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Collaboration in Culturally Responsive Therapy: Establishing A Strong Therapeutic Alliance Across Cultural Lines

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Abstract

Achieving effectiveness of therapeutic interventions across a diversity of patients continues to be a foremost concern of clinicians and clinical researchers alike. Further, across theoretical orientations and in all treatment modalities, therapy alliance remains a critical component to determine such favorable outcome from therapy. Yet, there remains a scarcity of empirical data testing specific features that most readily facilitate effective collaboration in a multi-cultural therapy relationship. This article reviews the literature on terminology, empirical findings, and features to enhance collaboration in multi-cultural therapy, suggesting guidelines for achieving this goal in therapy with patients (and therapists) of various cultural/racial backgrounds. This is followed by a multi-cultural case study presenting with several co-morbid Axis I disorders, to exemplify the application of these guidelines over the course of therapy.

The role of culture in psychotherapy has been gaining significant attention in the past few decades (Wohl, 1989; Seiden, 1999; Draguns, 1997), particularly as the populations seeking psychological services grow increasingly diverse. Indeed, an often prominently stated aim of training programs for mental health practitioners includes the need to ensure the cultural competency of those delivering psychological treatments (Heppner, Leong, & Gerstein, 2008). Unfortunately, often this recognized need is insufficiently met because (1) of a lack of a definitive structure and specific goals to achieve this cultural competency in therapists, and (2) scant empirical data to support one training model over another (Laungani, 2005; Whaley & Davis, 1997). This distinct gap between stated intent of incorporating cultural differences into current evidence-based treatments, and actual clear guidelines for accomplishing this goal must be more directly addressed.

Further, the importance of establishing a strong rapport with patients and developing a firm therapist-patient alliance to target emotional symptoms remains an overarching goal of the field of mental health (Taber, Leibert, & Agaskar, 2011). This article therefore aims to review the empirical literature on effective enhancement of collaboration in the multicultural therapy setting, to reveal the common and specific features across a range of treatment modalities. This is followed by a case study of an actual patient to exemplify how these features may be incorporated into treatment with a multicultural client, both in terms of establishment/maintenance of a strong working alliance during treatment, and then in healthy termination of the therapy relationship after a course of treatment.

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Key Terms

Researchers have provided several relevant working definitions within cultural therapy that are noted here. The first is culture itself, which in the currently discussed context broadly refers to a system of beliefs, perspectives, and values a group of a particular race/ethnicity or geographic region collectively share. Of course, cultural influence does not work in a vacuum, and Hays (2008) coined an acronym that serves as a reminder to clinicians about the multi-faceted nature of multi-cultural therapy (MCT) in terms of what they need to be ADDRESSING: Age and generational influences, Developmental disabilities and Disabilities obtained in later life), Religion and spiritual orientation, Ethnic and racial identity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and Gender. Such a term captures the complexity of cultural identity and the number of factors to consider when we discuss the impact of cross-cultural differences in therapy.

In addition, cultural identity of an individual is tied into other key processes not noted in even this rather comprehensive acronym, such as discrimination and acculturative stress. Briefly, cultural/racial discrimination can be described as a differential treatment of an individual specifically due to certain negative beliefs about that person's cultural/racial group membership (Karlsen & Nazroo, 2002), and has been found to be linked to negative psychological outcomes (Chou, Asnaani, & Hofmann, in press). Acculturative stress is more specific to recently immigrated individuals who are undergoing the often difficult process of acquiring and assimilating the cultural characteristics of the host country (Hwang & Ting, 2008), such that one's own cultural identity is constantly being challenged and changed to varying degrees. Finally, a major construct that certainly influences each individual's cultural beliefs is the idea of individualism versus collectivism, or independence versus interdependence (Markus & Kitayama, 1991). This broader concept delineates key differences between taking a collectivist/interdependent world view (i.e. that the greatest priority lies in maintaining harmony within the cultural group, and thus individual gain is deemphasized), from an individualist/independent value system (i.e. focus on individual achievement and success is deserving of the greatest social admiration/reward). Indeed, several empirical studies have found differences based on this construct in acceptability towards, and extent of, certain psychological symptoms, including social anxiety (Heinrichs et al., 2006), and depression, personality disorder features, and OCD (Caldwell-Harris & Aycicegi, 2006). Again, these are important considerations that inform our understanding of the cultural lens of patients engaging in something as personally revealing as psychological therapy.

One other concept that is of particular importance in the current discussion is that of cross-cultural competency, which provides an index of how skilled (1) a clinician feels about their abilities to manage cultural issues raised in therapy, and (2) a patient perceives the clinician to be in their ability to handle such topics in the therapeutic context (Lee, 2011). A survey of 689 APA-licensed psychologists found that while practitioners reported having discussions about cross-cultural issues, they only did this with less than half of their cross-ethnic/racial clients, although this was for a variety of verbalized reasons (Maxie & Arnold, 2006). Further, the therapists most likely to discuss cultural differences with patients were those who were older, female, of non-minority racial status, those who felt they were less experienced with treating diverse clients, and those who felt training is an important feature of effective therapy delivery. Indeed, a considerable amount of discussion has revolved around the need to develop a cultural competency in the field of cross-cultural psychotherapy (Sue, 1998; Kaweski, 2010; Taylor, Gambourg, Rivera, & Laureano, 2006). Yet, an empirical study examining the impact of the competency ratings by 143 patients of their therapists (N= 31) found no significant association between patients' perceptions of therapist cross-cultural competency and actual therapy outcome (Owen, Leach, Wampold, &

Rodolfa, 2010). Such a finding indicates that the process is likely to be more complex than simply providing superficial mention of cultural issues during therapy, or clinicians' degree of experience with diverse patients. Other experts in cross-cultural treatment have noted that simply instructing clinicians to simply be sensitive to cultural differences or to familiarize themselves with the culture-specific norms of clients is insufficient and not particularly beneficial (Sue & Zane, 2009). Given this inconsistency in the literature on the impact of cultural competency on outcome, there needs to be a more systematic empirical study of this concept across a diversity of populations.

Empirical Data Identifying Specific Features

While differential rates in report and diagnosis of certain disorders across race-ethnic groups in the United States have been noted in several large-scale epidemiological studies (Grant et al., 2005a,b; Pole et al., 2008; Asnaani, Richey, Dimaite, Hinton, & Hofmann, 2010), the empirical data in the efficacy and structure of culturally responsive therapy is still limited. One meta-analysis examining a mix of 65 experimental and quasi-experimental studies (which included 8, 620 participants) revealed a modest effect size ($d = 0.46$) in favor of culturally-adapted treatments for clients of color as compared to traditional treatment procedures (Smith, Rodriguez, & Bernal, 2011). Further, results indicated that when mental health treatments were designed targeting one particular cultural group in mind, these treatments outperformed other treatments serving patients from a variety of cultural backgrounds. Such findings highlight two needs: (1) more rigorous, stricter treatment designs to fully examine the relative benefit of culturally-specific treatments, and (2) more systematic research into the specific components of culturally-sensitive therapy that predict maximal benefit to clients. While both of these needs are recognized by proponents of culturally-responsive psychotherapy, there have been a reasonable number of smaller qualitative studies on specific aspects of multicultural therapy. Such studies provide rich insight into the factors that clinicians are advised to consider when engaging in therapy with clients of varying cultural backgrounds, and preliminary directions for most robust, experimental study designs.

One study by Tsang, Bogo, & Lee (2011) analyzed the session transcript data of nine cases from pre- to post-treatment. Complex coding procedures from a narrative research perspective were supplemented by the information provided on various process and symptom measures (which were both subjective and objective in nature). The analysis revealed that therapists who actively and positively engaged in cross-cultural conversations during therapy more effectively expressed an understanding of what the patient's goals and needs in therapy were, appeared more emotionally in-tune with clients, and demonstrated appropriate management of cultural experiences raised by the client.

Another qualitative study investigated the impact of how practitioners from a dynamic or relational treatment perspective addressed cultural issues with clients on the strength of the treatment alliance (Lee, 2009). The therapists in this study consisted of 4 white clinicians, and the content of their therapy sessions with 6 minority patients were analyzed using Conversation Analysis and Structural Analysis of Social Behavior. The study results revealed that therapists' specific interactions during cross-cultural discussions were associated with the Bond subscale of the Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006), which measures the interpersonal connection shared between clinician and patient. There was no significant association between these moment-by-moment interactions and the other two main subscales, i.e. extent of agreement on the target of treatment (Goals subscale) or degree of agreement on what needs to be done specifically to achieve these goals (Tasks subscale). Again, it appears that cultural congruence between client and therapist plays a role in enhancing the moment-to-moment

collaboration and alliance of the therapeutic relationship. Such a finding further points to the need to incorporate cross-cultural features explicitly into treatment to facilitate the therapy relationship, regardless of treatment modality.

Features of Effective Collaboration in Multicultural Therapy

Taken together, the empirical and observational findings discussed thus far reveal several data-driven guidelines and hypotheses about how therapists' cross-cultural competency may be improved, and how the therapeutic bond may be most strengthened in a cross-cultural therapy setting. In addition, there are several other cross-cultural models examining the establishment of a strong working alliance, which are themselves grounded in existing evidence-based research findings (e.g., Hays, 2009; Fontes, 2008; Sue & Zane, 2009). The common features and themes as gleaned from these various sources are integrated to produce the following guidelines for practitioners.

Guideline #1: Conduct a thorough culturally-informed but person-specific functional assessment of presenting problem

Before modifying an existing treatment to be more culturally sensitive, therapists should fully assess how much of the individual patient's presenting problems may be interlinked to his or her cultural identity/related constructs. That is, clinicians must be wary of premature adoption of a modified treatment simply because an individual is from a particular cultural group (Sue & Zane, 2009). All patients must still be regarded as unique individuals who lie on a more dynamic spectrum of cultural identification, and cultural groups must be seen as heterogeneous populations with some more or less likely dominant themes. Related to this, before engaging in any adaptation of existing treatment techniques, there must be adequate information gathered about how cultural beliefs are specifically shaping or maintaining problematic emotional symptoms. A clinician should not make blanket assumptions about how a specific cultural belief introduced by patients informs their experience of distress. After a comprehensive functional assessment of the patient's problems, the clinician can consider the remaining guidelines.

Guideline #2: Engage in self-education about specific cultural norms and consult the literature for culture-specific treatment techniques

As the meta-analytic findings by Smith and colleagues (2011) would indicate, patients might most benefit from treatments that have been specifically modified for a certain population rather than more generally culture-sensitive treatment techniques. As mentioned earlier, it is imperative that as we embark on cross-cultural therapy that we stay as close to the empirical data to guide us about effective treatments with different populations. Therapists should therefore first refer to the literature about whether specific cultural adaptations of existing treatments have already been tested and validated (e.g. Latinos: Borrego, 2010; Native Americans: BigFoot & Schmidt, 2009; East Asians: Hwang, Wood, Lin & Cheung, 2006; Southeast Asians: Otto & Hinton, 2006; African Americans: Kelly, 2006). Further, such a review of the literature will enlighten the therapist on what beliefs are the norm of that culture to reduce miscommunication in therapy, and will garner patient confidence in the therapist's abilities and knowledge.

Guideline #3: Ensure adequate and effective training of therapists in cross-cultural competency

While the literature is mixed (e.g. Owen et al., 2010), there is some evidence that patients' perceptions of how culturally competent the provider is can affect the working alliance (Maxie & Arnold, 2006). Also, it is clear that cross-cultural therapy is a complex and multi-layered process, and therefore ensuring cultural competency in mental health work is not

simple for trainees to undergo. It is therefore obviously not enough to assume that garnering cross-cultural competency is just a matter of educating oneself about cultural differences between therapist and client (Sue & Zane, 2009). Rather, others have suggested that therapists need to have a keen awareness of their own cultural and racial identity, and how this may impact their relationship with clients (Plummer, 1997). For instance, multicultural researchers have noted the importance of having practitioners discuss their feelings about treating cross-cultural patients with their professional peers or supervisors (Barbarin, 1984), and exploring attitudes toward psychological help-seeking in their own communities (Chung & Lu, 1996). Such a reflection is indicative of an appreciation for the bidirectional influence of culture in a therapy interaction, to facilitate a healthy dialogue about sensitive cross-cultural topics that might arise during treatment.

Guideline #4: Explore the patient's perspective on both seeking psychological treatment, and the nature of the therapeutic relationship

There have been observed differences in perceptions of obtaining mental health treatment among minority groups, and empirical evidence for the distinctly higher stigma associated with obtaining psychological help in a number of minority cultures (Shea & Yeh, 2008; Alvidrez & Azocar, 1999). Therefore, it may become necessary to first address the stigma around receiving such treatment, particularly assessing for the impacts of this on the individual's sociocultural network. For instance, an individual identifying with predominantly collectivist or interdependent cultural values may regard the need for therapy as a sign of weakness and embarrassment to one's family or community (Furukawa & Hunt, 2011), and this topic must be made explicit, particularly if treatment progress or adherence becomes stalled. In addition, giving validation and respect for the client's perspective on mental health treatment will further enhance clinician-patient trust and bolster the therapeutic bond.

A related matter is being aware of the preference for a preconceived ideal of an appropriate relationship between the client and clinician. Specifically, most treatment perspectives in the West emphasize a collaborative therapeutic relationship (Taber et al., 2011), but this might be isolating or confusing to individuals from certain cultural backgrounds. In fact, individuals identifying with cultures which are hierarchy-based (e.g., Eastern cultures) might expect a more directive, authoritarian approach in the therapy relationship (Tsui, 1985), and an over-emphasis on an equal therapist-patient relationship and socratic, open-ended questioning might raise doubt in the patient about the therapist's capabilities to treat the problem at hand. On the other hand, certain treatment perspectives (e.g. CBT) involve a considerable amount of direct questioning, which might be construed as disrespectful in other cultures (such as Native Americans, and older European Americans; Hays, 2009). Such considerations serve as a reminder of the importance of thorough initial assessment of an individual's cultural beliefs and influences, to prevent an early rupture in the therapeutic alliance.

Guideline #5: Be aware of the importance of respect in the cross-cultural therapy setting

Clinicians engaging in multi-cultural therapy must set an overarching tone of respect in order to meet the goals of therapy collaboratively with the client. This means allowing individuals to fully express their individual stories and to explain how their cultural beliefs have been uniquely part of this story (Coronado & Peake, 1992). Furthermore, establishing trust in the therapy relationship is intricately interconnected to the level of respect shared between the client and therapist. To that end, it is important that therapists validate the client's experiences, including encounters with cultural or racial discrimination, and possible oppression in the majority culture. Patients want to feel believed and therefore clinicians are advised to assume the reported incident occurred just as it was described by the patient, to

provide support around such an experience, and then to later examine how much that experience has influenced the current symptoms of interest (Kelly, 2006). Aligning oneself with patients by demonstrating full support for the difficult race- or culture-related stressors they may be facing will mitigate hesitation in discussing such sensitive issues with the therapist (Vasquez, 2007).

Guideline #6: Identify and incorporate client's culturally-related strengths and resources into treatment

One general guideline across contemporary models of psychotherapy refers to an exploration of individual strengths in order to enhance treatment success and adherence, and this can be taken one step further in MCT. For instance, the identified culture itself can be a major resource and provide an extensive support network for the client (Cross, 2003). Also, culture itself influences a range of culture-specific skills (e.g. naturalistic medicinal knowledge, cooking, fishing, farming, etc.), coping mechanisms (e.g. culture-specific metaphors for understanding emotional symptoms; Hinton, Lewis-Fernandez, & Pollack, 2009), interpersonal organizations and community resources (culturally-oriented political or social causes, places for worship, or financial resources), and artistic outlets for emotion (through dance, art, and music; Hays, 2007).

Thus, it is important to bring these culture-influenced strengths of the individual to the therapy discussion, particularly if these positive attributes may be incorporated into treatment techniques and practice. Hays (2009) astutely notes, however, that certain cultures (e.g. Asians & Native Americans) are culturally socialized to be modest about individual strengths, and therefore these might not be easily verbalized if such individuals are directly questioned about their own strengths. It is therefore suggested that individuals from this more interdependent cultural set-up be asked to think what other significant individuals in their lives might say the strengths of the patient are, in order to access this information and incorporate it into the therapeutic relationship more readily.

Guideline #7: Identify and utilize technique-specific cultural modifications

Finally, as clinicians and clinical researchers, our foremost concern in mental health treatment is ensuring adequate delivery of treatment techniques that will result in noticeable improvement in our clients' symptoms. Therefore, while it is reasonable to utilize treatment techniques that have been seen to be efficacious, we must be ready to modify these techniques in a culturally-sensitive fashion. Again, it is ideal to make cultural modifications that have been validated in the population of interest, but in the absence of definitive empirical evidence for all possible modifications, we must use our cross-cultural knowledge to make reasonable changes to effective techniques. For instance, in the CBT framework, we often ask clients to question the validity or reasonableness of a particular negative automatic thought, but this might be regarded as uncaring on the part of the therapist, and places negative judgment on the client's belief system (Wood & Mallinckrodt, 1990). The therapist might choose instead to take a more culturally responsive approach (Beck, 2005) and ask clients to question the utility or helpfulness of the thought, encouraging them to weigh out the pros and cons of holding on to this belief. Similarly, CBT often leads to an eventual challenging of core (negative) beliefs that a patient holds about themselves or the world. Therapists must be cautious of directing patients to challenge their core cultural beliefs, even if a particular belief of the client seems incongruent or problematic within the therapist's own cultural value system.

With these guidelines in mind, the next section describes a case treated by one of the authors (AA) and highlights the practical use of these techniques throughout the treatment episode.

The influence of these culturally-responsive directives are demonstrated in the progressive development of a strong working alliance in the following clinical case study.

Application of Alliance-Building Techniques: The Case of Karen¹

Karen was a 37-year-old Jamaican-American female and a single mother of 3 teenage-age children, who had recently lost her job due to a change in ownership at her medical insurance firm. Karen presented to our cognitive-behavioral treatment (CBT) clinic with a primary diagnosis of panic disorder with significant agoraphobia, and additional diagnoses of obsessive-compulsive disorder and generalized anxiety disorder. She had also had a past history of major depression and post-traumatic stress disorder from chronic and multiple traumatic experiences. Karen had pursued significant prior treatment, but with little relief in her ongoing anxiety symptoms.

She had decided to pursue treatment at our clinic because she had read about the efficacy of CBT for treatment of various anxiety symptoms. She also hoped that the more structured and short-term nature of this type of treatment might help her develop a more healthy attachment to her provider, which had been difficult in the past. It therefore became apparent from early on in treatment that one therapy goal would have to be to effectively develop a strong working alliance while balancing reasonable boundaries to keep the purpose of the therapeutic relationship clear. This goal was explicitly stated from the outset, and framed as being in the best interest of both the patient's progress and to maintain treatment fidelity and effectiveness. However, it was recognized that much of Karen's current support system lay in the familiarity of relationships in her religious and ethnic community, therefore it might take some time for her to feel comfortable with a more formalized and boundary-imposed relationship with her therapist.

Guideline #1: Conduct a thorough culturally-informed but person-specific functional assessment of presenting problem

The primary aim in the first several sessions was to fully explore the role of cultural beliefs in the development and maintenance of Karen's symptoms. Within the first session itself, Karen expressed her strong religious belief and heavy involvement in church. Related to this, it was clear that Karen received many negative messages from her children, mother, and church friends about both her experience of panic-symptoms, and her decision to receive "outside" (i.e. outside of the Caribbean American community) psychological help. This did not deter Karen from seeking treatment, but through therapist exploration, Karen admitted that this certainly fueled her own negative beliefs about being different from everyone around her and made her feel discouraged about ever becoming better. She also felt depressed about not being able to "kick these symptoms" on her own simply through prayer and faith as others suggested, and felt like a failure about this perceived deficiency.

With these larger cultural themes in mind, the therapy content started focusing on specific anxiety symptoms, and explored how culture infused her psychological symptoms in more detail. For instance, Karen reported that her obsessive thoughts about being poisoned by others (which would result in avoidance of eating or drinking items given to her by others at their homes, or in other settings outside her own home) stemmed from a strong belief in black magic, and that others were trying to harm her out of jealousy and control by the devil.

¹Name and identifying information changed to protect patient's privacy.

Guideline #2: Engage in self-education about specific cultural norms and consult the literature for culture-specific treatment techniques

The strong belief in black magic and having “an evil eye” cast upon someone was recognized as a widely-accepted, culturally-congruent belief in individuals from the Caribbean, and the therapist therefore did not question the validity of this belief. Pathologizing such a common belief from that cultural system as disordered or undesirable was regarded as culturally insensitive and potentially isolating for the patient. Instead, the therapist focused more on increasing her motivation to target the avoidance and interference associated with this thought.

Similarly, given the expressed importance of religion in Karen’s life view, the therapist explicitly incorporated Karen’s spiritual strengths into the treatment very early on, particularly to target the stigma she experienced from others surrounding her decision to pursue psychological treatment. Specifically, the therapist proposed the idea that Karen’s decision to seek formal help to address her anxiety symptoms was an example of her following her own internal spiritual compass in order to maximize her strengths and abilities to contribute to her community and family. Karen really started identifying with this perspective shift, and became much more receptive to the more traditional treatment techniques presented when they were framed with this religious lens.

Guideline #3: Ensure adequate and effective training of therapists in cross-cultural competency

An interesting feature regarding these two interrelated themes (philosophical perspective and stigma) was that Karen actually challenged the therapist to reflect at a very early stage in treatment about her own beliefs regarding these issues, and how that might affect the therapeutic relationship. Typically, therapists’ opinions on such topics are avoided; that is, as clinicians we are instructed to re-direct patients’ questions about our own personal beliefs. However, this was recognized as quite likely to be detrimental to the therapeutic alliance, and would run the risk of having Karen disengage from treatment because of a feeling of disconnection from the therapist. An excerpt from the session where the patient directly questioned the therapist about her own beliefs is given below:

Karen: “There’s one more thing I need to ask you before we end today. Do you think people who need therapy are weaker?”

Therapist: “I want to make sure I understand what you’re asking me, since this seems pretty important to you. Do I think such individuals are weaker than who - those who do not seek a therapist, or those who do not experience emotional distress? And why is it important for you to know how I feel about it?”

Karen: “Those who do not go to a therapist – I don’t think anyone is completely free from emotional distress. Do you think that I really should be able to deal with this on my own, and that generally your work is to help people who are weak?”

Therapist: “First, I completely agree with you – I think each and every one of us struggle with emotional distress, and therapy can be a great way for all of us to get some support and skills to deal with our tough times better. That also means that I actually think you’re not weak, but very strong to take the steps to come to therapy, *particularly* because I know you don’t get a lot of support for that from those who are close and important to you. Is that partly why you were asking, to see if I feel the way they [her mother, children, and church community] do?”

Karen: “Kinda, yeah. It’s hard not to feel weak, because no one else in my life is in therapy.”

Therapist: “I can completely understand that feeling. You know, Karen, when I told my family that I wanted to study Clinical Psychology, they were extremely resistant to it. They didn’t feel “mental health” was a real thing, and weren’t even quite willing to accept that anything except willpower or prayer to a higher power could affect our emotional distress. Yet, I had to make a tough decision to stay true to my course of study despite their protest, because I felt that while willpower and spiritual pursuits can be extremely powerful, they are not always effective on their own, in the absence of other resources. I think you and I are a lot alike in that way – both determined to do our best and get the most out of our lives, even when our families or communities might not agree. It’s hard to stay patient until they come around and see the benefits like we do though, isn’t it?”

Karen: “I know! Sometimes I just want them to open their eyes and minds to see that I was right about this being important and useful for me, and I even think some of them need similar help, but they’re too stubborn to get it. You’re right, I am determined, and I do feel good about sticking to my beliefs about making my mental health a priority. I can feel God’s guidance in doing that. So even if they disagree, I’m not going to give up on this. I need this jumpstart in my life.”

As exemplified in this excerpt, the therapist adequately revealed some personal beliefs and experience with stigma observed around seeking psychological help in her own life. This was presented after consultation with other clinicians, the literature, and reflection on her personal beliefs towards psychological dysfunction. Even with only this partial disclosure on the part of the therapist, Karen expressed feeling respected and more willing to continue with treatment with this provider.

Guideline #4: Explore the patient’s perspective on both seeking psychological treatment, and the nature of the therapeutic relationship

As mentioned previously, Karen reported having several past treatment episodes, with little sustained improvement in her anxiety symptoms. She noted, however, that she had deeply enjoyed several of these therapy experiences, specifically because of the strong therapeutic relationship she shared with the providers during those experiences. That being said, in the first session she verbalized a concern that her close relationship with her past therapists eventually became a disadvantage, primarily because she found it difficult to terminate these relationships or to continue with skills independently once therapy ended. This provided insight into Karen’s own perceptions and concerns around an ideal therapist-client relationship.

Boundary setting in the therapy relationship therefore became a shared goal throughout the course of treatment. This had to be handled in a culturally-responsive way, because it was important not to make Karen feel isolated in her experiences so she would feel comfortable confiding in the therapist. Yet, Karen often pushed the boundaries of the professional therapy relationship by wanting to call “just to chat”, asking the therapist details about her family and upbringing, and wanting the therapist to come to her home community to meet other members of her family and church. These were handled in a manner similar to how matters of religiosity, politics, and related beliefs are typically dealt with in therapy, but the cultural need to feel connected and incorporate the therapist into Karen’s own community was acknowledged explicitly.

Guideline #5: Be aware of the importance of respect in the cross-cultural therapy setting

One recurrent problem area was Karen’s ongoing worry surrounding a “love-hate” relationship with her mother. Specifically, she felt significant distress when interacting with her mother, and yet she worried constantly about her mother dying, and felt that she would

be unable to function with her mother gone. Most of her inner conflict in this relationship stemmed from a strongly ingrained cultural pressure to maintain an active relationship with her mother, but this relationship posed significant barriers to her own ability to be productive and stress-free. The therapist would have been remiss in this case to suggest to Karen that she disengage from this relationship with her mother (which would be inconsistent with the interdependent family/community system). Instead, Karen was asked to reflect thoroughly on this relationship (with various in-session exercises on the pros and cons of her relationship with her mother), to help the patient become comfortable with finding her own balance of meeting her familial responsibility and yet, protecting her own mental health.

Similarly, while Karen expressed many traditional cognitions associated with her agoraphobic concerns (e.g., inability to reach medical help promptly, or to escape when experiencing panic symptoms), she also reported anxiety during exposure exercises around the Center because of a prior experience of racial discrimination when in distress in a similar predominantly White location. This experience was met with empathic validation and it was discussed at length how much her own perceptions of being negatively regarded by others due to her race tie into her fears around being helpless when experiencing panic outside from her own geographic community. Once the patient felt supported and listened to around this concern, the therapist worked on gradually exploring how Karen may more rationally weigh out the probability that every individual around her will refuse to help her based on her race/appearance, and she was receptive to this. In particular, the therapist encouraged her to think of the instances in her life that others from the majority culture had actually been caring and helpful towards her, in order to more rationally evaluate her fears about being completely unsafe or alone.

Guideline #6: Identify and incorporate client's culturally-related strengths and resources into treatment

Again, Karen's major positive characteristics were many, but several were directly linked to her community and spiritual values. A recurrent theme throughout treatment was the importance of belief in God and service to her church. Consequently, this particular community/belief system was often referred to and integrated into the homework exercises and therapy discussions. Aside from its previously-described use to increase her motivation to address the anxiety symptoms that were interfering with her meeting her full potential, the use of her community and church involvement were utilized. For instance, as she was nearing the end of treatment, she independently volunteered to work with the clinic administrators to disseminate information about available services, e.g. by going into local churches in her neighborhood to share her positive experiences with therapy and anxiety reduction. This exercise was extremely empowering for Karen, and met this need to contribute meaningfully to her community. There was also a focus on strengthening interpersonal relationships with her family members (e.g. going to get her nails done with her young adolescent daughter), because of her highly expressed cultural value of staying close-knit as an immigrant family. Thus, spending time with such individuals served both as an exposure exercise (to reduce agoraphobic avoidance) and to meet this valued interdependent cultural goal.

Guideline #7: Identify and utilize technique-specific cultural modifications

Treatment therefore progressed using empirically supported techniques with these cultural guidelines integrated into the session content. Karen actually came for a relatively longer treatment course than what is typical for CBT in this treatment setting (around 30 sessions), primarily due to a other stressors (legal and significant medical conditions involving two of her children) that suddenly happened about 15 sessions into the treatment. At this point in

therapy, there had already been a considerable objective and subjective improvement in Karen's anxiety symptoms (particularly in her panic and agoraphobic symptoms). These sudden crises forced the treatment to take a different focus for about 5 sessions, in order to maintain the therapeutic alliance and to meet the immediate needs of the patient. Once these external circumstances had reduced in urgency, treatment focus returned to managing with her overall stress level and specific lingering anxiety symptoms.

There appeared to be a plateau reached in several of her symptoms (particularly her chronic worry symptoms), and therefore it was decided that first-line CBT skills needed to be supplemented with other related techniques. Of note, the technique of mindful meditation was presented to Karen. However, to make this technique more palatable to this client, mindfulness activities that emphasized resilience (with Karen's history of experienced racism and trauma as an explicit part of the extensive metaphor for meditation) and spiritual values-driven mindfulness practices were presented. Karen really enjoyed these exercises, and reported a significant relief in the frequency and severity of her chronic worry through consistent use of this skill.

Termination of therapy

Termination of therapy was collaboratively decided upon, on the basis of significant reduction in anxiety symptoms, and at a point where the patient herself verbalized a need to detach from her dependence on the therapeutic relationship to try the skills independently. At the last session, Karen brought in a gift (a velvet rose) and a card with religious themes as a gesture of gratitude for the therapist. At this particular treatment setting, gifts are usually declined, but the therapist regarded Karen's gift choice as a noted effort to stay within the discussed boundaries and recognized the card as her desire to express herself from within her own belief system. Given this, the token was accepted by the therapist, and Karen also asked if she could occasionally call the therapist to update her on how things were, which was discussed in terms of reasonable frequency of such updates. Three months after the termination of treatment, Karen called the therapist to let her know she had found a job, and was planning a trip to New York with her friends after over 20 years of feeling too anxious to leave her hometown. The therapist responded to Karen with warm reinforcement for her achievements, and reminded her of how far she had progressed since she had first started treatment almost a year earlier, encouraging her to keep using the skills she had learned.

Concluding Thoughts

This case highlights some practical applications of empirically-driven guidelines for enhancing collaboration when working with cross-cultural patients. Over the treatment episode, one may observe how the therapist modified the entire process (from assessment, to treatment interventions, and through to termination) to make it more culturally relevant to Karen. There was an equal emphasis on delivering evidence-based treatment techniques and on cultivating a strong therapeutic relationship to meet this goal. Tailoring the treatment procedures to Karen's individual needs (which were largely influenced by group-level cultural, religious, and societal beliefs), and doing this explicitly, contributed to her significant progress, as she expressed in the termination session. She reported feeling respected, listened to, and entrusted in contributing to her own progress, which gave her confidence to continue the skills on her own even after therapy had ended.

Certainly, the presented case study is not an exhaustive application of the described guidelines. The discussion in this article assumes primarily a traditional therapy set-up, and therefore the focus is on how to make more traditional modes of therapy more culturally responsive. There are, however, several other features that have shown some indication of aiding in treatment engagement in certain cultural groups in other countries, and should be

considered if feasible. For instance, clinicians should consider delivering therapy in more naturalistic, familiar settings (such as in the person's residence, place of worship, or general community area), in order to make the patient feel more comfortable and connected to the therapy interventions introduced by the provider (Hickling, 1994). Also, this case highlights the important role spirituality/religiousity can play in a patient's willingness to seek or adhere to treatment, particularly if religion is intricately tied into the person's cultural identity. Further, it is important to focus on both individual events in the patient's life (socioeconomic status, family structure, and potential trauma history), and the broader cultural events that may intrinsically and more systematically impact a particular population's views toward help-seeking and the therapist as a person (e.g. Holocaust experiences in Jewish patients, slavery/racism in African Americans, and English language difficulties and resultant discrimination in Latinos). Part of the process with familiarizing oneself with the customs and practices of a particular culture is being aware of, and assessing the impact of, these significant historical/social themes (Comas-Diaz & Greene, 1994; Sue, 2009).

Finally, even clinicians who are aware of the nuances of these various cultural considerations and who have engaged in extensive multi-cultural therapy must challenge themselves to treat each case as unique. This overall attitude of curiosity and respect towards clients, across treatment orientations, establishes a strong working alliance between the therapist and patient. Our primary aim should be to use such resources/guidelines to systematically provide the most comprehensive care, and to meet the needs of these individuals who, regardless of culture, gender, or sexual orientation, are coming to practitioners for help in their times of distress.

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