

# Ten Considerations in Addressing Cultural Differences in Psychotherapy

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As the United States population grows more culturally diverse, it is increasingly likely that psychologists will treat patients from dissimilar cultural backgrounds. Psychologists are often undecided about whether it is therapeutically appropriate to address cultural differences. Ten clinical considerations regarding the appropriateness of discussing cultural differences with patients are described. Examples are provided of how these suggested guidelines may apply to clinical practice. The literature that has supported addressing differences, including selected theoretical models, is cited in the context of these recommendations. All psychotherapy cases are distinct; therefore, these general guidelines should be adapted to the requirements of the individual patient.

Whether psychologists should address cultural differences within the psychotherapeutic relationship is a topic that has been increasingly discussed. Therapists grapple with two questions. First, should cultural differences be addressed? Second, if cultural issues are to be addressed, what approaches should be used? The population of the United States is becoming more diverse, thereby increasing the likelihood of cross-cultural psychotherapy (Bernal & Castro, 1994; Comas-Diaz, 1992). In 2000, 25% of the U.S. population was classified as "minority," and by the year 2050 it is predicted that more than half of the U.S. population will be from non-European backgrounds (U.S. Department of Commerce, 2001). It is unlikely that the exponential growth of the ethnic-minority population will be matched by a growth in the number of mental health providers who represent these diverse groups (Kruse & Canning, 2002). The cultural differences that exist between patient and therapist are numerous (e.g., race, gender, ethnicity, sexual orientation, socioeconomic status, age, educational level, religion, and language). Therefore, encountering cultural differences becomes inevitable in any psychotherapeutic relationship (Gonzalez, Biever, & Gardner, 1994).

It is difficult to discuss how cultural differences can be addressed in psychotherapy without first defining culture. Culture has been defined in many ways; however, we believe that Rohner's (1984) definition is the most comprehensive. Rohner defined cul-

ture as a highly variable set of meanings that are learned and shared by a group of people or by an identifiable segment of the population. Culture represents a way of life that can be transmitted from one generation to another. Consequently, culture is understood as constructions or meanings that are dynamic, complex, and representative of a multifaceted experience. Theorists have asserted that cultural identities are fluid and flexible, especially when individual change processes occur, such as migration or contact with different cultural groups (Berry & Kim, 1988; Carter & Qureshi, 1995).

Although the terms *race*, *ethnicity*, and *culture* are often used interchangeably in psychological literature, they are distinctly different (Abreu & Gabarain, 2000; Betancourt & Lopez, 1993). Race may be defined in terms of selected physical characteristics, criteria, or permanent attributes (Betancourt & Lopez, 1993). Historically, skin color and facial characteristics have been used extensively to determine how racial groupings are created (Landrine & Klonoff, 1996). Consequently, within any racial classification, multiple ethnic groups and tremendous cultural diversity exist. Ethnicity is more directly related to the broader definition of culture and may relate to a shared nationality, language, common values, beliefs, and customs (Betancourt & Lopez, 1993). The conscious identification with an ethnic group or one's ethnic identity may be determined by genealogical ties or other socially related factors, such as residence in an ethnic enclave (Alvidrez, Azocar, & Miranda, 1996). However, ethnicity may connote a more fixed, homogeneous, and stereotypical understanding of an individual's cultural experience and may not capture the complexity, vitality, and multifaceted nature of any ethnic minority experience. It is beyond the scope of this article to elaborate further on the limitations of these terms. Nevertheless, given an individual's complex, changing experiences, we believe that the broader definition of culture may be more suitable for individuals to use to define their experiences.

## Theoretical Perspectives

Cultural differences have been understood through three distinct perspectives: universalism, particularism, and transcendism (Se-

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gall, Lonner, & Berry, 1998; Tyler, Brome, & Williams, 1991). Research consistent with the universalist approach has asserted that common factors, such as degree of warmth and understanding, are necessary to facilitate successful psychotherapy (Kaduchin, 1972). From this perspective theorists assert that it is unnecessary to address cultural differences with patients given that these differences do not have a significant impact on the process of psychotherapy or its outcome. In contrast, the particularist perspective purports that culture, ethnicity, and race have a crucial impact on an individual's experience. From this framework it is asserted that individuals from different cultural backgrounds cannot understand each other (Dixon, 1976; Jackson, 1976; J. White, 1970); thus, cultural differences are insurmountable barriers that make it unlikely for patients and therapists to work successfully together. Lastly, the transcendist perspective stresses that persons from different ethnic/racial backgrounds are psychologically different but that these differences can be transcended. For example, S. Sue (1998) asserted that therapists can develop "cultural competencies" to treat culturally diverse patients, and once such competencies are acquired, the effectiveness of psychotherapy with diverse patients increases. Segall et al. (1998) argued that most clinicians subscribe to a transcendist model, locating themselves somewhere in between the universalist and particularistic perspectives regarding their views on the importance of cultural difference in psychotherapy.

In agreement with the transcendist approach, we argue that discussing cultural differences is an important skill for clinicians to develop. Although there is a growing literature that proposes various strategies to use in addressing cultural differences, these strategies are often proposed without a clear understanding of the meaning and implications of the concept of culture in psychotherapy. In this article we make 10 clinical recommendations consistent with a transcendist perspective and use the broad conceptualization of culture proposed by Rohner (1984). S. Sue's (1998) cultural competency model also informs these recommendations. Unfortunately, the empirical research on the effectiveness of addressing cultural differences in psychotherapy is limited (Chambless, 1996; Pope-Davis, Liu, Toporek, & Brittan-Powell, 2001); thus, these recommendations must be viewed as tentative clinical considerations to be tested through further research and practice.

### Ten Clinical Considerations in Addressing Cultural Differences

In order to help determine under what circumstances to discuss cultural differences in psychotherapy, we provide 10 clinical considerations. The goal is to help clinicians working with patients whose cultural backgrounds are different from their own. These guidelines are not meant to be a cookbook approach to addressing cultural differences, as individuals who seek treatment will ascribe variable meanings to these differences. Clearly, these considerations should be adapted to the specific characteristics of each patient. There is no adequate substitute for having good clinical judgment and an understanding of the unique requirements of an individual patient. Moreover, it is important to appraise all 10 considerations simultaneously rather than embrace one without regard to the others.

#### *1. Cultural Differences Are Subjective, Complex, and Dynamic*

First, in any psychotherapeutic relationship there may be some general agreement on what constitutes ethnic and cultural differences between patient and therapist. For example, skin color and language accent may be recognized immediately in the initial therapeutic meeting as cultural differences. However, the interpretations or meanings of these differences are subjective. Patients will understand these dissimilarities according to their own distinct set of experiences, and at times these subjective meanings may be more relevant than the "objective" differences themselves. Therefore, therapists should not assume a standard way to treat patients of a particular cultural background; rather, they should explore the meanings that patients ascribe to these cultural differences.

Second, beyond the subjective differences that will naturally exist, it is argued that cultural differences are multiple and complex (Bingham, Porsche-Burke, James, Sue, & Vasquez, 2002). As previously stated, cultural differences may include multiple variables (e.g., gender, sexual orientation, socioeconomic status, age, educational level, language, and religion). It is crucial to consider all possible differences, including attractiveness, height, and weight or body type, and to identify how these differences come together in defining an individual's identity and experience. For example, it might be more effective therapeutically to understand the multiple and interacting experiences of being a young, third-generation, gay Korean American man than to focus solely on his sexual orientation. Moreover, each of these characteristics is complex and composed of several possible meanings within different contexts. Hence, being a gay man may be acceptable in work settings but a painful secret within his extended family.

Third, the perception on the part of patient and therapist of what constitutes a cultural difference is dynamic rather than static. At different points in the therapeutic process, what is construed as a cultural difference may shift into the background, and other factors may come into the forefront. Therefore, therapists are encouraged to engage in ongoing exploration of these changing meanings of cultural differences rather than to assume that once these differences have been understood, it is no longer necessary to continue such explorations. Meanings change, and it is important to explore these changes and to understand the factors influencing these changes (M. White & Epston, 1990). A dark-skinned Latino male physician started changing his acquiescent attitude with his lighter-skinned Latino male therapist. The patient had angrily started questioning his therapist's ability to understand him. This questioning had been absent during the first year of psychotherapy. In exploring this change, the patient explained that he recently had been subject to discrimination. His colleagues were suggesting that he had obtained his medical degree because of affirmative action preferences, and he feared that his lighter-skinned therapist might also think that he was not smart enough to be a physician.

#### *2. The Most Salient Cultural Differences Should Be Addressed First*

The second consideration is based on two clinical assumptions: that cultural differences may have different levels of importance and that it is often beneficial if cultural differences are directly addressed by the clinician. With regard to the first assumption,

cultural differences are construed in many ways and have different ascribed levels of relevance. Not all differences will have the same relative value in the therapeutic relationship. Clinicians should explore these meanings and consider addressing the most salient cultural differences. It may be possible, for example, that dissimilarities in race may not hold the same weight as the differences in the marital status of the patient and therapist. The saliency of the difference is influenced by the histories of the therapist and patient, their interpersonal history, and the cultural context in which the differences are embedded. In spite of this fact, it is the patient's perceptions of difference in psychotherapy that are most important.

With regard to the second consideration, the clinician may have to address the cultural differences directly. Given the power differential that exists in the therapeutic relationship (Pinderhughes, 1989), the majority of patients will not initiate discussions of cultural differences. Hence, the therapist may need to communicate a strong openness to understanding the patient's unique experiences, including cultural perspectives (Whaley, 2001). A therapist who directly acknowledges the difference with the patient is taking a first step in determining whether the patient views the difference as problematic. In addition, addressing the patient-therapist differences will open up a dialogue for further discussion about their implications for the therapy. Many clinicians, however, believe that it is more appropriate to wait for the patient to bring up cultural differences. Although in certain situations it is recommended that the patient initiate the discussion, a therapist should seriously consider that when salient differences or multiple cultural dissimilarities exist, it may simply be more facilitative for the therapist to take the initiative. Some theorists have suggested that the therapist address differences in the first session with a patient (e.g., Gopaul-McNeil & Brice-Baker, 1998; Paniagua, 1998) or during the initial phase of therapy. We believe that it depends on several factors, such as the degree of saliency of the cultural differences between patient and therapist. Thus, the more salient the cultural differences, the sooner the differences should be addressed.

The following example illustrates this point. A 14-year-old African American male was mandated for counseling through the court system. In the first session with a middle-aged, White European American female therapist, it was obvious that the teen was reluctant to speak. He appeared very guarded, and the therapist sensed his intense anger for having to participate in the counseling session. The therapist therefore stated, "It must make you angry to be forced to talk with a White therapist." The patient defiantly responded, "We live in different worlds." The therapist validated the adolescent's point, and during the session she determined that he did not communicate with White people. The therapist had to address the meaning of their difference. Without an explicit discussion of difference, it would have been difficult to bridge the cultural gap that existed between them. As the adolescent relayed 6 months later, this discussion helped him to open up slowly and talk more about his experiences. We believe many clinicians are concerned that in discussing differences with patients, they are lessening their ability to utilize the commonality of human experience in the therapeutic work. Nevertheless, it should be kept in mind that therapists can effectively utilize both patient-therapist differences and similarities in their work with culturally diverse patients.

### *3. Similarities Should Be Addressed as a Prelude to Discussions of Cultural Differences*

As previously stated, therapists and patients not only differ in a number of cultural attributes but may also share many cultural similarities (Speight & Vera, 1997). A patient may benefit from the therapist's acknowledging certain similarities that exist between them. Addressing therapist-patient commonalities may serve to reduce the patient's ambivalence and increase the therapist's credibility (Speight & Vera, 1997). The acknowledgment of similarities may assist the therapist in establishing an initial rapport, and the patient may experience more comfort, security, and acceptance. This strategy may also serve to reduce apprehensions about treatment, especially in the presence of significant cultural differences between therapist and patient. One approach that may be useful is to explicitly share commonalities before cultural differences are fully explored. For example, during the early stages of treatment or during stressful periods (i.e., when the patient is presenting high anxiety or depression), acknowledging similarities may help establish rapport with the patient. By the therapist's mirroring this experience of being similar yet different, the patient may develop a more open sense of himself or herself and may feel more fully respected and accepted within the psychotherapeutic relationship. As a consequence, this strategy can assist the patient in engaging more successfully in psychotherapy. The initial emphasis on similarities, however, does not negate the need to consider addressing differences.

The following example illustrates a situation in which the therapist addresses similarities with a new patient through self-disclosure. A gay man was disappointed that he was not assigned to the lesbian therapist who had been recommended by his partner. The lesbian therapist he wanted to see had no available openings, and he had to settle for a heterosexual female therapist. The therapist decided to reveal in the first few sessions several commonalities: They were both graduates of New York University and had lost their fathers to cancer at a very early age. After a few months of psychotherapy, the patient relayed that discussing these commonalities helped him to initially bond and develop trust with the therapist.

### *4. The Patient's Levels of Distress and Presenting Problem Will Often Determine When and If Cultural Differences Are Discussed in Psychotherapy*

It is crucial to assess the degree of emotional distress and the severity of the patient's chief complaint (Lopez, 1997). The more stable a patient is, the more likely it is that he or she will benefit from a discussion of cultural differences. In contrast, the more frail and less stable patient the patient is (e.g., extremely anxious, severely depressed, delusional, or substance abusers) the more likely he or she will benefit less from this dialogue. Moreover, we agree with Wilkinson and Spurlock's (1986) assertion that the issue of differences should not be brought up during a crisis intervention, regardless of whether it is the first therapeutic encounter. Concerns for safety, focusing on mental status, and working toward improving functioning should be paramount in working with any patient.

It is important to keep in mind that it can be harmful to repeatedly address these differences when patients are pressed by

other concerns. With the best of intentions, some therapists may attempt to be culturally sensitive by initiating several discussions of cultural differences at various times during the course of psychotherapy when patients are clearly not interested or ready to engage in such dialogues. As a result, patients may perceive that therapists are not understanding them or being sensitive to their concerns. Working with similarities in these circumstances may be more productive than initiating discussions of differences (Speight & Vera, 1997). Nevertheless, therapists should still seriously consider how cultural factors influence the severely distressed and how further treatment should incorporate addressing cultural issues.

### *5. Cultural Differences Should Be Addressed as Assets That Can Help in the Therapeutic Process*

Many minority patients have often experienced how the majority group construes their differences as deficits (S. Sue, 1998). Being a person of color, female, gay or lesbian, non-Christian, disabled, or as having an accent are viewed as deficiencies, whereas being White, male, Christian, and heterosexual are viewed favorably. Given the intensity and frequency of these cultural messages, patients and therapists often feel they are walking on eggshells when cultural differences are finally discussed. During such moments it is often helpful to suggest to the patient how these difficulties are a reflection of the conflicting or negative messages held by the mainstream culture rather than limitations that reside within patients (M. White & Epston, 1990). However, efforts to discuss these differences should proceed gradually, gently, and carefully and should follow the patient's lead. Moreover, whenever possible, clinicians should attempt to examine how differences are related to a patient's strengths rather than view them as deficits. Recently, one of us was supervising a White, female psychology intern who stated to her Latino patient, "Feel free to ask me any questions if you don't understand my English." Although the psychology intern was encouraging the patient to ask questions, she inadvertently also assumed that it was her patient's responsibility to know English rather than her own responsibility to have some fluency in Spanish.

### *6. The Patient's Cultural History and Racial Identity Development Are Important Factors in Assessing How Best to Conceptualize Presenting Problems and Facilitate Therapeutic Goals*

Recent research has focused on intergroup differences, arguing that the patients' cultural history and development (e.g., level of identification with their cultural group) and acculturation status (e.g., exposure to different cultural groups) mediate the effectiveness of the match between patients and therapists from different cultural backgrounds (Carter, 1995). Helms and Cook (1999) formulated a cognitive-developmental model in which the level of acceptance of therapists who are from different cultural backgrounds is dependent upon the patients' level of racial identity and consciousness. An alternative explanation of intergroup differences focuses on levels of acculturation (Berry & Kim, 1988). This model proposes that ethnic matching between patients and therapists can result in "cultural mismatches" if therapists and patients from the same ethnic group show markedly different levels of

acculturation. These models emphasize cognitive and developmental characteristics of patients and imply that therapists cannot help to facilitate changes that are in conflict with their patients' developmental stages.

Furthermore, the literature has suggested techniques or strategies for working with patients at specific stages of racial development (Helms & Cook, 1999), because patients are at different levels of readiness to explore certain issues dependent on their own cultural awareness. A case in point involves a therapist working with a family who had emigrated from China. The therapist became aware of the differences in acculturation status among family members. The family had come to this country when the son was 12 years old. The parents had identified their teenage son, now 17, as being rebellious and considered his new friends from high school to be a negative influence. The father thought that limiting his contact with these friends would immediately resolve their familial issues; however, this restriction only increased his rebelliousness. After the therapist assessed the family, she found the son to be struggling with his own conflicted sociocultural development—although he wanted to immerse himself in his friends' mainstream world, he did not want to betray his family and Chinese values. The therapist found it necessary to work individually with the son. She did so by first assessing and helping him to identify his cultural values, and then by helping him to develop practical strategies for bridging the cultural gap between his family and friends. As the son became more culturally aware of his conflicted values, his rebellious behavior diminished, and he started internalizing his own cultural values (Helms & Cook, 1999). This therapeutic process would have been impossible if the therapist had not assessed the family's level of cultural development, identifying that the son was ready to confront some cultural issues, although his family was not. In addition, it was crucial that the therapist was knowledgeable of Chinese traditional values. A lack of knowledge could have led her to believe that the son's struggle was an attempt to individuate from an enmeshed family, and she might therefore have encouraged his family to give him more freedom. In turn, the family could have understood this recommendation as a threat to the family unit. Chinese families often value interdependence and harmony more than autonomy and independence (Lee, 2000); consequently, after this recommendation they may have dropped out of psychotherapy.

### *7. The Meanings and Saliency of Cultural Differences Are Influenced by Ongoing Issues Within the Psychotherapeutic Relationship*

Each psychotherapeutic relationship develops specific interpersonal dynamics that might encourage some topics to be discussed and other topics to be overlooked. The potential to discuss cultural issues is partially dependent upon this interpersonal history. An illustration of this point is when a female patient realizes that her male psychotherapist dismisses her ongoing gender issues with her boss. The patient may not only stop bringing up these issues but may also avoid discussing other cultural differences with her therapist. Therapists may not recognize important cues that can lead to beneficial discussions of differences. Additionally, therapists may misunderstand the issues that are being brought up by their patients. Consequently, cultural issues may not get the attention patients desire. Clinicians should strive to listen carefully to

the dialogues that take place in cross-cultural encounters. They are encouraged to critically evaluate the content of these dialogues and to question whether some cultural issues are overlooked and other issues are inappropriately emphasized.

### *8. The Psychotherapeutic Relationship Is Embedded Within a Broader Cultural Context That Affects the Therapeutic Relationship*

The therapeutic relationship takes place in the context of an external world that is constantly providing messages about cultural differences, which will influence what takes place in psychotherapy (La Roche, 1999). Events that take place outside of the therapeutic session can contribute to whether patients choose or do not choose to address cultural differences during the course of treatment. For example, we have noted that after a publicized event of discrimination within the community, patients will discuss experiences of discrimination more frequently than they did before the event. The event often opens the door to discussions of cultural differences between patient and therapist. Discussions of societal racism often foster a discussion about patient-therapist differences.

However, it is also conceivable that patients may be more hesitant to bring up issues of difference due to negative feelings they experience with regard to current events or other occurrences taking place outside of the therapy. In these situations, the therapist's awareness and sensitivity to raising the issue can be of critical importance. For example, a young African American woman began therapy with a White, European American therapist during the same week that the O. J. Simpson verdict was announced. During this time, the media were consumed with reporting the considerable divide between how Whites and African Americans were responding to this controversial verdict. The African American patient entered therapy believing that "White people just don't get it" (Jones, 1997) and thought that perhaps the new therapist would also not understand her and what her life experiences have been. She had already had difficult discussions at work with White colleagues and dreaded another discussion about anything related to racial difference. Understandably, the patient did not want to talk with the therapist about their racial and ethnic differences, and neither did the therapist, who had experienced a similar frustration in recent months discussing the topic of cultural differences. However, the astute therapist who is skilled at addressing differences may ask the new patient if she has any concerns about being treated by a White therapist at this first encounter. The patient's response to the inquiry will, of course, dictate the course of the discussion. It may be likely that the patient expresses no concern. Nevertheless, the therapist is also given an important opportunity to communicate the following to the patient: "Please let me know if there are things that I say in our work together that do not fit with your values, beliefs, or life experiences. I would like for you to challenge me on these differences, because I think it will be useful in our working together."

### *9. The Therapist's Cultural Competence Will Have an Impact on the Way Differences Are Addressed*

Although the therapist's level of cultural competency is difficult to operationalize, the literature on multiculturalism has identified

three common dimensions (D. W. Sue, Arredondo, & McDavis, 1992). First, the therapist's beliefs and attitudes toward culturally different patients will play an important role in psychotherapy. Clinicians should actively explore their feelings and thoughts (e.g., countertransference, prejudice, and ethnic biases) in providing treatment to patients from different cultural backgrounds. In doing so, therapists will be more attuned to their own comfort levels regarding addressing cultural differences with patients. Second, although therapists and patients may be dissimilar in their cultural backgrounds, therapists should possess some basic knowledge of their patients' cultures (Atkinson & Lowe, 1995), including an understanding of sociopolitical influences. Lastly, the therapist's development over time of specific skills, interventions, and strategies (S. Sue & Zane, 1987) comes about through education and clinical experience with diverse patients.

There are many ways in which clinicians can enhance their cultural competence (Allison, Echemendia, Crawford, & Robinson, 1996); these range from reading about culturally diverse groups to seeking consultation or supervision from culturally diverse peers. In addition, many of our colleagues have found traveling to foreign countries or exposure to and participation in ethnically diverse neighborhoods and communities equally helpful in learning more about dissimilar cultures. Finally, and perhaps most important, is the understanding that the pursuit of cultural competency is a lifelong learning process that is never completed. This process may include formal cultural competency training and, most important, critical self-evaluation and questioning of what is taking place in cross-cultural therapeutic encounters (S. Sue, 1998).

### *10. Dialogues About Cultural Differences Can Have an Effect on the Patient's Cultural Context*

The therapeutic relationship is embedded within a cultural and socioeconomic context. The cultural context can influence the psychotherapeutic process, but changes within the psychotherapeutic relationship may also have an impact on the cultural context. As patients and therapists become increasingly aware of their sociocultural contexts, they become more effective in responding to these contexts and transforming them (Ivey, 1995). Mainstream culture in the United States, for example, espouses values such as materialism, competition, and heterosexuality while it minimizes other values, such as spiritualism, collectivism, and homosexuality. Inadvertently, these mainstream values exert much control over our lives by encouraging pursuit of certain objectives, such as having a nuclear family, while minimizing other objectives, such as finding harmony with nature (S. Sue, 1998). The strength of this influence may be particularly intense among minorities who may not completely share U.S. mainstream values and who may feel pressured to adjust to or assimilate into a more mainstream way of life.

Nonetheless, as individuals start discussing cultural differences and related sociopolitical issues, they become more empowered to acknowledge and speak about important life changes that they may desire (Ivey, 1995; La Roche, 2002). Consequently, they are able to make more informed decisions about their lives. One way to increase this awareness is to acknowledge how the therapeutic relationship reflects the broader sociocultural environment (La Roche, 2002). An important dimension that needs to be addressed

is the issue of power inequities. Often therapists have more ascribed power than patients. As patients become aware of these power inequities and other cultural assumptions, they are encouraged to question the impact that these assumptions have on their own lives in both positive and negative ways. If patients are aware of the multiplicity and complexity of cultural differences and related influences both within the psychotherapeutic relationship and in society, then they may decide to embrace certain cultural values and reject others. At times this questioning can be experienced as a confrontation by clinicians, who can develop a strong negative countertransference, which can create a psychotherapeutic impasse (La Roche, 1999). However, if clinicians are able to keep providing patients with a "good enough" holding environment, then patients will explore and learn alternative ways to cope with cultural differences rather than the standard and ascribed means assigned by society (e.g., silent discrimination, acquiescence). This questioning is a unique opportunity to grow and develop beyond prescribed cultural expectations.

### Conclusion

There are no simple answers to the questions of when and how to address cultural differences in psychotherapy. Instead, we have raised 10 clinical considerations to guide therapists in exploring cultural differences in psychotherapy. Clinicians are encouraged to explore the meanings of cultural differences and similarities rather than to assume that patients will bring a particular experience or perspective to therapy because of their gender, ethnicity, or race. These discussions may actually make the difference in whether patients remain in therapy or prematurely terminate. We can only speculate that beneficial effects occur in the majority of cases, for we have also illustrated the possibility of harmful or counterproductive effects.

Clearly, empirical research is needed to confirm the validity of these considerations and to elaborate on the strengths and limitations of what have been proposed. There are many challenges for research in this area. Investigations should be designed within a theoretical framework in which culture, ethnicity, race, and other differences are clearly conceptualized. Numerous methods should be employed in examining culture as a multidimensional and dynamic construct. For example, qualitative and longitudinal research may help to further our understanding of addressing differences. Research should respond to the question of how to quantify and examine the sociopolitical context in a therapeutic encounter. It will be important to address such matters in order to understand fully what takes place in cross-cultural psychotherapy. In addition, Pope-Davis et al. (2001) have criticized the current multicultural competency research for lacking a patient perspective and relying too heavily on therapist and counselor competencies. Clearly, we must look at both patient and therapist perspectives in learning more about this important area of psychotherapy.

The sociopolitical importance of developing a culturally sensitive model to address differences cannot be understated. As the diversity in the U.S. population grows, so does the potential for cultural misunderstanding and injustice. These injustices can often translate into acts of discrimination and cultural marginalization, which in turn can make the barriers among cultural groups even more insurmountable. As the U.S. culture continues to transform into a multicultural community in which diverse ethnic groups

coexist, it is essential to develop effective ways to respect and validate our individual and group differences. The psychotherapeutic relationship is a unique opportunity for both patients and therapists to further develop these crucial skills.

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