therapists), with some therapists (by belonging to a particular theoretical orientation), and with no other therapists (due to their unique personal and cultural experiences). Multicultural clinicians engage in diverse therapy formats, including individual, family, and group. Additionally, some use community interventions, such as network therapy. In this section, I present specific examples of clinical interventions prevalent in multicultural psychotherapies.

Multicultural psychotherapies apply to everyone because they emphasize a person-in-context model. As such, multicultural practitioners attempt to use culturally appropriate assessment and treatment modalities. However, multicultural psychotherapies are particularly helpful when individuals present to treatment with identity issues, relationships problems, cultural adaptation, ethnic and racial stressors, and conflicts of diverse nature.

Treatment

A multicultural assessment is a process-oriented tool that leads to culturally appropriate treatment. Some examples of multicultural assessment include the explanatory model of distress, cultural formulation, the use of a cultural genogram, and ethnocultural assessment.

Explanatory Model of Distress

Clients' worldviews and life experiences affect how they present their problems to their psychotherapists, the meaning they attribute to their distress, their help-seeking behavior, their level of social support, and their perseverance in treatment (Anderson, 1995). The explanatory model is a culture-centered assessment based on an anthropological method developed to address these issues. In other words, an explanatory model elicits clients' perspectives of their illness, experience, and healing (Kleinman, 1980). Multicultural psychotherapists use the explanatory model to unfold clients' treatment expectations by asking the following questions (Kleinman, 1980):

- What do you call your problem (illness)?
- What do you think your problem (illness) does?
- What do you think the natural course of your illness is?
- What do you fear?
- Why do you think this illness or problem has occurred?
- How do you think the distress should be treated?
- How do want me to help you?
- Who do you turn to for help?
- Who should be involved in decision-making?

Cultural Formulation and Analysis

The cultural formulation is a clinical tool for assessment and treatment included in the American Psychiatric Association's (2000) *Diagnostic and Statistical Manual* (DSM-IV). The cultural formulation is a process-oriented approach that places diagnosis in a cultural context. Although the cultural formulation is a medical model that emphasizes pathology, its application increases psychotherapists' cultural awareness. The cultural formulation examines (1) individuals' cultural identity; (2) cultural explanations for individual illnesses; (3) cultural factors related to the psychosocial environment and levels

of functioning; (4) cultural elements of the therapist–client relationship; and (5) overall cultural assessment for diagnosis and treatment (APA, 2000).

The cultural formulation facilitates a cultural analysis. Like the explanatory model of distress, the cultural analysis uncovers the cultural knowledge people use to organize their behaviors and interpret their experiences (Spradley, 1990). Lo and Fung (2003) recommended a cultural analysis based on an object–relation treatment model, emphasizing the importance of self and relationships with others and with the world. The domains of the cultural analysis include self, relations, and treatment. According to Lo and Fung, the self domain captures cultural influences on the psychological aspects of the self that may be relevant in psychotherapy (i.e., affect, cognition, behavior, body, self-concept, plus individual goals and motivations). The relations domain relates to cultural influence on clients' relationships with family, groups, others, society, possessions, environment, spirituality, and time. The treatment domain accentuates therapy elements influenced by culture such as communication (both verbal and nonverbal), problem–solution models, and the therapeutic relationship.

Cultural Genogram

Psychotherapists use genograms to enhance their cultural self-awareness. A family therapy tool, genograms diagram a genealogical tree highlighting dynamics from a nuclear to an extended family perspective (McGoldrick, Gerson, & Shellenberger, 1999). Genograms are particularly useful when psychotherapists compare their genealogy to their clients' and examine similarities as well as differences. Many psychotherapists complete their own genogram during personal therapy or professional training. You can see how to complete a genogram at www.genopro.com/genogram_rules/default.htm.

Although the genogram is a well-known family therapy tool, few psychotherapists complete their cultural genograms, even when working with multicultural clients. Hardy and Laszloffy (1995) developed the cultural genogram as a tool to emphasize the role of culture and collective contexts in the lives of individuals and their families. Cultural genograms diagram the genealogical, developmental, historical, political, economical, sociological, ethnic, spiritual/religious, and racial influences in people's lives. The cultural genogram places individuals within their communal contexts.

Clinicians begin a cultural genogram with three or more generations of ancestors. If appropriate and if the information is unavailable, they invite clients to use their imaginations to summon up family information. To aid in this process, clients bring family photos to therapy sessions. This approach is useful when discussing racial differences and other types of physical characteristics. In preparing the cultural genogram, Hardly and Laszloffy recommended the use of color to designate different ethnic groups and mixed colors to identify mixed-race individuals. Likewise, clients can use their creativity—draw, paint, sculpt, and so forth—to prepare their cultural genogram. Cultural genograms share the symbols used in family genograms such as squares to designate males and circles for females.

The following factors can be used in completing a cultural genogram (adapted from Comas-Diaz and Ramos Grenier (1998) and Hardly and Laszloffy (1995)):

- Individual and family culture(s)
- Meaning of race
  - Identity and identification
  - Significance of skin color, body type, hair texture, phenotype
- Meaning of ethnicity
- National origin, collective history, wars, conflicts with other ethnic groups

- Languages spoken by client, family of origin, and current family
- Ethnocultural heritage
- Sexual orientation
  - Interaction of gender, ethnicity, race, class, and sexual orientation
- Family
  - Intact, blended, single parent, nuclear, extended, multigenerational, etc.
- Cultural meanings of family roles
  - Adoption and foster parenting
- Family of origin and multigenerational history
- Assessment of nonblood-related extended family members
- Family life cycle development and stages
- Family structure (nuclear, extended, traditional, intact, reconstituted)
- Gender and family roles
- Social class
- Educational level
- Financial history (e.g., Great Depression), culture of poverty, change in socioeconomic class
- Occupation, avocation
- Marriage
  - Common-law, civil law, religious, commitment ceremonies, same-sex unions, etc.
- Gender roles
  - Gender-specific trauma
  - Relations (intimate, friends, etc.)
  - Intra-ethnic, interethnic
- Migration
  - History of (im)migration and generations from (im)migrations
  - Patterns, reasons for migration
  - Refugee experience
  - Refugee trauma
  - Acculturation
  - Assimilation, separation, marginalization, integration
- Stress
  - Types of stress
  - Acculturative stress
  - Life stressors
  - Ecological stress (e.g., inner city living)
  - Stress management
- Spirituality and faith
- Spiritual assessment
- Use of contemplative practices
- History and politics

- Trauma
  - Political torture and repression
  - History of slavery, colonization, Holocaust, genocide, wars
  - History of human trafficking
  - Sexual and gender trauma
  - Rape, incest, molestation, harassment
- Meaning of differences
  - Individual, family, group, community

As learning about one's societal power is an important aspect of self-knowledge, multicultural assessments can be complemented with a *power differential analysis*. Such analysis requires going beyond the power differential inherent in the psychotherapist/client dyad. It should include an analysis of the client's cultural group's social status compared with the practitioner's. This comparison entails the identification and challenge of internalized privilege and oppression.

Ethnocultural Assessment

A multicultural tool for both evaluation and treatment, the ethnocultural assessment explores diverse stages in the development of cultural identity. The stages of ethnocultural assessment include heritage, saga, niche, self-adjustment, and relationships (Comas-Diaz & Jacobsen, 2004). During the heritage stage, therapists explore clients' ethnocultural ancestry (including parents' genealogy), history, genetics, and sociopolitical contexts. Of particular relevance is the examination of cultural trauma. Exploring family saga entails examining the family, clan, and group story. During this stage, clinicians explore their clients' history of immigration and other significant transitions. The niche assessment stage entails the posttransition analysis. Special attention is given to clients' intellectual and emotional interpretation of their family saga. Therapists examine clients' individual adaptation separate from their family during the self-adjustment stage. Clients' coping styles, including cultural resilience, are assessed during this stage. The final stage of the ethnocultural assessment explores clients' significant affiliations, including the therapeutic relationship.

Evidence

Multicultural psychotherapists combine cultural knowledge with clinical skills and ecological understanding. Instead of endorsing cultural reductionism, they argue for research on the effectiveness of multicultural approaches to psychotherapy. That is, they advocate for research findings that are applicable to the lives of culturally diverse individuals and communities. Multicultural psychotherapies' evidence base is a reality-based perspective, one that moves from the "couch to the bench," and from the "clinic to the laboratory." Such an approach reflects the need for psychotherapy research to be culturally relevant and accountable to ethnic communities.

Some early psychotherapy research focused on ethnic similarity between psychotherapists and clients. Empirical findings suggested that clients working with psychotherapists of similar ethnic backgrounds and languages tend to remain in treatment longer than those whose therapists are not ethnically or linguistically similar. However, ethnic and linguistic match does not necessarily translate into mutual cultural identification (Hall, 2001), nor is it necessarily desirable for some clients. A review of the research on therapist/client ethnic matching revealed inconclusive results and low validity for ethnic matching (Karlsson, 2005). Nonetheless, research has indicated that clients of

color in similar-race dyads participate more in their care than do those in race-dissimilar dyads (Cooper-Patrick et al., 1999). In contrast, an empirical study on the effects of ethnic matching on treatment satisfaction among migrant patients showed that these clients did not view ethnic matching as important and considered clinical competence, compassion, and sharing their worldview as far more important factors (Knipscheer & Kleber, 2004). In toto, however, the available research suggests that culturally competent therapists enhance their clients' satisfaction with treatment.

Much more research is needed on multicultural psychotherapies. Some of the questions that need to be answered include the following:

- What kinds of treatments work best with which kind of clients?
- What is the connection between a psychotherapist's cultural competence and his or her treatment outcomes?
- What is spirituality's effect on psychotherapy effectiveness?
- What are the effects of cultural resilience on physical and mental health?
- How does language (e.g., bilingualism, being a polyglot) influence psychotherapy process?
- How do creativity and multicultural experiences affect mental health?
- What are the gender, ethnobiological, and neurohormonal factors that influence clients' responses to psychotropic medications?
- What are the cultural and ethical contexts of therapists' self-disclosure?

The empirical exploration of these questions and others can reveal the effectiveness of multicultural psychotherapies.

Psychotherapy in a Multicultural World

The inclusion of a new section in each chapter of *Current Psychotherapies* on multicultural psychotherapy—and more significantly, the addition of an entire chapter devoted to the topic in the current edition—underscores the growing importance of multicultural issues for all psychotherapists. Students who are reading this chapter are encouraged to now go back and reread the multicultural sections of all of the other psychotherapy-specific chapters and to evaluate these sections, chapters, and therapies *vis-a-vis* what they have learned from reading the current chapter. To facilitate this process, students can examine the clinical insights provided by the application of multicultural psychotherapies in the following case illustration.

CASE EXAMPLE

Grace: " I don't know why I'm here."
Dr. Martin: "You are wondering why you are in therapy."
Grace: "Don't paraphrase me. I hate it when shrinks do that."
Dr. Martin: "It sounds like you have been in therapy before."
Grace: "Yes, and I despised it."
Dr. Martin: "What did you despise?"
Grace: "I was never understood."
Dr. Martin: "Help me understand you."
Grace: "It's simple: Just listen to me, look at me. What do you see?
Dr. Martin: "An attractive young woman who needs help and doesn't know why she is here."

Grace: "Now you are getting somewhere. Anything else?"
Dr. Martin: "How do you see yourself"?
Grace: "What do you mean?"
Dr. Martin: "Let's start with where do you come from? Family, ethnic, racial, cultural background."
Grace: "You are the first shrink who asked me that. Hum. Although I look White, I'm mixed race."

Background

Grace was the daughter of an African American man and a White European American woman. She grew up in an upper-middle class family—her father worked as a clinic administrator and her mother as a high school teacher. Both parents grew up Catholic and sent Grace to Catholic school. She excelled at academics until her senior year, when she experienced a traumatic loss. A drunk driver killed her boyfriend Adolph, who was on his way home after leaving his 17th birthday party.

"I created a macabre dance," Grace told Dr. Martin without crying.

Grace was referring to her birthday gift to Adolph—a choreographed piece that she created for him.

After the tragedy, Grace's grades plummeted. She saw three different therapists, all of whom she fired.

Grace's developmental history was unremarkable. Her health history indicated episodic sleep paralysis during times of severe stress. Based on her sleep laboratory study, Grace received medication (Tofranil 25 mg) to control her symptoms. However, she stopped treatment due to side effects from the medication she was taking. "I have a sleep paralysis episode every year on Adolph's birthday," Grace said.

Upon the completion of the explanatory model of distress, Grace told Dr. Martin: "This is the first time I feel a therapist listened to me." Dr. Martin cemented the emerging therapeutic alliance by teaching Grace relaxation techniques. Grace expressed some relief from her anxiety symptoms.

Assessment

Grace's responses to the explanatory model of distress revealed a fear of being cursed. Immediately after her birth, Grace's father lost his job. The "curse" continued until 2 years later when her parents had a second child.

"My sister, Mary, brought joy and luck," Grace said. "My parents won the lottery and used the money to pay for my father's graduate studies."

"What did your parents think about your 'curse'?" Dr. Martin asked Grace.

"My mother denied it, but Dad has always been distant from me."

As further evidence of her "curse," Grace connected her "macabre dance" with Adolph's death.

When asked about her views on her problem, Grace responded, "I'm a 25-year-old woman looking for myself."

Cultural genogram

Dr. Martin invited Grace to complete a cultural genogram. Grace began to gather information by talking with her relatives. She traced her maternal family to Germany back three generations. Dr. Martin asked her to bring photos of her relatives to therapy sessions. In response, Grace compiled a photo album and complemented it with drawings. She chose a pink color to identify her maternal ancestors and used lavender to assign her

paternal side of the family. At this time, Grace did not choose a color to identify herself in the cultural genogram.

Grace had a dream about a town in Germany during the completion of her cultural genogram. She conducted research and discovered that part of her maternal family was from an area that Germany annexed from Denmark. She found a great aunt of German–Danish ancestry and began communicating with her through the Internet. Fortunately, her great aunt spoke enough English to communicate with Grace.

Grace became a genealogy fan and researched her paternal ancestry. She discovered that her father was a descendant of the free people of color in New Orleans. As the term implies, free people of color were not enslaved during the United States slavery period. Most of the free people of color were of mixed race and had similar rights to Whites. That is, they owned property, were educated, and participated in diverse occupations and professions. This legacy filled Grace with excitement and pride. "I'm the product of contradictions." The exploration of Grace's contrasts led to the examination of her cultural identity development. At the beginning of treatment, Grace appeared to be at the biracial identity appreciation stage. Her words during the first session with Dr. Martin, "Although I look White, I'm mixed race," denoted positive regard for her mixed-race identity. Interestingly, Grace's genealogy work signaled her movement toward an integrative stage where biracial identity began to coalesce. Grace selected a gold color to self-identify at the completion of her cultural genogram.

Treatment

Dr. Martin worked on Grace's complicated bereavement during the beginning stages of treatment. However, before deepening the treatment, Dr. Martin—a European American middle-aged married woman—engaged in cultural self-assessment. The process revealed an English and Italian ethnocultural heritage. Both maternal and paternal great-grandparents had been immigrants. Dr. Martin compared her ethnocultural heritage with Grace's. Like her client, she felt proud of being a product of the union of two ethnicities. Like her client, Dr. Martin had received a Catholic school education. Another connection between them was the loss of a significant person during adolescence; Dr. Martin's best friend died after an accident during her senior year in high school. These similarities seemed to facilitate Dr. Martin's development of empathy. Nonetheless, the therapist acknowledged not knowing what it was like to be a mixed-race woman.

Grief work helped Grace to accept Adolph's death. Her anxiety symptoms decreased. However, Adolph's next birthday/death anniversary found Grace with another sleep paralysis episode. Grace described it to Dr. Martin. "It's like someone is sitting on my chest and I can't move. Grandma says that when this happens, a witch is riding you."

Dr. Martin researched the topic of sleep paralysis and found that the condition is prevalent among some African Americans who suffer from anxiety (Paradis & Freidman, 2005). After reviewing the literature, Dr. Martin suggested that Grace consult her grandmother about the "riding witch." Grace, who was named after her paternal grandmother, reported that her grandmother believed Adolph to be the cause of her sleep affliction. When Dr. Martin asked her what she thought about this explanation, Grace replied that relationships don't end with death. Indeed, some people of color believe that relationships between significant others continue after death.

Dr. Martin used grief counseling to treat Grace's complicated bereavement. Although Grace was able to sleep better, she continued to experience sleep paralysis. Dr. Martin interpreted Grace's symptoms as survivor's guilt and treated Grace with cognitive behavioral techniques. After several months of treatment, Dr. Martin began to feel frustrated and angry toward Grace. She examined her countertransference and realized that she was comparing her own grief (around her friend's death) with Grace's experience of losing

Adolph. Dr. Martin consulted a colleague and worked through her own bereavement. Afterward, Dr. Martin suggested a guided imagery exercise to Grace. She asked Grace to remember the last time she saw Adolph. Grace used the relaxation techniques she learned in therapy to help her visualization.

"Adolph just turned into my father," Grace said during the exercise. "Was Adolph Black?" asked Dr. Martin. "Yes," Grace answered.

Dr. Martin realized that she had an ethnocultural countertransference involving a cultural denial: She had assumed that Adolph was White. The realization that Adolph was African American helped her to better understand Grace's circumstances around his death. Dr. Martin interpreted Grace's reaction to Adolph's death as a repetition of a pattern where Grace felt abandoned by significant others (like her father's reaction to her "curse"). Dr. Martin worked with Grace on this dynamic interpretation. She suggested another holistic guided visualization. In this exercise, Dr. Martin asked Grace to relax deeply and imagine a safe and serene place. Grace saw herself choreographing a new dance. While she danced, Grace envisioned herself getting healed. She named the piece the Dance of Life.

Grace did not experience sleep paralysis during Adolph's next birthday/death anniversary. She examined her relationships with significant others during the rest of psychotherapy. Grace improved her relationship with her father, and for the first time, she felt close to her sister Mary. Her grandmother died during the last phase of therapy. Grace experienced sadness, but she completed her bereavement. Afterward, Grace formed an advocacy group to raise community consciousness about drunk driving. Grace stayed in therapy for two and a half years. On her last therapy session, she said to Dr. Martin: "I found myself." She took a tissue from the Kleenex box. "I finally own my name. No longer a curse, I'm a Grace to my family, community, and to myself."

SUMMARY

The United States' population is becoming more culturally, racially, and ethnically diverse. The election of the first president of color of the United States is a sign of such diversity. Multiculturalism emerged as a product of sociopolitical and civil rights movements. Multicultural theories of psychotherapy came to light out of people of color's concerns and later expanded to embrace diversity regarding gender, sexual orientation, class, religion, spirituality, age, ability, and disability.

Originally considered a transforming force in psychology, multiculturalism is at the vanguard of psychotherapy. To illustrate, multicultural theories constitute a shift in psychological paradigm. They provide conceptual and practical methods designed to enhance all types of clinical interventions. Multicultural psychotherapies facilitate adaptation and growth because they address the management of diverse and complex environments. With their emphasis on context, multicultural theories enhance our ability to cope with change and thus foster transformation and evolution.

Multicultural psychotherapies promote the development of cultural competence as a lifelong process. Fostering flexibility, they facilitate the incorporation of pluralistic and holistic approaches into practice. Multicultural theories accommodate the current resurgence of ancient healing traditions and promote their integration into mainstream psychotherapy.

As every human encounter is multicultural in nature, multicultural psychotherapies are relevant to all individuals (Sue & Sue, 2008). They offer tools for the effective management of differences, similarities, and power disparities. Finally, multicultural theories facilitate our adjustment to the globalization of our society. They offer a compass for the multicultural journey upon which all of us embark.