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Cultural Self-Assessment: Knowing Others, Knowing Yourself

To know others is wisdom; to know yourself is enlightenment.

—Tao Te Ching

Sonia: I'll castrate him.

Dr. Jenkins: What?

Sonia: Dale won't abuse me anymore. [*Opens her purse.*] Got a light?

Dr. Jenkins: Sorry. I don't allow smoking in my office.

Sonia: Don't you see I'm upset? [*Crosses her legs.*] Can you do something?

Dr. Jenkins: [*Swallows hard as she stares at the dressed-for-success Colombian American woman sitting in front of her.*] What would you like me to do?

Sonia: Just do something.

Dr. Jenkins: Let's try some deep breathing. [*Teaches Sonia a deep breathing technique.*]

Sonia: Thanks, I feel better.

Dr. Jenkins: Are you upset enough to harm Dale? [*Tries to assess Sonia's violence potential.*]

Sonia: Whose side are you on? [*Eyes begin to mist.*]

Dr. Jenkins: If you tell me that you intend to hurt someone, I need to inquire.

Sonia: You got to be kidding. [*Tears wash her rouge from her checks.*] I can't believe you're taking me literally.

Dr. Jenkins: What did you mean when you said you wanted to castrate Dale?

Sonia: Do you remember Lorena Bobbitt?

Dr. Jenkins: The woman who cut off her husband's penis? [*Caresses the gold band adorning her ring finger in her left hand.*]

Sonia: Real men don't hit their wives. If they do, they're not *machos.* [*Uncrosses her legs.*] Lorena cut her husband because he didn't deserve to be a man.

Dr. Jenkins: What do you mean?

Sonia: Don't you get it?

Dr. Jenkins: Are you seeking revenge for Dale's abuse?

Sonia: No. [*Crosses her legs.*] You just don't understand.

How do you feel about this clinical encounter? The issues Dr. Jenkins must deal with? Did Dr. Jenkins misunderstand Sonia? Did she demonstrate cultural awareness toward Sonia's situation? How would you approach Sonia's behavior if she were your client?

As I discuss later in this chapter, Dr. Jenkins's apparent lack of multicultural awareness may have contributed to a therapeutic impasse: "You just don't understand." To understand one's clients, one needs to interpret their behavior in a cultural context. Being aware of clients' culture improves clinical communication, promotes the emergence of a therapeutic alliance, and facilitates clients' participation in treatment. Certainly, knowing oneself fosters multicultural awareness and sensitivity.

In this chapter, I discuss how to conduct a cultural self-assessment to increase one's *cultural self-awareness.* Succinctly put, cultural self-awareness involves becoming conscious of one's reactions to culturally different individuals. It entails being cognizant of similarities and differences among cultural groups, as well as being aware of the cultural differences that exist among seemingly homogenous cultural communities. Cultural self-awareness helps you to enhance your knowledge of self and others to promote sensitivity and responsiveness to culturally different clients.

One can engage in a cultural self-assessment to facilitate self-awareness. A building block of multicultural awareness, a cultural self-assessment is a useful clinical method to examine the cultural differences and similarities between clinician and client. This tool entails an ongoing process of critically examining one's culture, history, ancestry, and context.

ASSESSING WORLDVIEW

A cultural self-assessment helps to unearth one's *worldview.* The concept of worldview refers to the personal attitudes, beliefs, and behaviors that may unconsciously or consciously influence interactions with individuals of any cultural background.

Like all people, clinicians approach human interactions within the limits of their worldview. Differences in worldview between clients and clinicians may lead to communication problems, misdiagnosis, premature treatment termination by the client, or all of these. To illustrate, the U.S. surgeon general's report on culture and mental health (as cited in Satcher, 2001) notes that cultural misunderstandings between clinicians and their clients may prevent ethnic minorities from using mental health services and receiving appropriate treatment. The demographic changes and the mental health needs of diverse populations intensify the relevance of clinicians' multicultural awareness in addressing and eliminating the mental health disparities addressed in the surgeon general's report. Regrettably, clinicians unaware of the differences between their worldview and their clients' may help to foster this disparity gap (Caldwell-Colbert, 2003).

You can begin self-assessing your worldview using Kluckholn and Strodtbeck's (1961) cultural framework. According to this classic model, you can examine your worldview orientation by answering the following questions:

- What do I believe is the innate character of human nature? (good, evil, or mixed)
- What is my relationship with nature? (subjugation, harmony, or mastery)
- What is my temporal focus? (past, present, or future)
- What is my preferred form of self-expression? (being, being–becoming, or doing)
- What are my preferred social relations? (lineal, collateral, or individual)

According to Kluckholn and Strodtbeck (1961), White Americans tend to subscribe to a *mastery* over nature orientation, endorse a *doing* activity, are *future* time oriented, and support *individual* social relations. Readers can ask themselves how they compare with this White American cultural baseline. Given that Kluckholn and Strodtbeck's research was 50 years ago, does this baseline remain the same today? Have these cultural orientations changed? For example, does the current ecological, "green" movement affect the relationship between people and nature (i.e., shift from mastery over nature to harmony with nature)?

In addition, you can engage in a cultural self-assessment when you examine their worldview using an individualism–collectivism orientation continuum. Triandis (1995) classified worldviews into *collectivistic* or *individualistic* according to how people view the relationship between self and other: individualistic members frequently view themselves independently from others and from context. Consequently, they tend to define themselves primarily in terms of internal features such as traits, attitudes, abilities, and agencies (Rhee, Uleman, Lee, & Roman, 1995). Accordingly, individualistic people value personal agencies, such as assertiveness, competition, self-assurance, self-sufficiency, and self-efficiency (Church & Lonner, 1998). In contrast, members of collectivistic societies tend to value communal welfare, develop a relational self-identity, and form strong social and emotional connections with others. As such, the collectivistic worldview allows individuals to place themselves and their lives within a larger context. (See Chapter 4 of this volume for a discussion of

the collectivist values of familism, contextualism, and syncretistic spirituality.) Because collectivistic members attribute importance to relationships, they tend to prefer relational values, such as interdependence and harmony; to favor communication that minimizes conflict; to tolerate the views of significant others; and to share resources (Triandis, 1995). Research findings seem to verify these assertions: Individualistic persons tend to process stimuli as if they were unaffected by the context, in contrast to collectivistic members, who tend to process information while paying attention to their surrounding context (Berry, 1991; Kühnen, Hannover, & Shubert, 2001).

Although most multicultural individuals espouse a collectivistic worldview, they also adhere to individualism, depending on the specific context. For example, a Latina in the United States may exhibit individualism at work by being assertive, and she may subscribe to collectivism at home by tolerating the traditional views of her parents. Nonetheless, mainstream clinical practice in the United States mostly reflects individualistic cultural values. Unfortunately, if clinicians have limited multicultural awareness regarding their clients' worldview, they risk colliding with a cultural iceberg.

THE CULTURAL ICEBERG

Culture is an internal representation (Gehrie, 1979) that has been compared to an iceberg (E. T. Hall, 1976). Like an iceberg, most of culture's content lies below the surface (Weaver, 1998). Consequently, clinicians may see only a very small portion of clients' culture, and the rest is hidden deep below the surface. In clinical practice, the superficial culture, or the small portion of the iceberg, includes visible characteristics, such as clients' dress, manner, language, and other easily recognizable aspects. Superficial culture has a relatively low emotional load. Conversely, the majority of the cultural iceberg, or the *deep culture,* is unconscious and tends to have a high emotional valence—the kind of issues addressed in psychotherapy. Deep culture influences worldview, perception, and behavior. It frequently involves unspoken rules, such as norms that regulate family relations, intimacy, identity, relationships, boundaries, emotional space, and many others psychological areas. Such a cultural unconscious (Hoffman, 1989) permeates people's lives. When

clinicians are unaware of a client's deep culture and cultural unconscious, they run the risk of colliding with cultural icebergs and, consequently, limit the development of a therapeutic alliance. Multicultural care offers a map to help clinicians navigate the cross-cultural waters. You can begin this journey by examining your own cultural iceberg. Such a self-assessment explores the following questions (Locke, 1992; Pinderhughes, 1989):

Surface culture:

- What is the cultural connotation of my name?
- Does my physique bear a cultural meaning?
- Does my appearance (e.g., clothes, hairstyle) convey a cultural nuance?
- Does my skin color have an ethnic, racial, and/or cultural significance?
- Do my language (formal, informal) and speech (e.g., accent, modulation, style) have cultural implications?

Deep culture:

- What is my cultural heritage?
- What was the culture of my parents and ancestors?
- What cultural group(s) do I identify with?
- What is my worldview orientation (i.e., values, beliefs, opinions, and attitudes)?
- What aspects of my worldview are congruent with the dominant culture's worldview? Which are incongruent?

Professional/theoretical culture iceberg:

- How did I decide to become a clinician?
- How was I professionally socialized?
- What professional socialization do I maintain?
- How does my theoretical orientation influence my worldview?
- What do I believe to be the relationship between culture and clinical practice?
- What abilities, expectations, and limitations do I have that might influence how I relate to culturally diverse clients?
- How do I feel about the cultural differences between my clients and me?
- How do I feel about the cultural similarities between my clients and me?

Cultural icebergs interfere with your ability to recognize the existence of cultural variations in cognitive styles, conceptions of the self, the view of choice, notions of fairness, and visual perception, among many other areas. Moreover, if, as a clinician, you become culturally encapsulated, that is, insensitive to cultural variations, minimize evidence contrary to your assumptions, and judge from your self-reference criteria (Wrenn, 1985), you can collide with cultural icebergs.

If you focus on individuals' superficial culture without examining their deep culture, you can engage in cultural stereotyping. To illustrate, Levy (2010, p. 255) discussed that generalized statements (i.e., those that fit almost everyone in a particular category), such as those listed below, nurture cultural stereotypes:

- White Americans favor members of their own ethnic group.
- Hispanics/Latinos[1] can be very passionate.
- Italians enjoy food.
- African Americans are sensitive to certain words.
- Christians attempt to forgive.
- Jewish people yearn to survive.
- Minorities just want their rights.
- Senior citizens don't want to be ignored.
- Men care about success.
- Women resent being taken for granted.
- People with disabilities resent being seen as inferior.

Furthermore, when you are unaware of your own cultural assumptions, you run the risk of behaving in an ethnocentric manner—in other words, believing that your worldview is inherently superior and desirable to those of others (Leininger, 1978). Ethnocentrism compromises clinical practice because the definitions of *health, illness, healing, functionality,* and *dysfunctionality* are culturally embedded. For example, if a multicultural client (e.g., the Latina who is assertive at work) expresses tolerance of the limitations of significant others during psychotherapy, individualistically oriented

[1] Hereinafter, I use the inclusive term *Latino* to designate "Hispanic/Latino."

clinicians may misinterpret such tolerance as poor judgment instead of viewing it as a culturally accepted norm. What's more, if one is solely exposed to monocultural groups, one can encounter difficulties identifying his or her distinctive cultural characteristics.

Because the foundation of ethnocentrism is unawareness, becoming aware of cultural icebergs is a crucial step in the development of multicultural awareness. As people examine their cultural assumptions, stereotypes, and biases, they challenge their ethnocentrism. For instance, you can examine the dominant cultural assumptions in the United States and compare them with your own. Such an examination can prove useful because, regardless of one's socioeconomic class, if one is a White American, he or she may tend to endorse cultural values that reflect only his or her ethnic background (Katz, 1985). Along these lines, Steward and Bennett (1991) argued that due to its White, Anglo Saxon, Protestant founding fathers, the dominant, White U.S. culture includes the following values:

- individualism;
- action-oriented accomplishment;
- democratic majority-rule decision-making system (when White people are in power; hierarchical decision-making when White people are not in power);
- communication that depends on standard English (which tends to be abstract) as opposed to an associate language (which tends to be linked to a shared context for enhanced meaning) such as nonstandard English;
- official communication that relies more on written forms than on oral expression;
- future-oriented time perception;
- religious system based mainly on Judeo-Christian values and customs;
- patriarchal nuclear family system; and
- emphasis on White male European history.

In addition, monocultural assumptions have shaped the dominant society. To illustrate, N. J. Adler (1998) argued that monocultural assumptions prevalent in the United States include (a) homogeneity, or the belief in the melting pot; (b) similarity, or the assumption that "you are just like

me"; (c) parochialism, or the myth that "my way is the only way"; and (d) ethnocentrism, or the assumption that "my way is the best way." In contrast, a multicultural perspective includes (a) heterogeneity; (b) similarity and difference; (c) equifinity, or the belief that there are multiple ways of living one's life and, thus, that there are culturally parallel solutions; and (d) cultural contingency, or the belief that there are diverse and equally good ways to reach the same goal and that the best way is contingent on the cultural context.

Clinicians may have been trained to become aware of the monocultural assumptions in the mainstream society. However, they may be less conscious of the assumptions prevalent in their professional cultural iceberg. Clinical practice is a cultural activity replete of dominant cultural assumptions. Some of these monocultural assumptions include the psychological definitions of intimacy, relationships, motivation, activity, assertiveness, and agency, to mention a few.

Indeed, agency is a vivid example of the cultural differences in assumptions. Stephens, Hamedani, Markus, Bergsicker, and Eloul (2009) studied the perspectives on agency of observers and survivors regarding the people who "chose" to leave ("leavers") and those who stayed ("stayers") in New Orleans after Hurricane Katrina. These researchers found that observers evaluated leavers' behavior in positive terms as exhibiting agency—that is, they described the leavers as being independent and in control, in contrast to the stayers, whom the observers assessed negatively as being passive and lacking agency. Moreover, when the researchers interviewed the survivors, the leavers described their own behavior with an emphasis on independence, choice, and control, in contrast to the stayers, who emphasized interdependence, strength, and faith. Stephen and coworkers concluded that observers perceived agency as a White, middle-class concept consistent with an individualistic orientation and an ability to proactively influence the environment. Conversely, the stayers did not have the "choice" of leaving (because of a lack of significant others in other states, plus no socioeconomic resources for leaving) and, thus, described their agency in terms of a collectivistic orientation with a focus on interdependence, displaying strength against adversity, and having faith as a coping mechanism.

When you recognize your theoretical/professional assumptions, you can challenge ethnocentrism. To facilitate this process, consider the following cultural assumptions embedded in the dominant psychological assumptions (Pedersen, 2000; Weaver, 1998):

- Everyone is responsible for his or her actions.
- Everyone has a choice in every situation.
- Everyone is autonomous.
- Everyone has his or her own identity.
- Many clinicians assume that they are free of cultural bias.
- Individualism is presumed to be more appropriate than collectivism.
- Community support systems are not normally considered relevant in the clinical formulation of individuals' health.
- Ethnocultural ancestry and historical roots of individuals' backgrounds have minimal relevance in clinical treatment.
- Geopolitical issues bear no influence in clinical treatment.

Furthermore, contrast these assumptions with those of multicultural caring clinicians:

- Culture is complex and dynamic.
- Reality is constructed and embedded in context.
- Every encounter is multicultural.
- Clinicians' cultural competence is relevant to all clients.
- Clinicians' understanding of nonverbal communication and behaviors is crucial to healing.
- A Western worldview has dominated mainstream psychotherapy.
- Clinicians engage in cultural self-assessment.
- Healing is holistic and involves multiple perspectives.
- Healing entails empowering individuals and groups.

If you are unaware of your cultural assumptions, you risk ignoring the effects of diversity variables on individuals' help-seeking behavior and their adherence to treatment. To prevent these problems, you should avoid diagnosing multicultural clients' normative behaviors as resistance, deficit, and/or deviance (Young, 1990). Moreover, you should try to challenge your professional ethnocentrism by engaging in a critical examination of the established psychotherapeutic models and assumptions (such as the ones listed above). In fact, developing multicultural awareness is the beginning step in the journey toward cultural competence.

CULTURAL COMPETENCE: BECOMING A BETTER CLINICIAN

Cultural competence offers a compass to navigate the multicultural waters, and thus prevents colliding with cultural icebergs. Cultural competence applies to everyone because it enhances clients' treatment engagement, adherence, and completion. Research has shown that clients are more satisfied with their clinician not necessarily when they are ethnically matched but when they perceive the practitioner to be culturally competent, compassionate, and able to understand the client's worldview (Knipscheer & Kleber, 2004).

Cultural competence requires clinicians to be able to move from one cultural perspective to another (S. R. Lopez, 1997). In other words, cultural competence entails the awareness, attitude, knowledge, and skills that allow clinicians to understand, appreciate, and work with culturally diverse individuals (Betancourt, Green, Carrillo, & Ananch-Firempong, 2003). *Awareness* involves an ongoing self-reflection about one's worldview and cultural identity. Awareness also helps clinicians to recognize the presence of cultural icebergs as well as to identify their reactions to culturally different clients. *Attitude* involves developing sensitivity, respect, humility, empathy, and awareness of clients' contextual issues (Betancourt, 2003). Yet, an important aspect of attitude is the recognition that beliefs do not always coincide with behavior. For example, cognitive psychology studies have shown that individuals who in self-report measures appear nonprejudiced generally have negative attitudes toward African Americans (Dovidio, & Gaertner, 1998) and perhaps toward other people of color. Therefore, these individuals may engage in unintentional racist behavior even though they think that they are not prejudiced. *Knowledge* helps clinicians to understand how cultural, sociopolitical, and historical influences shape individuals' worldviews and related health behaviors (Betancourt, Green, Carrillo, & Ananch-Firempong, 2003). As a behavioral

aspect of cultural competence, *skill* involves being able to effectively communicate and interact, as well as to negotiate differences and similarities in multicultural situations. In addition, multicultural skills require that clinicians adapt their clinical work to the cultural contexts of their clients. Moreover, Whaley and Davis (2007) emphasized the need for the internalization of the cultural competence process into one's clinical repertoire, to regularly apply it to multicultural individuals. Furthermore, cultural competence is more than the sum of its parts—awareness, attitude, knowledge, and skill. It is the integrative application of the interrelated cultural competence components into clinical assessment and treatment (Hansen, Pepitone-Arreola-Rockwell, & Greene, 2000).

Cultural competence is at the heart of multicultural care. Becoming culturally competent is a developmental process in which multicultural awareness is an initial stage. You can enhance your cultural awareness when you do the following (Comas-Díaz & Caldwell-Colbert, 2006; St. Onge, 2009):

- acknowledge that differences are always present—because every encounter is multicultural, recognize the existence of cultural differences;
- locate your own cultures—examine your cultural contexts and use the cultural iceberg metaphor to understand your cultures;
- engage in cultural self-assessment;
- develop intimacy with the culturally different "other"—in other words, increase contact with culturally diverse individuals of similar social status;
- see the dominant culture as one of many—when one aspect of a person's identity is part of a privileged group, he or she may not see it as a culture (e.g., like being White, male, or heterosexual);
- discover the influence of geography—physical location and geopolitical factors contextualize individuals' experience; for example, being a Latino immigrant in Arizona is different from being a Latino immigrant in Washington, DC, or being gay in San Francisco is different from being gay in Salt Lake City;
- look for divergent cultural norms—examine clients' cultural norms that conflict with your own, and assess your ability to work within the specific situation, or make appropriate referrals;

- examine intersecting identities—be mindful of how different components of identity relate to each other, for instance, an African American, lesbian, disabled woman frequently faces four types of interacting discrimination; and
- consider race a major identity issue in the United States.

This last point is central to cultural competence. Racism and colorism (i.e., a preference for light-color skin) pressure individuals to identify along color lines in the United States. Although many visible immigrants may self-identify by ethnicity and/or nationality (not along racial lines), as they acculturate, they tend to succumb to the White, Black, Brown, Yellow, or Red classification pressure. In my experience, compared with their immigrant parents of color, first-generation individuals tend to endorse a racial cultural identity. Chapter 4 presents a detailed discussion on cultural and racial identity development.

In brief, a journey into cultural competence can help you to

- conduct cultural self- assessments,
- enhance your multicultural awareness,
- navigate safely around cultural icebergs,
- learn about different worldviews,
- examine your attitudes toward self and other,
- acquire and incorporate cultural knowledge into your interventions and interactions,
- increase your multicultural clinical skills, and
- become a better clinician.

MULTICULTURAL SENSITIVITY STAGES

An essential component of cultural competence is the development of multicultural sensitivity. APA Multicultural Guideline 2 (APA, 2003) exhorts psychologists to recognize the importance of multicultural sensitivity, responsiveness, and knowledge, and to enhance their understanding about culturally different individuals. After examining your cultural

iceberg, you can explore the developmental stage of multicultural sensitivity. This examination offers a baseline for cultural self-assessment. Bennet (2004) proposed the multicultural sensitivity development model as a useful structure to explore one's journey toward multicultural awareness and competence. Although Bennet's model describes a progression from one stage to the next, in reality, this model is a nonlinear development in which clinicians can find themselves in different stages, depending on the clinical context. Borkan and Neher (1991) adapted Bennet's model to a clinical setting and identified the stages of multicultural sensitivity developmental model as follows.

Ethnocentric stages:

1. *Fear.* Clinicians may fear working with a particular culturally diverse group, be mistrustful of differences, or both. The aim in this stage is to learn to decrease or eliminate fear by obtaining cultural knowledge.
2. *Denial.* Clinicians in this stage may exhibit cultural blindness and, thus, ignore and even deny cultural differences ("We are all humans"). Research findings revealed that cultural blindness is associated with lower levels of empathy (Burkard & Knox, 2004). The developmental task in this stage is to recognize the existence of cultural differences.
3. *Defense.* Clinicians in this stage tend to recognize the existence of cultural differences but feel threatened and, thus, defend against them. Defense mechanisms include dualistic negative stereotyping—that is, clinicians may feel their culture to be superior and denigrate other cultures. Conversely, they may denigrate their own culture as a result of identifying with another group's culture ("I wish I could give up my own culture and be one of these people"). The developmental task in this stage is to alleviate polarization.
4. *Minimization.* Reductionism and universalism characterize this stage. For example, a reductionism response emphasizes psychopathology and dysfunctionality while neglecting the effects of culture on mental health and on wellbeing. Clinicians who view their own culture as universal behave according to the minimization stage. They recognize cultural differences but minimize them, believing that similarities compensate for any difference. Similarity is assumed rather than known

("The other is just like me"). Cultural self-awareness can help clinicians to move into ethnorelative developmental stages.

Ethnorelative stages:

5. *Relativism.* Clinicians in the stage recognize, accept, and value cultural differences without judging those differences as positive or negative. They accept other cultures as complex and valid alternative representatives of realities. Cultural exploration and the acceptance of cultural differences build the foundation for empathy.
6. *Empathy.* Clinicians in this stage adapt to cultural differences and are able to shift in and out of alternative worldviews. As they embrace pluralism, they exhibit empathy—the ability to shift perspectives or capability to walk "in their multicultural clients' moccasins."
7. *Integration.* In the integration stage, clinicians expand their experience of self and other to include multicultural perspectives. They are able to engage in ethical decisions through a contextual assessment of critical cultural, individual and collective factors.

EXAMINING YOUR OWN CULTURAL COMPETENCE

After you place yourself in the multicultural sensitivity developmental continuum, you can use questionnaires to examine your cultural competence and obtain a baseline. Several of the cultural competence questionnaires are based on the work of Mason (1995), who developed the Cultural Competence Self-Assessment Questionnaire (CCSAQ). This instrument is a process tool. There are no poor performances with this questionnaire because cultural competence is a development. The CCSAQ assesses the areas of (a) knowledge of communities served, (b) personal involvement, (c) resources and linkages, (d) agency staffing, (e) service delivery and practice, (f) organizational policy and procedures, and (g) reaching out to communities. There are two versions of the CCSAQ, one for service providers and the other for administrative staff or human services organizations. I discuss in more detail the assessment of cultural competence in health and mental health organizations in Chapter 9.

Readers can assess their cultural competence baseline by completing the CCSAQ (available at http://www.rtc.pdx.edu/PDF/CCSAQ.pdf) before completing reading this book. Afterward, you can take this book's accompanying online course and complete its postassessment test. A list of cultural competence assessment tools can be accessed at http://www.transculturalcare.net/assessment-tools.htm.

Readers who are not interested in paper and pencil questionnaires can use a simple and practical tool to assess their cultural competence baseline. You can ask yourself the right questions. The Awareness, Skill, Knowledge, Encounters, and Desire (ASKED) method (Campinha-Bacote, 2002) is a simple mnemonic device to help you assess your multicultural literacy and competence. You can use the ASKED method in your ongoing cultural self-assessment by asking yourself the following questions

- Awareness: Am I aware of my biases?
- Skill: Do I know how to conduct an effective multicultural assessment?
- Knowledge: Do I know about culture-specific information, ethnopsychopharmacology, and biocultural ecology?
- Encounters: How many face-to-face encounters and interactions have I had with multicultural individuals?
- Desire: Do I want to become culturally competent?

CLINICAL ILLUSTRATION

As you explore the ASKED questions, you can enhance your multicultural awareness. With an improved culturally responsive perspective, let us take a second look at the clinical vignette presented at the beginning of this chapter. Of course, one can use diverse theoretical orientations to examine Sonia's vignette. However, an alternative scenario, in which Dr. Jenkins exhibits multicultural awareness, could yield different results from the first clinical scenario. To facilitate the illustration, I identify Dr. Jenkins's use of multicultural clinical strategies in parentheses.

Sonia: I'll castrate him.

Dr. Jenkins: You're quite upset.

Sonia: Of course I am. Dale has been abusing me and I don't know what to do.

Dr. Jenkins: Can you tell me more?

Sonia: [*Opens her purse.*] Do you have a light?

Dr. Jenkins: Sorry, I don't allow smoking in here. Do you want a glass of water instead?

(Empathic limit setting and acknowledgment of Sonia's anxiety)

Sonia: No, thanks. Can I have a tissue? [*Dr. Jenkins offers Sonia a box of tissues. Sonia takes a tissue and blows her nose on it*]. We've been married for 3 years, and he started the abuse right after the honeymoon.

Dr. Jenkins: Does your family know? (Using familism or the collectivistic value of family relations to explore Sonia's support system; see the discussion of familism in Chapter 4)

Sonia: Yes, but they told me to stay with Dale and pray. [*Eyes suddenly well up.*]

Dr. Jenkins: What is that like for you?

Sonia: I pray at times.

Dr. Jenkins: How does it make you feel? (Exploration of religious/spiritual orientation to assess violence potential)

Sonia: OK, generally. But it's of little use with my family.

Dr. Jenkins: How come?

Sonia: I don't think they care that much about me.

Dr. Jenkins: Can you tell me more?

Sonia: I don't want to talk about it now.

Dr. Jenkins: That's fine. Do you have children? (Taking Sonia's response at face value, engaging in sociocentric oriented assessment)

Sonia: Yes. A 2-year-old daughter.

Dr. Jenkins: Do you have a picture of her with you? (Use of a collectivistic interpersonal cultural approach)

Sonia: [*Opens her purse and pulls out from her wallet a picture of a girl wearing long black braids and a beaming smile.*] My daughter, Lluvia. [*Hands the picture to Dr. Jenkins.*]

Dr. Jenkins: That's an unusual name. What does it mean? (Showing interest in Sonia's culture) [*Returns Lluvia's picture to Sonia.*]

Sonia: Rain. [*Kisses the picture, places it back in her purse, and stops crying.*] Mami suggested the name Lluvia because rain comes from *el cielo*. In Spanish, the word *cielo* means both sky and heaven.

Dr. Jenkins: Is your mother concerned about Lluvia's well-being if you leave Dale? (Exploration of Latino traditional gender roles)

Sonia: That's what she says. She's old-fashioned and doesn't understand domestic abuse. [*Pulls another tissue from the box.*]

Sonia: Sometimes I think she blames me.

Dr. Jenkins: Umm . . .

Sonia: It's her religion. I'm so angry . . .

Dr. Jenkins: Do you really want to castrate Dale?

Sonia: No, he's already castrated. [*Blows her nose into the tissue.*] Real *machos* don't abuse their wives.

Dr. Jenkins: What do you mean?

Sonia: They protect their family. [*Leans forward in her chair.*] Can you help me protect myself?

This alternative scenario depicts Dr. Jenkins's helping to avoid a cultural misunderstanding. Dr. Jenkins's multicultural awareness fostered her exploration of Sonia's violence potential in a culturally and gender-sensitive manner and, thus, prevented a therapeutic impasse.

CONCLUSION

Increasing cultural self-awareness helps clinicians to understand themselves and others. An ongoing reflexive practice in the form of a cultural

self-assessment facilitates the cultivation of multicultural awareness. When one commits to developing cultural competence, one engages in a lifelong process to become a better clinician.

MULTICULTURAL CLINICAL STRATEGIES

- Assess your multicultural sensitivity along a cultural competence developmental continuum.
- Avoid assumptions: If you need to assume, then assume difference until similarity is proven.
- Recognize that clinicians' cultural competence is relevant to all clients.
- Become aware of your own worldview.
- Be open to multiple worldviews.
- Commit to an ongoing cultural self-assessment.
- Be aware that clinical practice is a cultural activity.
- Consider every clinical encounter as a multicultural interaction.
- Examine and challenge your ethnocentrism: Read cross-cultural literature, especially memoirs of culturally diverse individuals, watch foreign films and films by and about people of color, and aim to learn a foreign language and to travel to other countries or to culturally different areas in the United States.
- Examine your cultural bias against individuals similar to and different from you.
- Increase contact with culturally diverse individuals of similar social status.
- Identify the presence of cultural icebergs.
- Recognize intragroup variations but avoid ethnocultural and racial stereotyping.
- Become aware of your values that are inconsistent with those of culturally diverse clients.
- Elicit information in a sociocentric fashion (e.g., family-centered context).

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- Use the acronym ASKED as a method to assess cultural competence.
- Remember that multicultural clients prefer clinicians who are culturally competent, not necessarily ethnically matched.
- Recognize the culture-sensitive aspects of the ethics in being a multicultural caring clinician.

2

Engagement: Telling Stories

The one who tells the stories rules the world.

—Hopi proverb

Steve: I'm here because my doctor told me to.

Dr. Perez: Can you tell me more?

Steve: Yes, doctor! My internist said that I needed to see you.

Dr. Perez: Why do you think she asked you to see me?

Steve: Yes, doctor!

Dr. Perez: Let me ask you in a different way. How do you understand why she asked you to come here?

Steve: Maybe 'cause my heart hurts.

Dr. Perez: Can you tell me how your heart started to hurt?

Steve: I'm not sure.

Dr. Perez: Dr. Simpson mentioned in her referral note that you are originally from the Philippines.