MULTICULTURAL CLINICAL STRATEGIES

- Use intersectionality to examine the impact of diversity variables on cultural identity.
- Use a cultural analysis in clinical formulation and treatment.
- Identify clients' cultural identity development, as well as one's own.
- Examine clients' adherence to familism.
- For sociocentric individuals, being tolerant of the limitations of others does not always imply poor judgment.
- Bear in mind that spirituality is a central element in the lives of many people of color.
- Consider adopting a cultural interpretation into dream analysis.
- When appropriate, assess the client's psychospiritual journey.
- Consider conducting one's own psychospiritual assessment.
- Exercise ethical contextualism when working with multicultural clients.

5

Multicultural Therapeutic Relationship: Seeing Yourself in the Other

The challenge of being a human being is not only to be oneself, but to become each one.

—Robert Desnos

Marcia: It was racism! The White woman dissed me. She assumed I was lying about my lost registration form. [*Stares at the Haitian painting, a colorful depiction of women walking on a sunny beach carrying fruit baskets on their heads, hanging on Lillian's office wall.*]

Lillian: How did that make you feel?

Marcia: What do you think? [*Says this in a loud voice and emphasizes "you," as she continues to stare at the picture.*]

Lillian: You mentioned that the woman told you she was assisting the lecturer first, and then you later.

Marcia: Yes, but she needs more therapy than I do. [*Does not move her eyes from the Haitian women's brightly colored clothes in the painting.*] If I was White, she would have registered me before the conference began. [*Keeps*

staring at the Haitian women.] After I paid $55, the woman made me wait. I missed the first part of the lecture. [*Moves her eyes away from the Haitian women to Lillian's.*] Of course, when she found my name on the list, she was all apologies. She's a racist hypocrite.

Lillian: Are there alternative explanations?

Marcia: [*Eyes return to the painting; there is a long pause.*] Red makes me see blood.

Lillian: You sound angry.

Marcia: Of course I'm angry. It's easy for you to ask about alternative explanations. You're not Black.

How do you feel about this clinical encounter? What issues does the clinician (Lillian) need to deal with? Have you experienced similar situations? How do you handle clients' anger?

Marcia's vignette suggests that racial differences between the clinician and the client can affect the therapeutic relationship. As her clinician, I did not validate Marcia's presentation of an oppressive incident. My behavior resulted in a rupture in the therapeutic relationship.

The multicultural therapeutic encounter reflects the relationship between self and other. Moreover, the multicultural encounter can mirror Robert Desnos's challenge of being human as not only being ourselves but as becoming each other (see the opening quote in this chapter). I devote this chapter to the multicultural therapeutic relationship, an essential agent of change in multicultural care. First, I present the relationship between self and other as a backbone of multicultural care. Next, I discuss the management of the multicultural therapeutic relationship. I conclude the chapter with a presentation of cultural elements of transference and countertransference.

SELF AND OTHER

Research findings document the relevance of the therapeutic relationship in predicting psychotherapeutic change (Marmar, Horowitiz, Weiss, & Marziali, 1986; Norcross, 2002). Certainly, clinicians are aware of the centrality of the healing relationship in treatment. In addition, clinicians are

aware that culture mediates the therapeutic relationship. If the healing relationship is the vehicle for therapeutic change, then culture is its steering wheel (Comas-Díaz, 2011a).

Clinical work with multicultural clients tests the therapeutic relationship by providing rewards and challenges. On the one hand, working with multicultural clients can enrich one's life because it offers excitement and a deeper connection. In addition, multicultural encounters provide an opportunity for personal growth (Montuori & Fahim, 2004). On the other hand, developing a therapeutic alliance can be challenging because the multicultural encounter frequently acquires unconscious dimensions. Definitely, the multicultural clinical hour is a fertile ground for projections because each encounter is full of conscious and/or unconscious messages about the client's and the clinician's cultural backgrounds. For these reasons, managing the relationship between self and other is the foundation of multicultural care. As people try to make sense of their social world, they tend to categorize individuals as ingroup or outgroup members. Consequently, membership in one group helps to shape conscious and unconscious perceptions about same group and outside group members (Allport, 1954).

Unfortunately, relating to the cultural other can cause frustration because clinicians often feel more comfortable with clients who are like them. Empirical data seem to substantiate this assertion, as people habitually use themselves as the referent in comparisons with others, judging on how familiar they are (Catrambone, Beike, & Niedenthal, 1996; Hart et al., 2000). Notably, researchers have identified where and when racial similarities and differences matter at a neural level. Scientists recorded activity in the fusiform face area (FFA) of the brain as African Americans or European Americans studied pictures of faces from different races (Golby, Gabrielli, Chiao, & Eberhardt, 2001). Interestingly, the researchers found that the FFA was more active when either group was learning and recognizing faces of their same race. Such biological self-reference appears to aid in the communication of emotions. Notwithstanding the universality of some nonverbal expressions of emotions (Ekman, Sorenson, & Friesen, 1969), Marsh et al. (2003) found cultural differences in the facial expression of emotion through the existence of nonverbal accents—subtle differences in the appearance of facial expressions of emotions. The investigators concluded

that because people from their own race and culture look familiar while expressing emotions, they tend to develop favorable attitudes toward members of their own ethnoracial group. Consequently, nonverbal accents may explain attraction to individuals who are familiar (Byrne, 1997), as well as rejection of those who are different, and even the emergence of xenophobia (Warnecke, Masters, & Kempter, 1992). In sum, neurological and cultural findings attest to the tendency to recognize and affiliate with individuals of one's same culture or race, as well as to exclude individuals who are culturally and/or racially different from oneself.

People tend to be unaware of their racial bias. As I mentioned in Chapter 1, research has documented that White individuals who in self-report measures rated themselves as nonprejudiced often had generally negative attitudes toward African Americans (Dovidio & Gaertner, 1998). Known as *aversive racism,* this phenomenon involves dissociation between implicit and explicit stereotyping (Abelson, Dasgupta, Park, & Banji, 1998). Cognitive psychological studies have empirically showed that both liberal and conservative Whites discriminate against African Americans (and most likely against other people of color) in situations that do not implicate racial prejudice as a basis for their actions (Whaley, 1998). If a person is White and grew up as a member of a majority group, he or she may covertly harbor racist attitudes (Brown, 1997) and, thus, exhibit aversive racism. Certainly, clinicians' unexamined aversive racism, unconscious ageism, ethnocentrism, sexism, elitism, xenophobia, homophobia, and heterosexism, among other forms of bias, can profoundly affect the therapeutic relationship.

American Psychological Association (APA) Ethics Code, Principle E (APA, 2010b), Respect for People's Rights and Dignity, asks psychologists to try to eliminate the effects of the above-mentioned biases on their work. Likewise, APA Multicultural Guideline 1 (APA, 2003) encourages psychologists to explore their beliefs, values, and attitudes, including their own preferences toward their ingroup members and attitudes toward outgroup members. The client classifications of (a) young, attractive, verbal, intelligent, and successful (YAVIS) and (b) humble, old, unattractive, nonverbal, and dumb (HOUND; Schofield, 1964) constitute examples of stereotypic outgroup impression in clinical practice. According to this classification, the YAVIS person has been identified as an ideal client for

exploratory and problem-solving talk psychotherapy. Conversely, the HOUND person has been perceived as more suitable for nonverbal and supportive psychotherapy. Multicultural people can be misperceived as HOUND clients on the basis of their clinicians' inability to understand them (Comas-Díaz, 2006b). It is interesting to note that another acronymic concept, Western, educated, industrialized, rich, and democratic (WEIRD) cultures (Henrich, Heine, & Norenzayan, 2010), has emerged to counterbalance the HOUND notion. Because psychologists and clinical researchers routinely use WEIRD individuals in their studies, and according to Henrich, Heine, and Norenzayan (2010), such findings do not represent the majority of the global population, they consequently tend to make broad and unsupported claims regarding human behavior.

My clinical practice is composed of WEIRD and minority, immigrant, non-White, ethnic (MINE) clients. Clinicians should examine their own ingroup and outgroup membership classifications or acronyms. However, remember to challenge your categorizations, because impressions are resistant to change once formed (Gilbert, 1998). When you become conscious of your reactions toward culturally different clients, you improve your ability to trust yourself as a healing instrument. For example, a clinician can become aware of the pervasive influence privilege has on the lives of White individuals. To illustrate, ingroup favoritism—with its informal networks that provide contacts, support, mentoring, rewards, and benefits to same group members—tends to exclude people of color in predominantly White work environments (Rhode & Williams, 2007). Consequently, if one is unaware of White ingroup favoritism, he or she may minimize its effects on one's racially different clients (Galinsky & Moskowitz, 2000). Conversely, as you understand the stigmatizing effects of being a member of an oppressed group, you foster your multicultural therapeutic alliance. If you are White, you can examine your internalized privilege through a cultural self-assessment.

WHITE PRIVILEGE: UNPACKING THE INVISIBLE KNAPSACK

A clinician can become aware of White privilege by unpacking what McIntosh (1988) called the "invisible knapsack." McIntosh equated White

privilege to an invisible knapsack because unacknowledged systems give social power to White Americans and to men. She provided examples of how structural social privilege favors members of dominant groups as opposed to racial minorities. To illustrate, you unpack the invisible knapsack of White privilege when you realize that you can

1. go shopping alone most of the time, pretty well assured that you will not be followed or harassed;
2. turn on the television or read the front page of the newspaper and see European American people widely represented;
3. count on your skin color not to work against the perception of financial reliability whenever you use checks, credit cards, or cash;
4. be pretty sure of renting or purchasing housing in an area that you can afford and where you would want to live;
5. avoid the need to racially socialize your offspring to be aware for their own daily physical protection;
6. remain unaware of the language and customs of persons of color who constitute the world's majority without feeling any penalty for such oblivion;
7. exist with little fear about the consequences of ignoring the perspectives and powers of people of other races;
8. encounter a person of your own race if you ask to talk to the person in charge;
9. are confident that if a state trooper pulls you over, you haven't been racially profiled (singled out because of your race); and
10. take a job with an affirmative action employer without having your coworkers suspect that you got it because of your race.

Readers can review all of the examples of White privilege at http://seamonkey.ed.asu.edu/~mcisaac/emc598ge/Unpacking.html.

The discussion of White privilege can be clinically useful not only when working with White individuals but also when working with interracial couples and families. Such discussion can even be extremely useful when working with ethnic minority families. For example, when Pilar, a light-skin-colored Latina, realized that she benefited more from White privilege than Eduardo, her darker-skin-colored husband, she stopped

accusing him of being oversensitive to "subtle" forms of racism. It is not surprising that Latinos with dark skin encounter more discrimination in school, problems with the police, and difficulties in employment than do their lighter skinned Latino siblings (L. A. Vázquez, Garcia-Vasquez, Bauman, & Sierra, 1997).

MICROAGGRESSIONS: RACISM, SEXISM, HETEROSEXISM, AND XENOPHOBIA

As in the examples of White privilege, racial differences acquire significance in the daily lives of visible people of color. To illustrate, many individuals are exposed to racial *microaggressions,* that is, the assaults that occur on a regular basis solely due to their race and/or ethnicity (Pierce, 1995). Examples of racial microaggressions include being ignored by clerks in favor of White customers, being mistaken as service personnel, being labeled as an "affirmative action person" (i.e., a beneficiary of racial favoritism), being racially profiled, and other indignities. In the vignette at the beginning of this chapter, Marcia experienced the incident with the White clerk as a microaggression ("She's a racist hypocrite"). My question to her—"Are there alternative explanations?"—although intended to foster a cognitive reframing, was racially insensitive and, as a result, threatened our therapeutic alliance.

Incidents of aversive racism tend to be difficult to identify because of their subtle nature. Given the vague nature of Marcia's microaggression experience, perhaps my response reflected the irritating question as to whether the microaggression really happened (Crocker & Major, 1989). As a female clinician of color who has experienced racial microaggressions, I may have defended against vicarious trauma. To examine this issue, I consulted with a colleague and conducted a cultural self-assessment. I realized that I needed to validate Marcia's experience of being a victim of a microaggression and balance this understanding with the need to empower Marcia.

D. W. Sue and colleagues (2007) expanded the microaggression concept to include *microassault,* or the explicit racial derogation through verbal or nonverbal attack (e.g., name calling, avoidant behavior) with the

intention to hurt the victim; *microinsult,* or insensitive communications geared to demean a person's cultural heritage and identity; and *microinvalidation,* or communication that excludes, negates, or nullifies a person's of color's thoughts, feelings, or experiential reality. Microaggressions can result in long-standing effects as they retraumatize individuals' soul wounds. Microaggressions alter victims' sense of trust ("You cannot be trusted"), competence ("You are inferior"), inclusion–exclusion ("You don't belong"), normality ("You are abnormal"), and visibility ("You are all the same"; D. W. Sue et al., 2007).

Members of minority groups are exposed to microaggressions. For example, women and girls may be told that they cannot be presidents of their nation. Gay men and lesbians may be told that they cannot be good parents, or Boy Scouts or Girl Scouts leaders. Moreover, racial microaggressions rob people of color of their individuality by putting pressure on them to represent the whole ethnoracial group. Examples of racial, gender, and sexual orientation microaggression include the following:

- attribution of being alien, foreign, undocumented, or all three (see in this chapter the section on ethnocultural transference and countertransference; Asian Americans, Latinos, and other people phenotypically different from Whites are assumed to be foreign born);
- ascription of intelligence ("You are a credit to your race");
- assumption of inferiority ("You speak with an accent, you are dumb");
- assumption of heterosexuality (e.g., a clinician ignores her client's bisexuality);
- color blindness ("I don't see color, I see people" or "We are all the same under the skin");
- myth of meritocracy (verbal and nonverbal messages conveying that race and ethnicity play a minimal role in success in employment and in life); and
- sexist and heterosexist language (use of *he* when referring to all people, calling an assertive woman a "bitch," using the term *gay* to describe a socially ostracized student). (D. W. Sue & Sue, 2008)

Regrettably, racial microaggressions can also occur in clinical practice. These microaggressions range from the clinician's color blindness, denial,

or minimization of individual racism; to believing in the myth of meritocracy; to pathologizing culturally diverse values and styles (D. W. Sue et al., 2007). Lamentably, if a clinician denies, minimizes, defends against, ignores, or has all of these reactions to his or her clients' references to racism, he or she may engage in racial microinvalidation (e.g., when I asked Marcia about alternative explanations to her perception of the White clerk). Most clinicians believe that they are unbiased. Unfortunately, unawareness of one's implicit biases can result in microaggression during the clinical hour. Clinicians should be vigilant against "color-blind" statements such as "We are all human beings," "We are all unique," and others. Although these statements may be intended to provide support, in reality they can result in clients feeling misunderstood, negated, and invalidated (D. W. Sue et. al, 2007). Furthermore, a clinician's use of language can reflect bias, as well as unawareness of the effect of oppression on one's clients. For example, if you use words such as *blind analysis,* you convey insensitivity toward visually impaired individuals and their significant others. Similarly, clinicians should remember to use the terms preferred by the ethnic and racial groups for their self-designation. For example, avoid using the term *Oriental* or *colored* to designate some ethnic minorities (D. W. Sue et al., 2007). For a more comprehensive discussion of how to avoid language bias, see the sixth edition of the *APA Publication Manual* (APA, 2010a).

Clinicians can enhance their understanding of microaggressions when they examine the symbolic representation of the therapeutic relationship in the context of the effects of historical and sociopolitical events on individuals' lives. Indeed, APA Multicultural Guideline 2 (APA, 2003) encourages practitioners to understand the effects of historical and contemporary cultural oppression on individuals and the effects of being minority group members. The heritage of cultural oppression and trauma among most Americans of color includes, among other geopolitical events, the American Indian Holocaust; African American slavery; the forced annexation of Mexican territories; the 1846–1848 Mexican–American War; the colonization of the Philippines, Guam, and Puerto Rico (as a result of the 1898 Spanish–American War); and concentration camps for Japanese Americans. Most of these events are related to the Manifest

Destiny doctrine—the 19th-century imperialistic policy advocating for the expansion of the United States across North America, annexing Texas, Oregon, and California, as well as the nation's extension into the Caribbean (Puerto Rico) and the Pacific (Philippines, Guam). In addition, the proponents of this doctrine used Manifest Destiny as a rationale for appropriating the lands of Native Americans (i.e., Trail of Tears) and other non-European individuals.

Recent historical events, such as the September 11, 2001 attacks, nurtured the current climate of xenophobia, and hate crimes toward many Americans of color on the basis of ethnicity and religion. In addition to Muslim Americans, many Latinos were attacked solely because they physically look Arab (Dudley-Grant, Comas-Díaz, Todd-Bazemore, & Hueston, 2004). In a similar vein, the passage of the 2010 anti-immigration laws in Arizona targeted individuals who "looked Latino," as police were allowed to detain anyone whom they believed may be in the state illegally (Arizona State Senate, 2010).

Unfortunately, reactions to these historical and sociopolitical incidents can find their way into the therapeutic relationship. Consequently, some clients of color develop a historical transference (Duran, 2006) and become overly sensitive to oppressed–oppressor dynamics during the clinical encounter. As a vivid example, John, the African American gay man I introduced in Chapter 2, revealed in a later session that he feared Dr. Cassidy would attempt to "change" his sexual orientation.

The history of cultural oppression can bear a psychological mark—a soul wound—caused by historical trauma, suffering, ungrieved losses, internalized oppression, disconnection from ethnic roots, learned helplessness, and anomie (Duran, 2006). Moreover, the legacy of medical mistreatment against Americans of color, known as *medical apartheid* (Washington, 2007), has aggravated this soul wound. Examples of medical apartheid include the Tuskegee project—in which African American men who had syphilis were given a placebo, whereas White men were treated with penicillin, despite the fact that a cure for syphilis was found during the course of the research (Washington, 2007). In addition, women of color underwent forced sterilizations (Garcia, 1982), and many patients of color experienced psychopharmacological mistreatment (Melfi,

Croghan, Hanna, & Robinson, 2000; Rey, 2006) and other forms of medical malpractice. More recently, Green et al. (2007) presented medical residents with a story depicting White and Black emergency room patients who had symptoms of a heart attack, and asked the physicians if they would prescribe the appropriate medication. The results showed that although medical residents reported no explicit preferences for Black or White patients, their responses to a test measuring their implicit racial preferences revealed that they held more negative perceptions toward Black patients.

As you become aware of the legacy of cultural trauma, you can experience frustration, overwhelming guilt, paralysis, fear of offending again, patronizing, overidentification, and becoming a strident and ineffectual spokesperson, among other types of reactions (Tamasese & Waldegrave, 1994). In extreme cases, clinicians can even develop a hostage countertransference (Kauffman, 1992, as cited in Neumann & Gamble, 1995) because they may feel silenced by a client's reality. Moreover, a client's story can induce a vicarious traumatization that promotes the erosion of the clinician's personal and cultural history (Neumann & Gamble, 1995).

The unawareness of your reactions to clients' historical and contemporary cultural oppression can trigger an empathic break in the therapeutic relationship. To illustrate, I return to the vignette at the beginning of this chapter. As I indicated before, Marcia perceived my inquiry regarding alternative explanations for the White woman's behavior as a racial microinvalidation. Needless to say, a racial microaggression of any type compromises the multicultural therapeutic alliance. My insensitivity regarding Marcia's societal position as a Black woman, the social distance between Blacks and Whites, and her history of personal and collective racial discrimination seemed to test our healing alliance. Indeed, the single most common problem (regardless of social class) underlying psychotherapy with African American women is racism-related distress (Landrine & Klonoff, 1996, 1997). Marcia's reaction was no exception: It reflected the pervasiveness of racism in the lives of many African American women. Moreover, my question about alternative explanations appeared to rekindle Marcia's cultural trauma. Below, I examine Marcia's situation through a cultural oppression lens.

Marcia: Of course I'm angry. It's easy for you to ask about alternative explanations. You're not Black.

Lillian: You're right, I'm not Black. How do you feel about working with a non-Black clinician?

Marcia: Now, I'm not sure. Initially I wanted to see a woman of color.

Lillian: I'm sorry I was insensitive about your experience with the White attendant.

Marcia: You must have some sensitivity—you're not White. [*Continues staring at the picture of the Haitian women in the office.*]

Lillian: Can we talk about your experiences with racism?

Marcia: You really want to hear it?

Lillian: Yes, I really want to hear it.

Marcia: [*Turns her body toward Lillian; there is a long pause before she replies.*] First, you cry.

Lillian: [*Hands Marcia a box of tissues.*]

Perhaps you, as a clinician, have experienced ruptures in the therapeutic alliance as indications of crucial moments in therapy. When you address and effectively work through a rupture, you can strengthen the multicultural therapeutic relationship and even model a constructive way of handling interpersonal conflict. You can facilitate these processes when you examine the power differences between you and your clients.

POWER DIFFERENTIAL ANALYSIS

A *power differential* mediates the relationship between self and other in which the person who is labeled as the "other" is the one with less power. Many multicultural clients experience power differentials with their clinician because of their ethnicity, socioeconomic class, immigration status, acculturation pressures, color, and language, among other differences. The multicultural clinical encounter frequently becomes a fishbowl that magnifies power differences. Likewise, the inherently unequal power

dynamics within the client–clinician relationship may reinforce multicultural clients' societal powerlessness. You can learn to engage in a power differential analysis as part of your cultural self-assessment. A power differential analysis is a multicultural tool that helps you to examine the differences between your client's group's social status and yours. Going beyond the power differences inherent in the clinician–client dyad, a power differential analysis helps you learn about your position in relation to societal power, privilege, and oppression (Worell & Remer, 2003). As you compare your privilege and oppression areas with those of your client, you can identify and challenge internalized privilege and oppression. Succinctly put, a power differential analysis helps clinicians to enhance their cultural credibility.

As you conduct power differential analyses, be aware that all people occupy multiple positions, depending on specific contexts. For example, White European American women may have racial privilege but not gender privilege. Similarly, African American men have gender privilege but not racial privilege. Along these lines, location can change areas of power and oppression. As an illustration, while living in New England, my Spanish accent was a source of oppression; conversely, my accent became a privilege when I moved to cosmopolitan, multilingual Washington, DC.

I now analyze the power differential between my client Marcia and me. The areas that Marcia identified as sources of oppression include race and ethnicity (African American), color (dark skin color), gender (woman), gender–race combination (Black woman), body size (50 pounds overweight), mental health (history of family and domestic abuse, posttraumatic stress disorder [PTSD], anxiety, obsessive compulsive traits), history of substance abuse, physical health (diabetes, irritable bowel syndrome [IBS]), socioeconomic class (struggling middle class), employment status (retired government employee), age (Marcia considered her middle age as a negative status), marital status (divorced), family (deceased parents, adult daughter with substance abuse, adult son with manic depression), and interpersonal style ("I have a sharp tongue").

Marcia identified as privilege areas her education (college degree), religion (Methodist), sexual orientation (heterosexual), support system (Dora, her cousin; friends), voice (operatic voice, talented singer, church

choir member), lifestyle (commitment to her own healing), intelligence ("My wit cuts both ways, but I'm happy my brain works very well"), spirituality ("I'm blessed; I'm God's child"), and language ("I'm bilingual—Standard English and Black English").

My oppression areas include ethnic minority status (Latina/Puerto Rican), gender (woman), ethnoracial–gender interaction (mixed-race Latina), skin color (non-White, high yellow), speech (Spanish accent in most of the United States), and physical health (repaired cleft palate).

My societal areas of privilege include skin color (high yellow—this characteristic can be both an area of oppression and privilege, depending on the context), age (middle age as a positive status for a female psychotherapist), education (PhD in clinical psychology), employment (full time in private practice), sexual orientation (heterosexual), marital status (married), socioeconomic status (raised working class, currently upper middle class because of educational level), body size (petite, average), language (multilingual), lifestyle (commitment to healing), and spirituality (syncretism).

As is evident in this power differential analysis, even though Marcia and I are both women of color, my client's status as a woman of color is different from mine. To illustrate, body size emerged as a significant issue during the power analysis. Although Marcia had lost 50 pounds in 2 years, she still experienced difficulties with her body image due to sizeism. Her physician (who referred Marcia to me) recommended that Marcia join an online support group for dealing with body image issues. Marcia joined Health at Every Size (the Association of Size Diversity and Health; go to http://www.groups.yahoo.com and search for "ASDAH" for more information), a group for health care practitioners. Moreover, the power analysis revealed how oppressed Marcia felt by the interaction of her race, gender, and body size. In particular, as clinicians, we need to be aware of how the interaction of racism with other types of oppression (sexism, classism, heterosexism, sizeism) affects people of color. As you complete power analyses, you can examine your ability to be vulnerable and powerful in interactions with your clients, and to be able to validate your clients' pain and anger without engaging in defensive, passive, guilt ridden (Adams, 2000), and/or punitive behaviors. In short, power differential analysis can significantly enhance your cultural competence.

CULTURAL VARIATIONS IN THE CLINICIAN ROLE: HEALER, TEACHER, ELDER, RELATIVE, AND MORE

Do your multicultural clients see your clinician role the same way you do? APA Multicultural Guideline 5 (APA, 2003) encourages practitioners to understand the diverse cultural expectations people may have about the establishment and maintenance of the therapeutic relationship, as well as their expectations of their clinicians. The cultural variations in the clinician role extend beyond traditional clinical expectations (Portela, 1971). Multicultural clients often perceive their clinicians' clinical role, style, and persona through their cultural lens. In other words, they may identify the clinician's helper role as an authority figure, a member of their family, facilitator, mediator (i.e., they may expect the clinician to mediate their family intergenerational difficulties), or all of these roles. For instance, Latinos who endorse familism may relate to you as a member of their extended family. Accordingly, they will ask you personal questions in order to place you within a sociocentric matrix. Because many Latinos do not subscribe to asymmetrical reciprocity, they experience difficulties accepting your help unless they give you something in return (Simoni & Perez 1995). This means that many Latino clients may offer you a small token of their appreciation, demonstrate affection toward you in nonerotic ways, invite you to special family gatherings (Comas-Díaz, 2006b), or all of these. (See my discussion of the ethics of being a multicultural caring clinician in Chapter 4.) Likewise, some Asian clients may see you as a member of their family and expect you to adhere to hierarchical roles with reciprocal obligations (Shon & Ja, 1982). Moreover, when multicultural clients see their clinician as an authority figure, they tend to relate in a deferential, inhibited, ashamed, suspicious, and at times, hostile manner (Sakauye, 1996). As a result, if you subscribe to an egalitarian and nondirective approach, your clinical style may create dissonance with clients who expect you to be hierarchical and directive (Koss-Chioino & Vargas, 1992).

Multicultural clients' expectations are grounded in a sociocentric context. Consequently, these individuals pay inordinate attention to their clinicians' relational style. To illustrate, most American Indians (and other multicultural clients) expect clinicians to be empathic, warm, respectful, connected, and genuine (Trimble, Fleming, Beauvais, & Jumper-Thurman, 1996). Remember that many Latinos may expect you to engage in a *plática*, or the informal small talk that breaks the ice before discussing serious topics. Make sure to exercise your clinical judgment in discerning when plática is a defense, a cultural talk, or an evaluation of your cultural credibility. However, do not overanalyze a cultural practice. Sometimes a cultural cigar is just a cultural cigar. When in doubt, ask. In short, balance your clinical judgment with cultural sensitivity as you assess a client's expectations of your role.

Most collectivistic clients perceive therapy as an education and expect you to be a wise teacher (Yi, 1995). Within this framework, clients may expect you to act as a coach, mentor, guide, facilitator, or all of these roles. Moreover, some multicultural clients may see you as a wise elder. Likewise, they may anticipate that you will act as a philosopher versed in life lessons. The use of folk wisdom expressed through *dichos* (sayings; see Chapter 8 for a detailed explanation), proverbs, stories, fables, and other narratives are common ways of communicating life lessons among many people of color. Furthermore, most sociocentric clients bring their holistic views into your practice. For example, some Asian clients may expect you to be an expert of the heart (Chao, 1992), because they frequently translate emotional problems into an aching heart (Bernstein, Lee, Park, & Jyoung, 2008). Readers can see an illustration of an aching heart in a case vignette I presented in Chapter 2. I introduced Steve, a Filipino man, who was referred by his internist to a psychologist because of symptoms of heart ache without a physical basis. The research findings linking depression with cardiac problems (Penninx et al., 2001) seem consistent with the "aching heart" syndrome. Such holistic expectation recognizes the interconnection of mind with body. Indeed, alternative medicine and indigenous healing acknowledge the interaction of mind (thoughts), heart (emotions), body (somatic symptoms), and energy (spirit). Accordingly,

many multicultural clients expect their clinician to recognize the role of balance and harmony in healing. Moreover, some clients may expect their clinician to act as a folk healer because of their familiarity with indigenous healing. To illustrate, some of my clients call me *curandera* (healer–shaman; see Chapter 8 for a description of *curanderismo*) or psychic, simply because they associate my psychotherapist role with the function of a folk healer. These clients may not be that far off, because there are similarities between psychotherapy and folk healing (see Chapter 8 for a discussion on this topic).

Atkinson, Thompson, and Grant (1993) identified diverse intersecting roles that multicultural clients assign to their clinicians. These authors stated that low-acculturated clients expect clinicians to act as advisor, advocate, facilitator of indigenous support systems, or all three roles. They identified clinical strategies such as modeling, selective self-disclosure, and psychoeduction as congruent with the expectations of low-acculturated clients. These authors asserted that more acculturated clients may expect their clinician to behave as a consultant, change agent, counselor, psychotherapist, or all of these roles.

Of course, clients' presenting problem, level of distress, stage of therapy, developmental status, cultural identity, and sociopolitical factors, among other contexts, influence their expectations of treatment and of their clinicians. To examine the interaction of these factors, Comas-Díaz, Geller, Melgoza, and Baker (1982) studied the pretherapy expectations of people of color. The results of our investigation suggested that although clients of color expected to obtain relief from their distress, they also expected to work in therapy to overcome their contribution to their problems. Moreover, clients of color expected clinicians to be active, give advice, teach, and guide them. They believed that psychotherapists would help them to grow emotionally in a process that would at times be painful. In other words, clients of color exhibited psychological mindedness, viewed psychotherapy as a process for working through their problems, and endorsed complex expectations of their clinicians. In summary, multicultural clients expect their clinician to wear several hats and to engage in multiple helping roles such as advisor, advocate, change agent,

coach, consultant, counselor, elder, expert of the heart, family member, guide, healer, mentor, philosopher, psychotherapist, role model, teacher, witness, and other roles.

CULTURAL FATIGUE

Clinicians can develop cultural fatigue when they experience difficulties negotiating clients' expectations of the therapeutic relationship. A term coined in the sojourn literature, *cultural fatigue* refers to the exhaustion that results from the adjustments required to function in a different culture (Textor, 1966). These cultural adjustments involve the need to suspend automatic judgments, create new interpretations to seemingly familiar behavior, and develop constant alterations in activity, leaving individuals to feel fatigued (Textor, 1966). Similarly, as you adjust to work with multicultural clients, you may expend an inordinate amount of energy and feel fatigued. I use the term *cultural fatigue* in multicultural care to designate clinicians' exhaustion due to their adjustment to working with culturally different clients. Needless to say, cultural fatigue strains the multicultural therapeutic relationship. As you cope with cultural discord, you can develop frustration, defensiveness, and even hostility toward your clients. In fact, you can experience cultural fatigue in four stages: honeymoon, anxiety, rejection or regression, and adjustment (Textor, 1966). In the honeymoon stage, you may be fascinated by the differences between you and your culturally different clients. When you enter the anxiety stage you may experience frustration, fears, and perhaps impotence due to the weariness of interacting with multicultural clients. During the rejection or regression stage, you may encounter ruptures in the therapeutic alliance and consequently, you may question your cultural competence. In extreme cases, you may even want to retire from your multicultural work. Finally, in the last stage you adjust to the complexities of working with culturally different clients and feel more at home with the development of your cultural competence. Cultural fatigue can trigger missed empathic opportunities. In other words, when clients address

cultural issues and clinicians ignore the topic, clinicians miss an empathic opportunity (Suchman, Markakis, Beckman, & Frankel, 1997). In contrast, you earn your multicultural clients' trust when they feel that you empathize with them.

MANAGING THE MULTICULTURAL THERAPEUTIC RELATIONSHIP: CULTURAL EMPATHY

A foundation of any therapeutic relationship is the clinician's ability to empathize with his or her clients. Enhancing empathy with multicultural clients is a fundamental task in one's development as a culturally competent clinician. Within a multicultural context, empathy is a means of connection that involves the recognition of the self in the other. Such recognition is crucial because of people's tendency to like people who remind them of themselves, which can inhibit empathy toward individuals who are different. Cognitive empathy helps you to understand your clients so as to be able to witness their experience (Kleinman, 1988), and affective empathy facilitates the development of a subjective experience of being like the other (Kaplan, 1991). How do you experience being like your culturally different client? This can be particularly challenging when you try to recognize yourself in your client. In the words of Robert Desnos, how do you *become* your culturally different client?

To be multicultural caring, you need to expand your concept of empathy. Consider the following vignette.

Dr. Weinstein was working with Ann, a Cherokee woman. A Jewish Holocaust survivor, Dr. Weinstein felt deep empathy for Ann's history of cultural oppression. During a poignant session when Ann was relating her ancestors' experience with the Trail of Tears, Dr. Weinstein said, "I, too, know what it is like to experience exile." Ann felt hurt by her therapist's statement. She terminated treatment and told the referring physician that Dr. Weinstein did not understand what it is like to be exiled from one's own land and to slowly commit suicide with alcohol. Unfortunately, Dr. Weinstein's comment seemed to equate the Jewish genocide with the

American Indian genocide. Ann felt that Dr. Weinstein's statement invalidated her experience of belonging to a community that internalized cultural oppression as self-destruction. Moreover, Dr. Weinstein's comment appeared to ignore Ann's specific reality of being an American Indian woman who struggles with contemporary racism, neocolonialism, and sexism. As a lesson learned, it is important to recognize that all types of cultural oppression are unique and not interchangeable.

You can enhance your effectiveness with multicultural clients when you commit to develop cultural empathy. Simply put, *cultural empathy* is the ability to place yourself in your client's cultural shoes while acknowledging differences and similarities between the two of you. Indeed, Ridley and Lingle (1996) advanced the concept of cultural empathy as a process of taking the perspective of the other, using a contextual framework as a guide for recognizing cultural differences and similarities between self and other. These authors defined cultural empathy as "clinicians' learned ability to accurately understand the self-experience of multicultural clients informed by clinicians' interpretations of cultural data" (p. 32). Ridley and Lingle proposed a cultural empathy model that integrates a variety of perceptual, cognitive, affective, and communication skills, and places empathetic understanding and cultural responsiveness at the center of healing. Their model suggests a perspective taking—using a cultural framework as a guide for understanding the client from the outside in—as well as the recognition of cultural differences between you and your client. To convey accurate understanding of your clients' reality, you can explore their whole experience using sensitivity and asking clarifying questions.

Cultural empathy is similar to *affective attunement*—the process whereby the clinician focuses on the internal world of the client and in turn, he or she feels understood and connected (Stern, 1985). Cultural empathy requires that you manifest vicarious affect and express genuine concern. In other words, you express vicarious affect when you use similar experiences in your own life to understand your client's reality. Likewise, you show expressive concern as you manifest real concern for your clients' challenges and assert their achievements. A key factor in cultural empathy is to help clients to mitigate the negative effects of cultural disconnection and to

reconnect in an empowering manner. When you exhibit cultural empathy, you can help clients to benefit from multicultural experiences without compromising their cultural legacy and identity.

I extend the notion of cultural empathy to include the concept of cultural resonance. Defined as the ability to understand the other through clinical skill, cultural competence, and intuition, *cultural resonance* promotes a convergence between you, the clinician, and your multicultural client (Comas-Díaz, 2006b). Accordingly, you can use yourself as an instrument to culturally empathize with your client. For example, when you rely on body language, vibes, and intuition, you "resonate" with your client. Indeed, intuition is an effective means of communicating and relating during the multicultural encounter. An intuitive empathy relates to a preconscious nonverbal communication through hunches, dreams, imaging, and artistic creations that allows you to pick up your client's feelings of others to be aware of bodily sensations (Becvar, 1997). In my experience, intuition allows you to capture part of your client's unconscious as well as collective unconscious. Because there are no cognitive explanations, the transrational ways of knowing including images, sensations, and feelings, facilitate the deepening of an underlying connection. Similarly, anthropologist Joan Koss-Chioino (2006) identified a type of intuitive relatedness in which intra and interindividual differences converge into one field of feeling. She named this type of relatedness *radical empathy.* Remember to maintain an essential objectivity and avoid overidentification with your client, while sustaining the empathic connection during the transformative energy to bring about deep change (Bolen, 1985). Indeed, the results of a study on clinicians' use of intuition in psychotherapy suggested that you can enhance clinical intuition as you become open to this phenomenon, quiet your mind, develop a sense of feeling of connection with clients, and allow your sensations to surface without engaging in premature analysis (Dodge Rea, 2001). Finally, when you integrate cognitive, affective, cultural, and radical empathy into your multicultural work, you enhance your multicultural clinical presence. A multicultural clinical presence requires a combination of empathy, judgment, intuition, insight, acumen, style, awareness, communication, resonance, and cultural competence.

Awareness of cultural parameters in transference and countertransference is a critical aspect of multicultural clinical presence.

ETHNOCULTURAL TRANSFERENCE AND COUNTERTRANSFERENCE

An African American woman said to her White therapist, "How can I trust you? Although we are both women, you will never be able to feel what I feel." A Latina told her Latino therapist: "It's difficult for me to openly disagree with you. I respect you the same way I respect my father." A White male Vietnam veteran said to his female Chinese American therapist, "You have helped me very much, but I still feel I have to protect myself from you." How do you feel about these clinical interactions? Have you experienced similar clinical situations?

Although all of these clinical exchanges are presented out of their clinical context, they illustrate the complex effects of culture, race, and ethnicity on the therapeutic relationship. Because every therapeutic encounter is replete with conscious or unconscious messages, or both, about culture, clients tend to raise these messages in a subtle, nonsubtle, direct, or nondirect manner. Certainly, racial, gender, and ethnocultural factors are available targets for projection in multicultural clinical practice (E. E. Jones, 1985). Moreover, projections are frequently manifested through the cultural parameters of the therapeutic relationship.

Unfortunately, mainstream clinicians who endorse a culture- and race-neutral position ignore the role of cultural projections in psychotherapy (Pinderhughes, 1989). For example, identification and projection are defense mechanisms relevant to people who have experienced personal or historical colonization, or both. Identification plays an important role in people of African descent, according to Peltzer (1995), because child and adult development depend on changing multilateral identifications during the life span. Peltzer argued that participatory projection provides a defense against powerlessness and frustration. Moreover, he added that participatory projection increases self-esteem because it helps individuals to participate in the omnipotent powers of authority figures. Likewise, oppression engenders intense reactions of rage, shame, and/or guilt on both client and clinician. Minimizing these reactions or solely focusing on the negative aspect of oppression inhibits the exploration of cultural resilience and survival among many multicultural individuals.

Clinicians should be mindful of the projection iceberg floating in multicultural therapeutic waters. Indeed, multicultural practice tends to foster cultural fatigue and cultural disorientation because it provides more opportunities for empathic and dynamic stumbling blocks. Certainly, you can minimize empathic breaks in the healing relationship when you examine the cultural parameters of transference and countertransference. Regardless of your theoretical orientation, it is important to be aware of the cultural parameters of the therapeutic relationship because clients' references to race, ethnicity, or culture frequently signal the development of transference (Varghese, 1983; Zaphiropoulos, 1982).

My partner, Frederick M. Jacobsen, and I identified several types of ethnocultural transference and countertransference within the interethnic and the intraethnic psychotherapeutic dyads (Comas-Díaz & Jacobsen, 1991). We believe that the reactions that occur within the interethnic dyad need to be differentiated from those emerging in the intraethnic therapeutic dyad.

Within the interethnic clinical dyad, some of the transferential reactions include

- overcompliance and friendliness (when there is a societal power differential between you and your client),
- denial (when your client avoids disclosing racial, ethnocultural, gender, and other diversity variables issues),
- mistrust and suspiciousness (when your culturally different client questions whether you can understand him or her), and
- ambivalence (your client may struggle with negative feelings toward you while simultaneously developing an attachment to you).

For example, people of color in an interethnic psychotherapy dyad frequently struggle with negative feelings toward their clinicians while also developing an attachment to them. Moreover, issues of identification and

internalization within the interethnic dyad may strengthen the client's ambivalence. Some of the countertransferential reactions within the interethnic clinical dyad include

- denial of cultural differences,
- the clinical anthropologist's syndrome (you may feel excessive curiosity about multicultural clients' ethnocultural backgrounds at the expense of their emotional needs),
- guilt (results from societal and political realities that dictate a lower status for clients of color),
- pity (a form of guilt or an expression of sociopolitical impotence),
- aggression, and
- ambivalence (if you are ambivalent about your own cultural background class, national origin or other diversity variable, be careful of projecting such feelings onto your client).

It is equally important that you examine the ethnocultural projections within the intraethnic clinical dyad. Therefore, within the dyad, the transferential reactions may include

- omniscient and omnipotent clinician (your client may idealize you, aided by the fantasy of the reunion with the perfect parent, promoted by the ethnic similarity),
- traitor (your client exhibits resentment and envy at your success—equated with betrayal and the "selling out" of culture and race),
- autoracist (clients do not want to work with you because you are a member of their own ethnicity, and they project societal negative feelings about your shared ethnic group onto you), and finally,
- ambivalent (your clients may feel comfortable with the shared ethnocultural background, but at the same time fear too much psychological closeness to you).

Within the intraethnic therapeutic dyad, some of the countertransferential reactions are

- overidentification (you may lose your clinical compass if you overidentify with your client),

- "us and them" mentality (shared victimization due to ethnocultural discrimination may contribute to your overidentification, and consequently you risk neglecting your client's intrapsychic issues),
- distancing (you may feel too close to home and engage in distancing as a defense mechanism),
- survivor's guilt (you may feel guilty at having escaped the socioeconomic realities and harsh circumstances of your ethnic community, leaving family and friends behind),
- cultural myopia (you can develop an inability to see clearly because of cultural factors that obscure the therapeutic relationship),
- ambivalence (working through your own cultural ambivalence), and
- anger (being too ethnoculturally close to ethnically similar clients may uncover unresolved emotional issues).

The examination of ethnocultural transference and countertransference advances the psychotherapeutic process. Just as clinicians monitor regular transference and countertransference, it is important to monitor ethnocultural elements of these phenomena. Succinctly put, ethnocultural transference and countertransference play a significant role in the multicultural therapeutic relationship because clinicians and their clients bring their imprinting of ethnic, cultural, and racial experiences into the clinical arena. These reactions offer a blueprint for the relationship between self and other.

CLINICIAN OF COLOR AND WHITE CLIENT DYAD

Although the therapeutic dyad involving a clinician of color and a White client is presently uncommon, the demographic projections suggest that people of color will constitute a significantly greater proportion of the labor force (Toossi, 2006). This movement will include the increased presence of multicultural clinicians. The clinician of color and White client dyad can evoke strong projections because there is a power reversal in this dyad, because historical and racial divisions of labor and class are more consistent with a White clinician and a client of color dyad. However, White clients may see themselves as outsiders, and by working with a clinician of

color, they may consciously or unconsciously identify with the alienness of the clinician (Varghese, 1983). These clients may struggle with unresolved marginality issues and the clinician's racial visibility may facilitate the rapid unfolding of their struggle. However, the dynamics present in the clinician of color and White client tend to reflect the racial dynamics of the historical era.

My partner and I (Comas-Díaz & Jacobsen, 1995a) examined the specific ethnocultural transference and countertransference occurring within the clinician of color and the White client dyad. We identified the prevalent transferential reactions within this special dyad as

- cognitive dissonance (manifested through the client's resistance and a greater use of defense mechanisms),
- reaction formation (your clients may perceive you as being immensely superior because of the sociopolitical difficulties ethnic minorities have to overcome),
- tokenism (your client's unconscious antiminority mind-set and aversive racism may lead him or her to question your qualifications and assume that you are a token),
- cultural xenophobia (your clients may question your ability to help them because you are not White),
- fear of abandonment (your clients exhibit a fear that you will abandon them to move "back" to country of origin, or abandon them for clients of color),
- alien transformation anxiety (some White clients get anxious regarding your power over their lives, and may fear that they will "become" a member of your ethnocultural group),
- ethnocultural disinhibition (clients may confront you and act out more than with a White therapist due to the lower societal status assigned to you as a person of color), and
- racial guilt and shame (your clients may exhibit guilt towards you because of their struggle with White privilege).

The ethnocultural countertransferential reactions present in the clinician of color and White client dyad include

- the need to prove competence (if you have a conflicted cultural identity, you may struggle with superiority/inferiority issues and thus may fear being perceived as less competent than a White clinician),
- anger and resentment (while attempting to prove competence, you can become angry and resentful, potentially compromising the therapeutic relationship),
- avoidance (you can engage in emotional inhibition and self-censoring to avoid working with White clients, particularly if you have an expectation of working with clients of color),
- impotence (you may rationalize your client's excessive use of cultural factors as barriers to treatment and hence feel impotent to examine their dynamics),
- guilt (you may experience guilt at not working exclusively with clients of color),
- good enough concerns (you may feel concerned about not being good enough to work with White clients as a response to the client's defensive ethnocultural projections), and
- fear (sociohistorical power differentials between you as a person of color and your White client can disempower you and induce fear).

CONCLUSION

The multicultural therapeutic relationship is a crucial healing factor in multicultural care. You can develop cultural empathy, use power differential analysis, and monitor the cultural aspects of the relationship to help you see yourself in your culturally different client. Be aware of ethnocultural transference and countertransference (in both interethnic and intraethnic clinician–client dyads) because they can serve as catalysts for issues such as trust, anger, intimacy, ambivalence, and acceptance of disparate aspects of the self. Managing the relationship between self and other is a building block in the cultural competence journey. Below is a list of key multicultural clinical strategies presented in this chapter.

MULTICULTURAL CLINICAL STRATEGIES

- Become familiar with clients' collective history of oppression.
- Monitor cultural fatigue.
- Aim to develop cultural empathy.
- Bear in mind that all types of cultural oppression are unique, not interchangeable.
- Think about dealing with hostility, discomfort, and defenses as a result of cultural discord.
- Unpack invisible and unacknowledged areas of privilege.
- Make the invisible visible: Be aware of unintentional micro-aggressions.
- Conduct power differential analyses between the clinician and client.
- Consider an expansion of clinician style.
- Recognize that the multicultural therapeutic relationship has more opportunities for projections based on cultural issues.
- Examine ethnocultural transference and countertransference, both in the interethnic and intraethnic therapeutic dyads.

6

Psychopharmacology and Psychological Testing: Engaging in Cultural Critical Thinking

Your neighbor's vision is as true for him [or her]
as your own vision is true for you.
—Miguel de Unamuno

Connie: My mother is in the hospital.

Dr. Duncan: What happened?

Connie: The doctors said that she tried to commit suicide.

Dr. Duncan: How come? Your mother is a devout Catholic.

Connie: She got sick after she took the medication you prescribed me.

Dr. Duncan: I don't understand, she's not my patient.

Connie: [*Begins to sob.*] The pills helped me so I thought they could help her . . .

How do you feel about this clinical encounter? Do you work with clients who take psychotropic medications? Are your clients satisfied with their psychopharmacological treatment? Do you collaborate with your