Courtesy of Lillian Comas-Díaz

Lillian Comas-Díaz

15 MULTICULTURAL THEORIES OF PSYCHOTHERAPY

Lillian Comas-Díaz

OVERVIEW

Are the prevailing systems of psychotherapy relevant to culturally diverse individuals? Most therapeutic orientations recognize that individual differences must be respected and accepted. However, as a product of Western society, the dominant models of psychotherapy tend to be grounded in a monocultural perspective. As such, they support mainstream cultural values, neglecting multicultural worldviews. Unfortunately, a monocultural psychotherapy frequently promotes *ethnocentrism*. Ethnocentrism, the belief that one's worldview is inherently superior and desirable to others (Leininger, 1978), can compromise psychotherapy when therapists project their values and attitudes onto their culturally different clients. As a result, scholars and practitioners questioned the multicultural applicability of mainstream psychotherapy (Bernal, Bonilla, & Bellido, 1995; Sue, Bingham, Porche-Burke, & Vasquez, 1999). Multicultural psychotherapies emerged as a response to these concerns.

Proponents of multicultural psychotherapies advocate for cultural sensitivity—that is, awareness, respect, and appreciation for cultural diversity. Valuing diversity promotes a critical examination of established psychotherapeutic models and assumptions because definitions of health, illness, healing, normality, and abnormality are culturally embedded. Thus, multicultural psychotherapists examine their clients' as well as their own *worldviews*. The concept of worldview refers to people's systematized

ideas and beliefs about the universe. When multicultural psychotherapists engage in self-examination, they explore their professional socialization and potential bias. They also examine the cultural applicability of their interventions and promote culturally relevant therapeutic strategies.

Monocultural, dominant psychotherapy tends to be decontextualized, ahistorical, and apolitical. When it fails to examine the historical and sociopolitical contexts, mainstream psychotherapy ignores the role of issues of power and privilege in people's lives. Multicultural psychotherapists consider power differences based on diversity characteristics such as ethnicity, race, gender, social class, sexual orientation, age, religion, national origin, ability/disability, language, place of residence, ideology, and membership in other marginalized groups. They believe that ethnocentric psychotherapy paradigms resist change because they preserve the status quo. To embrace change, multicultural psychotherapists promote empowerment and social justice. Instead of focusing on deficits, they affirm strengths. This emphasis on diversity leads multiculturalists to endorse interdisciplinary approaches. Indeed, *unity through diversity* is a multicultural maxim. Consequently, multicultural psychotherapists benefit from the contributions of sociology, anthropology, cultural/ethnic studies, humanities, arts, history, politics, law, philosophy, religion/spirituality, and many other disciplines. Accordingly, Multicultural psychotherapists also are represented in diverse theoretical schools including psychodynamic, cognitive–behavioral, rational–emotive, humanistic, Jungian, and various other combinations of dominant psychotherapies. Regardless of preferred theoretical approach, multicultural psychotherapists work to develop *cultural competence.* A basic concept in multicultural psychotherapies, cultural competence refers to the set of knowledge, behaviors, attitudes, skills, and policies that enables a practitioner to work effectively in a multicultural situation (Cross, Bazron, Dennis, & Isaacs, 1989).

Basic Concepts

The demographic changes in the United States signal the increasing number of culturally diverse individuals in need of psychotherapy. However, multiculturalism has not fully reached dominant psychotherapy. Accordingly, the lack of cultural relevance in dominant psychotherapies gave birth to multicultural psychotherapies. Simply put, multicultural psychotherapies infuse cultural competence into clinical practice. Regardless of theoretical orientation, most psychotherapists can incorporate a multicultural perspective into their practice. The term *multicultural* refers to the interaction between people across cultures. In the United States, multicultural refers to the interaction between culturally diverse individuals such as people of color, internationals, immigrants, temporary workers, and the dominant European American culture. Cultural misunderstandings and communication problems between psychotherapists and their clients interfere with treatment effectiveness. This observation illustrates how psychotherapists' ethnocentric worldviews interfere with psychotherapy's usefulness.

Worldviews

Harry Triandis (1995) classified worldviews according to how individuals define themselves and how they relate to others. Those cultures where individuals' identity is associated with their relationships to others are called collectivistic. In contrast, members who frequently view themselves independently from others are denominated individualistic (Triandis, 1995). Western societies tend to be identified as individualistic since their members define themselves primarily in terms of internal features such as traits, attitudes, abilities, and agencies. In other words, their ideal personal characteristics include being direct, assertive, competitive, self-assured, self-sufficient, and efficient. On the

other hand, collectivistic members endorse relational values, prefer interdependence, encourage sharing resources, value harmony, tolerate the views of significant others, and prefer communication that minimizes conflicts (Triandis, 1995). Valuing connection, collectivistic persons frequently contextualize and have a holistic orientation. In reality, most people's worldviews can be placed within an individualist–collectivistic spectrum. For instance, many African Americans have a combined collectivistic and individualistic worldview.

The negotiation of client/therapist worldviews is crucial for effective psychotherapy. Regrettably, due to their individualistic worldview, mainstream psychotherapists tend to interpret multicultural clients' normative cultural behaviors as resistance, inferiority, and/or deviance (Young, 1990). For example, when collectivist members tolerate the limitations of significant others, individualist psychotherapists may misinterpret such behavior as poor judgment instead of viewing it as a culturally accepted norm. Moreover, individualistic psychotherapists can violate personal and family norms by asking collectivistic clients to reveal intimate personal information, soliciting the expression of emotion and affect, and requesting individuals to air family disputes, all before earning their clients' trust and establishing a positive therapeutic alliance (Varma, 1988). Since the notion of being understood is an important aspect in healing, effective psychotherapy depends on the therapist's understanding of his or her client's worldview. The development of cultural competence helps therapists to appreciate and manage diverse worldviews.

Cultural competence

Differences in therapists' and clients' worldviews frequently lead to communication problems, misdiagnosis, and/or client premature treatment termination. However, cultural competence enhances adherence to psychotherapy and completion of treatment. *Cultural competence* involves a set of congruent behaviors, attitudes, and policies that reflect an understanding of how cultural and sociopolitical influences shape individuals' worldviews and related health behaviors (Betancourt, Green, Carrillo, & Ananch-Firempong, 2003). Specifically, to become culturally competent you need to (1) become aware of your worldview; (2) examine your attitude toward cultural differences; (3) learn about different worldviews; and (4) develop multicultural skills (Sue et al., 1995). Likewise, culturally competent therapists develop the capacity to (1) value diversity; (2) manage the dynamics of difference; (3) acquire and incorporate cultural knowledge into their interventions and interactions; (4) increase their multicultural skills; (5) conduct self-reflection and assessment; and (6) adapt to diversity and to the cultural contexts of their clients. Since all therapeutic encounters are multicultural because everyone belongs to diverse cultures and subcultures, cultural competence enables psychotherapists to work effectively in most treatment situations. For the purpose of this chapter, *culture* is defined as individuals' total environment. It includes beliefs, values, practices, institutions, and psychological processes including language, cognition, and perception.

The American Psychological Association (APA) highlighted the importance of cultural competence by formulating a series of multicultural guidelines. The first set of principles, *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Clients,* exhorted practitioners to (1) recognize cultural diversity; (2) understand the central role culture, ethnicity, and race play in culturally diverse individuals; (3) appreciate the significant impact of socioeconomic and political factors on mental health; and (4) help clients understand their cultural identification (APA, 1990). Afterward, APA (2003) published a second set of principles—*Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change*—and encouraged psychologists to (1) recognize that we are cultural beings; (2) value cultural sensitivity and awareness; (3) use multicultural constructs in education; (4) conduct

culture-centered and ethical psychological research with culturally diverse individuals; (5) use culturally appropriate skills in applied psychological practices; and (6) implement organizational change processes to support culturally informed organizational practices and policy (APA, 2003). The six specific multicultural guidelines are listed below:

Commitment to Cultural Awareness and Knowledge of Self and Others

1. "Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves."
2. "Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals."

Education

3. "As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education."

Research

4. "Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds."

Practice

5. "Psychologists strive to apply culturally appropriate skills in clinical and other applied psychological practices."

Organizational Change and Policy Development

6. "Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices." (APA, 2003, pp. 377–402)

The interested reader can access the complete document at: http://www.apa.org/pi/multiculturalguidelines/homepage.html.

All multicultural guidelines provide a context for multicultural psychotherapies. Nonetheless, three areas are of particular relevance to multicultural psychotherapies. These are the commitment to cultural awareness and knowledge of self and others, guidelines related to psychological practice, and organizational change and policy development. Multicultural psychotherapists respond to their Ethics Code (APA, 2002) regardless of purview of practice and setting.

The development of cultural competence is a lifelong process that requires acknowledging the need for ongoing learning. Cross and colleagues (1989) identified the development of cultural competence across the following spectrum: (1) cultural destructiveness is characterized by attitudes, policies, and practices that are destructive to cultures and to individuals within cultures (e.g., "English only" mandates); (2) cultural incapacity—individuals believe in the racial superiority of the dominant group and assume a paternalistic and ignorant position toward culturally diverse people; (3) cultural blindness—individuals believe that culture makes no difference and thus, the values of the dominant culture are universally applicable and beneficial; (4) cultural precompetence—individuals desire to provide an equitable and fair treatment with cultural sensitivity but do not know exactly how to proceed; (5) cultural competence—individuals value and respect cultural differences, engage in continuing self-assessment regarding culture, pay attention to the dynamics of difference, continue expanding their knowledge and resources, and endorse a variety of adaptations to belief systems, policies, and practices.

Multicultural psychotherapies' emphasis on context nurtured the emergence of cultural competence guidelines for organizations. Since many psychotherapists function within formal organizations, APA formulated multicultural guidelines for psychologists within organizations through its multicultural guideline number 6. Addressing this problem, Howard-Hamilton and colleagues (1998) outlined principles for those counselors working with multicultural clients. They exhorted therapists to (1) evaluate their institution's mission statement and policies to determine whether they include diversity issues; (2) assess policies with regard to diversity; (3) evaluate how people of color may perceive specific policies; (4) acknowledge within-group diversity; (5) be aware that diversity requires examination from both the individual and the institutional levels; and finally (6) recognize that multicultural sensitivity may mean advocating for culturally diverse people. Similarly, Wu and Martinez (2006) asked multicultural practitioners to help their organizations achieve cultural competence by (1) including community representation and input at all stages of implementation; (2) integrating all systems of the health care organization; (3) ensuring that changes made are manageable, measurable, and sustainable; (4) making the business case for implementation of cultural competency polices; (5) requiring commitment from leadership; and (6) helping to establish staff training on an ongoing basis.

Empowerment

In addition to promulgating cultural competence, multicultural psychotherapists challenged dominant approaches with conceptual, methodological, ethical, and sociopolitical concerns. Dominant psychotherapists' ignorance of the historical and sociopolitical contexts further disempowered marginalized individuals. This is detrimental for visible people of color, who, unlike majority group members, have a history of individual and collective oppression. A specific example of such disempowerment is dominant psychotherapists' inattention to racial microaggressions. *Racial microaggressions* refer to the assaults that individuals receive on a regular basis solely because of their race, color, and/or ethnicity (Pierce, 1995). Some illustrations of racial microaggressions include being harassed in public places, being ignored by clerks who favor White customers, being accused of being an "Affirmative Action baby" (racial favoritism), being targeted for racial profiling, and so forth. Unfortunately, racial microaggressions also occur in therapy and include therapists' cultural blindness, denial of racism, adherence to the myth of meritocracy (without acknowledging the roles of oppression and privilege), misdiagnosis, and pathologizing culturally diverse behaviors (Sue et al., 2007). These therapists' behaviors promote disempowerment among culturally diverse clients.

Multicultural psychotherapists emphasize empowerment because many people of color tend to internalize their disempowerment as helplessness. Therapeutic empowerment helps clients increase their access to resources, develop options to exercise choice, improve self- and collective esteem, implement culturally relevant assertiveness, augment agency, affirm cultural strengths, overcome internalized oppression, and engage in transformative actions. Within their empowerment focus, multicultural psychotherapies frequently subscribe to the following assumptions: (1) Reality is constructed in a context; (2) experience is valuable knowledge; (3) learning/healing results from sharing multiple perspectives; and (4) learning/healing is anchored in meaningful and relevant contexts. Along these lines, several multicultural counselors espouse a liberation model, helping clients to critically analyze their situations, affirm ethnocultural strengths, promote personal transformation, and foster sociopolitical change.

Indeed, this emphasis on empowerment frequently leads psychotherapists to commit to social justice. The history of human rights violations against many minorities

has resulted in a *cultural trauma*, a legacy of adversity, pain, and suffering among many minority group members. Duran and Ivey (2006) called this legacy a *soul wound*—the product of sociohistorical oppression, ungrieved losses, internalized oppression, and learned helplessness. Cultural trauma continues to afflict minorities through racism, sexism, elitism, heterosexism, ablism, xenophobia, ethnocentrism, and other types of oppression.

Group membership dynamics seem to reinforce oppression and privilege. For example, research has identified a human tendency to categorize individuals into in-group and out-group members (Allport, 1954). Membership in one group helps to shape our perceptions about our group as well as about other groups. When people belong to one group, they tend to prefer members of their own identity classification. Indeed, some studies have documented the existence of unconscious negative racial feelings and beliefs. By using cognitive psychology techniques (e.g., response latency as measure of bias), Dovidio and Gaertner (1998) demonstrated that individuals who in self-report measures appeared as nonprejudiced often have generally negative attitudes toward Blacks. Known as *aversive racism*, this phenomenon demonstrated that both liberal and conservative Whites discriminate against African Americans (and probably against other visible people of color) in situations that do not implicate racial prejudice as a basis for their actions (Whaley, 1998). Likewise, the expression of unintentional or symbolic racism can take subtle forms and thus is harder to identify. As a result, White individuals who grow up as members of a majority group may have either covertly or overtly racist attitudes (Brown, 1997). As an illustration, in-group favoritism—the 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 (Rhodes & Williams, 2007).

Psychotherapy will be unsuccessful if clients feel that their therapist is unconsciously racist, ethnocentric, sexist, elitist, xenophobic, homophobic, or the like. To counteract bias, multicultural psychotherapists explore their beliefs, values, and attitudes toward their in-group members as well as their attitudes toward out-group members. That is, they become aware of and sensitive to their own attitudes toward others, as they may be unconscious of how culturally biased these attitudes may be. Besides becoming familiar with different worldviews, multicultural psychotherapists understand the stigmatizing effects of being a member of an oppressed group. More specifically, they recognize how minority members' history with the dominant society—such as African American slavery, concentration camps for Japanese Americans, the American Indian Holocaust, and the colonization of major Latino groups, including the forceful annexation of Mexican territories—can create cultural trauma and thus influence the worldview of people of color. An appreciation of such history requires awareness of how racism interacts with other types of discrimination such as sexism, classism, xenophobia, neocolonialism, and heterosexism.

To undertake this appreciation, therapists engage in cultural self-awareness. Therapists' cultural self-awareness includes learning about one's position in relation to societal power and privilege. Understanding power dynamics is an important part of appreciating the relationship between self and others. To achieve this goal, multicultural psychotherapists analyze the power differences between their life experiences and their client's. Different from most dominant therapies' analyses, a power analysis goes beyond the power differential inherent in the therapist/client dyad. Multicultural psychotherapists compare their client's cultural group's social status with their own. This comparison entails the identification and challenge of internalized privilege and oppression, since most individuals with power are unaware of its pervasive influence in their life. To increase awareness of power, Peggy McIntosh (1988) defined White privilege as unacknowledged systems that give power to European Americans and male individuals. She exhorted individuals to "unpack the invisible knapsack" by becoming aware of White privilege.

Examples of the invisible knapsack include those situations when European Americans and men can do the following:

1. Go shopping alone most of the time, pretty well assured that they will not be followed or harassed.
2. Turn on the television or open to the front page of the paper and see European American people widely represented.
3. Count on their skin color not to work against the appearance of financial reliability whenever they use checks, credit cards, or cash.
4. Rent or purchase housing in an area that they can afford and in which they would want to live.
5. Avoid the need to educate their children to be aware of systemic racism for their own daily physical protection.
6. Remain oblivious 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. Confront a person of their own race if they ask to talk to the "person in charge."
9. Be confident that if a state trooper pulls them over, they haven't been singled out because of their race.
10. Take a job with an affirmative action employer without having their coworkers suspect that they got it because of their race.

You can review all of the examples of White privilege at www.case.edu/president/aaction/UnpackingTheKnapsack.pdf.

The illustrations of White privilege reflect the importance of recognizing the effects of institutionalized power disparities on people's lives because such disparities favor members of dominant groups while disenfranchising members of minority groups. The denial of the unacknowledged privilege protects the status quo.

To summarize, multicultural psychotherapies' underlying assumptions include the following:

- Culture is complex and dynamic.
- Reality is constructed and embedded in context.
- Every encounter is multicultural.
- Multicultural psychotherapies are relevant to all individuals.
- Understanding nonverbal communication and behaviors is crucial to psychotherapy.
- A Western worldview has dominated mainstream psychotherapy.
- Psychotherapists engage in self-awareness.
- Cultural competence is central to effective psychotherapy.
- Healing entails empowering individuals and groups.
- Healing is holistic and involves multiple perspectives.

Other Systems

Multiculturalism draws upon the benefits and perspectives of many disciplines, and multicultural psychotherapists acknowledge the contributions of diverse psychotherapeutic orientations. Although many multicultural therapists self-identify as adherents to one

or another theoretical orientations, they also impart multicultural values into their specific therapeutic schools. Indeed, partly due to multiculturalism's criticisms, mainstream clinicians are revising psychotherapy's basic tenets with respect to their applicability to culturally diverse clients. Psychoanalysts, for instance, are including the experiences of culturally diverse individuals to incorporate their social, communal, and spiritual orientations into treatment. For example, Altman (1995) utilizes a modified psychoanalytic object relations framework, examining his clients' progress by their ability to use relationships to grow rather than by the insight that they gain.

Object relations theory focuses on the way in which significant interpersonal relationships are internalized and become central to the person's interactions with the world. Within this perspective, conflict and personality disturbance are viewed as arrest and/or damage to the development of the child's sense of self and others. Object relations theory views damage to the development of relationships as a cause of conflict and personality disturbance.

In addition to the cultural adaptations of dominant psychotherapies, the specific influence of multicultural approaches is increasing. Research has reported inconsistent findings regarding the cultural sensitivity of mainstream psychological services. Although some studies found evidence-based practice (EBP) to be effective for a number of culturally diverse populations (CIEBP, 2008), other findings indicated that clients of color tend to drop out of cognitive–behavioral therapy (CBT) at a higher rate than their European American counterparts (Miranda, et al., 2005). Research findings suggest that to be effective, EBP needs to be culturally adapted to clients' contexts. These findings are consistent with the results of a study that showed African American clients who expressed positive expectations about seeking mental health services found treatment less positive than their European American counterparts after utilizing such services (Diala, et al., 2000).

Indeed, after reviewing the research on dominant psychotherapies' cultural adaptations, Whaley and Davis (2007) concluded that culture affects psychotherapeutic process more than it affects treatment outcome. Dominant psychotherapies' ethnocentrism could partly explain Whaley and King's conclusion. To illustrate, a major area of discontent among people of color is the United States' history of medical experimentation and additional abuses toward these populations. Such history has aggravated people of color's mistrust of the medical establishment. Called medical apartheid, this history ranges from the Tuskegee project, a research project where African American men with syphilis were given a placebo instead of medication (penicillin), despite the fact that a cure for syphilis was found during the course of the research and administered to White men, to the involuntary sterilization of Puerto Rican women when they came in for routine medical examinations (Comas-Diaz, 2008). As many culturally diverse individuals endorse a collectivistic orientation, they situate themselves in place and time. Therefore, personal and collective history is an important element in the lives of people of color.

HISTORY

Precursors

Interest in the "other" dates from the beginning of time. At times, such attention has been in the form of concern, awareness, and even fascination. Diverse religious and spiritual traditions assigned an important role to the other. For instance, in Judaism the other is associated with sacred because *otherness* means *holy* in Hebrew. In Christianity, the concept of the "necessary other" facilitates the recovery of the divided self. Furthermore, a Buddhist view on the other as enemy is that enemies are our best teachers because we learn the most from them. In accordance with spiritual traditions, multicultural psychotherapies aim to enhance the relationship between self and other.

Beginnings

Multicultural psychotherapies have interdisciplinary origins. Early theoretical influences include psychological anthropology, ethnopsychology, cultural anthropology, psychoanalytic anthropology, and folk healing. The interest in the other arrived in the mental health fields during the period between the 1940s and the 1960s. Anthropologists and psychoanalysts collaborated on studying the relationship between culture and psyche. Proponents of these movements applied psychoanalytic analyses to social and cultural phenomena. Some scholars examined cross-cultural mental health; some studied the effects of oppression on ethnic minorities' mental health; still others questioned the universal application of psychoanalytic concepts, such as the Oedipus complex.

Members of the Cultural School of Psychoanalysis argued that culture shapes behavior because individuals are contextualized and embedded in social interactions that varied across cultural contexts and historical periods (Seeley, 2000). Although the anthropological psychoanalytic orientations enriched the culture and behavior discourse, they failed to develop cultural theories that could be applied to psychotherapy (Seeley, 2000).

Psychological and psychiatric anthropologists studied the effects of culture on mental health and gave birth to transcultural psychiatry. Similar to *culturalism*—the psychotherapeutic use of culture-specific folk healing—transcultural psychiatry and psychology advocated for the use of community and indigenous resources (clergy, teachers, folk healers, and other ethnic minority individuals) for mental health treatment.

The minority empowerment movements furthered the development of multicultural psychotherapies. These movements examined the power/oppression dynamics between dominant group members and minorities. Known as identity politics, women's rights, Black Power, Chicano/Brown power, and Gay, Lesbian, and Bisexual movements highlighted the civil rights and needs of marginalized groups. Adherents of these movements raised consciousness and worked toward empowering marginalized groups in order to redress social and political inequities.

The desire to understand the effects of oppression on mental health led some clinicians to examine the psychology of colonization. Frantz Fanon (1967) articulated the principles of the psychology of colonization in terms of the economic and emotional dependence of the colonized on the colonizer. He used the concepts of imperialism, dominance, and exploitation to examine the relationship between the colonizer and the colonized. The process of colonization echoed in the United States as the first president of color of the American Psychological Association, Kenneth B. Clark, identified the condition of Americans of color as colonization (Comas-Diaz, 2007).

A major influence on multicultural psychotherapies is the "education for the oppressed" model. Paulo Freire (1973) identified dominant models of education as instruments of oppression that reinforce and maintain the status quo and social inequities. He coined the term *conscientization*, or *critical consciousness*, as a process of personal and social liberation. Education for the oppressed teaches individuals to become aware of their circumstances and change them through a dialectical conversation with their world. Since oppression robs its victims of their critical thinking, the development of *conscientization* involves asking critical questions such as "What? Why? How? For whom? Against whom? By whom? In favor of whom? In favor of what? To what end?" (Freire & Macedo, 2000). Answering these questions helps clients to examine "what matters" and uncovers clients' existential reasons for being, purpose, and position in life. Critical consciousness helps oppressed individuals to author their own reality.

Re-evaluation counseling (RC) is another influence in the emergence of multicultural psychotherapies. RC is an empowering co-counseling approach where two or more individuals take turns listening to each other without interruption in order to recover from the effects of racism, classism, sexism, and other types of oppression (Roby, 1998).

Harvey Jackins developed RC based on his belief that everyone has tremendous intellectual and loving potential but that these qualities have become blocked as a result of accumulated distress. Recovery involves a natural discharge process through which the "counselor" encourages the "client" to discharge emotions (catharsis). Afterward, the "client" becomes the "counselor" and listens to the client. RC proponents are committed to ending racism at the individual, collective, and societal levels. For more information, visit www.rc.org.

The struggle against colonization and oppression challenged women's subservient position. As daughters of empowerment movements, feminist therapists embrace diversity as a foundation for practice. Such an empowerment position influenced the development of multicultural psychotherapies. Feminist clinicians believe dominant psychotherapists act as agents of the status quo; in contrast, feminist psychotherapy attempts to empower all people, women as well as men, and promote equality at individual, interpersonal, institutional, national, and international levels. Feminist therapy and multicultural therapies equally influence each other. For instance, women of color challenged feminist therapists to become culturally sensitive. As a result, cultural feminist therapy and Women of Color's feminist therapy were born. While cultural feminist therapists use the empathic relationship to increase women's connection to others' subjectivity, interdependence, and other female values (Worrell & Remer, 2003), Women of Color's feminist therapists address the interaction between racism, sexism, classism, heterosexism, ethnocentrism, ablism, and other forms of oppressions.

Ethnic Family Therapy

Like feminist therapy, family therapy has benefited from an interaction with multiculturalism. With its history of recognizing ethnicity and culture into its theory and practice (McGoldrick, Giordano & Pierce, 1982), family therapy witnessed the emergence of ethnic family therapy. Ethnic family therapists attempt to (1) know their own culture, (2) avoid ethnocentric attitudes and behaviors, (3) achieve an insider status, (4) use intermediaries, and (5) have selective disclosure (McGoldrick, et al., 1982). An illustration of ethnic family therapy is Boyd-Franklin's (2003) multisystemic approach for *Black Families in Therapy*. Just as family therapy uses genograms to show the relationships between family members (McGoldrick, Gerson, & Shellenberger, 1999), ethnic family therapists use cultural genograms (Hardy & Laszloffy, 1995). I discuss cultural genograms in more detail later in the chapter.

Several professional and academic organizations have supported the development of multicultural psychotherapies. For example, the American Psychological Association has a recent history of examining the needs of minority populations. Several of its societies, such as the Society of Psychology of Women, the Society for the Psychological Study of Ethnic Minority Psychology, and the Society for the Psychological Study of Gay, Lesbian, Bisexual, and Transgender Issues are examples. In particular, the Society for the Psychological Study of Ethnic Minority Psychology has promoted the need for multiculturalism in all aspects of psychology, especially in professional psychology. The society's official journal, *Cultural Diversity and Ethnic Minority Psychology,* is an important vehicle for dissemination of scholarly and professional work on multicultural psychology.

Counseling psychologists have demonstrated a commitment to multicultural issues and they have recognized the importance of multiculturalism in publications such as the *Journal of Multicultural Counseling and Development*. Feminist psychologists find an outlet for their writing in journals such as *Psychology of Women Quarterly*, the official journal of the American Psychological Association's Society of Psychology of Women. Additionally, the Association of Women in Psychology publishes its official journal, *Women & Therapy*.

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

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.