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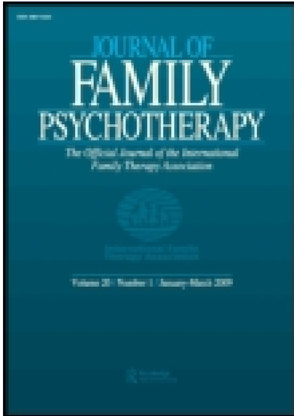

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Managing Worldview Influences: Self-Awareness and Self-Supervision in a Cross-Cultural Therapeutic Relationship

H. Luis Vargas [a] & Colwick M. Wilson [b]

[a] Marital and Family Therapy Program, California School of Professional Psychology, Alliant International University, San Diego, California, USA

[b] Department of Counseling and Family Sciences, Loma Linda University, Loma Linda, California, USA

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Managing Worldview Influences: Self-Awareness and Self-Supervision in a Cross-Cultural Therapeutic Relationship

H. LUIS VARGAS
Marital and Family Therapy Program, California School of Professional Psychology, Alliant International University, San Diego, California, USA

COLWICK M. WILSON
Department of Counseling and Family Sciences, Loma Linda University, Loma Linda, California, USA

Using qualitative research methods, a culturally diverse group of 22 graduated master's level marriage and family therapist interns were interviewed about their approach to relationship-building with a cross-cultural client. Interviews were conducted in southern California. Results indicate that participants rely on heightened efforts of self-supervision to manage the influences of their culturally informed beliefs and preconceptions of cross-cultural clients. Also, the findings suggest that self-supervision efforts are so pervasive that contextual variables contributing to psychosocial differences between therapist and client are relegated to secondary concerns. Implications for building therapeutic relationships and self-supervision processes are discussed.

KEYWORDS *therapist bias, cross-cultural relationships, cultural bias*

In the last 3 decades, mental health professionals in the United States have attempted to respond to the needs of an increasingly diverse population (Collins & Pieterse, 2007). As a result, cultural competency has emerged as a key theme in the literature on training mental health counselors (Sheu & Lent, 2007) and cultural competency models have been developed to

Address correspondence to H. Luis Vargas, Marital and Family Therapy Program, California School of Professional Psychology, Alliant International University, 10455 Pomerado Road, San Diego, CA 92131, USA. E-mail: lvargas@alliant.edu

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help students work more effectively with people from different ethnic backgrounds (Arredondo, Tovar-Blank, & Parham, 2008). Outside the United States, shifting demographic trends have intensified the need for mental health practitioners to be adequately prepared for clinical work with growing immigrant populations. For example, between 15% and 30% of the total population of northwest Europe (and English-speaking countries) is expected to be of first- or second-generation origin by mid-century, in some cases, similar to the projected proportion in the United States, suggesting increased diversity is a near-universal phenomenon in Western and Eastern Europe as well (Coleman, 2009). Beyond the United States and Europe, countries located on nearly every other continent are developing counseling services to meet their unique mental health needs (Hohenshil, 2010). To build on the strengths and resources of a diverse clientele, mental health workers must be sensitive to the unique experiences, beliefs, norms, values, traditions, customs, and language of each individual, regardless of racial, ethnic, or cultural background (U.S. Department of Health & Human Services, 2003). However, there are unique challenges that are associated with efforts to consider and integrate differences within and across cultures in mental health treatment. One significant challenge for multicultural training research lies in ascertaining effective ways to bridge what therapist trainees learn with counseling behaviors that promise a positive difference for culturally diverse clients (Sheu & Lent, 2007).

DeRicco and Sciarra (2005) suggest that an individual's willingness to expand his or her current network of relationships and to openly investigate his or her belief system will reduce the potential for bias. However, the degree to which therapist's culture influences his or her perceptions in the cross-cultural clinical context remains unclear. Although recent approaches have focused on increasing awareness (e.g., Collins & Pieterse, 2007), it is unclear how this is demonstrated in practice settings. Focusing on improving therapist responsiveness to diverse populations, we examine how master's level marriage and family therapist (MFT) interns manage the influence of culturally informed patterns and beliefs in the context of a cross-cultural clinical relationship. Strauss and Corbin's (1998) grounded theory approach was selected to analyze data about participants' efforts to build cross-cultural clinical relationships.

Self-awareness is an important first step in the process building effective cross-cultural relationships. Self-awareness is being cognizant of one's culturally informed attitudes, beliefs, and values regarding race/ethnicity and culture, along with an awareness of the sociopolitical relevance of cultural privilege, discrimination, and oppression (Constantine, Hage, Kindaichi, & Bryant, 2007). There is a growing awareness that therapists' culturally informed patterns may influence their conceptualizations of clients, thereby affecting their perspectives of therapy structure and process and their choice and effectiveness of specific techniques with cross-cultural clients (Arnold,

1993; Nolte, 2007). Constantine and Ladany (2000) also argue that self-awareness seems to be a critical factor in helping trainees and counselors to better understand how their cultural influences may affect their relationships and work with various types of clients. Specifically, cultural self-awareness is important for MFTs, particularly because people generally evaluate other cultures but rarely evaluate their own (Guanipa, 2003). It is also essential to competently and democratically work with clients and colleagues (McDowell, 2004). Although the task of establishing an effective therapeutic relationship applies to the entire helping spectrum, working with clients who differ from the therapist by race/ethnicity, culture, and sexual orientation poses special challenges (Sue et al., 2007). Therapists' self-efficacy could fluctuate significantly based on the racial or ethnic group memberships of their clients (Constantine, 2001).

Therapist bias might partially account for low utilization of mental health services and premature termination of therapy sessions by clients from different racial/ethnic and cultural backgrounds (U.S. Department of Health & Human Services, 2001). McDowell (2004) suggests that students often feel relationally unsettled when challenged to become more socially aware by inspecting issues of racial oppression and privilege. Arredondo et al. (2008) posit that issues such as multiple heritage populations, religion/spirituality, and global immigration are but a few of the challenges that culturally competent therapists face. Also, counseling training will need to broaden the competency lens further to shift from an increased xenophobia in the United States, for example, and confront personal and professional resistance. Although the helping professions have attempted to combat overt forms of counselor and institutional bias, the counseling profession has been less successful in addressing insidious forms of racism that influence the worldviews of well-intentioned helping professionals (Sue et al., 2008).

The process of therapy is systemically underscored in the cross-cultural therapeutic relationship. Clearly, the therapeutic relationship is central to the experience of both therapist and client in the general process of therapy (Flaskas, 2007). Nevertheless, Diaz-Lazaro and Cohen (2001) found that research on the development of multicultural counseling competencies neglected the relevance of cross-cultural contact altogether. Most often, therapist self-awareness in training programs tends to be overshadowed by focusing on learning about cross-cultural clients (Richardson & Molinaro, 1996) and cultural differences from the client (Paynter & Estrada, 2009). Historically, cross-cultural trainings described the experiences and cultural characteristics of specific racial or ethnic groups and offered suggestions on how to work clinically with clients from different groups (Andres-Hyman, Ortiz, Anez, Paris, & Davidson, 2006). It is this linear culture-specific approach that continues to provide the most common method to cross-cultural or multicultural training (Boyd-Franklin & Bry, 2000; Guanipa, 2003)

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and supervision (Paynter & Estrada, 2009). Dyche and Zayas (2001) posit that the culture specific approach "skirts the realm of affective connection and interpersonal relatedness" (p. 247).

Despite the importance of therapists' awareness of their own racial attitudes and beliefs, examination of the relationship between therapists' awareness of their own racial attitudes and beliefs and decision making in psychotherapy has received limited empirical attention (Burkard & Knox, 2004). Coleman (2009) moves a step further to suggest that the mental health profession has paid little attention to the effect of cultural or contextual factors on the counseling process or the mental health professional's competence.

Although little attention has been paid to the effectiveness of multicultural issues among mental health practitioners, much less empirical work has emerged that seeks to explore these; moreover, the value of multicultural training in producing culturally competent graduates is unclear (Cates, Schaefle, Smaby, Maddux, & LeBeauf, 2007). This article seeks to examine the efforts of master's level MFT interns at building cross-cultural relationships.

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METHODOLOGY

Grounded Theory

The basic idea of grounded theory is to read (and reread) a textual database and "discover" variables (called categories, concepts, and properties) and the interrelationships of the categories (Strauss & Corbin, 1998). The quality of a theory can be evaluated by examining the process of its construction and by using categories drawn from respondents themselves. The focus is on making implicit belief systems explicit through this analytical approach.

Participants

Twenty-two graduated master's level MFT interns (20 women, 2 men; 13 European Americans/White, 1 biracial, 3 Hispanic American, 5 Asian Americans) participated in this study. European American and Asian American participants ranged in age from 26 to 60, the Hispanic Americans ranged in age from 32 to 42, and the biracial therapist was 43 years old. The European American therapists possessed Master of Arts degrees (n = 11), Master of Science degrees (n = 2); Asian American participants held Master of Arts degrees (n = 4), Master of Science degree (n = 1); Hispanic Americans held Master of Arts degrees (n = 3); the biracial intern possessed a Master of Arts degree (n = 1).

In terms of training, all of the participants had taken one or more courses in multicultural counseling. That is, 50% reported having taken one course, 20% had taken two courses, and 28% had three or more courses. A

little more than half of the respondents attended professional workshops on multicultural training. All participants reported discussing cultural issues with their clinical supervisor and engaging in face-to-face cross-cultural counseling. However, details relative to the cultural issues discussed in supervision were not obtained. Sixteen described 50 or fewer hours of contact with a cross-cultural client, one respondent stated 100 or fewer hours of contact, two indicated 300 or more hours of contact, and three respondents reported 700 or more hours of contact.

Interviewer

A Hispanic American male interviewer conducted the audiotaped interviews. The interviewer endorsed a broad conceptualization of cross-cultural, including contextual variables such as ethnicity, culture, gender, age, religion, and socioeconomic status. The interviewer had taken one course with a primary focus on multiculturalism and attended no professional workshops or seminars on multiculturalism. Regarding supervision, the interviewer only had experiences with supervisors representing a different race and culture from his own.

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PROCEDURES FOR COLLECTING DATA

Recruitment

A snowball sampling technique was used to obtain participants. Colleagues known to the primary author (n = 4) were initially contacted and asked to identify as many people as possible, including themselves, who fit the inclusion criteria: MA and MS graduates with degrees in MFT who were actively engaged in the practice of marital and family therapy and registered with the California Board of Behavioral Sciences for no more than 6 years. Those who met the criteria (n = 33) were contacted by telephone or e-mail and invited to participate in the study. Once consent was obtained, participants were provided with the following case vignette:

> Rosy initially called the clinic, located in a predominantly Asian community, for help with marital problems. She had been in treatment previously at another clinic, where she received individual therapy. She terminated treatment when the therapist urged her to leave her husband, Ken. Clinical records from this therapist indicated that Ken was an alcoholic who became violent and angry when drunk. He was also reported to be extremely jealous and to restrict most of Rosy's social movement.

The case vignette was deliberately vague relative to the cultural description of the client as to elicit participant's perceptions of cross-cultural difference. The vignette was used as a springboard for discussion about participant's efforts at building a cross-cultural relationship.

Interview Protocol

The semistructured interview guide elicited participants' descriptions of their values, biases, and preconceptions of cross-cultural relationships and how they managed their assumptions in clinical practice. In the first section of the interview, broad questions were used to access therapists' definitions of terms such as multiculturalism and cross-cultural. With the vignette as the platform, participants responded to open-ended questions about (a) perceptions of their efforts at building rapport, (b) cultural self-awareness, (c) implications of cultural biases in therapy, and (d) their approach to managing the influence of culturally informed patterns and values on case conceptualization. Additional probes were asked depending on participants' responses to explore what they do differently in their work with cross-cultural clients, including how they proceed to understand the client's worldview without negative judgments.

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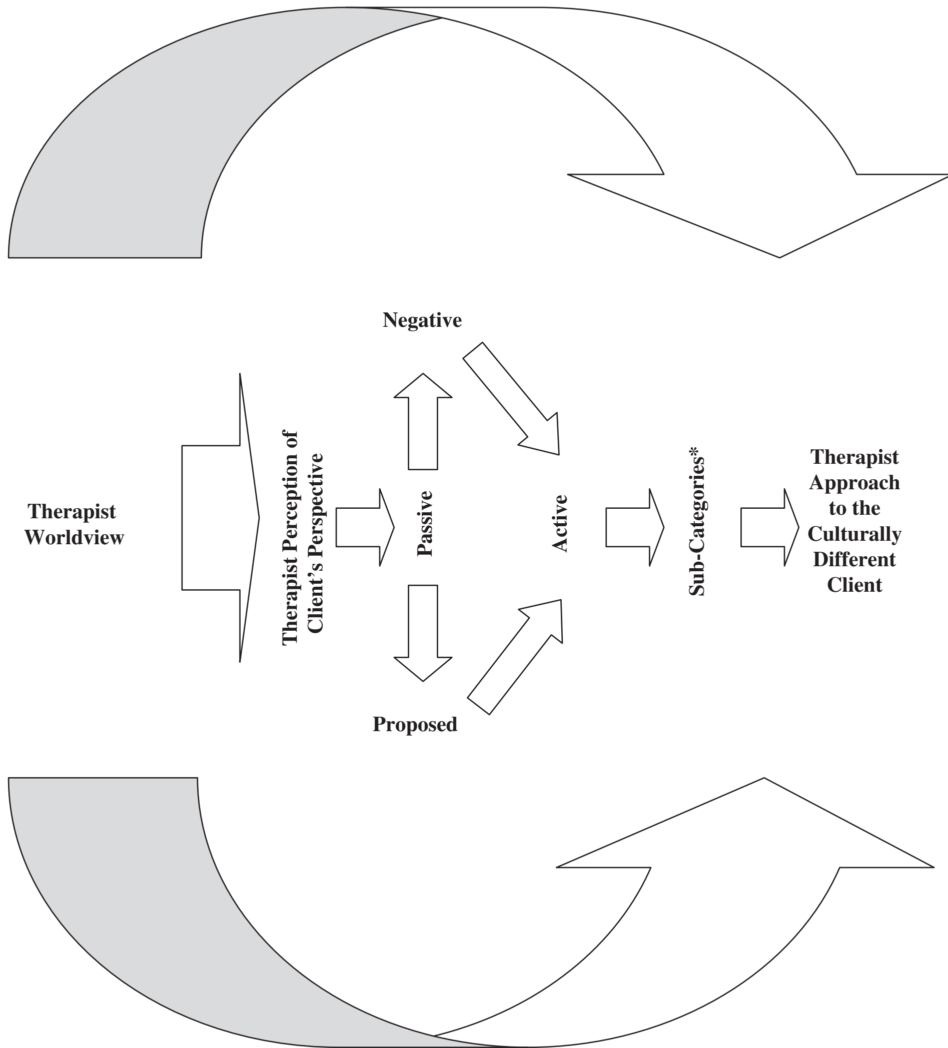
DATA ANALYSIS

Coding of Data

The analysis began with line-by-line "open coding" (Strauss & Corbin, 1998). The interviews were analyzed for distinctions in tenses, judgments, or values-based statements and positive or negative descriptions of actions, thoughts, or concepts. These distinctions were used to heighten theoretical sensitivity and to distinguish and classify data. This process assisted in organizing participants' perceptions and actions as determined by the properties and dimensions of each specific description placed on a time continuum. After this process was completed, the researcher employed "axial coding," which allowed the relating of categories to their subcategories, thereby linking categories together (Strauss & Corbin, 1998). In this case, based on the qualifier used, the actions were grouped under the appropriate primary categories specific to the reference of time, judgment, or quality of action description. The categories and subcategories were then linked with each other (see Figure 1). In linking the primary categories related to time, judgment, and positive or negative description of actions, an interrelated framework emerged that suggests each category influences and is influenced by the other.

RESULTS

Four primary categories emerged from the analysis: passive, active, proposed, and negative interaction domains. The following five subcategories were also developed: self-supervision, client-to-therapist directed cultural education, therapist-to-client directed cultural education, therapist cultural self-education, and empathy.



*Sub-categories include: (A) Self-Supervision, (B) Client-to-Therapist Directed Cultural Education, (C) Therapist-to-Client Directed Cultural Education, (D) Therapist Self-Education, and (E) Empathy

FIGURE 1 Roles of Interaction Domains in Approach to the Cross-Cultural Client

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Passive Interactions

The term passive is used to describe references to expectations, conventions, policies, and regulations specific to relationships. For example, typical responses falling in this domain include references such as "have to," "need to," and "I think." As a stand alone the phrase, "I think(.)" may indicate an active response; however, when "think" is placed as a prerequisite, or as part of a sequence of events, it becomes passive. For example, "I think it is

important to be impartial," versus "I think" as a stand alone action descriptor. For instance, the question was raised, "What is required of you to connect to the couple in the vignette?" A 41-year-old Chinese female intern respond, "I think like when you give the vignette like Rosie and Ken, the marital situation, my cultural value about marriage, things like that, would easily interfere with what I do . . . I think my cultural biases could easily kind of seep through, like my values about like what a marriage should be can easily seep in too . . ."

The respondent highlights the importance of being alert to the influences of cultural bias and assumptions that potentially circumvent her ability to effectively connect to the cross-cultural client. Interview questions about what is required of the participants to mediate their reconceptions of cross-cultural clients consistently yielded responses such as, "You really have to get in there and understand each person's point of view," and "We have to say 'educate me.'"

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Active Interactions

The absence of an action qualifier marked an active interaction. The term action qualifier refers to provisions in language that conditionally position an action. This study suggests that data describing a course of action in absence of a stipulation to that action represent what the participants may actually do in the moment. That is, when therapists expressed a plan of action that did not include a prerequisite or prequalifier to the effort, they were coded as active interactions. For example, "I teach" is distinct from the other interactions where the participants add an action qualifier that places an action in a relationship to time or a negative description that describes what the person does or would not do. For example, "I might teach," places an action on a continuum of time, and "I don't teach" suggests a negative description.

In the following interview passage, a 41-year-old Mexican male intern underscores the importance of increased efforts at active listening with the cross-cultural client:

> I learned this . . . just get to know them, tell me a little more about your culture and ask the family, so tell me your story, how you got to this country. They'll sit down for a good hour. All therapy has gone out the door. You're still doing therapy because you're building rapport, but you're not doing anything, you're just listening now.

This respondent highlights an important point of how therapists are often times actively engaged in heightened efforts to manage their biases and assumptions in the cross-cultural relationship.

Proposed Interactions

This interaction domain reflects proposals for future action. That is, proposed interactions are rendered by participants as predictions or potentials for future action. For example, "I would do X" suggest an action that is positioned to take place in the future.

In the following interview extract a 26-year-old White female intern addresses how she considers cultural influences on case conceptualization, "I would want to understand the different rules that they have in marriage, what is acceptable in their culture and not? I would still want to be sensitive to their cultural issues, but I would want them to know that as a therapist my number one goal is to make sure that you are both safe . . . I would want to learn from them what their desires are for marriage, you know, how that's influenced by their culture."

In the proposed domain it appears that a heightened emphasis is placed on efforts to understand the cultural context of the client with a view of providing confidence in the clinical relationship.

Negative Interactions

Descriptions of interactions with "can't," "don't," or "should not" were coded as negative action qualifiers. Negative descriptions reflect what participants suggest they do not do in their work with cross-cultural clients. For instance, a 39-year-old White woman highlights what she does not do to avoid her cultural influences on the client:

> . . . not to impose upon any of my clients any of my beliefs, my beliefs are my beliefs. They are not anybody else's beliefs and I don't feel that any of my clients need to be exposed to them—my own beliefs from my own culture, I don't want that to be getting in the way of me being able to help any of my clients . . . I try not to have any assumptions about what they're coming in for. I don't even like to know the problem they are coming in with until I see them . . .

In this example particular attention is paid to the importance of refraining from drawing assumptions.

SUBCATEGORIES

Each of the following subcategories that emerged in this study was found throughout each of the core interaction domains. That is, each subcategory could be found in any of the four domains identified. For example, although the phrase "I would have to work through my own issues" was linked to

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the proposed interaction domain, a subset of words from that phrase—work through my own issues—suggest that the therapist is monitoring what is going on inside of her during therapy. Thus, the client is engaging in proposed self-supervision, which is identified as a subcategory. Examples of combinations of primary and subcategories include active empathy, passive client-to-therapist directed cultural education, and proposed self-education. Hence the subcategories further define and distinguish how interns related with clients of difference in this study.

Self-Supervision

This subcategory is identified in participant responses that indicate the practice of and/or underscore the participants' positions relative to therapist self-monitoring. Self-supervision includes mindfulness; awareness, attentiveness to assumptions; sensitivity; and attention to potential sources of bias, judgments, and discomfort. Some responses in the self-supervision subcategory also fell in the proposed range. For instance, ". . . would think about how the session went." There were also active interactions that also embodied self-supervision. That is, a White woman with 400 hr of experiences in practice with multicultural clients states: ". . . step outside myself," and adds ". . . being open to them and their customs." Finally, an example of negative self-supervision; "I can't impose my values and my differences upon the client."

Client-to-Therapist Directed Cultural Education

Responses in this subcategory were marked by participants' actions and/or expressed need to learn from clients about their respective cultural backgrounds. A typical response, "Teach me about your values and culture" suggests that the therapist place the client in an expert position. In this expert role, the client is expected to teach the therapist about his or her worldview, cultural background, and beliefs.

Therapist-to-Client Directed Cultural Education

As opposed to the former subcategory (client-to-therapist directed cultural education), this subcategory encompasses therapist-to-client directed interactions where the interns assume a role as cultural educator and ". . . teach the client about our culture, our way."

Therapist Self-Education

This subcategory is made prominent by participants' responses indicating that some course of action is taken to suggest self-education is occurring

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or desired. Examples include, self-teaching on client culture through case consultation with a peer who has lived or learned experience related to the client. Typical responses included "visiting culture specific literature," "attending workshops," or "consulting with my clinical supervisor."

Empathy

The empathy subcategory is identified by data that indicate that the participant engages in a process meant to place the notion of "self" aside to facilitate entering the client's experience. Other typical responses in this subcategory include the following: A 30-year-old White female participant reports believing, "You have to take a step back and say not everyone believes the same thing," while a similarly aged White female participant proposes, ". . . would work within their context." A 42-year-old Mexican woman exclaims, "I don't bring myself into therapy."

Others indicate they actively engage empathy by connecting to the clients' lived experience. For example, one White female respondent reports, "I put myself in the picture with them," and a biracial Japanese/Mexican 43-year-old woman suggests she actively encourages clients to ". . . validate each of their experiences." These creative efforts at empathy suggest therapists often feel challenged in their attempts to get past their respective biases.

DISCUSSION

This study explored the perceptions of MFT interns' efforts to build a cross-cultural clinical relationship. The findings indicate that therapists engaged cross-cultural clients on at least four broad interaction domains: passive, active, negative, and proposed interactions. Consistently, across all four interaction domains, participants engaged themselves in self-supervision, soliciting client-to-therapist directed cultural education, conferring therapist-to-client directed cultural education, and pursuing a course of cultural self-education.

Although passive interactions may influence actions at an active level, this study suggests that passive posturing acts primarily as a conduit for practice that occurs at an implicit level. That is, passive interactions may reflect what the participants feel or think are important and required of them to be effective in a manner consistent with their preconceptions of client needs. Passive interactions may also reflect subjectively grounded philosophical positions consistent with a prior conceptual framework. Thus, the passive structure serves to possibly underscore the principles operating at an implicit level. That is, passive interactions may be reflective of participants' positions secondary to their respective conceptual framework and are used

potentially to guide interactions at an implicit level. The passive interaction domain possibly supports the "lens" through which participants view and interact with clients of difference.

This study suggests that active interactions are descriptive of what therapists actually do in practice as determined by what the participants stated they do with added confidence and directness. Within the active domain, there appeared to be increased efforts at listening, questioning, and heightened efforts of mindfulness. Yet, it appears that the participants were challenged more by parking their bias than the actual bias. As such, extra attention was paid to the importance of refraining from drawing assumptions. Although it may be argued that proposed interactions possibly reflect what therapists do at an active level, proposed interactions primarily reflect predictions or potentials for active level use in the future.

The negative interaction domain appears to support the importance of listening for the client's unique experience and drawing less from therapist's personal assumptions. Hence, this study suggests that negative interactions reflect the participants' efforts at establishing boundaries to maintain a position of relative cultural competence. In this case, the negative interactions suggest generally what "*not* to do."

Taken together, this study posits that the primary interactions and the subcategories subsumed may reflect a framework consistent with participants' personal worldview. This subjective framework may be used by therapists as a default system for practice. That is, the results suggest that interaction-based data reflect what the therapists perceive they need to do, are actually doing, and indicate they would do and can't do in their efforts to build a relationship with the cross-cultural client that are in line with and grounded in their worldview. Thus, the participants' worldview is composed of the therapist's lived experiences, which may be the engine that supports a therapist's interaction in a cross-cultural relationship. Hence, worldview has a powerful effect on how therapists perceive cross-cultural clients. Although the role of worldview is well established, the impact of worldview on practice is less recognized.

This study suggests that worldview superimposes and overwrites extraneous influences. In each of the four primary interaction domains participants highlighted the importance of being alert to the influences of cultural bias and assumptions that potentially circumvent the ability to effectively connect to the cross-cultural client. In addition, the interaction domains underscore an important point of how therapists are oftentimes actively engaged in heightened efforts to manage their biases and assumptions in the cross-cultural relationship.

The participants' creative efforts at empathy suggest therapists often feel challenged in their attempts to get past their respective biases. Therapists wanting to integrate academic knowledge with cues taken from their cross-cultural clients find themselves in a position that demands that they apply

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themselves in atypical ways, often in ways that challenge their worldview. This dissonance between worldview and incoming messages from cross-cultural clients impacts the way that therapists structure therapeutic approaches. For example, it appears that through therapists' attempts at "suspending self," "dying to self," and otherwise getting beyond one's own ethnocentrisms, participants of this study seemed to mostly avoid actively engaging their cross-cultural clients because of their felt need to be unbiased. Empathy necessitates a surrender of self-involvement and one's own preferences (Dyche & Zayas, 2001). Yet one must question whether cross-cultural clients feel empathy and understanding from therapists who remain passively in their own heads during therapy. Findings imply this process has important implications for empathic practices in cross-cultural clinical relationships. This is especially pertinent given that Dyche and Zayas (2001) state that cultural empathy has been defined as a general skill or attitude that bridges the cultural divide between therapist and client. They add that cultural empathy seeks to help therapists integrate an attitude of openness with the necessary knowledge and skill to work successfully across cultures.

According to Richardson and Molinaro (1996), culturally competent therapy tends to be impeded by the deleterious effects of ethnocentrism and cultural encapsulation. This study goes one step further to suggest that therapists in cross-cultural therapeutic relationships may find themselves in a relational bind. This bind is marked by the conflicts associated with efforts to engage in an empathic relationship in the cross-cultural context. Hence, in addition to the effects of ethnocentrism, the efforts to suspend self impede the therapist from effectively building a therapeutic relationship. That is, therapists' efforts at managing the influences of their worldview to build the foundation for a successful therapeutic encounter in terms of rapport building and empathy may be the very process that contributes to potentially blocking the pathway to a connection with their clients. For example, a positive therapeutic relationship may be impeded by the therapist's efforts at "suspending self," which keep the therapists "in their heads" and potentially experiencing the client from a distance (Lindblad-Goldberg, Dore, & Stern, 1998). These authors suggest that the "in the head" responses may include the therapist being captured by the seriousness of their role as therapist or educator; emotionally detached from their own affective reactivity; preoccupied with figuring the best move; and overdependent on intellectualization, thereby resulting in limited creative energy for empathic connection.

Although there is literature that suggests self-awareness is the first step toward developing cultural competence (i.e., Richardson & Molinaro, 1996), it appears that interns may lack whatever necessary skills may be required to possibly fend off the influences of their worldview. Together, it seems therapists of this study are in a bind that is impeding practice, and this bind may be internally located. Respect for the client, genuineness, and empathic understanding are products of a cultural context, and they will need to

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be interpreted differently in each complex and dynamic cultural situation, even for whom these goals are primary (Pedersen, 1996). It appears that therapists may often find themselves in a cross-cultural bind that not only encumbers displays of empathy in the therapeutic relationship but may also impede therapists' ability to apply technique to therapeutic endeavors in later stages of treatment. Hence, the challenge for participants of this study was more in managing the influences of their worldview than the differences in the client. Specifically, therapists appeared to be biased by a number of factors as demonstrated in their work with clients from a different cultural context. This biased orientation persists even when therapists know and acknowledge its existence and try to work against it influencing their work in a cross-cultural clinical context.

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Implications for MFT Clinical Practice

Findings suggest that marital and family therapy training may need to be modified to further examine training therapists' efforts at being mindful in the context of the therapeutic encounter. For example, practicum programs may place an increased focus on developing self-supervision skills, as well as further exploration into the influences of their worldviews and how their perceptions influence practice. Practicing therapist may also benefit from being aware of their biases prior to engaging in clinical work with a cross-cultural client. Probably more importantly, therapists should consider biases that persist as they work with clients and the impact of their efforts to reduce or eliminate elements of their worldview on the therapeutic process in the aforementioned context.

Despite its contributions, this investigation has a number of limitations. First, even though the sample reflects two geographically diverse settings in southern California, the majority of the participants were White and female. Also, this study obtained a nonprobability sample through a snowball sampling technique. As such, the participants in this study who referred other participants, likely suggested people similar to themselves. It is possible that the interns who declined to participate may not have been confident or even lacked interest in their cultural competencies. Future studies should include a more diverse sample to allow for an examination of potential differences across racial and ethnic groups and among different mental health providers.

Second, this study relied on participants' perceptions but could have been enhanced by actual observations of therapists working with cross-cultural clients. This may allow for more precise information about the relational processes occurring between the interactions domains identified in this study. Additionally, future studies might use a quantitative methodology to examine to what extent interns and/or clinicians may hold cultural biases and what efforts are made in therapy to eliminate these biases when working with a cross-cultural client.

CONCLUSION

It appears that therapists' perceptions of their approach to cross-cultural clients are secondary to how they respond to and approach the influences of their worldview. Therapists are possibly more often than not at an impasse between their worldview and perceived cultural differences rather than at a gridlock with their clients of difference. In other words, therapists may be challenged by the observable influences of a cross-cultural client, yet they may be more at odds with their own perceptions than with real cultural differences. Hence the cross-cultural client is the lesser influential force operating in the therapeutic relationship. However, therapists often attempt to employ creative efforts at managing the influences of their framework. The research presented offers clinicians a compelling opportunity to advance their understanding of the role of self-as-therapist in the cross-cultural therapeutic relationship. An emphasis on self-as-therapist and its influences on the therapeutic relationship is recommended in the context of continuing education as well as during the practicum training experience.

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