Chapter 2

Multicultural Issues in the Treatment of Survivors of Torture and Refugee Trauma: Toward an Interactive Model – Summary

This chapter explores the complexities of interacting with survivors of torture and refugee trauma across (and within) cultures. There is an emphasis on the professionals being open to engaging in the necessary work of self-exploration regarding their own cultural reference group identities. The chapter explores the mediating factors that help to determine how someone makes sense of their multiple cultural identities, and provides an interactive model of communication that facilitates the exploration of these issues. The importance of self-definition is addressed, not just in the context of culture, but across domains of psychological functioning.

* Introduction
    - Historical progress in multicultural understanding, but more progress needed
    - Not a "cookbook technique"
    - Not a simple study of "cultural others" – a focus on the interactive relationship

* Complex cultural beings
    - Multiple reference group identities
    - Salience of identities

* Assumptions of similarity

* Cultural values - Table 1: Existential cultural categories: Range and variation

* Mediating factors

* Interactive model - Figure 1: Interactive cycle in cross-cultural relationships

* The power to define

* Self-knowledge as clinicians and service providers

Multicultural Issues in the Treatment of Survivors of Torture and Refugee Trauma: Toward an Interactive Model

Hawthorne E. Smith, Ph.D.

Introduction

The field of psychology has come a long way in terms of multicultural perspectives to treatment, but there is still significant progress to be made. Psychology has moved past the era when beliefs in racial superiority/inferiority were widely held, and when people of color and individuals coming from non-Western societies were seen as being too unsophisticated to benefit from treatment (i.e. Evarts, 1913; Hall, 1904; Lind, 1913, cited in Carter, 1995).

The discipline of psychology has also largely moved beyond the era of espousing "cultural deprivation," where populations that did not conform to White/Western European standards of culture were stigmatized as being culturally deprived or deficient (Helms, 1990). Now we are in the era of "cultural difference," where differences in culture and approaches to mental health are not seen as being pathological, and culturally informed treatment is seen as a clinical necessity. Helping clients to develop a deeper understanding of their cultural identities can help them to navigate our increasingly diverse society (Carter & Goodwin, 1994; Elsass, 1997).

The necessity for culturally informed treatment is especially important for those of us working with refugee populations. By definition, we are working with individuals who have been uprooted from their homelands and normative cultures. Frequently, issues of identity and cultural difference may

be among the reasons that people have been persecuted and/or forced to flee their homelands (Elsass, 1997).

Refugees are moving across national borders and cultural boundaries under significant duress. They may be confronted with acculturation stressors such as linguistic barriers, alienation, prejudice, xenophobia and discrimination in their new environment (Pope & Garcia-Peltoniemi, 1991; Randall & Lutz, 1991; Silove, Tarn, Bowles, & Reid,1991; Stanton, 1985). We are challenged as caregivers to cross emotional, cultural, and social divides so that our clients may be better equipped to navigate the plethora of divides and challenges they are facing.

The notion of cultural difference is an important advance in thinking that helps caregivers to conceptualize treatment, but there are some common misconceptions that are important to avoid. The cultural difference paradigm (and multicultural psychology in general) is not meant to be seen as a "cookbook technique." It cannot be assumed that a person's identity will mirror the values attributed to his/her particular cultural group (Berry, 1990; Cross, 1994). A key theme in this chapter is that knowing how individuals construct their cultural identities is more important than simply knowing to which cultural reference groups they belong. Focusing on the client's perceptions of the importance of their cultural background helps clinicians to overcome "risks in exaggerating or underemphasizing the cultural dimensions in psychological treatment" (Silove et al., 1991, p. 489).

Another misconception frequently held about multicultural psychology is that it is a simple study of "cultural others." Many clinicians may undervalue or deny the importance that their own cultural background holds in terms of how they conceptualize and engage in treatment (Carter, 1995; Gurris, 2001). A clinician may see a client's behavior in terms of the

existing models of pathology within the clinician's population, leading to potential misdiagnoses and misunderstandings (Lansen & Haans, 2004). Frequently, psychology trainees and graduate students may expect that it will be sufficient to simply review cultural traits of different cultural groups they will contact in the course of their work. However, if training materials and academic curricula continue to place the onus on the "other," this actually falls back into the pattern of the cultural deprivation arguments, where the major scrutiny and the burden of change (adaptation) remain with disempowered groups.

Complex Cultural Beings

As clinicians we are not cultural blank slates dealing with some "other" who is "culturally different." We are engaged in a relationship between two people who are different from one another. Students and trainees are sometimes surprised (pleasantly or otherwise) to learn that working across (and within) cultures requires significant reflection on themselves as cultural beings (Pinderhughes, 1989).

We are all complex cultural beings with multiple reference group identities. Examples of cultural reference group identities are race, ethnicity, social class, religion (or lack thereof), gender, age, level of education, sexual orientation, urban v. rural, physical (dis)ability, linguistic group…just to name a few. All human beings possess these identities, although the salience attached to the identities (whether personal or societal) may vary widely.

Many survivors of torture and refugee trauma have been persecuted because they belong to, or are labeled as belonging to particular groups. For example, knowing the race or social class of a refugee from the genocide in

Rwanda may not be as salient as knowing about their ethnicity, since they are coming from a situation where being labeled a Hutu or Tutsi could mean the difference between life and death. Knowing the social class or race of someone who has lived through the "troubles" in Northern Ireland is probably not as salient as knowing their religious affiliation, because being Catholic or Protestant is often what defines a person's experience of that struggle.

Frequently the identities that are salient for the clinician are different from what is salient for the client. If the clinician is not aware of his or her own biases and assumptions, gross miscommunications can ensue. The following is a personal example from a training session conducted for new Customs and Immigration Services (formerly the Immigration and Naturalization Service) asylum officers.

As I began to speak about multicultural issues to the group of 50 asylum officer-trainees, I noticed that there were two White men who were probably in their mid-to late fifties sitting toward the back of the room. These men seemed somewhat disengaged from what I had to say from almost the beginning of my talk. My personal experience as a Black American has been that race is the most salient issue in terms of cultural identity and social interactions. I defensively assumed that perhaps these White men thought that they "could not learn anything from a Black man," and that is why they seemed to be tuning me out.

Fortunately, I had the time to talk with these men after my presentation. I asked them frankly about their apparent disinterest, and they answered me in an equally honest manner. One man stated that he had a "healthy skepticism" of psychology and psychologists, and figured I'd just be talking some "P.C. stuff" with little real world application. The other man

spoke about my age. He stated that when he saw how relatively young I was that he figured he'd "been working longer than I'd been breathing." The three of us had a lively conversation and learned a lot from each other.

I give this example because I had completely misread what was going on for these two men because of the assumptions I brought into the room. I had assumed that race was the salient issue when actually they were more concerned with my professional affiliation and age. By becoming consciously aware of my assumptions, and exploring them with the people with whom I was interacting, I was able to help foster freer communication and deeper understanding between us. This example illustrates the point made about clinicians knowing what is "going on in their chair" in order to know what is going on in the room (Pinderhughes, 1989).

Clinicians need to develop a deeper understanding of themselves as cultural beings in order to engage effectively with diverse client populations. This self-understanding helps to deepen awareness about the nature of objectivity and subjectivity in therapeutic interactions. This includes, but is not limited to, psychological assessment and the attribution of symbolism and status to specific verbalizations and behaviors. This deeper understanding is called for not only in situations where clinicians assume there will be cultural difference, but also in cases where clinicians assume that there is cultural similarity between themselves and the client.

Assumptions of Similarity

Another potential misperception regarding multicultural psychology is that it is only applicable when the client and clinician come from different cultural reference groups. A narrow focus on "difference" may lead

clinicians to a false sense of security when they are in a room with someone who appears to be culturally similar. Remember that it is more important to know what sense someone makes of their reference group identities than just knowing to what groups they belong. Assumptions of similarity can lead to collusions in silence, where clinician and client mistakenly assume they understand one another. Assumptions of similarity can be just as harmful to a therapeutic relationship as misreading cultural differences (Carter, 1995; Helms, 1990).

Clinicians should recognize that it is not always advisable to assign refugees to clinicians from their home country or culture. I have conducted trainings with resettlement agencies where they related stories about refugees from Russia and Haiti who were quite upset to be assigned clinicians from their respective homelands. The Russian refugees expressed anxiety about possibly having their personal affairs exposed, and being stigmatized, within the tight-knit Russian community. They also expressed fear of not really knowing "who was who," and any potential repercussions that might befall them if they spoke openly about their experiences. One of the first Haitian clients assigned at this particular agency was a mixed-race "métisse" who had strong opinions regarding racial issues. This client viewed his Black Haitian clinician as a less qualified "affirmative action" clinician, and requested an assumedly more qualified, White American therapist.

I worked for several years as a therapist in a high school for students with emotional difficulties on Manhattan's Lower East Side. I know that students from the same racial, ethnic and socio-economic backgrounds viewed me in diverse ways, even when I shared their racial and ethnic affiliations. I've had young Black American males express admiration and

respect for the fact that I had attained my doctorate and was "making it" in the world. Some even spoke of wanting to achieve similar goals. There were other young Black males who viewed me as a sell-out, an "Oreo," or an "incog-negro" because I was wearing a suit and tie and playing "the White man's game." Just because a young Black American man is assigned to a Black American male therapist does not mean that they will understand their reference group identities, or the world, in similar manners.

In addition to obstructing an accurate understanding of the client's worldview, assumptions of similarity may also feed into a clinician's idealized sense of the client, and fuel a type of pre-emptive counter-transference that can impede the growth of the therapeutic relationship (Eisenman, Bergner, & Cohen, 2000).

A clinician may also be surprised to find that the client views them in ways that are antithetical to how they view themselves. For example, I was once assigned the case of an escaped slave from Niger. As I am descended from slaves on both sides of my family, I took a particular interest in this case and expected that there would be a natural affinity between us.

During our first session the client from Niger spoke of a general distrust and fear of White people based on his life's experiences. He then shared that due to my relatively light skin tone, I would be much more likely to be a slave owner than a slave in his country. He perceived me as a White person even though I've been categorized and have identified myself as Black all of my life. The client and I worked through our perceptions, and I provided some information on the way race has been constructed here in the US. Our therapeutic relationship became a long and successful one, in part because we were able to address our perceptions and assumptions early in the treatment.

Cultural Values

Thus far this chapter has emphasized that it is more important to know what sense someone makes of their reference group identities than just to know what groups they belong to. Having discussed the complex nature of cultural reference groups, notions of cultural difference, the perceived salience of group membership, and assumptions of similarity, it is useful to acknowledge the existence of some broad cultural categories that are widely recognized in the psychological literature.

It is informative to consider how these cultural frameworks impact upon the development of an individual's stereotypes regarding other groups, as well as an individual's view of their own group. Judicious use of these broad cultural categories, and the ways cultural norms and expectations may impact therapy, give us a backdrop to help assess what meaning people make of their reference group identities, and what psychological stressors they may be facing as the cultural norms shift due to their flight from oppression.

These broad conceptions of cultural values are important in terms of context. What are the norms and expectations of a particular culture? Is there congruence and/or conflict between an individual's worldview and the worldview of the culture to which they once belonged? What changes in worldview are necessary to adapt to one's new cultural milieu? When people from different backgrounds engage one another how is it navigated? Whose values are dominant or valued in the therapeutic context?

There are many theorists who have addressed the notion of cultural values. Among them, Kluckhohn and Strodtbeck (1961) constructed a continuum of attitudes based on a society's views of human nature (good,

bad, or mixed); time orientation (whether they focus on the past, present, or future); relations with nature (mastery over nature, harmony with nature, or submission to nature); human relationships (linear, collateral, or individualistic); and activity orientation (focus on being and existence, focus on spiritual growth and "being in becoming," or focus on achievement and doing). The graph in Table 1 illustrates their framework.

Table 1. Existential Cultural Categories: Range and Variations

Human Nature	**Human Relationships**	**People and Nature**	**Time Orientation**	**Activity Orientation**
Bad	Linear-Hierarchical	Subjugation and Control	Past	Being
Good and Bad	Collateral-Mutual	Harmony	Present	Being in Becoming
Good	Individualistic	Power of Nature	Future	Doing

Note. From "Cultural value differences between African Americans and White Americans," by R.T. Carter, 1990, *Journal of College Student Development, 31,* p.71-79. Copyright 1990 by Journal of College Student Development. Adapted with permission.

White American and Western European cultural norms have been described by cultural theorists (i.e. Lind, 1995; Stewart & Bennet, 1991) as believing that human nature is evil or mixed as demonstrated by the notion

of original sin and the need for confession and/or atonement to reach paradise. Mastery over nature is sought and valued and the focus on time is geared toward the present and future. Value is placed on doing and achieving and the individual is seen as the preeminent social unit. There is a focus on personal preference and a general need to conform to social rules. The Judeo-Christian belief system is revered, and the aesthetic norms tend to be European. It should be noted that this is the cultural base from which psychology and psychotherapy have arisen (Frederickson, 1988).

Black or African cultural norms are described as focusing on collateral relations such as strong kinship bonds, extended family [blood and non-blood] and flexible family roles. The time orientation has been described as based in the present for Black Americans (i.e. Carter, 1995) and based in the past for many Africans who closely follow traditions and respect and revere their ancestors (Akinsulure-Smith, Smith, & Van-Harte, 1997; Akukwe, Smith, & Wokocha, 2000). This cultural group is seen as valuing harmony with nature and seeing human nature as mixed. There may be stigma associated with going to an "outsider" to discuss personal matters.

Native American cultures are widely described as valuing harmony with nature. The activity orientation is described as being in becoming, as there is a search for self-growth and development through one's activities. There is generally an optimistic view of human nature, and familial and social ties are paramount. Time is viewed as being cyclical and rhythmic, and there is great social importance attached to generosity and sharing (Atteneave, 1982).

The pan-Asian population is made up of many distinct cultural groups. There are several religions and philosophies within this group, but there are some significant points of cultural overlap such as linear-

hierarchical social roles, deference to authority, and emotional restraint. The extended family and fulfilling obligations to one's parents are viewed as being important (Lee, 1997; Sue & Sue, 1990). It has been our experience in the Program for Survivors of Torture that many Southeast Asian clients may experience emotional pain as physical pain. They may experience emotional symptoms in such a way that a stomach ache may be a manifestation of some sort of emotional distress (Du & Lu, 1997). In order to get a sense of how an Asian client makes sense of his/her culture it is necessary to explore their level of acculturation. More will be said about acculturation attitudes later.

The Latino/Hispanic cultural group is geographically and racially diverse. Cultural values are influenced by socio-economic status and acculturation attitudes. Some areas of consistency among and between diverse Latin cultures are a sense of fatalism, the importance of dignity and respect, and social affiliation/collaboration. The time focus is based in the present, there is generally deference to authority, and gender roles tend to be pronounced. Clinicians may encounter Latinos who may understand psychological phenomena in terms of external spiritual forces (Dillard, 1983; Pinderhughes, 1989).

As previously mentioned, these general frameworks provide only a limited context for understanding one's cultural background. Similar frameworks are found in the literature based on other cultural groupings (e.g. religious affiliation, gender, sexual orientation, etc.). In fact, clinicians working with client populations similar to ours may begin to think of their clients, regardless of their cultural background, as part of a relatively homogeneous group of "traumatized refugees" or "torture survivors," rather than maintaining a broader perspective of them as distinct individuals who

are responding to severe life stressors. Such diagnostic classifications, like the cultural groupings just discussed, may have some illustrative power, but may also have limiting effects on the accurate assessment and treatment of an individual (Briere, 2001; Pope & Garcia-Peltoniemi, 1991).

Therefore, it cannot be assumed that a member of one of these cultural groups will adhere to the general worldview put forth by their culture. We observe frequently that refugee groups are not homogeneous, and there may be factionalism among particular refugee groups (Silove et al., 1991). These cultural frameworks should not serve as a "cookbook" by which we categorize people into predetermined groups; rather, they may be utilized as contexts by which we see how people identify and understand cultural issues, within and between groups.

A woman once came to our program from an Islamic nation where the roles of women were strictly circumscribed in terms of docility, home-making, and deference to men. Assuming that this woman respected these cultural norms would have led to a gross misunderstanding of her, and her life situation. In fact, she had been forced to flee her native land because of her life-long agitation against these gender roles that she viewed as repressive.

Clinicians must go beyond surface understandings of cultural archetypes. In this arena, clinicians may take on a "learning posture," by which they may work with the client to explore mediating factors that may influence their self-perceptions and perceptions of their cultural groups (Gurris, 2001, p. 41).

Mediating Factors

For a refugee, forced to adapt to a foreign culture, a primary mediating factor affecting their psychological adjustment and perceptions of self may be their acculturation attitudes. Theorists have described four types of acculturation attitudes (i.e. Berry, 1990; Berry & Kim, 1988). There are: "separation" attitudes when an immigrant clings tightly to their original culture and rejects the new culture; "assimilation" attitudes when an immigrant adopts the new culture and rejects their original culture; "integration" attitudes when an immigrant synthesizes the two cultures; and "marginalization" attitudes when immigrant feel "betwixt and between," and uncomfortable in both the original and new cultural contexts

The role and history of one's cultural group, and whether that group is perceived by the immigrant as being valued or devalued within the new society, impact upon one's acculturation attitudes (Ogbu, 1986; Pinderhughes, 1989). The perceived hierarchies of power and opportunity affect how one views their cultural group and self. This seems to be particularly salient for refugee populations, in which many have been victimized because of their cultural group memberships.

The conditions under which immigrants arrive influence their views of their new country. Scholars describe "push" and "pull" factors of immigration. Many immigrants are "pulled" to their new land by the lure of positive things such as educational or professional opportunities. In contrast, the refugee populations we serve at the Bellevue program are better described as having been "pushed" out of their homelands. Since they are not in their new country by choice, the way they perceive their situation

psychologically may be drastically different than other types of immigrants who have chosen to be here (Berry, 1990; Stanton, 1985).

Other mediating factors that affect how one understands cultural group membership are cultural links and the strength of the communities that sustain them. It may be harder to navigate the divide between cultures for refugees who arrive to relatively small or weak communities, particularly if their culture is vastly dissimilar to, and is devalued by, the host culture (Ogbu, 1986). Greater social distance between the original and host culture is reported to create greater acculturation stress (Randall & Lutz, 1991).

The profound psychological effects of trauma - especially man-made, purposeful trauma- can become a vital factor in how a person views themselves and the world (Elsass, 1997; Herman, 1992; Smith, 2003). In fact, the trauma can begin to seem like its own reference group identity, more salient than race, ethnicity, religion, etc. Some may see being a torture survivor, rape survivor, and/or refugee as the only group membership that really matters.

Helping clients to place their traumatic experiences in a context where these experiences are no longer all that defines them is often an important aspect of treatment. Hopefully clients will come to see themselves as survivors as opposed to victims. This is one manifestation of helping the client to reclaim the "power to define," which is important in trauma work and in multicultural psychology in general.

Interactive Model

Individuals make assumptions about other people based on their reference group identities and appearances. People do this in everyday life when they make seemingly mundane decisions like whom to ask for directions or where to sit on a bus or subway. Although supporters of the notion of "political correctness" might argue that clinicians should not entertain such assumptions, others would argue that these assumptions are a normal part of the human thought process that needs to be acknowledged and examined (Carter, 1995).

An example of the subtle pervasiveness of such assumptions comes from my experiences teaching a graduate course, where students are asked to assess the race, ethnicity, religion, and social class of other students in their class without the benefit of speaking to them. The students generally balk at this initially, making the argument that they cannot make such assumptions without further verbal verification. As students share their classifications, and subsequently explain how they came to formulate their assumptions about their fellow students, they are surprised at the amount of "data" they have generated to make superficial judgments based on "first impressions." Another striking realization the students often verbalize is that making assumptions and judging people are, in fact, part of their everyday behavior.

One of the key concepts of this article describes a situation in which two people who are culturally different from one another engage in an interpersonal interaction. This complex type of dynamic interaction is captured in the Interactive Cycle of Cross-Cultural Relations (see Figure 1). This diagram illustrates how knowledge of one's self as a cultural being is a

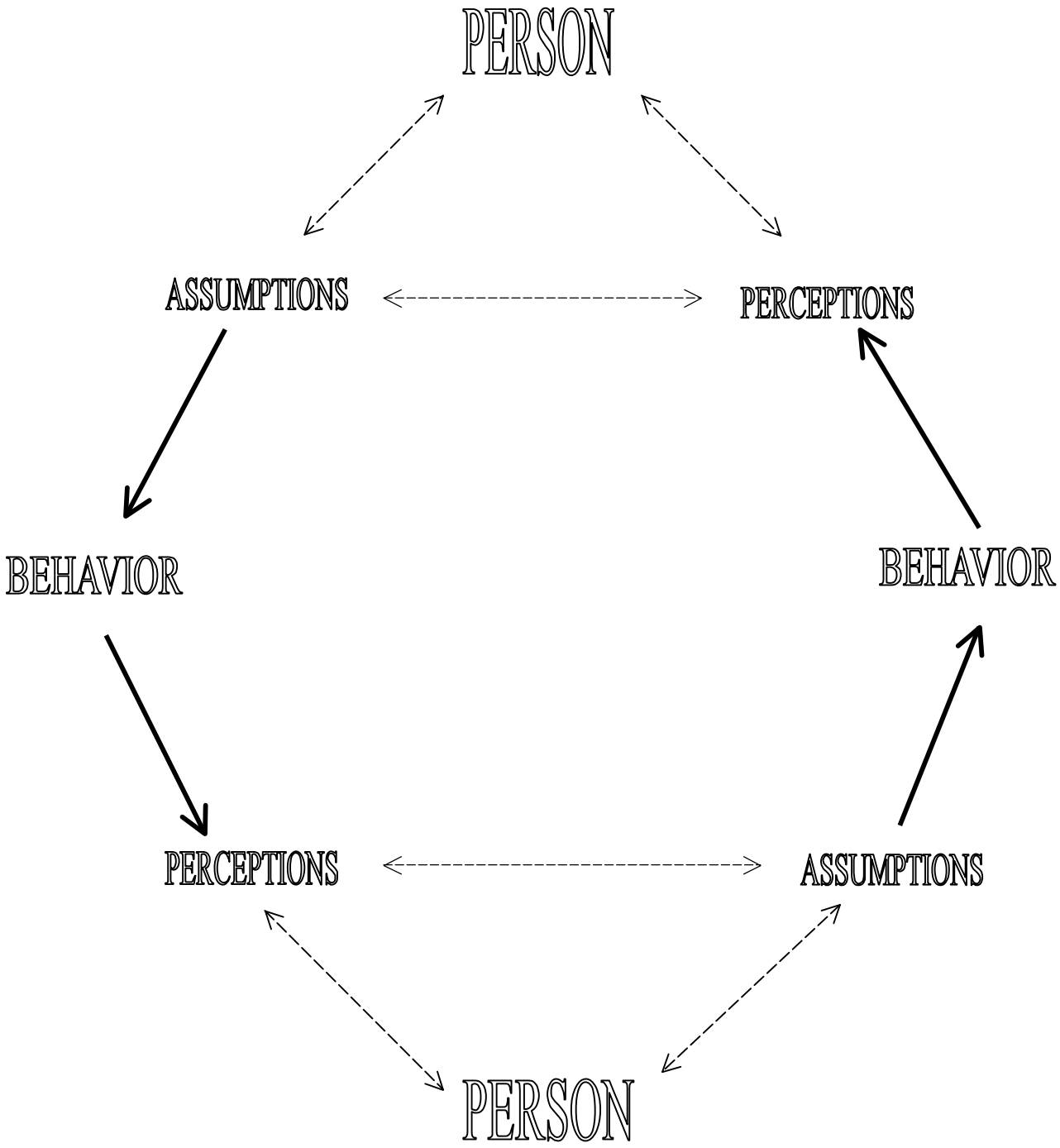
prerequisite for truly understanding what is going on within a therapeutic dyad.

Figure 1 shows that assumptions exist for the clinician and the client. The clinician's assumptions are affected by perceptions and previous experiences he/she may have had with people viewed as being similar to the client. The dashed lines in the diagram show how a person's perceptions affect their assumptions, and how their assumptions influence their subsequent perceptions. These subjective, intra-psychic notions are powerful for any person involved in an interpersonal exchange.

Figure 1 also illustrates that a clinician's assumptions will affect their observable behavior, which feeds into how the clinician is perceived by the client. The client's perceptions of the clinician are also affected by his or her assumptions. Just like the clinician, the client's assumptions and perceptions interact and influence one another. Consequently, the client's assumptions will affect their behavioral responses, which are perceived in turn by the clinician. This feeds back to the clinician's assumptions, perceptions, and behaviors, as the interactive cycle continues.

There is potentially rich clinical data available in such complex interactions, but a clinician will not be able to fully understand what is happening in the session or "in the room" unless he/she is able to understand what is going on in "his/her chair." Once again, multicultural psychology is not a simple study of the "other;" it is a dynamic interaction between complex cultural beings in a therapeutic context (Pinderhughes, 1989).

Figure 1. Interactive Cycle in Cross-Cultural Relationships



The Power to Define

The power to define one's self in terms of cultural identity is an essential aspect of multicultural treatment. It can be an important tool for clients to define themselves in other areas of psychological functioning, such as educational goals and behaviors, substance abuse, career choices, etc.

Self-definition may also pertain to perceptions of the conflict that the survivor has fled. Members of the host culture may misunderstand, or over-simplify the context in which torture took place and label these conflicts as "tribal warfare" or a manifestation of "age-old hatreds," as opposed to the complex socio-political circumstances that produce such violence (Berkeley, 2001; Weine & Laub, 1995). In contrast, it's generally the survivor who has a much more informed and nuanced understanding of the realities of the conflict situation from which they've fled. Empowering the client to express their contextual/political understanding can also help them to better comprehend the events that have impacted upon their lives, and the role that healing may play in the larger continuum as they endeavor to construct a future for themselves.

As such, aiding the client to develop understanding of their own reference group identities, within the context of the external messages that society sends, can help to empower the client to actively engage in the process of self-definition. When a client actively participates in the construction of meaning regarding their cultural identities, it can help them to navigate society more effectively (Elsass, 1997). The active construction of meaning can be a powerful tool for a traumatized refugee who is struggling to find their way in a new society, while preserving and treasuring their own cultural identity (Gurris, 2001).

An example of this pattern was an African adolescent client who was adjusting to life and school here in New York City. This young person was receiving a lot of pressure from local gang members to join the "Bloods" and engage in criminal behavior. In addition to threats, this client was frequently told that he was "selling out," not "keeping it real," or trying to "act like a White boy."

In session, we spent a lot of time exploring the client's views on what "Blackness" meant, and how life was different in his homeland. We talked about the history of the African Diaspora (the dispersal of African people through slavery and other population movements), and the wide variety of cultural and historical roles that Black people have played. After a few sessions, the client mentioned that he'd heard that there were probably a billion Black people in the world. He stated that, "If there are a billion Black people in the world, there must be a billion ways to be Black." The client began to internalize the power to define for himself what "Blackness" meant, and was eventually able to successfully resist the external pressures that were being placed upon him.

As refugees try to make sense of their situation, and struggle to keep a positive sense of self, it may be a helpful intervention to explore what foundation a person bases their self-opinion on. Clients have spoken eloquently about making a distinction between personal character and personal circumstances. Acknowledgement that one's current situation need not define one's value as a human being can be empowering for refugees who are enduring educational and professional devaluation. Considerations of what refugees have endured and overcome may help to deepen their insights about their current situation, and help them to persist in pursuing

their dreams and life aspirations. This can help a refugee to defend against externally defined negative evaluations of themselves.

Our refugee clients are also helped to understand and navigate situations when their personal identity is contradicted by the identity that society places on them. Many of the cultural groupings and labels change from country to country. For example, they may find themselves defined by racial group in the US, when ethnic identities were more salient in their country. Most racial or cultural divisions are man-made and man-interpreted, as opposed to being true biological/chemical differences, so there may be significant variance from place to place.

I give a personal example of when I led an educational trip for American high school students to South Africa. When I got on the plane at J.F.K. in New York I was seen as a Black man. When I arrived in South Africa I was no longer considered Black; I was now "Coloured." Only people belonging to one of the 11 indigenous groups in South Africa who have no other types of blood are considered to be Black. This is directly opposed to the "one drop" conceptualization in the US, where any Black ancestry means that a person will be categorized as Black (Asante, 1990; Cross, 1994). Having my race "magically" change during my flight helped me to appreciate the arbitrary nature of racial and cultural groupings. I realize, however, that these haphazard categorizations have real meaning in terms of understanding and navigating one's society.

Self-knowledge as Clinicians and Service Providers

As a way of summarizing the issues already covered and suggesting methods for clinicians to improve their multicultural skills, I would

emphasize the following: We are all complex racial/cultural beings with multiple reference group identities. As clinicians and service providers, we bring our strengths, cultural baggage, and preconceptions into the room with us. As illustrated in the interactive model (see Figure 1), these assumptions and preconceptions will have direct impact on our therapeutic exchanges with a client.

It is not incumbent upon the treating clinician to give up his or her own cultural or professional identity in order to engage with a client form another cultural background. Quite the opposite is true. Lansen & Haans (2004) write: "There is no reason to discard our Western concepts of diagnosis and treatment, provided we are able to translate the inner world and history of the patient into our concepts, and, in return, our concepts into their universe of thinking" (p. 326).

It is imperative, however, that clinicians and trainees move beyond their own resistance and engage in the hard but necessary work of self-exploration, in order to understand better "what is going on in their own chair." This will help to facilitate deeper understanding of the therapeutic relationship and will help to open up viable areas for exploration with the client (Gurris, 2001; Pinderhughes, 1989). Multicultural psychology is not just a study of the cultural other. We must recognize ourselves as cultural beings in order to navigate the complex therapeutic relationships we engage in with our increasingly diverse client populations.

References

Akinsulure-Smith, A., Smith, H., & Van Harte, E. (1997). *Psychotherapy with Africans in America.* Symposium conducted at Perspectives on Black Psychology: Past, Present, and Future, Pace University, New York City.

Akukwe, C., Smith, H., & Wokocha, E. (2000). Enhancing the Well-being of African Refugees. In S. Berhane (Ed.), *Proceedings from the conference "African Refugees and the US response: Twenty years of resettlement"* (pp. 67-74). Arlington, VA: Ethiopian Community Development Council/African Resource Network.

Asante, M. K. (1990). *Kemet, Afrocentricity and knowledge*. Trenton: Africa World Press, Inc.

Atteneave, C. (1982). American Indian and Alaskan native families: Emigrants in their own homelands. In M. McGoldrick, J.K. Perarce, & J. Giordano (Eds.), *Ethnicity and Family Therapy* (pp. 55-83). New York: Guilford Press.

Berkeley, B. (2001). *The graves are not yet full: Race, tribe, and power in the heart of Africa.* New York: Basic Books.

Berry, J.W. (1990). Psychology of acculturation: Understanding individuals moving between cultures. In R. W. Brislin (Ed.), *Applied cross-cultural psychology* (pp. 232-253). Newbury Park, CA: Sage Publications.

Berry, J.W., & Kim, U. (1988). Acculturation and mental health. In P. Dasen, J.W. Berry, & N. Sartorius (Eds.), *Cross-cultural psychology and health: Toward applications* (pp.207-236). London, Sage Publications.

Briere, J. (2001, July). *Evaluation, measurement, and assessment approaches with severely traumatized populations.* Presentation to the Clinical Leadership Conference of the National Consortium of Torture Treatment Centers, Minneapolis, MN.

Carter, R.T. (1990). "Cultural value differences between African Americans and White Americans," *Journal of College Student Development, 31,* 71-79.

Carter, R.T. (1995). *The influence of race and racial identity in psychotherapy: Toward a racially inclusive model.* New York: John Wiley & Sons, Inc.

Carter, R. T., & Goodwin, A. L. (1994). Racial identity and education. *Review of Research in Education, 20*, 291-336.

Cross, W.E. (1994). Nigrescence theory: Historical and explanatory notes. *Journal of Vocational Behavior, 44*, 119-123.

Dillard, J.M. (1983). *Multicultural counseling: Toward ethnic and cultural relevance in human encounters.* Chicago, IL: Nelson-Hall.

Du, N., & Lu, F. (1997). Assessment and treatment of posttraumatic stress disorder among Asian-Americans. In E. Lee (Ed.), *Working with Asian-Americans: A guide for clinicians* (pp. 275- 294). New York: Guilford Press.

Eisenman, D., Bergner, S., & Cohen, I. (2000). An ideal victim: Idealizing trauma victims causes traumatic stress in human rights workers. *Human Rights Review, 1*(3), 106-114.

Elsass, P. (1997). *Treating victims of torture and violence: Theoretical, cross-cultural, and clinical implications*. New York and London: New York University Press.

Evarts, A. B. (1913). Dementia precox in the colored race. *Psychoanalytic Review, 1,* 388-403.

Fredrickson, G. M. (1988). *The arrogance of race: Historical perspectives on slavery, racism, and social inequality.* Middletown: Wesleyan University Press.

Gurris, N. (2001). Psychic trauma through torture – Healing through psychotherapy? In S. Graesner & N. Gurris (Eds*.), Standing at the Side of Torture Survivors: Treating a terrible assault on human dignity* (pp. 29-56). Baltimore, MD: Johns Hopkins University Press.

Hall, G.S. (1904). *Adolescence*. New York: Appleton.

Helms, J.E. (1990). Introduction: Review of racial identity terminology. In J.E. Helms (Ed.), *Black and White racial identity: Theory, research, and practice* (pp. 3-8). New York: Greenwood Press.

Herman, J.L. (1992). *Trauma and recovery: The aftermath of violence – From domestic abuse to political terror.* New York: Basic Books.

Kluckholm, F.R., & Strodtbeck, F.L. (1961). *Variations in value orientations*. New York: Harper and Row.

Lansen, J., & Haans, T. (2004). Clinical supervision for trauma therapists. In J.P. Wilson & B. Drozdek (Eds.), *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims* (pp. 317-353). New York: Brunner-Routledge.

Lee, E. (1997). *Working with Asian-Americans: A guide for clinicians*. New York: Guilford Press.

Lind, M. (1995). *The next American nation: The new nationalism and the fourth American revolution.* New York: The Free Press.

Ogbu, J. (1986). The Consequences of the American caste system. In U. Neisser (Ed.), *The School Achievement of minority children: New*

perspectives (pp. 19-56). Hillsdale, NJ and London: Lawrence Erlbaum Associates, Publishers.

Pinderhughes, E. (1989). *Understanding race, ethnicity, and power: The key to efficacy in clinical practice.* New York: The Free Press.

Pope, K., & Garcia-Peltoniemi, R. (1991). Responding to victims of torture: Clinical issues, professional responsibilities, and useful resources. *Professional Psychology: Research and Practice, 22*(4)*,* 269-276.

Randall, G., & Lutz, E. (1991). *Serving survivors of torture.* Washington, DC: Association for the Advancement of Science.

Silove, D., Tarn, R., Bowles, R., & Reid, J. (1991). Psychosocial needs of torture survivors. *Australian and New Zealand Journal of Psychiatry, 25,* 481-490.

Smith, H. (2003). Despair, resilience, and the meaning of family: Group therapy with French-speaking survivors of torture from Africa. In R. Carter & B. Wallace (Eds.), *Understanding and dealing with violence: Multicultural Perspectives* (pp. 291-319). Thousand Oaks, CA: Sage Press, Inc.

Stanton, J.L. (1985). Adolescents, families, and cultural transition: A treatment model. In M.P. Mirkin & S. Koman (Eds.), *Handbook of Adolescent and Family Therapy* (pp. 363-381). New York: Gardner Press.

Stewart, E.C., & Bennet, M.J. (1991). *American cultural patterns: A cross-cultural perspective*. Yarmouth, ME: Intercultural Press.

Sue, D.W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice*. New York: Wiley.

Weine, S., & Laub, D. (1995). Narrative constructions of historical realities in testimony with Bosnian survivors of "ethnic cleansing." *Psychiatry, 58*(8), 246-260.