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Tsu-Yin Chang
Cultural Competence:
An Exploration of Its
Translation Into Therapeutic
Practice

ABSTRACT

This study explores the construct of *cultural competence* through clients' perceptions of treatment issues encountered when working with clinicians of a differing racial background. Utilizing interviews with twelve clients of color who had worked psychotherapeutically within cross-racial dyads, this exploratory study examines clients' experiences of treatment issues in this treatment context, clients' understanding of cultural competence in psychotherapy, and their suggestions for cultivating it in clinical practice.

Participants were recruited from the San Francisco Bay Area of California and sat for an hour-long audio-taped interview during which prompts designed to elicit information regarding their past treatment experiences were given.

The findings lend support to the urgency with which the mental health field currently emphasizes the importance of cultural competence, and illuminates a wide range of clinical practices and processes through which cultural competence can take shape. Participants' narratives also suggest that providing what a client perceives as culturally competent care is entirely possible, and sometimes has little to do with race or with level of cultural competence training. The study offers implications for practicing clinicians and outlines areas for further study in the growing cultural competence movement.

CULTURAL COMPETENCE:
AN EXPLORATION OF ITS TRANSLATION INTO THERAPEUTIC PRACTICE

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Tsu-Yin Chang

Smith College School for Social Work
Northampton, Massachusetts 01063

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CHAPTER I

INTRODUCTION

The purpose of this flexible-method, exploratory study is to illuminate, through the context of cultural competence in the therapeutic setting, the subjective experience of racial minority clients who have engaged in psychotherapy with clinicians of differing racial backgrounds. The study aims to contribute to the research and theory on the topic of cross-racial therapy by examining how a differing racial background in a therapeutic dyad influences the way in which a racial minority client experiences the therapeutic interaction, as well ways in which a clinician can be attuned to that experience.

The subjective experience of racial minority clients arose as a topic of inquiry in the midst of cultural competence having become a subject of significant emphasis in the mental health field. An increasing recognition that the “biased nature” of counseling and therapy services has, in recent years, ignited interest in incorporating cultural competence into mental health service delivery. According to some researchers, too often therapeutic services are “inappropriate to the life experiences of the culturally different client,” are lacking in “sensitivity and understanding,” and are perhaps even “antagonistic,” “oppressive and discriminating” towards clients (Sue and Sue, 1990, p. 7). The urgency to provide culturally competent care is heightened by the perceived need to respond to current (and projected) U.S. demographic changes, which not only have traced significant

increases in racial and ethnic minority populations over the past several decades, but also estimate continued rapid growth for years to come.

While much progress has been made in the field of “multicultural counseling” through the last fifteen years, many researchers contend that the current training for and practice with clients of ethnic and racially diverse backgrounds remains inadequate. Furthermore, given 1) that the field currently lacks concrete evidence that careful and systematic attention to culture really improves clinical services and 2) that it has been suggested that cultural competence in the way that it is currently conceptualized may even lead to potential negative outcomes, it is clear that further research is needed if we are ever to understand fully the role of cultural competence in therapeutic relationships.

Despite this lack of research, emphasis on cultural competence increases without a clear conceptualization of what is incorporated in the term, how cultural competence “looks” in practice, and how it might be limiting in a practical context. While researchers and scholars continue to provide guidelines, research findings, and clinical observations about the status and neglected needs of various racial/ethnic group members, many clinicians remain baffled by how cultural competence would translate tangibly into therapeutic practice, or even whether cultural competence is something that could ever truly be attained. The lack of clarity surrounding cultural competency’s conceptualization coupled with increasingly common organizational guidelines for competence can make for a confusing state of affairs for clinicians. Some see a disconnect between the call for competence and the increasingly common, but often overly-simplified and seemingly useless, in-service trainings on the subject. While still acknowledging the importance of developing competence in mental health service

delivery, many clinicians fail to see any direct correlation between the way in which competence is currently being emphasized and trained and an increase in positive outcomes.

Additionally, conversations around cultural competence in the workplace have the potential to become intimidating and charged, often requiring great tact to the point that many clinicians wonder whether it may be easier to avoid the topic altogether. As confusion and frustration around cultural competence builds, and the need to examine the efficacy of cultural competence as it is currently being conceptualized is increasingly recognized, one perspective that has been glaringly missing from the discourse is that of the clients.

This study hopes to give voice to such a perspective by investigating clients of colors' experiences which might illuminate the clinical practices and processes through which cultural competence takes shape in therapeutic interactions. Additionally, as cultural competence guidelines – the basis and efficacy of which are still unclear – are enacted among systems within which clinicians operate, it is important for clinicians to resist dismissing cultural competence training as so abstract, threatening, or useless as to disregard its importance in the outcome of clients' treatment and satisfaction. One hope for the present study is that “cultural competence” may be more clearly understood by clinicians of all backgrounds, and its need for consideration more easily recognized, when the positive impact of cultural competence (or negative impact of cultural incompetence) is evidenced through the actual voices of the populations which clinicians serve.

Brief Discussion of Terms

In the present study, several terms are used for which numerous definitions exist or have shifted over time. “Culture” in the context of cultural competence can be defined both broadly and narrowly so as either to incorporate a variety of cultural factors such as religious view, sexual orientation, physical disability (Pedersen 1994), or be conceptualized more restrictively, with a focus on “visible racial and ethnic group” members (Helms & Cook, 1999). Though concepts in this study are derived from literature that endorses the broader definition of multiculturalism, the purpose of this study will be to examine cultural competency through the lens of the experiences of clients that self-identify as members of visible racial and ethnic groups.

Although the screening criteria for the present study calls specifically for participants to be “people of color” who have experienced therapy with clinicians of a different race from themselves, the construct of *race* is used here solely as a tool to narrow the scope of what can be feasibly researched within the limitations of this project. The researcher recognizes that in the broader context outside of the present study, the distinction that the construct of race provides is essentially arbitrary. Here, *race* serves only as an initial framework within which the client perspective can be explored.

Throughout the study, *race* will be defined as one of the major groups that human beings have been categorized into according to phenotype, color and other physical features (Webster’s Dictionary, 2005), recognizing that attached to this definition of race are associations of inferiority, superiority, hierarchy and discrimination that have historical meanings (Clarke, 2003). *Ethnicity* will be defined as an “amalgam of strongly felt shared beliefs, common culture and sense of belonging, either real or imaginary, that

serves as a source of identity formation and solidarity which sets one group apart from the others” (Clarke, 2003, p. 41). Research participants were asked to frame their ideas and participation in the study with these mutually-agreed definitions in mind.

Overview

This exploratory study begins by introducing and examining the concepts of race and culture, cross-racial therapy, and cultural competence in the clinical literature, with the hope that it will later be contextualized through the experiences of twelve racial minority clients. Chapter II begins with a review of the literature in an attempt to frame the discussion of ways in which differing racial backgrounds in a cross-racial therapeutic dyad might influence the therapeutic process. In Chapter III, the methodology is outlined. The participants were interviewed in a semi-structured format which allowed them to describe their experiences of treatment issues encountered when working with clinicians of different racial backgrounds than themselves. This study also examined clients’ perceptions of cultural competence and how it impacts treatment. Emergent themes from these interviews will be identified and illustrated in Chapter IV. Chapter V discusses the research findings, the study’s limitations, and implications for clinicians in the field and as well as for future research.

In addition to providing empirical data regarding treatment issues which professionals working with a diverse clientele may encounter, the study also seeks to increase awareness of these treatment issues for those who may underestimate their prevalence or the complexity of their nature. Finally, this study attempts to give voice to the people of color in therapy whose perspectives have not yet been heard.

CHAPTER II

LITERATURE REVIEW

This chapter provides a review of the literature on the need for culturally competent mental health services, and the treatment issues of which clinicians must be conscious in order to improve treatment efficacy. Beginning with a brief historical review of literature on cross-racial therapy, most of the chapter focuses on literature published since the late 1980s, when a significant upsurge in cultural competence research began. Because the majority of literature on cultural competence has focused on ideologies and guidelines of which practitioners should be aware, minimal attention has yet to be paid to the actual experiences of clients who may be on the receiving end of these efforts. The purpose of this exploratory study is to illuminate the experiences of racial minority clients who have engaged in psychotherapy with clinicians whose racial backgrounds are different than theirs. This review aims to help conceptualize the role of a differing racial background between client and clinician in the therapeutic process, and thus provide a framework from which the experience of the racial minority client can be better understood.

Historical Perspective on Cross-Racial Therapy

Throughout the last century, the approach to race and race-related issues in the context of mental health has changed dramatically, keeping in line with societal beliefs and attitudes of the changing times. In the early 20th century, the first issue of *The*

Psychoanalytic Review (1913) contained three articles commenting on mental illness among Black people. Black people were referred to as “a race (of) relatively low social order,” and a people “whose development is lower than the White race and which furnishes numerous individuals showing psychological aspects quite similar to those of a savage.” Black people were seen as healthy psychologically if they exhibited signs of being “happy-go lucky” while remaining free of signs of protest despite their subservient role in society (Carter, 1995, p. 33). Not surprisingly, the mental health needs of visible ethnic/racial minorities were largely ignored in the early 1900’s. The social, economic and political events during the next half-decade, however, yielded increased physical and social mobility for people of color, which in turn, lead to greater access to mental health services. In the literature, researchers began to concede that people of color had been subject to social oppression as well as discrimination based on their race.

Despite this, the psychological and behavioral patterns that people of color experienced were attributed to factors such as “poor or aberrant ego functioning, uncontrollable id impulses, or an unrestrained superego,” rather than to difficulties associated with racial oppression. The “dysfunctional personality organization associated with race” was thought to produce “particularly distinct and difficult transference phenomena.” In the early 1900’s, countertransference was also thought to be stimulated by the “unique problems posed by a client of color,” and therapists had been instructed to “guard” against such influences (Carter, 1995, p. 36). Although therapists were to see people of color as individuals, many clinicians during the 1950’s worried that clients of color used their racial experiences “as a shield against revealing [their] true inner conflicts. According to these writers, focusing excessively on racial facts could create

“dangers” in the transference towards the clinicians, as well as overly sympathetic countertransference reactions. (Carter, 1995, p. 37).

Some theorists acknowledged that people of color experienced societal hardship not known to Whites, but believed that these experiences should be kept separate and should not impact their interpersonal experiences. Heine (1950) saw the patient’s concern with race-related issues as a symptom of disorder rather than as a problem itself worthy of attention in psychotherapy (1950, p. 376 as cited in Carter, 1995, p. 37). A few studies emerged later with a focus on the role of transference and countertransference in the interracial therapeutic dyad (Bernard, 1953; Schachter & Butts, 1968). These articles focused on the role and responsibility of the White therapist to analyze his or her own feelings about racial difference, and to use him or herself effectively in the treatment of clients of color. The assertion was that when the therapist hasn’t engaged in his or her own analysis, the client may be vulnerable to the “interference of a variety of positive and negative countertransference reactions stimulated by the ethnic, religious, and racial elements that are present in the analysis” (Bernard, 1953, p. 259). Noted in this study was the tendency for White therapists to either over sympathize with their “Negro” clients or to “have an apparent need to deny or sidestep any such effects [of racial dynamics] altogether” (Bernard, 1953, p. 262).

Beginning in the 1960’s, the counseling profession as a whole routinely began considering race, prejudice and discrimination to be significant factors in the counseling relationship, which mirrored the general societal attention being paid to the concerns of minorities (Jackson, 1995). With this decade came several research studies focusing on counseling issues related to the “culturally different” and “culturally disadvantaged”

(Grande, 1968; Reed, 1964; Wrenn, 1962). Over the next decades, interest in multicultural and cross-cultural counseling issues grew, resulting in an increase of research and articles on the subject. Researchers acknowledged that mainstream psychology did not attend to the needs and concerns of minorities (Sue and Sue, 1971; Vontress, 1971). Some studies looked at the role of race, in particular in the counseling process, and addressed counseling issues from a cultural perspective (Pedersen, Lonner, & Draguns, 1976; Vontress, 1971). As a result, counseling professionals sought to develop specialized skills and knowledge necessary to work with minority clients. The profession as a whole began to endorse a “cultural difference paradigm,” which asserted that “psychological and behavioral differences between whites and visible racial/ethnic groups are best explained by various influences related to racial and cultural background.” Social scientists studying the cultural difference paradigm began focusing their efforts on “describing the cultures of various visible racial/ethnic groups, and studying the psychological variables associated with these specific experiences” (Carter, 1995, p. 43). This paradigm has allowed for proponents of cultural difference who believe racial, class, and language differences have an important impact on cross-racial interaction. These proponents have focused their efforts on making sense of the cultures of various racial groups and developing specific interventions and guidelines for the racial and cultural experiences of the visible racial/ethnic group people. While valuable, Carter (1995) asserts that the “burden of change” is continually “inflict[ed]” on “those who are racially or culturally different, rather than on those [White individuals] or systems that provide mental health service” in this country (Carter, 1994, p.44). Thus,

the context of a normative of Whiteness necessarily places the responsibility of any difference on the client.

Recent relational approaches to therapy have conceptualized the therapeutic encounter as jointly constructed and negotiated, and are recognizing race, ethnicity, and culture as important components of the therapeutic process (Altman 1995; Hoffman, 1992; Renik, 2004). Race, ethnicity, and culture, which are thought to carry different power in the therapeutic interaction depending on the identification of the clinician and the client, are seen as encapsulating important material which is ever-present in the conscious and unconscious communication between clinician and client (Tang & Gardner, 1999). Yi (1998) argues that in most cross-racial therapy dyads, race, ethnicity and culture become salient issues in the treatment, often contributing to and shaping the nature of the therapeutic exchange. More recently, attention to these issues has manifested in the form of “cultural competence.”

Need for Cultural Competence in Mental Health Services

The need for culturally competent mental health care has been expressed increasingly over the last few decades, whether or not it has been specifically termed “cultural competence.” Currently, such a need is justified, first, by increasing demographic shifts toward more cultural diversity in the U.S. population. Recent increases in people of color – 20% in 1990 to 25% in 2000 – are thought to be the largest in history (U.S. Bureau of the Census, 2000). According to the 2000 census, approximately 25%–30% of the U.S. population self-identified as belonging to an ethnic or racial minority group (U.S. Bureau of the Census, 2000). It is predicted in the U.S. Census that by 2010, this figure will rise to 32.7%, and by 2050, to 47.5% (almost one

half of the entire population in the U.S.) and will continue to grow as birth rates and immigration for these groups, particularly Latino and Asian populations, continue to increase (U.S. Bureau of the Census, 2000).

Several sources argue that such a growing ethnic/racial diversity necessitates changes in the mental health system to meet the different needs of a multicultural U.S. population (APA, 1993, 2003; Atkinson et al., 2001; Bernal & Castro, 1994; Hall, 1997; Ridley, 1985; Sue, Arredondo, & McDavis, 1992). This literature specifically argues that the incorporation of cultural competence into therapeutic practice will become necessary if psychotherapy is to remain relevant and viable in the years to come (Sue, 1998; Sue & Torino, 2005).

Another push for the need for cultural competence in mental health practice has been understood through examining ethnic/racial disparities in the utilization of mental health services. Studies showing the underutilization of mental health services by members of major ethnic/racial minority groups were jumpstarted in the late 1970's by Sue's (1977) seminal research, and have since continued (Breux & Ryujin, 1999; Snowden & Cheung, 1990).

An additional reason for the call for cultural competence in therapeutic practice is based on ethical grounds. Arredondo and Toporek (2004) called attention to the significant overlap between the ethical guidelines of the American Counseling Association and the statement of competencies in their document on multicultural counseling competencies. Ridley (1985) framed cultural competence as an ethical obligation by placing "cross-cultural skill on a level of parity with other specialized therapeutic skills." He asserted that "the acquisition of cross-cultural competence

demands a similar depth of training and supervised experience as competence, for example, in treating sexual dysfunction or specific character disorders.” He then continued on to conclude that “delivering mental health services outside of one’s area of competence constitutes an ethical infraction. (p. 613).” Later, in much the same vein, Hall (1997) compared culturally-based courses to physiological psychology, sensation and perception; in other words, all fundamental to the psychology curriculum. These views are based on the assumption that cultural diversity is an essential component of human behavior requiring specialized knowledge and skills.

Although compelling cases have been made for the necessity of culturally competent delivery of mental health services, definitions of “cultural competence” itself are ever-changing. As the movement toward cultural competence in mental health gains national attention, an increasing amount of research is devoted to studying factors that promote cultural competence. What is “cultural competence” exactly? As it is increasingly recognized by policy makers, managed care administrators, academicians, clinicians, and clients as legitimate and relevant, an ongoing debate grows as to how to better define and operationalize such a critical yet broad construct.

Evolving Definitions of Cultural Competence

Early studies of cultural competence in practice focused primarily on ethnic/racial matching of client to provider. Ethnic/racial matching is seen as a type of “cultural responsiveness” to the mental health needs of people of color (Sue, et al., 1991). Later, this concept was expanded to “ethnic-specific” services, in which a critical mass of providers representing a specific ethnic/racial group was made available (Takeuchi et al., 1995). The ethnic/racial matching approach served as the basis for the call to increase the

cultural diversity of service providers. A few studies reported significantly better treatment outcomes for ethnic matching (Sue, et al., 1991; Takeuchi, et al., 1995).

However, reviews of the empirical research on ethnic/racial matching seem to yield inconclusive treatment outcomes (Maramba & Hall, 2002; Shin, Chow, & Camacho-Gonsalves, 2005). In addition, there continues to be insufficient representation for diverse ethnic/racial minority group members in the mental health professions (Bernal & Castro, 1994; Hall, 1997). This truth requires the mental health field to acknowledge the realities of the limited utility of ethnic/racial matching and the underrepresentation of ethnic minority professionals in the mental health system. Thus, the treatment of ethnic/racial minority members by majority group members (White clinicians) becomes the main focus in this particular discussion of competence. However, the nature of this conceptualization is not without its limitations, as will be discussed later in this chapter.

Realizing that any combination of cross-racial dyads can raise issues of cultural competence renders cultural competence training, which has been proposed as another strategy to increase the delivery of effective mental health services to people of color (Beach, et al., 2005; Bernal & Castro, 1994; Hall, 1997), relevant for all practitioners. Moreover, Comas-Diaz (1988) noted that training in cultural competence helps one gain effectiveness with clients from backgrounds defined by characteristics other than ethnicity/race. In other words, one view is that a culturally competent mental health professional is more adept at addressing the unique experiences and issues of all individuals regardless of cultural background.

Although mental health systems as a whole can be seen as culturally incompetent, many models for operationalizing cultural competence have emphasized the delivery system, particularly the clinician-client interaction. In this sense, cultural competence has been conceptualized as:

The process by which individuals respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each. (NASW, 2001, p.1).

Cultural competence has also been conceived more tangibly as the ability to transform knowledge and cultural awareness into psychosocial interventions that support and sustain healthy client system functioning within the appropriate cultural context (McPhatter, 1997). Hall (1997) takes it a step further and concludes that cultural competence is the belief that people should not only appreciate and recognize other cultural groups but also be able to work with them effectively. According to Hall, cultural competence is not merely an ideology, but rather a skills-base, and these skills should be in the repertoire of all practicing clinicians.

A number of different terms have been proposed to better articulate and encapsulate its meaning: cultural sensitivity (Ridley, et al., 1994), responsiveness (Sue, et al., 1991), effectiveness (Yutrzenka, 1995), and humility (Shellenberger, 2007). Each term emphasizes certain aspects of competence and together they reveal a lack of consensus about the priorities of this approach. Despite the prevalence of cultural competence in various forms, no one has yet reviewed the literature to develop a more comprehensive approach to thinking about and implementing cultural competence in mental health care at multiple levels and from multiple perspectives. However, the

recognition of its relevance, in any form, to today's delivery of mental health services is evident. Professional organizations and individuals have been quick to establish guidelines or standards of cultural competence in the mental health care of an ethnic/racially diverse population.

Mandates, Guidelines and Standards for Cultural Competence

Guidelines and standards have been promoted following the establishment of cultural competence as a service and training goal in the delivery of mental health care. The constantly increasing broad range of clients and the complexity associated with diverse populations has resulted in several organizations recommending standards in delivering culturally competent services, with the National Association of Social Workers (NASW, 2001) deeming it an ethical responsibility. The Association for Multicultural Counseling and Development (AMCD) produced guidelines outlining cultural competencies for the counseling profession (Arredondo, et al., 1996), and several other professional organizations have developed mandates holding practitioners accountable for rendering services characterized by cultural competence (APA, 2003; Lopez & Rogers, 2001; Malik & Velazquez, 2002; McPhatter, 1997; Substance Abuse and Mental Health Services Administration [SAMHSA], 2001; Ysseldyke, et al., 1997).

However, fulfilling such mandates remains a complex task. First, despite most of the guidelines toward culturally competent care taking the form of convenient lists, it is now generally acknowledged that cultural competence is understood as a process, not a product. If genuine cultural competence is considered a lifelong professional endeavor (APA, 2003; Sue, Arrenondo, & McDavis, 1992), then the message implicit is that fulfilling the mandates should *not* be an easy task. Second, the scope of cultural

competence can be overwhelming for any practitioner. The U.S. Department of Health and Human Services (SAMHSA, 2001) identified 58 competencies across 12 domains considered essential when offering services to underserved/underrepresented groups. Sue, et al. (1998) identified 34 competencies critical to cultural competence for psychologists, while other mental health disciplines have promoted their own permutations of cultural competencies (Lum, 1999). To illustrate such limitations, the National Association of Social Workers Standards for Cultural Competence (NASW, 2001) has published a document outlining its “first attempt to delineate standards for culturally competent social work practice”:

Standard 1. Ethics and Values—Social workers shall function in accordance with the values, ethics, and standards of the profession, recognizing how personal and professional values may conflict with or accommodate the needs of diverse clients.

Standard 2. Self-Awareness—Social workers shall seek to develop an understanding of their own personal, cultural values and beliefs as one way of appreciating the importance of multicultural identities in the lives of people.

Standard 3. Cross-Cultural Knowledge—Social workers shall have and continue to develop specialized knowledge and understanding about the history, traditions, values, family systems, and artistic expressions of major client groups that they serve.

Standard 4. Cross-Cultural Skills—Social workers shall use appropriate methodological approaches, skills, and techniques that reflect the workers’ understanding of the role of culture in the helping process.

Standard 5. Service Delivery—Social workers shall be knowledgeable about and skillful in the use of services available in the community and broader society and be able to make appropriate referrals for their diverse clients.

Standard 6. Empowerment and Advocacy—Social workers shall be aware of the effect of social policies and programs on diverse client populations, advocating for and with clients whenever appropriate.

Standard 7. Diverse Workforce—Social workers shall support and advocate for recruitment, admissions and hiring, and retention efforts in social work programs and agencies that ensure diversity within the profession.

Standard 8. Professional Education—Social workers shall advocate for and participate in educational and training programs that help advance cultural competence within the profession.

Standard 9. Language Diversity—Social workers shall seek to provide or advocate for the provision of information, referrals, and services in the language appropriate to the client, which may include use of interpreters.

Standard 10. Cross-Cultural Leadership—Social workers shall be able to communicate information about diverse client groups to other professionals.

While all ten standards seem infused with the benevolent spirit and efficacy-increasing intention characteristic of most cultural competence endeavors, the utility of these NASW guidelines is, save for a few standards, limited by the intangible nature of the language with which they are outlined. Aside from Standards 5, 7, and 9 (Service Delivery, Diverse Workforce, and Language Diversity), which lend themselves more directly to practical application, the remaining standards offer guidelines for *what*, but not *how*, to incorporate culture into one's professional identity. Particularly problematic is that several of these broadly stated guidelines are those meant to inform direct clinical practice. For example, the standard of Self-Awareness requires social workers to develop an understanding of their own personal, cultural values and beliefs as a way of

“appreciating the importance” of their clients’ multicultural identities seems agreeable in principle. However, the NASW does not offer tips on gaining awareness of personal values, perhaps because the process of investigating one’s own beliefs is a difficult one to manualize. And how exactly does one develop Cross-Cultural Knowledge? How does a practitioner who is not sure of the appropriate Cross-Cultural Skills use them?

A quick look at the guidelines outlined by the NASW would suggest difficulties in the measurement of each standard, which may not be unrelated to the greater difficulty of a practitioner knowing exactly how to enact each standard. Theoretically, the NASW requires mental health practitioners to be culturally competent and able to demonstrate this competence in the “provision of services that are sensitive to clients’ cultures and to differences among people and cultural groups” (NASW Code of Ethics, 1999, p. 9). In practice, however, it is unclear how clinicians are translating cultural competence mandates into their clinical work.

In general, there is abundant literature that indicates the need for therapists to build awareness, increase knowledge with respect to racial groups’ cultures, and develop a level of sensitivity to enhance cross-racial effectiveness, but it remains unclear which strategies a cross-racial therapist uses to be “competent” (Carter, 1995, p. 44). This explains the prevalence of another limitation of guidelines for cultural competence that presents itself in the literature: minimal research exists on how well such guidelines are followed by clinicians, which in turn cycles back to the issue of enactment and measurement.

Another type of limitation in guidelines for culturally competent practice is rooted in the process of their initial development. When concerns regarding the issues in cross-

cultural therapy prompted the American Psychological Association (APA) to establish guidelines for the provision of mental health service to members of ethnic minority groups (APA Office of Ethnic Minority Affairs, 1993), they produced the following recommendations to facilitate culturally competent treatment: 1) the necessity to know the culture of the clients, 2) to be sensitive and flexible in dealing with clients, and 3) to achieve credibility in the eyes of clients.

While each of these recommendations seem helpful, Sue (1998) asserts that such recommendations were based on theory involving cultural match or fit rather than derived from definitive research findings, and went on to note the lack of rigorous study examining the efficacy of treatment for any ethnic minority. Two reviews on research on psychotherapy with culturally diverse populations seem to bolster his assertion (Chambless, et al., 1996; Sue, Zane, & Young, 1994).

While it seems critical to recognize and even mandate cultural competence as an ethical responsibility of mental health practitioners, it is also important to move from abstract discussion of competencies and guidelines to the application of cultural competence in the context of individual-level – particularly cross-racial – therapy. Such a shift, it seems, will require further research.

Concerns with Cultural Competence

Several concerns have been raised about cultural competence, including its lack of evaluation research, the uncertainty with which clinicians perceive it as a set of skills that can be taught and learned, and potential negative effects for the clients for whom cultural competence is aimed to help.

First, while the current state of clinical practice is considered by some to be a “crisis of competence and conscience in the treatment of those clients whose ethnicity, race, or class renders them minority groups in American society” (Perez-Foster, 1998, p. 253), the claims surrounding the value of cultural competence for the practice of mental health are also not fully supported by evaluation research showing that careful and systematic attention to culture really improves clinical services. This leaves the notion of culturally-informed practice as a definitive method with which to improve clinical services contested (Kleinman, 2005; Lee & Farrell, 2006). However, as efforts have been made to introduce culturally informed strategies into clinical settings, some argue that the lack of evidence can be attributed to the failure of outcome research to prioritize assessing the effectiveness of culturally-informed practice (Kleinman, 2005).

A second major concern with the notion of cultural competence is that it seems to suggest to some that culture can be reduced to a technical skill for which clinicians can be trained to develop expertise (DeVecchio, 1995). In addition to such “skill” lacking concise explanation and elaboration, the definition of culture itself serves as a key limitation in this sense. The notion that culture equals ethnicity and race, or more specifically, culture equals an ethnic or racial minority group is pervasive throughout the literature. For example, SAMHSA’s guidelines for competencies were developed for the four main underserved and underrepresented racial and ethnic groups in the U.S. (SAMHSA, 2001). The focus on minority groups is understandable, as the justification for cultural competence is in large part based on the existence of disparities in the mental health care of these groups. However, a disadvantage of equating culture with ethnically or racially-defined groups is that it leads to a conception that what matters about culture

is packaged within distinct ethnic and racial boundaries. This is a drawback that the researcher herself came up against in designing the present study. Because cultural competence models seem to be based on group-specific information of “difference” in terms of cultural characteristics, the implication is that clinical intervention must be changed to accommodate presumed cultural difference of the minority group from the dominant White culture. This sort of approach may inadvertently promote stereotyping under the guise of cultural competence while failing in its intended purpose of addressing the individual needs of members of these minority groups.

However, in moving towards how mental health professions have approached training for cultural competence, there has been a recent shift toward facilitating learners’ understanding of the nature of “difference” (Montalvo, 1999; Van Soest, 1995). This includes issues of racism (including internalized racism) and of oppressed populations. These content areas point toward ways in which “difference” functions in making social distinctions in the power, access, and privilege that individuals and groups experience based on personal attributes, as perceived by members of the dominant culture and group affiliation.

Finally, while the importance of cultural competence within the clinical setting is believed to encourage minorities to seek treatment and to improve their outcome once in treatment, several authors raise concerns about the potential negative effects of cultural competence in the way that it is currently conceptualized (Betancourt, 2004; DelVecchio, 1995; Kleinman, 2005; Lee & Farrell, 2006). Not only does the field lack evidence that clinicians who adhere to a culturally competent approach provide better mental health care than those clinicians who do not, but some researchers also suggest that cultural

competence in its present form could lead to client dissatisfaction and even poorer outcomes in the treatment process. The primary concern lies in the “manualized approach” of many cultural competence training schemes (e.g. relying on institutional manuals with titles like, “How to Work with Latino Clients”). Although in certain situations learning about a particular community in this way can be helpful, these researchers argue that, when broadly applied, this approach can lead to stereotyping and oversimplification of culture. While most of the researchers remain proponents of cultural competence in principle, they call for continued research to address cultural competence’s conceptual and practical limitations.

Conclusion

A review of the literature on cross-cultural therapy reveals that cultural differences can affect the development of therapist-client rapport, the therapeutic alliance, the validity of assessment, and treatment effectiveness. The wide acknowledgement of this notion manifests itself in the numerous arguments for and enactments of policy relating to cultural competence by scholars and professional organizations alike. Despite the acknowledged need for mental health care to incorporate a cultural perspective, there are significant empirical and conceptual limitations to the study of cultural competence.

While a general need exists to examine the efficacy of cultural competence as it is currently being conceptualized, there is a particular dearth in the research that might illuminate the clinical practices and processes through which cultural competence takes shape in therapeutic interactions. It is this evidence of how clinical practice is impacted that is needed if cultural competence is to be implemented by systems of mental health care, and on a smaller scale, if clinicians working with an increasingly diverse population

are to more meaningfully understand how potential cultural ‘incompetence’ directly affects the experience of their clients. All this evidence suggests that the client perspective in cross-cultural therapeutic work, particularly when the client is a member of a visible racial/ethnic minority group, is deserving of research.

Given the potential negative impact on clients – and perhaps even on society as a whole – of failing to incorporate culture into the delivery of mental health services, efforts concerned with determining the prevalence of cultural competence-related treatment issues are insufficient; research into specific effective treatment methods and accompanying development of professional training for working with diverse populations is necessary if therapeutic practice is to be effective for the growing American population.

The current study seeks to begin to address this gap in the literature by identifying treatment issues at a basic clinician-client interaction level in instances when the client is a member of an ethnic/racial minority group working with a clinician of a differing racial background than him or herself. It is hoped this study will increase awareness among professionals working with diverse populations and clarify some of the unique problems faced by clinicians working with clients with whom they do not share similar cultural and racial backgrounds.

CHAPTER III
METHODOLOGY

Research Design

The purpose of this study is to examine the subjective experience of clients of color undergoing psychotherapy with clinicians of a different racial background. Since very little research has been conducted with a client perspective as a focus, an exploratory study using qualitative methods was chosen. An exploratory study allowed the researcher to gain a greater understanding of the topic from participants' points of view, and the choice of qualitative design was appropriate due to the relatively small number of participants who would be interviewed (Anastas, 1999).

In-depth, semi-structured interviews were conducted with twelve clients who self-identified as having worked with at least one clinician of a different racial background than their own. Findings were then analyzed qualitatively.

Sample

The target size for this sample was 12-15 participants. The participants comprised a non-probability sample of persons of color who within the last 5 years had received mental health services from a clinician whom the participant identified as belonging to a different racial group from his/her own. Exclusion criteria included individuals who were currently involved in mental health treatment, whether or not they intended to share information about their current therapeutic relationship, as well as

individuals who intended to discuss a cross-racial therapeutic relationship that ended more than five years ago. Those who had not yet reached the age of 18 at the time of interview were not included. Additionally, those not conversant in English (the language used when conducting interviews) were excluded from the study. The researcher accrued this sample from individuals who have received mental health services in the Bay Area of California. The small sample size meant it was not possible to ensure diversity among the participants regarding gender, age, race/ethnicity, or religious affiliation. However, every effort was made to recruit a diverse group of participants.

A total of 22 potential participants were screened for participation in this study. Of those, seven did not meet selection criteria, two met criteria but could not be interviewed due to scheduling conflicts, and one initially agreed to participate, but withdrew due to health reasons. The final sample was 12 clients.

Of the 12 participants, nine were women and three were men. Six were Asian (two Chinese, one Korean, one Indian, one Laotian), three were Black (two African, one Caribbean), two Latina (one Mexican, one Peruvian), and one participant was of Mixed racial heritage (Vietnamese Asian and White). Two participants were immigrants to this country (one from England, one from Korea), 10 other participants were born in the United States. Chapter 4 will outline the demographic information of these participants in more detail.

Procedures

Following the approval of the project from the Human Subjects Review Committee at Smith College School for Social Work (see Appendix A), the researcher recruited a geographically convenient sample of racial minority clients in the San

Francisco Bay Area. Potential participants were recruited using the non-probability technique of a snowball sample (Anastas, 1999).

The researcher began the recruitment process with personal contacts among individuals who work in the field and knew of existing support and focus groups for people of color. Copies of the recruitment letter as well as fliers were distributed to these contacts. The individuals notified their colleagues about the research study and distributed the provided recruitment letter as a basis for providing information to potential participants. Fliers were also posted by the researcher in local coffee shops as well as the publicly-accessible online forum, Craigslist.

Once contacted by each potential participant, the researcher conducted a brief screening interview by telephone or email. The screening interview also allowed the researcher to provide more detailed information about the study while using exclusion and inclusion criteria to narrow the sample. Participants were also briefed on the informed consent procedures. They were asked to provide a mailing address so that the interviewer could mail them a copy of the Informed Consent Form (see Appendix B). This copy was for the participant to keep for his/her own records and to review at his/her leisure; all participants were asked to be prepared to sign another copy in the presence of the interviewer at the time of the interview. At the start of the interview, the researcher reviewed the informed consent form with the participant and asked that the participant provide a signed consent before the interview proceeded. At this time, the participant received another copy of the consent form for their own records in the event that they had misplaced the one previously mailed to them. The researcher explained the details of the study, and after any questions the participant may have had were answered,

the researcher and the participant scheduled to meet at a mutually convenient location in order to conduct the interview. Locations included private rooms at local university libraries, private rooms at community centers, and private office spaces.

At the beginning of the 60-90 minute-long interview, the researcher identified and reviewed with participants the possible risks and benefits of participation. Although minimal risk from participation was anticipated, participants were informed that they might experience distress when reflecting on the course of their treatment experience(s), and would have access to a list of referral sources. Participants' concerns about how the researcher would utilize the data following the interview were discussed, as were issues of confidentiality addressed at the beginning of each interview. Participants were asked not to identify clinicians, agencies, or treatment clinics by name during their interviews. Participants were informed that they would not be compensated monetarily for their participation in the study, though they might gain new insight into their therapeutic process, along with helpful ways in which they may approach therapy in the future. In addition, participants might have also gained from knowing that their participation may be contributing to the betterment of other future clients' treatment, as the information gathered from these interviews was helping the researcher to find a way to present "cultural competence" to clinicians in a tangible manner, which may in turn inform their future provision of treatment.

Participants were also informed that their participation in the study was entirely voluntary. Participants were permitted to withdraw before the study began, or at any point during the interview. They were also told that they could refuse to answer any question, or request that any data already gathered be destroyed. For the one participant

who withdrew from the study, materials pertaining to him were automatically destroyed. There was no penalty for any of these actions. Participants were encouraged to contact the researcher via email and/or telephone if they had any further questions or concerns about the study, both before and after the interview. The researcher's contact information was listed on their consent form.

The researcher conducted individual, semi-structured interviews utilizing a list of interview questions (see Appendix C) that served as a guide as she asked the participants both closed and open-ended questions. Such semi-structured interviews as a data collection method allowed for the collection of rich, narrative data that might contribute to a greater understanding of this relatively unexplored topic (Anastas, 1999).

Open-ended questions were included in hopes of producing more detailed responses from participants. The interview guide was developed to elicit participants' narratives regarding their experience in cross-racial therapeutic interactions. Participants were asked to refrain from using names or identifying information about the clinician(s) being discussed during the interview. Demographic questions were included at the beginning of the interview, which asked participants to disclose information related to racial identification, gender, age, occupational and educational background, and therapeutic experience. Each interview adhered to a similar progression toward the exploration of the participant's experience of difference of racial background between her/him and the clinician conducting therapy. The selections from the full interview which are presented in the next chapter have been edited for clarity and to protect the identity of all participants.

The individual interviews were audio-taped using a digital recorder. Notes were taken by the researcher during the course of the interviews with participants. The researcher hired a professional to transcribe each gathered narrative in full. The researcher pledged that she and the transcriber would listen to the audiotapes in a private setting. The transcriber was asked to sign a confidentiality pledge. The participants were informed that the researcher's Research Advisor would have access to the data after identifying information had been removed. Data in this thesis and any future professional publications or presentations are presented such that illustrative vignettes and quote comments appear without reference to identifying information. The privacy of the participants is kept protected through the assignment of numerical codes to data, audiotapes, and notes. These materials, including consent forms, will be kept secure for a period of three years as stipulated by federal guidelines, after which time they can be destroyed or, if needed, can continue to be maintained securely. Data will be destroyed when no longer needed. In order to assure participant confidentiality, demographic information, researcher notes, transcripts, and audio tapes are kept separate from informed consent documents and are identified by numerical codes rather than names or other identifiable information. It was during the transcription process that any names or other identifiable information from participants that could potentially be recorded during the interviews were removed or disguised.

Data Analysis

Analysis began after the first third of the interviews had been conducted, and continued throughout the data-gathering process. This allowed for an opportunity to identify emergent themes within completed interviews and to explore those themes with

the remaining participants. After transcription, the narratives garnered through the interviews continued to be analyzed. The researcher read each transcript individually and coded excerpts according to themes and categories addressed. Passages which were similarly coded were sorted into sections and further coded into narrower topic areas. Each of these categorizations was noted on a spreadsheet. Representative quotes were used to substantiate these themes or ideas. Data were also compared to determine similarities and differences with respect to the literature review. Transcripts were also analyzed for important themes or ideas that had not been targeted by the semi-structured interview guide but which were raised during the interviews by participants.

These findings will appear in the next chapter, Chapter 4. In compiling these findings, the researcher was conscious of the implications of her status as an interviewer with her own racial minority status. Due to the small sample size, narrow geographic location of participants (Bay Area of Northern California) and selected research design, generalizations cannot be made from the results of this study. Rather, the findings provide an in-depth understanding of some of the experiences of clients who have undergone cross-racial therapy.

Finally, in the Discussion chapter, Chapter 5, the concepts and themes which have emerged from analyzing the participants' narratives are explored. Discussed in addition are the implications for clinicians practicing in the context of a profession in which cultural competence is so strongly emphasized.

CHAPTER IV

FINDINGS

This chapter contains the findings from interviews conducted with 12 participants who have undergone past individual psychotherapy with clinicians, all of whom were of a differing racial background than the participants themselves. Participants were asked to consider how, if at all, their experiences during their treatment were affected by such a difference in racial background. Although criteria for entry into the study required the participant to recall a therapy relationship in which racial differences existed between themselves and the clinician, any participants' reflections on broader issues of culture (and cultural differences) which arose during the interview were also noted and recorded.

The interview questions were structured to elicit information regarding clients' experiences of the major treatment issues that arose while working with these clinicians, to facilitate discussion of the cultural transference/countertransference that occurred, and to gain insight into clients' awareness of and need for cultural competence when undergoing psychotherapy. Participants were also asked to discuss any other relevant aspects of their clinical experiences with these clinicians that had not been addressed by the formal interview questions.

The data from these interviews are presented as follows: demographic data of participants and clinicians, participants' awareness of racial difference in the therapeutic

setting, major treatment issues, and participants' reflections on treatment as it relates to cultural competence.

Demographic Data

Participant Demographics

As noted in the chapter on methodology, this study was comprised of 12 participants: nine women and three men. In order to be considered for participation, each participant necessarily self-identified as a person of color. Six described themselves as Asian (two Chinese – one male, one female, one female Filipina, one female Korean, one female Indian, one female Laotian), three were Black (two male African, one female Caribbean), two were Latina (one female Mexican, one female Peruvian), and one female participant was of mixed race (Vietnamese Asian and White). Two participants were immigrants to this country (one from England, one from Korea), 10 other participants were born in the United States, and all resided in the Bay Area (San Francisco, Berkeley, Oakland or surrounding cities) of California.

For all but four participants, English was the first learnt language. Three of these participants described learning English simultaneously with another language spoken by their families of origin, and one participant, who was deaf, only learned English in order to learn American Sign Language at age 14, when her family emigrated from Korea to the United States. All spoke English comfortably and fluently.

Participants' ages ranged from 25 to 46-years-old, with the average age being 34-years-old. Four participants' ages fell between 25-29, one participant's age fell between 30-34, five participants' ages fell between 35-39, and two participants' ages were 40+.

Participants held various occupations, and two were Masters students in clinical fields (one of Social Work, one of Marriage and Family Therapy). One other participant held a Masters Degree in Communications and Marketing, and the remaining participants received some level of college education, but did not pursue higher levels of education than the undergraduate degree. Average number of years in therapy was 4 (range 1 to 12 years).

Clinician Demographics

Participants reported working with a total of 31 clinicians throughout their lifetimes. Of these 31, treatment with 19 of these clinicians fell within the last five years. Participants were asked to focus on experiences with those clinicians, in an attempt to enhance accuracy of recall. Each of these 19 clinicians was of Caucasian descent, and spoke English as their primary languages, according to participant report. Although participants who had worked with more than one clinician in the last five years were initially asked to choose one clinician to focus on during the interview as a way to maximize the richness of their descriptions, seven participants did not comply with this directive. Thus, all comments and reflections, as long as they pertained to a therapeutic experience that occurred within the last five years, were still recorded. Five participants (four female, one male) focused exclusively on one clinician during the interview. Seven (five female, two male) focused on one clinician for most of the interview but brought in differing experiences from other clinicians periodically.

In 14 instances, the participant reported that the clinician was older than him or herself. In three instances, the clinician was younger, and in two instances, the participant perceived the clinician to be the same age as him or herself.

Participants' Awareness of Racial Difference

Analysis revealed similarities within and differences between respondents' stories that reflected an awareness of racial difference from the majority which developed well before entering therapy. Participants seemed to indicate that the exploration of racial and cultural identity that often followed this initial awareness had an influence on future awareness of racial differences in the therapeutic setting. This section contains: (1) participants' reports of self-awareness and early life experiences as pertaining to racial difference; (2) exploration of this difference in relation to identity; and finally (3) an awareness of racial difference in the therapeutic setting when seeking therapy, or during it.

Self-Awareness and Early Life Experiences

Eight participants described their early childhood and adolescent experiences as times during which they first became aware of feelings of racial difference. Half of the participants described knowing from a young age of their non-majority status:

Very few Vietnamese around where I grew up [*in Southeastern region of United States*]. When I was 8, I knew I looked more Asian growing up [*than Caucasian, being of a mixed background*] ... definitely felt like an outsider. Conscious of my Asian-ness ... for sure. (*Participant 3, 31-year-old female, Mixed White / Asian-Vietnamese*).

Two other participants described their awareness of racial difference being marked by geography:

I definitely felt like the minority. Especially when I was younger. Where I grew up [*in England*] was not diverse at all. A big Indian population, but still, I was in the minority. (*Participant 1, 29-year-old female, Asian-Indian*)

Definitely, yeah, in elementary school growing up, I was in a private Catholic School in a suburb of [*large city in Texas*], of all places, and it was really hard for me. Me and the other two Asians were friends, and we'd be in the little corner all

the time. During recess time, I remember the three of us sitting down while the others were playing ... It was definitely segregated. Probably not as bad as other places, but we definitely felt it – being the minority. We were the stereotypical quiet ones, you know, got the good grades ... (*Participant 2, 29-year-old female - Asian-Chinese*)

This participant, in addition to echoing a recognition that her minority status was directly influenced by geography (and that geography was affected by cultural diversity), also acknowledged that her identity at a young age was influenced by stereotypical thought.

Only one participant emphasized that racial differences have never been her main concern in relating to the majority:

Well, I grew up in Korea, so what upset me most growing up was that I was hard of hearing. My sister would help me. However this is something that you can't ignore. [*Interviewer asks: You mean being hard of hearing is something you have to notice, have to address, when you're growing up?*] At any age! ... and then of course when we moved [*to California*], I had to learn ASL (*American Sign Language*), so that was something completely different... but that I am Korean has never been the main problem. (*Participant 4, 27-year-old female - Asian-Korean (Deaf)*)

However, the fact that she indicated that her ethnicity had never been the “main” concern suggests that this participant considered it a relevant issue of difference.

Exploration of Racial Difference and Identity Development

Six participants discussed an exploratory period during which their racial differences were integrated into their development of identities at different levels. Two participants spoke about their limited exposure to their own race and culture at a young age, leading to a radical shift in the way they sought out others from the same background during their adolescence and young adulthood:

When I went to college, I sought out only Asian friends, because I didn't have any of those growing up. And I took Tagalog language classes, because I always felt a little incomplete, you know, like searching ... always dating Asian guys. (*Participant 8, 25-year-old female - Asian-Filipina*)

And then in high school, I don't know what happened, maybe a high school thing, but I feel so bad to this day, I left my best friend who was Caucasian, totally ditched her, and went to the Asian Crew. My high school life was all Asian. All of a sudden, everyone in my life around me was Asian. And it overflowed to college. I joined an Asian sorority, everyone around me was Asian. I very much felt a strong affiliation and identity with Asians and the Asian community. (*Participant 2, 29-year-old female - Asian-Chinese*)

This participant continued on to say that this strong identification with her racial community could be viewed as negative, and that the struggle with her dual identity remained a pertinent issue at the time of the interview:

After college I felt the effects of [*having exclusively socialized with other Asians*], I felt like I could relate to Asians, obviously, but then what? And it wasn't necessarily a good thing anymore, since I realized it wasn't the real world, and I didn't want to be viewed as someone who was only identifying with Asians. So I probably think it's a struggle to this day. (*Participant 2, 29-year-old female - Asian-Chinese*)

Another participant also indicated that having navigated the balance between identifying with her minority group under the scrutiny of the majority group was challenging:

Going back to [*graduate school*] was when I first started actually meeting non-Asians again. You know 'cause when I was surrounded by Asians, they would keep introducing me to their Asian friends, and it just kept on being a big Asian bubble. So yeah, I was torn between loving it and wanting to identify with it, and it becoming almost like a gang or cult. (*Participant 12, 35-year-old female - Asian-Laotian*)

She confessed that her struggles continued to manifest themselves socially even up until the time of the interview:

Now, I'm venturing out again, and I'm beginning to become closer to one of my work mates who's Iranian, and we can actually talk about our cultural differences, and that's been neat. She hangs out with white people, and so she jokes about 'Oh, I'm gonna bring you out with my White friends... Sarah's first time out with White people!' (*Participant 12, 35-year-old female - Asian-Laotian*)

In contrast, another participant emphasized the role of other, non-racial components to his identity, despite race having played a significant piece of identity development during younger years:

Religion and spirituality are a big part of my identity, too. Educational and professional background make up a large part of my identity. Race is a big part. Race was the major piece growing up and in college ... but not now. [*Despite this*] I've still experienced issues over race stuff in therapy ... even not that long ago. (*Participant 9, 35-year-old male - Black-African*)

Still, he noted that “race stuff” continued to arise in therapy.

Racial Difference in the Therapeutic Setting

Nine participants reported that they had not been so aware of the racial differences between themselves and their therapists prior to entering therapy. In fact, once engaged in therapy, several participants pointed to several other types of factors of difference which first caught their attention:

Something that I think I've struggled with her a little bit in my own head about is that she doesn't have children. Which, I mean, not that, I don't know why that ... sometimes it makes me think that some of her understanding of some things might be different if she had children. I think it's been a personal struggle of hers to be accepted by society if she's chosen not to have children. And without wanting to, I did judge her for it. (*Participant 9, 35-year-old male - Black-African*)

[*Our difference in racial background*] played into things, but other times it was her age that was the obvious thing. Like a generational type thing. [*Interviewer asks: You said your therapist was late 50's, early 60's?*] Yeah, about. I thought she worried too much ... like a mom. (*Participant 8, 25-year-old female - Asian-Filipina*)

I used to be really overweight when I was a kid. And I just don't think she had ANY idea what that was like. To have that history and still struggle with this [*grabs gut*]. (*Participant 9, 35-year-old male - Black-African*)

Three participants, who would later report that major treatment issues arose due to racial differences in therapy, suggested that seeking a therapist with whom they shared

the same racial background initially never entered their minds as an option, primarily due to their preconceptions that the profession of practicing therapy was steeped in majority (White) culture:

I never thought, 'I'm looking for a therapist and so I'm looking for a Chinese one.' Mostly because I had never heard of a Chinese therapist before I came to the Bay! In my mind, therapists were white. (*Participant 6, 39-year-old male - Asian-Chinese*)

When [*participant's son*] got his tooth pulled, ain't like we went to look for no Black dentist or nothin'! [*laughs*] My doctor's white, my therapist's gonna be white. (*Participant 10, 46-year-old male - Black-African*)

Each of these nine participants indicated that the first time they became aware of the racial differences between themselves and their therapists, or that the racial difference could be a legitimate issue, was when a specific event occurred in therapy:

I did not think about racial background while seeking a therapist. It wasn't until later when something came up about cultural identity that she couldn't quite understand, that I was thinking about ... started thinking about racial differences. (*Participant 9, 35-year-old male - Black-African*)

The following section will detail the nature of some of these events and explore the mostly unanticipated treatment issues reported by study participants.

Major Treatment Issues

Regardless of the degree of self-awareness and the way in which participants integrated their racial minority status into their identities growing up, all participants, by treatment's end, were aware of the cross-racial nature of their respective therapies. A significant portion of the interview asked participants to elaborate on the influence of the differing racial background of their therapist. Contained in this section are participants' reports of the major treatment issues encountered during their work with therapists of differing racial backgrounds. Generally, participants suggested that their differing racial

backgrounds generated significant transference responses which were primarily negative. The section's data has been organized into the following: (1) frustration with participants' own inability to adequately explain an aspect of their culture to the therapist; (2) fear of racial generalization on the therapists' part; (3) therapists' espousing treatment values that may be in conflict with the values grounded in the culture of the participants'; and (4) participants' behavioral responses to issues of difference.

Participant Frustration

When specific events occurred that signaled to the participants that their respective therapists could not fully comprehend an aspect of the participant's culture, participants attributed the frustration that was felt not only to their therapists, but to themselves as well. A significant portion of the frustration seemed to arise when participants genuinely attempted to explain something to their therapists, but reached an impasse in doing so: "I didn't have the words to explain it, so that's what was going on, too [*in addition to the therapist not understanding*]. It wasn't all her fault [*when the therapist doesn't understand*]" (*Participant 4, 27-year-old female - Asian-Korean (Deaf)*). Others echoed this sentiment:

In the way that therapists will try to repeat back or summarize what you tryin' to say, it all just sounds ... wrong! Sounds wrong when she repeats it back. She totally didn't get it. Ha! But I didn't – couldn't – get her to get it, neither. No matter how hard I tried ... It was hard ... (*Participant 10, 46-year-old male - Black-African*)

Culture ... there's been times when I had tried to explain ... or, I did not even want to, but she'd try to ask questions about it. Um, and it gets a little frustrating to try to explain it. It's like I really appreciated that she was curious, that she was trying to get the whole picture. But um, it's so hard to summarize in the way she wanted me to. And it's hard to explain your culture in 5 minutes, you know ... (*Participant 11, 39-year-old female - Latina-Mexican*)

I'd get frustrated, and she'd try to get more out of me, and I kind of would just say, or I'd attempt at first, and then realize it was not getting any where, or I'd be too frustrated, and the more she repeated back, the worse her understanding sounded. She'd say something off track, and it was just like, 'Yeah, okay ...' and I'd move on. (*Participant 1, 29-year-old female - Asian-Indian*)

Generalization and Representation

Participants reported concerns that clinicians would make broad generalizations about specific racial or cultural groups based on limited knowledge or exposure:

That's what irks me. When my therapist said something that might be true, it kinda irked me because I could tell that it was coming from a place of limited knowledge. Like from a couple of experiences he's been told specific things. But it's not enough. Because I could tell he was just making guesses. Even though it might be true to my experience in that moment. (*Participant 7, 40-year-old female - Latina*)

One participant, who was training to become a clinician herself, discussed such a concern in the context of a work incident:

My old supervisor, she's worked with a couple Vietnamese clients. We just got a Vietnamese client at work, and of course, they gave the Vietnamese client to me. And um, that supervisor said to me, 'Well, you know, I've worked with Vietnamese clients and this is what they did.' And I was just like, 'Okay ... why is this relevant?!' And I was talking about, you know, how the client didn't want to talk about the death. And my supervisor said, 'Oh, that was exactly the same as the Vietnamese client I had.' And I'm thinking, 'Well, how many people don't want to talk about death!' And while that may be true of the culture in some senses, the fact that she made that generalization and assumption, that connection really quickly, even if it might be true, even if they might be right in some sense, it's the way they think about it that bothers me. That's the thing that bothered me about my therapist. The WAY she made these generalizations. Even if they might be true. (*Participant 3, 31-year-old female - Mixed White / Asian-Vietnamese*)

The same participant continued:

I told my supervisor, 'We have a sample of 2!' and she just kept going! She said, 'Well, I don't want to make generalizations...' but kept going off on the similarities between these clients. It's because the clients have the same name, you know. I told her I could find 2 of the same people, like I could probably find 2 people named Tom who had the same diagnosis and didn't want to talk about death. 'But you're not connecting them, because you don't connect Caucasian

clients ...' You know? That's what worries me. Because it's not that she was necessarily wrong; she might've been right about that cultural piece. The way she was talking about it, though. Scary, scary, scary. (*Participant 3, 31-year-old female - Mixed White / Asian-Vietnamese*)

The participant continued to emphasize that it was the manner in which her supervisor generalized about these clients that concerned her most, not whether or not her supervisor's assertions were, in fact, accurate. The participant expressed surprise that despite confronting her supervisor with her discomfort around her generalization, her supervisor continued to draw connections between the two unrelated cases.

Two participants seemed to be aware of the possibility that their therapists could be prone to making similar generalizations, and discussed a reluctance to bring up matters that might facilitate such a tendency:

I didn't want to tell [*the therapist*] that my siblings are both doctors. But they are. I don't think it has anything to do with the way I relate to them, and I probably wouldn't think twice about it ... if I were white. Okay, that's not true, but what I mean is that I wouldn't think twice if I didn't think ... didn't think that my therapist had some idea about my parents being disappointed that I also wasn't a doctor. Because that's just not the way it is in my family. So I'm always wary of saying stuff like that. Especially if it's a stereotype they've heard or read about, you're only reinforcing it. And it's just not true that that stereotype applies to everyone in the culture. (*Participant 6, 39-year-old male - Asian-Chinese*)

While this participant spoke about his reluctance to discuss issues that related to pre-existing stereotypes about his race, another participant described a similar fear of actually creating a stereotype for her therapist, simply by having answered to her therapist's responsible request for more cultural information:

Out of curiosity or wanting to show she was interested, she would ask questions, like, 'What ceremonies happened after your mom died. What did you do? What did it look like?' And I wouldn't want to go into depth and explain them because I felt like ... I think I actually had a conversation with her about me feeling like I was representing my culture to her, like, doing that, I might have ... it's a pressure. I think I explained it to her that like, you know it's like commercials. When an

Indian person's on T.V., they're representing all of us, whereas when a Caucasian person is on T.V., my therapist doesn't have to feel like they are representing her. Um, and so, I think anything I say about Indian culture I feel is representing everyone because it's just like such a small community. I think that's what got me all defensive when she reflected back, too. That, well 'That doesn't really represent Indian culture. And that's what she's taking as representative, not just my experience!' Especially if she has another Indian client, and she takes as what she's learned from me as part of the Indian culture ... (*Participant 1, 29-year-old female - Asian-Indian*)

The participant went on to acknowledge the complexities embedded in an interaction that deals primarily with an informational exchange around culture:

I think it's hard because if I'm talking about something in the context of my culture, then it's taken as culture! As opposed to, 'In my experience, my family liked to wear red pants.' Then she could probably take that separately, you know. But when I said, 'As part of this ceremony, we wore red pants,' and if it were a Hindu ceremony, then she was gonna think that's what Hindus do. (*Participant 1, 29-year-old female - Asian-Indian*)

Therapist Espousing Conflicting Treatment Values

Participants described moments in treatment during which their therapists asserted a cultural framing of a discussion that the participant deemed was inaccurate. In some cases, the assumption from the therapist's end was based on a misapplied stereotype about the participant's racial group, and in other cases, the therapist's misinterpretation could be attributed to their devaluing of particular experiences or his/her inability to see as valid traits those which are not in line with the mainstream U.S. American ethos. Each of these incidents were marked by the therapist's tendencies to suggest as fact a particular interpretation that participants found not only unhelpful, but damaging in their inaccuracy:

We were talking about how me and my sister ... generally how people want boys over girls ... my therapist and I were speaking about this ... and I said ... yes, that is true but that is too general. It was not really relevant to the context ... it could have been, I just didn't think it was ... I was not believing what she was saying

that the influence of that was important to what we were talking about, and so she said ‘Yes, I know that this is the way it is there [*that people prefer to have sons over daughters*]’ and I thought to myself, ‘Well, hmm ... not quite in the way you are thinking ...’ so it was a bit difficult to convince her to believe that.
(Participant 4, 27-year-old female - Asian-Korean (Deaf))

I was talking about my mom to [*my therapist*], and she started to suggest that I might be co-dependent on my mom, and have an attachment that was abnormal. I remember going home that night and thinking that I could see myself being co-dependent with my friend or a boyfriend, but I hadn't thought about my mom. I was trying to be open-minded, thinking ‘Well, SHE'S the therapist, she should know.’ I had no idea what therapy was, even. It wasn't until way later that I realized that she just didn't understand why I cared about my mom so much. She was just like, ‘From 18, you're out of the house. You shouldn't worry so much about your mom. You should be an individual.’ I could see that she wanted me to release that. But she didn't have to think that I needed to break that dependency. She didn't understand why I didn't just live on my own and care for myself and not be thinking about my mom so much. Whereas, to me, family is huge. And will always be until I'm 99 years old! I'll still be talking about my mom [*in a way that that particular therapist would think is unhealthy*] when I'm 99. (Participant 2, 29-year-old female - Asian-Chinese)

I remember talking about my mom a lot. My mom is a refugee from Vietnam. So, she brought a lot of her culture and her experiences. Her behavior and her parenting styles ... I just remember my therapist suggesting something like, ‘Well, she's in the U.S. now, she's not in Vietnam anymore, she needs to learn how to assimilate.’ I know where she was coming from when she said it, but still I had a twinge run through my body ... Like, ‘Who the hell are you to say she needs to assimilate?’ So we never really talked about it. I never really brought it up. I just remember thinking, ‘Here's this white woman, telling me and my momma that she needs to ASSIMILATE...!’ (Participant 3, 31-year-old female - Mixed White / Asian-Vietnamese)

Another participant who also talked about his relationship with his mother as something his therapist could not understand fully spoke about his frustration with a therapist who tried to reach out and connect with him as a fellow minority status member:

I would say something about my mom, and she would say, ‘Oh, kind of sounds like my Jewish mother who...blah blah blah blah’. She was trying to draw those comparisons, which for some reason, I was blocking. I'm like ‘Mm, nuh-uh.’ Because part of me is like ‘Our mothers are COMPLETELY different.’ If she were Asian, though, and she said ‘Oh yeah, my mom did the same thing,’ I would've taken it a lot better. I would've taken it in. I was kinda overwhelmed by

that. I rejected her trying to connect that way. (*Participant 6, 39-year-old male - Asian-Chinese*)

Even if there had been similarities that could be seen between this participant's mother and the mother of his therapist, the participant wanted his therapist to acknowledge that his experience as an Asian-American was unique, and one that was distinct from her own culture of Judaism.

Participant Response

How participants responded in therapy to such incidents varied. Half of the participants were able to recognize that for them, therapy did not necessarily include discussion of racial or cultural elements. For these participants, it was possible for them to compartmentalize and be conscious of which issues their therapist "can help with"

best:

I think if [*participant's Korean background*] were a bigger part of the problems I was having, I might think that there was no purpose for the therapy. But for the issues that I was discussing with her, it was not really such a big part. She can help with it. In the parts it does come up in, it's the part that I can provide the insight into, and explain [*for the therapist*] ... [*Interviewer asks: Which parts did it come up in?*] Well, [*participant's therapist*] didn't really understand my relationship with my parents. She didn't understand why I lived so close ... why I don't move away from them. But I explained to her the culture and she understood better. [*Interviewer asks: Right, and were you also saying that if this issue of living close to your parents had been a bigger issue, were a bigger problem that you wanted to talk about in therapy, then your therapist would have had a harder time truly understanding? There would have been more problems in your therapy with her?*] Right, yes. (*Participant 4, 27-year-old female - Asian-Korean (Deaf)*)

Other participants described a similar sort of self-censoring or active avoidance of cultural issues during therapy that seemed to hold more negative consequences for treatment:

I had kind of gotten to know what I could and could not say, almost. Um, like, this would be a good thing to be able to discuss with her. And, um, I am just going to leave this part over here. Culture is definitely a part of it. I mean, I could discuss the context, but, um, the actual cultural influences, it was hard to explain and it became a bit frustrating, so I just learned to leave it alone.

(Participant 11, 39-year-old female - Latina-Mexican)

Because I avoided it, culture didn't come up as much. Maybe once a month, if I saw her every week. But I could quickly deflect ... like, 'That's not it at all, but let's deal with this OTHER part of it.' But when we'd kind of clashed on it, or I'd gotten more frustrated ... Sometimes she could sense how frustrated I was, so then she'd be like, 'Then explain it to me,' and then I'd say I'm NOT frustrated, or I'd change the subject, or I'd say 'Well, this other thing is way more important to this piece.' *(Participant 1, 29-year-old female - Asian-Indian)*

For me, it's helpful to get insight from a therapist. And for me to explain something to him and for him to throw insight back to me. That would NOT have been helpful in cultural terms, because the way he was viewing it was ... very strange. It was just off. Better for me to provide that section of the insight. And, or talk to someone else with who I can just throw that out there ... yeah. Maybe my brother or sister-in-law. Or friends. And not necessarily Asian friends. Maybe other minorities in general. *(Participant 12, 35-year-old female - Asian-Laotian)*

This participant seemed to suggest that gaining insight from a therapist around cultural issues would ideally be helpful, but since it had proved unhelpful with this particular therapist, she reverted to either providing the insight herself or obtaining it from other minorities.

One participant questioned the logic of remaining in treatment with a clinician with whom she could not disclose fully the issues that arose for her (which include race-related concerns):

I wasn't surprised [*that an issue of cultural competence arose in therapy*], but I did think it was relevant enough that I thought about finding someone who did get what I was trying to explain. I did think about not seeing her anymore, you know, because of that, for sure. Would she really get the whole picture? And if I'm not talking to her about certain things, it kind of defeats the whole purpose of therapy, right? *(Participant 3, 31-year-old female - Mixed White / Asian-Vietnamese)*

However, this participant remained in therapy with the therapist for another year and a half before ending the treatment. Most participants reported that their therapists were never directly confronted with these issues. Two main reasons emerged to explain why this seemed to be the case. One was that participants simply felt too uncomfortable to bring the topic up with their therapists during their sessions, and the other was that participants were unaware during the time of their treatment that the tension could be attributed to racial and cultural difference:

So, [*the therapist assuming I needed to individuate from my mother*] really bothered me. And I stopped seeing her after two sessions. And at the time, it wasn't like I knew why I stopped seeing her ... it wasn't conscious ... it was just like 'It's not working out.' So I couldn't ever tell her that I figured out it was because of this clashing of cultures or whatever. Not that I would've had the guts to do it if I had figured it out back then ... (*Participant 2, 29-year-old female - Asian-Chinese*)

The anxiety that underlies this participant's prediction that she would have not been able to confront her therapist regardless of the timing of her realization could be seen in the responses of several other participants:

I never told her [*how dissatisfied she was with her therapist's cultural competence*]. I just left. [*Interviewer asks: Did you give a reason for leaving?*] Yeah, um, I'm pretty sure I said something about my work ... my boss giving me extra hours ... work schedule picking up. So I didn't have time anymore [*for therapy*] and had to take a break. (*Participant 5, 36-year-old female - Black-Caribbean*)

I'm not so sure I'd be willing to say somethin' about the therapist ... to the therapist ... when she's totally off. It's a hard thing to talk about ... you know ... especially if you've been "wronged." It's not easy to talk to YOU about it! And you ain't ever wronged me! (*Participant 10, 46-year-old male - Black-African*)

This last participant touched both on the discomfort created by confrontation and the difficulty in talking about taboo subjects like racial difference, especially when speaking to someone of a different racial background. Several participants alluded to the

idea that the topic can take on a “personal” quality, and that expressing any sort of acknowledgment of another’s cultural incompetence, even in the context of constructive feedback on ability to be effective in one’s profession, in itself can be offensive: “It just seems like such a big insult. Not just, ‘You’re a bad therapist,’ but almost, ‘You’re a bad person.’ Somehow, it’s really personal” (*Participant 8, 25-year-old female - Asian-Filipina*). Another participant reflected a similar reluctance to avoid seeming offensive:

I mean, anytime you leave therapy, regardless of the reason, you always make up an excuse, right? Otherwise, it’s too personal. Leaving, like, your car mechanic is different. They don’t need an excuse. But leaving a therapist, they wanna know ... ‘What’d I do wrong?’ ... They probably wouldn’t put it like that, but ... ‘What DIDN’T you get from this?’ I’d never tell them the real reason, ESPECIALLY if the reason was just that it was because they were a clueless white person. Or Asian person, or whatever. (*Participant 9, 35-year-old male - Black-African*)

Participant Reflection on Cultural Competence and Its Implications

The latter portion of the interview protocol asked participants to speak toward their knowledge and understanding of “cultural competence” as a concept in the field of psychotherapy. The data is presented as follows: (1) initial reflections on cultural competence; (2) implications for future choice of therapists; (3) suggestions to increase level of competence; and (4) participants’ willingness to help increase clinicians’ level of competence.

Initial Reflections

Prior to the interview, only four of the participants had heard of cultural competence formally in the context of therapy, but the remaining eight demonstrated almost-immediate comprehension when introduced to its meaning by the interviewer. Some intuited the complexity behind the concept and the pressure that clinicians might encounter when faced with cultural competence in their practice:

I didn't know [*cultural competence*] existed as, you know, a real, sort of legitimate term, concept. Makes sense. It should [*exist*]. I can see it definitely being a charged topic, though. (*Participant 7, 40-year-old female - Latina*)

My feeling about it is that, like a desire to feel competent leads to people jumping the gun and feeling like they understand things. So that's tough. People assuming they know how you work, what you think, based on the color of your skin ... and just because they WANT to know so bad. Both because they want to and it's their job, in a way. (*Participant 5, 36-year-old female - Black-Caribbean*)

Once participants began to reflect more on cultural competence, some also shared ideas on cultural competence and training:

In terms of organized training, if they're done well, it's useful, but if it's not done well, I can see it being a huge waste of time. (*Participant 3, 31-year-old female - Mixed White / Asian-Vietnamese*)

If you ask me, I think [*cultural competence*] should be brought up in grad school ... from the get go. And that stuff should be ongoing ... not somethin' you just do in therapy school for coupla years and then you can be all, 'Okay, I'm ready!' That ain't right, either ... it should be an ongoin' thing ... always aware, always askin' ... I bet people don't do this though. And who has the brains to do it, let alone the time? But for sure, if someone gon' be payin' you, ask yourself: 'What would make me a better therapist?' (*Participant 10, 46-year-old male - Black-African*)

This participant raised the issue of cultural competence being an ethical and professional responsibility of the clinician. Another participant demonstrated insight when discussing the difficulty of training someone on the topic:

If you are trying to gain expertise in substance abuse counseling, then you go to learn about it. Maybe there are ways in which that education is also failing, I'm sure there is, but it's interesting because it would be kind of weird if someone came up to someone who was really uncomfortable working with an Asian client, and was just like, 'How do I do this?' (*Participant 8, 25-year-old female - Asian-Filipina*)

One participant felt certain that a culturally competent therapist was necessary in every situation, even for those who did not feel the need to discuss "culture" in their treatment:

The people that are new to therapy and don't realize how important culture is to their experience, and then they realize it is, and they get a [*culturally incompetent*] therapist, then they're screwed. They'll think that therapy is not good at all. And therapy – good therapy – is awesome. (*Participant 12, 35-year-old female - Asian-Laotian*)

All participants agreed that cultural competence was an important trait for any practicing clinician to possess.

Implications for Choice of Future Therapists

After reflecting on the cultural competence of their past therapists, participants were asked whether they would choose for their next therapists to be of the same racial or cultural background as themselves. All participants indicated that they would consider it, but that such a set-up wouldn't necessarily eradicate the existence of cultural issues. Seven participants indicated that the option had never been considered by them until significant issues rooted in racial and cultural difference came up in their respective treatments. However, even those participants acknowledged that seeing a therapist with whom they shared a racial or cultural background wouldn't guarantee competence or the absence of other issues:

My first instinct is that I want someone of the same culture, but it's kind of tricky. You have a whole set of different problems. Plus, it doesn't seem like [*there are*] that many Latinos in the system. (*Participant 7, 40-year-old female - Latina*)

I would probably be more inclined to talk more about cultural stuff with a therapist of the same cultural background. There would be a lot of maternal [*transference*] going on, too, though. (*Participant 5, 36-year-old female - Black-Caribbean*)

Two participants raised the issue that therapists of the same racial background would not be immune from making the same types of generalizations and quick assumptions that were topics of concern for therapists of a differing racial background:

I'm sure there's some pitfalls [*to seeing a therapist with whom one shared a racial background*]. I think it would be ... it would be that sometimes you might have thoughts or beliefs about the way things could be ... but are not necessarily the case. Generalizations about my race and the people I hang with that don't apply to everyone. So if a person is thinking within that box ... yeah, but they can miss a lot of things. Sometimes they're right on, but ... the danger of being locked into those ideas ... seems like it can be detrimental to the therapy. (*Participant 9, 35-year-old male - Black-African*)

But I thought about actually seeing an Indian therapist, and I don't know if it'd be a good idea either. It's almost like in the same way that people who don't know can stereotype; it's this understanding that 'I get it because I'm part of that culture. So I understand.' And sometimes that's limiting, because your experience might not quite have been theirs. But yet, that cultural piece is important. It's just a hard balance. (*Participant 1, 29-year-old female - Asian-Indian*)

Finally, participants acknowledged that there were ways for therapists to gain cultural competence, and that there would be “hope” for this possibility, despite past “mistakes”:

A person who was not Korean or Korean-American would have to work harder [*to understand participant's family and social history*], but – I will give an example – my last therapist acknowledged, and apologized [*for any culturally-insensitive moment*], and wanted to learn, I would give her that chance. (*Participant 4, 27-year-old female - Asian-Korean (Deaf)*)

My last therapist kind of proved to me that I don't need a therapist that's Asian, but just someone that's competent and open to learning. That's not close-minded or prejudiced. So, I think I'm open [*to whether any future therapists of hers should be of her own racial background or not*]. As long as they try to get to know all of who I am. (*Participant 3, 31-year-old female - Mixed White / Asian-Vietnamese*)

The following section will address in more depth ways in which clinicians can become more culturally competent, as outlined by participants in the study.

Increasing Levels of Competency

Based on their past experiences, participants were asked to share their recommendations and thoughts on how any clinician could gain cultural competence.

Although some of these thoughts had already been shared in passing at previous points in

the interview, participants were asked to recount them again and more succinctly during this segment.

One participant commented on cultural competence in the form of tangible resources:

She gave me referrals for my mom, and she gave me Chinese-language speaking therapists and she knew about resources that were focused on Asian families and Asian immigrants. I was like, ‘Wow. She was so thoughtful.’ (*Participant 2, 29-year-old female - Asian-Chinese*)

Most of the other suggestions given focused on specific traits of clinicians. Several participants expressed that a culturally competent clinician had to be inquisitive and genuinely curious:

A good therapist ... she will ask, she will not assume. But if I say something, and, um, it's taken to mean ... she is got it, and I see that ding! – there is some sort of preconceived something, she is open to you correcting her. She wants to know and she is curious. (*Participant 11, 39-year-old female - Latina-Mexican*)

With that particular therapist [*who participant had indicated earlier was culturally competent*], I felt like she tried really hard to get me. She was very interested in learning from me, learning my culture, so she'd ask questions. She's very curious about how I view family. (*Participant 12, 35-year-old female - Asian-Laotian*)

Wanting to learn about my people, about my values as a black man. If someone felt like it was important for them to learn, and that it would be important for our therapy. I'd think they were really good. (*Participant 9, 35-year-old male - Black-African*)

One participant stressed that gaining exposure to different cultures was a good way to gain cultural competence, and also warned about the dangers of generalizing:

Most of it is exposure, and I just don't think my therapist had had a lot of exposure. Not just reading out of textbooks. Like this is how Asians do this or that. Not necessarily exposure to the culture itself [*via cultural and community events*], but exposure to clients of different cultures. And it doesn't have to be a particular understanding of a culture, but just the sense that, while it makes someone who they are, it's not all of who they are. That it's not applicable to everyone.

She went on to reflect on the complexities of applying knowledge gained from exposure:

Therapists should have some understanding that if someone tells you something about their culture, you can't necessarily generalize it to another situation. But then again, the more exposure you have, the more understanding you get of a culture, so there are some generalizations that could be made. But just being able to not make the generalization when it doesn't apply. How the heck are you supposed to do that, right? (*Participant 8, 25-year-old female - Asian-Filipina*)

Several participants' responses focused on the clinician displaying an ability to acknowledge the need to increase their own cultural competence:

She was not intimidated or scared to tell me that she didn't know about something. It was all in her questioning. She'd miss a big piece of who I am if she didn't ask. It's sort of like the big elephant in the room. (*Participant 7, 40-year-old female - Latina*)

This participant went on to acknowledge the difficulty in displaying such a vulnerability:

I feel like a therapist could potentially know that they need to address [*the fact that the client wasn't Latino*], but they wouldn't want to. (*Participant 7, 40-year-old female - Latina*)

Another participant indicated the mere presence of physical evidence in her clinician's office was sufficient to assure her that her clinician recognized a need for cultural competence:

Ideally, she would know ahead of time about my culture. But if not, then at least some indication that she DOESN'T know is nice. When I noticed that my last therapist had some books [*addressing multiculturalism*], I felt like that demonstrated caring and learning ... wanting to learn. I didn't think that that automatically made her competent, since some of those books are awful, but her effort to be culturally competent definitely, definitely did not go unnoticed with me. I don't think it'd go unnoticed with anyone. (*Participant 3, 31-year-old female - Mixed White / Asian-Vietnamese*)

Finally, participants emphasized the important of constant self-awareness and self-exploration on the part of the clinician, particularly in regards to traditionally difficult or taboo subject matter:

For people that think they have an understanding, I guess I would say, explore that understanding. Where are you getting your understanding from? There are so many different factors that play into a culture. (*Participant 7, 40-year-old female - Latina*)

In discussing the importance of self-examination, participants seemed to display an intuitive sense of how difficult it might be for clinicians to adhere to the advice they were giving:

I think really bringing to the table what people are afraid of talking about – discrimination and biases, just being really honest with your own thoughts and your own views about other people – the tricky part with that, though, is that you have to do it safe. Where people can feel safe to open up and share those thoughts. 'Cause you know people have them, they just don't talk about them. And to work through those. It's possible to work through that stuff, but it takes time, I'm sure. It can't be done in one seminar, one workshop. But that's usually all the time you professionals have, you know? (*Participant 5, 36-year-old female - Black-Caribbean*)

Therapists need to really look at what it is that may really push their buttons. When it comes to race, gender, income, socioeconomic status, just looking at all of those. Being really holistic. And religion. Just figuring out what it is that might make you really uncomfortable. Or what might make you really upset, or really angry. You know, and just drawing those out a little more. Self-awareness, questioning, and I think, once you start there, start questioning yourself, you can bring your questions to the table in a therapeutic way. But that's easier said than done. I think it would be very difficult to do that! (*Participant 3, 31-year-old female - Mixed White / Asian-Vietnamese*)

Perhaps an empathic understanding of the difficulties clinicians face in gaining cultural competence contribute to clients' willingness to support such a gain in competence while undergoing therapy. The extent to which this is the case is explored in the next section.

Willingness to Help Increase Clinicians' Level of Cultural Competence

Generally, participants were willing to support if not facilitate their therapists' gaining of cultural competence. However, while the desire to help with this process is present, most participants recognized that there was a limit of some nature:

If the moment came up, I could educate, I could share what I know. It would be based on my family or my personal experience, so I can see myself, if she were just totally clueless, to educate her. But I'd have to be comfortable [*with therapist*]. (*Participant 9, 35-year-old male - Black-African*)

Another participant cited a limit which he attributes to the inability to adequately “explain” a cultural difference to a therapist:

Person doesn't necessarily have to be Black ... I'd try to explain ... But I do think there's some things I can't ever break down for her ... there's always gon' be somethin' that somebody don't get, no matter the therapist. (*Participant 10, 46-year-old male - Black-African*)

Most participants held the perspective that the responsibility to “train” the clinicians was not in their hands:

It would be her job to get her own formal training. I want to help inform my therapist, but I'd want someone intrinsically open to learning. Like, they wouldn't have to try so hard. (*Participant 6, 39-year-old male - Asian-Chinese*)

I would tell my therapist everything I know ... yes I would answer their questions and any concerns, but overall, I do not think it is MY responsibility to train them. I mean, formally. (*Participant 7, 40-year-old female - Latina*)

This participant went on and alluded to the theme of difficulty in “teaching” about racial difference and cultural competence by suggesting:

We need to find white people who are already with it, and have THEM do the trainings. I bet that when people want to put together, what do you call it, cultural competence trainings, they find people who are not white to give them. Even though the white person might be a much better teacher on it, and can talk from the experience, and could explain it to the person getting trained in a way that they could actually understand it. (*Participant 5, 36-year-old female - Black-Caribbean*)

A few participants' responses suggested that they did not consider themselves immune from making generalizations, or echo the previously discussed fear that what one explains to the therapist will end up in a script for a future generalization. To this end, they could identify myriad difficulties in “helping” the therapist “gain competence”:

When people approach me and I know they're only asking me something because I'm a minority, I'm just like, 'Why are you asking me??' [*annoyed*]. And why do we respond that way? Because people are asking, and that should be a good thing! And they have good intentions. But I'm like, 'That black person's experience might be totally different from mine ... but it might help if this person has some insight.' It's a Catch-22. And what's the more damaging? Giving them nothing to go on, or just slowly, in this process, chipping away at getting this exposure? (*Participant 5, 36-year-old female - Black-Caribbean*)

For example, there's such a huge difference between Indians from India, and Indians from Africa ... there's just a different culture there ... but yet, if I tried to explain the differences, it'd be all generalizations. I'd be afraid to do that. Because then you're boxing everyone else up. (*Participant 1, 29-year-old female Asian-Indian*)

Participants' desire to help therapists gain competence was certainly not without its limitations.

Summary

The data presented in this chapter reflect the participating clients' experiences of working with clinicians of differing racial backgrounds. The findings suggested that there are a myriad of components which make psychotherapeutic treatment by clinicians of a different racial background both comfortable and uncomfortable. Participant narratives reflected the complexity in differentiating themes that tended to overlap and intersect. The implications of these findings will be addressed and discussed in the next chapter.

CHAPTER V

DISCUSSION

This chapter presents a discussion of the findings of this study, which sought to explore the experiences of clients who have undergone past individual psychotherapy with clinicians of a differing racial background. Within limits imposed by the qualitative methodology employed, the present findings have several implications for practice with clients of color. This section investigates the findings presented in the previous chapter – demographic data of participants and clinicians, participants’ awareness of racial difference in the therapeutic setting, major treatment issues, and participants’ reflections on treatment as it relates to cultural competence – and continues exploration of their implications.

Demographic data gathered about both the participants and the clinicians prompts the first area of discussion. The fact that two participants were master-level students in clinical fields might suggest that their level of insight into the therapeutic process would result in especially attuned observations of their experiences with regard to cultural competence. However, the level of insight provided by the other participants was on par with that of the student clinicians; clinically related graduate-level training was not necessary for participants to assess the competence of their past therapists. In fact, despite that the majority of the participants had been unfamiliar with the term “cultural competence” before entering the interview, all grasped the meaning of the concept

quickly, and, in their narratives, identified ways in which they believed it had played into their previous courses of treatment.

Similarly, while the time the participants had been in therapy ranged from one to twelve years, this variation did not affect the ability to name and pinpoint instances in which therapists were felt to have displayed cultural insensitivity. One might imagine that clients with more therapy experience would have greater understanding of cultural competence and better recognition of when their clinicians did and did not display such competence. Although this proved true to an extent (e.g. in the case of the less-experienced participants who terminated their treatment without quite knowing the reason and only later were able to attribute the perceived mis-match to cultural difference), participants' narratives also revealed that dissatisfaction with cultural competence could be felt within the initial meeting with the therapist.

In the interviews, participants were asked to focus on treatment they'd received within the last 5 years, and to choose one clinician on which to focus, in order to maximize the descriptive richness of their recollections. More than half of the participants, however, spoke about multiple clinicians during their interviews. In the end, this phenomenon did not seem to compromise the richness of the participants' narratives. It seemed that the participants felt compelled to include thoughts about other clinicians due to the relevancy of those treatment experiences, which resulted in the provision of more data for the study.

Two-thirds of the study sample identified their early childhood and adolescent experiences as times during which they first became aware of feelings of racial difference. For these participants, many years of exploring racial difference followed,

suggesting that racial identity development might play an integral role in treatment for any client of color, and hints at the challenge faced by clinicians, to the extent to which a clinician has not experienced a similar identity development process.

Geography provides another dimension for understanding the identity development of these clients. Clients of color that had lived in small towns and rural areas described feeling that they had had limited exposure to others sharing minority status and minimal resources for addressing issues with racial identity. Clinicians should be aware of both the role geography plays in both their clients' personal histories as well as in the current settings in which treatment is taking place.

Participants were also quick to note that race and ethnicity were not the only factors shaping their identities. As other studies have explored, one danger in delivering culturally competent care is the tendency to overemphasize a client's race or ethnicity in treatment, often because it is the most visible and thus, salient area of difference. Clinicians should be careful to refrain from reducing their clients to the color of their skin, and hold in mind that the "culture" in cultural competence comes in many, often-times invisible forms, whether it is religious affiliation, professional identity, or the ability to hear. This recommendation is bolstered by the fact that three-fourths of the participants in the study reported that, when initially entering therapy, racial differences between themselves and their clinicians were not foremost in their thoughts. In fact, other areas of difference came up more readily. While it is important to acknowledge that racial and ethnic difference might be a source of transference issues for the client, it is equally necessary to keep in mind that other issues of difference might be of even greater importance to the client than race or ethnicity (e.g. age gaps, lifestyle choices of

the therapist, weight differences, etc.). In fact, precisely because they are not so obvious, these are the sorts of differences that clinicians might want to be especially sensitive toward. Realizing that the “elephant in the room” that is racial difference might in fact not be of primary importance to the client could reduce the general atmosphere of intimidation that many clinicians feel when beginning treatment with clients of a different racial background.

The difficulty involved with explaining one’s culture to another holds consequences for both clients and clinicians alike, and the burden of responsibility when a “failure” occurs needn’t automatically fall on the clinician. Many participants in the study attributed their frustration to their own inability to convey something “cultural” to another person, clinician or not. Understanding that the client may be grappling generally with the challenge of communicating cultural difference, not just in the context of the clinical relationship, should serve to reduce potential feelings of intimidation for clinicians addressing major treatment issues. Participants suggested that the clinician, does, however, have a responsibility to be aware that frustration might ensue if he or she is striving to provide culturally competent care.

Clinicians should also be aware that a client’s frustration might come from a reluctance to “speak for” an entire culture. Several participants emphasized their unwillingness to have their words “mean more” than they do outside the context of their own experiences. Many times, clients of color recounted experiences in which their thoughts, opinions, or mere presence were tokenized. Thus, clinicians are caught in a bind: when they fail to ask their clients about cultural meaning and influence, they might be seen as negligent or dismissive; when they do display genuine curiosity in learning

about a client's culture, they may still face resistance and frustration. Clinicians may be able to foster more willingness if they are able to demonstrate that the information gleaned from their clients' experiences will not automatically be generalized for others who the clinician perceives to share the same culture.

Several participants described an ability to "compartmentalize" while in session with a clinician that had displayed cultural insensitivity in the past. They learned to approach their therapists with issues with which they knew the therapists would be helpful – mostly non-cultural concerns. While it may be unrealistic to expect a clinician to have the expertise necessary to adequately treat all presenting issues of a client, there should be some concern about the idea of a client "hiding" or "silencing" their cultural identity in a treatment relationship. Whenever a client is self-censoring or actively avoiding a topic, no matter the nature, the clinician's ability to see the case holistically may be compromised. The prevalence of "specialists" in the field (e.g. trauma specialists, substance abuse specialists) seems to indicate our willingness to accept a clinician with a narrow area of expertise, but the absence of "culture" as a field of specialty would suggest that every clinician is expected to have cultural competence, or that an ability to work competently with differing cultural populations is not perceived as a special skill set. More and more, clinicians of all kinds do seem to be expected to possess some level of cultural competence, and at the same time, it is clear that whatever "special skill set" that signifies cultural competence cannot easily be outlined, taught, or learned.

Regardless of how the participant reacted to culturally related treatment issues, it was clear that the participants in this study were not eager to directly confront their

therapists. Clinicians need to be aware of the possibility that these issues may exist for clients, or may have existed with past clients, even if there is no indication that this is the case. Although being overly attuned to cultural differences may intimidate a clinician working with clients of a differing racial background and, thus, may not always be helpful, other clinicians who are minimally concerned should look to develop a healthy awareness that their clients may not be communicating these types of concerns, or alternatively, that their clients may be unaware that the tension felt could be attributed to racial and cultural difference.

Several participants, by acknowledging that seeing a therapist with whom they shared a racial background would not guarantee competence or the absence of other treatment issues, suggested that understanding the intricacies of one's culture may not have anything to do with one's race or ethnic affiliation. A Chinese therapist seeing a Chinese client may make the same types of generalizations and quick assumptions as a White therapist treating that same Chinese client. While this suggests that no clinician may have a natural advantage in providing culturally competent care, the outlook is far from bleak: most of the study's participants – clients who have experienced major treatment issues related to cultural understanding, or lack thereof – felt optimistic that clinicians hold the ability to “gain competence.” Participants provided a number of suggestions for improving one's cultural competence: gaining and providing access to material cultural resources; expressing a genuine interest in learning about culture (as long as one refrains from broadly generalizing to others the information learned); seeking out exposure to new and different cultures; being aware of and willing to continuously

explore and question one's own understanding of culture; and merely acknowledging that one will always have a lot to learn.

While some of these suggestions might be difficult to achieve, and ways of achieving them still elusive, the clients' own realization of the complexity of gaining cultural competence, as well as their own recognition of being far from "mastering" these ideas themselves, made them extremely sympathetic to the difficulty clinicians face in realizing these suggestions. Clients may be more willing to support clinicians in the endeavor toward cultural competence than clinicians may realize. That cultural competence is as difficult to define and achieve for clients and professionals alike might be the unifying force that moves us through the trials and errors necessary in implementing cultural competence into our practices and everyday living.

Limitations and Implications for Future Research

One major limitation of the present study is highlighted by participants whose narratives demonstrated the complexity of "race" as a construct, including its role in identity formation, concerns about what it meant to be a "member" of a particular racial group, and issues around tokenization. While much of the literature examining cross-cultural practice emphasizes "race" as an obstacle in the therapeutic dyad, it seems clear that the racial make-up of a therapeutic dyad is only part of the dynamic in any given treatment relationship. Although many participants acknowledged that the topic of their racial backgrounds was addressed in some form during treatment duration, many of these participants indicated that race only partially formed their identities. In fact, too much emphasis on racial heritage by their therapists could lead to discomfort; participants felt pressure to "speak for" their race, and were aware of their experiences potentially being

generalized or tokenized. Ironically, it is important to recognize that these individuals were recruited through racial criteria for participation in the present study, and in effect, were being asked to “speak for” their races. Although race seemed to be the most useful tool for organization, implicit in recruiting only people of color for the study (and asking them to speak to cross-racial therapeutic experiences) was the assumption that the racial minority groups in this country are populations that have particularly specialized cultures that need to be studied or understood. As it can imply that the majority (White) group is without “culture” itself, and even somewhat homogenous as a group on its own, this difference-focused paradigm is very marginalizing (or “other-ing”). Since the practitioner population in this country is currently predominantly White, special attention should be paid by future researchers to the conceptualization of this dynamic, and the utility of using “race,” “ethnicity,” and other categories of culture in discussing “cultural competence.”

Another limitation of this study was its sample size. A larger number of participants would have permitted analysis of within-group variation in terms of factors such as gender, ethnicity, and age. Additionally, geography limited the scope of generalizability; all participants were based (and mostly received therapy) in the Bay Area of Northern California. A sample that included a wider range of types of therapists discussed would have better captured the variation that exists in the types of therapists drawn to the Bay Area and the clients that seek treatment from them. Although generalizability of the findings is limited to the characteristics of the sample studied, the study only attempted to generate rich qualitative data that would stimulate questions and help inform our understanding of cultural competence and what it might look like.

While the researcher's identification as an ethnic minority may have facilitated the research process – most of the participants seemed at ease with providing personal information about their backgrounds and openly discussing details of therapeutic exchange – she also recognizes that her role as a participant-observer may have impacted both her formulation of the study and her understanding of the data.

Nevertheless, these findings address a gap in our knowledge of cross-racial therapy, particularly in how culturally competent practice may or may not manifest itself. Although not generalizable, the findings of the study can also be used to inform further research in this area. Since this study is one of the few qualitative investigations on the experience of ethnic/racial minority clients working with clinicians of a different racial background, almost any further research conducted could prove informative.

Recommendations for further research in the field that might be particularly helpful include: (a) a large-scale attempt to identify the prevalence of culturally rooted “incompetencies” in the field and categorization of types of “infractions” through study of clients and clinicians alike; (b) an assessment of the efficacy of current models of trainings and mandates; (c) a theoretical study of strategies and techniques for working with clients of color who perceive cultural difference as a main issue in therapy, based on identified failures in efficacy of past programs; and (d) testing of the theoretical strategies and techniques gained in the last recommendation via clinicians who have implemented them in actual practice.

This exploratory study examined the perceptions of a small sample of clients of color who have worked with clinicians of different racial background. As suggested by the stories of these twelve clients, the scope of cultural competence is vast and far-

reaching. Despite this, however, there are specific ways in which a clinician can create or damage an atmosphere of cultural sensitivity during therapy. While this knowledge might be expected to further engender feelings of intimidation around cultural competence or call into question the plausibility of its being achieved, exposing oneself to real subjective experience in the form of this type of qualitative research can also have the effect of making cross-racial therapy appear less threatening. Additional research and publication about cultural competence and clinical relationships between people with cultural differences of any sort is needed to aid in the progression of the cultural competence movement.

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(Appendix A)

Human Subjects Review Approval Letter

January 19, 2008

Dear Tsu-Yin,

Your revised materials have been reviewed and you have done a fine job with their amendment. All is now in order and we are glad to give final approval to this interesting study. We would suggest that you try to get the flyer all on one page.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your recruitment and with your project. It will be interesting to see who agrees to participate.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Fred Newdom, Research Advisor

(Appendix B)

Informed Consent Form

Dear Research Participant:

My name is Tsu-Yin Chang, and I am a graduate student at the Smith College School for Social Work. I am conducting a research study to learn more about how people of color experience therapy when they have therapists that are of a different race than their own. Data from this study will be compiled into a thesis, which will be submitted in partial fulfillment of the requirements for the degree of Master of Social Work, and may be used in professional publications and presentations on this topic.

Your participation is requested because you are a person of color who has had a therapeutic relationship within the last 5 years in which you and the clinician were from different racial groups. If you are interested in participating in this study, you must be 18 years of age or older, and must not currently be involved in mental health treatment of any kind. You must also be able to communicate your thoughts comfortably in English. If you choose to participate, I will ask for some demographic information and then interview you about your thoughts on cross-racial therapy. I will also be interested in ways in which you may or may not have perceived your and your clinician's difference in racial background to have affected your experience. The interview will be conducted in person by me in a private setting, will be tape-recorded, and will last approximately one to one-and-a-half hours.

The risk of participating in this study may be that some interview questions could elicit uncomfortable thoughts, feelings, or memories. You will be provided a list of referral sources for the Bay Area that you may refer to if you find that you are experiencing psychological distress as a result of participation in this study.

The benefits of participating in this study include having the opportunity to contribute to an area of research that has been neglected. Your thoughts might positively affect how a clinician in the future conducts his or her next session, and may improve the experience of his or her client. You may also gain insight into your own experience. Unfortunately, I am not able to offer financial compensation for your participation.

Your participation in this study is completely confidential. Audio tapes and interview notes will be labeled with number codes instead of your name or any other identifying information, after which, my research advisor from the Smith College faculty will have access to the data collected. I will lock consent forms separately from audio tapes and interview notes, all in a secure location during the thesis-writing process and for three years thereafter, in accordance with federal regulations. After this time, I will either maintain the material in its secure location if it is still needed, or destroy it. In the written thesis, there will be no way to identify you. I will not use your demographic information to describe you, nor will your words or stories be recognizable, as they will be carefully

disguised. Finally, if an additional data handler, transcriber or analyst is used in this study, I will require her/him to sign a confidentiality agreement.

Participation in this study is voluntary. You may refuse to answer any question(s). You may withdraw from the study at any time during or after the study without penalty until April 1st, 2008 when I will begin writing the Results and Discussion sections of my thesis. If you choose to withdraw, all materials pertaining to you will be immediately destroyed. If at any point you have any other questions, or wish to withdraw, you may email me at xxxxx@email.smith.edu or telephone me at xxx-xxx-xxxx (ext. xxx), and any information pertaining to you will be destroyed.

You may also contact the Chair of the Smith College School of Social Work Human Subjects Review Committee with any questions or concerns at (xxx) xxx-xxxx.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY. PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

Signature of Participant _____ Date _____

Signature of Researcher _____ Date _____

If you have any further questions about this study, participation, rights of participants, or this consent form, please feel free to ask me at the contact information below.

Thank you for your time, and I very much look forward to having you as a participant in my study.

Sincerely,

Tsu-Yin Chang
xxxx xxxxxxxx St.
San Francisco, CA xxxxx
xxxxx@email.smith.edu
xxx.xxx.xxxx (ext. xxx)

(Appendix C)

Semi-Structured Interview Guide (including Demographic Questions)

Establishing “Culture”

1. How old are you?
2. How do you identify racially? Ethnically?
3. How do you identify gender-wise?
4. What is your occupation?
5. Can you describe your educational background?
6. Where were you born?
 - A. And is that where you grew up? If not, where?
 - i. Did you feel you were in the majority or minority there? In what way?
7. What was your first language?
 - A. If not English, when did you learn English?
 - B. In what language are you most comfortable conversing?
8. Is there anything else you’d like me to know that you’d say is important to your identity, your culture, or who you are? (e.g. sexual orientation, more specific indicators of class, religion, political affiliation, etc.)
9. On a scale of 1 to 10, 1 being Not at All and 10 being Very, how big a role has your racial background played in your life? [Repeat the number participant states]. What does that mean exactly?
10. On that same scale, how important is it for a therapist to understand that racial background in order to understand you? [Repeat the number participant states]. And what does that mean exactly?

Therapy Background

1. When was the first time you sought therapy?
2. How many therapists have you had?
 - A. Of those, how many have been of a different racial background than your’s? What backgrounds?
 - B. [Is he or she who] / [Was there a particular one] you had in mind when you first thought about participating in this study?
 - i. How old is he or she?
 - ii. How does he or she them self identify racially? Ethnically?
 - iii. What was the language spoken in this therapy? Was this the therapist’s primary language?
 - iv. For how long did you see this therapist?

The Therapeutic Relationship

1. Tell me about the relationship you had with this therapist.
 - A. How was it that you began seeing him/her? How did you choose him/her?
 - B. How would you describe your relationship with him/her?
2. How do you think you are similar to one another?
3. How do you think you are different from one another?
 - A. What would you say is the biggest different between the two of you?
4. You said you stopped seeing this therapist after [x amount of time]. How did that come about?

Therapy Content Involving “Culture”

1. How often would culture come up in your sessions? And what about race, specifically?
2. Can you tell me about one or two of those conversations?
 - A. What have those conversations been like for you?

B. What were the circumstances behind the conversations? (e.g. Who initiated?
How were they brought up?)

Self Within Therapeutic Context

1. How aware of your own racial background were you in therapy?
2. In what ways, if at all, were you aware of your racial differences before you started seeing _____?
 - A. Did this shift over time at all? Please explain.
3. Were there parts of you that felt hidden or unexpressed in this relationship? Please explain.
4. Do you think that you acted or could've been perceived any differently in this relationship than if you'd been in one in which the therapist and you shared the same racial background?

The Therapist and Cultural Competence

1. What was your sense of how well your therapist understood your racial background?
2. Are you familiar with the term, "cultural competence"? [Discuss participant's understanding]
 - A. In what ways do you think your therapist was culturally competent? Can you give an example? How did this make you feel?
 - B. What about ways in which he/she was not culturally competent? Can you give an example? How did this make you feel? What could he/she have done differently?
3. How do you think this therapist would've rated his/her own cultural competence, on a scale of 1-10?
 - A. How would you rate it? (If different answers): What do you think accounts for this?
4. Do you think your therapist was consciously trying to be culturally competent in therapy?
5. Any closing thoughts you'd like to share? Would you see this therapist again, or recommend him/her to a friend with your same racial background?