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Saralyn M. Masselink
What is Culture? What is
Competency? What is
Latino?: An Exploratory
Study of Clinicians'
Perceptions and Practice of
Cultural Competency with
Latino Clients

ABSTRACT

The objective of this study was to explore how clinicians conceptualize and practice cultural competency with Latino clients. This study is qualitative and exploratory in design, and based on in-depth, semi-structured interviews with 12 licensed clinicians in the Los Angeles area; experience in the field while licensed ranged from 1.5 years to 27 years. The study also investigated how clinicians perceived their own cultural identities influencing clinical work, and the relationship between culturally-specific knowledge and cultural competency.

The literature review outlines a social constructionist concept of culture as appropriate for culturally competent practice, and investigates the usefulness of traditional concepts of competency as mastery when applied to cultural competency. Insights from racial identity development models, cultural countertransference and the reflexive self are also presented. Selected Latino cultural trends are then presented.

Several findings emerged from this study which supported literature on social constructionist concepts of culture and the importance of the reflexive self in therapy. Findings include: a) perceptions of cultural competency as a lifelong process, which

includes awareness of racial power dynamics, critical self-reflection, measured self-disclosure, and humility and openness to new learning; b) specific cultural knowledge is important in cultural competency when “held lightly” and used as a tool for structuring curiosity toward specific clients.

WHAT IS CULTURE? WHAT IS COMPETENCY? WHAT IS LATINO?:
AN EXPLORATORY STUDY OF CLINICIANS' PERCEPTIONS AND PRACTICE
OF CULTURAL COMPETENCY WITH LATINO CLIENTS

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

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2008

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CHAPTER I

INTRODUCTION

In 1996, the National Association of Social Workers (NASW) adopted ten “Standards for Cultural Competence in Social Work Practice” charging social workers with the ethical responsibility to be culturally competent (NASW, 1997). The Standards expect social workers to recognize how culture and ethnicity influence clients’ coping strategies and to gain familiarity with varying cultural traditions and norms. The Standards continue for several pages outlining the many facets of cultural competency, emphasizing both clinicians’ self awareness around their own cultural values, as well as specialized knowledge and understanding about the cultural trends of the major client groups served.

While these ethical standards may sound clear enough at first glance, the word “culture” has been referred to as “one of the least understood words in the English language,” (Cohen, p.66). With this in mind, it is not surprising that many definitions of cultural competency have evolved in the psychotherapeutic field. Brock and Fraserirector (2000) claim that most definitions are variants of the one developed in 1989 by a team of mental health researchers, who defined cultural competence as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations” (Cross, Bazron, Dennis, & Isaacs, 1989). Cross et

al. (1989) were in all probability responding to a surge of research in the 1980s on the delivery of mental health services to ethnic minority clients. Sue (1977), Sue and Zane (1987) and Sue and Sue (1990) reported on their groundbreaking research illustrating the inadequacies of provision of mental health services to ethnic minority clients. One of the earliest studies (Sue, 1977) included nearly 14,000 clients, indicating in its results that non-white clients were clearly underrepresented in mental health care. Sue and Zane explained these results by naming the “inability of therapists to provide culturally responsive forms of treatment...The assumption...is that most therapists are not familiar with cultural backgrounds...of various ethnic-minority groups and have received training primarily developed for Anglo...Americans” (p. 37).

Criticisms have been directed at therapists’ bias against minority groups, illustrated by questions raised in clinical literature about “the value of even using insight-oriented therapies with minority patients...[assuming that] people from racial minority and immigrant groups lack the capacity for insight and the ability to explore the meaning of their experiences” (Perez Foster, 1998, p. 254). It may be no surprise that when ethnic minority patients do seek mental health treatment, they have shown the highest premature termination rate of any social group (Sue, 1998 as cited in Perez Foster 1998, p. 254). Given social work’s ethical mandate for cultural competency, and the field’s commitment to the “person-in-context” approach to clinical work, it is imperative that clinical social workers investigate the evolving conceptualization and practice of cultural competency. Lieberman (1990) asserts that it is important to say that “sensitivity to cultural differences is essential in working well with minorities. But what is cultural sensitivity?” (as cited in Rosenthal, p. 218). And how do clinicians develop cultural competency? What relation

does a clinician's cultural background play in culturally competent practice? This study explored the meanings of cultural competency for clinicians with particular attention paid to their work with Latino clients.

La Roche (2002) states that the Latino community is growing rapidly in the United States; from 1990 to 2000, the population increased by 57.9% (from 22.4 million to 35.3 million). Census projections for 2050 are set at more than 133 million Latino Americans—more than one quarter of the population (Taylor, Gambourg, Rivera & Laureano, 2006, p. 429). Panigua (2006) asserts that California alone presently has at least 11 million Latino American residents (p. 48).

Studies (as cited in La Roche, 1999, p. 389) have suggested that Latinos have experienced a disproportionate number of psychological difficulties, including high anxiety and depression levels. Latino Americans have the lowest per capita income relative to other racial and ethnic groups in the United States and are the least likely group to have health insurance coverage (Andres-Hyman, Ortiz, Anez, Paris & Davidson p. 695). However, as compared with non-Latino whites and African Americans, Latinos have a significantly higher prevalence of diagnosable affective disorders and “active comorbidity” (three or more concurrent mental disorders) (Organista & Munoz, p. 256). Research has shown that Latinos rarely seek psychotherapy; they are only half as likely to utilize mental health services as their white counterparts, and when they do, they are more likely to drop out quickly (Andres-Hymen et al., p. 695). Furthermore, Latinos have been twice as likely to be hospitalized in a restrictive psychiatric facility (as compared to non-Latino whites), and thus *are* overrepresented in acute levels of mental healthcare (Andres-Hymen et al. 2006; La Roche 2002). As noted in Rosenthal (2000),

Latinos constitute such a sizable part of the United States population that “their problems of mental health, when properly defined and understood, should, in theory, contribute to the production of established psychiatric knowledge itself” (p. 218).

Clinical therapists will be working with greater numbers of Latino Americans in the future, who are seeking supportive services for the challenges of immigration, acculturation, and negotiating family relationships in a bicultural context. Cultural competency is not only desired, but mandated for clinical social workers in their clinical practice. While there have been myriad studies on theoretical concepts of cultural competency, assessing and applying cultural competency to an agency or institution, and forming culturally-specific interventions for Latinos in particular, little is known about the evolving perceptions and stories of therapists who are striving to be culturally competent therapists with Latino clients. This research project hopes to provide on-the-ground qualitative data from clinicians in practice. The question driving this study is: How do clinicians conceptualize and practice cultural competency with Latino clients?

For the purposes of this study, *culture* will be initially defined as the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. Culture often is referred to as “the totality of ways of being passed on from generation to generation” (NASW, 1997) The definition of culture will be analyzed and juxtaposed with other concepts of culture in the literature review. Next, the use of the word *competency* was chosen because it is the language used in NASW’s code of ethics. The Standards explain that the term competency “is used because it implies having the capacity to function effectively within the context of culturally integrated patterns of human behavior defined

by the group” (NASW, 1997). Finally, the term *Latino* refers to a highly diverse group of people who can trace their heritage back to any 1 of 20 Spanish-speaking nations. In the 1970s, the U.S. government recognized the term *Hispanic* to categorize all persons of Spanish cultural roots. However, because the term *Hispanic* refers to Spain, it can be linked to Spanish colonial history, which did not recognize peoples of indigenous or African genealogy (Andres-Hymen et al, p. 695). In contrast, Organista and Munoz (1996) illustrate that while many Latinos speak Spanish, they may belong to any racial group including those with roots in Europe, Africa, Asia and the Middle East (p. 256).

This study is qualitative and exploratory in design using flexible methods for research with a focus on narrative data collection. It focuses on cultural competency as experienced in clinical therapy space with individual Latino clients in the Los Angeles area. The study is based on in-depth, semi-structured interviews with 12 licensed clinicians; experience in the field while licensed ranged from 1.5 years to 27 years. Clinicians must have worked with at least five Latino clients (for more than one session each) while they were licensed in order to participate. Of the 12, 10 were Licensed Clinical Social Workers while 2 were Licensed Marriage and Family Therapists. Participants were recruited via a snowball method, using a non-probability purposive sample of convenience. In-person interviews, ranging from 35 to 65 minutes in duration were conducted to collect participants’ perceptions of cultural competency and examples of how they practiced cultural competency with Latino clients. Through this, the study explored participants’ past trainings and current conceptualizations of cultural competency in working with Latino clients. Also, the study investigated how clinicians perceived their own cultural identities influencing clinical work, and the relationship

between culturally-specific knowledge and cultural competency. Lastly, this study examined participant narratives that illustrated culturally competent practice and elicited their suggestions for future education in culturally competent practice.

There were two intended audiences for this study. First, the intended audience is professional clinicians who are presently in practice with Latino clients and find the current discussion of cultural competency to be confusing, contradictory, or at times irrelevant to the realities of their work. Second, the intended audience is social work students and social work educators, as the findings provide important feedback to the efficacy of past educational endeavors to teach cultural competency, and offer suggestions from clinicians in the field regarding improving future educational experiences.

In conclusion, the findings of this study will offer the social work field qualitative data reporting on the evolving perceptions and stories of therapists who strive to be culturally competent with Latino clients. This study sought to provide clinical insight and reflection regarding current practices, struggles and successes in the ongoing development of culturally competent practice.

CHAPTER II

LITERATURE REVIEW

This chapter provides a review of the literature emphasizing the importance of cultural competency, definitions and philosophical underpinnings of culturally competent practice, and suggestions for clinicians to consider when engaged in cross-cultural therapeutic work. While the experience of culture and cultural differences extends into history, the review begins with literature published since the 1980s when an interest in cultural competency rose to acknowledgement in American Psychological Association (APA) and National Association of Social Workers (NASW) guidelines for clinical practice. It seems that current research and discussions on culturally competent practice reflect the nuanced nature of the work. Many articles reference a tension in the discussion: on the one side, an emphasis on culturally-specific knowledge and subsequently informed practice and on the other a push toward a “not-knowing” stance in therapists who maintain a general investigative curiosity toward their own and a particular client’s cultural identity and experiences. This oxymoron of being a well-informed, “not-knowing” clinician illustrates the circle that current articles on cultural competency are clarifying, nuancing and looping back around.

The review begins by outlining the guidelines and standards for culturally competent practice as described in the APA and NASW literature. These guidelines are followed by exploratory definitions of cultural competency. Culture is a multi-faceted

concept that proves hard to define, and authors are cited who offer complex definitions and describe what is at stake in the work of defining culture. The concept of competency, how it has historically been understood as a form of mastery and acquired skill, is then troubled as applied to cultural competency. Perspectives on nuanced understandings of competency informed by social constructionism are presented. Finally, selected themes in Latino culture are presented with suggestions for how to use cultural-specific knowledge most appropriately.

Cultural competency has become increasingly significant in discourse in social work and psychological practice in recent years, and subsequently licensure bodies are sounding a call for culturally competent practice. The APA adopted “Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations” in 1988 in response to the “increased awareness about psychological service needs associated with ethnic and cultural diversity” (APA, 2008). The NASW adopted ten “Standards for Cultural Competence in Social Work Practice” in 1996, charging social workers with the ethical responsibility to be culturally competent (NASW, 1997).

The APA guidelines outline “principles that are aspirational in nature and intended to provide suggestions to psychologists” (APA, 2008). The guidelines cover the importance of psychologists educating clients on the nature/goals of psychotherapy. Practitioners should be cognizant of relevant culturally-specific research and training to better understand their clients, and if not, they should seek consultations with culturally-specific informed clinicians. The guidelines further suggest that psychologists gain awareness of how their own cultural backgrounds may bias their practice as they facilitate clients’ discoveries of cultural values and norms. Psychologists ought to assess

clients' acculturation to "majority culture as well as to the ways in which the client's culture may add to or improve various aspects of the majority culture and/or society at large" (APA, 2008). Psychologists should also assess the role of racism in any client's presenting problems, and take into account each client's cultural and spiritual beliefs around healing when considering intervention possibilities. Furthermore, psychologists should be able to provide a client with linguistically appropriate services and be able to assess the impact of adverse social, environmental and political factors when addressing clients' concerns. At last, psychologists should work to "eliminate biases, prejudices, and discriminatory practices" in the field.

NASW supports the goals of eliminating biases, prejudices and discriminatory practices. As a way of embracing these goals, The NASW Standards for social work practice describe their expectations for cultural competency as an ethical mandate. Furthermore, the social work profession has an historical precedent of considering the "person-in-environment," which accents an investigative stance towards a client's immediate context, as well as how the larger socio-political context exerts influence on a client. The Standards charge social workers to recognize how culture and ethnicity may influence an individual's coping strategies and familiarity with varying cultural traditions and norms. Cultural competence requires that social workers acknowledge the strengths that exist in all cultures. Social workers are asked not to universally accept the practices of all cultures (i.e. subjugation of women, corporal punishment, etc.) but rather to be guided by the United Nations' Declaration of Human Rights (www.un.org/Overview/rights.html). Social workers shall know and acknowledge their own cultural backgrounds including how "fears, ignorance, and the 'isms' have

influenced their attitudes, beliefs, and feelings” (NASW, 1997). They are called to have cultural-specific knowledge of history, traditions, values, family systems and artistic expressions of major client groups served. Furthermore, they should translate this knowledge into “culturally appropriate” methodological approaches, skills, and techniques. Acknowledging environmental influences, social workers are mandated to be knowledgeable and skillful in providing clients with helpful services in the community, and to be aware of the effect of social policies and programs on diverse client populations. Social workers shall advocate for recruitment, admissions and hiring that ensure diversity within the profession. They shall seek to provide and advocate for linguistically appropriate services for clients. At last, social workers shall be able to communicate information about diverse client groups to other professionals.

It seems clear that no clinician can credibly ignore issues of cultural competency. It also seems clear that culturally competent practice is multi-faceted, difficult to define and recognize “on the ground,” and may be different with each client. How, then do we break down these expectations of culturally competent practice?

What is Culture?

If clinicians are seeking competency in cultural interactions or culture, it seems natural to begin by defining terms. What is culture? “Culture” has been cited as “one of the two or three most complicated words in the English language” (as cited in Park, p. 14). Anthropologist Susan Wright noted 164 definitions of what anthropologists might mean by the term culture (as cited in Park, p. 13). Calling clinicians toward cultural competency is an exquisitely difficult undertaking in the very first step of defining terms.

The APA guidelines “for providers of psychological services to ethnic, linguistic and culturally diverse populations” do not provide a definition for culture or ethnicity (APA, 2008). NASW defines culture as “the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group” (NASW, 1997). They continue, suggesting that “culture often is referred to as the totality of ways being passed on from generation to generation” (NASW, 1997). As a follow-up, NASW outlines how social work literature in the past few years points to a range of potential content areas that require cultural sensitivity: racial identity formation for people of color as well as for white people, the interrelationship among class, race, ethnicity and gender ... the importance of religion and spirituality in the lives of clients, development of gender identity and sexual orientation, immigration, acculturation and assimilation stresses, biculturalism, people with disabilities, among other things (NASW, 1997).

Other definitions of culture have included “roads, buildings and tools as physical elements of culture, and myths, roles, values and attitudes as subjective ones (Triandis (1980) as cited in D’Ardene & Mahtani, p. 3). Cohen (1998) suggests that culture “refers to the mostly unwritten rules and conventions of thought, communication and behavior that people use so that they can interact in an orderly way” (p. 62). Reber (1985) understood culture as the “system of information that codes the manner in which the people in an organised [sic] group, society or nation interact with their social or physical environment” (as cited in D’Ardene & Mahtani, p.3).

Sashidharan (1986) observed in psychiatry that defining culture was a power-laden event (as cited in D’Ardene & Mahtani, p.3). Fernando (1988) purports that

psychiatry has used culture in an ethnocentric way, in which non-Western cultures are somehow seen as pathological so that “culture” becomes synonymous with a problem that accounts for abnormal behavior (as cited in D’Ardene & Mahtani, p. 3).

Park (2005) would agree that defining culture is a value-laden event. Park asserts that defining culture is “an inscription of differential positions and hierarchical identities...to demarcate whatever a particular set of interests ...should be set apart from something else; included or excluded from the rest” (p. 12). She underlines how culture is a constructed concept that is biased toward the position of the person defining it, relegating that which differentiates racial or ethnic minorities and immigrants from the rest of society as “culture.” Park might propose that the enterprise of cultural competency is problematic in its inception, illustrated by publishers who have historically offered handbooks for competency in many racially identified cultures, although never for the dominant one—which is white culture in the United States (p. 21). By offering the opportunity to be “competent” in minority racial cultures, the field of social work may collude with the culture-as-deficit model supporting the assumption that white culture is the dominant paradigm, against which all other cultures are measured. While it is beyond the scope of this study to dissect the hegemonic culpability of the “culturally competent” enterprise, Park offers an important critique in suggesting that culture be viewed as “a descriptor of inevitable human variation” (p. 30). In this, Park moves towards de-centering the definition of culture: making differences *and* similarities normative in every cross-cultural dyad, noting that each person may conceptualize those points of similarity and difference in diverse ways.

Defining a concept of culture proves to be complex, nuanced and easily misleading. In reading a definition of culture, there may be an assumption that culture is thereby concrete and able to be captured, according to a certain definition. Laird (1998) counters the idea that one can truly learn about culture through “first-order learning,” or the memorization of theories and definitions of ethnicity that outline clusters of common characteristics or behavior patterns (p. 23). These normative theories, suggests Laird, “encourage stereotyping, narrow our field of possibilities and prevent us from recognizing the dynamic complexity and continuously changing nature of ethnic, racial, gender, social class, or sexual identity and experience” (p. 23). Both Park (2005) and Laird (1998) seem to agree that the task of exploring how clinicians can recognize or conceptualize culture is an important responsibility. Laird suggests the task begins by “learning *how to learn* about culture” [italics added] (p. 23).

Gonzalez, Biever and Gardner (1994) recognize a social constructionist perspective on culture, where the meaning of culture is derived from social interactions (p. 515). Laird (1998) argues for a “moveable feast” metaphor for culture, or “the idea that gender, race, and other cultural notions are constantly in motion, changing in meanings and definitions on the parts of both the beholder and the beheld” (p. 24). Keenan (2004) uses the metaphor of a lens, comprised of the “beliefs, expectations and meanings,” through which we interpret our choices, actions and experience that enact these “beliefs, expectations and meanings” (p. 541). Common in all of these understandings is how culture is dynamic and changing, affected by how each person is performing culture everyday.

Laird (1998) describes culture as “performative...improvisational... [and] fluid/emergent ... [persons] ‘perform’ cultural stories of gender, ethnicity, race” each day, as they move through different contexts and interactions. Keenan (2004) highlights how “we are thrown into cultural practices before we have language to describe them, so we experience culture as normative, as ‘what is,’ as the backdrop of assumptions regarding our hopes, goals and values” (p. 541). Culture is made of the building blocks of “common sense,” which is understood differently in different cultural contexts. Culture can be experienced as an “inner guide that brings meaning and direction to our daily actions, opinions about others, and life decisions” (Keenan, p. 541). Landrine, Klonoff and Brown-Collins (1992) suggest that “culture can be regarded as the unwritten social and psychological dictionary that we have each memorized and repressed and through which we each unwittingly interpret ourselves and others” (p. 148). Individuals and groups will adhere to cultural norms on a spectrum: some will resist cultural practices or work to change them, while others will embrace cultural norms as important aspects of their identity. No matter where they are on the spectrum of agreeing or disagreeing with cultural norms, *culture* acts as “a tether that connects groups of people together” (Keenan, 541).

The emphasis in social constructionism is how people create knowledge and understanding; it is designed so that there are not universal meanings, no “right” way, but rather multiple valid perspectives. The “inner guide” of culture develops through interplay of cues from social interactions and how each person uniquely improvises meaning and behavior in response to others, which is part of a person’s identity. Identity then, “cannot be separated from one’s group identities, which are rooted in cultural

membership and shared cultural experiences” (Keenan, p. 541). Laird (1998) illustrates how identity, “is contextual...no two contexts are ever quite the same...we are all multiple cultural selves...I am different in the classroom than I am ...vacationing [or] ...eating dinner at the college president’s house” (pp. 24-25). Laird acknowledges, however, that certain aspects of one’s identity can remain salient in many contexts, such as race, ethnicity or gender. Any cultural identity that is closer to the margins brings with it a heightened awareness of how this identity is being “othered” (and deprivileged) by those persons in the center, or dominant culture. When one’s cultural identity places him at the margins, it becomes important to nurture a “dual perspective,” where one remains attentive to both one’s own culture as well as the dominant culture (Laird, p. 25).

Cultural identity never stands alone. No woman is simply Latina. Rather, each person is an “intersection” of multiple cultural identities which are fluid and changing (Laird, p. 26). A middle-class, well-educated Mexican-American woman may be a clinician at work, well-versed in psychological and developmental theories, whereas at home she is a mother and a marriage partner, which calls for a different set of skills and aspects of herself. Furthermore, when she returns to Mexico and visits her parents, she may speak and behave differently, and experience herself differently than when she is at work. Her cultural identity is always an intersection of several identities. She is all of these: middle-class, well-educated, Mexican-American, clinician, mother, partner, and daughter. However, in certain contexts, one aspect of her identity may be more salient than in others. Laird (1998) notes here that there is remarkable “within-group diversity” and one can not assume common sets of meanings within any one grouping (e.g. “middle-class” or “Mexican-American”) (Laird, p. 27). However, the groupings that a

person shares about in her or his life narrative might guide a clinician to ask competent questions: “How is *this* person performing culture?” (Laird, p. 27).

Laird (1998) proposes that culture is “definitional...constitutive... [and] political” (pp. 27-28). Here is where Laird seems to strongly criticize “normative theories” on culture; she states that ethnicity “cannot be decontextualized and held up for examination and definition, because it is not a thing, an object...it is a narrativized cluster of meanings drawn from past, present, and future that is itself definitional and constitutive” (p. 27). Laird strongly supports a person’s freedom to constantly evolve and re-story themselves, re-story their cultural identities. However, she acknowledges that all “people do not have equal voice in shaping their personal narratives” (p. 28). Oftentimes larger cultural narratives may present limits to possible cultural meanings for ethnicity, or gender, for example. If those parameters are unusually narrow, a person may develop defeating self-narratives. In the context of a white majority at her workplace, a Mexican-American clinician may sense that her Latina identity is somehow less-than or shameful. She may re-story this part of herself as an aspect that she should downplay or disavow. The work of re-storying is part of this clinician’s cultural identity that is fluid and changing.

In sum, Laird (1998) suggests that culture is constantly shifting and can only be understood in the context of a person’s life and how she is *storying* her life: her past, her present and her hopes for the future. Ultimately, she proposes that culture is about interaction, meaning-making, “linguaging,” and is in itself constitutive (p. 29). How, then, can one imagine being “competent” in culture?

What is Competency?

The Random House Unabridged Dictionary cites “competence” as “the quality of ...adequacy; possession of required skill, knowledge, qualification, or capacity” (<http://dictionary.reference.com/browse/competence>). In a similar, misleading way that a definition of the word “culture” may suggest that it is somehow tangible and concrete, the word “competency” may suggest that clinicians can “possess a skill” that will signify competency, mastery or adequacy, once and for all time.

Freud (1915) emphasized the role of a clinician (or analyst) as a neutral presence in the therapeutic encounter, with the goal of avoiding countertransference (as cited in Meissner, p. 1090). Freud posed early images of the psychoanalyst as a mirror or a surgeon; one who views a client objectively and does not impose one’s own attitude or values on a client’s experiences (Meissner, p. 1100). While modern psychodynamic perspectives have shifted from Freud’s early concepts of psychoanalysis, the image of the clinician as a neutral expert has continued to appear in concepts of therapeutic dynamics.

Miehls and Moffatt (2000) point to how social work students tend to search for answers in the vein of the Enlightenment era; they search for objective knowledge that is *outside* themselves in hopes that it will provide key insights that unlock the secrets of therapeutic competency and thus lessen their anxiety about clinical work. Irving and Young (2004), and Dyche and Zayas (2001) have suggested that a central challenge in post-modern social work education is helping students (and clinicians) embrace ambiguity and uncertainty. When clinicians bypass the opportunity (and struggle) in tolerating anxiety, they miss a chance for self-discovery—which is the same process in which clinicians ask their clients to engage.

Moffatt and Miehl (1999) note how historically, the social work profession has defined clients as an “other” who is diagnosed or pathologized, and the social worker as “a helper who has removed his or herself from the problem of the client” (p. 67). This relegates the “normal” identity to the social worker, and the subjectivity of the client is the only recognized subjectivity in the room. Edward (1996) suggests that the objective perspective of the therapist was designed to limit power relations and abuses of power by the clinician (as cited in Moffat & Miehl, p. 68). Postmodern understandings of social relations suggest that concepts of objectivity and neutrality themselves are correlated to power. Foucault (1979) has shown that power functions “everywhere in a continuous way” as relational dynamics between a person and herself, a person interacting with others, and/or a person interacting with institutions surrounding them (as cited in Moffatt & Miehl, p. 69). The importance of engaging clients in an inter-subjective manner, or in a way that “honors the mutual creation of complex meaning of one’s past and present experiences,” seems evident (Miehl, p. 230; Perez Foster, 1999). In other words, the clinician’s subjective identity must be recognized, reflected upon and considered as a dynamic and influential part of all therapeutic endeavors. This is not to say that clinicians’ identities should overshadow clients’ narratives, rather, it is important to remain reflective on the ways in which clinicians affect the therapeutic dynamic.

What is Cultural Countertransference?

Prejudice and bias exist deep within our psyches, and not engaging in a dialogic, open and reflective process around them does not mean that racial factors are not present in cross-cultural therapist-client dyads. Instead, they may be functioning in implicit and unacknowledged ways. Perez Foster (1999) investigates how unacknowledged racial

dynamics function through clinicians' cultural countertransference, which is multi-faceted and consistently impacting therapeutic work with clients who the clinicians perceive as different from themselves. She describes a clinician's cultural countertransference as a pre-existing set of cognitive and emotional perceptions that include: "1) American life values, 2) Academically informed theoretical beliefs and practice orientation, 3) Personally driven idealizations and prejudices toward ethnic groups, and 4) Personally driven biases about [her or his] own ethnicity" (1998, p. 257).

Salient in United States culture per Perez Foster is an emphasis on autonomy of the self as a developmental ideal. She suggests that American clinicians are so steeped in this perspective that they seldom question whether this developmental trajectory may be contextual to westernized cultures. Perez Foster (1998) cites contemporary social scientists who point out that "the psychological theories which carry the strongest power are those which rationalize and extend a group's most deeply rooted and dearly held traditions and beliefs" (p. 259). Therefore, American clinicians who are oriented in theoretical perspectives based on an ideal of individual autonomy may be challenged to take a second look at their theory and practice when working in cross-cultural dyads.

Perez Foster (1998) emphasizes that it is often the personally driven biases and prejudices that go disavowed and thus unacknowledged by clinicians. She suggests that clinicians might strive to be "politically correct," which could function as resistance to processing deeper and more troubling feelings. In this way, clinicians who claim to be culturally aware might present themselves as "special exceptions" to ethnic prejudice and thus relegate themselves to a superficial understanding of cultural competence (1998, p. 260). However, much of what is kept unconscious is enacted, nonetheless. Perez Foster

strongly suggests that disavowed cultural bias can be perceived by clients, and if clinicians are not critically self-reflective, their clients will pick up on their cultural bias before they do.

Cultural bias can be sensed in a clinician's body posture, or way of looking at a client. Shome (1999) notes that cultural bias is transparent when another person is functioning only with a politically correct understanding of cultural competency; nonverbal behaviors expose racism that is discernible in conversations and interactions. She describes how there can be "that *thing in their look*... they welcome you, but then the way they look at you makes you feel as though your whole body is up for examination and scrutiny...it almost feels as though they hunt my body for difference...it's such a systemic thing, they don't even realize half the time that they do it" (as cited in Miehl, 2001, pp. 233-234). Alcoff (1999) describes that "to feel one's face studied with great seriousness, not for character lines, or its distinctiveness, but for its telltale racial trace, can be a peculiarly unsettling experience" (as cited in Miehl, p.233).

Perez Foster (1998) urges clinicians to "remain vigilant of the potential for using the clinical situation to enact personally driven, culture-laden conflicts" (p. 262). Due to the reality that many ethnic minority clients are un-empowered in other areas of their lives, Perez Foster predicts that they will tend not to confront clinicians about these obvious discomforts. They will simply walk away from treatment. She suggests that the "hidden discomforts and anxieties of cross-cultural therapeutic interactions, and most particularly the disavowed prejudices and fears of the clinician, are in fact the propelling factors behind the stunning statistics that ethnic minorities show the highest premature termination rates of all mental health service consumers" (p. 271).

Constantine (2004) researched clients' of color perceptions of "racial microaggressions" from white clinicians. While there were myriad microaggressions named, many of them came from "good intentions" on the part of the clinician. For example, some clinicians tried to overidentify with their clients, dismissing individual racial bias because of assumed similarity; one female clinician named how her experiences of sexism have informed her about what it is like for her client to experience racism. Others included clinicians normalizing potentially dysfunctional behaviors on the basis of a client's cultural group, such as substance abuse being "common" and thus "culturally sanctioned" (Constantine, p. 5). Some therapists minimized the importance of racial-cultural issues in therapy, suggesting that a client's depression is a general, situation-based depression that does not have much to do with racial identity.

What is Racial Identity?

Racial identity seems to be a particularly salient aspect of unacknowledged power in United States culture. Wilkinson (1995) notes that race may be the "principal molder of multiple forms of interaction... that affects the clinical social work process" (as cited in Miehl, 2001, p. 234). Dobbins and Skillings (2000) suggest that racism functions as a "clinical syndrome," likening it to an addiction, and they allude to how all therapists—most notably white therapists in United States culture—must recognize the power of privilege and racism as ego-dystonic in order to be culturally competent. Sue and Sue (1990) describe how cross-cultural training emphasizes cognitive understanding and skills-based learning, but "what is missing for the trainee is self-exploration of one's own racism" (p. 15). Laird (1998) notes that "Our own cultural narratives help us to organize our thinking and anchor our lives, but they can also blind us to the unfamiliar and

unrecognizable and they can foster injustice” (p. 22). Similarly, Werkmeister Rozas (2004) explains how information dealing with cultural and racial differences is not comprised of “objective, neutral, universal” knowledge (p. 231). Rather, experiences of culture, racism and racial identity are personal and subjective. Clinicians are better equipped to understand clients who are culturally different from them by first working to understand their own cultural identity development. Tatum (1992) and Helms (1990) maintain that “encouraging the secure development of an individual’s racial identity may decrease racial prejudice and racism in ...United States society” (as cited in Werkmeister Rozas, p. 232).

Identity formation includes the narrative that we construct about who we are, how we interact with others, and the meanings we make from those interactions. According to Erikson (1963, 1968), the most recognized identity theorist in the past half-century, identity is formed as a dynamic process involving the person’s cultural and social context (as cited in Miller & Garran, 2008, p. 105). Erikson suggests that those with cultural privilege “project their unconscious, negative identities onto those who are oppressed...buttressing their sense of superiority at the expense of those who are... socially constructed as ‘less than’” (Miller & Garran, p. 105).

Several theorists (Miller & Garran, 2008; Lee et al., 2007; Sue & Sue, 1990) have presented models of racial identity development that outline general stages, guiding persons in a process of reflexivity around experiences of race and racism. While these stages seem linear, they are better conceptualized as an ascending spiral; individuals may move from one stage to another based on different contexts. Some individuals may skip steps altogether. These development models are presented as a framework for exploring

identity development that will essentially be unique for each person. However, these theories do suggest fundamental differences between identity development for people of color and white people. While it is beyond the scope of this project to present a detailed account of racial identity development theories, it is important to outline a general sense of how racial identity theories shed light on the process of cultural competency.

Miller and Garran (2008) describe a framework for racial identity development for persons of color. They begin by describing a person whose opinion is that race does not matter or influence experiences, moving to a place of acknowledging that he or she is a member of a targeted group, or a person of color. Sue and Sue (1990) suggest that individuals start by consciously or unconsciously devaluing their own cultural identity, and valuing white values and ways (p. 94). A range of explanations and emotions may arise from these initial realizations, which could lead to experiences of denial or support-seeking. Lee et al. (2007) name this experience as a time of dissonance, where a person is in psychological conflict, questioning her sense of self-esteem and cultural identity (p. 91). During this period, individuals may experience significant guilt and anger over being “brainwashed by White society” (Sue & Sue, p. 95).

The next stage, named “Resistance and Immersion,” involves a burgeoning sense of pride and appreciation for one’s cultural group, although this is emphasized by a rejection of dominant cultural values (Lee et al., p. 2007). People of color face the challenge of both understanding how whiteness functions and how to survive in a white world, while also contemplating their own racial and ethnic ties, and the relationship between both worlds. Part of the task in identity development here is to recognize and reject internalized stereotypes. The next stage, while named differently by theorists,

suggests a growing concern for self-appreciation and questioning ethnocentrism as a basis for judging others. In the last stage, often named for its integrative process, a person learns to “shed internalized oppression,” and internalize a sense of pride and peace with one’s own identity while respecting the identities of others (Miller & Garran, 2008, p. 120). However, this does not mean acceptance of racism. Ideally, working against racism becomes part of a self-actualized racial identity.

White people face the challenge of unlearning racism and forging a non-racist identity. Sue and Sue (1990) begin their description of white identity formation by naming a “conformity stage.” This stage is characterized by an ethnocentric perspective, where there is little awareness of being a racial being and one assumes that her experience of the world is the same as everyone else’s, more or less. Sue and Sue note how this stage is rife with contradictory and oftentimes compartmentalized opinions. People may not consider themselves racist, yet think that migrant agricultural work is “Latino work,” and still maintain that “people are people” and that we are all created equal. Movement into the next stage happens when white persons have to deal with the inconsistencies that have been compartmentalized. McIntosh (1989), a white woman, describes how she came to realize that assumptions she made about her identity as being “neutral, normative and average” blinded her to her own racially privileged identity. She states, “I was taught to see racism only in individual acts of meanness, not in invisible systems conferring dominance on my group.” In this stage, it is common for persons to experience guilt, shame, anger or depression.

White people may rationalize their behaviors by the belief that racism is too engrained in society, and that they are powerless to make changes (Sue & Sue, 1990, p.

115). As McIntosh models in her article, the next stage is characterized by opening one's eyes and recognizing racism in its many forms. White persons may experience a form of racial self-hatred. They may intentionally distance themselves from racial privileges in their identity, may idealize persons of color and harshly judge other white persons (Miller & Garran, 2008, p. 120). Sue and Sue suggest that a form of the "white liberal syndrome" may develop, where persons may attempt to overidentify with persons of color in order to escape their whiteness, or they may form a paternalistic attitude toward persons of color in hopes to shield them from racism (p. 115). A clinical manifestation of this stage might be the "clinical anthropologist syndrome," where clinicians are excessively curious, overcompensating for perceived differences by discussing at length cultural details over and above concerns of the client (Falicov, 1989, p. 109). Oftentimes, persons will not be successful in these attempts to connect with others. Again, persons may move into a form of denial or rationalization, or they may shift into an introspective/integrative stage. Eventually, they will find a way to move through the guilt, accept their social identity but not the unearned privilege, and be able to respect and appreciate people who are racially different from them. They can then commit to working against racism as a part of their identity in the world.

What is Cultural Reflexivity?

How then, shall therapists apply knowledge of racial identity development to clinical work? Perez Foster (1998) suggests that clinicians divest themselves of positivistic claims on human reality or development. Instead of having universals in human meaning systems, therapists may need to accept the limitations of their worldviews. Irving and Young (2004) suggest labeling all theories and models as

metaphors, grounded in a certain context and time (p. 215). Clinicians can then reflectively apply theories, questioning what theory or model might be helpful in this situation, and why? Therapists must be willing to disclose to clients when they feel they have lost their way culturally, or that they do not understand the cultural dynamics at work. This divesting of power is aimed toward a more co-therapy mode, where clients are encouraged to become co-creators. Perez Foster suggests that a “narrative turn” might be helpful, where the focus of the therapy shifts away from a therapist’s interpretation and towards “the cooperative activity of two people who are focused on creating the narrative understanding that will produce the client’s desired change” (p. 265). Perez Foster seems to advocate for appropriate therapist self-disclosure to allow for a two-person process in therapy, thus viewing the clinician as a subjective psyche in the room.

Along the same lines, Falicov (1989) highlights how the “cultural equation” in therapy includes both the therapist’s and the client’s cultural and personal constructions of mental health. She notes how both the clinician and the client are “caught in the same web, influenced by the same historical forces, and shaped by the dominant narrative structures of our times” (E.M. Bruner, 1986, as cited in Falicov, p. 7). As has been highlighted earlier, a clinician must remain vigilant about operating with a hidden standard of “normalcy” based in his or her own cultural ecology. Falicov (1989) notes that she preserves a tension when talking about cultural themes: between making generalizations about specific groups and yet “honoring the cultural borderlands with other groups” that inevitably happen in unique ways in the lived experiences of each client (pp. 6-7).

Miehls and Moffatt (2000) advocate for social workers to nurture a “reflexive self.” One meaning of the word “reflexive” is to reflect back on oneself, or to “[throw] back images” of oneself, as a reflective mirror (<http://dictionary.reference.com/browse/reflexive>). The need for social workers to be self-aware in cross-cultural therapy has often been cited as important, but reflexivity suggests something more. Reflexivity “refers to a continuous process of questioning one’s interpretations of experience (of oneself and others) and one’s actions in the service of effective listening to, questioning, and understanding self and others” (Keenan, 2004, p. 545). Foucault understands the self to be “a relationship of reflexivity which is integral to its power and freedom” (as cited in Miehls & Moffatt, p. 342). If the self is understood as a relationship, then the identity of the clinician becomes linked to the identity of each client. In this way, a therapist’s identity is rooted in intersubjectivity—the self’s relationships with itself and to others—rather than solely on intrapsychic dynamics (Miehls & Moffatt, p. 342). Werkmeister Rozas (2004) suggests that learning about one’s self is a process that is rooted in dialogue and social interaction; “the self cannot be whole, or even exist without dialogue...in a tensile relationship with ...other selves” (p. 233). The “other” becomes essential to learning about self-identity. Miehls and Moffatt note how, in an intersubjective understanding of the self, a “task of the self [is] working on the self in order to escape political, social and psychological determinants of identity” (p. 343). Through reflexivity, the self discovers “power and freedom,” imagining new possibilities for relationships.

In therapeutic relationships, empathy opens up possibilities for connection. Smith (1997) suggests that empathy might involve a process of “substitution,” which is a

practice of “imaginatively and affectively putting oneself in the place of another” (as cited in Miehls & Moffatt, 2000, p. 344). However, knowing that one can never fully understand or “substitute” themselves for another creates tension for the clinician. Miehls and Moffatt encourage clinicians to embrace this tension; an easy escape from the tension for a clinician is to slip into a neutral or expert stance (p. 344). Miehls and Moffatt draw on Bakhtin’s (1993) reflections of empathy, outlining how empathizing with a client “does not imply that the social worker... loses her-or himself completely, nor her or his unique place outside the other, even for a moment” (p. 344). Instead, the act of empathy is a process initiated by a clinician that is his “creation of the other and myself...empathizing is also about the self working on the self” (Miehls & Moffatt, p. 344). Empathy here is not just a process to better understand a client; it is also a process for clinicians to better understand themselves. Only when we have others by which to contextualize ourselves, do we more fully understand who we are. Miehls and Moffatt suggest that “the function of empathy, then, is not to only understand the position of the other but fundamentally to allow one’s self to be altered by the other” (p. 345). In this sort of empathic exchange, both clinician and client are mutually enriched and might understand themselves in more complex ways than before.

Laird (1998) proposes that clinicians adopt a stance of “informed not-knowing.” The “informed” aspect speaks to clinicians’ lifelong pursuit of continued learning, discerning theories and practice models that may be helpful, reflecting on the powerful influence of oppression and privilege in mental health, and learning about cultural trends, to name a few (Gonzalez et al., 1994, p. 519). However, the “not-knowing” part recognizes that all knowledge is partial and subject to perspective (Keenan, 2004, p. 543).

This stance maintains clients as the experts of their own experiences, respecting the unique dignity of each human life.

What is Latino?

Falicov (1989) suggests that the “current dilemma” in psychotherapy exists in the tension between clinicians learning enough culture-specific knowledge to feel competent to respect the cultural beliefs of the client, yet not conduct therapy from a pre-conceived notion of stereotypes that ignores the nuances and uniqueness of each client’s life and narratives (p. 5). In agreement with Perez Foster (1998), she notes that psychotherapeutic training in the United States is enmeshed with values from American culture, which muddies clinicians’ lenses in learning about cultural complexities. She draws a term from Wrenn (1962) to describe these clinicians and their muddied lenses; these clinicians are wrought with “cultural encapsulation” (p. 5). Falicov accents the ethical dilemma of a “culturally encapsulated” clinician who is unable to understand others through a different cultural lens and thus pathologizes behaviors or perspectives that are abnormal in a clinician’s cultural context, yet may be normal in a client’s context.

Rosaldo (1989) questions the possibility of “pure” cultures. By necessity, “cultural borderlands” are created, which are “overlapping zones of difference and similarity within and between cultures” (Falicov, 1989, p. 6). Focusing on these borderlands, Rosaldo suggests that social borders “become salient around such lines as sexual orientation, gender, class, race, ethnicity, nationality, age, politics, dress, food or taste” (p. 208). Rosaldo highlights that these borderlands are sites of “creative cultural production” that invite analysis. Rosaldo suggests, that in studying Latino culture, we are never studying a contained group, although race relations in North America push to “keep

each culture pure and in its place” (p. 212). Rather, we are investigating literal and metaphorical “practices of everyday life,” which each person will adopt and weave into their “many-stranded identity,” using the threads of social borders named above. Falicov also hopes to muddy the conceptually often-too-sharp boundaries between cultures; she puts forward that each person participates in diverse and multiple contexts at once. As a guide for discerning complexity and nuance, Falicov purports that all “persons are multicultural rather than belonging to a single ethnic group that can be summarized easily by a single label” (pp. 6-7). Falicov reminds clinicians that “when it comes to the individual experience, there is no such a thing as Latino culture, rather there are only approximations of patterns that appear in some cases and not in others” (p. 2).

Falicov (1989) designed a “cultural generalist” framework that ideally draws out cultural differences and similarities between client and therapist in the service of enhancing therapeutic work. She names her approach, “MECA” or “multidimensional ecosystemic comparative approach,” which identifies, for the purposes of this project, three dimensions:¹ “migration, ecological context and family organization...that can be used to describe and compare similarities and differences among cultural groups” (p. 8). Using this “map,” Falicov suggests that therapists consider multiple cultural contexts in which both they and the client are embedded.

Migration

Falicov (1989) and Paniagua (2005) suggest exploring with clients why, how and with whom Latino immigrants came to the States. They note that migration can exert

¹ Falicov (1989) mentions four dimensions to the MECA approach: migration, ecological context, family organization and family life cycle. Due to the limited scope of this project, the final dimension has been omitted.

significant mental health difficulties and stress on individuals and family systems, including loss and grief. Both suggest exploring the circumstances under which, when, why and how a family came to migrate, especially who voluntarily migrated and who came under pressure from others. Falicov notes close attention to pre-migration dynamics and events offers clues to the readiness of individuals for the migration journey, the meaning of present symptoms and obstacles to adaptation (Falicov, p, 50). Posttraumatic stress has been seen in clients whose journeys involved trauma. There have been reports of beatings, rape and sexual trafficking in migration journeys, which have caused symptoms of “recurring nightmares, dreams...guilt, shame, phobias or panic attacks” (Falicov, p. 51). For these reasons, Falicov advocates asking about detailed migration narratives (sensitive to whether the client is ready for this), even when clients have been in the States for several years.

Falicov (1989) illustrates migration struggles with an “uprooting” metaphor, outlining how clients experience physical, social and cultural uprooting. In early stages of migration, Falicov suggests that clients recover even a few familiar physical objects in their new home, such as ingredients to cook certain dishes or music that they had listened to in earlier times (p. 53). She outlines how social uprooting from familiar relationships can compound feelings of alienation, and therapists can help clients mobilize themselves to find support groups to ease loneliness and provide important information (p. 54). In cultural uprooting, meanings change. The experience of and the meanings behind a client’s gender, race, social class and education level can shift dramatically. Clients may simultaneously mourn the loss of the home they had known before, and experience high levels of anxiety as they adapt to new settings. Therapists shall pay attention to those

who were left behind, those arriving, and those who have been in the United States as important people in the migration experience.

Sluzki (1989) researched the impact of relocation on an individual's and family's social network and his findings suggest that co-ethnic networks of support provide important cultural and social continuity (as cited in Falicov, 1989, p. 65). At times, these connections might also provide coaching in the new culture. Falicov (1989) and La Roche (2002) note that therapists may need to act as social intermediaries between clients and institutional resources; they encourage clinicians to resist being rescuers, to offer support but honor clients' internal resources.

Ecological Context

How therapists understand their therapeutic role will vary depending on how they conceptualize the process of adaptation to American culture. Many migration theorists have described an acculturation or "Americanization" process whereby there is an implicit transformation toward the dominant culture (Falicov, p. 69). Historically, the American identity has been portrayed as a white identity (Devos & Banaji, 2005; Ngai, 1999), which begs the question, how does a Latino-identifying client engage in "Americanization"? Falicov (1989) cites a number of studies that have shown that immigrants who abandon their old culture in a rapid manner to assimilate to the new are more vulnerable to psychological problems and drug use (p. 71). Ideally, clients find ways to retain cultural meanings, identities and language while also engaging in the new context.

Falicov (1989) names two models of adaptation: the alternation model and the hybridization model. Both feature a chance for individuals and families to have

“both/and” where they retain their old culture while also learning the new culture, depending on the context. In the alternation model, individuals have contexts that preserve their old culture (e.g. church, co-ethnic groups, family environment) while also participating in the new culture (e.g. an English speaking job, educational class, volunteer work). LaFramboise et al. (1993) assert that bi-culturally competent individuals who alternated between cultures had less anxiety than those who tried to assimilate (as cited in Falicov, p. 73). The hybridization model suggests that individuals create “hybrid cultures...situations in which traditions are not quite past and modernity is not yet wholly present” (p. 74). Here, individuals form complex collective identities in contexts that acknowledge culture-blending, as often seen in artistic environments. Chicana poet Gloria Anzaldua developed the idea of people living at the crossroads of cultural borderlands. She describes the potential for creating hybrid and multi-faceted identities in this space:

The new mestiza [a woman of mixed Indian and Spanish ancestry born in the United States] copes by developing a tolerance for contradictions, a tolerance for ambiguity. She learns to be Indian in a Mexican culture, to be Mexican from an Anglo point of view. She learns to juggle cultures. She has a plural personality, she operates in a pluralistic mode—nothing is thrust out, the good, the bad, and the ugly, nothing rejected, nothing abandoned. Not only does she sustain contradictions, she turns the ambivalence into something else (as cited in Falicov 1989, p. 15).

Instead of clinicians stressing acculturation too quickly and unwittingly exerting dominant cultural norms, therapists might conceptualize and imagine with clients different models for adaptation. Falicov (1989) notes that individual and family problems may stem from unprocessed cultural change. It can be helpful to frame

problems through the lens of cultural transition, which can permeate relationships, job dynamics and life cycle transitions (p. 81).

In cultural transition to the United States, it is important to acknowledge racism. Therapists must assess the effect of marginalization on Latino clients. Weaver (2006) conducted a quantitative study which illustrated how “Latino Americans of both sexes were ...likely to say they believe that people [cannot] be trusted, [and will not] try to be fair... [or] helpful” (p. 1160). Dyche and Zayas (2001) report that therapists who have worked with clients who have experienced marginalization have “learned that trust is often elusive, that many clients will censor their experiences, and the discrepancies of power and status exert a quiet but substantial hold on the growth potential of therapy” (p. 249). Mistrust can function as a healthy defense in the context of oppression. La Roche (2002) purports that marginalized clients’ transference toward clinicians can be “representative... [of] the various socio-cultural meanings regarding therapists’ authority and assumed group” (p. 391). She suggests that clinicians reflect on clients’ transference with the sociopolitical context in mind. As therapy unfolds, clients’ adversarial feelings *and* idealization toward the therapist can be representative of their feelings about dominant cultural norms. If articulated how a patient’s narrative may be affected by dominant and marginalized features of culture, this can be made conscious. La Roche encourages a gradual back and forth focus between the therapeutic experience and the larger cultural context of discrimination. She asserts that this process can encourage clients to define themselves as complex—and most notably, keep clients from blaming themselves for social issues. This process may help to further awaken clients’ social consciousness, honing an eye for the complexity of social situations, which could also

serve as a positive coping mechanism. In Latino culture, the family serves as important coping support as well.

Family Organization

The traditional Latino family unit tends to be an extended one, including grandparents, aunts, uncles, cousins, close family friends and others. *Familismo* (familism) encompasses the strong values placed on familial relationships; it emphasizes interdependence over independence, affiliation over confrontation and cooperation over competition (Comas-Diaz, 1989, p.32). Some have described Latino individuals as having a “familial self” that includes close relationships as a part of who one is, and a “private self,” comprised of unshared feelings and fantasies (Falicov, 1989, p. 163). La Roche (1999) suggests that Latinos tend to “define themselves through others, emphasizing social relationships and highlighting group goals rather than individual needs” (p. 390). *Familismo* may affect mental health issues in that patients may see their families’ needs as more important than (or as part of) their own individual needs. Some have argued that mental illness among Latinos is a family affair and not an individual situation (Canino, 1982, as cited in Comas-Diaz, 1989, p.33). Given this, it might be just as illuminating to ask patients about their families as asking about themselves; family stories can reveal much about adherence to cultural scripts such as *familismo* and *simpatia*.

In the spirit of *familismo*, several authors have noted the importance of *personalismo* (personalism) in therapy, or engaging clients on a personal level, communicating that a clinician is not just working for a paycheck. Organista and Munoz (1996) and Falicov (1989) support an initial social phase for treatment, where therapists

can possibly share with patients about their background as a way of building trust. Latino culture also values *simpatia* in verbal communication, which places an emphasis on maintaining a pleasant demeanor and promoting a sense of harmony among people that avoids conflict (Comas-Diaz, 1989, p.38). Latino parents praise children who have a warm and considerate demeanor toward others. Falicov (1989) writes, “In short, from early on Latinos are raised with the notion that much can be achieved interpersonally if people talk nicely, explain a lot and give compliments” (p. 179). A patient’s *simpatia* may keep her or him from asserting feelings in therapy, as well as in other relationships. Therapists must assess to which degree such patterns of indirect communication are adaptive or maladaptive for a particular client.

Respeto (respect) alludes to relationships involving “highly emotionalized dependence and dutifulness within a fairly authoritarian framework” (Diaz-Guerrero 1975, as cited in Falicov, 1989, p. 169). Older people deserve respect from younger ones, men from women, parents from children, authority figures from lay persons. Likewise, clinicians are offered respect as an expert in their field due to their education. As a special emphasis, children shall respect their parents throughout life which only slightly changes in adulthood. Due to the authoritarian nature of parenthood, La Roche (1999, 2002) suggests that therapists be more directive at the beginning of treatment, trying to alleviate concrete aspects of the presenting problem. Organista and Munoz (1996) echo that possible homework assignments and concrete tasks might help Latino patients to think of therapy more as a classroom experience, alleviating some of the cultural stigma attached to mental health.

In Latin American countries, mental health funding is limited and thus often reserved exclusively for psychotic patients (Falicov, 1989, p. 259). Participation in therapy itself may pose cultural conflict, because cultural value is placed on seeking help from within the family. Latino patients may use therapy as a last resort, after exhausting other family and community resources. They may subsequently present with severe symptomatology at the beginning of treatment (La Roche, 1999, p. 393). When Latino clients seek therapeutic help, clinicians must also assess the positive or negative adaptiveness of gender roles, as historically understood in Latino culture.

Gender Roles

Historically, *machismo* has been used to represent a negative stereotype for Latino men: “a man should be very strong physically, indomitable in character, and potently virile... one who can drink the most, defend himself the best, dominate his wife (even through physical force or violence...) command the respect of his children, have more sexual relations, and engender more sons” (Falicov, p. 195). However, there are positive aspects of *machismo* as well, including devotion to the women in a man’s family, his biological mother above all others. *Machismo* is a complex phenomenon, expressed in subtle and explicit ways. Falicov (1989) asserts that *machismo* may be used as a bridge to more effective therapy by emphasizing the values of a man caring for his family, being devoted as their provider and a man of morals. It may be helpful to explore potential gender role strains on the family, and frame therapeutic interventions in pro-social values such as loyalty, duty and respect (Andres-Hyman et al., 2006, p. 699).

Marianismo (from the Virgin/Mother Mary) is often embedded in a Latina female mystique. Latina women are expected to remain sexually chaste and virtuous until they

are married. Once a woman has a child, she is elevated to a spiritual superiority over men, as she is responsible for educating her children in cultural and religious values. However, in keeping with the image of Mary, mothers are called upon to be selfless and to suffer with dignity (Andres-Hyman et al., 2006, p. 699). Paradoxically, the Latina mystique is also influenced by *hembrista* (femaleness) which is a female-version of *machismo*; *hembrista* females are those who can “do it all” and show determination to overcome every obstacle. Some women may find themselves acting as a *hembrista* female at work and a *marianismo* female at home. *Marianismo* has many positive aspects as well: a woman’s self-esteem is connected to her sense of herself as a generous mother. She is respected by the family and community, as well as by her husband and sons (Falicov, 1989, p. 200). Comas-Diaz (1988) has found that depression symptoms in Puerto Rican women appeared related to unrealistic sex-role expectations. Andres-Hyman et al. (2006) suggest that therapists frame therapeutic goals in line with personal and cultural narratives (e.g. helping a mother take time for herself so that she can be a better mother to her children) (p. 699).

Spanish Language and Communication Styles

Therapy has been named by some as a “language system and a linguistic event” (Taylor et al., 2006, p. 433). With this in mind, literature emphasized the importance of being proficient in Spanish when working with Latino clients whose first language was Spanish. Several authors have raised misgivings about using translators in therapy (as described in Andres-Hyman et al., 2006, p. 696). As a lexical construction, Spanish has been cited to have “a gentility and civility that contribute to politeness of demeanor, deportment and address” (Falicov, 1989, p. 178). On a deeper level, language carries

with its memory, meaning and emotion; “it is representational, ... [it] reflects reality, given facts, and the natural order of things” (Taylor et al, p. 436). There are meanings and concepts in the Spanish language that cannot be accurately translated into English and vice-versa. Especially in therapy, when working with nuanced communication and abstract concepts such as emotions, word choice can constitute a significant shift in meaning. Post-modernists might add that understanding clients in their native language helps to create a holding space that is not dominated by English, and symbolically a “colonizing force” (Taylor et al, p. 436). When exploring early life experiences, emotions are anchored to the first language that a child learned (Andres-Hymen et al, p. 696). Bilingual providers may be able to encourage “code switching,” or strategic use of both languages that provides psychological distance or nearness to an emotional experience, as needed in the therapy. Code switching has been used to recognize “forms of avoidance and to approach difficult topics” (Andres-Hyman et al., p. 696).

Summary

This chapter has provided a context for understanding the complexity of cultural competency in therapy beginning with the very understanding of the terms employed. Literature suggests that cultural competency involves a nuanced, multi-faceted, dialogical process between clinicians and clients. While there have been various publications from licensing boards outlining cultural competency and studies on specific cultural trends, with the exception of Taylor et al. (2006), there is a dearth of research on the evolving perceptions and stories of therapists who are striving to be culturally competent. This study is designed to elicit narratives from therapists who practice therapy with Latino

clients, reflecting on how they conceptualize culturally competent practice, the subtleties of their interactions, and their attention to cultural cues and power dynamics.

CHAPTER III

METHODOLOGY

A qualitative, flexible research method design was used to gather and analyze data from a diverse group of therapists practicing therapy with Latino clients. The research question driving this study is: How do clinicians conceptualize and practice cultural competency with Latino clients? The literature review revealed that cultural competency is a nuanced art. Much has been written about various types of cultural competency, the dangers of over-simplifying cultural competency, the importance of being culturally flexible with each Latino client and techniques for a clinician to remain culturally self-aware. However, a question remains, how does one actually practice cultural competency with Latino clients? Due to the exploratory nature of the study, in-depth, semi-structured interviews were used to gather data, resulting in thematically analyzed narratives from each of the participants. This chapter presents the methods of research used for this study; it will describe the sample selection, data collection, data analysis procedures, as well as strengths and limitations of the study.

Sample

Participants for this study were originally limited to licensed therapists who have been practicing in their field for at least three years. The rationale for three years licensed experience included a hope to find clinicians who had been practicing in their field for significant period of time, so that each clinician might have developed his/her

particular style of cultural competency. In consultation with my thesis advisor, I adapted criteria to one year experience with licensure, to get a diverse sample. Valid licensure in the fields of social work, psychiatry, psychology and/or marriage and family therapy was suitable. Clinicians must have worked with at least five Latino clients (for more than one session each) while they were licensed in order to participate.

The participants for this study were recruited through a non-probability, snowball sampling technique. I began the process with personal and professional contacts in the Los Angeles area. These contacts approached therapists who met selection criteria via email or phone, and several agreed to participate in the study. Participants then suggested and/or contacted other therapists who they thought might be interested in the study. Four participants came to the study by their association with one agency, while eight heard about the study through personal contacts.

I often contacted potential participants by email, and included a recruitment letter (Appendix A) that outlines the purpose of this study. If the therapist was interested in participating, he/she was screened to meet the study's criteria, and then received the letter of consent (Appendix B), the list of interview questions (Appendix C), and scheduled over email a time to meet with me. Every effort was made to recruit as diverse a group of participants as possible, by varying contact people.

Interviews were done in local coffee shops, therapists' offices, and my internship office. Before starting the interview, each participant filled out a demographic questionnaire (Appendix D). After the interview, each participant was referred to by a code assigned to the questionnaire.

There were 12 participants interviewed for the study. Of those 12, 3 were male and 9 were female. Participants were asked how they identified culturally on the demographic questionnaire. Six participants identified as white/Caucasian. Of those 6, 2 further identified as Jewish, 1 as Irish-Catholic (lapsed), and 2 as Californian/Liberal (one wrote Socialist). One of the white participants further identified as gay and another specified identification with being culturally American. Two participants identified as black/African American. One participant identified as Chinese-American. Three participants identified as Latino/Chicana-Mexican American/Salvadoran American.

Six out of the 12 participants were Spanish-speaking, while 6 had minimal to no Spanish language experience. Of the 6 who spoke Spanish, 3 participants were native Spanish speakers, and 3 were non-native Spanish speakers.

Ten out of the 12 were Licensed Clinical Social Workers, while 2 were Licensed Marriage and Family Therapists. Participant experience while licensed in their field ranged from 1.5 years to 27 years. The median years of practice for the sample was 7 years, mean was 10.5 years. Five participants had been practicing with their license for over 15 years. Most participants had further social work/clinical experience prior to becoming licensed. Nine participants noted that they worked with Latino clients in an outpatient setting. Two of those 9 had special expertise in working with specific populations: 1 in addiction medicine and 1 with gang-affiliated patients. Three participants had both inpatient and outpatient experience in working with Latino clients.

Data Collection

First, the instrument for data collection was created, based on literature available in the field and consultations with practicing clinicians for cultural sensitivity. Second, a

proposal for the study was sent to the Human Subjects Review Committee at Smith College School for Social Work and approved for implementation (see Appendix E). Before collecting data for the study proper, I conducted three pilot interviews. Two pilot participants identified as Latino, and 1 identified as white. All 3 were fluent Spanish-speakers. During the pilot interviews, I gained valuable feedback about the order of questions and ways to word the questions so that more storytelling and case examples might be elicited. Based on these pilot responses, I made minor adjustments to the order and the phrasing of questions. Finally, I conducted interviews with participants who matched selection criteria for the study.

In-person interviews, ranging from 35 to 65 minutes in duration were conducted to collect participants' perceptions of cultural competency and how they practiced cultural competency with Latino clients. Participants were asked a series of questions designed to elicit reflection on their definition of cultural competency and case examples that involved cultural factors. Questions were left open-ended as much as possible, to encourage participants to engage in critical thinking and brainstorming about what cultural competency looks like in their experiences with Latino clients.

Approximately one hour was designated for an interview. This allowed time for introductions, participants to fill out the demographic questionnaire, ask any questions they might have, sign the letter of consent and conduct the interview. I recorded all interviews on a Zen Creative Vision: M player, and then transferred them to my computer in a .wav format. I transcribed each interview using the Windows Media Player. Each interview was then assigned a code based on cultural demographics of each participant.

After transcription was completed, the transcribed interview was assigned a matching code to the .wav recording.

I fully understand that participants may fear that any case material shared could be recognizable to their clients, should they read any publications of this study. Data in this thesis is presented without reference to identifying information. This study consists of interviews that were digitally recorded and listened to in private in order to transcribe the data. While I cannot guarantee anonymity to participants involved in this study, I am committed to protecting participants' confidentiality and that of their clients, and expressed this to each participant in the interview.

Data, digital recordings, notes and consent forms will be kept secure in my office for a period of three years as stipulated by federal guidelines, after which time they will be destroyed or continue to be maintained securely. In order to assure participant confidentiality, demographic information, researcher notes, transcripts, and digital recordings will be kept separate from informed consent documents and will be identified by number codes rather than names or other identifiable information. Any names or other identifiable information from participants has been removed and/or disguised during transcription and for use in this thesis.

Data Analysis

For data analysis, all transcribed interviews were entered into the Atlas.ti 5.2 program file and investigated for general, but not exhaustive, themes. Each transcript was reviewed to identify data relevant to the specific research area and was also probed 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.

During data collection I noted relevant information and mentally highlighted particular common themes or unusual responses. The data were then transcribed and reread again for commonalities or contrasting views. Finally a process of data reduction was undertaken by way of coding the content of the interviews. First the transcripts were compartmentalized by question, and then into discrete categories based on occurrence of similar words, phrases and themes across the responses of the study participants. Representative quotations were used to substantiate these themes or illustrate the range of responses. Data were also compared to determine similarities and differences with respect to the literature review.

Strengths and Limitations of the Study

Strengths of the study include the enthusiasm and willingness of the participants to reflect on and discuss their therapeutic choices in striving for culturally competent practice. Several participants asked for a copy of the study's findings, and two participants expressed the need for more critical narrative research on the topic of cultural competency in the field of social work. Another strength is my interest in the project and an ongoing, self-critical examination of any biases in the study. In light of this, I did everything possible to be sensitive in developing a research instrument, pre-tested and re-worked it based on feedback gained, and sought a diverse sample of participants. Limitations include a narrow geographic area from which participants came, so that the study involves a select sample of clinicians in Los Angeles, an unusually diverse city. Another limitation includes my cultural background: a white, heterosexual, female Smith social work student. Participants may have adjusted their responses based on their comfort with a researcher who is studying culturally competent practice with Latino

clients, yet is not Latina herself and may represent a culturally privileged (or normed) background. Furthermore, interviews were conducted in English, and may not have been able to access certain nuances which might have emerged by conducting interviews in Spanish or a Spanish/English mix. The small number of participants gives the study limited generalizability, although insights gained through the research might inform future studies.

CHAPTER IV

FINDINGS

The research question driving this study explores how clinicians conceptualize, recognize and put into practice cultural competency with Latino clients. Findings from the study illustrate the flexible and complex nature of cultural competency in practice with clients. Generally, respondents resisted an easy, concrete definition of culture and competency, opposing a checklist-type of learning process which is conducive to stereotypes. Rather, clinicians' responses advocate for cultural competency as a lifelong process, rooted in social work values and rife with nuance and fluidity.

This chapter begins with clinicians' reflections on cultural competency courses or trainings, and describing participants' concepts of culture. This leads into a presentation of interviewee's perceptions of cultural competency as a lifelong process, which includes awareness of racial power dynamics, critical self-reflection, measured self-disclosure, humility and openness to new learning. Then, an exploration of cultural competency as specific knowledge follows. Clinicians' suggestions to "hold knowledge lightly" are followed by reflections on selected Latino cultural themes in four areas: migration stories, ecological context, family organization and Spanish language and communication styles.

Cultural Competency as Knowledge

One hundred percent (100%) of clinicians interviewed stated that they remembered some sort of cultural sensitivity or cultural competency-type coursework in their graduate studies. However, most of them either could not remember much about their training, or they critiqued the teaching as superficial or negative, teaching the opposite of what they thought was cultural competency by indirectly encouraging or justifying stereotypes. One clinician described her graduate level (Masters of Social Work) cultural competency class as:

And the class was set up, one week we talked about African American clients... and then they had Latino clients, how to work with gay/lesbian clients, clients with disabilities. And it was like every week, it was like the topic of the week. And I left always feeling like, because I was actually one of the only black women in the program, so I was always looked at, when it got to talking about black culture, students-and I don't think they did it intentionally, but students and faculty would turn around and say, "So what do you think?" And I'm like "um, well I can only speak for my experience, I can't speak for the entire black experience," so I always had to precursor with that. But I found myself always having to explain that I don't represent what black culture is, that I don't represent what it says in the book, you know? ... It wasn't helpful.

Another clinician responded to the term cultural competency in light of past trainings and classes in this way:

I kind of hate the word, to tell you the truth. I feel like it's one of these catch-all meaningless phrases that loses a lot. It doesn't invite people into further exploration and curiosity--I just think it's kind of a label...I don't know if it's the term itself, but its how it's been used. I feel like "cultural competency" and "cross-cultural" clash, and all that ghettoizes the idea of culture. It makes it a skill that you check off and you're done with, or that you take a class on, rather than it being a sort of ongoing, fluid... like in my view, no one is ever culturally competent.

One hundred percent (100%) of clinicians interviewed expressed some degree of reservation about assuming they knew about a Latino client's cultural background from

learning general cultural trends. The clinicians who had positive cultural competency trainings or coursework described experiences where the concept of culture was fluid and multi-dimensional. One clinician named a shift that she perceived in education for culturally competent practice:

In the beginning they used to say Latinos do this, and blacks do this, and this and this. But then I really saw a shift, and now it's--you can't make stereotypes because if you're Latina and you've been here three generations...And so now, I really like the emphasis on getting to know your client and your clients' understanding of their culture. Because everyone... does it differently.

Another clinician who is Latino stated:

I think you know, when it was pushed heavily in the schools of, you know, being able to work in a variety of multi-cultural settings or a variety of cultures, whether that's ethnicity or even religious culture, that was sort of my perspective coming from that... the whole gender, sexual orientation issue. So it was emphasized that it wasn't just one's ethnic background, it's the whole thing, all the different aspects of it. So that was a good thing for me to broaden it, not just being about ethnicity in that sense.

One participant reflected on a valuable assignment from her MSW classes, "We were asked to... write an autobiography of our cultural life..." she affirmed, "and the teacher's premise was one that I very much agreed with. It was that this identity is fluid and changing over time." Another interviewee reported, "I'm always discovering who I am culturally, basically."

All clinicians, those who had positive and negative training experiences alike, seem to have resisted a straightforward, stagnant definition of culture, and subsequently cultural competency. Instead, they suggest that cultural competency involves a longer-term investment and learning process.

Cultural Competency as Process

If cultural competency is not simply knowledge, then what is it? Interviewees suggested that cultural competency involves knowledge, but knowledge alone is not enough. One clinician, who was especially troubled by the term, “cultural competency,” suggested using “cultural engagement” as a better goal for clinical work. In this, she noted, “I feel like the minute you start resting on being culturally competent, you’re incompetent. Like I just feel like, there’s always difference and unless you’re curious about that, it’s just, you miss the boat.” Another participant added, “People don’t become culturally competent people because you only come from one culture—we’re all a mix of cultures...it’s too overwhelming to think about culturally competent people. So it’s really about learning to become a competent practitioner with different types of people.” Another respondent stated that cultural competency is “more than a skill, it’s who you are, and it’s almost like you’re adapting it to your professional style... Because as a *skill*, I think of ‘Oh I can use this and it will help me to understand who black people are’...I don’t think it’s--it’s greater than that. It’s very complex.”

Fifty-eight percent (58%) of interviewees and 70% of social workers interviewed commented on how cultural competency is grounded in social work values, although it has not always been discussed in this way. One clinician stated:

It’s just based in our social work values; it’s just looking at person-in-environment. So I feel like it’s a new, sexy word for stuff that we should’ve already been doing, and knowing about. Social work as a profession has always been working with different cultures...so it’s just very in line with our values. I don’t--it’s not that big of a divide from what we’re doing, I don’t think, or at least it shouldn’t be.

Another Latina clinician confirmed, as she described a cross-cultural therapy session, “I’m obviously very different, I look different and I talk different... and acknowledging that I’m not going to understand everything, or know everything...can you help me? And if you think about it, it’s about engaging, you know-they’re fundamentals of social work.” One participant suggested that “even as social workers, we don’t talk about it much. Because it’s something that’s kind of like, the assumption is that because you’re a social worker, you must know and you must be sensitive; you should be so therefore you are.”

Do clinical social workers assume cultural competency in themselves and others, and thus, in the words of one respondent, “become incompetent...as soon as you think you’re culturally competent?” Has cultural competency become more of a requirement to prove to licensing boards, or is it engaged in as a longer-term learning process for clinicians? Cultural competency, based on the findings of this study, necessitates discussion of uncomfortable material, namely, dynamics of racial power.

Cultural Competency as Awareness of Racial Power Dynamics

One Latino clinician eloquently suggested that when there is difference among people, the question of “which one is better or worse” lingers as well. He described his childhood in this way:

So, we lived in an area that was predominately [an] Irish-Catholic neighborhood, so we were the only Salvadorian family in the school except for my cousins. There were very few other non-Irish families, so that whole identity thing is something that I’ve grown into more and more. And I’m grateful for that and all of the emphasis on cultural competency. You know I always felt when we were growing up that we weren’t Irish... We were Catholic, but not Irish. And there was a sense of feeling different, and whenever there’s that sense, there’s also a sense of there’s something wrong on some level. Not that people ever gave us that feeling, but there’s always that sense.

One hundred percent (100%) of clinicians of color who were interviewed shared stories about personal experiences where they seemed to feel that they were not part of what one clinician called “the standard American culture,” or what I would call a “white norm.”

One black clinician, when asked if the process of a white clinician becoming culturally competent was different than a clinician of color’s process, responded:

I think so...because we could have the same scenarios or the same situations, but the way the people perceive me and the way the people perceive [a white person] is very different. So then we’ll have different experiences, although we’ve experienced the same thing--different perceptions of the same--so that in and of itself we have to be aware. And what I’ve seen in the social work programs is--oftentimes Caucasian, white people tend to minimize that. Minimize what they represent, the power that they hold. Because social workers usually want to help an oppressed situation. And usually it’s women. So it’s different being a woman that’s oppressed, or women, gender and then also you add ethnicity...there’s a difference. And I think that’s where as far as the differences, and white people or white social workers being able to tell and understand that--and accept that in who they are. It’s not a bad thing or a good thing, it’s just how our society socializes us...I don’t choose, I show up and this is who I show up in--already, people are like, “oh that black lady.”

Another Latina clinician described her experience of being a therapy client:

My therapist was white, she was from the south...I experienced a lot of initial caution, and an assumption that she couldn’t understand me. And a certain amount of shame in sharing parts of my history... She said in the first or second session, “There’s a lot that I’m not going to understand. There’s a lot that I don’t know. But will you help me to understand you?” And I thought, “Oh!” And so I would say, “Well, I know that you’ll think this is awful, but in my family...” And she would respond... “Why would that be awful? ...What is in that that feels shameful to share?”...If I talked about the way my father was, I didn’t want her to imagine... “Oh, yeah, I get it...” Because sometimes when a therapist says, “Oh, oh yeah, I get it,” and a person, I, would have felt on the other end, “No. You get what you think it is. But as a new person to you, how could you possibly get it?”...The client is very aware of the stereotypes, so even when a therapist goes, “Oh yeah, I’ve been to Mexico.” Oh,--so you think that we all are this, or that. And that’s not as helpful. Or, when you... say, “Oh, but my boyfriend is black, or you know my housekeeper is Salvadorian.” It’s like, okay, so now you know what it’s like. So to somehow find a way to convey, “I don’t know what it’s like”...Because inherent to being of color, there is an obvious difference. That can’t be concealed... I did not want to be the stereotypical girl that you would see

on TV, who is usually in trouble or something. But then there's also the-- you can't hide it! And you think that everybody sees it... you always feel different...I can't really imagine ... a person of color who would see a white therapist and not feel something--more than a white person seeing a white therapist...So I just think it's very important to be aware of it...And their fantasy is that you're white, you have a perfect life.

This “white norm” surfaced several times in the interviews, in a variety of ways. Another Latina therapist described how she perceived a white norm functioning when sitting with other Latino clients:

If it's a person that is listening, I think that they may have a concern in terms of what it's like to sit with a Latina—that could come up in that direct way. How through the transference relationship--that will work through them. And not even assuming in being Latina, and if my patient's Latino, that that's not necessarily going to be a fit for them. Because they may not--if they have a devaluing sense of themselves, in part because of their cultural identity, and I look the same or similar, then how are they going to be able to take something from me if they're giving value to some--to a dominant culture figure. So I may not be you know, perceived or you know, someone can't take from me, or might not be able to--so it's important to talk about that... I'm working with a Latina family and it's not because where they think I'm from, but the fact that basically I'm Latina and what I know therefore... their own sense of not trusting what they knew. But they needed somebody from--that they perceived as having authority or knowledge and that doesn't come wrapped in a brown face, as far as they were concerned.

This finding suggests that internalized racism, as illustrated by clients who have learned to devalue themselves and thus Latino therapists, functions in subtle and covert ways in the therapy space—whether the therapist is white or a person of color. Another therapist, who is also Latino, further troubles the idea of assumed similarities with Latino clients:

When Latino clients say, “Oh, you know...” whereas to a white clinician, they'd say, “Oh you don't understand.” And I respond, “I might know what *I* would feel, but there's no way I could know what you're feeling unless you tell me.” Or whatever other things are...if I ask questions, there may be many reasons why you're doing this, but help me understand *your* motivations. People assume, they see your color and they say, “Oh, well you know how it is.” And that can be just as detrimental...On the one hand there is an automatic comfort, and the

assumption that I'm going to understand them, so that works in my favor. But I think that they can also experience a sense of, when I challenge them... a "You don't really understand," or "You're not who I thought you were"--and it's kind of based on an over-identification, like "You're like my daughter" or "You're taking her side"... Like if you're trying to help them in being more assertive--or they're getting a lot of job stress and they're telling you how horrible their supervisor is--and you try to move in the direction of what's going on with *them*... They experience me aligning with the dominant culture of business, or whatever, people who are educated, "Oh you're one of them, so you don't understand what it's like to be..." and then it feels like a betrayal.

These findings suggest that clients' transference can illustrate noteworthy aspects of racial (and class) power dynamics that they might experience outside of the therapy space. How do clinicians acknowledge and discuss racial power differences that function within and beyond the therapy space?

One Latina participant suggested that the study of cultural competency has been used to refer to "minority" cultures and point out differences with white culture, although that is not always explicitly stated. She described how her understanding of cultural competency has shifted over time:

I think that by and large it's meant or been used in reference to people of color, or "minority" cultures. And I think that that's been the thrust. And um... having some understanding, or awareness of what could happen when you come from, or one of your patients come[s] from a minority culture. To me, maybe as I understand it now, and being a person of color, to me then it requires one, knowing not only my own culture and Latino cultures-which are varying and various, but everybody else's as well. My own and everybody else's because I think that I need to know Anglo-Saxon culture, I need to understand what it [is], because it's not my personal cultural background, so I can't ... just like I don't want someone to assume about me, I can't make assumptions about white folks or anybody else... Just as much as it might be present, or is present, for someone Latino, someone African-American, Asian, Pacific Islander, I mean, everybody that can walk in the door comes with that reference. So I have to be open to thinking about how that is influencing what they're presenting.

Instead of accepting white culture as an invisible norm, this clinician has universalized the concept of culture to apply to any and every client. Fifty eight percent (58%) of

participants commented on the importance of de-centering and making visible white culture as a part of cultural competency. One therapist noted how in living in Los Angeles, she's "walking through life with people of different cultures." She explained, "[My hometown is] pretty homogenous and...I just knew white people...and then when I came to LA... I was like, Jewish people? Armenian people? What's that, you know? So I put all white people in one thing, one pot or whatever. And then here, it's so diverse."

Another clinician, who is Latina, described ongoing therapy with a white client who challenged some of her assumptions about white culture:

She grew up in a well-heeled family, very secure financially, and educationally... here was what I had assumed would be the ticket—the ticket out of worry... But yet, with all those things... Well, she didn't have a ticket out. And I thought, oh my gosh!... I didn't have a competence in a real way, around her culture and her socio-economic situation and the complexities of what I assumed... [She was] messing up my picture! And I...felt like I had to re-structure, everything that I had projected onto folks who present [as white]... I can't do it with the same ease that I used to. Because I know something now that goes against that—which is a good thing... She's somebody that stays with me, well beyond the years.

One therapist, who is white, critiqued the content of education in cultural competency stating, "There's never a chapter on white Americans in those books, or middle class Americans, so it becomes like an ethnic studies thing rather than a focus of social welfare or psychology. It doesn't actually ever become part of the whole discipline; it becomes a focus within a discipline." Cultural competency engages a sense of de-centering cultural/racial differences from the white norm—which means naming the white/Anglo Saxon experience as a subjective culture and not a norm; it involves recognition that cultural differences are present in all clinician-client interactions, albeit in different and nuanced ways.

These findings suggest that the process of cultural competency includes critical self-reflection on the ways racial power has influenced a clinician's identity, how a clinician's identity might be perceived in session, and how dynamics of racial power might be affecting a client's sense of self.

Cultural Competency as Critical Self-Reflection

Ninety-two percent (92%) of clinicians interviewed mentioned the importance of self-reflection or self-awareness in cultural competency. A white clinician, when asked if learning about her own cultural background was a part of cultural competency, responded:

I think it is because what you're doing in that, you're not doing the default, which is that white is the norm. By owning your culture, however you define that... rather than saying "You're different, and I need to learn about you, you're different." Instead, you're saying, "I'm different, you're different, I'm trying to get clear about my identity and cultural orientation... what's yours?" So, it's very different. I think it's really important to not make it all about learning about "other different people."

A black clinician explained how:

Even in my own family, there was a lot of like--not wanting to accept being black. My family was big into assimilation...the darker you were the more prejudices they had against one another--there was a self-hatred about being black. Wanting to be assimilated more and more into the majority of the culture, and so there's a lot of self hatred, so I kind of grew up learning that black is bad, or behaving or talking slang, or behaving that you know, you're from the hood or whatever, is that it's bad. And that you have to—there's a certain way of being, a certain way of acting, a certain way of talking and I rebelled a lot to that. Because I just, wanted to be me, and whatever that was... And I think that more and more, I became more comfortable in my body and in my skin--and being able to be with people through any kind of socio-economic class, or whatever culture they are, and be comfortable in my own skin to be with them, you know, I'm okay...to have my client talk about those things, because I realize it's not about me. Obviously I have reactions and feelings about it, and I may or may not share that. But I have to constantly stay focused on what's going to help this person out. So I take it all in, my goal is just to focus on this person's healing, so that they can obtain their goals, and culture is a part of that, you know.

A Chinese-American clinician described an important process of “finding”

herself, which seemed to be an integral part of cultural competency:

I like to put myself in [client’s] shoes and to understand and to see really where they’re coming from ... I’ll go home and I’ll think about that, the context and where they come from. But that’s everybody’s culture, and trying to find out what it means to them. So that is what I usually go by... if people stay just on the edge of differences only, you know, it’s kind of like not really having found themselves. “I’m not this, I’m not that,” and needing to project and say, “You’re this and you’re that,” but you know, go beyond that, your own stereotypes... I got out of college in the ‘60s, and ...I went south to Atlanta to work with people in the civil rights movement...I really admired people speaking up for themselves and stuff like that, and the changes going on in the country and I was kind of like trying to be a part of them, and I worked in the black community and stuff. And I really loved it, and people were wonderful...But you know, beyond a certain point, you know—you relate to people one on one, you know what I mean? It has to go deeper than like this or that stereotype... I was trying to kind of find myself. And um, the Asians weren’t doing so much, and I was admiring the blacks...well, I found that you know, I’m for them and we have common goals and such, but I’m not them either! ... I was trying to define myself...from the outside, but later on as I came around it—it was from the inside first.

Forty-two percent (42%) of participants explicitly suggested that some form of individual or group therapy would help clinicians to critically reflect on their own cultural and racial background. One clinician described the rationale for critical self-reflection in this way:

Me, my ethnicity, coming to see me, my age, all of those things...It’s being able to use me, use our experiences as a tool to use with our clients--where it’s both using what’s in the room, but recognizing that it brings things up for clients--assumptions, pain. And then I have to get my shit in check, so that I don’t take it personally! ...I’m going to start thinking, “I don’t know what I’m doing!” When the reality is, that I do know what I’m doing--You know, client’s objections, it’s their behavior coming into the room, they’re actually showing you themselves, and it’s an opportunity to be curious and learn more. And I think you have to have a level of confidence in your own self in order to be able to go there. So I think that’s why it was very important--and we spend so much time talking about race, ethnicity and culture--you know you don’t know who you’ll get in your office, and being able to hold on to yourself...without projecting your stuff onto the client and reacting from that place.

These findings suggest that a clinician's personal experiences of culture and race are relevant to cultural competency; it seems important to critically reflect on one's own cultural background. Yet, how explicit of a role do a clinician's experiences play? What role does self-disclosure play?

Cultural Competency as Measured Self-Disclosure

Fifty-eight percent (58%) of clinicians reflected on the role of self-disclosure in the session space, with various perspectives. Of those clinicians who commented on self-disclosure, more than half of them expressed general reticence to disclose. One clinician explained:

Self-disclosure is important on one hand, but that it must also be very measured. At points, you need to choose not to share your feelings to give clients space to express their feelings about where they are... I'm very particular about the reasons that I disclose--like I use self-disclosure to support the client, and before I'd self-disclose more because of my insecurities.

Other clinicians described the circumstances or the details that they might disclose to clients. One Salvadoran clinician whose parents immigrated to the States explained:

Kids are raised here and then there's a clash with the parents who are coming from Mexico or El Salvador or something... I think trying to be able to help parents recognize that their kids are not like the kids in Mexico, for instance, who are culturally sort of to be seen and not heard... So when I disclose, I share a little more about my background so that the kids can see that I've grown up in this independent type of culture, and that at the same time, helping the parents see too what the kids' needs are, so it's helping them go back and forth. So it's promoting that understanding when there's often miscommunication between the two and not connection. Parents might think you know, my son is disrespecting me... and it's not that at all, it's just part of this culture in the States... So it's just clarifying those types of things. So those are the things that I might disclose.

Another white clinician stated:

I think that many assume that I don't know a lot about their personal culture, their values. I think there's often a sense of reticence to talk about some things, assuming I won't understand or I'll judge... one or the other of us will bring up

the topic of culture...I'd say the vast majority of the time I disclose about my own background at some point or another...That I'm married to a black man, have a mixed race son and that I live in a largely black community. And while I don't know what it's like to grow up a minority and to have a very different culture, there are certainly gradations of that, even in white society. And that even in my position now, there's a lot that I experience that can help me understand.

However, a Latina clinician reported:

The client is very aware of the stereotypes, so even when a therapist goes, "Oh yeah, I've been to Mexico." Oh, so you think that we all are this, or that. And that's not as helpful... when you say to somebody, "You don't really understand what it's like to be of color." And they say, "Oh, but my boyfriend is black, or you know my housekeeper is Salvadoran." It's like--okay, so now you know what it's like. So to somehow find a way to convey, "I don't know what it's like."

According to these findings, the effectiveness of self-disclosure in culturally competent practice—however measured or well-intentioned—seems to be unclear. One aspect that does seem clear in these findings is that making mistakes, although humbling, provides important learning in cultural competency.

Cultural Competency as Humility and Openness to New Learning

Fifty-eight percent (58%) of clinicians stated that they have learned important aspects of cultural competency by making cultural "mistakes." One white clinician described a powerful learning experience in this way:

I was doing this group...mostly Latino...It wasn't even my group. I came in, because someone wanted me to sub...and this one Latina woman was dominating the group, in my view. She talked and talked...and you know--I was basically trying to get her to shut up, you know what I mean? ... I said something like, "Well, has anyone else in the group experienced that?"—I interrupted her to say this. And she turned to me and said, "You know what? You white social workers are never comfortable with me—because I'm Latina, and I'm expressive and I have emotions. And you want everyone to be quiet and fit." And she was so pissed at me... I obviously stepped on her toes... I didn't have an established relationship. I was making the assumption that she was dominating the group, and I wasn't letting the group take responsibility for that. And I wasn't thinking about how I look, might shape the hearing of my words—you know what I mean?

...And also, I was pissed! Because I was like—“You don’t know me!” And... I just realized that—I just blew it, I really blew it. So I just said to her, “You know, I’m sorry...” And she said to me, “I can tell that I’m making you anxious!” And I said “You know, I am feeling anxious, but not because you’re emotional. I’m feeling anxious because I’m feeling worried about the rest of the group, and if they’re getting their time.” And so I said, “Yeah, I guess I did kind of shut you down, and I’m sorry about that—and it sounds like that’s something that has happened to you a lot with white women.” So I feel like in that way, it was actually a very good interaction. And we talked more about her experience with white women...but it was really hard to hear and to acknowledge that I did that...The heat of her response was me, but also the history of oppression, and one more...white social worker...to tell her to shut up...It turned into a really good cultural experience because she was able to engage with me and accept my apology...So I guess, when you mess up like that, it’s the most possible and exciting, if you can hold on to yourself to lean into the difference, and lean into what you don’t know, it’s actually one of those really great cultural interactions. Because she had the opportunity to tell me about how she hadn’t been listened to before and then have me come in and not listen, and then the group got engaged around it. So it was pretty good at the end of it, but it was horrible initially, for me and for the group.

Another black clinician described a difficult, yet rewarding learning experience in this way:

I mean I am prejudiced, I do have my stereotypes about certain people...My biggest counter-transference was working with gay clients... So, when I was working...with this young African American boy...his mom...comes, and when she came in for the first time, she was this black woman, about my mom’s age. And I thought, “Wow!” You know, I felt like I really connected with her. And she asked... “So do you mind if I bring my partner in, I’d like my partner to be part of the treatment.” And I was like, “Oh yeah. We could do that... what would be good is to have me meet your partner first, and get to know him?” ...Well, she came and she brought a woman... and for about a month I’d go to the book...*Working with Gay and Lesbian Couples*...And when I met with them, I was always so anxious and uncomfortable in meeting with them, and I was always saying that it was about them...So this is...the aha! moment. My supervisor said, “You know, why don’t you just tell your client that you’re not familiar in working with this population. And you may not say the right things, you may not do the right things, but your heart is there, you’re open to learning.” And I was like—she doesn’t know what she’s talking about! But being a student...I was like okay, I’m going to try, but I’m going to show her next week what a dumb idea this was. So the next Sunday, I did what she said...And they were like, “Yeah, we knew that.” I was like, “You did?”... --And then we had a conversation about that and what people represented. And I was like, “Oh my god... I thought I had that

taken care of.” So that’s when I realized wow, my stereotypes and my assumptions they all come in, and I just have to be open to it. And I have to be transparent in that aspect and let clients know, “Hey, I don’t know I might make a mistake, and I may even screw up and say a word that is not sensitive, but please let me know and please know that that’s not my intention.” And actually, we ended up, and I can still talk to her this day--and it actually ended up being my best client, family that I’ve ever worked with. Ever in my practice...So that’s when I began to put things together...and understanding the work with the Latino clients and I realized, wow—my behavior... influenced probably some of the therapeutic process, so it was probably about me as much as it was about them.

Both therapists described instances where they showed humility with their clients—admitting that as clinicians, they can make mistakes—and suggesting that making mistakes might be part of the role of being a competent clinician. Their “mistakes,” ended up being important learning experiences that facilitated therapeutic healing with their clients.

Sixty-seven percent (67%) of respondents reflected on cases with Latino clients that they wish they would have handled differently and stated they wished they would have asked more questions, been less judgmental or made fewer assumptions about their clients. One clinician reported, “The only patient who has ever complained about me...was one Latina lady...and she could feel the disapproval. Even though I didn’t say anything, now, from retrospect I think...It wasn’t any word that I used, but it was a dismissive quality of “Yes, I understand.”—that communication of “I don’t want to hear the whole story.” Another therapist described how, “In the beginning, my Spanish wasn’t as good...I think that I missed a lot of nuance...I wish I would’ve asked more questions about what things meant...or repeated back more to make sure that I got it.”

Sixty seven percent (67%) of participants, when describing cases with Latino clients that they thought were successful, told about experiences in which they practiced

embracing ambiguity and “wading into the muck together.” One interviewee who did not speak Spanish explained:

Initially when I first started working with [a mother and son], I was thoroughly frustrated with the gender roles they played. But as I learned more about being Cuban ... I was less judgmental about their relationship... and you know, moving out and having a life of your own. So, I think our work was really positive. At least I learned a lot from it, but I also felt like they were very, they just felt really seen, I think. You know, they spoke in Spanish and English, and translated for me. I mean, they did a lot of work that maybe they wouldn't have had to do with a Spanish speaking therapist... I think what made it successful is me acknowledging my difference with them, and expressing my limits. Like being very authentic about how I was feeling my own limits in terms of not speaking Spanish. I think that it gave them an opportunity to almost like, be co-therapists in some way. I think for them it felt very... valuing. So I guess the thematic would be expressing my limits, and also though, honoring who they were. Then together...we kind of, together just waded into this muck, which was, “What are we going to do?” That was scary, I think, but ultimately being able to figure out a way to work together that felt really good for all of us...a big part of it for me is being very honest and apologetic almost, about my limits and what I don't know.

Another respondent reflected on cultural “mistakes” in this way:

My story is that you can't teach someone to avoid [making these mistakes]... I'm human, I'm different, you're human, and I'm going to [make mistakes] ultimately, and I don't think I'm ill-intentioned culturally, but it happens. So I don't think you should train people about “this is what you need to do to have a great therapeutic interaction,” but you do have to teach people what you do when you have really disrespected someone culturally. So it's not how to avoid hurt in relationships, but how do you attend to it in the moment, in following up... its how do you heal it?

Not only did this participant suggest that clinicians cannot be taught to avoid making cultural mistakes, but she advises that it is not the right question to ask in the matter. Rather, the question involves admitting that these mistakes will happen, and how will culturally competent clinicians recognize them, and respond? According to these findings, cultural competency as a lifelong process, awareness of racial power dynamics, critical self-reflection, humility and openness to new learning—seem generalizable for all

cross-cultural therapy. This begs the question... is specific cultural knowledge necessary at all?

Cultural Competency as Holding Knowledge Lightly

One respondent noted that “these ‘Latino cultural generalities’ can be a starting point, but they should be held lightly, with curiosity.” Seventy-five percent (75%) of interviewees emphasized the importance of the common experience of being human: all of us are imperfect and trying to work out our lives in the best way we can. A Chinese-American participant, when reflecting on the role of specific cultural knowledge in cultural competency, stated:

I’ve had somebody say to me, and meant really very well, ah, you know, “Do all Chinese do things like that?” ...They’ve asked, “Tell me, explain the culture to me.” And you know, at that point I’ve said, “Bottom line, there’s a similar standard for all of us,” and you know, there are cultural differences and this and that, and you want to be sensitive, but bottom line is... we’re all human beings.

These findings allude to how specific cultural trends and knowledge may fog a clinician’s ability to recognize points of connection with a client because the clinician is focusing intently on “cultural competency” as specific knowledge. Another participant explained, “I’m... interested in exploring where our [self and clients’] multiple cultural identities are located on a continuum of similarity/difference, power/oppression, ‘normal’/‘different’.” This interviewee suggests that each therapeutic dyad might have multiple points of connection and disconnection throughout their work together. Culturally competent practice invites therapist and client to discover those points of similarity/difference, and offer language and reflection to these experiences as they may shift and change in time. One interviewee reflected on Latino cultural trends in this way:

I'll use the word Latino...the general word, general big umbrella...but within that then, pay attention to the specifics of who all is underneath that umbrella. Because if we don't, you're going to lose so much of who the person is. Just as I would say that, you know, all the white folks can be under one umbrella, but if I don't pay attention, I'm going to lose all the subtleties of how that's understood and lived by each person that lives underneath it...[The umbrella gives us] some ideas, some ways to think, a beginning...it's just a jumping off place.

If cultural competency involves a willingness to remain open and ask questions, specific cultural knowledge might guide clinicians toward the types of questions that might be helpful to ask, and effective ways to ask those questions.

Seventeen percent (17%) of participants mentioned using humor when asking clients about cultural trends. One interviewee described her work with court-mandated Latino teens:

I usually use humor. I'll say, "You know what, I'm a square." Seriously! I tell people... "I'm a square... I know you don't want to be here, you don't like being here,...[but] we have to be here so let's make the best of it"...And then I say, "What would help me is to... be able to let people [the courts] know... what's really going on. Otherwise, what it will lead me to, is what it says in your report... "Oh no, that's not it, I don't want you to think..." And then, that's usually where I start. And then I'm open, I just listen... and that's usually how I'm able to break through... Sometimes what I'll do is I'll use references, you know, "I once had a Latino client and this is what she said. Is that happening for you?" and they'll say, "Oh no, she's probably El Salvadoran," or "She's probably..." you know, and I don't say yes or no, but "Okay I just want to make sure, like I said, I'm [a square], you know I just don't understand. So help me understand." Oftentimes they'll laugh, and it empowers them, because they'll want to help me to understand where they're coming from, and that empowers them too. So that's how I usually am able to breakthrough.

Another clinician spoke about using humor when discussing gender roles:

If the husband never helps with the kids and never does the dishes... We will laugh about that, and I'll often say... "My grandfather used to give my grandmother a foot massage every night before they went to sleep..." And I've used examples that my dad does the dishes every night, and my mom cooks every night, that's their deal. So I use those examples, and I usually use those examples in front of the husbands. I'll say you know, "It's 2008 now, and times have changed." And then I make jokes about me being very American, and these are

more American values, but this is where a lot of the world is turning. So I do a little equal rights education, but I make it light and joking so I'm not too insulting. And of course they'll come back and say... (laughs). But I do, I have a good rapport so it doesn't come across as preachy... I use lots of humor, and I think that it really helps the divide. I think humor is a wonderful way of connecting quickly.

It seems as though using humor was a way to connect with clients while also assessing their relationship with cultural trends and encouraging reflection.

One respondent reflected on the art of asking questions in light of cultural trends in this way:

I think it is about recognizing, is this a difference/similarity that I share with this person from a cultural place? And, can we explore that?... Is that something that you feel you relate to on a greater cultural scale with other people with whom you identify? ... And do you call that cultural? ...Social workers are data collectors, and so in order to gather the most appropriate information, they have to gather all of that. They must ask about culture, and migration, and relationships with spirituality and food and family, and do these things interplay for this person, client, family system or not? Do they relate to, do they consider themselves in line with their cultural identity or do they consider themselves the outsider with their cultural identity?

Another participant noted:

I mean I do think that as you have experience, it's just part of your model- it's just the way you work. But I think that to make that happen, you have to stay on top of things...which is reminding yourself about asking certain things, really looking at how class and certain cultural issues like religion and um, and cultural norms in their family influence them now. So just, it's really just remembering to ask all of that stuff. And be aware of, being able to braid and weave that in to what makes up this person...and acknowledge, yeah that you don't know it all. Because now it's just more automatic, and I know when we're talking about certain things, that's just a good time to ask about migration, or when we're talking about other things, it's a good time to talk about church. So it all kind of flows now, but you have to create that in yourself.

Knowledge, as an aspect of cultural competency, seems to offer clinicians tools with which to invite clients to reflect on their relationship with some of the many cultures in which they participate. One Latino participant noted:

The understanding then, comes [in] trying to pick up on diverse cues that [clients] give, but also recognizing that I need to ask them as well... how they see things or how they experience things from their point of view, their sense of spirituality, religion or cultural point of view... so it's really...showing them respect in that regard ...trying to not to feel like I'm any better than they are. So in that sense, it's sort of an exercise in humility.

Cultural Competency as Sensitivity to (Selected) Latino Cultural Trends

According to this study's participants, clinicians should be able to approach specific cultural trends with humility, holding in balance a complex understanding of culture while learning about specific trends. When this tension is preserved, knowledge about cultural trends can, in the words of one participant, offer "face credibility, rapport, and trust." It is beyond the scope of this study to extensively analyze these findings regarding Latino cultural trends. At the risk of engaging in overgeneralization, I present this study's findings as related to selected cultural trends in three areas: migration stories, ecological context, and family organization.

Migration stories

Eighty-three percent (83%) of participants agreed that asking Latino clients about migration stories is important. Thirty-three percent (33%) of therapists mentioned how "sometimes it is a tricky question, because some people feel you're pushing immigration concerns." One interviewee stated that she does not "always ask on the first time because they're still building trust, and not exactly sure that we're not going to call I.N.S. But I will incorporate it somewhere." However, participants seemed to inquire about migration stories for a variety of reasons.

Forty-two percent (42%) of interviewees mentioned the importance of asking about migration stories as a tool for assessing trauma history, grief and loss, and isolation issues. One Latina therapist explained:

What motivated them to come? ...Was it a forced migration? Was it a voluntary migration? That makes such a big difference... as to... how they present in this country, and in themselves...I think that those are really essential...Just a real importance of knowing people's background, their political/social backgrounds... How important it [is] to really get, hear that story and hear what it was like for them, especially if they came illegally, or under duress. So, you appreciate what ...they've got in terms of stressors.

Another Latina therapist shared:

I do ask for migration stories, but a lot of times it's because I'm working with families and I want to know about loss and separations. Otherwise, it is relevant if you're working with immigrants...People look very different depending on...[from] where they emigrated... I've had clients who basically came here because they had no food and nothing to offer their families, and they left their homes when they were 13 years old, from Mexico, for example. And I've had clients who've had college educations and were doctors before they immigrated, so they're going to be different... You have immigrants, who really didn't want to leave their culture and came here because they had to, in order to support their families.

In addition, 16% of clinicians inquired about migration stories as a way of gaining information about a client's socioeconomic condition. One participant described how “for migrant families who came here recently, it's very obvious that they're struggling financially...I can't think of any families I encountered who had immigrated to the U.S. very recently who were not very poor.”

In contrast, seventeen percent (17%) of participants suggested that they don't ask about migration stories if clients have been in the United States for a long time. One interviewee explained, “I don't want to assume that they all came from another country, rather than being here for years. I'll let them tell me and then I'll ask.”

Another aspect of migration involves the community and country that a client has left behind. Seventy five percent (75%) of clinicians interviewed spoke about the importance of asking and learning about specific countries and cultures of origin for each client, or client's family. One participant explained, "In terms of my experience, like people that are from El Salvador are really different than people from Cuba, you know, or Mexico. And *they* feel they are really different." Another Latina interviewee noted, "If I'm meeting with someone for the first time... I ask, "Where are you from, or how do you culturally identify?" Sometimes I assume I know... but most times I'll ask—especially with Latino patients, because where they come from matters. So I don't cut us with the same scissor, so to speak."

Seventeen percent (17%) of participants made further distinctions between indigenous, tribal populations and urban, more westernized populations in each country. One medical clinician described working with a Meztec family, which is an indigenous cultural group in Mexico. He related an anecdote which graphically illustrated the danger of mistaken assumptions:

I [had] a referral and they were telling me that this Mom is so slow, she doesn't get it, gives blank stares, etc. I asked, "Does she speak English?" and they said, "No, she speaks Spanish, and such." So, I met with her and I started to do an interview, and she was very flat, and uh... which maybe was personality, maybe it was cultural. And I asked her to explain some things to me, or answer some questions, and her Spanish grammar was so poor, and her language was so poor. And she kept asking me to repeat myself and say things in different ways. And then finally, I just asked her, "Do you speak Spanish?" And she said "No."

Thirty-three percent (33%) of interviewees mentioned that it has been helpful for them to learn about the histories of their clients' countries of origin, whether it be Castro's rise to

power in Cuba, cultural conflicts between Mexico and El Salvador, or a country's experience of a civil war.

These findings suggest that migration stories may reveal important aspects of a Latino client's context for therapy: description of a client's homeland, insight into trauma history, and/or clues to socioeconomic conditions. How clients (or a client's family members) have coped with adversity in their homelands and/or in the journey of migration may offer important history informing their present context in the United States.

Ecological Context

Ecological context includes an analysis of how Latino clients are interacting with the larger context of United States culture. Fifty eight percent (58%) of participants stated that their Latino clients were dealing with issues of acculturation on a daily basis, although it may not have been the main focus of the therapy.

Sixty seven percent (67%) of clinicians described parent-teenager interactions as the most prominent example of acculturation issues. Generally, therapists outlined a cultural clash between the burgeoning independence of an American teenager and a strong Latino cultural emphasis on familial loyalty and parental respect. One clinician explained:

[The parents] liked it the way it was [in Mexico]: the big family, the wife at home, [and] their kids living with them until they got married. And then, they have children who like part of their [Mexican] history and [who] like part of the American culture. [The teenagers] like that kids have more freedom, voice... that school is highly valued and that they're encouraged and rewarded for going to school. But then the parents... they're happy about that, but also they're not happy about that... "You want to spend the night at your friend's house? Why?" It's a rejection, you know, "Why would anyone want to spend the night at their friend's house or go away to college? There are good colleges here!"... So,

depending on what generation... it's not this wonderful time where a girl is individuating. It's more like this tragedy, "Why is she doing that?"

Another respondent illustrated how intergenerational disconnect might bring up feelings of shame for Latino parents:

My clients think that their kids are embarrassed of them because they're laborers... And when teenagers developmentally begin to think that they know more than their parents, it's not because you have a third grade education, that's because all teenagers feel that way. But they don't know that... Then, I present the idea, of is it possible that teens in general feel that way about their parents, no matter who their parents are. That's when I would use an example of someone very affluent and point out that those kids are embarrassed of their parents too. ... Because in the structure of our society, they are at the lower end of the scales so they already feel inadequate and insecure, so when that happens in their family... it's like "oh, it's because I'm old or no good anymore or I'm this, or I'm that". And it's like..." no! They're just teenagers."

Participants worked to normalize cultural clashes between teenagers and parents, and tried to keep parents from blaming themselves for cultural differences or realities.

Internalized racism about what it means to be Latino, and assumptions about a person's subsequent abilities or worth, also surfaced. One therapist described her clients' cultural sense of themselves in this way:

A sense that others don't expect them to be doing well, or to achieve what they've achieved. A sense of maybe some guilt and do I deserve this... and how do I bridge that gap? ... I had a student... she graduated [from undergraduate studies] and went to [a Master's degree program]... and I continued to see her. Her first paper in grad school, she got an A on it and she showed it to her father. And he said, "Did Frank write this?" And Frank is her white American friend. He couldn't believe his daughter would write in English and get an A. Never mind that she was a... grad student... But he just hadn't seen that.

Participants put forward the importance of scanning clients for "cues" around negative internalized stereotypes. Fifty percent (50%) of clinicians of color commented on how their "non-white" identity helped them to connect with Latino clients around issues of internalized racism. One participant, who is black, explained:

Obviously there... can be a lot of tension between Latinos and blacks. It's interesting, being both minorities, we can sort of use each other; we're all kind of running for the scraps or something. But, um, I've found it to be a very enriching experience...Often people think that they can say more to me, because I'm not the cultural norm.

Clinicians did not have consensus on what the process of acculturation entails. Is it a progression of Latino clients trying to assimilate with white culture? When commenting on acculturation issues one participant, who is white, stated, "With clients that I view more as, you know, people who have not been here as long or are newly immigrated to the U.S., definitely...I am using the filter [of cultural competency]... Not as much in the clients who I perceive to be more, 'white' or 'American.'"

In contrast another clinician, who is Latina, offered this perspective:

I did go to one training... about acculturation; it went through the steps of immigrant, first generation and second generation. And it was like, how acculturation is about being able to hold on to your culture and integrate the parts of the dominant culture that you value. And to feel good about this and this and this... you know. Because we're a mix. We have to take that culture that we love, and we find new things in this culture that's like... we get to be assertive? Oh, my gosh! (laughter) I'm so lucky!

Participants did seem to agree that it is important to be attentive to the ways in which clients are negotiating with American culture. While remaining sensitive to how clients may not be ready to discuss cultural identity issues, participants alluded to how they remained conscious of clients' self-reflections as participants in Latino culture.

What does it mean for them to be Latino, and how universal is their struggle?

Two respondents, who worked with clients from very different backgrounds, addressed this issue. One respondent described how:

My little internal therapist... is watching and tracking [for cues to discuss race and cultural issues]... I've known that this one client really struggles with her ethnicity, she really does. She's from Panama, and comes from a very affluent

family. And I see her denying her cultural bonds, like even when she's taken on roles, she's an actress... when she has to take on Mexican roles and an accent, that she struggles with that, being pigeon-holed in roles, and not really liking being seen only as a "Latina woman." But I know that she's not right now, willing to go there to talk about that. And I don't press it. But...I see it, and I'm tracking her, working with her, but I don't push talking about it. There might be an opportunity where I might ask a leading question, but if I see...that she's not going there, then I won't push it... I know that that is an area that she might need to work on, being more connected to, I guess, being more accepting of herself.

Another participant offered:

I've... worked with young kids who are gang-affiliated who really had somehow internalized this idea that Mexican is like gang and violence--they've really internalized... dominant discourse about themselves as Mexican-Americans, as being bad, or less than, or violent...And then I've also worked with people who are just trying to re-connect with a positive, say, Mexican identity. You know, who grew up with parents who didn't speak Spanish in the home because they so much wanted him or her to assimilate and become American, and just this tremendous loss that some of the, you know, even young adults I've worked with, who now are like "that's a part of me."

These findings suggest that Latino clients' experiences in American culture can involve family struggle, shame and internalized negative self-images. In the face of struggle, Latino families seem to serve as important buffers. In addition to being attentive to clients' context in United States culture, it is also important to pay attention the culture of the family.

Family Organization

Eighty-three percent (83%) of interviewees mentioned a theme of "family relationships as a strong, centralized focus of the culture." A Latina therapist described family as a basis for connection:

We connect based on family... Yeah, "Are you a mother?", "Do you have kids?", "What grade are they in?" That's very typical, versus "What do you do for a living" or "What are your hobbies?" ... I have ladies who want to give me a hug at the end [of a session], and I don't have a problem with that, that doesn't feel strange. So I think we are more physical.

According to these findings, family relationships seem to represent trust and loyalty; in this way, it is not surprising that therapist-client dyads notably resembled aspects of familial relationships. One participant commented about how her Latino clients want to “know me on a personal as well as professional level. I am...flexible with boundaries in terms of talking to them between sessions if they need to touch base...I have had Latinas tell me that it’s important to them that I’m not just doing this for my job.” Another interviewee added how one of her Latino clients referred to her as “auntie” throughout the course of treatment. Twenty-five percent (25%) of participants shared that they think they came to be seen as part of the family with their longer-term clients. Subsequently, 17% of participants described how they have seen more than one family member in individual therapy. One respondent reported:

[One] client, I saw her for a long time and she’s a victim of domestic violence. And she, you know, she got better, and her husband...she decided to stay with him, and then one day he decided he wanted help. He would only come see me. And I tried really hard to get him to see someone else. But culturally, that does happen that they want to stick with the same provider... I think culturally, if his wife feels safe with me and trusts me, then he will. And I already know them, so that they don’t have to start again...and so I decided to not fight that.

In support of this, another clinician pointed out that she would often ask her individual Latino clients if they might like to bring family members in to session.

As a way of describing familial relationships in more detail, 42% of participants mentioned the importance of *respeto* (respect) in Latino culture. One clinician stated, “The word respect is like a key word in that whole population,” and continued to comment on a hierarchy involving deference to parents, elders and authority figures. A clinician, who is Latino, reflected on authority figures in relation to Latino clients:

You know, when we look at sort of people like doctors, social workers, mental health people, teachers... are up here, you know, up on a pedestal, priest, you know. So folks, you know, will... they put people like that on a pedestal. So there's great power to manipulate that. You can really, you know, destroy somebody, or you can really build somebody up. And I think that the ones who are most effective are the ones who come down to that level and say, you know I'm off the pedestal, I'm on the same level, I smile, I listen to you, I'm attentive to you in the little things. Like recognizing everybody in the room, or recognizing the baby if there's a baby there and spending maybe a little time with the baby even. Those are the little things that make us all more human, you know, and off of the pedestal. And um, those little cues go a long way-huge.

Another participant related how he discovered the importance of respect by once missing this cultural cue:

I used to do hospice work, and there were a lot of home visits. And...I was told that ...there was a 31-year old woman and she was dying, and the father was... well the nurse told me that the father was a real SOB... I was kind of intimidated after she told me, to be kind of honest...So I went to the house and I met everybody, and I saw this father, and I was intimidated by him and I hadn't even met him. But I stayed away from him... And that was a big huge no-no for me, to stay away from one of the main figures, father-mother figures in that situation. So I learned that I need to make some contact with the elders in the family system. I was going by the nurse's evaluation that he's rude, mean, you know, all that kind of a thing. And I knew clinically that I needed to make contact with him, but I gave in to the nurse's evaluation of him. So I didn't. And then, at the end of the visit he came up to me, and he said, "And I'm the father, and you should've come and talked to me." Well, I felt just about that small. And I sort of shrunk, and I knew that I blew it. So since then, I've always learned, even if it's just a simple hello of recognition, I make sure that I follow up on that cultural cue.

This vignette not only portrays the importance of respect in relationships, it also suggests that respect can carry particular significance based on gender roles. One area in which clinicians seemed to struggle to remain open to their differences with clients included gender roles.

One hundred percent (100%) of respondents mentioned that they will ask about gender roles and relationships in a client's family of origin as part of their initial

assessment, although many noted that this is not specific to Latino clients. Fifty percent (50%) of clinicians recalled specific instances where they were keenly aware of differences between their own concepts of equality in gender roles and their Latino clients' more patriarchal concepts. One participant explained:

One of my identities that I... wear on my sleeve is a feminist identity. And so when I was working with a family from Argentina... mom and dad came in, and dad was very like, you know he did all of the speaking for the whole family. It was interesting, like they, the mom and the daughter sat together on the couch and he sat in this chair and, even when I tried to ask questions directly to them, he would always take over...I was so mad at the guy!... I kind of stopped trying to ask them questions, because I just realized for whatever reasons, at this point, he's speaking for the family...because the bottom line is, if I don't engage with him, no one's coming back...I think though that it's a very hard and thin line to walk though. Because for example, in this couple there turned out to be domestic violence. And ... he was not coming any longer and I was working with her, and I think this was a cultural mistake of mine. I, she was finally telling me one day what he did to her and was doing to her, and so I really kind of took her on about abuse, and I told her it was abuse, "This is violence, you know." And she got so angry at me...She was totally offended, and that is not what she thought was going on, and you know—and so I mean, p.s. a lot later, she came and she did identify it as abuse. But it wasn't because of anything I said... I realized in that moment, that that was so clumsy culturally on my part, you know? ... [I] learned a lot about timing and about language because I don't think she actually would have been offended or disrespected if I had asked for more about the impact of him hitting her. But to use the language "abuse" and "domestic violence," ...not only what I said with the labels and the words, but how I said it, because if you think about it, I was dominating her in the same way that her husband was dominating her. So, how's that useful?

Another clinician described:

I tend to be a strong black woman, and...I even have to like shift some out of that role, I mean, I don't deny myself, but it's like, sometimes I have to adjust my mode so that I can get more of their vulnerability. Well, I have this guy...and he came into one group meeting about an hour late, stormed in, very angry. I told him on the phone... "Do what you can to get here, but after fifteen minutes you'll be considered unexcused and absent...and you know you will not be able to count this as an attendance at the group." Well, he was pissed off, and he came to my group, stormed in, opened the door... we were in an intense kind of thing, and ... he was just an asshole. Anyways, so the next meeting we had, he was on time and everything... and he was making passive aggressive statements to me, directed to

me. And um, you know I said, “Can we talk about last week?”...And he gave me a long list of... what a horrible person I am. And initially, I got really defensive and kind of angry about this, as he continued to blame me for all of his behavior. And of course, the group was kind of going along with things... and so I had to adjust myself, calm myself, and I said, you know what... and I know this guy’s been struggling to even make it to group and be present and share himself. He’s very very... um, private. He doesn’t share stuff. And I said, “You know what, I do not want you to be scapegoated in this group. I want you to feel welcome to be in this group, and you know... it is very important to everyone to be on time, and I can imagine that it’s really uncomfortable to be coming back to the group after that situation...but you came, and I’m really glad that you came. And you’re expressing your anger to me... that’s good! You know? You’re talking to me about it, and that’s actually a really good thing. So obviously, you know what the rules are now for the group, and I’m hoping that you’ll continue to keep showing up and sharing...” That was not something that he expected from me. He actually called me the next day... I think he was actually calling to say that “I’m sorry, you know, that wasn’t cool...” And he did apologize to the group about the way that he treated them...I decided to do something different, because he needs to be in control, to be the man, okay. You know, he’s macho...And what I need to do is just validate him, hear him, that he’s showing up and doing work, that it’s uncomfortable.

Participants indicated that there is a tension between respecting clients’ gendered understandings of their roles and behavior, and therapeutically assessing how these roles may be maladaptive or limiting for clients and their families. Several interviewees also described how they re-frame cultural concepts of gender in new ways. One clinician asserted:

Women are very strong, but say this woman may say to me that she feels inferior, not having a voice, etc. It’s being able to use examples, such as how her mother got through this or that. You know, showing that there is strength within the culture, but she may not be seeing it. And how she can maybe use it indirectly with her relationship with her husband, that obviously going at him isn’t going to work. So maybe there might be another way to get across what you need, but not in a very in-your-face way... making it more “his idea” than yours, although it really was your idea.

Another participant reported:

It’s kind of like the strengths based approach...With the batterers... this [therapy]is an investment in your family that you act non-violently, because your

family is important for you. ...It's tapping into what their strength is... tapping into the male, sort of, sense of wanting to be responsible, wanting to work hard at things, wanting to be a good parent...

The *machismo* desire to be responsible, to work hard and to be a good parent is likely communicated in the sentiments and meanings carried in specific Spanish words and phrases.

Spanish Language and Communication Styles

Participants reflected on the relationship between Spanish language skills and cultural competency with Latino clients with mixed feelings. Interestingly, it seemed that Spanish-speaking therapists leaned toward the opinion that, while cultural competency is difficult without speaking Spanish, it is possible with bilingual clients. However, non-Spanish speaking clinicians tended to describe a feeling of “missing out” on important nuances of language. Both groups provided creative suggestions for mitigating language and communication barriers.

Specifically, one non-Spanish speaking participant remarked:

I do think that... people feel respected when you speak their language, in some ways, so that no matter how you try to minimize barriers, only speaking English, it's different, you know... if you speak Spanish in any way, it's added value, a demonstration that you want to try to communicate in their language. I think, sadly ... the status quo here for most Latino clients is that most clinicians do not speak Spanish.

Another Spanish-speaking clinician added:

Salient for me... is how much respect goes into language and how formal a lot of my relationships seemed, even though we were having intimate work, related to death and dying and illness, the language and the way we communicated was always quite formal... I always tried to reflect back the same formality...the Spanish language is wonderful because it allows you to have a formal and/or informal conversation and it sets that place immediately for you. So it's just a simple way to express the same amount of respect back to your clients.

Seventy five (75%) of participants suggested that cultural competency “is harder [in English]...but possible” with bilingual clients. One interviewee noted that cultural competency is more about remaining “curious about the difference,” while another suggested that “it’s about the humanness.” When asked about the relationship between speaking Spanish and cultural competency, a Spanish-speaking participant explained:

I think that if a client speaks English, then [the therapist] can be... culturally competent. You know... I think that it could be therapeutic. I think there’s a lot of shame in not being proficient in the dominant language. So to be able to sit with someone who can be patient and give you that space, can be very validating and therapeutic. So I don’t know if I would minimize it, but to acknowledge it and to ask, what’s it like that you can’t let it all out with me in the same way as if I were Spanish speaking. That could be very therapeutic. Because we all have limitations, all therapists.

Another Latina clinician, who at first felt that non-Spanish speakers could not be culturally competent, added:

I think...[cultural competency] means that you have an openness. And it can’t be assumed that because I am brown, and because I am bilingual that I am [open]. I think that that would be a big mistake. And because you’re not, that you aren’t or can’t be [open]. I think those are big assumptions that we’ve tended to operate under. But they’ve ended up biting us in the butt more often than not...My ability to speak Spanish gives me the opportunity to do the work in the language that we can more or less communicate in...I’ve met [non Spanish-speaking] people who have so much more respect and knowledge about not only my own culture, but other people’s cultures than I do.

In contrast, 42% of participants acknowledged that nuances are lost when doing therapy in a client’s non-native language; there are certain non-translatable words or concepts. Non-Spanish speaking interviewees generated various ways to minimize language barriers, including allowing clients to speak in Spanish first and “listening for the emotional content,” and slowing down conversations to check in with clients and reflect on what is being heard compared to what is being said. Another participant

suggested using art as a medium for communication and expression of strong emotions. One non-native Spanish speaking clinician described how she could speak the language, but missed out on some important cultural insights. She reflected on work with Latino clients in this way:

Because I speak Spanish but I don't necessarily speak the dialect that they speak, so then there creates this barrier... I'm not bicultural. When I was a first year intern...I was really excited that I spoke Spanish. So I was like, "Oh! I can connect with these clients, they can understand me and I can understand them." What became very clear to me is that language is only one component of really understanding them...I actually further alienated myself from them because I tried to assimilate, but I didn't really understand how complex that was... to understand their culture... I didn't get it the first whole year that I was in my internship. So I would then always talk about how the clients were resistant, how the clients were not amenable to treatment, so I would always put it back on the clients. And then as I started doing some more self-discovery and some more reflection... I realized after...understanding more about cultures and just experiences, not necessarily in the book. Then I realized... I didn't allow myself to understand them because my assumption was that I spoke the language, and so I should be able to understand them and they should understand me.

According to these findings, it seems clear that language and communication are important, both on the lexical and symbolic level. However, respondents saw aspects of cultural competency both in being fluent in Spanish, and creatively working with clients around language barriers. The red thread through these comments shows again, the importance of humility and openness.

These findings suggest that there are important trends in Latino culture to be aware of: the centrality of familial relationships including gender roles, the importance of respect, and awareness of differences in language between Spanish and English. While these trends exert formidable influence on families and individuals, they are also not stagnant. Participants emphasized the importance of respect and creativity in assessing and engaging all Latino clients, and valuing their uniqueness.

Participants described cultural competence as a nuanced, lifelong process of learning. They highlighted important themes of learning: a) attentiveness to racial power dynamics between client and clinician, b) clinicians' critical reflection on their own racial identities, c) embracing humility and openness to new learning in cross-cultural therapy. These findings suggest that therapists hold knowledge about specific cultural trends lightly, always allowing clients to define themselves. It is important to bring these findings into conversation with previous literature, to accentuate similarities and/or contrasts with the literature and unique findings of the study.

CHAPTER V

DISCUSSION

This project explored the ways clinicians conceptualize, recognize and put into practice cultural competency when working with Latino clients. The study explored how clinicians perceive their own cultural identities affecting practice with Latino clients, whether they employ specific cultural knowledge, how they viewed cultural competency in others and in themselves, as well as suggestions for future cultural competency education. Many of the findings resonated positively with previous literature on cultural competency and social work identity. However, there are points where interviewees offered important “experience near” views that clarified the literature in helpful ways, offering suggestions for future research.

In this chapter, I begin by returning to licensing boards’ guidelines for culturally competent clinicians and juxtapose them with interviewees’ experiences of subsequent classes and trainings. This leads to a discussion of conceptualizations of culture, comparing and contrasting theoretical views and project findings. Next, I present ways that project participants explored how their own cultural identity affected practice with Latino clients and the confirmation these perspectives find in previous literature. Discussion of selected Latino cultural trends and their application to clinical practice follows. Finally, I outline future implications for social work practice and clinical theoretical orientation.

Learning about Competency and Culture

Project participants seem to echo licensing boards' emphasis on cultural competence; each participant remembered specific training in graduate school and some noted other trainings post-graduation. All participants agreed that cultural competency is an important part of competent clinical practice; most (70%) of the social work practitioners acknowledged that cultural competency is rooted in their clinical identity. However, many of the participants did not remember their graduate level training or critiqued it as superficial. It seems that participants resisted the ways that competence, when used in cultural competency, was juxtaposed with competence in other graduate classes. Namely, cultural competency trainings became a class that each student could pass, or receive a positive mark in, and that positive mark is then interpreted as competence.

The most positive educational experiences from these findings were invitations to explore one's own cultural identity, or the multi-faceted nature of cultural formation. Participants preferred learning about culture in clinical practice as an ongoing focus of clinical work, not a skill to be mastered. Furthermore, one social work participant wondered if social workers do not discuss struggles or problems with cultural competence because, it being an ethical mandate in licensing standards, clinicians need to present themselves as fully competent? Perhaps NASW's emphasis on mandated cultural competency might be having the opposite effect, decreasing social workers' flexibility in discussing cultural factors in fear that they will be seen as culturally incompetent. Findings from this study suggest that no one is ever completely culturally competent, but rather, it is a lifelong process from which we are continually reflecting and learning.

Perhaps an ethical mandate on “cultural engagement,” (and learning from mistakes!) as voiced by one participant, might better foster an environment for clinicians to devote themselves to the process of fostering cultural competency.

The literature supports participants’ sentiments that the concept of “competency” as defined in Random House Dictionary, does not fit well with the process of cultural engagement. As noted in Miehl and Moffatt (2000), it might encourage clinicians to assume positions of “expert” or use objectivity as a means of mitigating their anxiety in cross-cultural encounters. Overall it does not seem helpful to use binary terms of competence and/or incompetence, as it suggests simple judgment on what is actually a process rife with mistakes and missteps as important pieces of the learning. As one participant explained:

I think the [social work] field is stuck in a modern conceptualization of culture... people try to challenge us in naming these “things” as solid, structural pieces, when really they are much more fluid identities. And that we actually live on the borderland of many of these identities all the time... immigration status, migration, education, language... you know, country of origin. So, plus, you know-gender and sexual orientation... So for me, I really think that we are stuck in an old way of thinking about culture... I feel like it’s not about our lists or our chapters... it’s about our whole paradigm in talking and training people about culture.

Perhaps the language of “competence” limits discussion and education to conceptualizations of culture that can be mastered, or turned into “possession of an acquired skill” (<http://dictionary.reference.com/browse/competence>). This supports Laird’s (1998) thesis that we must begin by “learning *how to learn* about culture” [italics added] (p. 23).

Participants acknowledged that cultural competence has often been used to describe “minority” cultures and not white culture, supporting Park’s (2005) assertion of

the problematic culture-as-deficit model. In tandem with Park, participants showed evidence of de-centering their understanding of culture, and subsequently cultural engagement. One Latina interviewee noted:

As I understand [cultural competency] now, and being a person of color, to me then it requires one knowing not only my own culture and Latino cultures...but everybody else's as well... because I think that I need to know Anglo-Saxon culture, I need to understand what it [is] because it's not my personal cultural background, so I can't...just like I don't want some one to assume about me, I can't make assumptions about white folks or anybody else...Just as much as it might be present...for someone Latino, someone African-American, Asian, Pacific Islander, I mean, everybody that can walk in the door comes with that reference. So I have to be open to thinking about how that is influencing what they're presenting.

Another white clinician added that “by owning your culture, however you define that...rather than saying ‘You’re different, and I need to learn about you, you’re different,’ Instead, you’re saying, ‘I’m different, you’re different, I’m trying to get clear about my identity...what’s yours?’”

In agreement with the literature, participants did not settle with easy definitions of culture. Even in focusing on Latino clientele in this project, 92% of interviewees pushed for nuanced understandings of Latino culture; they questioned how differences due to sexual orientation, migration status or gender might change one’s experiences. One clinician noted that we “participate in many cultures at the same time.” Another reported that “we are all many cultural identities.” This supports Falicov’s (1989) and Rosaldo’s (1989) sense that boundaries between cultures are diffuse, and rather there are several “cultural borderlands” in which people syncretize and create unique identities. There are then, several points of similarity and difference between each therapist and client. One

participant seemed to speak directly to Falicov's concept when she echoed, "we actually live on the borderland of many... identities all the time."

Project findings affirm previous literature outlining the importance of critical reflection when defining "culture": namely whether one focuses on a more multi-faceted process involved in identity-building, or more on a set of trends that can be recognized and codified. Participant voices suggest that pairing culture with "competency" may limit definitions of culture toward the latter and thus limit engagement of culture on a deeper level. Laird (1998) and Park (2005) most notably disagree with a definition of culture that codifies trends, and instead conceptualize culture and thus cultural competency as a complex process in which one engages. Interviewees affirmed that a more fluid and dynamic understanding of culture guided them to critically reflect on their own cultural identities, and how their particularity might influence clinical work with Latino clients.

Consistent with previous literature, project participants acknowledged race as a salient identity that carries too often unacknowledged power. Interviewed clinicians illustrated an emphasis on self-reflection in cultural engagement, which included more than just self-awareness. In agreement with Sue and Sue (1990), Laird (1998) and Werkmeister Rozas (2004), they seemed to recognize that clinicians are better able to understand clients who are culturally different from themselves by first critically reflecting on their own cultural identity development.

Stages of racial identity development as presented by Miller and Garran (2008), Sue and Sue (1990) and Lee et al. (2007) can be recognized in participants' stories. One clinician of color described growing up in a family where "there was a lot of like—not

wanting to accept being black...there was self-hatred...and I rebelled a lot to that.” This aptly describes an early stage of racial identity development as described by Sue and Sue (1990), where “individuals start by consciously or unconsciously devaluing their own cultural identity and valuing white values and ways” (p. 94). This clinician described a process whereby she became “more comfortable in my body and in my skin—and being able to be with people...whatever culture they are.” She reflected on how her process helped her to recognize what might come up for her clients based on her racial identity, and hone the ability to “hold on to [her]self...choose not to share [her] feelings to give clients space to express their feelings about where they are.” This resonates with Miller and Garran’s (2008) integrative process, whereby individuals internalize a sense of pride and peace with one’s identity while respecting identities of others, working toward social justice.

One participant of color commented on how white social workers seem to “minimize what they represent, the power they hold...it’s just how our society socializes us...I don’t choose, I show up and this is who I show up in—already people are like, ‘oh that black lady.’” Another Latina clinician expressed disdain at non-Latino clinicians assuming similarity with a Latino client based on their “visits to Mexico.” These examples highlight navigation of a dual consciousness; individuals note how whiteness functions and how to survive in a white world, yet also contemplate their own racial and ethnic ties and the relationship between two worlds. Also, Laird’s (1998) assertion holds true here, in that “people do not have equal voice in shaping their personal narratives” (p. 28). In these cases, others were “storying” these participants before they had a chance to narrate their own particular experiences of race and culture. A white clinician, when

discussing self-disclosure noted that she thinks “many [clients of color] assume that I don’t know a lot about their personal culture, their values.” In response, she stated that she often discloses to non-white clients that she is married to a black man and lives in a largely black community. Contextualized in white racial identity development, white therapists *may* try to distance themselves from their whiteness and over-identify with clients of color in hopes to escape the stigma of white privilege.

One Latina clinician reflected on a case early in her career in which she described what seems to be an illustration of Perez Foster’s (1998) cultural countertransference. Interestingly, this happened with another Latina client, where she described, “Even though I didn’t say anything, now, from retrospect I think...it wasn’t any word that I used, but it was a dismissive quality of ‘yes, I understand’—that communication of ‘I don’t want to hear the whole story.’” This clinician noted that this was largely an unconscious communication; she explained that it took her several years to admit that she might have played a role in this client’s termination of therapy. Shome (1999) might have described this “dismissive quality” as “that *thing in their look*...they welcome you, but then the way they look at you makes you feel as though your whole body is up for examination” (as cited in Miehl, 2001, p. 233-4). Perez Foster (1998) describes how cultural countertransference can be conceptualized in diverse ways, yet notable to this example is how a “clinician’s personally driven biases about her own ethnicity” influence countertransference (p. 257). Clinicians of color’s attitudes towards Latino clients might be influenced by the clinicians’ attitudes toward their own cultural identities. In other words, internalized racism may function in therapist-client dyads. In this way, Perez

Foster underscores the importance of remaining aware of cultural countertransference in cross-cultural dyads, although culturally-matched dyads seem to be affected as well.

Perez Foster (1998) noted the importance of remaining vigilant so that personal cultural countertransference does not get acted out in therapy. Yet these findings suggest that they (most likely) will get acted out at some point, and if received appropriately, these mistakes can offer important insights into cultural engagement. This is not to say that clinicians should cease to critically reflect on cultural differences and power dynamics, trusting that “the mistakes” will serve as their cultural education. Rather, I am suggesting that as clinicians, we wrestle with our concepts of competency to include mistakes and missteps as expected learning opportunities, instead of instances for embarrassment. Particularly clinical social workers, who have historically claimed “person-in-environment” as a grounding principle, might subvert common understandings of competency (i.e. mastery) and focus on critical self-reflection and engagement of cultural missteps as the type of “competency” needed in the field. La Roche (2002) asserts that “when therapists complement their diagnostic understanding with sociocultural issues, the result is not only a more comprehensive understanding of their patients, but also less-pathologized and more-empowered patients” (p. 119).

Perez Foster (1998) suggests that clinicians loosen their claims on universalistic perspectives on human development. Falicov (1989) suggests that American psychotherapeutic training is caught in a web of American culture, where clinicians are unable to critique psychological theories *because* they are so steeped in individualistic, American values. Like a fish in water, American clinicians may not know how to see this cultural bias. How can clinicians practice reflexivity with psychodynamic theories? It is

interesting to note that none of the study participants critiqued psychological theory. Given that the interview log for this study did not pose questions specifically on the relationship between psychodynamic theories and cultural engagement, it seems to be a compelling area of future research. Can clinical social workers embrace fluid and dynamic concepts of culture, using a sociocultural lens to critique psychological theory? If social workers critique psychodynamic theories too rigorously, are they putting their perceived competency and thus the competency of the field at risk? Or by refining the universal applicability through a cultural lens are they broadening our knowledge base?

Miehls and Moffatt (2000) discuss the reflexive self as a relationship; we learn about ourselves through interactions with others and with ourselves (in reflection). One interviewee spoke about “what made [therapy with Latino clients] successful is me acknowledging my difference with them and expressing my limits.” This therapist learned her differences and limits in working with this couple; she did not come in knowing about these. Thirty-three percent (33%) of clinicians, when discussing cases that they thought were successful spoke about clients who had an influence on them; they mentioned these therapeutic interactions as important in their own development as professional therapists. It seems as though these clients made an impact on these therapists; they were changed by the process of working with them. This supports Miehl's and Moffatt's (2000) idea that empathy is more than self-awareness; it involves the reflexive self remaining open to being changed by others.

On a similar note these findings suggest that, in order to learn in meaningful ways that “mutually enrich” both client and clinician, clinicians must be able to tolerate their own anxiety in cross-cultural therapy (Miehls & Moffatt, 2000, p. 345). One participant,

who was white, described an anxiety-provoking interaction in group therapy where a client accused her of “never [being] comfortable with me—because I’m Latina, and I’m expressive and I have emotions. And you want everyone to be quiet.” While this clinician admitted that this interaction was “horrible initially,” she engaged the group in a reflective discussion on experiences of racism and reflected in retrospect, that “it turned into a really good cultural experience.” Another participant described struggling to manage her anxiety when sitting with a lesbian couple; after several sessions she stated to her clients, “I might make a mistake...even screw up and say a word that is not sensitive, but please let me know.” The therapy benefited from the clinician’s openness, and the clinician stated that “I can still talk to [these clients] to this day—and it actually ended up being my best...family that I’ve ever worked with...ever in my practice.” By managing their own anxiety in the midst of cross-cultural interactions, both clients and clinicians were enriched by the experience.

Fifty eight percent (58%) of clinicians stated that they learned important aspects of cultural competency by making cultural “mistakes.” One participant, after describing a difficult cultural “mistake,” noted that “when you mess up like that, it’s the most possible and exciting, if you can hold on to yourself and lean into the difference, and lean into what you don’t know, it [can be] actually one of those really great cultural interactions.” Sixty seven percent (67%) of participants reflected on cases with Latino clients that they wish they would have handled differently, stating they wished they would have asked their clients more questions or made fewer assumptions. Participants seemed to *not* ask these questions in fear of appearing incompetent, or assumed they were already competent and knew the answers instead of asking clients. Perhaps participants

might have been more willing to risk asking their clients more questions, had they been taught how to respond to cultural mistakes with their clients as a part of their training.

Selected Latino Cultural Trends

Findings suggest that clinicians should be able to approach specific cultural trends with humility, holding in balance a complex understanding of culture while learning about specific group trends. This echoes Falicov's (1989) assertion of a current dilemma in the field of psychotherapy as "acquiring sufficient cultural literacy...to understand and...respect the cultural beliefs of the client, and yet not fall prey to stereotypical evaluations that rob clients of their individual histories and choices" (p. 5).

Migration

Eighty-three percent (83%) of participants explicitly supported Falicov's (1989) insight that it is important to ask Latino clients about migration stories; 42% supported her emphasis on exploring the circumstances under which a client migrated. As a way of exploring migration circumstances in detail, interviewees pointed to the importance of learning about clients' specific country of origin, socio-political history of their countries, and whether clients identified with more indigenous populations or Westernized, urban populations there. Sixteen percent (16%) of clinicians inquired about migration stories as a way of gaining information about a client's socioeconomic status. Falicov (1989) and La Roche (2002) would add the importance of the therapist acting as a possible social intermediary, connecting clients to institutional resources when needed.

Ecological Context

Fifty-eight percent (58%) of clinicians noted that acculturation was happening on a daily basis for Latino clients, but did not offer much detail about what the process of

acculturation entailed. One participant reflected an older model of acculturation as a process of transformation toward a dominant culture (as described in Falicov 1989, p. 69). She stated that she does not worry as much about cultural competency with her Latino clients “who [she perceives] to be more ‘white’ or ‘American.’” Another participant described Falicov’s hybridization model of adaptation as she realized “acculturation is about being able to hold on to your culture and integrate the parts of the dominant culture that you value...and to feel good about this.” It could be helpful to educate new clinicians about models of acculturation, providing them with a framework for conceptualizing this process. By having a framework, clinicians could reflect on ways that they might be unwittingly upholding dominant culture values, and conceptualize how to creatively engage clients in discussion on “both/and” models of acculturation.

Family Organization

Participants’ relationships with their clients seemed to reflect values of *familismo* and *personalismo*. One respondent described how she checks in with clients between sessions as a way of communicating *personalismo*, or that she is not just working for her paycheck. Other clinicians expressed feeling as though they were considered part of their clients’ families.

Interviewed therapists seemed to struggle to remain open to differences between themselves and clients when discussing gender roles. Most of participants’ struggles involved female Latina clients who stayed in relationships with men who were abusing them. While this is undoubtedly a complex situation, one participant reflected on her use of the word “abuse” with a particular female client as unhelpful. This may support

Andres-Hymen et al. (2006) suggestion to frame therapeutic goals in line with cultural and personal narratives. Perhaps it could have been helpful to explore the meaning of family for this Latina client, and then speculate on how she can best take care of herself so that she can support her family. Another participant described what she felt was a successful interaction with a Latino male, due to her reflection on gendered norms. Instead of framing therapeutic goals in line with cultural narratives, she affirmed this client for showing up for therapy and sharing about his feelings—both of which are not in line with a “*machismo*” identity. By being familiar with Latino cultural scripts around gender, this clinician was able to affirm him for the ways he might be stepping outside of his comfort zone, toward positive growth.

Spanish Language and Communication Styles

In support of the literature that strongly advocates for Spanish fluency with bilingual clients, participants acknowledged that cultural competency with Latino clients is difficult in English. However, respondents also emphasized the possibility for clinicians’ cultural competency despite language barriers. It is possible that participants emphasized non-Spanish speaking cultural competency because they were interviewed by a non-Spanish speaker.

One clinician described how speaking Spanish with Latino clients can start therapy on a note of respect; the clinician respects Latino culture and has spent time learning the language. Furthermore, Spanish has a formal style for addressing others, so therapists can linguistically “express the same amount of respect back to [their] clients.” Those participants who did not speak Spanish felt that at points in the therapy, nuances of expression were lost in the translation. On a different note, some interviewees framed

English/Spanish language barriers as an opportunity for creative collaboration with clients. Two interviewees reflected on the importance of clinicians recognizing their limits, and how the inability to speak Spanish is a clear limitation. One participant found that her clients became “co-therapists in some way” when she acknowledged her limitations in Spanish, which added to the success of the therapy. Spanish language skills are important, yet this study pushes the literature’s emphasis on language toward an emphasis on humility and openness. When humble and open, these participants suggest that creative collaboration might result from language “barriers.”

Suggestions for the Future

This study has engaged and analyzed clinicians’ orientation in approaching and applying cultural competency. How are we defining our terms, and how does that affect our practice? If we are to remain open to a dynamic, multivalent, socially constructed concept of culture, we must re-examine our ideas of competency and “success.” This study seemed to turn conventional ideas of success and competence on their head, and instead propose a lifelong process of cultural engagement as an ideal. With that in mind, is it helpful to categorize “cultural competency” as an aspect of ethical clinical practice? Or does cultural competency necessitate a shift in the foundations of clinical work, imbuing all theory with metaphorical value, and emphasizing reflexivity as an ethical mandate?

Results of this study showed that consciousness of racial identity development is important, both for clinicians’ to reflect on their own process as well as remaining attentive to internalized racism in Latino clients. Internalized racism and privilege have exerted formidable influence on client and therapist dyads, whether culturally matched or

culturally different. Culturally engaged therapists must remain attentive to power dynamics: those reflected in the therapy space as well as those in the larger sociopolitical context. With this consciousness, they may be able to recognize and better engage transference based in socio-cultural dynamics. An important prerequisite for cultural engagement, or perhaps a necessary evolving skill, is the ability for clinicians to tolerate their own anxiety and mistakes. This study shows that most likely, unconscious assumptions will get acted out, and if clinicians can accept them and appropriately voice them with clients, it can be a mutually enriching experience for both. Psychological theory, notably concepts of enmeshment/separation-individuation seem less than helpful when working with Latino clients. Culturally engaged clinicians might need to continually reflect on the contextual nature of psychological theory, acknowledging their clients as important resources in learning about human development as well.

Latino culture has shown itself to be diverse and complex. Knowledge of cultural trends, when held lightly, can offer clinicians a helpful framework for engaging their curiosity in work with particular and unique clients. By knowing these trends, therapists can assess (in conversation with the client) a client's relationship with her culture: how she might critique and resist parts of Latino culture, how she internalizes a Latina identity, how aspects of her cultural narrative may show unique strengths or be maladaptive, how she is living in the borderlands of several cultures at once. As clinicians gain a sense of clients' personal and cultural narratives, they can frame therapeutic goals in line with clients' values. When therapists find themselves culturally lost with a client, if they can tolerate their anxiety and "lean into" what they don't know

with humility and openness, they may find an opportunity to collaborate with clients in a mutually enriching way.

As a final question in the interview, participants were asked to describe their ideal training for Masters of Social Work students in cultural competency. Forty-two percent (42%) of them echoed the importance of clinicians' knowledge and engagement of their own cultural identities. These participants suggested that students be in individual therapy, ideally with a clinician from a different cultural background than themselves. Seventeen percent (17%) of them encouraged group therapy for students, because "if people start getting too caught up in their story, [it's because] they're having so much difficulty facing each other in the room." In group therapy, participants are offered a structured opportunity to engage one another's stories. Twenty-five percent (25%) mentioned the importance of relationships with people who are culturally different than themselves in their personal life. One participant emphasized that, "when you have an actual experience with somebody else who's different, that's transformative—that will change your life." Seventeen percent (17%) of clinicians mentioned the importance of art, music, books and poetry when learning about culture. In stories, clients and clinicians can find role models, versions of themselves and others they know; clinicians can connect points of similarity in a seemingly "different" culture. One participant eloquently explained:

I remember in school, one of my professors had said...the people...[that] made some of the best therapists were people who had English majors or lit majors, because they were so curious... because if you ... enjoy literature, you enjoy story. You're open to those stories and you're open to the characters, and then you have a way, and even though you might live in a relatively insular world, you expand it by the narratives of other people, whose books you read, and stories you're listening to. You develop that way of listening to character and subtlety...

A common thread through all of these responses is clinicians' openness to being changed by the other. This heartily supports Miehl's and Moffat's (2000) assertion of the intersubjective self: we cannot fully know ourselves without relationships with others. In this, clinicians grow to know themselves in richer ways by being open to the unique presence of others. This may be the foundation of cultural engagement.

In reflection on this study, I find myself wanting to offer practical advice to the field, hailing to an original impetus for the project, hoping to bridge the split between the academic theory of cultural competency and practical, easily-applicable interventions. Instead, perhaps I better understand what at first glance seems like a split. The well-informed, "not-knowing" clinician does not signify an impossible split but rather, preserves an important balance. There is no way to culturally engage with clients without anxiety and struggle... but hopefully also, with laughter and enrichment. Cultural engagement is a process, a choice—an identity to live into, which necessitates ambiguity, humility and an openness to change. I recognize this complexity, even as I yearn to offer "sure-fire practical interventions." So the task lies in shifting the paradigm. The goal of competence is misleading. Perhaps there are no easy answers to the "how to" questions, but rather, as poet Rainer Maria Rilke suggested, we "live the questions now. Perhaps then, someday... [we] will gradually, without even noticing it, live our way into the answer." Cultural engagement in the field of clinical social work, involves a robust commitment to authentically *live* the questions.

References

- Andres-Hyman, R., Ortiz, J., Anez, L., Paris, M., & L. Davidson. (2006). Culture and clinical practice: Recommendations for working with Puerto Ricans and other Latinas(os) in the United States. *Professional Psychology: Research and Practice, 37*(6), 694-701.
- American Psychological Association. (2008). *APA guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations*. Retrieved on June 23, 2008 from <http://www.apa.org/pi/oema/guide.html>
- Brach, C. & I. Fraserirector. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review, 57*(1), 181-217.
- Cohen, M. (1998). *Culture of intolerance*. New Haven: Yale University Press.
- Comas-Diaz, L. (1988). Mainland Puerto Rican women: A sociocultural approach. *Journal of Community Psychology, 16*(1), 21-31.
- Comas-Diaz, L. (1989). Culturally relevant issues and treatment implications for Hispanics. In D.R. Koslow and E.P Salett (Eds.), *Crossing cultures in mental health* (pp. 31-48). Washington, DC: SIETAR International.
- Constantine, M. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*(1), 1-16.
- Cross, T. L., Bazron, B.J., Dennis, K.W. & M. R. Isaacs. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who Are severely emotionally disturbed*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.
- D'Ardenne, P. & A. Mahtani. (1989). *Transcultural counseling in action*. London: Sage.
- Devos, T., & M. Banaji. (2005). "American = white?" *Journal of Personality and Social Psychology, 88*(3), 447-466.
- Dyche, L., & L. Zayas. (2001). Cross-cultural empathy and training the contemporary psychotherapist. *Clinical Social Work Journal, 29*(3), 245-258.
- Falicov, C. (1998). *Latino families in therapy: A guide to multicultural practice*. New York: Guilford Press.
- Gonzalez, R., Biever, J., & G. Gardner. (1994). The multicultural perspective in therapy: A social constructionist approach. *Psychotherapy, 31*(3), 515-524.

- Irving, A., & T. Young. (2004). 'Perpetual liminality': Re-readings of subjectivity and diversity in clinical social work classrooms. *Smith College Studies in Social Work*, 74(2), 213-227.
- Keenan, E.K. (2004). From sociocultural categories to socially located relations: Using critical theory in social work practice. *Families in Society: The Journal of Contemporary Social Services*, 85(4), 539-548.
- Laird, J. (1998). Theorizing culture: Narrative ideas and practice principles. In McGoldrick, M. (Ed.), *Revisoning Family Therapy*, (pp. 20-36). New York: Guilford.
- Landrine, H., Klonoff, E., & A. Brown-Collins. (1992). Cultural diversity and methodology in feminist psychology: Critique, proposal, empirical example. *Psychology of Women Quarterly*, 16,145-163.
- La Roche, M. (1999). Culture, transference, and countertransference among Latinos. *Psychotherapy*, 36(4), 389-397.
- La Roche, M. (2002). Psychotherapeutic considerations in treating Latinos. *Harvard Review of Psychiatry*, 10, 115-122.
- Lee, W., Blando, J., Mizelle, N., & G. Orozco. (2007). *Introduction to multicultural counseling for helping professionals (2nd ed.)*. New York: Routledge.
- McIntosh, P. (1989). White privilege: Unpacking the invisible knapsack. *Peace and Freedom*, July/August.
- Meissner, W.W. (1998). Neutrality, abstinence and the therapeutic alliance. *Journal of the American Psychoanalytic Association*, 46, 1089-1128.
- Miehls, D. (2001). The interface of racial identity development with identity complexity in clinical social work student practitioners. *Clinical Social Work Journal*, 29(3), 229-244.
- Miehls, D., & K. Moffat. (2000). Constructing social work identity based on the reflexive self. *British Journal of Social Work*, 30, 339-348.
- Miller, J., & A.M. Garran. (2008). *Racism in the United States*. Belmont, CA: Thomson Brooks/Cole.
- Moffatt, K., & D. Miehls. (1999). Development of student identity: Evolution from neutrality to subjectivity. *Journal of Teaching in Social Work*, 19(1/2),65-76.
- National Association of Social Workers. (1997). NASW standards for cultural competence in social work practice. Retrieved June 23, 2008, from http://www.socialworkers.org/sections/credentials/cultural_comp.asp

- Ngai, M. (1999). The architecture of race in American immigration law: A reexamination of the immigration act of 1924. *The Journal of American History*, 86(1), 67-92.
- Organista, K., & R. Munoz. (1996). Cognitive behavioral therapy with Latinos. *Cognitive and Behavioral Practice*, 3, 255-270.
- Park, Y. (2005). Culture as deficit: A critical discourse analysis of the concept of culture in contemporary social work discourse. *Journal of Sociology and Social Welfare*, 32(3), 11-33.
- Perez Foster, R. (1998). The clinician's cultural countertransference: The psychodynamics of culturally competent practice. *Clinical Social Work Journal*, 26(3), 253-270.
- Perez Foster, R. (1999). An intersubjective approach to cross-cultural clinical work. *Smith College Studies in Social Work*, 69(2) 269-291.
- Rosaldo, R. (1989). *Culture and truth: The remaking of social analysis*. Boston: Beacon Press.
- Sue, S., & N. Zane. (1987). The role of culture and cultural techniques in psychotherapy. *American Psychologist*, 42(1), 37-45.
- Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist*, 32(8), 616-624.
- Sue, D.W., & S. Sue. (1990). *Counseling the culturally different*. New York: John Wiley & Sons.
- Taylor, B., Gambourg, M., Rivera, M., & D. Laureano (2006). Constructing cultural competence: Perspectives of family therapists working with Latino families. *The American Journal of Family Therapy*, 34, 429-445.
- Weaver, C. (2006). Trust in people among Hispanic Americans. *Journal of Applied Social Psychology*, 36(5) 1160-1172.
- Werkmeister Rozas, L. (2004). On translating ourselves: Understanding dialogue and its role in social work education. *Smith College Studies in Social Work*, 74(2) 229-242.

Appendix A

Recruitment Letter

Dear Potential Research Participant,

My name is Saralyn Masselink, and I am a graduate student at Smith College School for Social Work. I am conducting a research project designed to explore how clinicians put into practice concepts of cultural competency with Latino clients. This study is being conducted for the Master's of Social Work degree at Smith College School for Social Work, and may be used in possible future presentations or publications on the topic.

You have been asked to participate in this study because you have experience working with Latino clients. As a participant, it is understood that you are a licensed clinician (A.P.A., L.M.F.T., L.C.S.W., Ph.D., M.D.) with at least three years experience in your field. In addition, participants should have experience in individual psychotherapy with at least five Latino clients, with whom you have met for more than one session each.

If you choose to participate, I will ask you to sit for a taped interview with me that will last approximately 50-60 minutes. Prior to the interview you will be asked to answer a few demographic questions. The interview itself will consist of semi-structured questions focusing on your experience when working with Latino clients. I will travel to your job site to conduct the interview or will meet you at some other mutually agreed-upon location that is private and convenient for you.

All interviews will be kept confidential, data in this thesis and professional publications or presentations will be presented in the aggregate without reference to identifying information. After the interview, I will refer to our audio-taped conversation by code numbers instead of by your name.

While there will be no financial benefit for taking part in the study, participation will allow you to share your knowledge and experience about cultural competency. Your contributions will provide important information that may be helpful in furthering the knowledge of culturally competent clinical practice within both the professional and educational spheres. You may benefit knowing that you are contributing to a potential taxonomy of techniques that can be adopted by clinicians with less experience in cultural competency. In thinking about the study, you may also envision new techniques in cultural competency that could be implemented in your own practice. Furthermore, you will have the opportunity to put your struggles and successes in culturally competent practice in context with other clinicians' experiences.

THANK YOU FOR YOUR INTEREST IN PARTICIPATING IN THIS STUDY.

**PLEASE CONTACT ME OR ALLOW ME TO CONTACT YOU AT YOUR CONVENIENCE TO
DISCUSS SCHEDULING AN INTERVIEW.**

Saralyn M. Masselink

Appendix B

Informed Letter of Consent

Dear Research Participant,

My name is Saralyn Masselink, and I am a graduate student at Smith College School for Social Work. I am conducting a research project designed to explore how clinicians put into practice concepts of cultural competency with Latino clients. You have been asked to participate in this study because you have experience working with Latino clients. This study is being conducted for the Master's of Social Work degree at Smith College School for Social Work, and may be used in possible future presentation or publication on the topic.

As a participant, it is understood that you are a licensed clinician (APA, LMFT, LPC, LCSW, PhD, MD) with at least three years experience in your field. You should also have experience as a licensed clinician working in individual therapy with at least five Latino clients, with whom you have met for more than one session each. If you choose to participate, I will ask you to sit for a taped interview with me that will last approximately 50-60 minutes. Prior to the interview you will be asked to answer a few demographic questions. The interview itself will consist of semi-structured questions focusing on your experience when working with Latino clients. I will travel to your job site to conduct the interview or will meet you at some other mutually agreed-upon location that is private and convenient for you.

Participation in this study may trigger feelings related to your cultural experiences as a clinician. Please utilize therapeutic resources available to you, if you should want to process experiences that come up in the interview.

While there will be no financial benefit for taking part in the study, participation will allow you to share your knowledge and experience about cultural competency. Your contributions will provide important information that may be helpful in furthering the knowledge of culturally competent clinical practice within both the professional and educational spheres. You may benefit knowing that you are contributing to a potential taxonomy of techniques that can be adopted by clinicians with less experience in cultural competency. In thinking about the study, you may envision new techniques in cultural competency that could be implemented in your own practice. Furthermore, you will have the opportunity to put your struggles and successes in culturally competent practice in context with other clinicians' experiences.

Your confidentiality will be protected in a number of ways. The demographic questionnaire and the audiotape of the interview will be assigned a number for identification. You will not be asked to identify your name while the tape is running, and you are asked not to include any identifying information in any examples of case material you may use. Some illustrative quotes will be used in the thesis, but will be reported

without identifying information and disguised if necessary. I will be the primary handler of all data including tapes and any transcripts created. My research advisor will have access to the data collected during the interview including any transcripts or summaries created only after it is coded and will assist in the analysis of the data. In addition, any person assisting in transcription will be required to sign a confidentiality agreement. I will keep the demographic questionnaires, tapes, transcripts, and other data in a locked and secure environment for three years following the completion of the research, consistent with Federal regulations. After that time, all material will be kept secured or destroyed.

As a voluntary participant, you have the right to withdraw from the study at any time – before, during, or after the interview. You have the right to refuse to answer any of the questions in the interview. Should you withdraw, all materials pertaining to your participation in the study will be immediately destroyed. You may withdraw from the study up to two weeks after the date of your interview.

You may contact the Chair of the Human Subjects Review Committee at Smith College School for Social Work with any questions or comments at (413) 585-7974.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION; 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.

Signature of Participant

Date

Signature of Researcher

Date

Thank you for participating in this study. If you have any questions or would like to withdraw from the study, please contact:

Saralyn M. Masselink

Appendix C

Interview Guide

1. When did you first hear term cultural competency? Is it new?
 - a. If you have heard it before, how and in what context? What was your understanding of the definition of cultural competency at that time?
 - b. How do you now define cultural competency?
2. How do you identify culturally?
 - a. How do you think your own cultural identity informs practice with Latino clients?
 - b. Can you tell me about moments when you were aware of cultural differences/similarities?
3. How do you feel about the broad strokes linking together “Latino culture,” knowing that there are many differences within this group? Are there similarities among Latino clients that are recognizable?
 - a. What are these similarities?
 - b. Do you ask your Latino clients about:
 - i. Migration stories? Why/why not?
 - ii. Issues of acculturation/biculturalism? What do they look like?
 - iii. Gender roles/family structure?
 - iv. Indirect styles of communication?
 - v. Socioeconomic status?
4. Do you speak Spanish?
 - a. Do you think it is possible to be culturally competent in Latino culture without speaking Spanish?
 - b. How do you minimize language barriers?
5. Are there particular challenges/successes that you have experienced in your strivings to be a culturally competent clinician?
 - a. Can you talk about one case that you recognized cultural factors at work and you think was handled well? What made this case successful?
 - b. Can you talk about one case that you wish you would have handled differently? What did you learn from this experience?
6. What is a reliable source of cultural competency?
 - a. Relationships with Latino folks outside of practice? Books? Consciousness of current political events? Making mistakes and learning from them in practice?

7. Is cultural competency a skill that can be taught?
 - a. How might you teach cultural competency?
 - b. What are the most important qualities in a culturally competent clinician with Latino clients?
8. Are there any questions that I should have asked you or that you had expected me to ask that I didn't?
9. Do you know of anyone else who may be interested or willing to participate in the study?

Appendix D
Demographic Questionnaire

Date of Interview:

Gender:

How do you identify culturally?

Licensure:

How long have you practiced with this Licensure?

Please state briefly the nature of your clinical work with Latino clients since licensure:
(i.e. inpatient, outpatient, with certain diagnosis/sxs, age groups, etc.)

Appendix E

Human Subjects Review Committee Approval

January 15, 2008

Saralyn Masselink

Dear Saralyn,

Your revised materials have been reviewed and all is now in order. We are glad to give final approval to your project.

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 study.

Sincerely,

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

CC: Holly Simons, Research Advisor