

Introduction

What Is Cultural Psychotherapy?

It would hardly be fish who discovered the existence of water.

—Clyde Kluckhohn, *Mirror for Man*, 1959

Psychotherapists often ignore culture until it is too late. When our interventions backfire or fail to work, we find ourselves like fish out of water; only then do we recognize the unspeakable importance of our surroundings, context, and culture. Culture, however, is ever present in complex and multifold ways both in the psychotherapeutic session and in people's lives. Cultural psychotherapy underscores cultural influences and explains that our understandings are embedded within cultures, which gives significance to what unfolds in the therapeutic session. Without a cultural understanding that includes clients' and therapists' contexts, underlying meanings are likely to be misinterpreted. Cultural psychotherapy explains that if we are not aware of the multiple, ongoing cultural forces influencing the psychotherapeutic process, then we will unknowingly reproduce them. We will blindly follow cultural norms and assume that they are rigid, unquestionable, or universal. An enhanced awareness of these cultural forces can lead us and our clients to have a greater degree of freedom, flexibility, and empowerment.

In this book, I describe an emerging field of study and type of psychotherapy that is transforming the psychotherapy literature. Labels such as cross-cultural psychotherapy and counseling (Marsella & Pedersen, 1980), ethnic family therapy (McGoldrick & Giordano, 1996), multicultural counseling (Sue, Ivey, & Pedersen, 2007), medical anthropology/cultural psychiatry (Kleinman, 1988), and diverse culturally sensitive or cultural competent psychotherapies are often used to describe similar ideas. I, however, believe that the term *cultural psychotherapy* is more accurate because it is broader and more inclusive than other prominent terms.

In addition to the fast growth of cultural approaches, an increasing number of culturally adapted interventions for specific disorders (e.g., depression, conduct disorder, and anxiety) are being developed and tested (see Griner & Smith, 2006; Huey & Polo, 2008, for reviews). As a result of these investigations, many ethnic minorities who would not have otherwise received treatment (or would have received inappropriate care) are benefiting from culturally competent psychotherapeutic strategies. However, what in fact differentiates most culturally competent psychotherapies from others is that they are designed for specific racial and/or ethnic groups.

In contrast, cultural psychotherapy emphasizes the need to understand that race and/or ethnicity alone is insufficient to design a psychotherapeutic intervention. Race and ethnicity do not predict psychological attributes (Helms, Jernigan, & Mascher, 2005); thus, it is necessary to measure, rather than to assume, psychological characteristics to design psychotherapeutic interventions (see Chapter 6). Cultural psychotherapy defines cultural variables not only through ethnicity and race, but also through sexual orientation, gender,¹ disability status (e.g., deaf, blind), socioeconomic status (SES), religious background, ethnic identity, and discrimination experiences, among other variables. The large number of differences within ethnic or racial groups raises questions about the standard use of culturally adapted interventions for specific ethnic/racial clients, as well as their viability (Lau, 2006).

Unfortunately, cultural differences are often construed as deficits that lead to segregation, over-pathologization, substandard treatment, and discrimination. For example, at times some characteristics of ethnic minorities (e.g., intellectual quotients) are considered inferior to those of Whites² (e.g., Herrnstein & Murray, 1994). Cultural psychotherapy attempts to move beyond these shortsighted views by emphasizing the need to understand these differences within their cultural context. Furthermore, we all live in contexts that give meaning to our lives; thus, these recommendations are applicable not only to ethnic minorities, but to each and every one of us. A thorough and more complex consideration of cultural variables rather than the use of more broad terms such as race and ethnicity enhances the efficacy and effectiveness of psychotherapy. Cultural variables are herein defined as meanings that are overall more frequent in one cultural group (e.g., ethnic, religious, gender orientation) than others. Nevertheless, there is much variability amongst individuals within each cultural group.

In addition to this conceptual and methodological approach, cultural psychotherapy operationalizes and systematizes a model to intervene that I call the three-phased cultural psychotherapeutic model, which is a coherent and specific set of interventions derived from these conceptual ideas. An overview of this psychotherapeutic model is presented in this introduction with significantly more detail in later chapters (1–3, 7).

The purpose of this book is not to review the fast-growing number of cultural psychotherapeutic models or to summarize important and new research or to develop a thorough conceptual definition of culture; instead, the goal of this book is to propose a coherent type of psychological treatment that considers individual, relational, and contextual factors. This model is illustrated through numerous clinical cases and some research studies. The bulk of this book is a description of this psychotherapeutic model. However, it is important to acknowledge that many important ideas have influenced the development of this model. For this reason, some of cultural psychotherapy's historical antecedents are summarized here first.

SOME HISTORICAL ANTECEDENTS OF CULTURAL PSYCHOTHERAPY

Cultural psychotherapy is not a new movement. Its origins can be traced back to 1879 and the official birth of psychology as a scientific discipline. Wilhelm Wundt is traditionally considered the father of psychology and was the first to introduce the scientific method into the study of mental processes (Boring, 1957). The mind, Wundt argued, could be measured and explained according to the canons of experimental science. In addition, Wundt conceived psychology as consisting of two parts, where each part is based on a distinctive

layer of human conscience and each follows its own laws and methodology. The first part Wundt talked about was physiological psychology, which is assessed through the experimental method (e.g., laboratory studies) and investigates the fundamental mental processes that underlie all human beings. The second part that Wundt (as quoted by Cole, 1998) spoke about was the *Volkerpsychologie*, or elements of folk psychology, which is the study of human behavior in different cultural contexts.

Although Wundt wrote 10 volumes on the *Volkerpsychologie*, these ideas were neglected for almost a century before experiencing a recent revival. A growing number of researchers (e.g., Cole, 1998; Heine, 2008; Markus & Kitayama, 1991; Triandis, 1994) have rediscovered and expanded his ideas. These fruitful efforts are producing a vast and fast-growing cross-cultural and cultural psychology, much of which is the conceptual foundation of cultural psychotherapy. Researchers have noted that the basic psychological processes such as attention, memory, perception, and motivation and even the wiring of the brain are dependent upon cultural processes (e.g., Heine, 2008; Markus & Kitayama, 1991; Park & Huang, 2010). Cultural psychotherapy, like cultural psychology, argues that it is impossible to understand any psychological processes without understanding the context in which these processes are embedded. Cultural psychotherapy, however, emphasizes the need to use these findings to develop effective psychotherapeutic interventions, whereas the tenets of cultural psychology focus more on the understanding of basic psychological processes.

Cultural psychotherapy is highly indebted to medical anthropology (e.g., Hinton & Good, 2009; Kleinman, 1988) and multicultural counseling and therapy (Sue et al., 2007). Both have advanced important ideas on how to assess and treat people in culturally sensitive manners. Medical anthropology explains that psychological disorders are unlike viruses or bacteria. Bacteria, for example, present similarly wherever they appear, whereas the presentation of psychological disorders may vary by context (Kleinman, 1988). Multicultural counseling and therapy starts with the premise that culture always permeates how we assess and treat others. Research, assessment, psychotherapy, consultation, and supervision are culture bound. Similarly, cultural psychotherapy underscores the need to consider the cultural context in all aspects of a theory—research, assessment, treatment, and supervision. Psychological concepts, research methodologies, and even data are embedded in the social systems that influence their meanings (Kleinman, 1988). If the cultural context is not taken into account in these practices, they will inevitably end up being restricted by this absence. Although cultural psychotherapy aligns with most of the basic tenets of medical anthropology and multicultural counseling and therapy, practitioners of cultural psychotherapy attempt to further specify into concrete psychotherapeutic interventions their theoretical assumptions. The three-phased cultural psychotherapeutic model is a result of these efforts. Additionally, cultural psychotherapy underscores the need to bridge findings from different psychotherapies and disciplines.

As such, cultural psychotherapy is also influenced by diverse disciplines that range from anthropology to physics. I will briefly highlight three major and very distinct influences from the realms of cultural anthropology, hermeneutic theory, and the theory of relativity. Cultural anthropology (e.g., Geertz, 1973; Shweder, 1990) emphasizes the impact of culture in understanding psychological processes. It underscores the influence of the context on all human behaviors and meanings. Hermeneutic theory (e.g., Gadamer, 1975) construes the meanings of texts (e.g., the Bible, the American Constitution), actions, or behaviors as inseparable from the historical times from which they are derived. Hermeneutic

approaches warn us about the dangers of analyzing texts without the contexts in which they are embedded. If a text is analyzed in a historical vacuum, we will very likely misinterpret its meanings. Finally, Albert Einstein's relativity theory dethroned the dominant Newtonian conception of a universal and inert space and time. Einstein explained space and time as active, dynamic change agents that shape reality. Furthermore, Einstein specified the mechanisms (e.g., the warping and curving of space) by which space/time shapes events. Similarly, cultural psychotherapy aims to identify cultural processes that affect the psychotherapeutic process and systematically use these—through the development of the three-phased cultural psychotherapeutic model—to enhance the effectiveness of our psychological interventions. Below is a description of a couple I treated in my Cambridge private practice. It is a case that will help to introduce the three-phased cultural psychotherapeutic model and clarify some of the basic assumptions of cultural psychotherapy.

Case Illustration: Sophie and Omar

A young professional couple came to psychotherapy because they were increasingly arguing for no apparent reason. Omar, a 26-year-old, soft-spoken Palestinian software engineer had been dating Sophie, a 25-year-old, assertive, Jewish clinical social worker for 2 years. They both felt it was time to define their relationship, that is, to move in together, or end it. Their therapeutic goal was to clarify the future of their relationship and if they were to stay together to reduce their frequent arguments. Omar and Sophie reported "loving each other very deeply" and agreed that their arguments were "absurd" and "seemed to come out of the blue." Neither could identify triggers for these arguments, which would escalate and lead to prolonged and tense periods of silence. During these periods, Omar retreated emotionally and Sophie demanded his attention. Furthermore, Omar and Sophie's frustration would lead them to get angry at each other for long periods of time. As a result, Omar felt bombarded by her demands and Sophie felt abandoned by him. In discussing these interpersonal dynamics, they decided to call this the "retreat-demand pattern." As we started psychotherapy, much of the clinical effort was directed toward exploring, identifying, and then having them express their feelings of being "bombarded" or "abandoned." In treatment, Omar realized that his tendency to be quiet was a result of his father's belief that Muslim men should solve problems in silence. In contrast, Sophie described how she would have been criticized if she had remained silent. In treatment, they agreed that if either one started noting the emergence of the retreat-demand pattern, they would bring it into the open and explore strategies to prevent it from building up.

In therapy, we further explored how Omar and Sophie's relational and cultural histories contributed to the retreat-demand pattern. Omar explained that as a Muslim it was his duty and part of his upbringing to unquestionably listen and follow his father's prescriptions even though he would at times feel enraged by his father's traditional views. In fact, Omar reminded Sophie that the word *Islam* meant surrendering, an act of love, which is what he attempted to do during his silences. In contrast, Sophie described how she was repeatedly encouraged to voice her opinions as she was growing up. Although her parents divorced

when she was a child, both consistently supported her efforts to assert herself. As she came to disagree with them on certain issues, however, they seemed to distance themselves from her, just as she feared Omar would do. With tears in her eyes, Sophie explained that she now often kept her views to herself, as she feared that Omar would retreat emotionally just as her parents had. With new understanding of how their past relational histories contributed to their retreat-demand pattern and through the use of different behavioral techniques (e.g., they would identify when they were sinking into the retreat-demand pattern), the intensity of their problems was assuaged but they both felt there was still much yet to be addressed.

As we continued to explore possible triggers for their conflicts, we discovered that Omar's preparations for Ramadan irritated Sophie, while Sophie's activities for Passover and Rosh Hashanah annoyed Omar. Soon, we also noticed how their "silences" intensified as religious holidays approached as well as when the Israel-Palestine³ conflict escalated. In the early stages of their relationship, Sophie and Omar learned to avoid political discussions given that these inevitably led to endless arguments and painful silences. However, with my encouragement they hesitantly discussed their views on religion and the Palestine-Israel conflict. At that time, the latest news had Hamas gaining strength in Gaza and threatening to violently separate from Israel. Although Omar did not believe in war, he sympathized with this movement and repeatedly expressed his anger toward the state of Israel for appropriating his family's home (one that had been in the family for generations) in the West Bank. Omar voiced his belief that the only way to deal with Israel was through force, a statement that offended Sophie. Sophie firmly supported Israel's right to protect itself, particularly given the history of genocide involving Jewish people. During the Second World War, many of her family members were executed in Nazi concentration camps.

Their clashing views intensified, making the relationship unbearable for both. Many times it seemed inevitable that they would break up, just as Israel and Palestine seemed headed inevitably toward bloodshed. The conflict in the Middle East seemed too large and beyond the reach of psychotherapy. It seemed futile to discuss a conflict that had been raging for generations, just as it seemed hopeless that Omar and Sophie would be able resolve their differences. It was almost as if a heavy shadow of hopelessness had enveloped the sessions that clouded their ability to see each other and their willingness to work things out. In exploring this hopelessness, Sophie and Omar noted how increased tension in their relationship seemed to occur in tandem with the growing intensity of the Palestine-Israel conflict. They shared their fears that the Israel-Palestine conflict would never be resolved. Similarly, they discussed the possibility that their relationship would end.

Just as they were disappointed in the international community's lack of support in the Palestine-Israel conflict, they blamed me for not saving their relationship. Although the goal of treatment was to define their relationship, not save it, I too felt disappointed in my inability to "rescue" their relationship. In exploring the intensity of my feelings, I realized that my desire to "rescue" them was not just a result of sociopolitical interpersonal and forces; it was also heightened by my identification with them. My wife and I are also from different ethnic and religious backgrounds, and I wondered if my failure to help them would undermine my belief that differences can enrich relationships, including my own. An important premise of cultural

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psychotherapy is that multiple forces (e.g., individual, relational, societal) constantly affect our behavior, and it is important to identify what forces are in play to more effectively respond to them. In this case, my sensitivity to their situation was greater because of the similarity between their issues and mine. This self-awareness increased my effectiveness. Thus, I was able to contrast their initial treatment goal with our current hope of “rescuing” their relationship. This allowed them to explore why they now wanted their relationship to be rescued, while at the beginning of treatment they did not feel that way.

Despite Omar and Sophie’s significant political differences, they kept talking and coming to therapy, and slowly they found common ground. They agreed on the need to establish a sovereign Palestine state that worked in conjunction with a strong Israel, as they agreed on the need to listen to each other even when “bombarding” or “retreating.” As they identified, explored, and at times reconciled their differences, their relationship grew stronger. They also started to understand the impact of political forces on their relationship: When the turmoil in Israel-Palestine increased, Sophie construed Omar as a threat to the foundation of her faith and identity. In turn, Omar viewed Sophie as part of a group that had robbed his family of its land, wealth, and security. Throughout their sessions, I was left feeling as if I represented the international community that led and fueled the conflict. Our views of each other and our feelings (e.g., hopelessness) were affected by historical and political events that transcended our experiences and relationships.

Powerful sociocultural and political forces that had been shaping lives and countries even before we were born were in play both inside and outside the psychotherapeutic session. For example, Sophie and Omar would often hear their friends exclaim, “It is unbelievable that you guys are together!” As Omar and Sophie’s awareness of these contextual forces expanded, they realized they did not have to respond to them in the same ways they had in the past. Instead of automatically reacting to them (e.g., getting defensive or hopeless) or following cultural expectations (including the expectation of being rescued), they had a choice in how they responded and they could do so “head on.” They realized they could discuss events in the Middle East rather than avoiding them until they escalated and “exploded.” They educated themselves about the Palestine-Israel conflict and started to participate and support organizations that promoted both the State of Palestine and the existence of Israel by frequenting rallies, particularly those in support of Palestinian refugees. They wrote to their legislators and attended fund-raisers for Palestinian refugees. As they became more politically active, they met other Muslim-Jewish couples that were dealing with similar issues. This helped them realize they were not alone and that others felt the same way. After a few more months of psychotherapy, they moved in together.

THE CONCEPTUAL FOUNDATIONS OF CULTURAL PSYCHOTHERAPY

Cultural psychotherapy starts by assuming that we can understand the psychotherapeutic process in multiple and simultaneous ways. Although there are countless theories that make sense of our clients’ issues, in this book I emphasize only three of the most relevant

sets of psychotherapeutic theories, or paradigms, namely (1) individualistic, (2) relational, and (3) contextual/ecological. Underlying cultural psychotherapy's integrative approach is the assumption that clinicians are more effective as they are able to conceptualize the psychotherapeutic relationship through different conceptual lenses (Gold & Wachtel, 2006; Ivey, 1999). Below, each of these three approaches is briefly explained.

For individualistic approaches, the basic unit of analysis is the client. The object of treatment is to understand and heal individuals. Concepts such as ego-strength, self-actualization, self-esteem, self-coherence, self-efficacy, and insight have grown in individualistic treatments. In the case illustration, I noted how understanding Sophie and Omar's individual characteristics and history benefited treatment of the retreat-demand pattern. For example, it was clear that Omar's father's belief that Muslim men should solve their problems in silence influenced the way he expressed (or did not express) himself with Sophie.

In contrast to individualistic approaches, relational psychotherapies underscore the exchange between clients and therapists as central for the understanding and treatment of individuals. For these approaches, the relationship is the unit of analysis. The emergence of relational psychotherapies has created a revolution within the psychotherapeutic literature that has not only expanded our ability to understand and treat our clients but also developed research methods that emphasize the influence of the observer on the observed. Clients cannot be understood without therapists, just as Omar and Sophie's relationship in the session could not be understood without consideration of my influence (e.g., my feelings of hopelessness, or my identification with them).

An integral component of cultural psychotherapy is the assertion that individualistic and relational approaches are insufficient to fully grasp the complexity of the psychotherapeutic process. This leads to a third level of understanding, the contextual/ecological level, which is required to more thoroughly understand what happens in assessment, treatment, supervision, and research. In cultural psychotherapy, the context is an important and complex element that influences the psychotherapeutic process. Not taking the context into account is missing an important set of variables within the psychotherapeutic process. Omar and Sophie were highly influenced by events outside the four walls of psychotherapy (the Israel-Palestine conflict). The underlying issues affecting their relationship could not have been appropriately explained solely by using relational or individual variables. Only as these forces are understood can people develop strategies to respond differently to contextual forces. Furthermore, an acknowledgment that individuals and relationships are embedded in cultural contexts also motivates people to change unjust social situations. Often, it is not enough to transform oneself (as individualistic psychotherapies aim for) or our relationships (as relational psychotherapies aim for). Sometimes, it is also necessary to change our contexts.

For the most part, relational psychotherapies highlight the importance of the cultural context (e.g., Ballou, Matsumoto, & Wagner, 2002; Brown, 1994) to the point where some talk about relational cultural therapy (Jordan, 2010); however, more frequently relational therapists seem to lump relationships and culture into one broad category (e.g., Slife & Wiggins, 2009). Systematic recommendations to address contextual issues are often lacking. Throughout this book, I argue that the influence of the context (e.g., influence of the Palestine-Israel conflict) is distinct and irreducible to that of relationships and individual characteristics. Not distinguishing these different influences limits our ability to

understand and intervene. As clients and therapists recognize the impact of contextual influences on the psychotherapeutic process, they become more effective in dealing with these social forces (see Chapter 3).

The context is a multilayered construct that includes systems, situations, and people (Zimbardo, 2008). The context is more than the time and place (socioeconomic conditions, history, and geography) of a person. The context influences the interaction between client and therapist as well as the prevalent cultural meanings (e.g., cultural values, beliefs, gender roles) and language (verbal and nonverbal) of a specific group. Some of these contextual influences may be interiorized; nevertheless, this does not mean that the contextual attributes parallel those of an individual. Furthermore, some of these contextual meanings are expressed relationally, but this does not mean they are equivalent. Contextual forces are not reducible (although they can overlap) to individual or relational variables (Na et al., 2010; Shweder, 1973), and there is much individual variability within cultural groups. For example, most Muslims may adhere to the precepts of the Qur'an; however, the meanings people make of it vary from group to group and from person to person. Not all Muslims and perhaps only a very reduced number would agree with Omar's interpretation that to submit or to surrender is the ultimate act of love. Omar did not understand why Sophie kept "attacking" him by repeatedly inquiring about why he did not express his feelings. Omar explained that he experienced these remarks as accusations, or "what is wrong with you?" In fact, in psychotherapy we may often convey this stigmatizing feeling when our clients do not conform to our specific cultural norms.

"Expressing feelings," "being assertive," or "connecting," as Sophie assumed was appropriate, is not always a culturally appropriate way to address clients' issues. Each culture reinforces specific relational styles from which healing strategies are derived (Cushman, 1995; Kleinman, 1988; Sue et al., 2007). The question of what is normal or abnormal arises at this point. Was Omar's "surrender" or Sophie's "assertive" approach correct? Who defines what is normal or abnormal? Much of the American psychotherapeutic literature is highly influenced by Judeo-Christian values that clearly side with Sophie's approach and probably stigmatize or even pathologize Omar's "surrender," which could be misconstrued as a "passive-aggressive pattern" or as "learned helplessness." Cultural psychotherapy attempts to avoid pathologizing clients' problems by exploring and including their context and cultural understandings. In exploring Omar and Sophie's context, it was revealed that Omar was attempting to show love and strength by his restraint, which was perceived by Sophie as neglect. Understanding Omar's silences in context permitted both Sophie and myself to avoid stigmatizing his behavior and allowed us to develop strategies to effectively work with it.

Noting the ways in which cultural meanings vary highlights how culture is present in not just one, but multiple and complex ways (e.g., the influence of the Israel-Palestine conflict in Sophie and Omar's arguments). Cultural psychotherapy recognizes that the cultural context affects the nosology and etiology of mental disorders—their presentation, course, and outcomes, and the development of interventions required to treat them. Cultural psychotherapy attempts to expand our understanding of the psychotherapeutic process by contextualizing the psychotherapeutic relationship and the client's individual history. To accomplish this goal, however, clinicians need to actively and constantly explore how our

actions, beliefs, comments, or lack thereof are informed by cultural assumptions (Sue & Sue, 2008), as these will have a powerful impact on the therapeutic relationship. In working with Omar, I reread the Qur'an and literature about psychotherapy with Muslims. I am also aware of the strong negative biases toward Muslims in the United States, particularly heightened after the attacks on the World Trade Center and the Pentagon on 9/11 and the growing tensions in Iran, Iraq, and Syria. In psychotherapy, we explored how these events were affecting Sophie and Omar.

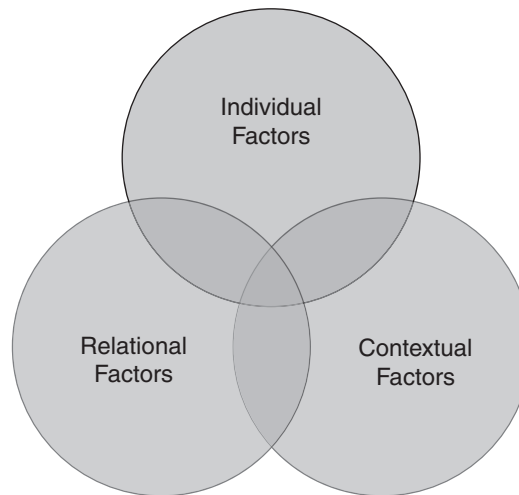
One of the main assumptions of cultural psychotherapy is that the psychotherapeutic process is embedded within a context that gives significance to our understandings and interactions. Figure I.1 illustrates how cultural psychotherapy emphasizes these three interactive and at times overlapping perspectives. Without any one of these three perspectives, cultural psychotherapy's understanding of the psychotherapeutic process is incomplete.

At this point, a general equation for developing cultural psychotherapy is proposed:

cultural psychotherapy = individual factors × relational factors × contextual factors.

This equation highlights the need to include all three factors. This equation may be used to evaluate any of our interventions or clinical formulations, research hypotheses/methods, or any psychological concept. In looking at Figure I.1, it can also be seen that some parts of these factors tend to overlap, just as parts of Omar's communication style could be considered individual, relational, and cultural. Although much of cultural psychotherapy stems from this contextual epistemological model (**knowledge = object × subject ×**

FIGURE I.1 Cultural psychotherapy's conceptual model



context), it is important to highlight that additional factors (e.g., genetic, neurological) are likely to be considered.⁴ Another implication of this equation is that culture and context are not equivalent; culture is more than the context. Culture manifest itself within individuals (e.g., cultural variables), relationships (e.g., the way people interact) and contexts (e.g., sociocultural processes). However, not all is a shared cultural meaning; some are unique individual or relational variables. Yet much of what is contextual is cultural.

An important corollary of this equation is that cultural factors are ever present, not just for ethnic minorities but for all. Initially, it might have been easier to recognize culture in ethnic minorities, as I, too, selected an interethnic couple to illustrate cultural psychotherapy's core ideas; however, we are all embedded in specific contexts that give meaning to our experiences. Thus, cultural psychotherapy recommendations are also applicable to people of the dominant culture (e.g., White Americans). The three-phased cultural psychotherapeutic model, which is described below, is an attempt to systematize and organize these ideas.

THE THREE-PHASED CULTURAL PSYCHOTHERAPEUTIC MODEL

Cultural psychotherapy develops an integrative framework that attempts to complement current psychotherapeutic approaches by emphasizing the need to consider individualistic, relational, and contextual elements not only during the psychotherapeutic process⁵ (Chapters 1–3, 7), but also in the way we theorize (Chapter 5) and conduct psychotherapeutic research (Chapter 6) and in the world beyond psychotherapy (Chapter 8). Given this emphasis on complementing and coherently benefiting from different approaches, a wide variety of theories, disciplines, and models inform cultural psychotherapy (e.g., psychodynamic; dialectical behavioral therapy; neuroscience; three-staged trauma recovery models, particularly Judith Herman's [1992] model; anthropology; economy; social psychology; acceptance and commitment therapy, etc.). Nevertheless, these diverse ideas are organized through the three-phased cultural psychotherapeutic model that includes the following three phases: (1) addressing basic needs and symptom reduction, (2) understanding clients' experiences, and (3) fostering empowerment.

Although the three-phased cultural psychotherapeutic model is presented in "phases," it is important to underscore that these phases are not independent of each other as there is much overlap. What happens in one phase has an effect on what happens in the others. In my previous work (e.g., La Roche, 2002; La Roche & Christopher, 2010; La Roche & Tawa, 2011), I described this psychotherapeutic model in terms of "stages." However, I have found that the term *stage* seems to convey a rigid, stepwise sequence of the psychotherapeutic process that is far from the fluidity that in fact characterizes psychotherapy.

It is also important to emphasize that some individuals may spend very little time in the first phase and move quickly to the second or third phase.⁶ Others will stay in the first or remain in the second phase, never reaching the third phase. Clearly, there is much variability in the way clients use therapy. Furthermore, it is likely that some individuals benefit from some phases more than others. For example, it could be hypothesized, following Blatt's (1992) or Triandis's (1994) conceptualizations, that individuals who are more *introjective* (preoccupied with establishing and maintaining autonomy and self-definition) and/or *individualistic* (understand themselves in terms of self-attributes and pursuing individual

goals) benefit more from the first phase, while more *anaclitic* (preoccupied with issues of relatedness) and/or *collective* (understand themselves in relation to others and seek group goals) benefit more from the second phase. Clearly, research is needed to explore the specific contributions of individual differences in each phase. Nevertheless, this point underscores the need for therapy to adjust to the characteristics of each client in relation to the therapist and context.

However, if there is so much fluidity and complexity within the psychotherapeutic process, the question arises of why it is useful to order this process through phases at all. The clinical answer is that each phase has a set of preconditions that are required for clients to meet if they are to deal with the typical issues at certain therapeutic times. For example, it is necessary for clients to develop a relationship with the therapist in order for this dynamic to be used therapeutically as suggested in the second phase of cultural psychotherapy. The therapeutic relationship does not emerge immediately; it takes time to develop and time for clients to trust it and benefit from it. Most clients and therapists can only establish a therapeutic relationship after interacting and getting to know each other for a while. In addition to the development of a therapeutic relationship, there are other conditions for Phase II and several conditions for Phase III. These conditions are specified in the second and third chapters of the book.

The first phase—addressing basic needs and symptom reduction—focuses on meeting clients' needs/goals and assuaging their most prominent symptoms. Omar and Sophie came to therapy because they wanted to define their relationship (end it or move in) and reduce the number of arguments they had. Much of treatment during this phase focused on using cognitive behavioral strategies to identify triggers for their conflicts and help them develop alternative ways to respond to silences. The assumptions of an individualistic framework are fundamental for this phase. Thus, the general equation of cultural psychotherapy during this first phase can be reformulated as

$$\text{Phase I} = \text{individual factors}^2 \times \text{relational factors} \times \text{contextual factors.}$$

The quadratic factor (**individual factors**²) is not intended to reflect an exact quantity; it instead aims to illustrate the importance of individualistic factors during this first phase of treatment. Similarly, during different phases, other factors are considered. Furthermore, each of these variables (i.e., individual, relational, or contextual factors) is not an absolute value; rather, they change depending on how important they are for clients. For example, although individualistic factors were underscored during the first phase with both Sophie and Omar, I may have emphasized these more with Omar because they were more important for him, while with Sophie I may have highlighted relational variables that were more relevant for her. The emphasis given to each variable is a function of how important these are for a client.

The second phase—understanding clients' experience—explores and enriches clients' narratives through the psychotherapeutic relationship. The goal of this phase is to develop a better understanding of how important experiences have marked our lives. Omar and Sophie learned not only how their past relationships (e.g., Sophie's parents' divorce) influenced their current lives, but also how the therapeutic relationship was affecting their lives (including my own identification with their issues). Many of the basic ideas of the second phase are informed by relational approaches (Boston Change Process Study Group

[BCPSG], 2010; Jordan, 2010; Wachtel, 2008) and neuropsychological ideas (e.g., Schacter, 1992; Westen & Gabbard, 2002a, 2002b). This emphasis on relational issues (**relational factors**²) during the second phase can be illustrated through the following equation:

Phase II = individual factors × relational factors² × contextual factors.

The third phase—fostering empowerment—aims to increase clients' abilities to understand and consequently transform their social contexts. During this phase, contextual factors are emphasized (**contextual factors**²). As Omar and Sophie deepened their knowledge about the Palestine-Israel conflict and their religions, they were better able to respond to these influences. They not only learned more about each other's backgrounds and ways of relating but also collaborated with similar couples (Muslim/Jewish) to support a partnership between Israel and Palestine, particularly in helping Palestinian refugees. The third phase, thus, can be illustrated as:

Phase III = individual factors × relational factors × contextual factors².

However, after all conditions (i.e., for Phases II and III) are met, the psychotherapeutic process does not unfold in a linear fashion (first phase followed by second phase and finished with the third); instead, it is more fluid, complex, and cyclical. After all conditions are met, some clients/therapists may simultaneously or intermittently focus on issues typical of the first, second, and/or third phases.

CULTURAL PSYCHOTHERAPY'S THEORY OF PSYCHOTHERAPEUTIC ACTION

Just as with any theory of psychotherapeutic action, cultural psychotherapy must describe both what changes in psychotherapy and also the strategies used to pursue those changes. "What changes" in psychotherapy refers to the general objectives of treatment and the factors that change, while the "strategies used" refers to the specific techniques employed to accomplish change (Gabbard & Westen, 2003). The main therapeutic factors (objectives) that change in each phase are emphasized in this introduction, while subsequent chapters (Chapters 1–3, 7) describe the different techniques or specific clinical recommendations necessary for this change to occur.⁷

The three-phased cultural psychotherapeutic model assumes that during each phase a distinct mechanism of therapeutic action is underscored that supports the utility of depicting the psychotherapeutic process with phases. In the first phase, the primary aim is to improve clients according to their needs and characteristics. The therapeutic factors or change resides within the client. Successful individualistic treatments are described through some of the following therapeutic outcomes: increased insight, enhanced self-awareness, self-organization, self-coherence, self-actualization, enhanced self-esteem levels, improved coping strategies (distraction techniques or relaxation), optimal levels of emotional regulation, increased psychological flexibility, or balanced levels of serotonin or dopamine.

TABLE I.1 Characteristics of the Three-Phased Cultural Psychotherapeutic Model

	Main Factors That Change	Psychoneurological Systems Emphasized	Psychological Functions Targeted	Psychotherapeutic Paradigm Emphasized
Phase I Addressing basic needs and symptom reduction	Individual change	Explicit systems or conscious processes	Increased ability to regulate affect, psychological flexibility, and problem solving	Individualistic paradigm (CBT, existential psychology, psychoanalysis, etc.)
Phase II Understanding clients' experience	Relational change	Implicit systems or unconscious processes	Enhanced ability to develop fulfilling relationships	Relational paradigms (e.g., feminism, object relations)
Phase III Fostering empowerment	Contextual change	Not known	Enhanced empowerment	Contextual or ecological paradigms

During the second phase, the client's main therapeutic objective is to develop more fulfilling relationships, in which case the therapeutic change resides within relationships. One of the most relevant tools to accomplish this goal is the use of the psychotherapeutic relationship (Jordan, 2010; Wachtel, 2008). Finally, cultural psychotherapy comprises a third phase focusing on empowerment, which is often neglected within the traditional psychotherapeutic literature. This involves a deeper understanding of contextual influences coupled with an enhanced ability to comprehend and transform sociocultural contexts (Ivey, 1999; Roysircar, 2009). In this third phase, a central therapeutic objective is to change the context. See Table I.1 for a summary of the characteristics of the three phases of cultural psychotherapy.

NEUROSCIENCE INFLUENCES: EXPLICIT AND IMPLICIT SYSTEMS

There is a growing consensus among neuroscientists that human thought involves at least two types of memory, explicit and implicit (Schacter, 1992, 1995, 1998). Explicit memory⁸ involves the retrieval of information—childhood memories, facts, or ideas—that is intentional and conscious. Implicit memory⁹ refers to memory that is observable in behavior but not consciously brought to mind (Schacter, 1992, 1995, 1998); it is one way in which the influences of past experiences are expressed in subsequent task performance—unintentionally and without conscious recollection of a learning episode (Schacter, 1995).

In reality, neuroscience talks about explicit and implicit memory. In this book, however, the explicit and implicit terms are broadened to systems as a means to include many

processes (e.g., perception, beliefs, attitudes, attention, motivation), not solely memory. These distinct psychoneurological systems are in play during each phase of cultural psychotherapy. During the first phase, however, explicit systems are underscored, while in the second phase implicit and explicit systems are highlighted.

Given that explicit systems are conscious, while implicit systems are unconscious, I often use these terms interchangeably (e.g., implicit/unconscious). Nevertheless, it is important not to confuse cultural psychotherapy's use of the word "unconscious" with the way the word is used in the traditional psychoanalytic literature. For the psychoanalyst, the unconscious is a place filled with repressed desires, memories, or thoughts. All that is vanished from consciousness is stored in the unconscious, and many of these repressed desires end up influencing our lives; thus, a central goal of psychoanalysis is to make this repressed content conscious. In contrast, I use the term unconscious to refer to the mind as a giant processor that quickly and quietly manages large amounts of data, which is necessary to keep human beings functioning. Through our unconscious, we are able to size up the world, and in turn, recognize danger, which influences our goals and at times motivates decisions around actions (Wilson, 2002). Many of the processes we ordinarily conduct are automatic and do not require conscious attention. Cultural psychotherapy argues that not all of what resides in the unconscious (or implicit systems) is repressed; it is simply that the human mind is too complex to simultaneously process all mental processes in a conscious manner (Schacter, 1992; Wilson, 2002).

Piaget (1954) revolutionized our thinking about infants' meaning making by demonstrating that rather than verbally categorizing objects as older children do, infants make meaning of an object from what they can do with it. There are no balls or spoons but things that are "throwable" or "mouthable." This is reminiscent of Garcia Marques's depiction in his classic book *One Hundred Years of Solitude* of the origins of Macondo:¹⁰ "The world was so recent that many things lacked names, and in order to indicate them it was necessary to point."

Meanings often have a significant sensorimotor ("it was necessary to point") component, which is akin to procedural memory in adults (Tronick & Beeghly, 2011). Procedural memory refers to the "how to" do certain activities, such as throwing a ball or riding a bike—processes that are not possible to explain verbally but are learned (Schacter, 1992, 1995, 1998). However, more relevant to the psychotherapeutic process than physical activities are relational procedural memories (implicit systems) of the ways we relate, such as unarticulated social rules (often preverbal). These implicit systems continue across the life span to shape our experiences without us fully acknowledging, articulating, or understanding their influence (BCPSG, 2010; Ivey, 1999; Stern, 1995; Stolorow & Atwood, 2002; Wachtel, 2008).

The basic goal of the first phase of cultural psychotherapy along neuroscientific lines is to underscore the role of explicit functions such as enhancing self-awareness, increasing psychological flexibility, learning new coping strategies, or enhancing affect regulation skills. While some implicit processes are evident from the onset of therapy, and implicit and/or relational change can occur in the first phase (and even in the first session), it is only as therapists glean more information about their clients that they can systematically and more effectively address implicit systems or even know that they are changing.

In the second phase of cultural psychotherapy, therapists tap into implicit or unconscious systems that are not explored in depth in the first phase. Many implicit meanings or unconscious processes are not especially susceptible to change by interpretation, insight, psychoeducation, learning emotional regulation skills (e.g., relaxation), or other verbal strategies that are typical of the first phase. Instead, they are mainly changed through noninterpretative and nonverbal means of feeling understood, test passing, rupture/repair processes (see Chapter 2), or other relational experiences. What goes on procedurally or implicitly is largely a matter of how the words, gestures, metaphors, intonations, subtle interactions, and other nonverbal cues are used within the psychotherapeutic relationship (implicit systems/unconscious), rather than what is in fact said (explicit systems/conscious). Explicit and implicit memories are distinct and not necessarily correlated; instead they process information as parallel systems (Barry, Naus, & Rehm, 2006).

Furthermore, neuroscience studies are also finding that there is a relative degree of functional and neuroanatomical independence between implicit and explicit systems (Gabbard & Westen, 2003; Schacter, 1995, 1998). This could further support the idea that it might be beneficial to specify therapeutic actions (i.e., objectives and techniques) within different phases of treatment. For example, studies of clients with brain damage suggest that explicit and implicit systems rely on different neural mechanisms (Schacter, 1995). In noting these neural correlates, however, I do not hope to explain grief or love through the limbic system, but to inform our interventions and theories according to mind-brain interactions.

It is also important to note that distinguishing between explicit and implicit systems is a psychoneurological finding that is also influenced by a medical cultural taxonomy (Cushman, 1995; Gergen, 2010). Classification systems (e.g., conscious versus unconscious, explicit–implicit, mind–body, object–subject, matter–spirit, white–black) are constructed through cultural categories that organize and give meaning to scientific findings. Cultural categories are a reflection of the prevalent beliefs of a particular time and place. Currently, many of our psychotherapeutic taxonomies are highly influenced by the medical model (Cushman, 1995; Gergen, 2010), which emphasizes an objective, decontextualized, and fragmented view of the “individual.” Perhaps in a different time and place what we call explicit and implicit could have different meanings and emphasis. Consistent with this idea is the fact that no studies (that I know of) have examined (or even considered) underlying neurofunctional processes responsible for contextual change. It is not surprising that neurological findings responsible for contextual changes have been neglected from a literature that overlooks this possibility.

However, neuroscience has advanced many studies that support the idea that culture shapes both explicit and implicit systems (Dovidio, 2009). Furthermore, cultural psychotherapy emphasizes the need to understand explicit and implicit systems in relationship to specific contexts. The context gives meaning to both explicit and implicit systems. One of the basic assumptions is that different cultures promote distinct child-rearing practices that lead to implicit relational systems that influence meanings (e.g., different cultural variables), social interactions, and narratives (La Roche, 1999; Tronick & Beeghly, 2011). However, research noting the impact of culture is not limited to child-rearing practices. Culture is continuously and relentlessly shaping our emotions, cognitions, and lives through explicit and implicit messages. An explicit message is information that we are aware of, and implicit is information that we do not notice but that has an effect on our behavior.

In the United States, we are surrounded every day by explicit and implicit messages linking some attributes with good (e.g., white skin = good; black skin = bad) (Dovidio, 2009; Steele & Aronson, 1995; Weisbuch et al., 2009). It is not that we choose to make positive associations with the dominant group; we are conditioned to do so. Just opening the newspaper or turning the TV on, we are immediately bombarded by explicit and implicit messages about the meanings of race, religion, gender, and many other attributes (Dovidio, 2009; Steele & Aronson, 1995; Weisbuch, Pauker & Ambady, 2009). Unfortunately, we are often not aware of the influence these messages have in our lives. Cultural psychotherapy aims to clarify these messages. For example, the psychologists Claude Steele and Joshua Aronson created a well-known and now classic experiment to test the toxic effects of what they called “stereotype threats.” They asked a group of African American students to take 20 questions of the Graduate Record Examination, the standardized test used for entry into graduate school. When the students were asked to identify their race on a pretest questionnaire, that simple act was sufficient to prime them (with an implicit message) with all the negative stereotypes associated with African Americans’ academic achievement. As a result, the number of questions they answered correctly was cut in half. In contrast, a similar group (controlling for IQ and previous results on the GRE) that was not asked about their race performed significantly better than the first group. The detrimental effects of these stereotype threats during a lifetime of exposure are often catastrophic. Cultural psychotherapy aims to enhance clients’ understanding of these social forces and the development of strategies that will not only inoculate them but also allow them to transform these toxic influences (see Chapter 3 for more details on how to accomplish this goal). While the impact of context on behavior is an important premise of cultural psychotherapy, it also holds that we can influence our contexts.

Neuroscience studies find that sustained exposure to a set of cultural experiences can change neural functioning. An emerging literature suggests that fundamental cultural values (e.g., individualism and collectivism) influence the neural networks activated when recognizing and thinking about others (Park & Huang, 2010). The study of the “cultural brain” is a critically important, growing area of research that demonstrates the influence of cultural processes in sculpting the brain (Park & Huang, 2010). It is not that there are permanent neuroanatomical or neurofunctional racial differences between groups, but rather that social and cultural processes have the power to influence neural functions, which, in turn, affect our behavior. Far from being deterministic, cultural psychotherapy underscores the tremendous flexibility and hope contained in the new data on brain plasticity (Eberhardt, 2005). Again, this emphasizes the bidirectional influence of the person and context. By exploring both molar and molecular processes, we may find better ways to understand how these processes intersect, which will lead us to develop more effective therapeutic strategies.

CULTURAL PSYCHOTHERAPY’S RESEARCH STRATEGIES

Cultural psychotherapy asserts that there are multiple understandings for similar processes and many valid strategies/methods to know. Cultural psychotherapy emphasizes the need to use diverse methodological and interdisciplinary research approaches to

address psychotherapeutic questions. Rigorous/objective research strategies (randomized control trials, laboratory studies) and qualitative ones (e.g., phenomenological studies, content analyses) are encouraged to explore specific questions.

Cultural psychotherapy, however, underscores the need to contrast results using not only different methodologies, but also samples from different cultures (including, e.g., socioeconomic status, gender orientation, race, and ethnicity). By contrasting samples from different backgrounds, we start exploring what may be universal (nomothetic) from what is particular (ideographic) in our psychological interventions. Nevertheless, cultural psychotherapy consistently proposes the need to consider nomothetic findings as working hypotheses when applied to individuals. As already noted, not all Muslims would equate loving someone to “surrendering,” as Omar did with Sophie. However, the levels of endorsement or lack thereof are important pieces of clinical information that are useful in designing culturally sensitive interventions (see Chapter 6). It is essential that we constantly assess our ideas and continue to learn from our clients, ourselves, therapeutic relationships, and contexts. The aim of cultural research is to gain information about clients, relationships, and contexts as well as how these factors interact.

The need to study questions through multimethods and in different cultures is consistent with the epistemological idea that what we know is influenced by the observers’ attributes (researchers/clinicians and participants/clients) and the observation process (e.g., laboratory study, psychotherapeutic relationship) as well as by the context in which the research takes place (e.g., during certain times and places some variables/questions are underscored while others are overlooked). The relative validity of some research methods is dependent upon the cultural context. Thus, it is important that research incorporates individual, relational, and contextual variables. Not including any one of these may lead us to develop incomplete or even erroneous understandings.

Cultural psychotherapy’s research approach leads us to develop many hypotheses for one question. However, through the systematic use of the scientific method, many hypotheses could lose credibility. Cultural psychotherapy is currently attempting to create guidelines to seek, organize, and assess available scientific evidence (La Roche & Christopher, 2008, 2009) or even how we define scientific evidence. Much work still remains to be conducted in this area.

Cultural Ethics

Cultural psychotherapy acknowledges that within the psychotherapeutic session we are constantly making decisions that reflect specific social values and/or have ethical meanings. Cultural psychotherapy emphasizes the need to become aware of these values and their consequences. If we do not make these assumptions explicit, they will end up narrowing our views and possibilities. Underlying this approach is the belief that many perspectives inform our understandings and decisions. Diversity and complexity can enrich our lives if presented in an appropriate environment. However, diversity and complexity are values that also need to be questioned by both therapists and clients.

In principle, cultural psychotherapy openly endorses social justice, which is defined here as actively advocating for the well-being of all, not just clients or their immediate context; but, in practice, each client in fact decides what is important for him or her. It is

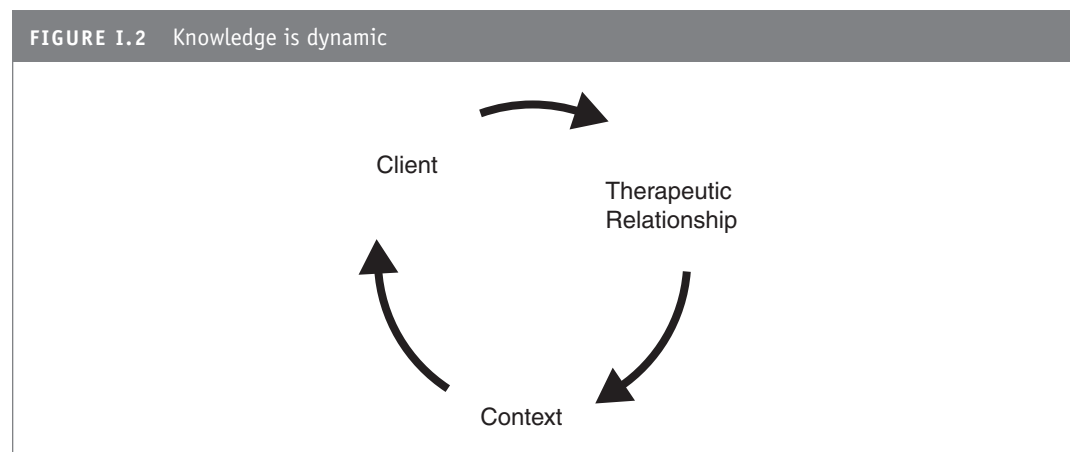
not for cultural psychotherapists to impose our social justice stances upon others. Instead, clients need to decide what they value and what is good for them. The clinicians' role is to clarify these decisions. Therapists must respect and avoid influencing clients' decisions and limit themselves to presenting options that emerge within the session.

Although during the first phase most clients and clinicians may never directly discuss the ethical implications of their decisions, it is increasingly important to do so as they learn more about their cultural contexts. Clients and therapists learn that they can in fact have an impact in their cultural contexts. An enhanced awareness of this power entails a gradual increase in social responsibility. Cultural psychotherapy does emphasize the influence of social forces but in doing so it does not intend to minimize individual responsibility. That is, the impact of social forces does not exonerate us from making "bad" decisions. In fact, as we become aware of our social influences, we become increasingly responsible for our acts.

To close this chapter, I provide a summary of some of the basic assumptions of cultural psychotherapy for review.

BASIC ASSUMPTIONS OF CULTURAL PSYCHOTHERAPY

1. The race and/or ethnicity of an individual does not determine the existence of any psychological characteristic. Cultural psychotherapy emphasizes the need to measure cultural variables rather than to assume psychological characteristics, according to the ethnicity and race of a person. Cultural variables include ethnicity and race as well as gender orientation, gender, disability status (e.g., deaf, blind), socioeconomic status (SES), religious background, and discrimination experiences, among other variables. Cultural psychotherapy argues that a more thorough consideration of cultural variables can increase the efficacy and effectiveness of our psychotherapeutic interventions.



2. Cultural variables are herein defined as meanings that are overall more frequent in one cultural group (e.g., ethnic, religious, gender orientation) than others. Nevertheless, there is much variability amongst individuals within each cultural group.
3. All psychological processes (e.g., assessment, research) and concepts (e.g., meaning, narratives, self-concept) are more thoroughly understood as a result of the interaction of individualistic, relational, and contextual variables. Culture manifests itself in each of these three levels.
4. Each of these factors (individual, relational, and contextual) interacts and at times overlaps with the others, transforming and being transformed by them, which emphasizes the dynamic nature of knowledge (see Figure I.2).
5. Cultural psychotherapy aims to complement current psychotherapeutic approaches by providing an integrative framework that allows therapists to formulate clients' individualistic, relational, and contextual variables as well as providing therapists with specific treatment and assessment recommendations.
6. Cultural psychotherapy proposes an integrative, three-phased psychotherapeutic model in which individualistic assumptions highly inform the first phase, while the second phase underscores relational assumptions, and the third phase emphasizes a contextual/ecological understanding.
7. Cultural psychotherapy emphasizes the need to consistently consider explicit and implicit systems in a systematic manner throughout the psychotherapeutic process.
8. Cultural psychotherapy seeks not only individual change (emphasized during the first phase) but also relational change (second phase) and contextual change (third phase).
9. Cultural psychotherapy highlights the need to bring interdisciplinary research methods that combine multiple disciplines (clinical, ethnographic, mathematical, epidemiologic, etc.) to the study of psychotherapeutic processes as well as to continue questioning and refining the research strategies used to glean data.
10. Given that we are all embedded in specific and increasingly interconnected contexts, it is impossible to remain neutral when social injustices occur. Injustices affect us all. In theory, cultural psychotherapy emphasizes the importance of social justice, not just individual or relational justice. Nevertheless, clients are ultimately the ones making decisions about what is right or wrong for them.
11. Given that we all have multiple cultures and live in context, it is important to note that cultural psychotherapy is applicable not only to ethnic minorities but to each and every one of us.
12. The development of cultural psychotherapy is an ongoing conceptual and integrative process based on clinical data and empirical evidence from diverse fields, but it still requires significant research to confirm and support many of its assumptions. This book is the first systematic effort to coherently describe these ideas.

Notes

1. Gender, as noted by feminist authors, is an extremely powerful variable that influences our understandings. Cultural psychotherapy attempts to underscore the influence of gender as well as that of many other cultural variables.
2. I reluctantly use the term *White*—given its common usage—to encompass a wide range of diverse individuals (e.g., Irish, Italian, Scottish) living in the United States who are part of the dominant culture, speak English, and trace their background to a European country.
3. In this chapter, when I refer to the Palestine-Israel conflict, I alternate mentioning one or the other first (Israel or Palestine), as it was very important for Omar and Sophie to do so during our sessions.
4. For factors to be included in this model, they need to have clear psychotherapeutic effects. To date and to the best of my knowledge, it is still unclear to me, for example, how changing our DNA can be used to improve clients' behaviors.
5. In this book, when I discuss the "psychotherapeutic process," it is also meant to include the processes of assessment, formulation, consultation, and supervision.
6. All phases are important, and the movement from one phase to the next is a gradual and qualitative one. It is more aptly true to say that a client is mostly dealing with issues typical of the second phase and moving to the third phase, than that the client is in the second phase and will soon cross the line to be in the third phase. There are no clear-cut demarcations between phases.
7. Each of these clinical recommendations is assigned two numbers to allow for easy reference. The first number reflects the phase number (and chapter number) and the second the clinical recommendation number. For example, clinical recommendation 2.3 is the third clinical recommendation of Phase II and it appears in Chapter 2. The clinical recommendations for addressing cultural differences start with the number 4 and appear in Chapter 4. Thus, clinical recommendation 4.5 refers to the fifth recommendation in Chapter 4, "addressing cultural differences." When a letter appears with a number it refers to a prerequisite of a phase. For example, 3a refers to the first prerequisite of Phase III, which appears in Chapter 3.
8. There are two main types of explicit memories—generic and episodic. Generic (previously called semantic) refers to the general knowledge of facts (e.g., names, meanings of words), and episodic refers to specific autobiographical incidents (e.g., a visit to a grandparent).
9. Similarly, there are two types of implicit memories. Procedural memory refers to the "how to" do certain activities, such as the motor memory of throwing a ball or riding a bike. Procedural meanings are encoded in a sensorimotor language rather than a verbal one (Schacter, 1995, 1998; Tronick & Beeghly, 2011). The second type involves associative memory, which refers to the associations that guide mental processes and behavior outside consciousness.
10. Macondo is the fictional town in which the protagonists of *One Hundred Years of Solitude* live.

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