my English." Although the psychology intern was attempting to empower her client to ask questions, she inadvertently also assumed that it was her client's responsibility to know English rather than her own responsibility to have some fluency in Spanish. Although many of us value differences and view them as assets, this is not an easy message to convey in therapy, particularly given the large number of explicit and implicit messages suggesting that differences from the dominant groups are problematic.

Furthermore, cultural differences can make it difficult for clients and therapists to understand each other and develop an appropriate therapeutic relationship or even a good working alliance (Bordin, 1979). In the psychotherapeutic process, as in any social interaction, cultural differences can be misconstrued and lead to misunderstandings that rupture the therapeutic relationship. Nevertheless, if therapists are able to learn strategies to repair these ruptures, an opportunity for clients (and therapists) to broaden their explicit and implicit systems through cultural dialogue emerges. Through this rupture-repair process (see Chapter 2), our self-awareness is enhanced and we become more flexible in responding to our context by developing new ways to understand ourselves, our relationships, and our context.

4.6 It Is Necessary to Consider the Client's Cultural Past and Racial Identity Development

Research finds that clients' cultural history and development (e.g., racial identity and acculturation levels) can mediate the effectiveness of the ethnic/racial match between clients and therapists from different cultural backgrounds (Carter, 1995; Chun, Balls-Organista, &

Marin, 2003; Helms, 2007). Helms and Cook (1999) formulated a cognitive-developmental model in which the level of acceptance of therapists from different cultural backgrounds depends upon the client's level of racial identity and consciousness. This model proposes that ethnic matching of clients and therapists can result in "cultural mismatches" if therapists and clients from the same ethnic group show markedly different levels of racial identity. This model emphasizes cognitive and developmental characteristics of clients and implies that therapists cannot help to facilitate changes that are in conflict with their clients' cultural developmental stages. Furthermore, the racial identity literature proposes techniques or psychotherapeutic strategies for working with clients at specific stages of racial development (Helms, 2007; Helms & Cook, 1999), because clients are at different levels of readiness to explore certain issues depending on their own cultural awareness.

Similarly, within the acculturation literature (e.g., Chun et al., 2003) effective treatment recommendations are being developed. A case in point involves a therapist working with a family that had emigrated from China. The therapist noticed differences in acculturation status and racial identity among family members. The family had come to this country when the son was 8 years old. The parents had identified the son, now 17, as rebellious, and they considered his new friends from high school to be a negative influence. The father thought that limiting his contact with these friends would immediately resolve their familial issues; however, this restriction only increased his rebelliousness. After the therapist assessed the family, she found the son to be struggling with his own sociocultural development. Although he wanted to immerse himself in his friends' mainstream world, he did not want to betray his family and Chinese values. The therapist found it necessary to work individually with the son. She helped him identify his own cultural values and then develop practical strategies for bridging the cultural gap between his family and friends. As the son became more culturally aware of his own conflicted values, his rebellious behavior diminished, and he started making decisions about what was important for him (Helms, 2007; Helms & Cook, 1999). This intervention would not have been possible if the therapist had not assessed the family's level of cultural development and realized that the son was ready to confront some cultural identity issues even though his family was not. In addition, it was crucial that the therapist was knowledgeable about traditional Chinese values. Without this knowledge, she might have believed that the son's struggle was an attempt to individuate from an enmeshed family, and she might therefore have encouraged his family to give him more freedom. In turn, the family could have understood this recommendation as a threat to the family unit. Chinese families often value interdependence and harmony more than autonomy and independence (Lee, 2000; Sue & Sue, 2008); consequently, if the family had received this recommendation, they may have dropped out of psychotherapy.

4.7 Meanings and Cultural Differences Are Influenced by the Psychotherapeutic Relationship

This and the next clinical recommendation are particularly useful during the second phase of cultural psychotherapy, "understanding clients' experiences." To explain these recommendations, it is important to underscore that each psychotherapeutic relationship develops unique interpersonal dynamics that encourage some topics to be discussed and

others to be overlooked. From the very first session, the way differences are examined powerfully influences what happens in treatment. Thus, the potential to discuss cultural differences is partly dependent upon this interpersonal history. Relational factors begin to play a larger role in the second phase, in which implicit systems get played out in treatment (see Chapter 2).

An illustration of this point comes from Gina, a 31-year-old single Italian American architect who realized that her White male psychotherapist was ignoring her ongoing gender issues with her boss. She repeatedly brought them up but he failed to validate them. Gina wondered if he did not comment on these differences because he did not think it was clinically important do so. As a result of this oversight, Gina stopped bringing up gender issues and then also avoided discussing cultural issues with her therapist (who had a Scottish background). She felt that if he could not understand her gender issues, he surely could not grasp the meaning of her Sicilian-Italian background. She was born into a large, close-knit, and at times loud family that was still very present in her life. Unable to share many of her important gender and cultural experiences, she considered terminating treatment. Fortunately, her therapist sensed her frustration and sought supervision in which he realized that he was dismissing Gina's gender and cultural issues. He realized that even though both were "White," they endorsed different cultural beliefs. As a result, he soon started addressing her gender (e.g., experiences with her boss) and cultural issues (e.g., how it is to grow up in a large family), which had become the elephant in the room. Once these issues were brought to the surface and thoroughly explored, Gina felt empowered to address gender issues with her male boss. This example underscores the usefulness of exploring cultural differences among members of a majority group.

Unfortunately, it is fairly common for therapists and clients alike to miss important cultural cues that could lead to beneficial discussions of cultural difference. By overlooking cues, we may misunderstand the issues that are being brought up by our clients. Consequently, cultural issues may not get the attention they require. Therefore, we should strive to listen carefully for cultural issues in all psychotherapeutic encounters. Cultural psychotherapy encourages clinicians to critically evaluate the content of psychotherapeutic dialogues and to question whether some cultural issues are overlooked or, conversely, inappropriately emphasized.

4.8 The Clinician's Cultural Competence Has an Impact on the Way Differences Are Addressed

Although the therapist's level of cultural competency is difficult to operationalize, the literature on multiculturalism has identified three common dimensions (Sue et al., 1992; Sue & Sue, 2008). First, the therapist's beliefs and attitudes toward culturally different clients play an important role in psychotherapy. Consequently, we should actively and consistently explore our feelings and thoughts (e.g., countertransference, prejudice, and ethnic biases) in providing treatment to clients from different cultural backgrounds (or any clients in general). In doing so, we will be more attuned to our own comfort levels in dealing with cultural differences. Second, although therapists and clients may be dissimilar in their cultural backgrounds, we should possess some basic knowledge of our clients' cultures

(Atkinson & Lowe, 1995; Sue & Sue, 2008). Last, the therapist's development over time of specific skills, interventions, and strategies (Sue & Zane, 1987; Sue & Sue, 2008) comes about through education and clinical experience with diverse clients.

There are many ways for clinicians to enhance their cultural competence. These include reading about culturally diverse groups, seeking consultation or supervision from culturally diverse peers, or even attending different cultural events. In addition, many of us have found that traveling to foreign countries or exposure to and participation in activities in ethnically diverse neighborhoods and communities is equally helpful in learning more about dissimilar cultures. Finally, and perhaps most important, is the understanding that the pursuit of cultural competency is a lifelong learning process that is never completed. This process may include formal cultural competency training, but what is most important is critical self-evaluation and questioning of what is taking place in cross-cultural therapeutic encounters (Sue, 1998; Sue & Sue, 2008). But perhaps even more important than this ongoing learning process is a genuine desire to learn with people of other cultural backgrounds.

4.9 Cultural Contexts Affect the Therapeutic Relationship

The final two clinical recommendations are particularly useful during the third phase of cultural psychotherapy, "fostering empowerment." These recommendations emphasize the fact that the therapeutic relationship takes place in a sociocultural, political, and historical context that is constantly producing contextual (explicit and implicit) messages (La Roche & Tawa, 2011). These contextual messages influence what takes place in psychotherapy (Ivey, 1995; La Roche, 1999, 2002). This recommendation underscores the point that psychotherapy does not occur in a historical and geographical vacuum—as seems to be assumed by many psychotherapeutic models that fail to underscore the cultural context as a source of clinical information. Although contextual messages are present even before client and therapist meet, they are often more effectively understood during the third phase of treatment. For example, it was only after a few months of treatment that some of my White clients divulged that they almost "no showed" at their first appointment with me, because they could tell by my accent on the phone that I was Latino, and that made them uncomfortable. This highlights the point that clients can sometimes be hesitant about being treated by someone from a different ethnic background, perhaps fearing that someone different from themselves may not be able to understand and therefore help them.

Furthermore, events taking place outside the therapeutic session can contribute to whether clients and therapists address cultural differences. For example, discussions of societal racism can facilitate a discussion about client-therapist differences as described in Chapters 2 and 3, where I discuss how events of discrimination and violence within the community triggered significant dialogues about differences. Alternatively, it is also conceivable that some clients are hesitant to bring up issues of difference due to negative feelings with regard to these same events taking place outside of therapy.

To avoid problems, it is often useful for a therapist to directly ask clients if important contextual events have taken place recently, or if they have any concerns about being treated by a therapist of a different background (e.g., male, heterosexual, Latino). Exploring

these issues is useful in generating discussions about cultural difference or making assessments about the importance of contextual events in relation to therapist-client differences. As previously discussed in this chapter, the most salient differences should be addressed first. The client's response to the inquiry will dictate the course of the discussion. It may be that the client expresses no concern. Nevertheless, with this questioning the therapist is also conveying the message that cultural differences are important and can be addressed at any time the client feels it is important or that he or she is ready to do so. Additionally, it may be relevant to communicate the following to the client: "Please let me know if there are things that I say in our work together that do not fit with your values, beliefs, or life experiences. I would like for you to let me know about these differences because I think it will be useful in our working together."

4.10 Dialogues About Cultural Differences Can Impact the Cultural Context

There is a bidirectional relationship between the therapeutic relationship and clients' context, which means that not only can the cultural context influence the psychotherapeutic process, but changes within the psychotherapeutic relationship can potentially impact the cultural context[2] (see Chapter 3 on how a group of disfranchised adolescents had an impact on their context). As clients and therapists become increasingly aware of the multiple and complex influences of their context (e.g., systems and situations), they become more effective in responding to and transforming it (Ivey, 1995; La Roche, 2002; La Roche & Christopher, 2009).

Mainstream culture in the United States, for example, espouses values such as materialism, competition, and heterosexuality while it condones other values, such as spiritualism, collectivism, and homosexuality (Cushman, 1995; Sue & Sue, 2008). Through explicit and implicit messages, these values inadvertently exert much control over our lives by encouraging us to pursue certain objectives while minimizing others (Sue & Sue, 2008). Contextual influences seem particularly powerful among cultural minorities, who may not completely share U.S. mainstream values but feel even more pressured than people from the dominant culture to adjust to or assimilate into a more mainstream way of life. Nonetheless, as we start discussing cultural differences, identifying explicit and implicit messages and related sociopolitical issues, we become more empowered to acknowledge, choose, and speak about our important life values and goals (Ivey, 1995; La Roche, 2002). Consequently, clients are able to make better-informed decisions about their lives rather than blindly following the path that society has prescribed for them.

One way to increase this awareness is to explore how the therapeutic relationship reflects the broader sociocultural context (La Roche, 1999, 2002). Therapists often have more ascribed power than clients, and it is useful first to identify these power differentials and second to examine their consequences and meanings. As clients become aware of these power inequities and other cultural assumptions, they are encouraged to question the impact that these assumptions have on their own lives in both positive and negative ways. If clients are aware of the multiplicity and complexity of cultural influences both within the psychotherapeutic relationship and in society, they may decide to embrace certain cultural values and reject others.

This enhanced awareness of cultural assumptions often leads clients to question their therapists' privileged position (e.g., power, education, religion, ethnicity). Unfortunately, at times, this questioning is experienced as a confrontation, or resistance, by clinicians who may feel clients are attacking what is most precious to them. As a result, clinicians may develop a strong negative response, which can create a psychotherapeutic impasse (La Roche, 1999). However, if clinicians are able to keep providing clients with sufficient support and validation through the therapeutic relationship, then clients will explore and learn alternative ways to cope with cultural differences rather than the standard and ascribed means assigned by society (e.g., avoidance, silent discrimination, acquiescence). Cultural dialogues are a unique opportunity to grow and develop beyond prescribed cultural expectations.

Conclusion

As we become an increasingly diverse society, it is more pressing to design psychotherapeutic interventions that consider and benefit from cultural differences. Culture plays a crucial role in our lives, and if we do not acknowledge its powerful influence, it will restrict our growth. We will blindly succumb to its influence, and we will follow prescribed cultural standards rather than creating our preferred lifestyles. Unfortunately, many universalist psychotherapeutic models have yet not incorporated elements of cultural understanding and as a result have not developed strategies that could benefit from cultural dialogues. Universalist models have often ended up reinforcing the conceptions of the dominant group. In contrast, cultural psychotherapy argues that as we explore cultural differences, we become more aware of different cultural forces (e.g., explicit and implicit messages). This enhanced understanding can lead us to improve both our communities and ourselves. However, if differences are not appropriately addressed, this can discourage our efforts to examine these differences and lead us to avoid the "others." The 10 clinical recommendations described in this chapter are an attempt to reduce these risks and promote a better understanding of cultural differences in the clinical encounter.

There are, however, no simple answers to the questions of when and how to address cultural differences in psychotherapy. Instead, these 10 clinical recommendations should be understood as general guidelines framed within the three-phased cultural psychotherapeutic model and are provided as a means to more systematically guide clinicians in these efforts. Clinicians are encouraged to explore the meanings of cultural differences and similarities rather than to assume that clients will bring a particular experience or perspective to therapy because of their religion, ethnicity, or race. Cultural discussions may actually make the difference in whether clients remain in therapy or drop out prematurely. Since cultural differences are defined broadly, it is argued that they are present to some degree in all clinical encounters.

Finally, the sociopolitical importance of developing a culturally sensitive model to address differences cannot be understated. As the diversity in the U.S. population grows, so does the potential for cultural misunderstandings and injustice. Both misunderstandings

and injustices can exacerbate acts of discrimination, microaggressions, terrorism, and even ethnic cleansing or genocide (see Chapter 8). Not exploring cultural differences can make the barriers between cultural groups seem even more insurmountable. As the United States becomes ever more multicultural and a place in which diverse ethnic groups coexist, it is essential to develop effective psychological strategies that respect and validate our individual and group differences.

The psychotherapeutic relationship is a unique opportunity for both clients and therapists to further develop their cultural awareness. That type of growth, however, is not enough for social and cultural transformation. To accomplish that, it is necessary to develop and promote systematic community efforts that allow individuals from a very young age to interact with and learn from people of diverse backgrounds. It is important that we know, as well as experience, how cultural differences are assets that enrich our lives and possibilities. Nevertheless, empirical research is clearly needed to confirm and refine the validity of these approaches and also to elaborate on the strengths and limitations of what has been proposed. This research could benefit by not being limited to psychotherapy, but extended also into communities, schools, and even international relations.

Notes

1. I have read many EST manuals and do not remember reading any explicit strategies for therapists to explore cultural differences. Nevertheless, this is just an observation that is not based on a systematic and representative review of the literature; it is an observation that requires significantly more rigorous study to be confirmed.

2. Unfortunately, the impact of the psychotherapeutic relationship on the context is often more restricted than that of the context on the psychotherapeutic relationship.

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