HANDBOOK OF PSYCHOTHERAPY SUPERVISION

edited by
C. Edward Watkins, Jr.

1997

John Wiley & Sons, Inc.
New York • Chichester • Weinheim • Brisbane • Singapore • Toronto
CHAPTER 29

Cultural Competence in Psychotherapy: A Guide for Clinicians and Their Supervisors

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The purpose of this chapter is to outline a model of culturally competent psychotherapy that can be used to guide both supervisors and trainees in their clinical work with culturally diverse clients. Since Lópe (1977), I have been interested in operationalizing what it means for clinicians to integrate a cultural perspective. Cultural competence, multicultural competence, and cultural sensitivity all concern therapists’ ability to treat people of diverse cultural backgrounds in ways that respect, value, and integrate their sociocultural context (Comas-Díaz & Griffith, 1988; Cross, Bazzon, Dennis, & Isaacs, 1989; Kleinman, 1988; Pedersen & Ivey, 1993; Ridley, Mendoza, Kanitz, Angermeier, & Zenk, 1994; D. W. Sue & D. Sue, 1990; S. Sue & Zane, 1987; Vargas & Koss-Chicino, 1992). In an effort to study the empirical basis of cultural competence, I first began by examining practitioners’ clinical judgment, particularly their judgment of clients’ presenting problems and symptomatology (Lópe, 1983, 1989; Lópe & Hernandez, 1986, 1987). Based on qualitative observations of clinical trainees, I then extended my work to psychotherapy (Lópe et al., 1989). More recently, I have applied these ideas to formal psychological assessment (Lópe, in press; Lópe & Taussieg, 1991).

In this chapter, I critically review this line of research and the model of cultural competence that it suggests. Next I address the model’s limitations, in part by drawing on Kleinman’s (1988) cultural perspective. I then present a revised model of cultural competence and illustrate the model with clinical cases of my own. I have chosen to present some of my mistakes and oversights as a means to discuss what culturally competent psychotherapy is. Addressing cultural issues in one’s clinical practice can at times be difficult. It is important to establish and maintain an open dialogue about these matters with colleagues, supervisors, and trainees. By discussing my slips and errors, I want to demonstrate that part of maintaining such a dialogue requires that we reveal our vulnerabilities, which include our errors, oversights, questions, and uncertainties.

The model of cultural competence presented here is applicable to one’s clinical work.

I refer to culturally diverse individuals as those from U.S. ethnic and racial groups other than the majority group of Euro-American backgrounds. These groups include the four largest ethnoracial groups in the United States, African American, American Indian, Asian American, and Latino American, as well as groups of mixed ethnoracial heritage and other recent immigrants (e.g., Persians).

Note: I would like to thank Rena Repetti for her most helpful comments on a previous version of this chapter.
with ethnic majority and minority clients alike. The principles of effective psychotherapy and culturally competent psychotherapy overlap. I believe, however, that the application of a cultural perspective is particularly important in working with clients from ethnocultural minority groups. In working with clients from culturally diverse backgrounds, the implicit and explicit models of human behavior are less likely shared by the client and clinician, particularly when the clinician is from a different ethnocultural background than that of the client. These differences may impede the provision of effective mental health care. Thus, although the model of culturally competent psychotherapy presented here is likely to be applicable to the treatment of clients from all ethnocultural groups, it may be most applicable to the treatment of people from ethnocultural minority groups.

DEVELOPMENT OF A CULTURAL COMPETENCE MODEL

In my prior clinical judgment research, I demonstrated that clinicians can both overpathologize and minimize actual pathology given their understanding of the cultural context of their clients’ behavior (López, 1989; López & Hernandez, 1986). Let us consider the case of a highly religious and spiritual person who reports hearing God’s voice directing him to take certain actions in his life. If a clinician assumes that hearing voices reflects psychosis, without assessing the possibility that this experience may reflect a culturally normative belief, then the clinician is at risk to judge culturally normative behavior as reflecting pathology. If hearing God’s voice is indeed reflective of the patient’s religious or spiritual belief system and not psychosis, then this would be an instance of overpathologizing, judging normative behavior within a specific cultural context to reflect more pathology than is actually the case. This is the type of mistake that most writers refer to when pointing out errors that clinicians can make when not familiar with the cultural context (e.g., Jones & Korchin, 1981).

Much less attention has been given to a second type of error, first recognized by Chess, Clark, and Thomas (1953). This error is referred to as a minimizing error or underpathologizing actual symptomatology. To continue with the example of hearing God’s voice, if this experience is judged to be reflective of a client’s religious or spiritual background, without careful assessment of the client’s religious or spiritual values, or of the possibility that this may be psychosis, then the clinician is at risk to judge a symptom of psychosis as normal behavior. If hearing God’s voice is indeed reflective of psychosis, then this would be an instance of a minimizing error, that is, judging abnormal behavior within a specific cultural context to reflect more normative behavior than is actually the case. The main difference between the overpathologizing and the minimizing errors is that in the former case, the clinician fails to consider the client’s cultural context. In the latter case, the clinician indeed considers cultural factors but does so without taking into account the applicability of such factors for the specific client.

To assist clinicians in considering the role of culture in their evaluations, my colleagues and I argued that it was important for clinicians to keep in mind the cultural context in evaluating clients, but to do so carefully. Given the increasing push for clinicians to apply alternative cultural norms, clinicians may not be carefully applying these alternative cultural norms. For example, one therapist described in the following case summary how she considered the client’s cultural background:

In my work with a particular Hispanic female, my judgment of her ego-strength or self image was quite different than it would have been had I not taken into account cultural patterns which “condoned” the male being unfaithful and having other relationships. Accepting this
practice is not considered a deviant choice in a female of the Hispanic culture. (López & Hernandez, 1986, p. 603)

In this example, it is not clear how this practitioner knew that the client accepted extramarital affairs as part of her cultural norm. Given the great heterogeneity among Latinos, there are many women and men who do not hold this cultural norm. Thus, whereas it is important to consider culture-specific norms in clinical evaluations, it is equally important to assess the client’s adherence to the presumed cultural behavior pattern.

In a qualitative study of how student-therapists take culture into account in their clinical work with culturally diverse clients (López et al., 1989), we expanded the notion of considering the cultural basis of specific presenting problems to identifying cultural competence in psychotherapy. We learned that cultural competence reflects moving between alternative cultural frameworks. We argued that the alternative cultural lenses were those that reflected culture-specific (emic) belief systems and culture-general (etic) belief systems. We drew from previous cross-cultural research (Draguns, 1981) that suggested working with culture requires balancing both culture-specific and culture-general norms. Culture-specific belief systems were thought to pertain to the cultural group to which the client belonged. For example, a parent who often interrupts his or her son during family therapy sessions may be judged as reflecting culture-specific processes, such as beliefs that adults’ roles have greater value than those of children. Thus, in this context, the interruptions would not be viewed as family dysfunction. Culture-general belief systems, on the other hand, were thought to pertain to most if not all groups, those which could be considered universal. Therefore, the same behavior of a parent’s interruptions in family therapy sessions could be construed from a culture-general position to reflect intrusiveness, an aspect of the family’s behavior that reflects dysfunction. In López et al. (1989), we argued that a culturally competent therapist collects data to test hypotheses derived from both culture-specific and culture-general frameworks. The culturally competent therapist does not assume that any one perspective is applicable. Instead, he or she checks out their applicability with each individual. By doing so, the clinician considers the cultural context without stereotyping.

We later applied the notion of entertaining presumed culture-specific and culture-general norms to psychological testing, particularly in the assessment of Spanish-speaking adults (López & Romero, 1988; López & Taussig, 1991). We argued that the norms based on a U.S. standardization sample could be considered culture-general norms, as psychologists oftentimes apply such norms in assessing people from many different cultural backgrounds. (We later discuss the limitation of this assumption.) When using these presumed culture-general norms, Spanish-speaking elderly were found to be functioning at an impaired level when they were not impaired. In other words, normal elderly, without any history of impairment, were found to be functioning in the below-average range of cognitive-intellectual functioning because the test norm was not appropriate for them. The U.S. standardization sample was higher in educational level and socioeconomic status than the Spanish-speaking adults, thus leading to the impression that they were low functioning. This finding is similar to the overpathologizing error that was noted earlier, that is, failing to consider the cultural context and thus overestimating the degree of pathology. On the other hand, we also found evidence that when presumed culture-specific norms were used, that is, norms based on Spanish-speaking adults from a low-income and a low educational background, Spanish-speaking elderly with significant cognitive impairment were found to be functioning at a higher level than they actually were. Specifically, using such culture-specific measures underestimated the degree of cognitive impairment when compared to other mea-
sures of impairment, such as activities of daily living (e.g., ability to eat by oneself) and a global cognitive impairment measure. Based on a standardization sample characterized by low education and low socioeconomic status, the presumed culture-specific norms then may not have been sensitive enough to identify low functioning. This pattern of findings is similar to the previously mentioned minimizing error ofunderestimating the degree of pathology because an inappropriate cultural-specific norm is applied.

Given the potential error in using either the presumed culture-general and presumed culture-specific normed tests, we argued that a culturally sensitive psychologist carefully considers which norm might be most appropriate for the given individual being tested. This means, for example, not assuming that a primarily Spanish-speaking person requires Spanish language tests and their corresponding norms, particularly norms derived from a Spanish-speaking community with limited education and low socioeconomic status. Such norms might not be appropriate for a given individual, for instance, a highly educated Mexican professional. Thus, it is important to consider the fit between the individual's sociocultural background and the normative sample's sociocultural background. In addition, a culturally competent psychologist would include multiple sources of data, for example, a good history, other tests, and reports of significant others to assess properly the person from a cultural and linguistic background that is different from the majority of U.S. residents. Considering the applicability of different norms and integrating the findings from other measures reflect culturally competent psychological assessment.

EVALUATION OF PAST RESEARCH

The main contribution of this line of research is that it points out that two cultural perspectives are needed to identify the cultural meaning of given observations, whether the observations concern symptomatology, therapy-related behavior, or psychological test results. Prior research and writings that have advanced a cultural perspective have largely argued for using culture-specific norms with people of diverse cultural backgrounds (e.g., Dana, 1993; Malgady, Rogler, & Costantino, 1987). This is an important point as psychological research, in general, and models of psychopathology, therapy, and testing, in particular, too often ignore the sociocultural context (Betancourt & López, 1993; Graham, 1992; Guthrie, 1976). The disadvantage of the culture-specific perspective is that there is great heterogeneity among people from the same broad cultural group. Due to individual variability and subcultural variability within given cultural groups, what clinicians presume to be culture-specific norms may not be applicable for a given individual. Therefore, if clinicians assume that culture-specific norms are needed for specific Latino, African American, Asian American, or American Indian clients, they are at risk of misapplying norms. This is reflected in minimizing actual pathology, misunderstanding the clinical behavior of one’s client in therapy, and judging someone to be less impaired based on presumed culture-specific test results. To guard against the potential errors in ignoring the sociocultural context or overattributing clients’ behavior to their sociocultural background, it is important that the clinician consider two cultural frameworks simultaneously. In my view, this represents the essence of cultural competence, the ability of the therapist to move between two cultural perspectives in understanding the culturally based meaning of clients from diverse cultural backgrounds. Considering both cultural perspectives has been an important contribution of this work thus far.

A related strength of this work is that it focuses on process, not content. Process refers
to *how* therapists ascribe meaning rather than *what* therapists know about specific groups. Much of the past literature advancing a cultural perspective emphasizes the ways in which cultural groups differ from the majority group with regard to illness categories, cultural values (e.g., individualism versus collectivism), reliance on families, use of alternative healers, and so forth. Oftentimes, books about cultural issues in clinical practice are organized around the different ethnocultural groups. In these books, authors highlight the specific issues relevant to providing clinical services to these groups. On the one hand, it is important for clinicians to learn about the different sociocultural issues pertinent to each group. However, the data to support much of what is believed to be culture-specific is limited (López, 1988). For example, the notion that Latinos somatize psychological distress, a notion commonly held by clinicians (López, Nuñez, & Magaña, 1993), is based on very limited data. Yet, it is frequently noted as a culturally acceptable way in which Latinos express their distress. Given the limited database, content approaches to cultural competence can lead to either creating or reinforcing stereotypes of given groups. Ultimately, as educators and researchers, we want to broaden, not limit, clinicians’ thinking about specific cultural groups. (See S. Sue & Zane, 1987, for another process model regarding culture and therapy.)

The advantage of focusing on the process of how to ascribe meaning in one’s clinical work is twofold. First, it recognizes the importance of culture-specific norms. In other words, this process orientation acknowledges that there are alternative meanings of given behaviors depending on specific sociocultural contexts. Accordingly, this approach addresses past concerns of clinicians overlooking the clients’ cultural context. Second, this process (meaning) approach recognizes the considerable heterogeneity within cultural groups. By focusing on how clinicians know which cultural meaning to apply in specific contexts, stereotyping can be significantly reduced. The focus on process in ascribing cultural meaning is an important strength of this past research.

In addition to considering the strengths of the ideas generated by the prior research, it is also important to recognize their limitations. The first weakness is that the two cultural perspectives used by clinicians cannot be considered culture-specific and culture-general. What we first labeled in López et al. (1989) as culture-general is really the therapist’s culture-specific framework. It was rather presumptuous of us to consider the therapist’s framework as reflecting what might be considered culture-general or universal belief systems. The therapist is immersed in his or her culture-specific context to the same degree as the client. Although an imposed-etnic or a tentative culture-general view (Berry, Poortinga, Segall, & Dasen, 1992) perhaps best captures how we applied this notion in the past, it still implies a hierarchy. According to this view, the clinician’s framework is thought to be closest to what might be considered universal, whereas the culturally diverse client’s framework is simply reflective of a specific cultural perspective. Assuming such a hierarchy, whether implicit or explicit, is wrong. It is important to recognize that both the client’s and the clinician’s frameworks reflect specific cultural lenses. This does not mean that universals or shared human processes do not exist. Universals indeed exist. However, for the clinical context, ascribing meaning to specific cultural contexts is most important. For that reason, I emphasize the cultural particulars of clients’ and clinicians’ perspectives.

A second limitation of this line of research is that it has primarily focused on assessment, from clinical judgment of presenting problems and symptomatology to formal psychological testing. In López et al. (1989), we applied and extended the initial ideas identified in a clinical judgment context to the broader context of psychotherapy. The examples we used, however, still very much reflected a clinical judgment perspective. This may not be sur-
prising, as clinical judgment underlies a great deal of clinical work throughout therapy. Nevertheless, our use of clinical judgment tended to reflect one aspect of therapy, assessment. Although assessment is an important component of psychotherapy, there are other aspects to consider, specifically those directly related to intervention. It is important that models of cultural competence in clinical practice apply to intervention as well as to assessment. I now address the noted limitations, and, in doing so, present for the first time this process model of cultural competence across several specific domains of psychotherapy.

A PROCESS MODEL OF CULTURAL COMPETENCE

The essence of cultural competence in working with clients from diverse cultural groups is moving between two cultural perspectives, that of the therapist and that of the client. It is important to recognize that each perspective reflects a specific sociocultural context. Both the therapist and the client maintain their own culture-specific frameworks. One advantage of this view is that no hierarchy in meanings or cultural frameworks is assumed. The client’s cultural perspective is thought to be as valuable as the clinician’s cultural perspective. For example, some clients express distress in somatic terms (e.g., headaches, physical weakness), whereas most clinicians frame distress in psychological terms (e.g., anxiety and depression). The differences in conceptualizing distress may reflect different cultural frameworks. Recognizing that both clients and clinicians operate from their own culture-specific perspectives, particularly when they are from different ethnocultural backgrounds, may contribute to reducing the risk of clinicians imposing their model of functioning as the ideal model. Instead, the clinician’s culture-specific model may simply be an alternative model to that of the client’s.

Moving between two culture-specific models is consistent with the work of Kleinman (1988). Drawing from anthropological theory and methods, he has advanced a cultural perspective for mental health research, practice, and training. In my view, Kleinman’s single most important contribution has been to communicate for the mental health researcher and clinician the value of moving between the professional and lay systems of meaning to ascribe meaning to behavioral observations. This is captured in the following quote about the ethnographer’s mission:

The ethnographer’s focus moves back and forth. The task is to interpret patterns of meaning within situations understood in experience-near categories; yet, ethnographers also bring with them a liberating distance that comes from their own experience-near categories and their existential appreciation of shared human conditions. . . . Getting at mediating psychological processes requires that eventually we shift to the view from afar—we cannot otherwise abstract universalizing processes from the particularizing content of ethnopsychological meaning—but to understand actual situations we must use both lenses. (Kleinman & Kleinman, 1991, p. 278)

Kleinman has demonstrated the utility of this ethnographic approach or anthropologically informed perspective to several clinical research domains, for example, the study of depression and neurasthenia in China (Kleinman, 1986), patients’ and healers’ explanatory models (Kleinman, 1980), and more recently pain (Kleinman, 1992). He has also outlined in general terms the application of this perspective to clinical training and practice (Kleinman, 1988).

It is important to translate the notion of moving between the lay and the professional systems of meanings for treating clients of culturally diverse backgrounds. Building on both
my prior research and Kleinman’s important conceptual contribution, I now extend this
cultural perspective to four specific domains of clinical practice: engagement, assessment,
topraphy, and method. These domains are not unlike what Kleinman (1988) has identified as
three universal aspects of symbolic healing: identifying the casual agent (assessment and
theory), applying therapeutic procedures (methods), and removing the casual agent within
an interpretative system (theory). Nor are they unlike the areas of psychotherapy identified
by S. Sue and Zane (1987) in their influential work on culture and psychotherapy. They
argued that therapists’ credibly, or client’s perception of the therapist as an effective
helper, can be achieved in three specific domains; conceptualization of the problem, means
for problem resolution, and treatment goals. Also, the clinical observations of Bernal and
Flores-Ortiz (1982) in treating Latino families overlaps with the areas of psychotherapy that
I have identified, particularly their concern with engagement and evaluation.

There probably is no one correct way to organize the domains of psychotherapy, in part
because there is considerable interrelatedness between domains. What the client presents
as the problem during the engagement process is going to be related to the therapist’s assess-
ment, theoretical formulation, and treatment. Despite this overlap, it is useful to discuss the
different domains to ensure that most aspects of psychotherapy are considered.

Given that the focus of this book is on clinical supervision, it is important to consider
cultural issues in contexts other than those pertaining to the specific interaction between a
therapist and a client. These include observations of other therapist-client interactions, case
conferences, and interactions with one’s supervisors. A cultural perspective that respects the
sociocultural context of the specific interactions can be applied to these areas as well.

Engagement

Two of the most important issues that arise in the early phase of psychotherapy are defin-
ing the problem and setting the treatment goal(s). A culturally competent therapist is able
to understand what the client views as the problem and what the client wishes to gain
from therapy. At the same time he or she may need to maintain a formulation of the prob-
lem and treatment goals that differ in significant ways from those of the client. If this is
the case, it is important that the clinician consider simultaneously both the lay and the pro-
essional perspectives in the early phases of therapy. From the point of view of the client,
the therapist understands his or her specific circumstances well. From the point of view
of the therapist, key theoretical issues, diagnostic formulations, and historical factors are
entertained as hypotheses. A careful balancing of both perspectives is oftentimes neces-
sary to successfully engage the client in psychotherapy. In the following case, such a bal-
ance was not achieved. I did not adequately assess the client’s views with regard to her
problem, nor did I properly consider her perception of appropriate treatment goals:

Maria\textsuperscript{2} is a single Mexican American woman, 23 years of age. She has some college edu-
cation and was working in a law firm as a high-level secretary. During the first session, she
pointed out a number of factors that contributed to her seeking help. Her boyfriend had left
her, and she felt her brothers and sister were taking advantage of her occasional financial
assistance. Maria reported that a minor incident occurred at work, and she went to the bath-
room crying for about 15 minutes. She indicated that she had overreacted and probably needed

\textsuperscript{2}In presenting case material, the client’s name and, in some cases, the client’s background in-
formation have been changed to maintain his or her anonymity.
psychological help. She acknowledged some depressive symptoms, but not severe enough to warrant a diagnosis of major depression or dysthymia.

During the second session, Maria focused primarily on her relationship with her father. She stated that her father held rather traditional beliefs. He did not allow her to date till she was 18 years old, to receive phone calls at home, or to participate in after-school activities. In addition, Maria reported that he had a drinking problem and was at times “emotionally” abusive toward her through his yelling and his other reactions. For example, she recalled that when she decided to move out of the house at the age of 20, her father said that he would be unable to help her move. So she asked her uncle for assistance, which bothered her father quite a bit. When she and her uncle arrived at the house, the father took her keys, told her to take all her belongings, and insisted that she never come by without first calling. Maria acknowledged feeling a little angry and hurt over this and related incidents, but, in general, she appeared to minimize her emotional reactions. Toward the end of the initial session, I suggested some possible goals for therapy. One such goal was to improve her communication with her father. I indicated that eventually it would be a good idea for him to know how she feels about the way he treats her. Maria said that it would be very difficult for her to let him know this. I said that we could work on it. The possibility of opening the lines of communication with her father may have been threatening to Maria, as she responded to this possible treatment goal in an anxious manner.

At the end of the session, we set an appointment for the next visit to take place the following week. She never showed. I called and left a message on her answering machine. A week later I sent her a letter indicating that she could set an appointment at her convenience. I never heard from her again.

It is hard to know exactly why Maria did not return. Given her reaction to the possibility of speaking more directly to her father, she may not have been willing to work on improving communication with her father. In part, I had defined the problem as poor communication with her father (and others). She, on the other hand, defined the problem as her being “too emotional.”

In working with culturally diverse patients, it is important that the therapist validate the client’s definition of the problem and work toward the corresponding treatment goal. In many cases, the client and the therapist will agree on what the problem is and what the treatment goals are. In other cases, such as that of Maria, there may not be agreement. The therapist may have different ideas of what the problems and treatment goals are. In these cases, the therapist should be careful not to impose what he or she believes to be the problem and the treatment goal. Instead, within certain limits, it would be best for the therapist to demonstrate that he or she understands and accepts the client’s definition of the problem. The clinician may then entertain parallel problem definitions and treatment goals, those defined by the client and those defined by the therapist. Over time, additional problems and solutions can be identified and addressed, including those defined by the therapist. But this will take place only after having established a positive working relationship. In the case of Maria, such a relationship had not been established.

Assessment

The collection of data regarding the client’s functioning is an ongoing process that takes place throughout psychotherapy. It can be based on both formal assessment procedures (e.g., MMPI-2) and informal procedures (e.g., clinical interviews). Because of space limitations, only the use of formal assessment tools is discussed here.

As noted earlier, culturally competent assessment requires the application of two sets of cultural-specific norms, that of the mainstream culture and that of the client’s culture. Using
both sets of norms reduces the potential errors in using just one set of norms. There are two ways of using two sets of norms. First of all, one can administer two versions of the same test, one that is normed on an English-speaking U.S. standardization sample and one that is normed on a standardization sample reflective of the cultural and linguistic background of the individual client. For example, in assessing a bilingual Latino child, a psychologist might administer the English-language WISC-III as well as one of the two Spanish-language versions of the WISC-R that were normed on a Mexico City public school sample (WISC-RM; Gomez Palacios, Padilla, & Roll, 1984) and on a Puerto Rican Island standardization sample (EIWN; Herrans & Rodríguez, 1992). Although ideal, having available two sets of empirically derived norms for the same test is more the exception than the rule. There are few standardized tests that have been normed on an English-speaking U.S. standardization sample and on a linguistic, ethnic, or racial minority group standardization sample as well.

With no alternate group-specific normed tests, psychologists may then entertain subjectively determined norms. In other words, psychologists may adjust their interpretation of the test scores on the basis of the client’s linguistic or cultural background. Take the example of a limited English-speaking woman from Southeast Asia who runs a successful business. On a given test, her scores fall within the borderline range of cognitive-intellectual functioning. One set of culture-specific norms that could be used then are the test’s “mainstream norms.” The psychologist, however, may judge that the person’s limited English language skills contributed to the test scores as underestimating her psychological functioning. This interpretation rests on the assumption that there are no data to suggest other plausible explanations for the inconsistency between her test performance and her functioning in daily life. By interpreting the test data in this manner, the psychologist is adjusting the available set of norms and, in essence, applying a second set of culture-specific norms, specifically, norms for people with limited English-language skills. In this case, the culture-specific norms are subjectively derived.

Clinical judgment is required in deciding how to use the two culture-specific norms, whether they are empirically derived norms or a combination of empirically derived and subjectively derived norms. It is important that the psychologist carefully consider all available data to decide how best to use both sets of norms. It could be that the data from the two sets of norms converge. In that case, the psychologist can argue with some confidence that the person’s level of functioning is the same across cultural contexts. It could also occur that the data from each set of norms suggest a different level of functioning. In that case, the psychologist has two options: to argue that either the data from one set of norms are more applicable or that the data from the both sets of norms are equally applicable, depending on the cultural context. In the former case, the client’s clinical history, the report of significant others, and other test data may converge to support one set of norms more than the other. Accordingly, the psychologist would apply what appears to be the more appropriate test norm. When there is not a clear convergence of the available data, however, it could be that both sets of norms are applicable, depending on the sociocultural context. In other words, when compared to an English-speaking U.S. standardization sample the client is functioning at a particular level, and when compared to a standardization sample from the person’s linguistic and cultural background the client is functioning at a different level. This interpretation reflects the possibility that an individual’s psychological functioning may vary depending on the sociocultural context. A slightly different interpretation is that the person’s actual performance may change under different linguistic circumstances because of anxiety or other factors.

Regardless of how psychologists interpret data from two sets of culture-specific norms, the important point is that culturally competent assessment requires that data be obtained
from the vantage point of mainstream norms as well as culture-specific norms. The following case, which took place during my internship year, illustrates the value of using two cultural perspectives:

Mrs. Encinas, a 42-year-old Mexican American, was being seen by a fellow intern. He was having some difficulty in teaching her parenting skills, so he decided to assess her cognitive-intellectual functioning to determine whether it was a factor in her slow progress. Mrs. Encinas spoke English with a heavy accent. As part of the clinical training, I and the other interns, as well as our supervisor, watched the assessment through a one-way mirror. Mrs. Encinas performed poorly on the Wechsler Adult Intelligence Scale—Revised, which I attributed to her apparent limited English-language skills. After the testing, I approached both my peer and supervisor and asked if I could test her in Spanish. They agreed, as did Mrs. Encinas. We arranged an appointment for the following week.

For the second testing, I conducted the evaluation solely in Spanish; at least, that was my intention. After the first three or four questions from the information subtest, most of which she failed, Mrs. Encinas asked me, in her thick accented English, “Could we please do this in English?” I was dumbfounded—in part by her low performance in what I thought was her dominant language, but more importantly by my failure to assess her language skills. On the basis of her heavy accent, I had assumed that Spanish was her dominant language. I did not even ask her what language she preferred. It was clear that Mrs. Encinas was low functioning in both English and Spanish.

This case points out the value of using two culture norms. Had we relied strictly on the results from the English-language version, we would have had some doubt about her “true” level of functioning. We might have concluded that she was low functioning, as this was consistent with our clinical observations as well. But then, given her accented speech, the degree to which her presumed limited English-language skills were responsible for the test scores would not have been known. On the other hand, we might have simply assumed that her low performance was due to what we thought were poor English-language skills. Taking this position would have been similar to applying a second set of culture-specific norms, ones that are subjectively derived based on adjusting the English-language set of norms. In applying these norms, however, it would have been unclear how much adjustment would actually be needed. Interpretations based on only one set of norms, whether empirically derived or subjectively derived, are limited. By administering two empirically derived sets of linguistic and cultural norms, we were able to avoid having to adhere solely to the English-language norms or to the adjusted set of norms. With both sets of norms, we learned that language was not a significant factor in Mrs. Encinas’s cognitive-intellectual functioning.

Cultural competence requires the consideration of two culture-specific norms. Questioning the validity of the interpretations generated by Mrs. Encinas’s responses on the WAIS-R was necessary for two reasons: People of Mrs. Encinas’s background were either not included or were not well represented in the normative sample of these tests, and the tests are administered in English, frequently their second language. Applying a second set of cultural norms has the potential, such as in Mrs. Encinas’s case, to rule out the possibility that the observed level of functioning is related to linguistic or to cultural factors.

Theory

Theory refers to the explanatory models used to explain a person’s psychological functioning and correspondingly how therapy works to affect behavior change. For example, cognitive models of depression suggest that dysfunctional thoughts lead to depressed mood.
Therefore, to alleviate depression, therapists must help clients alter their dysfunctional thinking. A cultural perspective to psychotherapy recognizes that clients may hold theoretical models different from those held by practitioners. Accordingly, it is important that clinicians identify, recognize, and discuss the client’s model that is embedded in his or her culturally specific framework. After having defined the problem and treatment goals, the clinician would do best to understand what the client believes to be the causes of the problem and the means by which the problem is maintained. In some cases, clients may not know. In most cases, clients entertain certain notions. Some of these beliefs include that they are being punished by God; as children, they had poor relations with their parents; they are bewitched; they have an unspecified physical disorder that leads to the psychological problems; their spouse treats them poorly; they do not like their job; they can’t get a certain thought out of their minds; and so forth. The important point is that clients’ beliefs and explanations for their problems are embedded in their cultural context. Clinicians would do well to recognize these beliefs as part of their client’s cultural context and work within that context. How one integrates the client’s explanatory model is central to culturally competent psychotherapy. The following case illustrates the importance of integrating the client’s explanatory model:

Janet and her husband Jorge sought psychotherapy to help them address their long-standing marital difficulties. At the time, Janet was 37 years old and Jorge was 42 years old. They were married in Argentina 17 years earlier and had come to this country to flee the political conflict at that time. Both are college educated, but because of their limited English-speaking skills they were employed in jobs well below their level of preparation. They have two adolescent children, a boy and a girl. Therapy was conducted in Spanish.

Initially, I saw them both in conjoint therapy to improve their communication and problem-solving skills, with occasional individual sessions for each partner. In the third session, Janet reported having experienced some panic symptoms. Based on her responses to selected questions from the Anxiety Diagnostic Interview Schedule—Revised, taken from Barlow and Cerny (1988), it was clear that she met criteria for panic disorder. Nevertheless, she preferred focusing on improving the marriage. I gave her some reading about panic disorder and regularly inquired about her anxiety symptoms and panic attacks, which she reported had decreased during the course of marital treatment.

After four months of couple’s therapy, Janet experienced an increase in her anxiety symptoms and some depressive symptoms as well. We continued marital therapy, but I also initiated regular individual sessions with Janet. I adhered to the cognitive-behavioral treatment model of panic disorder (Barlow & Cerny, 1988). Janet learned the progressive muscle relaxation technique. She learned the role of automatic thinking and poor hypothesis testing in maintaining anxiety. During the first few sessions, it was clear that she was not consistently practicing her relaxation exercises, nor was she regularly completing her cognitive homework assignments. At the beginning of the fifth session, Janet stated that she did not agree with the cognitive model of anxiety. “I don’t think first and then feel. I feel first and then think.” She went on to say that she thought learning ways to combat anxiety would not help her. She wanted to understand why she was anxious. I then asked her what she wanted to do. She said she wanted to talk about her childhood. I agreed to shift the direction of therapy. Janet then went on to talk about the impact her father’s death had had on her and her family’s life. She was 12 at the time. Her mother became very depressed after his death and for years did not fulfill her parental role. I saw Janet for four more sessions, and then Janet and Jorge terminated, primarily because of their

3At the time of treating this case, the important component of focusing on interoceptive bodily cues in cognitive-behavioral treatment of panic disorder had not been introduced.
limited finances. Janet reported that she benefited a great deal from therapy; this was supported by some reduction in her anxiety symptoms since she was first evaluated. Jorge, on the other hand, reported that there was little change in their marriage.

The important point of this case is that there was not a good match between the theoretical basis of treatment and the set of issues (theory) that Janet expected the therapy to address. I presented the assumptions of the model through written material and through didactic presentations. One could think of this as the therapist’s culture-specific explanatory model. Janet learned the main points of the model, and, although not consistently, she did make some efforts to implement the therapeutic strategies. After five sessions, she informed me that she did not agree with the basic assumptions of the model. She expressed a set of beliefs with a psychodynamic bent, that is, learning skills is not important; understanding her childhood is what matters.

As a therapist, I had the choice of following Janet’s lead in helping her to understand her childhood or of redirecting her back to cognitive-behavioral therapy. At the time, I remember thinking that I might not have presented the treatment effectively and that was why she was doubtful of the treatment approach. I considered reviewing the basic premises of cognitive therapy with her. Instead, I opted for following her lead and shifting the focus of therapy. To clarify, I did not see myself as shifting to a psychodynamic approach to meet her expectations. My goal was to allow her to talk about her childhood and related experiences, and through reflection and “supportive” therapy I hoped to help her better understand that experience. Furthermore, I was open to the possibility of reintroducing cognitive-behavioral principles and methods as needed. I was not going to push that perspective; however, I was going to be ready should the opportunity present itself. For instance, if Janet’s recollection of her childhood experiences contained cognitive distortions, which I had no doubt they did, I would have used or at least recommended cognitive-behavioral means of addressing them.

The mistake I made with Janet is that I did not provide her adequate opportunity to express her views as to why she suffered from panic disorder. In part this was due to the original focus of treatment being on their marital relationship. When we began working in individual therapy, however, I moved immediately into the cognitive-behavioral approach, teaching her about the model. There was little opportunity for her to propose other explanatory models. Given that she was motivated to attain symptom relief as soon as possible, she may not have given as much thought to her own beliefs about what underlay her problem.

It is difficult to know if I made the right decision to shift the direction of therapy. We are not able to compare the achieved outcome with the outcome that would have been associated with having stayed the course. I believe, however, that being open to following the client’s direction reflects cultural competence. It demonstrates a willingness to respect and validate the client’s theoretical model, which I believe was related to her sociocultural beliefs.4 The theoretical notion that changing thoughts can alter one’s mood may run counter to some people’s belief systems, which place more significance on emotions than on thoughts. This is not to say that I completely disregarded the culturally embedded theoretical framework from which I worked. I was open to incorporate it at an appropriate

4It is important to note that the therapist should have some background in the treatment approach suggested by the client’s framework. If not, it would be best to refer the client to a therapist whose treatment approach would provide a better match.
time in the future, after Janet could see that I had accepted and worked within her framework. Furthermore, the use of my perspective at a future time would probably work only if I grounded it in the framework of helping her understand her childhood, at least initially.

It is worth noting that there are risks in agreeing to work within the client’s theoretical model. It could be that the client’s framework may reflect more than just an alternative way of understanding the presenting problem; it could also reflect dysfunction, an effort to undermine the treatment, or both. In this case, Janet’s efforts to shift the therapy focus, whether they were intentional or not, could have led to less effective treatment. A therapist should not follow the client in whichever direction he or she wishes to go at any given time. A careful consideration of the pros and cons of such treatment modifications is necessary at all times, particularly if changes are being requested often. Nevertheless, an openness to consider working within the client’s proposed theoretical model, however presented, is likely to be useful in working with culturally diverse clients.

Methods

The treatment methods refer to the procedures clinicians use to facilitate behavioral change in their clients. These methods are frequently tied to the practitioner’s theoretical orientation, which now can include an integration of different therapeutic methods and theoretical approaches. For example, Wachtel (1977) discusses the integration of behavioral and psychodynamic principles and methods. Cultural competence reflects an openness on the part of the therapist to adapt one’s intervention to the client’s cultural belief system. This could range from referring clients to other healers to receive treatment that the mental health professional is not capable of providing (e.g., folk healing) to maintaining one’s treatment methods intact but describing the method as being similar to a known culturally syntonic method. An example of the latter is encouraging patients to use injectable long-lasting depot medication rather than oral medication by alluding to cultural beliefs in which injections are viewed as a most effective form of medical practice, a belief adhered to by some Mexican and Latino families. In order for the clinician to adapt his or her intervention to the client’s cultural perspective, it is important that the clinician learn about culturally syntonic treatment methods for his or her clients. This can come about during the initial evaluation after the problem has been defined. The practitioner can inquire as to how such problems have been addressed in the past by the client and his or her family. Or the practitioner can be open to the clients’ reactions to the treatment methods that are implemented and consider adapting the procedures to better fit the client’s cultural background.

I now present a couple’s case in which I attempted to improve their communication and problem-solving skills. It was not until therapy had ended unsuccessfully that I realized the lack of congruence between their cultural belief system and my efforts to increase “appropriate” communication of both positive and negative affect. This case, and others like it, taught me the importance of making sure that the treatment methods one uses are compatible with the clients’ cultural system of meanings.

The eldest of four adult daughters initiated the first contact between me and the Siqueiros family. Mr. and Mrs. Siqueiros were born in northern Mexico and came to the United States as young adults. They were both 54 years old, and their four daughters were in their twenties. The parents had been married for about 30 years. The family ran a business from their house; the father was the owner, two daughters ran the office, and the mother helped out occasionally. The main presenting problem was the couple’s considerable and long-standing
marital strain. According to the daughters, they were either not talking to each other or were verbally abusive. The couple agreed to begin therapy, but Mr. Siqueiros would do so only on an individual basis. Although couples therapy was my preference, I agreed to see them individually for three or four sessions and then to reevaluate the treatment plan. My goals were to establish a working relationship with each of them, help them define goals for their marriage, and then bring them together for conjoint therapy. After seeing each one for three consecutive sessions, Mr. Siqueiros ended therapy, stating, "My feet are on the ground—she's the one who needs help." He further added that he fulfilled his obligations as a husband; he worked hard and provided well for the family. However, he indicated that his wife intentionally refused to fulfill her responsibilities, particularly cooking meals for him, washing his clothes, and being available for sexual relations. Because of this, Mr. Siqueiros believed his wife was to blame for their marital problems. Mrs. Siqueiros was disappointed that her husband had decided not to continue psychotherapy; nevertheless, she continued for six more sessions. Before ending therapy, she stated that Mr. Siqueiros was depending on her more and she found him to be more communicative.

Fourteen months later, Mr. and Mrs. Siqueiros returned and requested to be seen for family therapy with their daughters. They agreed to have short-term therapy, five weeks only. As was the case a year earlier, there was considerable marital strain, and the daughters took turns in trying to mediate their difficulties. Furthermore, the mother was seen by all as intrusive. In an effort to decrease the tension, as one treatment goal I attempted to teach them how to communicate both positive and negative feelings following Gottman, Notarius, Gonso, and Markman (1976). In the last session, in an effort to assist Mr. Siqueiros further with communicating negative feelings in a specific situation, I suggested that he might have felt hurt that his needs were not considered by his wife. He responded vehemently that no one had ever hurt him, but if they ever did he would make sure that they would know it. I interpreted his comments as meaning that he does not let others know when he is hurt by their actions. Expressing hurt would mean that he was not strong. He stated that his wife and daughters have tried to make him a mandilion [wimp], but he was never going to succumb to their wishes. At the end of the session, I referred the couple for marital therapy. They did not follow through.

Therapy helped the family in some ways. For example, the daughters learned that their mother's intrusiveness was in part due to her feeling excluded from their lives, both in terms of the family business and their personal lives. As a result of family therapy, the daughters began taking steps to spend time with their mother in ways not related to the business or to their father (e.g., going shopping or going out to eat). Little progress was made, however, in improving the central problem, Mr. and Mrs. Siqueiros' chronic marital distress. There were many factors that contributed to my unsuccessful efforts in working with the couple. One factor that was particularly significant from a cultural perspective was the mismatch between the treatment methods and the clients' cultural values. I attempted to teach the couple and daughters ways to communicate their considerable negative feelings in a manner that would enhance their relationships. Mr. Siqueiros's clear rejection of my interpretation that his wife may have hurt him is an example that his cultural views ran counter to this approach. Directly expressing to his wife that she did something to hurt him violated some sociocultural standard. From his view, he was not supposed to show vulnerability; as the head of the household, he had to be strong. As a result, he was not at all receptive to learning how to communicate negative feelings, let alone acknowledge that his family did things to offend or hurt him.

In retrospect, I had assumed that the direct communication of negative (and positive) feelings was the cultural standard in effective communication in marriages and families. It made sense to me, it was written up in treatment manuals, but it may not be the cultural
standard for all families. This direct form of communication may run counter to the standard in some cultural groups. In the case of the Siqueiros family, particularly from the father’s perspective, normative communication between spouses may not be directly stating negative or even positive feelings. Words may be valued less. Action or behaviors may be emphasized. This is consistent with what Mr. Siqueiros had said; he had fulfilled his obligations, yet his wife had not.

The important point is that as clinicians we need to recognize that the treatment methods we use are embedded in culture-specific models of human behavior. Rather than proceed along usual treatment paths, particularly with clients from diverse cultural backgrounds, the effectiveness of one’s treatment might be enhanced by first assessing whether the assumptions underlying chosen treatments are consistent with clients’ models of human behavior. By collecting this type of information, not only will clinicians learn how their clients’ cultural ways of life are important for their treatment, but also clinicians will inform their clients that they are interested in learning from them what treatment models might work best. As a result, the clinician will be in a position to adjust his or her tools to meet the specific needs of the client. For instance, had I assessed the Siqueiros’s ideal form of communication, I might have learned that they prefer expressing negative sentiment in indirect or subtle ways. If that was the case, then we could have structured the communication skill building around those forms of communication.

It is important to note here, as is the case in other therapy domains, that there are risks in trying to adapt one’s treatment methods to the clients’ cultural belief system. For the cultural outsider, it can be difficult to distinguish culturally different forms of adaptive functioning from simply maladaptive forms of functioning. For example, indirect forms of communication may be the norm for the Siqueiros family, but had I worked with them in improving the effectiveness of their supposed indirect forms of expressions, we might have learned that they were actually unable to communicate effectively in that mode as well. So it is important that clinicians carefully consider the cultural context of their intervention methods, but not completely abandon their methods or radically modify them on the basis of limited information about the cultural congruence between their method and the client’s belief system. It is possible that little modification is necessary. Or, it may be that initially a major change is thought to be needed but after pursuing that path for some time both the therapist and client(s) may agree that still further modification is needed. That modification could even be a return to the standard treatment method used by the therapist. Culturally competent psychotherapy requires an openness to consider the lack of fit between one’s treatment methods and the client’s cultural background. Deciding whether or not changes are necessary and then knowing when and how to implement such changes reflect culturally competent practice.

Extraclinical Aspects of Therapy and Training

Issues of culture can be difficult to address with one’s clients or with the clients of one’s trainees. Addressing such issues can be even more challenging when they come about outside the therapist-client relationship, in case conferences, and in observing colleagues’ clinical work. I now present a case in which culture was a salient theme during a case conference I attended during my internship. What made this incident especially challenging for me is that the case concerned a Mexican woman, and part of the discussion focused on the Mexican culture. Being Mexican American, I could not help but think that the discussion of the Mexican culture was at least in part a discussion of my culture as well.
At a case conference of the adult outpatient clinic within the Department of Psychiatry, a psychiatry resident presented the case of Mrs. Sambrano, an 18-year-old Mexican woman. She had been living with her common-law husband for more than 2 years. They were the parents of a 5-month-old baby. At the age of 12, Mrs. Sambrano immigrated to the United States from Mexico with her family. She was referred by the psychiatric emergency unit for having significant depressive symptomatology that began after the birth of her child. The depression had been exacerbated recently by a series of life events: becoming pregnant again, her spouse threatening to leave her, and obtaining an abortion one week prior to her ER visit. In addition to her depressive symptoms, Mrs. Sambrano also presented “seizure-like” behaviors described in the ER records as an “arching back, flinging arms, rolling eyes up in her head” and “alternating periods of unresponsiveness.”

After presenting the case, the resident brought the patient into the conference room from the hallway where she had been waiting. Mrs. Sambrano was then interviewed by a psychiatrist with approximately 30 clinical staff members observing. The client spoke English with a marked accent but was easily understood. After a 15-minute interview, her husband, who had also been waiting, was called in. The psychiatrist interviewed the couple together. Interestingly, Mr. Sambrano took it upon himself to serve as his wife’s translator. When the psychiatrist asked Mrs. Sambrano a question, he translated the question into Spanish, she responded to her husband in Spanish, and then he translated into English what she had said. This was rather curious given that we knew that she communicated well in English.

After the interview ended and the patient and her husband left, an interesting discussion about diagnostic and treatment issues took place primarily among the psychiatrists and residents. Near the end of the discussion one of the experienced and well-regarded psychiatrists commented that his wife’s aunt, who was also Mexican, had a similar hysterical style as that of the patient. He then went on to argue that the patient’s reactions reflected a “cultural pattern,” in part due to the controlling nature of the spouse. No one questioned or challenged his comments; as a whole, the clinical staff appeared to have been persuaded by his argument.

This case conference raises many issues. One issue is the limited evidence that the psychiatrist had regarding the cultural basis of the client’s symptoms and his tendency to explain away her considerable distress as a “cultural thing.” His explanation reminds me of one of Meehl’s (1973) comments as to why he does not attend clinical case conferences. He says that in case conferences, clinicians tolerate “feeble inferences.” Had the psychiatrist commented on the literature with regard to ataque de nervios, or had he expressed even the slightest tentativeness in his assessment, then perhaps an interesting discussion could have evolved about the cultural basis of Mrs. Sambrano’s presenting problems. But that did not happen. Instead, this well-regarded psychiatrist convinced the clinical staff that the symptoms were cultural in nature, his argument largely based on the fact that his aunt-in-law, who was also Mexican, had similar symptoms.

During this discussion, I recall feeling considerable tension. I am not one to speak out in public settings, particularly when I have little status. A psychology intern in a department of psychiatry has little status. But I had hoped that my supervisors would speak up, especially the two who were Mexican American. They did not. It is awkward when a member of your ethnic group is being discussed by a group of people who are largely not from your same ethnicity. You want to contribute and shed some light on the issue, but you want to do it in a way in which your ethnicity is irrelevant. You simply want to be judged on the quality of your ideas. However, one cannot divorce one’s ethnicity from the discussion, let alone one’s thinking. Perhaps my supervisors felt this awkwardness as well.

As a result of not questioning the psychiatrist, many people left the staff meeting with a presumed better understanding of the Mexican culture. Later on, the psychiatry resident
who was treating Mrs. Sambrano told me that he agreed with the cultural interpretation. I should have spoken up at the case conference.

This incident occurred 15 years ago, when the awareness of cultural issues was more limited and the ethnic composition of mental health professionals reflected little cultural diversity. Although I have not encountered this situation now as a clinical supervisor, I am sure that similar issues arise in case conferences today. Supervisors should model appropriate professional behavior by critically evaluating claims about the role of culture in the lives of clients with the goal of enhancing an understanding of the case. Modeling such behavior would likely help all trainees feel more comfortable in contributing to such professional discussions. It would be especially helpful for trainees of ethnocultural minority groups to help them learn how to integrate their own local cultural experience in professional activities, perhaps without feeling the awkwardness that some of us have experienced.

CONCLUSION

Culture matters in psychotherapy and in clinical supervision. I have presented a model of cultural competence derived from both research and clinical practice to serve as a guide in providing culturally appropriate mental health services for culturally diverse clientele. Cultural competence is not a simple formula that can be easily followed from session to session. Nor is it a set of cultural facts that one can apply. Instead it is a perspective that respects the complexity of each individual and his or her cultural context. Moving between the cultural frames of the client and the clinician is essential to cultural competence. To develop this skill, supervisors and trainees alike must think critically about the role of culture in clinical practice.

REFERENCES


