The ethnic minority psychological associations—the Asian American Psychological Association, the Association of Black Psychologists, the National Hispanic Psychological Association, and the Society of Indian Psychologists—have been powerful advocates for the mental health needs of people of color. Other organizations include the Council of National Psychological Associations for the Advancement of Ethnic Minority Issues (CNPAEMI). This coalition is composed of the APA Society for the Psychological Study of Ethnic Minority Issues, the Asian American Psychological Association, the Association of Black Psychologists, the National Hispanic Psychological Association, and the Society of Indian Psychologists. This group advocates for the delivery of effective psychological services to people of color. Additionally, the Society for the Study of Culture and Psychiatry is an interdisciplinary and international society devoted to furthering research, clinical care, and education in cultural *aspects* of mental health and illness (www.psychiatryandculture.org/cms/).

Current Status

The collectivistic concept of unity through diversity achieved preeminence during the 21st century. Multiculturalism promotes empowerment, change, and a transformative dialogue on oppression and privilege. The creation of the American Psychological Association Office of Ethnic Minority Affairs advanced the role of multiculturalism in psychological theory and practice. This office provided a forum for ethnic minority psychologists to voice their concerns about the lack of cultural relevance in psychological practice. Afterward, the establishment of the American Psychological Association's Society for the Psychological Study of Ethnic Minority Issues cemented the position of multicultural psychotherapies.

Currently, multicultural psychotherapists practice following three models: (1) cultural adaptation of dominant psychotherapy, (2) ethnic psychotherapies, and (3) holistic approaches. Frequently, psychotherapists combine these frameworks.

Psychotherapy can be culturally adapted through the development of generic cross-cultural skills or through the incorporation of culture specific skills (Lo & Fung, 2003). The generic term *cultural competence* refers to knowledge and skills required to work effectively in any cross-cultural clinical encounter. Psychotherapists working within the culture-specific skills level assimilate ethnic dimensions into mainstream psychotherapy. As an example of culture specificity, Bernal, Bonilla, and Bellido (1995) recommended the inclusion of eight cultural dimensions—language, persons, metaphors, content, concepts, goals, method, and context—into mainstream psychotherapy. Within this framework, therapists use culturally appropriate language to fit a client's worldview and life circumstances. The dimension of *persons* refers to the therapeutic relationship. *Metaphors* relate to concepts shared by members of a cultural group. The dimension of *content* refers to the therapist's cultural knowledge (e.g., Does the client feel understood by the therapist?). *Concepts* examine whether the treatment concepts are culturally consonant with the client's context. The dimension of *goals* examines whether clinical objectives are congruent with clients' adaptive cultural values. *Methods* pertain to the cultural adaptation and validation of methods and instruments. Finally, Bernal and his associates defined *context* as clients' environment, including history and sociopolitical circumstances.

In another example of culture specificity, Ricardo Muñoz (Muñoz & Mendelson, 2005) suggested culturally adapting cognitive behavioral treatments (CBT) through (1) involvement of culturally diverse people in the development of interventions; (2) inclusion of collectivistic values; (3) attention to religion/spirituality, (4) relevance of acculturation; and (5) acknowledgment of the effects of oppression on mental health. Notwithstanding CBT's evidence-based foundation, there is a dearth of empirical studies

on the cultural validity of empirically supported treatments (Hall, 2001). Consequently, multicultural practitioners identified the need for culture-specific psychotherapy with an evidence base to address the day-to-day realities of people of color. As a response, the American Psychological Association Presidential Task Force included in its definition of evidence-based practice in psychology the integration of patients' characteristics, culture, and preferences with clinical expertise and research (APA, 2006).

Pamela Hays (2001) provided an example of a successful incorporation of cultural elements into therapy, highlighting cultural complexities in the conceptualization of identity. Her ADDRESSING framework recognizes the interacting cultural influences of age, developmental and acquired disabilities, religion, ethnicity, socioeconomic status, sexual orientation, indigenous heritage, national origin, and gender. Another culturally adapted psychotherapy, culturally sensitive psychotherapy (CSP), targets specific ethnocultural groups so that one group may benefit more from a specific intervention than from interventions designed for another (Hall, 2001). Furthermore, ethnocultural psychotherapy integrates cultural variables in treatment through the examination of worldviews, cultural transitions, relationships, and context (Comas-Diaz & Jacobsen, 2004).

Notwithstanding psychotherapy's cultural adaptation, several multiculturalists advocated for the use of ethnic psychotherapies in order to reaffirm their ethnocultural roots. As ethnic psychotherapies provide continuity, they may help clients repair their fractured identities. Ethnic and indigenous psychotherapies appeal to culturally diverse individuals because they are grounded in a cultural context and thus are responsive to clients' life experiences. They offer a culturally relevant framework that validates racial and ethnic meanings. Moreover, ethnic psychotherapies are based on a philosophical spiritual foundation that promotes connective, ancestral, and sacred affiliations in healing. As a result, they impart hope to sufferers, particularly when dominant approaches fail. Ethnic psychotherapies empower at both individual and collective levels. Some of the ethnic psychotherapies include folk healing, network therapy, narratives, the psychology of liberation, and holistic approaches based on Eastern philosophical traditions.

A historical antecedent of multicultural psychotherapies, folk healing is a form of indigenous psychotherapy. Folk healing re-establishes clients' sense of cultural belonging and historical continuity, promotes self-healing, and nurtures a balance between the sufferer, family, community, and cosmos (Comas-Diaz, 2006). Folk healers utilize mechanisms similar to those that mainstream psychotherapists use; the main difference is folk healers' spiritual belief systems. That is, folk healing fosters empowerment, encourages liberation, and promotes spiritual development. APA multicultural guideline number 5 encourages psychologists to strive to learn about non-Western healing traditions that could be appropriately integrated into psychotherapy. When appropriate, this guideline encourages psychologists to acknowledge and enlist the assistance of recognized helpers (community leaders, change agents) and traditional healers in treatment.

Carolyn Attneave developed network therapy as an extended family treatment and group intervention (Speck & Attneave, 1973). Based on a Native American healing approach, network therapy recreates the entire social context of a clan's network in order to activate and mobilize a person's family, kin, and relationships in the healing process. Network therapy is a community-based form of healing.

Another communal ethnic psychotherapy is the psychology of liberation. Based on Latin American theology of liberation, the psychotherapy of liberation emerged as a response to sociopolitical oppression. Its architect—Ignacio Martin-Baro (in Blanco, 1998)—was both a psychologist and a priest. Likewise, psychology of liberation resonates with African American psychology based on Black liberation theology and Africanist traditions. Such a spiritual basis affirms ethnocultural strengths through indigenous traditions and practices. Liberation practitioners attempt to work with people in context through strategies that enhance awareness of oppression and of the ideologies and

structural inequality that have kept them subjugated and oppressed. Similar to Paulo Freire's critical consciousness, liberation therapists collaborate with the oppressed in developing critical analysis and engaging in transformative actions.

Ethnic psychotherapists frequently use narratives as a form of treatment. Therefore, stories are context-rich communications full of cultural nuances and meanings. Indeed, telling a story is a collectivistic way of relating. A reaction to Latin American political oppression, *testimonio* chronicles traumatic experiences and how these have affected the individual, family, and community (Cienfuegos & Monelli, 1982). Another healing narrative, *cuento* therapy, has been empirically proven to be an effective treatment for Puerto Rican children (Costantino, Malgady, & Rogler, 1997). Furthermore, *dichos* (sayings) are a form of flash psychotherapy that consists of Spanish proverbs or idiomatic expressions that capture folk wisdom (Comas-Diaz, 2006).

PERSONALITY

Theory of Personality

Multicultural psychotherapists recognize the development of identity within several contexts. As mind inhabits the body, personality develops within multiple contexts. Multicultural clinicians acknowledge multiple perspectives; hence, they adhere to diverse theories of personality and follow theories that are consistent with their preferred theoretical orientation. However, multicultural psychotherapies' unique contribution to the theory of personality is the formulation of cultural identity development theories.

Cultural Identity Development

Multicultural psychotherapists view the self as an internal representation of culture. For instance, being a member of an oppressed minority group influences identity development. People of color's identity formation involves both personal identity and cultural racial/ethnic group identity. Minority identity developmental theories illuminate people of color's worldviews. The minority identity development theories offer a lens for understanding how individuals process and perceive the world. Indeed, the ethnic and racial identity stage affects beliefs, emotions, behaviors, attitudes, expectations, and interpersonal style. As a result, these stages influence how individuals present to treatment and even how they select their psychotherapist.

The diverse models of minority identity development propose that members of racial and ethnic minority groups initially value the dominant group and devalue their own group, then move to value their own group while devaluing the dominant group, and in a final stage integrate appreciation for both groups (Atkinson, Morten, & Sue, 1998). More specifically, minority identity development stages include (1) conformity—individuals internalize racism and choose values, lifestyles, and role models from the dominant group; (2) dissonance—individuals begin to question and suspect the dominant group's cultural values; (3) resistance-immersion—individuals endorse minority-held views and reject the dominant culture's values; (4) introspection—individuals establish their racial/ethnic identity without following all cultural norms, beginning to question how certain values fit with their personal identity; and (5) synergistic—individuals experience a sense of self-fulfillment toward their racial/ethnic/cultural identity without having to categorically accept their minority group's values. Moreover, a key milestone in people of color's racial identity development is overcoming internalized racism and becoming critically conscientized.

Racial identity development potentially interacts with client and therapist ethnic match. Consider the case of Jose, a bilingual, bicultural teacher. Jose's racial ethnic identity placed him at the dissonance stage (characterized by suspicion of Whites). When

referred to a mental health center, Jose refused to see a European American therapist. He asked to see a counselor who "spoke his language and understood" his culture. When Dr. Delgado was assigned to see Jose, the therapist said, "I'm sorry, I don't speak Spanish." Jose's answer: "That's okay, I just didn't want to see a White therapist." Jose's experience illustrates the relevance of understanding racial identity developmental stages.

Racial identity development models extend to members of the dominant society. A White American identity developmental theory suggests that European Americans develop a specific cultural identity due to their status as members of the dominant majority group. According to Janet Helms (1990), White American cultural racial identity occurs in specific stages: (1) contact—individuals are aware of minorities but do not perceive themselves as racial beings; (2) deintegration—they acknowledge prejudice and discrimination; (3) reintegration—they engage in blaming the victim and in reverse discrimination; (4) pseudoindependence—they become interested in understanding cultural differences; and (5) autonomy—they learn about cultural differences and accept, respect, and appreciate both minority and majority group members. Similar identity developmental stages have been proposed for biracial individuals (Poston, 1990). These are as follows: (1) personal identity; (2) choice of group categorization; (3) enmeshment/denial; (4) appreciation; and (5) integration.

Multicultural psychotherapies also contributed to the formulation of gays' and lesbians' minority identity development. Gay and lesbian identity developmental stages include (1) confusion—individuals question their sexual orientation; (2) comparison—individuals accept the possibility that they may belong to a sexual minority; (3) tolerance—recognition that one is gay or lesbian; (4) acceptance—individuals increase contacts with other gays and lesbians; (5) pride—people prefer to be gay or lesbian; and (6) synthesis—people find peace with their own sexual orientation and reach out to supportive heterosexuals (Cass, 2002).

Feminist identity developmental theory also emerged from the minority identity developmental models. The feminist identity development theory articulates the premise that women struggle and continuously work through their reactions to the prejudice and discrimination they encounter to achieve a positive feminist identity. According to Downing and Roush (1985), feminist identity develops in the following stages: (1) passive acceptance, (2) revelation, (3) embeddedness–emanation, (4) synthesis, and (5) active commitment.

PSYCHOTHERAPY

Theory of Psychotherapy

Multicultural psychotherapists do not subscribe to a unifying theory of psychotherapy; instead, they endorse multiple perspectives. However, at the center of their theoretical approach, multicultural psychotherapists attempt to answer the question, "How can a therapist understand the life of a culturally different client?" Multiculturalists view the cultivation of the therapeutic alliance as a crucial aspect in healing and critically important to understanding clients. For this reason, the therapeutic alliance guides the multicultural psychotherapy process.

Cultural Self-Awareness

Multicultural therapeutic encounters are full of conscious and/or unconscious messages about the client's and the therapist's feelings and attitudes about their cultural backgrounds. Indeed, the perception of cultural differences evokes feelings of being excluded, being compared, and being relatively powerless (Pinderhughes, 1989). To address these

issues, multicultural psychotherapists engage in cultural self-awareness. They initiate the self-awareness by identifying the dominant culture's values in which they communicate and practice. Psychotherapists can explore these issues through the following questions (adapted from Pinderhughes, 1989):

- What is my cultural heritage?
- What was the culture of my parents and ancestors?
- With what cultural group(s) do I identify?
- What is the cultural meaning of my name?
- What is my worldview?
- What aspects of my worldview (values, beliefs, opinions, and attitudes) do I hold that are congruent with the dominant culture's worldview? Which are incongruent?
- How did I decide to become a psychotherapist? How was I professionally socialized? What professional socialization do I maintain? What do I believe to be the relationship between culture and psychotherapy/counseling?
- What abilities, expectations, and limitations do I have that might influence my relations with culturally diverse individuals?

Other potential questions include:

- How do my clients answer some of the questions above?
- Are there differences between my answers and those of my culturally diverse clients?
- How do I feel about these differences?
- How do I feel about the similarities?

To further their cultural self-awareness, psychotherapists can use Bennett's (2004) multicultural sensitivity development model. Bennett divided multicultural sensitivity development into ethnocentric and ethnorelative stages. The ethnocentric stages include: (1) denial—individuals deny the existence of cultural differences and avoid personal contact with culturally diverse people; (2) defense—individuals recognize other cultures but denigrate them; and (3) minimization—individuals view their own culture as universal, and although they recognize cultural differences, they minimize them, believing that other cultures are just like theirs. The ethnorelative stages of developing multicultural sensitivity are (4) acceptance—individuals recognize and value cultural differences without judging them; (5) adaptation—individuals develop multicultural skills—that is, they learn to shift perspectives and move in and out of alternative worldviews; and finally (6) integration—individuals' sense of self expands to include diverse worldviews.

The development of multicultural sensitivity facilitates appreciation of diverse worldviews and the emergence of a positive therapeutic alliance. Indeed, a successful therapeutic relationship rests on the recognition of the self in the other.

Process of Psychotherapy

The Therapeutic Relationship

Most psychotherapists recognize that a positive alliance increases psychotherapy's effectiveness. Moreover, research has repeatedly demonstrated the importance of the therapeutic relationship as a curative factor. However, the development of a therapeutic alliance requires cultural congruence between clients' and therapists' worldviews. When both therapist and client share worldviews, the development of a positive alliance is enhanced. Conversely, different worldviews may obstruct the development of the

therapeutic alliance and may require adjustments. For example, Kakar (1985) modified his psychoanalytic approach when working with East Indians by being active and didactic. In addition, he emphasized feeling and expressing pity, interest, and warmth.

Culture affects how clients perceive therapists. For example, cultural attitudes toward authority and healing figures shape clients' expectations about their therapists. If Eastern collectivistic clients perceive therapists as wise teachers, then they will adopt the role of students. The ideal therapist role varies from culture to culture. Hence, psychotherapists need to understand culturally diverse expectations. For example, therapists who have an egalitarian and nondirective style may not work well with clients who prefer hierarchical and directive relationships and specific instructions about what to do to change (Koss-Chioino & Vargas, 1992).

Similarly, Atkinson, Thompson, and Grant (1993) identified eight intersecting therapist roles that depend on clients' acculturation to the mainstream society. They asserted that low-acculturated clients expect therapists to behave as *advisor, advocate,* and/or *facilitator of indigenous support systems*. As an illustration, the use of modeling, selective self-disclosure, and didactic strategies seems culturally relevant for low-acculturated immigrant clients. More acculturated clients may expect their clinician to act as a consultant, change agent, counselor, and/or psychotherapist.

However, in reality, culturally diverse clients have complex expectations of their therapists. Besides acculturation, clients' expectations are shaped by interpersonal needs, developmental stages, ethnic identity, spirituality, and numerous other factors. Even though clients' expectations range from a collaborative to a hierarchical therapeutic style, these expectations are not mutually exclusive. For instance, regardless of clients' level of acculturation, psychotherapists tend to respond according to their clients' needs. In other words, therapists move from one role to another or simultaneously engage in several helping roles.

Along these lines, an empirical investigation found that although clients of color expected to get relief from their problems, they also expected to work in therapy to overcome their contribution to their distress (Comas-Diaz, Geller, Melgoza, & Baker, 1982). Even though they expected their therapist to be active, give advice, teach, and guide them, they also believed that psychotherapists would help them to grow emotionally in a process that at times would be painful. Concisely put, clients of color exhibited psychological mindedness and viewed psychotherapy as a process to work though their issues.

Cultural Empathy

Clients of color expect psychotherapists to demonstrate cultural credibility. Credibility refers to the client's perception of the psychotherapist as a trustworthy and effective helper. For example, many American Indians expect psychotherapists to exemplify empathy, genuineness, availability, respect, warmth, congruence, and connectedness. Certainly, a therapist's credibility and trust foster a positive therapeutic alliance. To achieve this goal, multicultural psychotherapists aim to develop empathy for the "other." Empathy is an interpersonal concept referring to a clinician's capacity to attend to the emotional experience of clients.

In dominant psychotherapy, empathy has somatic, cognitive, and affective components. The somatic aspect of empathy refers to nonverbal communication and body language. Therapists develop cognitive empathy for culturally diverse clients by becoming empathic witnesses. As empathic witnesses, psychotherapists study clients' culture and reaffirm clients' experience and reality. Empathy's affective component involves emotional connectedness, a capacity to take in and contain the feelings of the client. Succinctly put, affective empathy is similar to the subjective experience of *being* like the

other. Therapists who can only empathize at a cognitive level keep their identity separate from their client's. This "separation" hinders the therapist's development of affective empathy for culturally different clients. Such empathic failure is associated with the difficulty of being "like the other." Indeed, the development of affective empathy is critical in multicultural psychotherapy because we tend to empathize with people who remind us of ourselves and, conversely, have difficulty empathizing with those who are culturally different from us.

Besides cognitive and affective empathy, therapists need to develop cultural empathy. Cultural empathy is a learned ability to obtain an understanding of the experience of culturally diverse individuals informed by cultural knowledge and interpretation (Ridley & Lingle, 1996). Therefore, cultural empathy promotes therapists' cultural responsiveness through the integration of perceptual, cognitive, affective, and communication skills. Cultural empathy involves a process using a cultural framework as a guide for understanding the client and recognizing cultural differences between self and other (Ridley & Lingle, 1996). Interestingly, research has suggested that practitioners reduce their stereotypic and ethnocentric attitudes if they are able to take the perspective of others (Galinsky & Moskowitz, 2000). Thus, cultural empathy entails an attunement to the other—a combined cultural, cognitive, emotional, affective, and behavioral connection to the culturally different person.

In short, cultural empathy is the ability to place yourself in the other's culture. As such, it facilitates the recognition of self in the culturally diverse other. Multicultural psychotherapists develop cultural empathy by engaging in self-reflection, unpacking their invisible knapsacks, exploring their own worldviews, challenging ethnocentrism, developing openness and respect for cultural differences, and understanding power dynamics.

Ethnocultural Transference and Countertransference

The therapeutic relationship is a fertile ground for the projection of conscious and unconscious feelings, and every therapeutic encounter promulgates the projection of conscious and/or unconscious messages about the client's and the therapist's cultures. The examination of transference (clients' projection of feelings from previous relationships onto their therapists) and countertransference (therapists' reaction to clients' transference) helps to manage these processes. Although the examination of transference reactions can be an important part of psychotherapy, most dominant psychotherapists ignore transferential cultural issues. Instead, they adhere to the universalistic perspective that endorses a culture-blind and race-neutral position of human relations (Pinderhughes, 1989). Simply put, many clinicians ignore ethnic, cultural, and racial aspects of transference and countertransference. Multicultural psychotherapists examine transferential reactions through the initiation of a dialogue on cultural differences and similarities. They specifically ask clients: "How do you feel about my being from a different culture from yours?" or, "How do you feel about our being from similar cultures?" This line of questioning fosters a discussion of ethnocultural transference and countertransference.

Ethnocultural transference and countertransference play a significant role in the therapeutic relationship because providers and clients tend to bring their imprinting of ethnic, cultural, and racial experiences into psychotherapy. Ethnocultural reactions can provide a blueprint for the relationship between self and others.

Comas-Diaz and Jacobsen (1991) described several types of ethnocultural transference and countertransference within intra- and inter-ethnic dyads. Some of the interethnic transferential reactions include the following: (1) overcompliance and friendliness (observed when there is a societal power differential in the client/therapist dyad); (2) denial (when the client avoids disclosing issues pertinent to ethnicity and/or culture);

(3) mistrust, suspiciousness, and hostility ("What are this therapist's real motivations for working with me?"); and (4) ambivalence (clients in an inter-ethnic psychotherapy may struggle with negative feelings toward their therapist while simultaneously developing an attachment to him or her).

Intraethnic transference may transform a client's image of the therapist into one of several predictable roles: (1) the omniscient/omnipotent therapist (fantasy of the reunion with the perfect parent, promoted by the ethnic similarity); (2) the traitor (client exhibits resentment and envy at therapist's successes—equated with betrayal of his/her ethnoculture); (3) the auto-racist (client does not want to work with a therapist of his or her own ethnocultural group due to projection of the strong negative feelings onto the ethnoculturally similar therapist); and (4) the ambivalent (clients may feel at once comfortable with their shared ethnocultural background but at the same time they may fear too much psychological closeness).

Some inter-ethnic dyad countertransferential reactions include: (1) denial of cultural differences ("We are all the same"); (2) the clinical anthropologist's syndrome (excessive curiosity about clients' ethnocultural backgrounds at the expense of their psychological needs); (3) guilt (about societal and political realities that dictate a lower status for people of color); (4) pity (a derivative of guilt or an expression of political impotence within the therapeutic hour); (5) aggression; and (6) ambivalence (ambivalence toward the client's culture may originate from ambivalence toward a therapist's own ethnoculture).

Within the intra-ethnic dyad, some of the countertransferential manifestations include: (1) overidentification; (2) *us and them* mentality (shared victimization due to racial discrimination may contribute to therapist's ascribing the clients' problems as being solely due to membership in a minority group); (3) distancing; (4) survivor's guilt (therapists may have the personal experience of escaping the harsh socioeconomic circumstances of low-income ethnic minorities, leaving family and friends in the process, and generating guilt. Survivor's guilt can impede professional growth and may lead to denying their clients' psychological problems.); (5) cultural myopia (inability to see clearly due to ethnocultural factors that obscure therapy); (6) ambivalence (working through the therapist's own ethnocultural ambivalence); and (7) anger (being too ethnoculturally close to a client may uncover painful, unresolved intrapsychic issues).

Identifying the cultural parameters of transference and countertransference is central for multicultural psychotherapists. They recognize that ethnic, cultural, gender, and racial factors often lead to a more rapid unfolding of core problems in psychotherapy.

Mechanisms of Psychotherapy

Multicultural psychotherapists utilize whatever tools and techniques they learned in graduate school and those endorsed by their theoretical orientations and professional organizations. However, these techniques are not applied automatically and thoughtlessly; they also think carefully and hard to use psychotherapeutic mechanisms congruent with their clients' worldviews. For instance, many individualistic group members prefer a verbal therapy that works through and promotes change by externalizing, or moving from the unconscious to the conscious. Conversely, a significant number of collectivistic members require a holistic healing approach that acknowledges nonverbal communication and promotes change by internalizing, or moving from the conscious to the unconscious (Tamura & Lau, 1992). Therefore, many multicultural psychotherapists integrate holism into their practices. Most of these practices are based on non-Western philosophical and spiritual traditions. In addition to verbal therapy, many clients of color require a mind, body, and spirit approach. For example, Cane (2000) successfully used mind, body, and spirit self-healing practices complemented with a liberation method.

Also known as *contemplative* practices (see chapter 13), holistic approaches such as meditation, yoga, breath work, creative visualization, and indigenous healing are gaining popularity among mainstream psychotherapists. With their holistic emphasis, many multicultural psychotherapists promote spiritual development. Spirituality—a sense of connection to self, others, community, history, and context—is an important aspect in the lives of many people of color. Spirituality provides a worldview, a way of life, and a meaning-making process. Within this context, multicultural psychotherapists help individuals to overcome adversity and find meaning in their existence. Many people of color require liberation approaches in order to recover from historical and contemporary cultural and racial trauma.

Multicultural psychotherapists foster creativity as part of a holistic approach and they encourage clients to use art, folklore, ethnic practices, and other creative cultural forms. The therapeutic use of creativity enhances resilience and *cultural consciousness*—the affirmation, redemption, and celebration of one's ethnicity and culture (Comas-Diaz, 2007). For example, many psychotherapists use clients' oral traditions in healing because people of color frequently answer questions by telling a story. This communication style is consistent with an inferential reasoning based on contextual, interpersonal, and historical factors. In other words, telling a story is a creative way of constructing reality in both linear and nonlinear ways, and the patient's narrative combines both analytical and gestalt elements. Asking clients "What happened to you?" offers a cultural holding environment in which the therapist can become an emphatic witness. It is not surprising that storytelling has been found to be effective in cross-cultural psychotherapy (Semmler & Williams, 2000).

Moreover, due to their experiences of disconnection and trauma, people of color use creativity to cope with past trauma and create meaning and purpose in their lives. Examples of such resilient creativity include flamenco music (originated by Gypsy or Roma people), spoken word (New York Puerto Rican and African American urban spoken poetry), people of color's memoirs and narratives, and other narrative performances. For example, Southeast Indian novelist Chitra Banerjee Divakaruni began to write creatively after immigrating to the United States and confronting her first racist incident (personal communication, May 1, 2002).

Using photos for storytelling enhances self-esteem among visible people of color (Falicov, 1998) and addresses issues of skin color and race. Many oppressed people of color have used creativity as a means of resistance, recovery, redemption, and identity reformulation.

It is clear that creative activities promote healing, and songs, chants, music, and dance induce emotional states in patients that affect the way the immune system responds to illness (Lyon, 1993). Holistic healers understand this process very well. They use metaphors to help their clients manipulate sensory, emotional, and cognitive information to alter their perceptions of illness. For example, empirical studies revealed that folk healers who encouraged their patients to publicly perform their dreams in poetry, song, and dance were significantly more effective in healing as opposed to therapists who encouraged their patients to talk about their dreams in private (Joralemon, 1986).

There is an intimate relationship between multiculturalism and creativity, and research has demonstrated that exposure to diverse cultures enhances creativity. Leung, Maddux, Galinsky, and Chiu (2008) empirically showed that the relationship between multicultural experiences and creativity is stronger when people are open to new experiences and when the creative context emphasizes flexibility. In summary, multicultural psychotherapists use holistic approaches in addition to more traditional psychotherapy mechanisms used in mainstream healing approaches. Out of this amalgamation, with its specific emphasis on cultural strengths, healing emerges.

Ethnopsychopharmacology

All clients come to therapy expecting amelioration of symptoms and some relief from their distress. Medications such as antidepressants are often the quickest way to offer at least temporary relief from pain; consequently, psychotherapists need to work in tandem with physicians, prescribing psychologists, advanced practice nurses, and other health care providers to help patients access the medications they need.

Regrettably, ethnocentrism has resulted in culturally diverse clients' mistrust of psychopharmacology. This problem is compounded by the fact that different racial and ethnic minority groups may respond differently to medication than European American individuals (Rey, 2006). Notwithstanding the empirical evidence of the relevance of ethnicity in assessing likely pharmacological response to psychotropic medications (Ruiz, 2000), ignorance of the ways in which different ethnic groups respond to different medications has contributed to misdiagnosis and mistreatment. Ethnopharmacology is the field that specializes in the relationship between ethnicity and responses to medications. For example, African Americans with affective disorders are often misdiagnosed and thus mistreated with antipsychotic medications (Lawson, 1996; Strickland, Ranganeth, & Lin, 1991). Similarly, due to the fact that many health care providers do not understand or appreciate the different metabolic rates associated with different ethnic groups, many Asians and Latinos are treated inappropriately with psychotropic medications (Ruiz, 2000). Consequently, many people of color have deepened their mistrust of mental health establishments, especially with regard to the prescription of psychotropic medications. These individuals fear, sometimes correctly, that psychotherapists' ignorance of ethnic variations in drug metabolization reflects cultural unawareness, incompetence, and/or indifference.

The field of ethnopsychopharmacology emerged out of the need to address the specific mental health needs of culturally diverse people. Ethnopsychopharmacologists take special care in assessing potential gender and ethnic interactions when prescribing medications. Additionally, they are knowledgeable of the interface of multiculturalism and psychopharmacology (Rey, 2006). For example, it is common for Latinos to share medications with family members and significant others. This practice reflects the cultural value of familism, where family interdependence naturally and predictably results in the sharing of resources. Additionally they may self-medicate and combine medications with herbal remedies. Therefore, multicultural psychotherapists are alert to the need to educate clients about the dangers of self-medication, sharing medications with relatives, use of medications obtained over the counter from outside the United States, and combining herbal remedies with psychotropic medications.

Besides exploring the biological characteristics that affect response to medications, multicultural clinicians examine their clients' lifestyles. For example, the diets of some people of color contain foods (i.e., Mexican Americans' consumption of cheese) that are incompatible with certain kinds of psychotropic medications (MAOIs), but this problem can't be assessed unless the clinician knows something about the dietary habits of his or her client. In addition, multicultural psychotherapists collaborate with psychopharmacologists who are knowledgeable of ethnicity medication interactions.

APPLICATIONS

Who Can We Help?

Paraphrasing Murray and Kluckhohn's (1953) words, every multicultural therapist is "like all other therapists, like some other therapists, and like no other therapist." In other words, multiculturalists share similarities with all therapists (by virtue of being