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CULTURAL COMPETENCE AND PSYCHOTHERAPY: APPLYING ANTHROPOLOGICALLY INFORMED CONCEPTIONS OF CULTURE

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Abstract

The authors apply two contemporary notions of culture to advance the conceptual basis of cultural competence in psychotherapy: Kleinman's (1995) definition of culture as what is at stake in local, social worlds, and Mattingly and Lawlor's (2001) concept of shared narratives between practitioners and patients. The authors examine these cultural constructs within a clinical case of an immigrant family caring for a young boy with an autism-spectrum disorder. Their analysis suggests that the socially based model of culture and the concept of shared narratives have the potential to broaden and enrich the definition of cultural competence beyond its current emphasis on the presumed cultural differences of specific racial and ethnic minority groups.

Keywords

culture; psychotherapy; cultural competence; narratives; autism

Mental health services have historically not been responsive to the mental health needs of racial and ethnic minority groups in the United States (U.S. Department of Health & Human Services, 2001). Minority group members with diagnosable disorders are less likely than majority group members to use mental health services (e.g., Barrio et al., 2003) and to receive quality mental health care (e.g., Melfi, Croghan, Hanna, & Robinson, 2000). As one effort to address these noted disparities, numerous clinical scholars and researchers have argued that mental health systems and practitioners need to integrate a cultural perspective in providing services to these communities (e.g., Hall, 2001). Generally speaking, initiatives aimed at increasing cultural competence take two basic forms. At the institutional level, hiring practitioners who are knowledgeable of the communities they serve and who speak the languages of those communities are examples of ways institutions can move in the direction of cultural competence (Betancourt, Green, Carrillo, Ananeh-Firempong, 2003; Guarnaccia, Vega, & Bonner, 2006). At the clinical level, clinicians are encouraged to integrate cultural matters in their assessments and interventions (e.g., cultural formulation, Lewis-Fernandez & Diaz, 2002).

Despite the acknowledged need for mental health care to incorporate a cultural perspective, there are significant empirical and conceptual limitations to the study of cultural competence. Currently, there is no evidence that clinicians who adhere to a given culturally competent approach provide better mental health care than those clinicians who do not adhere to such an approach. Perhaps the best evidence in support of cultural competence concerns ethnic and linguistic match. Sue and colleagues (1991) indicate that Mexican- and Asian-origin patients in a public mental health system who receive services from clinicians who are ethnically and linguistically matched are likely to drop out less, receive more services, and improve in functioning more than patients who receive services from clinicians who are not ethnically or linguistically matched. Although these data are consistent with the notion that clinicians who provide services in a culturally competent manner will provide better services than those who do not, ethnic and linguistic match is a distal indicator of cultural competence. Such distal indicators do not illuminate the clinical practices and processes through which “cultural competence” takes shape in therapeutic interactions. It is evidence of how clinical praxis is impacted that is needed if cultural competence is to be implemented by systems of mental health care.

There are a number of conceptual models that address cultural competence within the clinical domain (e.g., D. W. Sue and D. Sue, 2003); however, there are key limitations with many of these models. One limitation concerns the definition of culture. The notion that culture equals race and ethnicity, or more specifically, culture equals racial or ethnic minority group is pervasive throughout the cultural competence literature. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) supported the development of guidelines for four underserved and underrepresented racial and ethnic groups in the United States: African Americans, American Indians, Asian Americans, and Latino Americans (Center for Mental Health Services, 2000). The emphasis on minority groups is understandable as the justification for cultural competence is based largely on the existence of disparities in the mental health care of these groups. At the same time, there are drawbacks with equating culture with ethnically or racially defined groups.

One significant disadvantage is that this conception leads to a view that what matters about culture is packaged within distinct ethnic and racial boundaries. There is supposedly an Asian American culture and an American Indian culture, for example, that can be seen as unique and separate from each other. Cultural competence models are largely based on group-specific information of “difference” in terms of cultural content or other characteristics, with the implicit comparison being one of minority group “culture” with the dominant Euro American “culture.” One example of difference found in the cultural competence literature is the characterization of Latinos as being more family-oriented or collectivistic, in contrast to Euro Americans who are viewed as more individualistic. Accordingly, family treatment is perceived as culturally congruent for Latinos. In line with the focus on distinctive groups marked by characteristic differences, providing culturally competent therapy comes to be seen as changing clinical interventions in ways that map onto the presumed cultural difference of the minority group. This is a limited vision of cultural competency. A one-size-fits-all within the group approach is an essentializing view that may inadvertently promote group stereotypes in the guise of cultural sensitivity while failing to address individual needs. Beyond this, treating group membership as a proxy for culture pays insufficient attention to the many ways in which culture enters into people’s daily lives. Here, experience-grounded and process-oriented conceptualizations of culture that do not depend on group membership (see Garro, 2003, 2005a) offer a base for advancing an understanding of cultural competency in clinical contexts.

Shifting Cultural Lenses

To address the limitations with group-oriented content-based models of cultural competence, some clinical writers have proposed process-oriented models (Falicov, 1998; Leong, 1996; Sue, 1998), including models that focus on how clinicians ascribe meaning and integrate such meaning in the clinical encounter rather than what therapists know about specific groups. For example, drawing on Kleinman and Kleinman's (1991) depiction of the ethnographer, López (1997) proposed a process model referred to as Shifting Cultural Lenses. In this model, López (1997) argued that the "essence of cultural competence...is moving between two cultural perspectives, that of the therapist and that of the client." The clinician accesses the client's cultural perspective and then integrates it within the clinician's cultural perspective. For example, a patient may define her presenting problem as not being a "good mother" in caring for her children, whereas the clinician may define her presenting problem as depression. The Shifting Cultural Lenses model argues that the clinician should access and validate the patient's problem definition and incorporate it within the clinician's problem definition. By doing so, the treatment can then focus on helping the patient be a better mother, and perhaps one strategy to accomplish that goal can be to address her depressed mood (through psychopharmacology, psychosocial interventions or both). In defining the problem from the patient's view, the clinician is more likely to succeed in engaging her in treatment and addressing the presenting problem from both vantage points. Thus, the main point of this model is to encourage clinicians to access and incorporate the patient's cultural meanings or models throughout the evaluation and treatment. Note that the integration of perspectives is not based on some presumed cultural difference or factor associated with the client from a specific ethnic or racial group. Instead it focuses on the process of defining the problem from both the therapist's and client's perspective. The model conceives the identification or construction of a presenting problem as a cultural process that must be informed by both parties.

Limitations of Model

Although this processual approach is a conceptual advancement over group-oriented content approaches to cultural competence, it still retains vestiges of the ethnic and racial minority approach in which culture is defined as the set of values, beliefs, and practices associated with specific "cultural groups." For instance, López (1997) focuses on cultural belief systems: "Cultural competence reflects openness on the part of the therapist to adapt one's intervention to the client's cultural belief system" (p. 582). Moreover, he notes that the Shifting Cultural Lenses model was developed for "culturally diverse clients" whom he refers to as "those from U.S. ethnic and racial groups other than the majority group of Euro American backgrounds." (p. 570). Focusing on culture as values, beliefs, and practices of specific minority groups tends to overlook the considerable influence that social worlds have in people's daily lives. Contemporary definitions of culture within anthropology emphasize the local social world (e.g., Kleinman, 1995); culture is seen as much as a part of the social world as it is part of the individual (López & Guarnaccia, 2000).

Another limitation of the Shifting Cultural Lenses model is that there are no conceptual guideposts for the clinician regarding how to integrate both lay and clinical perspectives. Clinicians are encouraged to bring both perspectives to bear on a given case, but it is not clear what the optimal degree of integration is. Recent conceptual and empirical developments in medical anthropology suggest that patients and health practitioners develop narratives or stories regarding the patients' health condition and its treatment. In particular, Mattingly and Lawlor (2001) observed in a pediatric hospital setting that the congruence between both health practitioners' and parents' narratives was related to the success of the clinical interaction. These findings suggest that the optimal degree of integration occurs

when both parties work together to develop a shared narrative. The notion of a shared narrative has the potential to inform models of cultural competence regarding just how to integrate the lay and professional perspectives.

Overall Aim

The main purpose of this paper is to apply two contemporary notions of culture to advance our understanding of cultural competence in psychotherapy. In particular, we draw from Kleinman's (1995) conception of culture as what is at stake in local social worlds and Mattingly and Lawlor's (2001) concept of shared narratives between practitioners and patients. Kleinman's definition of culture has the potential to draw clinical attention to relevant aspects of the social world whereas Mattingly and Lawlor's shared narratives have the potential to operationalize how clinicians can best integrate the lay and professional views. To carry out the overall goal, we present and analyze a clinical case in which the primary author served as the therapist. We examine the degree to which the clinician applied a socially informed definition of culture and developed a shared narrative between her and her patient. It is important to note that we are not going to be pointing out specific cultural factors presumed to be associated with the clients' ethnic or cultural background and how we integrated such cultural factors in the treatment. Instead we are going to focus on the process of meaning making between the two parties, in ways that draw on the social world and that reflect shared narratives. We then discuss the implications of this analysis for the Shifting Cultural Lenses model in particular and cultural competence models of psychotherapy in general.

This project began with a case conference at a clinical psychology internship and postdoctoral program in Southern California. The primary author, a clinical psychology intern at the time, presented this case at a family therapy seminar. She has a strong interest in cultural issues dating back to her childhood during which she and her family lived in Swaziland, Africa, where her father was a minister. She bolstered this personal experience with formal training in cultural issues during her doctoral studies in counseling psychology. The second author, a researcher of cultural issues in clinical processes, served as a "cultural" consultant in the training program and was present at the case conference. He was so impressed with the richness of the case and the manner in which the therapist addressed the complex social and cultural issues, particularly given what appeared to be a large cultural divide between her Euro American roots and that of the immigrant family from El Salvador she was treating. After her presentation, the second author invited the primary author to collaborate on a paper that examined the case from the perspectives of a socially grounded conception of culture. Later, they agreed to include a consideration of shared narratives. To assist them with contemporary conceptions of culture, the two authors then invited the third author, a psychological medical anthropologist with interests in narrative who has studied cultural issues in health contexts across different communities, including indigenous communities in Canada and Mexico. The second and third authors are largely responsible for the conceptual framework and cultural analysis which was informed, in part, by how the therapist carried out her clinical work. The case analysis began toward the end of the therapist's contact with the patient and was carried out largely after termination. Thus, because the analysis is largely retrospective in nature, it influenced very little what the clinician actually did.

Contemporary Conceptions of Culture

Prior to presenting the case, we review Kleinman's socially based conception of culture and Mattingly's conception of shared narratives. Although it is possible to draw parallels between Kleinman's early work on explanatory models of patients and healers (e.g., Kleinman, 1978) and Mattingly's formulation of shared narratives (as well as the Shifting

Cultural Lenses Model), what stands out in recent work by both Kleinman and Mattingly is a clear move to conceptualizing experience in situated contexts (see Kleinman & Seeman, 2000, for reflections on this intellectual trajectory). Unlike psychologists who emphasize the psychological or somatic components of experience, Kleinman argues that experience represents the felt flow of the intersubjective medium or nexus between humans' mind and body and their social world. Furthermore, he posits that for practical purposes this intersubjective medium is what is at stake or what matters in a given local moral world. He concedes that "preservation of life, aspiration, prestige, and the like" is relevant for all; however, it is that which is at stake in peoples' daily lives that is tied closely to culture. He goes on to argue that the central concern for culturally informed scientists (and culturally informed clinicians) then is to identify what is at stake for others given their particular local worlds. Identifying what matters most will help the observer recognize culture's influence in others' behavior or daily life. Culture defined as "what is at stake in local worlds" may not seem all that different from culture defined as values and beliefs. What is different, however, is that "what is at stake" is grounded in the everyday lives of people, not some presumed notion of race, ethnicity, or "cultural" group. Accordingly, attention will focus on how clinicians understand the local social worlds of their clients and integrate this understanding in their clinical activities.

Drawing on the work of Jerome Bruner (1986, 1990) and others, Mattingly (2006) has developed a conceptual approach that could prove useful in helping practitioners negotiate cultural meanings in mental health care settings. In particular, she argues that making sense of others' actions requires placing those actions in the context of an unfolding story. Thus, at the center of her approach is the narrative; to understand the actions of others one must be able to emplot or place those actions in a larger story. According to Mattingly, when clinical encounters are successful it is because the practitioner and client are able to read each other well or create a shared narrative. She refers to these as healing dramas or therapeutic emplotment (Mattingly & Lawlor, 2001). When clinical encounters are unproductive or are unpleasant, significant mistakes are likely made in interpreting the other's behaviors, or, as Mattingly states, mistakes occur in narrative mind reading. Thus a shared narrative between the patient and the clinician is likely to reflect a considered integration of both parties' perspectives.

In both Mattingly's notion of shared narratives and Kleinman's conception of culture, the focus is on processes in which meaning is negotiated. This approach differs from the usual cultural competence approach that focuses on cultural differences or cultural factors of specific groups. We will present how the clinician integrates her understanding of the clients' social world, and how together with her clients she develops a shared understanding of the origins of the presenting problems and their resolution.

The Case of a Family Caring for a Son With a Pervasive Developmental Disorder

Background

Antonio is an 11-year-old boy who was brought in by his parents because they had just learned that he had been sexually abused at school.^{1,2} Initially, they took him to his pediatrician because they "didn't know where else to go." The pediatrician then referred the family to the psychology department at a Children's Hospital. During the initial visit, the parents reported that the dean at the middle school where Antonio is a sixth grader had called to inform them of the incident. Three of Antonio's classmates told the dean that while

¹All names were changed to protect the family's anonymity.

lined up outside the gymnasium waiting for their Physical Education class to begin, four boys began to tease and taunt Antonio. Two boys then took an ATM receipt from Antonio which he had found on the ground earlier in the day. (The ATM receipt was of obvious importance to Antonio in a way that may have seemed peculiar to the other children). When Antonio became upset and asked one of the boys to return the receipt, he said that Antonio could get it back if he would orally copulate the other boy. Antonio did as he was told, in the presence of the class of 50 students, many of whom laughed at what was happening.

Although Antonio's parents were appreciative of the dean calling to inform them of what took place, they were bothered by the fact that he contacted them several weeks after the incident. During the initial session, they raised many questions: Why did it take him weeks to inform them? Why did the dean call instead of speak to them in person? Were the perpetrators going to be punished? Why did the dean say so little? With such limited information and many unanswered questions, the parents perceived the dean and the school administration as unsupportive and showing little concern for Antonio's welfare.

Since the time of the incident, Antonio's parents observed no specific changes in Antonio's behavior. However, they did note that he had become noticeably withdrawn, and he appeared depressed since middle school began several months earlier. They stated that he often cried when he came home and his clothing and back-pack were frequently torn. Antonio's father reported that on several occasions when he picked up his son from school he heard children taunting Antonio and yelling out "*Antonia, Antonia*," the female version of "Antonio." The parents were very concerned about him. Apparently, Antonio had not talked to them about the teasing or the abuse.

Based on the initial assessment carried out after the abuse occurred, Antonio met criteria for an autism spectrum disorder (Pervasive Developmental Disorder, Not Otherwise Specified). His parents reported that he did not speak until he was nearly seven years old. In addition, his interests were limited to very specific domains and he repeatedly engaged in activities related to those domains. For example, in the first interview, he talked about watching the daily traffic report on the 5:30 AM news, drawing maps of the city freeway and public transit systems, and making flags. Antonio also did not develop peer relationships appropriate to his age, and he had difficulty with abstractions. Although Antonio fell just short of meeting six of the A criteria for autism (American Psychiatric Association, 2000), his behavior is consistent with what other authors have referred to as high functioning autism (Kasari & Rotheram-Fuller, 2005).

Past Services

Antonio was placed in special education classes from kindergarten through the fifth grade based on the diagnoses of autism and learning disability. He also received services from the Regional Center for Developmental Disabilities (a state agency) and the Social Security Administration, for which he was evaluated and qualified for Social Security Disability Income (SSI). Antonio's parents were not sure what his diagnosis was that qualified him for

²Although Antonio's mother and father were equally committed to treatment and showed up at all sessions, the father's perspective is presented here more often than the mother's perspective. One reason for this is that Mr. Morales appeared to be the accepted spokesperson for the family—he often represented Mrs. Morales' thoughts and feelings to the therapist even while Mrs. Morales was in the room. Also, Antonio has three siblings, and they required supervision in the waiting room; it appeared that the parents saw this as primarily the mother's role. On a number of occasions, Antonio's grandmother accompanied the family thus freeing up Mrs. Morales to participate in the session. Additionally, language played a role; the therapist was not fluent in Spanish. Although the parents raised their children to speak English as their first language, Mrs. Morales expressed some discomfort with speaking English outside of the family. She stated that she was embarrassed to speak English because she did not feel that her skills were on par to those of her husband or children. At the onset, the therapist offered to provide an interpreter, but both parents indicated that it was not necessary. Mrs. Morales stated that she was able to understand all that the therapist said, and, if needed, Mr. Morales could interpret for her to ensure that she understood.

special education or SSI. When he was transferred to middle school for sixth grade, Antonio was mainstreamed and no longer received any special education services. His parents reported knowing little about why they changed his schooling. They believed that he still needed special education services.

A thorough review of Antonio's school records, including a review of his Individualized Education Plans (IEPs), revealed no explanation for the decision of mainstreaming. The lack of certain records suggested that no IEP review had taken place and his parents did not recall a meeting in which mainstreaming was discussed. Therefore, at the recommendation of the therapist, Antonio's parents requested an IEP shortly after beginning treatment. The school's evaluation took place a few months after treatment began, and the school psychologist concluded that Antonio did not meet the requirements for a diagnosis; therefore, no special education was warranted. The abbreviated evaluation consisted of only screening measures (e.g., the Wide Range Achievement Test-3 [WRAT-3]), which indicated that Antonio was functioning at or above grade level in rote mathematical abilities, spelling, and reading single words. Based on this limited assessment, the school's evaluation team determined that he did not qualify for further special education services. A prominent omission was any mention of his pervasive developmental disorder and corresponding difficulties with reasoning and social-emotional functioning. When asked about this, the school psychologist indicated that she knew little, if anything, about autism. Furthermore, she was unaware that Antonio had previously received special education services in elementary school. She stated that he must have "outgrown" the autism because he appeared normal to her and had done well on the WRAT-3.

Family History

Antonio's father, Mr. Rogelio Morales, was a 49-year-old man born and raised in El Salvador, the son of well-positioned and wealthy parents. He was educated in the finest schools in El Salvador and aspired to become an architect. Although he was from a military family, he had no desire to be involved in the military or politics. When Mr. Morales was 19, he met his wife, Leticia Sifuentes de Morales, who was from an economically deprived family in El Salvador. During their courtship, she became pregnant and they decided to marry. Mr. Morales' father objected to the marriage and indicated that if they married he would terminate all support (including paying for Mr. Morales' college tuition). They wed in spite of the father's objection, and the newlyweds attempted to continue their education at the public university. The university was closed soon afterward because of students' antigovernment protests. Subsequently, he was unable to find work and enlisted in the military to support his wife and soon-to-be-born child.

Mr. Morales shuddered when he spoke of his experience in the El Salvadorian military. He stated that he had clutched his rifle and "cried like a baby" the first time he killed a man. He shook his head and stated that he tried not to think about what he had seen and done. He looked to his wife when talking about the nightmares he experienced for many years after serving in the military. She nodded and indicated that this had been very difficult for her to watch. When asked about how his experience in the military ended, Mr. Morales reported that on one occasion he and three fellow soldiers were ordered to go into a village to kill women and children. He said that killing a man—a soldier—was one thing, but that he could not kill a woman or child. The four soldiers refused their orders, and subsequently, the military imprisoned them. Mr. Morales stated that they all expected to be executed; however, after a number of months, his uncle, a high ranking official in the military, arranged for the men to be released from prison and dishonorably discharged. Mr. Morales said that he returned to his wife and daughter (who was then around a year old), but that he was rejected by his father and his father's family because of the disgrace he had brought on them, through both his marriage and his dishonorable discharge.

Mr. Morales reported that around the same time, his father “threw” his mother out of the house and took a new, younger wife. Mr. Morales’ mother obtained a “green card” and moved to California, but she had no marketable job skills, as she had always been wealthy and never worked. She took the only job she could find—cleaning houses. Mr. Morales and his siblings were angry at their father and very concerned for their mother. According to Mr. Morales, one of his brothers was so distraught about the father’s treatment of their mother that he committed suicide with a self-inflicted gunshot to the head. The father was diagnosed with cancer several years later and lived his final days in a nursing home, estranged from his first wife and children. Mr. Morales maintains contact with his mother and a sibling, who both reside in Southern California.

In the early 1970s, Mr. and Mrs. Morales decided that they too would move to the United States to “have a better life for our children.” Mr. Morales traveled from El Salvador to Canada and while in Canada successfully obtained permanent resident status to live in the United States. Within a year, he was able to obtain the necessary documentation for his wife and child, and they settled near his mother. As a family, they have lived in the United States for a total of 24 years.

Mr. and Mrs. Morales attempted to have another child, but the child was born with many defects and died soon thereafter. When Mrs. Morales became pregnant again and had a miscarriage, they feared that they would not be able to have more children. While in the military, Mr. Morales had suffered unspecified neurological damage that he attributed to chemicals he was exposed to in combat. They believed that this exposure contributed to the loss of the children and they stopped trying to conceive. More than 10 years later, Mrs. Morales became pregnant with Antonio. After his birth, she had three more children within six years. Antonio and his siblings all have characteristics of autism spectrum disorders, although the symptoms are most pronounced in Antonio’s case. Mr. Morales stated that he believed his exposure to chemicals in the military caused his children’s developmental disabilities. He reasoned that before he entered the military they had no trouble in conceiving their first child and she was born healthy. Since his military duty, he and his wife had difficulty conceiving and all four of the subsequent births had some disability. Moreover, Mr. and Mrs. Morales report that they know of no one within their families who has a related disorder.

In raising the family in the United States, the Moraleses continued to struggle. With the exception of Mr. Morales’ mother and a few other family members, the couple was socially isolated. They were not involved with the El Salvadorian community in Los Angeles because they believed that most Salvadorians would reject them given his role in the military. Likewise, they believed that Salvadorians who were involved in the military would reject them because of his dishonorable discharge.

In 1997, the Morales family faced a number of challenges related to housing and social services. Their landlord failed to maintain the premises and complained frequently about the noise the children made, which the parents explained was sometimes difficult to manage given the children’s disabilities. The landlord went so far as to register a complaint to children’s protective services that led to the family being investigated for neglect and abuse. Although the investigation revealed no evidence of neglect or abuse, Mr. and Mrs. Morales recall that incident as both shameful and hurtful. Both expressed a strong desire to be good parents, and being thought of as neglectful or abusive had deeply injured their dignity.

Two years prior to the start of treatment, Mrs. Morales seriously injured her leg, in part, because of their landlord’s negligence in correcting a safety hazard. The injury left her with limited mobility, and she was unable to drive and to continue her full-time employment as a

housekeeper. The oldest daughter was raising her own family outside of California and was not available to help. As a result, Mr. Morales began transporting their four young children to and from school and other appointments. To do so, Mr. Morales quit his two jobs (full-time electrician and part-time wallpaper hanger). It is possible that the culmination of many hardships and the resulting depression and hopelessness that Mr. Morales experienced may have also contributed to his decision to withdraw from the workforce. With their limited financial resources reduced even further, they moved to a very low-rent area in an extremely impoverished and high crime area of Los Angeles City. They had lived in this area 2 years at the time Antonio was sexually abused at school.

Case Analysis

Treatment Overview

There were four primary components to the therapy offered Antonio and his parents. First, the therapist worked with Antonio on an individual basis to teach him what sexual abuse is and to help him prevent future occurrences of such abuse. In particular, Antonio was taught how to identify and express his feelings (including how to ask for help), how to read facial expressions of others, how to communicate his needs and feelings, and how to better understand the needs and feelings of others. These treatment goals are particularly relevant for children with autism-related disorders as they oftentimes rely on the literal meaning of what others say and have a difficult time understanding the intentions of others (Heerey, Capps, Keltner, & Kring, 2005; Ochs, Kremer-Sadlik, Solomon, & Sirota, 2001). Antonio also participated in group therapy to help him transfer the skills he had learned in individual therapy to a group setting. Specifically, he participated in a 16-week sexual abuse prevention group for children with developmental disabilities offered by the Children's Hospital. The group, which was run by two other therapists, focused on teaching social and safety skills as well as providing sex education and sexual abuse prevention education. Third, Antonio and his parents participated in family therapy. The purpose of this modality was to address family issues that came about after the sexual abuse and to enhance family communication. Finally, collateral therapy was provided to Mr. and Mrs. Morales with the primary goal of empowerment; to help them better care for themselves and their children. For the father who experienced occasional bouts of depression and anxiety, cognitive therapy was also provided as part of collateral therapy. Our cultural analysis focuses on the individual sessions with Antonio and the collateral sessions with the parents.

What Is at Stake in the Patients' Local Social Worlds

What mattered most to Mr. Morales was "to do right what (his father) did wrong." He proudly stated that he had been faithful to his wife for all of their 30 years together, adding that this was not common in their culture. He explained that he saw how damaging infidelity was in his family and that he did not want to make the same mistakes his father made. Throughout treatment, Mr. Morales talked about loving his children unconditionally and reported that he would never reject them, no matter what they might do. He stated that he wanted to provide them with a safe environment, a stable home, and a solid education so that they would have a good future. As he talked about his desire for his children to have a strong educational foundation, he became saddened, looked at his wife, and talked about the educational opportunities they lost in El Salvador. Mr. Morales proudly reported that Mrs. Morales was smart, emphasizing her abilities in mathematics. It was apparent that they both felt a significant loss in not realizing their educational goals.

What was at stake for the parents, especially the father, informed important aspects of the treatment. One area concerned the problem definition. Initially, they were concerned about addressing Antonio's recent abuse, and his emotional and behavioral difficulties that

resulted from being mainstreamed. As the parents were encouraged to share their local, social worlds with the therapist, within a few weeks of treatment the problem definition expanded to include helping the parents regain their dignity. The parents' unique social context, alienation from Antonio's paternal grandfather, unrealized educational goals, perceived treatment from countrymen, loss of employment, and accusations of child abuse, had all contributed to a loss of dignity for Mr. and Mrs. Morales. Also, in seeking help from the Regional Center, Social Security, and the educational system, the father thought that he was perceived to be "a stupid wetback." He stated that this was particularly frustrating because he was both educated and a legal resident. Thus, from the parents' perspective, addressing the sexual abuse and the parents' loss of dignity were the key presenting problems.

Given past interactions with service providers, Mr. Morales was initially very cautious with the therapist. Being of the same background as many of their past helpers, that is, English-speaking Euro Americans, may have contributed, in part, to his caution. As the therapist sought to understand him and as she expressed genuine caring for him and his family, Mr. Morales responded by sharing more of his life story, opening up his world to the therapist. In fact, on several occasions, Mr. Morales brought pictures from his past in El Salvador to treatment sessions to share with the therapist. This then helped the therapist to demonstrate the necessary trust and respect, qualities missing from much of his past relationships with helpers.

With the early assurance of respect, Mr. Morales did not hesitate to express the multiple stressors in his life. The therapist acknowledged his need for additional resources and, in addition to serving as a psychotherapist, she also took on the role of advocate for the family. Treatment methods of the collateral sessions with Antonio's parents included the provision of educational materials about sexual abuse, autism, and special education rights. In addition, she discussed strategies for effectively communicating with professionals and requesting services in accordance with the special education law. For example, in previous IEP meetings, Mrs. Morales had not participated actively because an interpreter was not provided.³ Informing the parents that having an interpreter present was a right, not a favor, allowed them to advocate assertively for their needs. In addition, the therapist encouraged Mr. and Mrs. Morales to place their requests of the school district in writing and to keep postal service delivery confirmation slips for the letters. At least one session with the parents was spent working through the process of composing a letter to the school district requesting a formal meeting to review an IEP. To further assist them in pursuing the educational needs of Antonio and his siblings, the therapist helped the parents to connect with a well-known attorney specializing in educational law who accepted cases on a no-fee basis but billed the school district for her services. Mr. and Mrs. Morales were extremely receptive to the discussions around advocacy and were eager to expand their skills in this area. It is clear that the therapist not only acknowledged the importance of the social world in working with Antonio's parents but also integrated that understanding in significant ways when working with the parents, particularly in the domains of problem definition and treatment methods.

Observations of Antonio in treatment, his parents' reports, and Antonio's very own comments indicated that what was most at stake for him was maintaining structure in his

³The reason why an interpreter was needed at the IEP meeting and not in therapy was that the parents thought that the IEP meetings were much harder to understand. The content of the IEP meetings, the unfamiliar terminology, and the fast-paced speech of the school personnel all contributed to making the meetings hard to follow. The father reported that even he was confused and that he did not understand all that was said. In contrast, in therapy, the clinician made efforts to avoid confusing terminology and to explain terms with which the parents were not familiar. The father recognized the difference in the two settings when he told the therapist that he could ask her to explain something (such as the diagnosis of autism), but that he could not do the same at school because they would not take the time to explain things to him.

daily life. Not unlike others with autism-spectrum disorders, disruptions to Antonio's routine had a markedly negative impact on his well-being. For example, the parents reported that on one occasion he sobbed uncontrollably after accidentally oversleeping and missing the 5:30 AM traffic report that he watched every morning. Consistent routines made him feel secure. Throughout elementary school, Antonio had a predictable, structured school day. He spent most of the day in a small special education classroom. When he began middle school, he lost this structure. He was required to change classrooms each hour and during these brief breaks other children frequently teased and picked on him. To protect him from further abuse, Mr. and Mrs. Morales pulled him from school and he began home instruction until arrangements could be made for Antonio to receive the support he needed at school. These well-intentioned changes to Antonio's daily routine were especially difficult for him. For example, Antonio became more anxious, needing to know what to expect and what he would be doing at all times in therapy as well as outside of therapy.

The need for structure was an important guiding principle for much of the treatment. Early in therapy, Antonio drew a picture of his "family" and included more than 20 people who were important to him. Although all the stick figures he drew looked alike, each had a name and date of birth written above the head. After completing the picture, Antonio recited the names and dates of birth of cousins, aunts and uncles, a maternal grandparent, and immediate family members. Then he informed the therapist that he needed to know her date of birth. The therapist gave him that information to help Antonio fit her into his clearly defined "family."

Structure was also important in scheduling therapy appointments at the same time every week. On one occasion, the therapist came to the waiting room six minutes after the designated appointment time. Antonio was noticeably frustrated and jumped up and said, "Let's go. We only have 54 minutes left." Even though he was assured that he would still get 60 minutes, he was clearly agitated. Once in the office, it took most of the session to help him focus on the task at hand. Beginning his appointment exactly on time on the same day of every week was most important to the treatment.

Termination also had to be structured. After nine months of treatment, Antonio's case was transferred to another clinician because the original clinician had completed her training program and was leaving the hospital. In consultation with her supervisor and Antonio's parents, the therapist decided that Antonio and his family needed further support and would continue with a new therapist. To accommodate Antonio's needs for consistency, the termination process began early, requiring a full six sessions. As a termination activity, the therapist encouraged Antonio to map his experience in therapy on a poster board. When asked to draw a picture and talk about how he felt when he first came to treatment, Antonio stated, "I felt confused. I thought this is something new." Next, Antonio was encouraged to express what he had done during therapy. First, he made a list of the games he'd played with the therapist (e.g., *The Talking, Feeling, and Doing Game*) and next to each game, he put an accurate tally of the total number of wins for him and for the therapist. When asked how he felt during this part of treatment, Antonio stated, "it felt great" and "I felt amazed to be with Kimberley." He also then made a list of what he learned about abuse (e.g., "It is not my fault") and wrote, "I felt sad and scared" when talking about the abuse. In the last session, the therapist had a "good-bye" party with Antonio and his family. Antonio shared his poster with his family, which in some ways served as a summary of his progress in treatment. Given the importance of structure and routine, the carefully planned termination that integrated many familiar therapy themes for Antonio facilitated a smooth transition to Antonio's new therapist.

Shared Narratives

We now examine the extent to which the therapist established shared narratives in working with this family. Not only do we consider the degree to which such narratives were formed, but also how the narratives came about. We selected examples that differ in important ways. For the parents, we chose two narratives in which the therapist and the father did not initially share and point out how the narratives were negotiated. For Antonio we point out the challenges in working toward a shared narrative when the very illness in which the presenting problem is being addressed works against clear therapist-patient communication.

In the first month of treatment, the therapist noticed that Mr. Morales came to his early afternoon session smelling of alcohol and exhibiting poor hygiene, having not bathed or shaved in several days. Although the focus of the treatment was on the sexual abuse of Antonio, the clinician took the father aside and addressed what she initially viewed as problem drinking. He acknowledged that he was undergoing a difficult time and felt helpless and frustrated. The therapist pointed out that these life challenges can oftentimes lead to depression and anxiety. She also carried out a thorough assessment of his drinking and learned that every day he was drinking a beer or two at lunch. The drinking was not severe enough to suggest an alcohol-related disorder, but it may have been enough to impair his driving. The therapist encouraged him to talk openly about his coping with the multiple stressors in his life, and she gently addressed drinking as a coping strategy that could conflict with his desire to be a “good father.” After discussing alternate methods of coping, such as therapy to talk about his concerns, the therapist contracted with him not to drink before driving. After this discussion, the therapist did not smell alcohol on his breath again, and within three months, there was a remarkable improvement in his hygiene.

The narrative implied by this scenario was initiated by the father’s drinking prior to therapy meetings and his unkempt appearance. From the father’s point of view he was having a couple of beers to relax. He initially did not perceive the drinking as linked to his circumstances and the resulting depression. The therapist, on the other hand, considered the possibility of a drinking problem, the possible impairment to his driving, and the risk to his and his family’s lives. Given the father’s agreement not to drink before driving and given evidence that he no longer came to therapy sessions smelling of alcohol, it appears that the therapist was successful in altering the father’s understanding of his drinking to align more with the therapist’s view. One factor that may have facilitated Mr. Morales viewing the drinking as a potential problem is that the therapist pointed out how such behavior is, in some circumstances, inconsistent with what matters to him, which is being a “good father.” It is worth noting that Mr. Morales similarly contributed to the therapist altering her initial view of a possible drinking problem in need of clinical intervention. Together the therapist and client constructed what appears to be an agreed upon or shared narrative that provides a structure for future action.

Another example of negotiating shared meanings took place after the father began trusting the therapist. He called her frequently, whenever he was feeling anxious about a wide range of issues, including accessing services from the school district. Initially, the therapist saw Mr. Morales as very demanding and even “pushy.” In fact, she was frustrated and irritated with his many demands, which included paging her several times each day. After considering his perspective (having many needs and no resources) and her own perspective (wanting to maintain boundaries so that he not become overly dependent on her assistance), she was better able to respond with empathy. She set reasonable limits to his contacts between treatment sessions which helped her address her need for maintaining boundaries and ensured that she had sufficient time for other patients. The father accepted these limits and in fact apologized for the frequent calls stating, “You were the first one to help us.” In addition, the therapist made appropriate referrals and connections with other professionals,

such as the previously mentioned attorney. Mr. Morales' respect for the limits set by the therapist and the therapist's responsiveness to many of his multiple needs likely facilitated the increasing congruence between the therapist and client's narratives. This is suggested by the shift in the therapist's original view of Mr. Morales as being pushy to her later view of Mr. Morales as having several unmet needs.

Antonio's young age and his limited abstract reasoning made it difficult to discern a negotiated shared meaning between him and the therapist. Nevertheless, he contributed to some of the shared meanings throughout treatment. One instance concerned the definition of the problem. In the individual sessions with Antonio, the therapist initially identified the problem as the distress that Antonio must have been feeling following the abuse. On several occasions early in treatment, she spoke directly to Antonio about the incident. On each occasion, the boy responded by looking up at the ceiling, becoming quiet, and withdrawing. His nonverbal behavior suggested that he had no interest in addressing that topic. When the therapist shifted to a discussion of hypothetical problem-solving scenarios similar to the one in which the abuse occurred, Antonio looked back to her and engaged in a discussion once again. For instance, the clinician asked Antonio, "What would you do if someone asked you to touch him in a way that you did not want to?" Antonio initially said, "I don't know," but then was eager to hear suggestions from the therapist. Situations that he had not faced were acceptable topics of discussion for the problem solving. Thus, early in the treatment, the clinician directed the focus away from the specific incident of abuse and toward addressing social and problem-solving deficits to help prevent future abuse. Although there was not a clear verbal discussion of what the treatment goals should be, the therapist and client were able to agree upon a given direction.

Later in treatment, Antonio was able to talk at least to some extent about the incident. In response to the therapist's query, he commented that he was afraid to talk to his father about this. When asked why, Antonio stated that he believed his father was angry with him for what took place because he noticed that his father became angry after having learned of the sexual abuse. This suggested that he blamed himself, at least in part, for the incident. In family sessions, the therapist encouraged Antonio to express these feelings to his parents. This allowed them to tell Antonio that the abuse was not his fault and that their anger was directed at those who hurt him, not him. This approach appeared to result in a change in Antonio's perception. At the time of termination, when asked to write what he had learned in therapy, Antonio's statements included the following: "It's not my fault. Be safe. Talking helps." Thus, this partial explanatory model that Antonio communicated during treatment was judged by the therapist as dysfunctional and in need of change. The therapist once again initiated a given narrative (the sexual abuse was not his fault), but with this issue, the client was open to address it, and, over time, they apparently were able to develop at least a partially shared narrative.

Discussion

Culture as What Is at Stake in Local, Social Worlds

The single greatest contribution of a socially based definition of culture is that it guides the clinician to examine the client's the social world to identify what is at stake or what matters for the individual client. Our case focused on an immigrant family from El Salvador. From the parents' perspective, particularly that of the father, what was most at stake was to do "right" what his father did wrong, mainly in establishing a strong marital union and in providing love and support for their children. Through a careful social history and the establishment and maintenance of a collaborative relationship with the parents, the clinician learned from the parents' perspective that the origin of the high regard for their children stems in large part from the difficult family relations that the father, and to some extent the

mother experienced in their own family of origin. Thus, the clinician's understanding of what is at stake for this family is grounded in the local social world of the family.

The understanding of the individualized experience of culture can inform the clinical encounter in significant and meaningful ways. First, it provides a basis for the individual tailoring of interventions given the sociocultural experience of the client. In this case, this socially based notion of culture guided the therapist to expand the problem definition to address a loss of dignity and to broaden the therapist's role to include advocacy, especially in helping the parents work with the school district to obtain the necessary services for their children. Addressing cultural notions tailored to the individual patient is likely to promote a collaborative spirit between therapist and client, and, in turn, enhance their working alliance.

Second, this conceptual approach encourages clinicians to directly assess the evidence for what is at stake and not rely on distal indicators of culture such as race, ethnicity, and national origin. In this case, the therapist ascertained that Mr. and Mrs. Morales held their children in the highest regard. This is not unlike the presumed cultural value of Latinos' familism or family orientation (Sabogal, Marin, Otero-Sabogal, Marin, & Perez-Stable, 1987), a concept oftentimes referred to in the group-oriented cultural competence literature. One important difference in applying the socially based conception of culture versus the group-based conception of cultural values is that in the former approach no assumptions are made. Evidence is required to document what matters for a given case. The risk of applying cultural stereotypes is likely to be significantly reduced with such an approach. A third advantage of this view of culture is that it requires the clinician to understand the importance of family within the local world of the person. Family orientation is not a cultural construct looking to be applied but rather an experience grounded in the context of the daily lives of this family.

A fourth advantage of the socially based perspective of culture is that it is open-ended. There is no limit to the factors that matter in a given case. It is incumbent on the clinician to identify what in particular matters for that given case. This flexibility allows for the considerable heterogeneity that exists with regard to cultural processes. Finally, this definition helps clinicians, even those from very different cultural backgrounds as was the case here, to cross cultural divides in meaningful ways for individual patients.

Considering what is at stake in Antonio's local social world provides a very different sociocultural perspective than what we observed with his parents. We argued that what is at stake for Antonio is maintaining structure and routine throughout his daily life. This central organizing theme in Antonio's life informed the treatment in many ways, from scheduling appointments to structuring the termination. Insofar as structure and routine are critical in caring for children with autism spectrum disorders (Norton & Drew, 1994), the question arises whether the need for structure is cultural, particularly given our definition of what is at stake in local *social* worlds.

After much reflection and discussion among the authors, we believe that the need for structure is embedded in the social world and reflective of cultural processes, just like family orientation is embedded in the social world of the parents and reflective of cultural processes. Support for this interpretation lies in the conception of experience that underlies Kleinman's notion of culture. Recall that experience reflects the intersubjective space between people's mind and body and their social worlds. Thus, what is at stake can be informed as much by the soma and psyche as by the social world. In the case of a pervasive developmental disorder, neurocognitive dysfunctions underlying the disorder must be expressed in the social world. The soma, the psyche, and the social world interact in such a manner as to make order, routine, and structure of vital importance to the daily life of

Antonio. For example, Antonio's need for structure takes shape in relation to a specific sociocultural context as evidenced by his stick figured family with names and birth dates for each of the 20 members. Antonio's distress over the temporal disruption in the patterning of daily activities takes place in a local world organized in ways (e.g., through school, therapy, and the routines of everyday family life) that directly relates to what is "at stake" for him. In a local world organized differently, the nature of what matters will differ, with a corresponding change in what culturally competent care entails. A similar argument can be extended to patients with diseases such as end stage renal disease, diabetes, or cancer that shape what matters to many of these patients and their families (e.g., Reiss, Gonzalez, & Kramer, 1986). This is not to say that there are cultures of diabetics or of cancer patients, but rather that what is at stake for persons facing life threatening illness must be situated in relation to personally experienced social and cultural worlds. The "cultural" matters as much here as when considering, for example, what is at stake for recent immigrants to the United States.

This perspective raises the question that if culture reflects illness experiences then what about the illness experience is not cultural? If one cannot distinguish the boundaries between behavior that is cultural and behavior that is not cultural then this raises serious questions regarding our conception of culture. In earlier work, Kleinman and colleagues explored how medical "problems" in clinical contexts were perceived differently by physicians and patients (Kleinman, Eisenberg, & Good, 1978). Physicians tend to view client's problems within a framework of disease—the biological aspects of health conditions. Patients, in contrast, focus on problems in living, that is, on the social aspects of health conditions. Both frameworks, they note, are insufficient by themselves because neither alone rises to the challenge of understanding the "dynamic interplay between biologic, psychologic, and sociocultural levels of sickness" (Kleinman, Eisenberg, & Good, 1978). In the case of Antonio, his need for order could be seen as the cultural expression of the neuropsychological underpinnings or the "disease" of autism. With Kleinman's current emphasis on experience, the social world and psychophysiological processes are intertwined. One cannot easily identify what is social (cultural) and what is biological (noncultural). Instead culture, the soma, and the psyche interact in complex, dynamic relationships. We acknowledge the risk with this approach in overemphasizing the role of the social world in the everyday lives of others. However, attempting to derive what is specifically cultural and what is not cultural risks promoting false dichotomies.

Shared Narratives

Mattingly and Lawlor's notion of shared narratives also proved useful in advancing a cultural analysis. Some of us began this project with the idea that clinicians are the main players in negotiating meaning in clinical contexts. This may be the case in some circumstances. However, we were most impressed by how both the patient and the practitioner play significant roles in constructing the shared meaning, even when the patient is a child with impaired relational skills. This was most clearly demonstrated in how Antonio and the clinician negotiated the problem definition that served as the initial focus of their individual treatment. By not responding to the therapist's efforts to address his reactions to the sexual abuse, and by responding to hypothetical scenarios to enhance his skills to prevent future instances of abuse, Antonio partially negotiated the underlying narrative of their treatment. This is not the same negotiation that one observes in the verbal exchange between therapists and clients, but the movement toward a more congruent model of treatment (shared narrative) was accomplished nevertheless.

We also learned that there is variability in the developmental trajectory of shared narratives. In the case of the clinician and the father, there were instances in which the congruence between the two parties' views appeared to be very similar from the time the given issue

was first discussed. For example, the victim narrative in which the parents were viewed as having been treated unjustly was held by both sides early on in treatment. In contrast, there were other narratives in which the clinician and the father came from very different positions. In particular, the drinking narrative and the “pushy” versus “needy” narrative required some adjustment on both sides to come together. The clients’ observed trust of the therapist and the therapist’s noted respect for the clients probably facilitated each side over time moving closer to the other’s positions.

The fact that narratives can change throughout treatment point out their dynamic nature. A more systematic longitudinal assessment of the clinician’s and patients’ narratives may reveal that both parties’ narratives are continuously being modified and updated. Rather than view shared narratives as reflecting a final fixed point that reflects good therapy, a more realistic view may be that narratives are in flux and that good therapy oftentimes reflects movement toward congruence, not necessarily reaching a given agreed upon position. A good example of the fluidity of narratives is reflected in the parents’ narrative of hope and empowerment in obtaining quality educational services for their children. Throughout treatment, the therapist worked with the parents to develop their advocacy skills in seeking improved educational services for their children. During the last parent session, Mr. and Mrs. Morales surprised the therapist by applying this same narrative to their own personal lives. Specifically, Mrs. Morales spontaneously stated, “We are going back to school—both of us.” She reported that they were enrolling in classes to earn their General Education Degrees (high school equivalent) and that she would be taking English and computer classes as well. Her eyes lit up as she talked about wanting to go back to work and working with computers (a reasonable goal even with her physical disability). Also, Mr. Morales reported that he planned to renew his certification as an electrician. Even though never addressed in therapy, the parents modified the hope and empowerment narrative to include their own personal ambitions and goals. This added dimension not only points out the dynamic nature of narratives but also that therapy enabled the parents to emplot a future, where through education, they saw the possibility of transforming their lives and enhancing their ability to achieve what they wanted for their family.

Implications for Models of Cultural Competence

After discerning what is at stake for the parents and Antonio, the therapist used these conceptions at different times in the treatment. They served as a resource from which she could draw when needed. For example, in addressing the drinking of Antonio’s father, the clinician determined that his drinking did not reflect a clinical disorder but that it still may have impaired his driving and put his family at risk. One way the therapist attempted to reduce his drinking before driving was to point out the incongruence between his behavior (drinking before driving) and what mattered to him, taking care of his family. This was one of several strategies used by the therapist to reconsider his drinking. Together they appeared to reduce his driving while under the influence of alcohol.

The clinician also drew from the cultural themes in directing some of her clinical activities. Serving as an advocate for the family in the school district and teaching the parents advocacy skills were geared in part to help the parents address the key cultural theme of providing for their children. Similarly for Antonio, the cultural theme of facilitating structure and routine touched aspects of his treatment (e.g., consistency of scheduling and carefully planning termination). Although some aspects of the treatment were informed by the cultural themes, many were not so informed. Nevertheless, the therapist did draw on this resource in treating both the parents and Antonio.

The emphasis on understanding the local social world of one’s clients and integrating that understanding with practice is consistent with the American Psychological Association’s

Multicultural Guidelines (APA, 2003). In particular, Guideline 5 is of particular relevance: “Psychologists strive to apply culturally appropriate skills in clinical and other applied psychological practices.” One emphasis of this guideline is to treat clients within their context. Consistent with our conception of culture, context is broadly defined, not limited solely to race and ethnicity. Clinical encounters are not simply the interaction between two or more individuals addressing a given set of presenting problems. The encounter is linked to broader social, political, economic, and cultural processes (Good & Good, 2000). Guidelines are useful in directing clinicians more generally; however, it is important to identify what is involved in carrying out specific guidelines on the ground. For example, with regard to context, issues of power differential and gender, among the other already discussed issues were relevant to the treatment. Language, educational status, institutional roles, and knowledge of the systems of care all contributed to a clear power differential between the therapist and the Morales family. Also, issues of gender likely played an important role in several facets of treatment, including the female therapist assisting the male head of household in caring for his family and in addressing issues of sexual abuse with Antonio and his family.

We believe that the individualized approach of identifying what was at stake in the family’s local social world, helped address these and related issues. Incorporating the client’s perspective empowers the client, which in turn reduces the power differential. When clinicians are the presumed “experts” and move ahead with their perceptions of the problem and their treatment goals, the client is disempowered, and the power differential is strengthened. With this clinical case, the therapist remained open to the Morales family’s perspective and altered her understanding of the problems accordingly. As a result, the initial power differential lessened, resulting in a strengthened working relationship enabling the treatment to address challenging issues, including the gendered topics of sexual abuse and family roles and responsibilities.

Mattingly’s notion of shared narratives can also serve to enhance models of cultural competence, particularly the Shifting Cultural Lenses model. In the original presentation of this model, López argued that the clinician should work to integrate the patient’s cultural perspective with the clinician’s cultural perspective. However, there was little discussion of how much integration was needed. The degree of integration was assumed to vary depending on the circumstance. This flexibility is helpful given the varied circumstances but there are no guidelines regarding the degree of integration that is optimal.

Conceptualizing the therapy encounter as a shared coconstructed narrative can serve as a guidepost regarding the optimal degree of integrating the patient’s and clinician’s cultural perspectives. The key question then is not the degree of integration between the patient’s and clinician’s cultural perspectives. What matters is that the patient and clinician are working from the same shared narrative. In the case of Antonio, we observed some occasions when the therapist largely adhered to her own cultural perspective. For example, with little apparent input from Antonio, she taught him not to blame himself for the sexual abuse. At termination, among the things that he said he had learned in therapy was that he was not at fault for the incident. Although there appears to have been little to no integration of the patient’s model with the therapist’s model with this example, there is evidence that at the end of treatment they had established at least a partially shared narrative. In this case, the patient learned the clinicians’ model. Instead of promoting integration of cultural perspectives, Mattingly’s work suggests that the overall goal of Shifting Cultural Lenses might best be for the patient and clinician to negotiate a set of shared meanings.

The focus on these cultural processes rather than group-specific notions of Salvadorians may give the impression that the therapy reflects simply good therapeutic processes with little

attention to culture. We agree that adherence to these processes represents good therapy, but given our conceptualization of culture, we believe that adherence to these processes reflect considerable knowledge and understanding of the sociocultural worlds of the clients (see also Garro, 2005b). We have recently obtained funding to assess whether adherence to these processes will lead to better outcomes in the treatment of Latinos in a public outpatient mental health setting (López, 2005). Ultimately, data will help discern the viability of this approach.

Limitations

Considering contemporary notions of culture as they relate to cultural competence in psychotherapy with a given case is useful as a preliminary step to assess their potential contribution. However, there are some limitations. First, the data are largely based on the clients' report with their inherent drawbacks. Second, the analysis is retrospective and prone to biases in the selection of materials to report and in the therapist's recall. The clinical chart and the therapist's additional notes helped address the latter. Third, because of Antonio's youth and autism spectrum disorder, we had limited access to his narratives and cultural models, though we made use of his nonverbal behavior to discern some of his views. Another limitation concerns the validity and reliability of the inferences about what is at stake in local social worlds. Cross-cultural psychology's advances in identifying specific cultural elements that can be measured with specific instruments (familism, individualism/collectivism, or spirituality) are laudable. However, in the early phase of applying contemporary anthropological conceptions of culture to psychotherapy, we are less concerned about measuring specific cultural units or perceived cultural units and more interested in casting a wide net to capture the varying cultural landscape of psychotherapy processes. Accordingly, as a first step we are examining the potential utility of these conceptual approaches. Future research will have to address the psychometric properties of the assessment of these sometimes vague and abstract notions.

Conclusion

Disparities in mental health care for racial and ethnic minority groups have served as an impetus to develop models of culturally competent care. Many of the existing models of cultural competence are limited in their conception of culture—particularly those that equate culture as values, beliefs, and practices of groups delineated by ethnic or racial boundaries. Contemporary anthropologically informed models of culture go beyond racial and ethnic boundaries, situate culture as much in the social world as in the individual or group, and reflect the dynamic, changeable nature of culture. Our initial analysis suggests that the socially based model of culture and the notion of shared narratives have the potential to broaden and enrich our definition of cultural competence in psychotherapy.

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