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CLINICAL CASE REPORT

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New approaches to diversity in clinical work

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Abstract

The inclusion of diversity issues in clinical work has risen in the last years. With APA's multicultural guidelines and diversity courses becoming a requirement in doctoral programs, we see a concerted effort to increase awareness, knowledge, and understanding of diversity issues in clinical work. Yet, there is still much to do. In this issue of *Journal of Clinical Psychology: In Session*, seven authors conceptualize diversity from various therapeutic approaches, including relational cognitive behavior therapy, couples therapy, multicultural counseling, and psychodynamic psychotherapy. We learn how diversity and clinical work are not mutually exclusive regardless of the therapeutic approach used as long as the therapist is culturally sensitive and competent, and motivated to pursue such integration. We also learn that regardless of their commitment to social justice, and their understanding of the consequences of inequality and oppression on individuals' mental health, clinicians vary considerably in the extent to which they actively integrate diversity considerations in the treatment room. The authors in this issue present clinical vignettes describing how they have integrated diversity into their therapeutic work. Furthermore, they discuss how the process of addressing issues of diversity has impacted their work. Lastly, the authors offer recommendations from their experiences as clinicians.

KEYWORDS
acculturation stress, diversity, inequality, minority stress, social justice

We express our great appreciation to all the contributors to this issue of *Journal of Clinical Psychology: In Session*.

This issue of *Journal of Clinical Psychology*: *In Session* introduces several new approaches to diversity in clinical work. The selected articles address diversity issues from various perspectives, including therapeutic approaches, clinical presentations, special populations, and considerations related to institutions and systems. Through their clinical examples, we learn how the authors integrate their understanding of the client's cultural uniqueness with their sense of the client's intrapsychic dynamics and overt behaviors to formulate a comprehensive conceptualization of the case.

Among contemporary psychodynamically oriented therapists, integrating awareness of diversity issues into clinical work is not new. In fact, psychoanalytic approaches to culture and its relation to human beings is longstanding. Altman (2010) offers a comprehensive historical review of the trajectory of psychoanalysts and contemporary psychodynamic psychotherapists integrating culture and clinical work. Danto (2005) documents the work of early psychoanalysts in bringing free psychoanalysis to the poor and describes their early efforts to develop free clinics. In the last decade, we have seen an increase in scholarly work stressing progressive psychoanalysis that integrates culture, politics, and social advocacy (Altman, 2015; Aron & Starr, 2013; Layton, Caro Hollander, & Gutwill, 2006). Yet, there is still some skepticism about psychodynamically oriented approaches being able to integrate cultural diversity, and diversity more broadly, into clinical practice.

While reading these articles, I suggest that readers reflect on the necessary skills and attitudes a therapist must attain to be a culturally competent therapist. I will summarize what I understand to be the main themes around this idea throughout the readings. First is the importance of having awareness of one's own worldview. Second, the ability of the therapist to integrate clinical and cultural perspectives in the conceptualization of the case. Third, the importance of considering existing social structures and gaining awareness and understanding of how they perpetuate inequalities and oppression. Last, the therapist's role as an advocate and an activist. I will elaborate on each of these aspects.

The inclusion of diversity in psychotherapy has taken myriad paths through the course of recent years. Aside from the traditional individual and multicultural approaches, psychotherapists from multiple theoretical perspectives (i.e., not just psychoanalysts) are advocating for clinical social activism and advocacy. This is encouraging and uplifting, particularly during these current times. A common aspect of these various approaches is the call for cultural sensitivity and competence. The latter is the ability to understand, communicate with, and effectively interact with people across cultures (Sam & Berry, 2010). Cultural competence encompasses being aware of one's own worldview, developing positive attitudes toward cultural differences, and gaining knowledge of different cultural practices and worldviews.

An important tenet of cultural competence in clinical work is that therapists develop a sense of awareness and understanding of their own diversity, and in doing clinical work are able to attune to their own diversity issues (American Psychological Association, 2000). Being aware of one's own worldview is paramount. It is also a dynamic ongoing process. Therapists with little or no awareness of their own worldview and its potential impact on clinical work are doomed to perpetuating in the clinical space the negative and alienating experiences of their clients. We must ask how comfortable one is in exploring one's own worldview. How much awareness has one developed, and how much understanding is there of the significance of one's worldview in conducting therapeutic work? Furthermore, how much awareness and understanding is there about the affect tolerance associated with one's own diversity when in interaction with that of the client in the therapeutic space?

To become aware of one's own worldview is to increase one's awareness of one's diversity experiences. While ideally this process should begin before and outside of the therapy setting, in many instances, therapists become aware of their assumptions and culturally mediated worldviews when clients begin to discuss their backgrounds and their cultural experiences in their own therapeutic work. It is during these times that therapists can show great cultural humility by acknowledging to the client that which was not recognized until then.

In her paper, *The Loss of innocence: Confronting class differences in the practice of psychotherapy*, Susan Bodnar describes how her patient reminded her of her own cultural disconnect from her social class background during her younger years. The patient exposed her own vulnerability around social class and by doing so, the therapist was

able to connect with her own cultural vulnerability. This can be a challenging process; however, if the therapist shows cultural humility and is able to self-disclose about his or her own cultural issues, as was the case in this vignette, it can be a powerful moment for both.

Second, a culturally competent therapist can and should integrate clinical and cultural perspectives in the conceptualization of the case. This involves the ability of the therapist to include cultural context in conceptualizing psychological profiles of clients. It is about not jumping to clinical conclusions before considering the unique diversity aspects of this person and its impact on him or her. All the authors within this issue concur on the relevance of this aspect. Bodnar nicely highlights the significance of the therapist developing sensitivity and understanding of each individual's uniqueness. In the same vignette described earlier, she began to conceptualize the client's presenting dynamics as consistent with a clinical profile typically associated with a borderline personality disorder. However, as time went on and she delved more deeply, she reframed this clinical presentation as *status anxiety*. Bodnar defined *status anxiety* as a person's stress reactions that form in response to traversing new class-bound systems of meanings. She sees this as a derivative of acculturation anxiety. A similar example is presented by Melanie E. Brewster, Wei Motulsky, and Elizabeth Glaeser, when referring to the *minority stress* experienced by gender-expansive clients in their article, *Working with gender expansive clients in psychotherapy*. Jacqueline Patmore, Brianna Meddaoui, and Helen Feldman refer to this same phenomenon as *acculturation stress* in their paper, *Cultural considerations for treating Hispanic patients with eating disorders: A case study illustrating the effectiveness of CBT in reducing bulimia nervosa symptoms in a Latina patient.*

While cultural competence calls for withholding clinical judgment before considering social-cultural aspects of clients, it is also about understanding and finding clinical meaning in the ways in which cultural dynamics influence the development and maintenance of symptoms and client presentation in treatment. These are not mutually exclusive goals. In the latter case, a therapist must understand, for example, that disconnecting from one's social class and entering a new one can be experienced by a client as a sense of loss or a small trauma generating feelings of loss and grief, all aspects that can be addressed clinically.

Third, cultural competence is about the therapist considering existing social structures and establishments, and about gaining awareness and understanding of how they perpetuate inequalities and oppression. This is nicely presented by Daniel José Gaztambide in his article, *Re-considering culture, attachment, and inequality in the treatment of a Puerto Rican migrant: Toward structural competence in psychotherapy*. Gaztambide writes about how structural inequities disrupt one's ability to trust others interpersonally and across cultural difference. He reconsiders the relationship among cultural competency, psychotherapy, and social justice using the case of two Puerto Rican migrants in psychotherapeutic treatment. Further, he integrates his vision of social justice, cultural competence, attachment theory, and the social, medical, and mental health impact of inequality on the client. Brewster, Motulsky, and Glaeser echoed a similar sentiment. They focus on issues of oppression and inequality specifically with gender-expansive clients, which include but is not limited to the use of terminology that perpetuates old models of gender while continuing to alienate and exclude people that do not fit in the old binary. They also highlight the need for therapists to become aware of specific nonmedical procedures tailored to work with the gender-expansive population, such as *social transition or social affirmation* procedures. Furthermore, they underscore other clinical distinctions inherent in treating gender-expansive clients.

In their article, *Campus Diversity, Jewishness, and Anti-Semitism*, Barry A. Farber and Arielle Poleg also emphasize the relevance of clinicians' awareness of sociopolitical situations with a direct impact on clients. Given the current increase in antisemitism and anti-Israel protests––phenomena with potential negative effects to Jewish students––they suggest that understanding global political currents and the various movements endorsing antisemitism is of great relevance for therapists working with this population. Their article includes qualitative data culled from interviews given to Jewish students, faculty, and leaders of Jewish organizations. Some of the comments support the idea of how macrosystems, in this case, in higher education settings, enable microaggressions and alienation of the Jewish student community. Some of those interviewed felt administrators and diversity officers were poorly trained and lacked knowledge on Jews and Jewish concerns. Many interviewees

felt that Jews were perceived as a religious group, not an ethnic or national group. Even more troubling from the perspective of diversity is the fact that, according to these interviewees, many campus individuals and organizations do not consider Jews as a diverse or multiethnic group. Unlike Latino, African American, Asian, gender-expansive, and some religiously diverse individuals, Jewish students are included in the category of White privilege, often leading to a sense of alienation and exclusion from progressive causes. Farber and Poleg assert that seemingly progressive campus politics too often leaves Jewish students silenced, unable to have a voice, and that too many therapists are unaware that Jews, like other minorities, have a history of oppression that may well affect their worldviews and clinical presentations.

But once therapists develop awareness of their own worldview, facilitate a diversity dialog with their clients, show cultural humility and self-disclose about their own diversity with clients, and become aware of existing societal structures that reinforce and perpetuate inequality and oppression, how do they become effective in their work given the social structures that continue to perpetuate that which they are trying to challenge in therapy? The authors within this volume concur that outside social structures perpetuate many of the stereotypes that increase client feelings of shame and guilt, generate and/or exacerbate other psychological symptoms, and create ruptures in interpersonal trust, making culturally competent therapeutic work especially challenging.

Each author in this issue proposes ways to address this problem. In particular, I would like to highlight the work of Virginia Barber Rioja and Alexandra Garcia-Mansilla. In their paper, *Special considerations when conducting forensic psychological evaluations for immigration court*, they describe the challenges faced when working with immigrants experiencing psychological symptoms due to the trauma and persecution they often experience before arrival, and during their stay in the United States––particularly during the present time when immigration policies have become more restrictive and larger numbers of immigrants are facing deportation proceedings and/or detention. These issues, in addition to fears of deportation and systemic barriers to access to care, have the great potential to lead to psychological distress and instability.

A beautiful example of working within rigid social and cultural structures yet being able to integrate cultural values to the clinical work, is provided by Shigeru Iwakebe in his article, *Working through shame with an intercultural couple in Japan: Transforming negative emotional interactions and expanding positive emotional resources*. In this clinical case, the author demonstrates his use of couples therapy with an intercultural couple, integrating the influences of cultural expectations around gender, family roles and patterns of communication, child-rearing, and extended family relationships practices through relational work.

Finally, yet importantly, is the culturally competent therapist's role as an activist and advocate. For some therapists, this is manifested within the therapy room, while for others, it is manifested outside. Bodnar suggests three components of effective therapy-related activism: Financial access to therapy, a client-centered theoretical approach that enables the client to own and tell their own story, and the ability to question the utility of a diagnostic and theoretical frame that has class bias fundamentally built into the paradigm. Gaztambide sees activism as the ability to address the effects of inequality at the individual level by repairing trust and using that trust to work toward change. For Brewster et al., to be a good advocate is to be aware of local and/or community-based resources such as legal clinics, victim advocates, trans-inclusive domestic violence or homeless shelters, and health centers. This awareness and these actions all have the potential to increase the support provided for members of minority groups.

As we continue to reflect on the important themes articulated in these articles, I would like to conclude with three points I consider highly relevant in becoming a culturally competent therapist. The first one is mindfulness (broadly defined). We must be mindful of the need to allocate time and effort to develop greater awareness of the ways in which issues of social class, sexual orientation, race, ethnicity, religion, acculturation, and disabilities, influence one's own worldview. We also need to be mindful about what it is like to be a member of any of these minority groups. Lack of mindfulness and awareness about aspects of culture and diversity will likely increase unintended aggression toward and alienation from others. Thus, we need to be aware of our own

countertransferential reactions, including those elicited by a client's race, ethnicity, gender, sexual orientation, religion, social class, immigration and acculturation history, and physical, cognitive, and emotional abilities.

People with membership in the majority category of any of the groups noted above have the privilege to "opt-out" of having to think daily about what it is like to be a member of the minority. Individuals with membership in any minority group(s) cannot opt-out as members of majority groups do. Regarding race: It is not part of the common daily life of White Americans to be alert and mindful about how the world reacts to their behaviors and place in the world. This has been coined White privilege (Altman, 2010; Du Bois, 1995; McIntosh, 1989). Some suggest that becoming aware of one's privilege can result in despair and guilt (Altman, 2010; Aron, 2013; Suchet, 2007). Regardless of the feelings evoked by becoming mindful, clinicians are encouraged to face those feelings as a means of empowering themselves to empower others. Adding cultural curiosity to our clinical curiosity is my second point. We not only ought to instill curiosity in our clients, but we also must experience it ourselves. According to Buechler (2004), curiosity motivates a good deal of active effort through selective focusing. Selective focusing as selective attunement implies the capacity of the clinician to opt-in or out in discerning ways. There are many contributing factors and explanations as to why this may occur. However, becoming mindful of opportunities to become curious about diversity will increase opportunities for dialog and exploration. Curiosity makes the strange familiar (Buechler, 2004). A clinician with curiosity can create the conditions and opportunities for clients of minority groups to talk about their feelings of oppression, discrimination, and stigmatization in a safe place, particularly if the clinician is a nonmember of the minority group(s) represented by the client. The question here would be, what is our level of comfort with delving into strange spaces with our clients? Is our selective attunement keeping us at a distance from becoming curious about aspects of diversity unfamiliar to us?

Finally, the promotion of courage is among psychologists' many clinical endeavors. Courageousness here involves exploring and facing dark places within one's self and in the world, in new and different ways. It is about facing unknown emotional, unconscious, and interpersonal territories—in particular, by addressing the microaggressions and macroaggressions experienced by our clients. Clinicians must have the courage to facilitate and to hold the intensity of the darkness that emerges. Buechler (2004) states that patients and analysts both show courage each time demons are confronted. She also states that the courage of the patient is not very different from that of the analyst in that both struggle with difficult judgment calls and both make their most courageous choices when the alternatives seem evenly matched and the stakes are high. As therapists sensitive to matters of diversity, we must demonstrate our courage by allowing uncomfortable conversations into the clinical space. Many of the demons that are held clinically are the consequences of racism, discrimination, oppression, prejudice, and stereotypes.

In summary, mindfulness, curiosity, and courage are three fundamental components that any therapist must have but especially so when working with populations of diverse backgrounds. These qualities and values will empower the culturally competent therapist to become a tool for change. Including matters of diversity into our clinical mindfulness, curiosity, and courage should be an essential, rather than a selective part of our interactions with members of minority and marginalized groups. It is the most responsible thing to do. I invite you to engage with our authors and inquire how they experienced and demonstrated their mindfulness, curiosity, and courage in their clinical work.

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