Development of Culturally Sensitive Psychotherapists

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We propose a developmental model to describe how student-therapists learn to appropriately consider cultural factors in their clinical work with culturally diverse clients. The model is derived from discussions held in a seminar concerning mental health services and culture and from students' written accounts of how they considered cultural factors in providing therapy. Vignettes based on the written accounts are presented to illustrate the key developmental processes hypothesized to underlie psychotherapists' growing cultural sensitivity. The proposed model is contrasted with past models of therapist development. A research agenda guided by a social cognitive perspective is offered to test the proposed model.

Many authors have written about how mental health professionals need to be sensitive to cultural issues in their clinical practice. Some authors have framed these concerns within the context of ethics (Pedersen & Marsella, 1982). Others have attempted to identify specific competencies and guidelines associated with the effective treatment and assessment of special populations (Figueroa, Sandoval, & Merino, 1984; D. W. Sue et al., 1982; S. Sue & Zane, 1987). The perspective taken in this literature is that of the expert pointing out why cultural skills are important and what one should do to enhance one's expertise in this area. Authors have given little attention to the perspective of the student developing or improving skills in the assessment and treatment of special populations. Given the overall lack of attention to students' training in these areas, we know little about the developmental processes associated with such training.

Our main purpose was to consider the process by which therapists-in-training develop cultural sensitivity. Our conceptualization is guided by a developmental perspective (Loganbill, Hardy, & Delworth, 1982; Stoltenberg & Delworth, 1987) and a social cognitive perspective (Abramson, 1988; Fiske & Taylor, 1984; Showers & Cantor, 1985). First, we believe that the concept of developmental stages is a useful heuristic for examining the growing expertise of student-therapists; that is, therapists' functioning is likely to proceed through stages or levels that build on previous levels and represent progressively more complex and adaptive responses (Stoltenberg & Delworth, 1987). Second, the social cognitive framework enables us to consider how student-therapists process information (e.g., test hypotheses) as they develop their expertise. This framework is particularly helpful in delineating hypotheses that can be tested in evaluations of the proposed developmental model of cultural sensitivity.

The impetus of this article came from a seminar concerning issues that arise in the delivery of mental health services to cul-

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tural minorities. Borrowing from a recent study in which clinicians were asked to briefly recount a time when they considered cultural factors in their evaluation of culturally different clients (López & Hernandez, 1986), the instructor asked the students, who were all involved in some clinical work, to keep a weekly journal describing how they considered cultural issues in their clinical practice. The students were enrolled in doctoral programs in either counseling or clinical psychology. The class was composed of 5 White women, 1 White man, and 1 woman born in India and raised primarily in the United States. Initially, the weekly journal assignment was viewed by the instructor as a minor adjunct to a course that was to be concerned primarily with research. The journal entries proved to be a most stimulating vehicle by which to address many of the complexities inherent in considering cultural factors. As the course progressed, the clinical issues raised by the journal entries proved to be of considerable interest to both the students and the instructor. After just a few weeks, much more time was devoted to the vignettes and the ensuing discussions than was originally planned. From these discussions came the idea that students were proceeding in a stagelike fashion as they increased their cultural sensitivity. Further discussion and reflection served to identify the hypothesized stages.

We present vignettes to illustrate the characteristics of the stages that we believe reflect the development of cultural sensitivity. Stage 1 is an unawareness of cultural issues; Stage 2 is a heightened awareness of culture; Stage 3 is the burden of considering cultural issues; and Stage 4 is moving toward the integration of culture in one's clinical work. After presenting the vignettes representative of each developmental stage, we describe the stage, paying particular attention to what we believe to be the critical processes associated with the therapist's development. Furthermore, to assess this model's comparability with previous work, we discuss how each stage compares with those presented in other models of therapists' development (Loganbill et al., 1982; Stoltenberg & Delworth, 1987). Last, we offer a research agenda to assess the social cognitive processes that underlie this developmental model.

It is important to note that we broadly define culture as the values, beliefs, and practices that are frequently shared by groups identified by variables such as ethnicity, gender, and sexual orientation. Although nearly all of the vignettes concern ethnic minority group members, there are references to issues concerning gender roles and sexual orientation. Though few in number, the latter references illustrate our belief in a broad definition of culture.

Developmental Stages

Perhaps the biggest struggle for psychotherapists and students who attempt to consider cultural factors in therapy is to know when to apply specific norms for a particular group member and when to apply universal norms. This conflict has been identified as the etic-emic conflict: Etic refers to universal norms, and emic refers to group-specific norms (Draguns, 1981). Practitioners can err on the side of assuming that certain behaviors have the same meaning for all persons, when in fact the meaning of these behaviors is quite different for certain cultural group members. Egeland and her colleagues made this point in describing how diagnosticians may have misinterpreted the nervous laughter of Amish bipolar patients as characteristic of a hebephreniclike schizophrenia, instead of social anxiety that results from being in a public institution (hospital) outside the Amish community (Egeland, Hostetter, & Eshleman, 1983).

In contrast to this type of error, therapists can err in the opposite direction of applying special norms to the behavior of a specific group member, when in fact the special norms may not apply; rather, a more universal norm is more appropriate. On the basis of a survey of how mental health professionals consider culture in evaluations, López and Hernandez (1986) provided suggestive evidence of this second type of error. They found that clinicians were at risk to normalize or minimize their judgments of pathology when taking cultural factors into account. For example, one clinician reported that he judged a Hispanic woman's ego strength in a more positive light because her culture "condoned" men's having extramarital affairs. In other words, he saw the woman as better adjusted as a result of his consideration of the Hispanic culture. Although cultural adjustments may be appropriate in many cases, such adjustments may be inappropriate in other cases, as suggested by the example.

Unlike the clinical judgment reflected in the examples just given, cultural sensitivity refers to clinicians' ability to balance a consideration of universal norms, specific group norms, and individual norms in (a) differentiating between normal and abnormal behavior, (b) considering etiologic factors, and (c) implementing appropriate interventions. In addition, an assessment of the hypotheses generated by these differing perspectives, rather than an a priori acceptance of a given perspective, further reflects cultural expertise. For example, it may be true that some Hispanic woman view their husband's extramarital relationships as culturally normative and acceptable behavior; however, many Hispanic women do not. Moreover, there is no systematic evidence to support the notion that the marital relationships of Mexican Americans, for example, are characterized by a dominant husband and a submissive wife (Cromwell & Ruiz, 1979). Therefore, it is critical that clinicians vigorously assess what the client's view is in regard to the supposed culturally normative behavior. A failure to do so could result in the clinician's minimizing or overlooking actual pathology (López, 1989; López & Hernandez, 1987). Cultural sensitivity then involves balancing different norms and constantly testing alternative hypotheses. The following stages reflect the student-therapists' development of these important skills. (See Table 1 for a summary of the proposed developmental stages of cultural sensitivity.)

An Unawareness of Cultural Issues

A lack of awareness regarding cultural issues appears to be an initial stage in the development of cultural sensitivity. The following two vignettes reflect the therapist's failure to consider the potential role of culture in shaping the presenting problems.

A 41-year-old man requested an emergency session in regard to his marriage. Upon his request, I saw him Saturday morning. He spoke
With an Asian accent, and identified himself as half Chinese and half Spanish. He was born in China.

As we discussed his presenting problem, he resisted any of my suggestions that perhaps part of his problems had to do with his wife being Caucasian and her parents and siblings disapproving of him. He had come to appose his wife who said she would leave him unless he sought counseling. They have a poor sex life and he was resistant to discuss this in any detail. He kept insisting that he had the problem; he described himself as cold and not liking to be around people.

I noticed myself becoming very frustrated. He refused to accept the idea that he and his wife had a relationship problem. I guess he sensed my frustration because he asked me if I could refer him to another therapist. He had many demands regarding times to be around people.

One family that I worked with for almost a year at the clinic has been a Hispanic family. The mother brought her seven-year-old daughter into the clinic because she was having a lot of difficulty at school and was not obeying her mother's requests. The mother had two other children, a one-year-old and a nine-year-old son, all from the same father. The mother never married the father. The father was living with another woman and their children. My client and her children were aware of this situation. The father would wander back into the family's life when he so desired and assume a parental role, resulting in major disturbance in the children's behavior.

The mother’s choice to remain indecisive regarding her relationship with this man greatly affected the children’s self-esteem and their acting out. The children were attached to their father and would beg him not to leave. Sometimes he would promise to attend a school activity and would not show up. In therapy, I wanted to focus on the mother’s failure to set limits on the father’s visits, particularly given the children’s disruptive behavior after he left. Whenever I broached this subject, the mother did not want to talk or she was not willing to discuss this in any detail.

Reflecting back on this case, it dawned on me that maybe the couple’s dynamics reflected cultural issues more than relationship issues. Maybe in this client’s cultural upbringing it is considered normal for the husband to maintain more than one family and for the wife to accept this arrangement. Finding out about a person’s cultural norms is a very delicate and sensitive issue. How does one go about assessing the role of culture in such situations, besides doing some research of the literature pertaining to that particular ethnic community?

These vignettes indicate that the respective therapists did not consider cultural factors in their work with ethnic minority clients. In the first case, the therapist appears to be defining the problem for the client without considering the client’s definition of the problem and working from there. This is not to say that the therapist is wrong in her assessment; the client is likely having marital problems. However, her failure to validate his explanatory model (Kleinman, 1980) or interpretation of the problem may have led to his request for another therapist. In the second vignette, the clinician appears to be entertaining cultural explanations for the first time after having worked with the family for nearly a year. As one would expect, her first cultural considerations fall short of reflecting cultural sensitivity. For example, the comment that the couple's dynamics may be normal given the client’s cultural upbringing reflects a cultural stereotype. The couples’ cultural background is only one of several possible explanations for the nature of their relationship. The important point of this vignette is that for nearly a year the clinician did not consider cultural factors in the treatment of this Hispanic family.

Given the lack of sufficient attention to culture in these cases, it appears that both therapists were working from an etic or universal view in regard to their evaluation of the problems and their considerations for treatment. The cultural-specific or emic views of these patients were not entertained. As suggested by these vignettes, an early stage in the development of cultural sensitivity is adhering to an etic perspective with little or no regard for emic considerations. Given this view, therapists do not assess the cultural context of the presenting problems. The therapist’s question about how to assess the role of culture reflects this early stage of development.

This first stage parallels Loganbill et al.’s (1982) first stage in therapist training: unawareness and stagnation. In this stage, therapists are viewed as being unable to recognize difficulties and deficits in their clinical work. The therapists in both cases did not recognize the potential for cultural interpretations of the identifying problem, which was clearly a deficit in their clinical work with ethnic minority clients. Furthermore, this stage is consistent with part of the initial stage of Stoltenberg and Del-

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**Table 1**

Proposed Stages and Stage-Specific Consequences in Therapists' Development of Cultural Sensitivity

<table>
<thead>
<tr>
<th>Description</th>
<th>Consequence</th>
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<tbody>
<tr>
<td>Unawareness of cultural issues</td>
<td>Therapist does not entertain cultural hypotheses Does not understand the significance of the clients’ cultural background to their functioning</td>
</tr>
<tr>
<td>Heightened awareness of culture</td>
<td>Therapist is aware that cultural factors are important in fully understanding clients Feels unprepared to work with culturally different clients; frequently applies therapist’s perception of the client’s cultural background and therefore fails to understand the cultural significance for the specific client; can at times accurately recognize the influence of the clients’ cultural background on their functioning</td>
</tr>
<tr>
<td>Burden of considering culture</td>
<td>Therapist is hypervigilant in identifying cultural factors and is, at times, confused in determining the cultural significance of the client’s actions Consideration of culture is perceived as detracting from clinical effectiveness</td>
</tr>
<tr>
<td>Toward cultural sensitivity</td>
<td>Therapist entertains cultural hypotheses and carefully tests these hypotheses from multiple sources before accepting cultural explanations Increased likelihood of accurately understanding the role of culture in the client's functioning</td>
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worth's (1987) developmental model, specifically the domain that they referred to as “individual differences.” This concerns, in part, clinicians’ awareness of cultural differences. Stoltenberg and Delworth pointed out that beginning therapists either downplay cultural differences or exaggerate them. Our experience at this early stage of development is consistent with the former: Culture is not even acknowledged.

Growth toward an awareness of the importance of culture likely came about because of the student-therapists’ participation in a course focusing on culture and mental health. Outside influences such as coursework, supervision, or personal experience may serve as an impetus for therapists to begin valuing the cultural context of their clients’ lives. These influences help therapists learn that there are many valid world views or frames of reference other than their own. Furthermore, clinicians begin to respect these various interpretations and begin not to judge them as better or worse with respect to psychological adjustment. Therapists without this perspective may plod along until they note a pattern in the premature client-initiated terminations of their culturally different clients or until they recognize their frequent misinterpretations with these clients. Even then, clinicians may not be open to the notion of cultural variability. Another impetus for considering culture can come from clients themselves, who educate therapists in regard to the significance of cultural nuances. Without such experiences, clinicians are likely to remain in Stage 1, with little awareness of the importance of culture. As a result, culturally different clients are likely to receive less-than-optimal mental health care.

A Heightened Awareness of Culture

Because of previous clinical and personal experiences, not all students began the course at the unawareness stage. However, most if not all appeared to go through, to some degree, a stage in which awareness of group differences grew quite rapidly. Students reported having a heightened interest in learning about different groups. This was evident in their bringing newspaper articles to class or discussing ideas from recent journal articles related to cultural issues. Students frequently referred to this newly acquired interest or more fully developed interest with great enthusiasm, as is evident in the following vignette:

As a result of last week’s class, I realize how little I know about the experience of being bilingual. I know I was sensitive to the issue in that I was conscious of not being able to communicate with some people in their native tongue. But I did not understand the depth of the bilingual experience. This understanding reinforces my own policy as a therapist of asking clients to define the words they use. For example, I often ask my clients to explain what they mean when they say they are “gay.” I never assume that their definition and my definition are the same. I spent the rest of last week asking friends who were bilingual what it was like for them. I enjoyed talking to them to see how they use or don’t use the other language.

The appreciation of group differences seemed to have several consequences. On the one hand, it may have assisted therapists in identifying factors that would have gone unnoticed. Another apparent consequence was that students became more aware of potential difficulties in treating culturally different clients and may have been discouraged. Some students rightly questioned their ability to work with specific group members. A third consequence appeared to be an increased consideration of cultural explanations for presenting problems at the expense of considering other explanations. In other words, some student therapists may have been too quick to apply cultural interpretations. The following three vignettes capture each of these apparent consequences of a heightened awareness to group differences:

In a marital session today with a professional woman who triples her husband’s income, we were discussing the impact this fact has on the power structure in their relationship. Although the husband is glad that she brings home the money, it also contributes to a sense of lowered worth. He says that lately she has been “throwing it in his face” that she makes more money and that he should be doing more housework and parenting. I suspect that this situation is becoming more common in today’s culture. Unfortunately, the men and women of today were raised with the values and mores of yesterday. Men obtained status and value by how much money they made and women earned respect by how well they kept the house and raised their children.

This discussion led to a related gender issue. The wife was complaining that her husband kept his feelings inside and that she wanted a partner and more emotional intimacy. However, she didn’t have the energy to be his therapist. She wanted me to work with him individually to help him find his “lost self.”

Until today I had a definite bias that women were the ones who had to sacrifice their identities for the sake of their men. It occurs to me that men also sacrifice a part of their identities too—the more sensitive, vulnerable side, for the sake of being a so-called real man.

... my perspective has been jostled and I am humbled by the challenge that awaits. Increasingly I am becoming aware of how much I do not know and how many skills I have yet to acquire, and I wonder if it is at all possible. Perhaps the answer lies in being aware of my limitations and becoming more comfortable seeking answers, forgetting the awkwardness of my occasional feelings of voyeurism, and trying to enter the world of the person I am trying to understand, no matter what the initial barriers may seem to be. I can try... and I can also be aware of when I am in over my head.

Because I had done so much clinical work with low-income and minority families in New York, I thought that I had a fairly good understanding of the needs of these populations and that I was free from stereotypes and prejudice. However, I have recently begun to question how free from stereotypes I actually am. I have developed an image of what it is like to be poor, Black, and living in the slums of New York. I have associated the anger, the frustration, the aggression, and the uncontrolled behavior I have seen in emotionally disturbed inner-city children to growing up in these conditions. It provides me with a framework with which to understand the people with whom I work. As a result, I think I have been more patient with the acting-out behavior of my clients, believing that they did not know other ways to act, that they had legitimate reasons for their anger, and that patience, empathy, and structure would help them.

I am not sure that I feel too differently now. It is just that the image I have of the poor minority, inner-city family may have several variables confounded within it. As a result, I may be projecting onto families characteristics which are not there. I may also be attributing characteristics to the wrong causes. The anger, the aggression, the uncontrolled behavior, was that a function of minority status, of living in slum conditions, of having a chaotic family household, of biological factors, or of some combination of any of the above? It isn’t clear to me.

When I first started seeing Jeanne, I classified her as being from a poor, Black, slum-dwelling family. As a result, an image of this type of family was conjured up in my mind, one which may have prevented me from seeing the case in a different light. I may have
imposed my stereotypes on to this family and may have not been sensitive to some of the factors that made them different. For example, it was interesting for me to hear classmates suggest that Jeanne’s lack of ethnic identity may have exacerbated her borderline pathology. I had been attributing everything to her living in a poor chaotic family. I was not noticing the differences (which there clearly are) between Jeanne’s family and the families I saw in New York. This was an important lesson for me to learn and one which helped widen the blinders I seem to be wearing. (I realize that we all do to some extent.) In order to understand group differences, I think I need to work with a much more heterogeneous population, including wealthy White families. Only then will I begin to be qualified to make statements about group differences.

Stage 2 represents an increased awareness of group differences or an increased awareness of culture-specific issues. The developing emic perspective can lead to the recognition of issues that escaped attention in the past, as was revealed in the therapist’s recognition of the potential costs of the male role. This newfound perspective, however, is not without limitations. The heightened awareness can also lead to the recognition of one’s own lack of knowledge or training in treating certain populations, as evident in the second vignette. The responsibility of providing therapy to a client from a culturally different background may now seem overwhelming. Another apparent consequence of a growing emic view is the application of perceived culture-specific norms in situations that may call for more etic views, as suggested by the vignette of the Black family. This emic overemphasis may reflect an overcorrection of the therapist’s previous adherence to a strictly etic perspective. In all, this stage reflects a beginning awareness of culture’s import and the beginning efforts to translate this awareness into treatment.

In comparing this stage with the stages of other models of therapists’ development, we found no overlap with Loganbill et al.’s (1982) model and considerable overlap with Stoltenberg and Delworth’s (1987) model, particularly the first two developmental levels. According to the latter model, some trainees at the first developmental level may believe that the differences between cultural groups are so great that clinicians feel incapable of understanding the experience of a client with a background different from their own. This is consistent with the second vignette, in which the student-therapist wondered whether she could learn the requisite skills to treat culturally different clients. Stoltenberg and Delworth pointed out that at the second level, the trainee is likely to be more aware of cultural influences; however, he or she tends to apply this knowledge in a stereotypical fashion. This may have been the case with the therapist who worked with the African-American family. She considered the possibility that she was applying a stereotype of the urban Black family that she learned in a prior clinical setting without carefully considering the specific dynamics of that individual family.

Despite the limitations of student-therapists at this stage, they are now more amenable to training than they were in the previous stage; they now accept the view that the client’s cultural background is significant. With proper supervision, student-therapists can learn that they have the capability of understanding and helping someone from a distinct cultural group. Furthermore, they can learn to monitor their use of stereotypes and learn to be more cautious in applying what they think might be (but actually may not be) culture-specific norms. Although significant errors in considering culture are likely to occur during this stage, a heightened awareness of cultural factors appears to be critical in developing cultural sensitivity.

The Burden of Considering Culture

An unexpected development in the seminar was that some students felt overburdened with having to keep in mind ethnic issues in their clinical work, to the extent that it detracted from overall clinical endeavors. This phase seemed to appear after students passed through the heightened-awareness stage. One student aptly captured this experience in reacting to another student’s concerns:

I too have experienced the new awareness of ethnic issues as cumbersome baggage in the therapy room. I have felt that to some extent in my groups, especially since I have so many international students. I feel like for the first few weeks (maybe three or four) I felt almost intellectually preoccupied with “paying attention” to the ethnic innuendos of the group experience. I also felt preoccupied with trying to “figure out” how to process this ethnicity “stuff” once I noticed it. Then, during the past few weeks I just felt sick of being preoccupied. I decided I was just going to try to be more present and to facilitate my groups in whatever way felt natural for me. If ethnicity “stuff” came up, fine; if it got addressed, fine; if it did not come up, fine; if it did not get addressed, fine. I just wanted to shake off this sense of being preoccupied and I missed being more present with my groups. I have actually enjoyed my groups much more the last several weeks and have felt better about my work as a facilitator. I have not been as consciously aware of ethnic issues and yet the group experience has been rich, some of the discussions dealing directly with thoughts, feelings and experiences about special populations.

In reflecting on my experience it seems like this could be a developmental aspect of becoming a culturally sensitive therapist. The process of over-extension and then gradual integration may be a process that many go through in an attempt to become something new—in this case becoming culturally sensitive.

This stage may be an extension of overemphasizing an emic perspective: the developing therapist is forever vigilant in considering how culture relates to the clinical material even when it may not be relevant, or this stage may reflect the therapist’s awareness of the increased effort that is required to integrate an emic perspective. Whatever the explanation, most students appeared to go through this phase, which suggests that this sense of feeling burdened is part of the normal progression toward cultural sensitivity. It is important for therapists who go through this stage to distinguish between their devaluing cultural issues and their beginning to integrate this newfound awareness in a mature manner. It seems possible that a therapist could misperceive his or her growing disinterest in this area as part of a developmental stage that is leading to a greater cultural sensitivity when in fact it is leading to less sensitivity.

In Stoltenberg and Delworth’s (1987) discussion of how trainees progress in being aware of group differences, there was no mention of this type of therapists’ behavior. However, in the overall model of therapist development as presented by Loganbill et al. (1982) and Stoltenberg and Delworth (1987), the noted sense of feeling burdened may reflect a broader issue of therapists’ development addressed in Stage 2 of both models. Both groups of authors suggested that as students question and challenge old ways and values, they become confused and am-
bivalent. Students rightly question their old views about their clients and their roles as therapists, but they are not yet able to integrate new perspectives. Stoltenberg and Delworth referred to this stage as one of "adolescence." Although a sense of confusion and ambivalence is different from the sense of feeling burdened that we identified, there are similarities. Perhaps this feeling of being burdened reflects the trainees' confusion over how much to emphasize cultural issues, or perhaps it reflects ambivalence regarding the significance of culture. In either case, the three developmental models are consistent in that this stage is viewed as the critical transition to "adulthood" in practicing psychotherapy and, more specifically, practicing psychotherapy with culturally diverse clients. Supervisors who provide a supportive atmosphere and allow student-therapists to voice their sense of feeling burdened or their confusion are likely to contribute to their trainees' maturing cultural sensitivity.

**Toward Cultural Sensitivity: A New Synthesis**

The following vignette reflects a more sophisticated view of cultural issues, one that best approximates a culturally sensitive approach. In this case, the therapist considered a cultural explanation for a child's behavior and collected additional data to assess the appropriateness of this explanation.

I worked for several summers at a camp for emotionally disturbed children. The population of children is largely Black and Hispanic; most are from low-income, inner-city families. During my first summer as a supervisor, a problem arose with a five-year-old Hispanic girl who was refusing to take showers at night and had difficulty dressing and undressing with other people around. She was throwing huge tantrums and required considerable individual attention from her female counselors. They were about to install a behavior modification program to get her to take showers and dress in the morning. Her behavior was considered to be a consequence of her emotional disturbance. However, it was not clear to me that her tantrums were symptoms of emotionally disturbed behavior. She seemed terrified of being violated. I wondered if there might be any issues related to her cultural background and/or upbringing. I called her parents to discuss this case. They confirmed that the child was brought up to be very modest about her body and to not expose herself to anyone except her mother. One can imagine the terror that this child must have been feeling when her counselors were trying to get her in the shower. The staff was asking her to violate her parents' code of honor and to act in ways that previously would have resulted in punishment. A behavior modification plan would have been disastrous. Instead we took the cultural issues into consideration and modified camp rules, allowing her to shower with just one other adult and to dress quickly after other children had left the bunk. The tantrums stopped. I learned a very big lesson in considering more than one angle on a case. Issues arose for me concerning whether presenting problems were a reflection of upbringing, of culture, and/or of emotional disturbance.

The therapist in this vignette acted in a culturally sensitive manner because she went beyond both the etic and emic perspectives by considering the cultural relevance as it applied to the individual client. She hypothesized that the girl's "tantrums" might be related to cultural or familial beliefs about undressing in front of others. Instead of assuming that the child's behavior was culturally based, as might have been the case for a therapist in Stage 2, the therapist very appropriately contacted the parents, who verified the cultural hypothesis. Thus clinicians in this stage of development (a) recognize the importance of culture and behavior, (b) are able to entertain more than one interpretation of their client's observed behavior (in this case, tantrums vs. fear), (c) have some knowledge of how culture influences behavior, and (d) collect clinical data to test their cultural hypotheses.

This stage is consistent with the last stage of the general developmental models offered by Loganbill et al. (1982) and by Stoltenberg and Delworth (1987). In general, their final stages represent a synthesis or an integration of the new and old learning. Unlike their earlier stages of confusion and transition, clinicians in this final stage, like the therapist in the vignette just given, are able to apply new perspectives to their clinical endeavors. Our stage is also consistent with the manner in which Stage 3 therapists, as designated by Stoltenberg and Delworth, address group differences; they are able to balance a consideration of the individual and his or her cultural background without applying stereotypes. In sum, there is considerable overlap between the last stage of our model and the last stage of the other two models.

In the next and final vignette, a student summarized her personal development in increasing her cultural sensitivity. Whereas the previous vignettes represented only one developmental stage, this entry reflects passage through most of the identified stages. Furthermore, she rightly identified the ongoing struggle in assessing whether specific group norms or more generic norms are applicable to a given client.

I know that I have passed through several developmental stages and I am becoming progressively more comfortable as the semester passes. The first few weeks I was just receptive to acquiring factual information about different cultures and how to use this information in therapy. As the weeks went by and I did more and more reading, I discovered that being culturally sensitive meant more than that. Looking at the way I process information and examining my own personal values was an important part of developing this sensitivity. I became confused as I learned to consider both etic and emic aspects of a given case. Looking back on it now, I suppose that a therapist faces the etic-emic struggle with all clients. Reflective of this struggle are the questions going through therapists' minds: How much of the symptoms and presenting problems is due to developmental issues, how much is due to society, how much is due to intrapsychic conflicts, and how much is due to family systems? I am now more relaxed with all these areas and I am now integrating the client's culture as just one more area to keep in mind as I listen and try to understand my client's life world. At first I was concentrating on ethnic issues to such an extent that I was not staying with my clients. With any beginning therapist, a new idea or perspective seems stilted and inauthentic until it becomes ingrained through practice and consultation. The cultural issues are now flowing more smoothly for me. I no longer have to think about the client's ethnicity with so much effort. It is one of the many factors to take into account during a session.

**Discussion**

In regard to training student-therapists to become sensitive to cultural issues, these vignettes suggest that it is important to view this training from a developmental perspective. Moreover, we believe that the identified stages provide a useful heuristic for understanding how therapists develop this sensitivity. Accordingly, clinicians and supervisors may be able to use these stages to monitor their own progress or that of their trainees in learning how to provide culturally sensitive psychotherapy. For
example, knowing that therapists may feel the consideration of cultural factors to be burdensome may assist supervisors in better addressing this issue in the therapist’s development. With this knowledge, supervisors might best be supportive, allowing trainees to vent their frustrations. Validation of this frustration might serve to facilitate the therapists’ progression to the integration stage. Supervisors without this developmental perspective might perceive the trainees’ sense of feeling burdened as resistance to cultural issues and possibly intervene to challenge this “resistance.” Such an approach is less likely to further the development of cultural sensitivity.

The vignettes also suggest that the etic–emic conflict (Draguns, 1981) is a useful conceptual tool for understanding clinicians’ development of cultural skills. We found that therapists progressed from an etic perspective to an overemphasized emic perspective and then to a balanced etic–emic perspective. It is worth noting that cultural sensitivity is not the replacement of etic (universal) norms with emic (culture-specific) norms. Rather, it is the ability to entertain both etic and emic views within the context of the individual.

Although some students appeared to progress through the identified stages in the outlined sequence, it is important to note that others did not. For some students, their early work at times reflected cultural sensitivity, whereas their later work at times did not. Also, there were times when students showed considerable insight into cultural issues with one client but not with others. There are many plausible explanations for this variability. Some students had considerable exposure to cultural issues before the course, although few, if any, had previous opportunities to integrate an academic/research focus with a clinical focus. Another explanation is that there were differing levels of motivation to explore these issues. Also, the noted variability may have been in part a function of the therapists’ clients; some clients and their presenting problems may have facilitated cultural sensitivity for a given therapist, whereas other clients may not have elicited such sensitivity. Probably the best explanation is that this developmental process, particularly early in one’s training, may be better characterized as a fluid, discontinuous process than as a continuous stage-like process.

The implication of considering therapists’ development as fluid and discontinuous is that sensitivity to cultural issues is a process or a set of processes in which clinicians must engage with each client throughout psychotherapy. Given the ongoing nature of this process, we do not assume that the students in this course are now definitively culturally sensitive and will function as resistance to cultural issues and possibly intervene to challenge this “resistance.” Such an approach is less likely to further the development of cultural sensitivity.

We encourage researchers to test and further refine the proposed developmental stages of cultural sensitivity. We propose beginning a program of research to assess clinicians’ development of cultural expertise by examining two important concepts: clinicians’ knowledge base and hypothesis-testing strategies. These concepts are drawn from our understanding of the development of cultural sensitivity and from social cognitive research on how we make sense of our world (Fiske & Taylor, 1984). Of particular interest is how such researchers have conceptualized and studied differences between novices and experts in nonclinical domains (Fiske, Kinder, & Larter, 1983; Showers & Cantor, 1985).

In regard to knowledge base, psychotherapists should have various amounts of information concerning culture and its relation to psychopathology, assessment, and intervention. Clinicians unaware of cultural factors (Stage 1) are likely to have little cultural knowledge, whereas clinicians at later stages are likely to have more cultural knowledge. At the last stage, not only should therapists have the greatest amount of information, but such information should be most efficiently organized. For example, therapists with more cultural expertise should have more linkages among concepts stored in memory, which would allow quick and easy access to the underlying body of information.

With regard to hypothesis testing, clinicians who are unfamiliar with the significance of cultural factors (Stage 1) are unlikely to entertain cultural hypotheses as explanations for the client’s presenting problem. They are not likely to know that the client’s cultural values can shape the meaning that the client ascribes to his or her functioning. At Stage 2, a heightened awareness of culture, not only are clinicians likely to entertain such hypothesis, but they are likely to apply them in a stereotypic fashion, failing to consider other plausible hypotheses. At this stage, therapists are likely to use a confirmatory hypothesis-
testing strategy, collecting only evidence that confirms their cultural explanation (Snyder & Thomsen, 1988). Hypothesis testing may also explain, in part, the sense of feeling burdened that trainees experience in Stage 3. Their feelings of overload may be the result of overusing cultural explanations, even for behavior or presenting problems that are not likely to have cultural associations. This may then interfere with their consideration of other important hypotheses.

In the final stage of development, therapists are expected to more discriminatingly generate cultural explanations and then reject or accept such explanations after carefully considering multiple hypotheses. This careful evaluation of all plausible hypotheses is likely to represent a disconfirmatory hypothesis-testing strategy in which clinicians seek evidence to disconfirm cultural and noncultural hypotheses alike (Snyder & Thomsen, 1988). By doing so, psychotherapists are more likely to avoid biases in their evaluation and intervention with culturally diverse clients.

These rather general research hypotheses are presented as recommendations to begin examining the development of cultural sensitivity. Although we have not discussed specific methodologies, the interested reader is encouraged to examine specific studies of expertise (e.g., Fiske et al., 1983) and overviews of social cognition and related research (Abramson, 1988; Fiske & Taylor, 1984; López, 1989; Showers & Cantor, 1985; Turk & Salovey, 1988) to identify the significant methodological issues pertaining to this type of research.

Conclusion

The development of cultural sensitivity is an ongoing process that requires an ongoing dialogue. The vignettes demonstrate that trainees are able to monitor their personal reactions to significant cultural issues, thereby contributing to this dialogue. We hope that clinicians take the necessary steps to continue this dialogue by sharing their questions, thoughts, and feelings about cultural issues with supervisors, colleagues, and, to some extent, their clients. The willingness to address these issues in an open fashion will likely lead to a reduction in the stereotypes, misunderstandings, and prejudices that can adversely affect the quality of therapy to all. A frank dialogue can also contribute to generating the necessary research agenda to better understand the development of cultural sensitivity in psychotherapists.

References


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