Culturally Competent Psychotherapy

Hung-Tat Lo, MB, BS, MRCPsych, FRCPC[1], Kenneth P Fung, MD FRCPC[2]

To provide effective psychotherapy for culturally different patients, therapists need to attain cultural competence, which can be divided broadly into the 2 intersecting dimensions of generic and specific cultural competencies. Generic cultural competence includes the knowledge and skill set necessary to work effectively in any cross-cultural therapeutic encounter. For each phase of psychotherapy—preengagement, engagement, assessment and feedback, treatment, and termination—we discuss clinically relevant generic cultural issues under the following headings: therapist, patient, family or group, and technique. Specific cultural competence enables therapists to work effectively with a specific ethnocultural community and also affects each phase of psychotherapy. A comprehensive assessment and treatment approach is required to consider the specific effects of culture on the patient. Cultural analysis (CA) elaborates the DSM-IV cultural formulation, tailoring it for psychotherapy; it is a clinical tool developed to help therapists systematically review and generate hypotheses regarding cultural influences on the patient's psychological world. CA examines issues under 3 domains: self, relations, and treatment. We present a case to illustrate the influence of culture on patient presentation, diagnosis, CA, and psychotherapeutic treatment. Successful therapy requires therapists to employ culturally appropriate treatment goals, process, and content. The case also demonstrates various techniques with reference to culture, including countercultural, cultural reinforcing, or culturally congruent strategies and the use of contradictory cultural beliefs. In summary, developing both generic and specific cultural competencies will enhance clinician effectiveness in psychotherapy, as well as in other cross-cultural therapeutic encounters.

(Can J Psychiatry 2003;48:161–170)

Information on author affiliations appears at the end of the article.

Clinical Implications

- Cultural competence is the product of generic cultural competence and specific cultural competence; both are important in each phase of psychotherapy.
- Systematic consideration of cultural influences on a patient can enhance understanding and facilitate the employment of culturally appropriate psychotherapeutic goals, process, and content.
- Therapists can expand their vision by using cultural knowledge to generate hypotheses and treatment strategies, all of which must always be verified against clinical data to avoid misguided stereotyping.

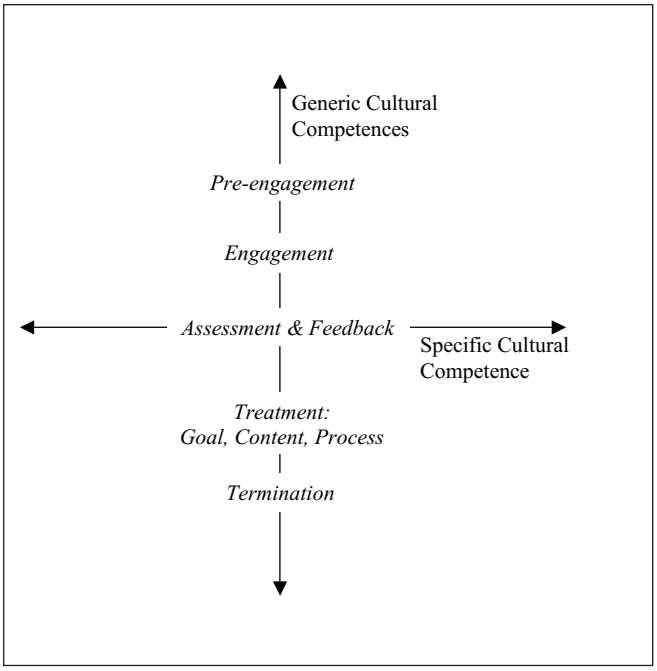
Limitations

- A validated, comprehensive measure of cultural competence, needed for research and training, is lacking.
- Process and outcomes research in cross-cultural psychotherapy is needed.

Key Words: *cultural competence, cross-cultural, ethnocultural, culture, ethnic, psychotherapy, psychotherapeutic skills, formulation, process, world view*

Psychotherapy is one of the major interventions in psychiatry's therapeutic armamentarium. Even interventions such as pharmacotherapy have a psychotherapeutic element, although they are not usually considered within the realm of psychotherapy. However, psychotherapy as developed in the West may not be directly applicable in other cultural settings. As North America rapidly becomes more culturally diverse, there is increasing demand for culturally appropriate mental health services. Clinical cultural competence, including the modification of psychotherapy practice to serve the culturally different, is imperative (1,2). A growing body of literature comments on various cultural aspects of psychotherapy (3).

Figure 1 Generic and specific cultural competence in psychotherapy



We systematically examine this topic according to the competencies required in the various stages and components of therapy.

Generic and Specific Cultural Competence

The term cultural competence (4) denotes the capacity to perform and obtain positive clinical outcomes in cross-cultural encounters. In considering culturally competent psychotherapy, we will examine the broad field of interactions that influence any sort of primarily verbal exchanges carried out to effect positive change in a patient. There are 2 distinct yet related sets of competencies, each having different training and clinical implications: generic cultural competence is the knowledge and skill set needed in any cross-cultural therapeutic encounter, and specific cultural competence enables clinicians to work effectively with a specific ethnocultural community. To provide culturally competent psychotherapy, both are essential. Schematically, they can be conceptualized as 2 intersecting dimensions: a vertical "generic" axis and a horizontal "specific" axis (Figure 1).

Generic Cultural Competence Axis and Phases of Psychotherapy

Generic cultural competence refers to competence in working with issues that emerge at different phases of psychotherapy, regardless of the cultural group to which a patient belongs. For heuristic purposes, the process of psychotherapy can be divided into the following phases: preengagement, engagement, assessment and feedback, treatment, and termination. Within each phase, we discuss relevant clinical issues in the following areas: therapist, patient, family, and techniques (Table 1).

Preengagement

Factors at work prior to clinical contact may influence the eventual clinical outcome. Working with a culturally different patient places certain demands on the therapist's skills, some of which may be intuitive, some of which can be learned, and all of which should be considered as essential components of psychotherapeutic training. One such quality is cultural sensitivity, which encompasses attributes such as curiosity, perceptiveness, and respect. Cultural sensitivity is the foundation of cultural competence. The patient's understanding of the problem is an important factor influencing preengagement. Patients and therapists often have very different explanatory models for an episode of illness. Incongruent understandings of the critical elements of the disorder, its probable etiology, and appropriate solutions can have a profound effect on the clinical encounter (5). The pathway leading to therapy can also influence clinical outcome (6). For example, a patient who has received positive recommendations about a therapist from a community elder may progress more smoothly to the engagement phase than a patient with a cursory referral from a hospital emergency department.

Engagement

Engagement begins with actual clinical contact. In this initial phase, the therapeutic alliance starts to develop and solidify. In practice, this phase unfolds concurrently with the assessment phase. Research documenting that minority patients have high dropout rates from the mental health care system highlights the critical importance of therapeutic engagement (7).

During this phase, ethnic match is an important consideration. Although some evidence suggests that patient–therapist matching according to ethnicity, language, and value system leads to improved therapeutic outcomes (8), such arrangements are not always feasible. Further, some patients are concerned about confidentiality and stigma. These patients may prefer a therapist who is not a member of their ethnocultural community. Whether the engagement process involves an ethnic match or not, highlighting such commonalities as educational background can facilitate the engagement process (9).

Respective conceptualizations of the therapist and patient roles also affect the engagement process. Some patients may find psychotherapy within a health context incomprehensible and may cast the therapist as a "village elder." This role can engender a sense of familiarity and kinship and is simultaneously imbued with healing authority, power, and wisdom. Patients in some cultures expect the therapist to be knowledgeable and not to ask too many questions. In such cases,

Table 1 Generic cultural competence axis in psychotherapy

	Therapist	Patient	Family or Group	Technique
Preengagement	• Cultural sensitivity	• Explanatory model • Help-seeking pathway	• Attitude of group	• Positive referral
Engagement	• Therapist role • Ethnic match	• Patient role	• Group agenda	• Cultural naiveté • Psychoeducation
Assessment and Feedback	• Therapist's world view	• Patient's world view • Cultural identity	• Family dynamics • Community dynamics	• BPSS • Cultural analysis • Cultural consultant • Gift • Pretherapy preparation
Treatment goal	• Therapist's goal	• Individual goal	• Group goal	• Negotiation
Treatment content	• Content defined by Therapist	• Content defined by patient	• Content defined by group	• Negotiation • Response to concrete content
Treatment process	• Therapist's language and communication style • Counter transference	• Patient's language and communication style • Transference	• Involvement of family • Community healing practices	• Language independence • Cultural independence • Cultural reattribution • Social role prescription • Avoidance of inappropriate techniques
Termination	• Tolerance of dependency	• Need for ongoing support	• View of treatment	• "Door ajar" • Institutional transference

BPSS = bio-psycho-social-spiritual

patient expectations about therapist insight may be at odds with some authors' admonitions about the value of therapists' displaying curiosity and cultural naiveté (10). Therefore, to avoid making erroneous assumptions and indulging in unjustified stereotypes, therapists must learn to recognize and operate within the contrasting frameworks of therapeutic omniscience and naiveté. They should maintain a constantly open attitude, while making opportune and appropriately formulated enquiries about the patient's culture.

In many ethnocultural communities, shame about seeking mental health services is an important issue for both the patient and the family (11). Reassuring patients and their families about confidentiality is important. Psychoeducation may also help to modify some prevalent cultural myths—for example, that mental illness is incurable or implacably heritable.

Assessment and Feedback

During assessment, sensitivity is required to foster and maintain the therapeutic alliance. Therapists should approach such taboo subjects as sex cautiously. Attempts to understand patient problems should begin with what the patient deems important.

A comprehensive approach to assessment includes examining the problems from biological, psychological, and social perspectives (12). The spiritual perspective is another significant component in many cultures (13). For a thorough assessment, knowledge of the patient's particular culture and world view is necessary, as described below. A cultural consultant is sometimes needed. This consultant may be (for example) a bicultural professional who can describe the home country sociopolitical situation, help interpret certain aspects of the patient's mental state, or suggest community resources in the resettlement country.

Cultural identity is an important and multidimensional area of exploration. A given individual may have different cultural preferences for language, food, entertainment, and value system, and none of these dimensions can be inferred from another. For example, individuals may cling to the foods they ate in a parental home, while simultaneously abandoning parental values regarding sexual behaviour or filial obligation in favour of those prevalent in the larger Canadian society. It is also important to recognize that cultural identity is fluid and dynamic and may be differently invoked, depending on the context and situation (14,15). Further, the diverse acculturative strategies used by immigrants may have an impact on mental health and psychosocial adjustment (16,17). Immigrants may adopt the host culture with or without maintaining their heritage culture, employing, respectively, "integration" or "assimilation" strategies. It has been proposed that integration—a harmonious blend of both cultures—leads to

good psychological adjustment. Conversely, immigrants may adhere to their heritage culture without acculturation. This "separation" strategy may not create problems if the ethnic community is sufficiently large and sufficiently developed to provide a viable ethnic enclave (18,19). Individuals who fail to fit within both their heritage culture and the host culture may become marginalized and are at particular risk of developing mental health problems (16–19). Clinicians should explore each patient's particular type of acculturation strategy, paying particular attention to its rigidity and fit with the environment.

Family dynamics is another element to be assessed, especially in collectivist cultures. At times, this assessment has to be conducted in various subgroups, allowing for subsystem interventions (11). For example, a separate discussion with the father may help him avoid the loss face that would result from admitting errors in front of the family. Sometimes, a family member can be enlisted to act as the therapist's auxiliary to effect certain interventions. Understanding the patient's relations with the local communities, with the country of origin, and with the dominant society can alert the therapist to problems with acculturative stress and intercultural conflict (such as discrimination at the patient's workplace).

After an initial assessment, therapist feedback may be particularly important for the culturally different patient. The idea of a "gift" to the patient, offered even in the first assessment session, is a useful technique that encourages the patient to continue with therapy (20). Engagement-enhancing gifts include explanations about problems, reassurances, or a prescription for medications.

Therapists can also use feedback as an opportunity to introduce the concept of psychotherapy to patients, who may not share the therapists' underlying assumptions (such as assumptions about the process and about the respective roles of therapist and patient). A pretherapy introduction to psychotherapy in the form of a brochure, a video, or a group discussion has been shown to reduce premature termination (21,22).

Treatment

We discuss this phase in terms of 3 interrelated components: goals, or the desired endpoints of therapy; content, or the specific area that is worked on; and process, or the way in which therapy is conducted. For example, in treating a patient with depression, the goal may be to elevate mood and restore functioning, the content may be grief over a mother's death, and the process may be interpersonal psychotherapy. Sue has emphasized the importance of culturally appropriate goals and process in psychotherapy (23).

Goals. It is important for therapists and patients to establish goals collaboratively. Treatment goals set by the therapist alone may be incongruent with the patient's cultural frame of reference. The patient's primary group may have different goals from those of the patient, which adds to the complexity of goal setting (24). For example, an Asian adolescent's desire for autonomy may conflict with the traditional values of his or her family. Ultimately, the primary principle in setting appropriate goals should be the patient's subjective well-being, conducive to healthy functioning in the patient's environment.

Content. The patient's culture often influences the choice of content in psychotherapy. Cultural analysis (CA), as we will discuss later, helps direct the therapist's attention to potential content areas. The explanatory model of the patient may differ from that of the therapist, and a process of negotiation may be necessary. For example, some patients may want to work on practical issues, such as somatic symptoms or relationships with neighbours, that may appear to be too concrete to therapists. Initially, therapists may need to respond to these issues to maintain the therapeutic alliance before embarking on other relevant issues. Empathizing with the patient, teaching problem-solving skills, supporting the patient in seeking Western or alternative solutions, and even giving direct advice may all be useful psychotherapeutic techniques. We further explore other specific process-related issues in the following section.

Process. Effective communication is the basis of any psychotherapeutic intervention. Therapists may need to accommodate their communication style, both verbal and nonverbal, to that of a culturally different patient because, for example, apparently linguistically equivalent words may evoke different psychological associations. This phenomenon is termed "language independence," defined as the capacity to maintain 2 sets of languages with different lexical, syntactic, phonetic, and ideational components (25,26). A bilingual therapist familiar with the concept of language independence can help patients elucidate the various meanings of words like "love," which in English can be used to cover many different emotional states. Some patients report different comfort levels when using different languages to discuss certain topics like sex: for example, bilingual Chinese patients may choose to speak about sexual matters in English rather than in Chinese (27).

Expanding on the concept of language independence, "cultural independence" has been proposed. Cultural icons such as temples may assume different meanings in different cultures. Maintaining cultural independence and actively exploring assumptions with the patient helps the patient to reexamine issues from a fresh perspective (27). Culture not only modifies meanings and associations, it can also guide the process and direction of psychotherapy. Depending on each individual case, therapists may find reinforcing cultural norms the most

helpful route. Conversely, a countercultural direction may be required when patient adherence to certain aspects of culture is part of the problem. In the latter case, reframing problems in the context of culture is a useful technique to reattribute blame and help patients reduce personal shame and guilt. For example, if an Asian husband from a male-dominated society is told that his controlling way of relating to his wife may have stemmed from his culture, he may be encouraged to modify it.

The development, maintenance, and use of the therapeutic relationship in cross-cultural psychotherapy can present unique challenges. Patients' culturally based expectations may challenge conventionally defined therapeutic boundaries, such as the convention that therapists refuse gifts. Problems may also arise from specific ethnocultural transference and countertransference (28). Patients may distrust a therapist from a culture that has oppressed them, or they may discount cultural issues, feeling that they are already quite assimilated. On the other hand, therapists may also minimize cultural differences, trying to appear less discriminating. Often, power dynamics are at the root of transference problems. Frank discussion of the discrepancy in power between therapist and patient may facilitate therapy (29,30). Conversely, problems can arise when the patient and therapist share the same cultural background, and cultural differences may in some cases actually have a positive transference effect that facilitates rather than impedes therapy (27). Asian patients, for example, may feel that a Western therapist is less judgmental than a culturally matched therapist about subjects taboo in their culture, such as homosexuality.

Beyond the traditional therapeutic dyad, it is often necessary to involve family members actively, although not necessarily in conventional family therapy. Therapists can invite family members to participate in part of the treatment, in a culturally appropriate manner. In some collectivist cultures, part of the self-identity and the interdependent self may be defined by the patient's social role in relation to other family members. For example, eldest sons may need to follow their fathers' footsteps, or the patients' vocational status may determine how they will be treated in the community. To assist these patients, it may be necessary to use resources in either the ethnic or the mainstream community creatively to procure volunteer work or develop an alternative social role. Other community resources include indigenous healing ceremonies, such as sweat lodges among Aboriginal populations (31), and more recently developed interventions such as network therapy (32,33,34).

Some conventional techniques may not be culturally appropriate for some patients. For example, open confrontation is not acceptable in some Asian cultures, with their emphasis on preserving "face." Other techniques, such as paradoxical intervention, role-play, and relaxation therapy, may be difficult for some patients to grasp or use (35).

Termination

Ethnic patients and their families may particularly need to maintain contact after termination, owing to limited support in the community and to their cultural understanding of relationships, which are rarely terminated artificially. Therapists may choose to leave the "door ajar" and maintain a link with patients and family members by defining appropriate circumstances in which they should reconsult. Sometimes, an institutional transference may be established, enabling patients to derive continued support from institutions such as hospitals or community agencies, should a particular therapist become unavailable.

Specific Cultural Competence Axis and Cultural Analysis

Specific cultural competence empowers therapists to use specific cultural knowledge effectively. Conceptually, the "specific" axis intersects with the "generic" axis to map out a 2-dimensional plane for the practice of culturally competent psychotherapy. In practice, culturally specific knowledge begins to be useful in the engagement phase and is often most fully used from the assessment phase onward (36).

The DSM-IV proposes the use of cultural formulation to systematically assess cultural influences on diagnosis and treatment (37). This process consists of examining 1) an individual's cultural identity, 2) cultural explanations for individual illnesses, 3) cultural factors related to the psychosocial environment and levels of functioning, 4) cultural elements of the therapist–patient relationship, and 5) overall cultural assessment for diagnosis and care. Although the DSM covers several important and broad cultural issues, we propose a more elaborate scheme to examine specific effects of culture: we extend the commonly used biopsychosocial model of formulation and use a more detailed framework, which we call "Cultural Analysis (CA)," to guide the exploration of patients' psychological worlds.

Culturally specific knowledge should inform biological, psychological, social, and spiritual components of the clinical assessment. (Biological difference is a less significant issue in psychotherapy, but it can be an important consideration in pharmacotherapy [38]). Psychologically, culture may considerably affect the patient's world view. CA is used to help clinicians arrive at a culturally specific understanding of the patient's world view; it informs and interacts with all phases of psychotherapy. In evaluating social factors, therapists can examine many relevant facets, including the sociopolitical history of the patient's country of origin and culture; current forces in the host society, such as discrimination; and the

Table 2 Cultural analysis: self, relations, and treatment

Self	Relations	Treatment
Affect	Environment, nature, universe	Communications
Behaviours	Family	Problem-solution models
Cognition	Groups, others, society	Relationship (therapist–patient)
Aims, goals, motivation	Materials	
Body	Spirituality	
Self-concept	Time	

particular dynamics and resources in the patient's local ethnic community. Knowledge of specific spiritual beliefs and practices is useful in both assessment and treatment.

Cultural Analysis

In all schools of psychotherapy, the therapeutic process is guided by theory, principles, and models of understanding regarding patients and their problems. CA is a framework designed to facilitate a systematic approach to integrating specific cultural knowledge derived from various disciplines, including cross-cultural psychology, psychiatry, anthropology, and sociology. Its goal is to achieve a more complete and culturally informed psychological understanding of the patient. However, this model should be flexibly revised during psychotherapy. While CA can inform and expand clinicians' thinking, we emphasize that it should be treated as a hypothesis-generating strategy: it highlights potential areas to be explored, but it is not a shorthand device to stereotype and label patients. Hypotheses unsupported by clinical data should be discarded.

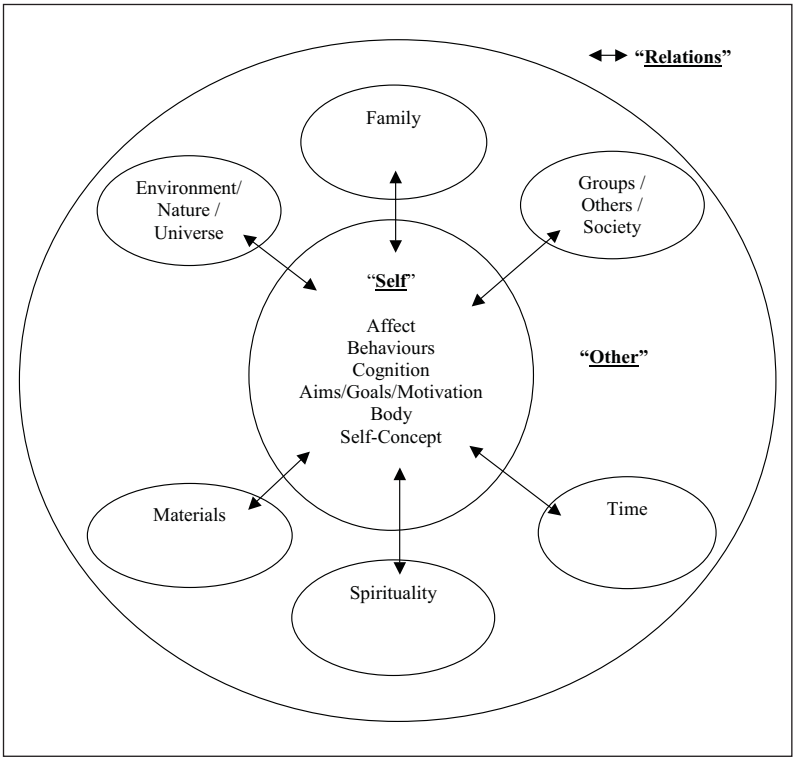
Various approaches are used to capture the diverse world views of different cultures (23). We propose that clinicians begin to understand patients' world views by using a structure based on an object-relation treatment model, with an emphasis on the importance of self and its relationships with others and with the world (39). In addition, clinicians need to consider each patient's culturally specific understanding of the treatment process. CA is therefore conceived as a framework with 3 broad domains: self, relations, and treatment. Within these domains, we identify basic elements, illustrated in a grid format (Table 2). Culture may affect the way in which each element is conceptualized, including its nature, relative importance, and ideal or desired state.

The self domain captures cultural influences on the psychological aspects of the self that may be relevant in psychotherapy. Culture may affect the very building blocks of internal psychological experiences and observable actions, including affect, cognition, and behaviour. Individual aims, goals, and motivating forces in life also depend on culture. For example, Freud's emphasis on the importance of repressed sexual desires as basic, dominating motivational forces may have been considerably influenced by the culture of his time. Similarly, his conception of the death instinct was influenced by the wars of his era (40). Culture also influences the conceptualization of the body, which has given rise to the study of different presentations of somatic and psychological symptoms across cultures. To give another example, Cartesian dualism has influenced Western thought and culture and contrasts with the more blurred conceptualizations of body and mind espoused by traditional Chinese beliefs and reflected in such classical medical texts as the *Huangdi Neijing* (41). One's overall self-concept is intrinsically tied to one's culture. One of the most often cited broad cultural variations is the distinction between independent and interdependent self-construals, reflecting individualistic and collectivist cultures, respectively (42).

Using affect as a more extensive example, one can systematically consider empirical data and relevant theories about how the patient's specific culture modifies each element's nature, importance, and ideal state. First, culture may influence the nature of affect, from its internal experiences to its outward display. Some researchers believe that the internal experiences of affect are inseparable from sociocultural constructions of experiences (43,44). Other researchers suggest that certain emotions may be universal across cultures, with apparent variations deriving from socioculturally defined display rules (45). Recent research has studied universal as well as culturally specific aspects of emotions beyond cultural display rules. For example, it has examined the different interpretations and antecedents of specific emotions (46). In psychotherapy, patients' subjective conceptualization of affect may be even more relevant, influencing both assessment and treatment. Cultural metaphors and beliefs—such as the belief that uncontrollable substances within the body cause anger or bodily illness—may uniquely influence patient beliefs regarding the origins and controllability of affect (41,47). Second, culture may modify the importance of affect by perceiving it as something to be either emphasized or ignored. For example, Western cultures have been influenced by Plato and Eastern cultures have been influenced by Confucius; cognitive faculties in the former and social hierarchy in the latter may be privileged above personal emotions. Finally, culture may modify the perception of the ideal state or the acceptability of specific types of emotions (for example, pride) (48). However, there may be a discrepancy between ideal values and actual practices. For example, it may be a particular cultural ideal not to feel or express pride, but pride may nevertheless be readily observable in the culture. Exploring internalized cultural ideals with patients may uncover internal conflict and guilt regarding certain disavowed emotions. Reframing emotions in a culturally acceptable way may at times relieve this conflict (for example, in a collectivist culture, pride may be reframed as relatively acceptable if expressed for family members) (49).

The relations domain captures cultural influence on patients' world views regarding their relationships. Culture powerfully influences patient relationships with immediate family members, friends, and the community at large. These relationships are guided by socioculturally defined roles, expected deportment, value systems, and the power hierarchy. Apart from human relationships, culture may influence patient relations with "others": culture influences patients' conceptions of nature and their attitude toward it. They may regard nature and the environment as something to be subservient to, live in harmony with, or dominate (23). The importance of material possessions may vary, with some belief systems advocating that the ideal state is nonpossessive of material things and others affirming that material wealth is power. Even the exchange of specific material things may take on cultural meanings. To some Chinese, for example, it is a cultural faux pas and an insult to give clocks as gifts, because the phrase "giving a clock" in Chinese sounds like "seeing you off to your final end or death." Time orientation—the relative importance allocated to the past, present, or future—has been shown to differ among cultures (23). This may affect psychological adjustment and therapy for those who suffer from depression about past trauma (50) or anxiety about future uncertainties. Spirituality is an often neglected yet important issue (13): in many cultures, spirituality may be inseparable from the culture itself. This often becomes particularly important when patients are confronting life-threatening events or existential crises.

Figure 2 Conceptual diagram of the internal representations of self and relations in cultural analysis



The treatment domain highlights elements of therapy that may be especially influenced by culture. These elements have been discussed above, under general cultural competence, but are included as part of the CA framework because they are critically important. Communication patterns, both verbal and nonverbal, are the very basis of the therapeutic process, yet they are subject to cultural influences. Problem-solution models refer to how patients conceptualize their difficulties. This term is preferable to the notion of illness models because patients may not necessarily think of their symptoms or difficulties as being related to illnesses. The therapist–client relationship, including the specified roles and transferences discussed above, is affected by the patient's specific culture.

Culture not only influences each element within the 3 domains individually but may also cause interactions both within and across domains. For example, the patient's cultural conception of emotions (affect) in the self domain may influence the treatment domain if the theapist interprets the patient's difficulties as emotional rather than physical.To illustrate some of the principles discussed, we present the following case.

Case Illustration

Clinical Presentation

Mr Lee, a 40-year-old, married Chinese, lived with his mother, wife, and 2 children in Toronto. He worked as a renovation worker until 2000, when he was involved in a severe motor vehicle accident. The van in which he was a passenger rolled over and crashed, killing 2 of the 4 occupants. He was dragged out of the vehicle by his friend Mr Chan, the other survivor. Mr Lee sustained no major physical injuries but complained of chronic headaches and neck pain. Several weeks after the accident, he began to experience depressed mood, irritability, anhedonia, middle insomnia, impaired short-term memory, decreased concentration, decreased energy, feelings of worthlessness, and passive thoughts of death. He also had occasional nightmares and increased vigilance when riding in a car. He was referred to one of us by his family doctor after a 6-month treatment of his headaches and neck pain with analgesics and physiotherapy failed to produce much benefit.

Mr Lee had a normal childhood development in a small town in China, with no history of abuse. His father was a carpenter, and his mother was a farmer. He could only describe his parents as "good." He had a grade 10 education and immigrated to Canada in 1985. After various jobs, he worked as a renovation worker for the same company for 5 years before the accident. He met his first wife in Toronto and married in 1990.

Table 3 Cultural analysis: some potential influences of Chinese culture on Mr Lee

Self	
Affect	Indirectly expressed or suppressed? (41)
Behaviour	Decreased eye contact - cultural? (23)
Cognition	Field dependent? (52) Less "psychological mindedness"?
Aims, goals, motivation	Individual and collective (family) goals? (10)
Body	Less body–mind distinction? Somatization? (53)
Concept (self-concept)	Independent < interdependent self? Acculturated cultural identity? (55)
Relations	
Environment	Karma? External locus of control (for example, fate)? Virtue of forbearance to outside forces? (23,56,57)
Family	Responsibility to children? Insiders vs outsiders? (11)
Groups, others, society	Confucian values of hierarchy: inferior social status leading to decreased assertiveness?
Materials	Less materialistic due to communist upbringing?
Spirituality	Buddhist and Taoists? Folk beliefs and superstitions?
Time	Past- and present-oriented? (58)
Treatment	
Communications	Indirect and passive style? (58)
Problem-solution models	Multimodal therapy expected (including herbs and acupuncture)? (59) Concrete plan, action vs talk therapy expected? (23)
Relationship	Authoritative healer–passive obedient patient relationship expected? A "respectful" distance observed? (23)

They had a child, but his wife died unexpectedly in 1995. He remarried in 1998 and had a second child.

When examined, Mr Lee presented as sullen and irritable, with intermittent eye contact, often focusing on the ground. While deferential, he tended to answer questions briefly, without elaboration. His mood was "not good," and his affect appeared depressed, with decreased range. He was preoccupied with physical pain and lack of energy. He had no active suicidal thoughts. Initially, his insight appeared limited and his judgment undisturbed.

Diagnosis and Treatment Course

Although Mr Lee presented with somatic complaints, specific questioning revealed a range of symptoms leading to a diagnosis of major depressive disorder. This sequence is consistent with with research on somatization (51,52). He also exhibited some subthreshold posttraumatic stress disorder symptoms. To develop a comprehensive understanding and treatment plan, his therapist used CA to take Mr Lee's Chinese background into account. Table 3 lists some of the initial hypotheses generated.

The initial treatment plan included assistance with insurance matters, pharmacotherapy, and cognitive-behavioural psychotherapy. The therapeutic alliance solidified after Mr Lee felt that his physical symptoms were taken seriously and that he was supported in his efforts to seek physiotherapy and to use traditional herbal ointments for pain. In addition, through treatment goal process negotiation and psychoeducation, he began to acknowledge and accept his affective symptoms and started taking an antidepressant (sertraline), which significantly improved many of his symptoms. With an enhanced therapeutic alliance and explanation of therapy, he began to participate actively, despite his initial somatization and brief, concrete responses, which at first and perhaps erroneously suggested he lacked "psychological mindedness."

As Mr Lee became more open and his thoughts were explored using cognitive-behavioural techniques, it became evident that his firm belief in fate and hard luck was a persistent source of entrenched cognitive distortions, leading to amotivation and social isolation. This belief exacerbated his survivor guilt. He revealed that he stopped himself from visiting relatives during Chinese New Year, isolated himself from his children's activities, and cut off his contacts with his friends. Based on the death of his first wife and coworkers, Mr Lee began to fixate on a superstitious folk belief that his hard luck would bring bad luck to those around him, even though he himself would not be harmed by bad events.

At this phase of treatment, various approaches were considered and used. A countercultural approach with standard cognitive-behavioral techniques was used to challenge his beliefs directly. He was helped to evaluate personal counter-

examples. For example, he had many other relationships and had previously gone on other social outings, none of which were ever subjected to danger. He was also challenged as to whether survivors of floods in China should be thought of as having hard luck. These techniques produced limit effects: they raised some doubts in Mr Lee's mind but failed to effect major shifts in his belief system. A cultural reinforcing approach was briefly explored, including such possible indigenous solutions as consulting with a fortuneteller or the temple. Unfortunately, Mr Lee quickly dismissed them because he did not believe in their power to shift hard luck. Several other approaches, framed to be culturally congruent, were then used successively. Tapping into his sense of an interdependent self and using techniques of interpersonal psychotherapy with a grief focus, his therapist helped him rebuild and strengthen his relationships, including those with his friend Mr Chan; with family members of his deceased friends; and most important, with his own family members. While respecting Mr Lee's sense of fate, his therapist encouraged him to explore existential questions, such as finding new meaning in his survival that included his responsibilities to his family. Although family sessions might have helped address some of these issues, Ms Lee's work schedule made this difficult, and before arrangements could be made, Mr Lee had improved so greatly that family sessions no longer seemed necessary. Finally, within the complex and diverse Chinese culture, it was possible to find contradictory cultural beliefs to challenge Mr Lee's belief in hard luck. These included alternative folk beliefs based on ancient Chinese sayings that suggest "survivors of great catastrophe surely will have good luck later on," and "good people are protected and helped by heaven."

Mr Lee gradually improved and eventually returned to work after a year and a half of therapy. He and his family were reassured that they could contact the therapist again, if necessary.

This case illustrates the influence of culture on various aspects of therapy, including nonpsychotherapeutic interventions; the therapeutic alliance; and suitable psychotherapeutic goals, process, and content. When informed by culture, psychotherapeutic strategies can be approached from diverse treatment perspectives and strategies. The success of the therapy sometimes depends on combining different strategies across time. When a particular approach leads to an impasse, therapists should have the flexibility to shift therapeutic strategies while keeping in mind the influence of culture.

Conclusion

Insofar as therapists and patients have different reference groups, all encounters may be considered cross-cultural (60). If this perspective is endorsed, then one may indeed consider cultural competence to be essential to overall clinical competence. Therapists should strive for cultural competency by acquiring both generic and specific cultural knowledge and skill sets. Various generic cultural issues may arise at each phase of psychotherapy, and specific cultural knowledge guides their resolution. To guide clinicians, we conceptualize and propose 2 intersecting axes, each embedded within a matrix of relevant issues. Similar considerations may be useful in other cross-cultural clinical encounters apart from psychotherapy.

References

1. US Department of Health and Human Services. Mental health: culture, race and ethnicity—a supplement to mental health: a report of the Surgeon General. Rockville (MD): Office of the Surgeon General; 2001.
2. Canadian Task Force on Mental Health Issues (CTFMH). After the door has been opened: mental health issues affecting immigrants and refugees in Canada. Ottawa: Health and Welfare Canada; 1988.
3. Tseng WS, Streltzer J. Culture and psychotherapy: a guide to clinical practice. Wahington (DC): American Psychiatric Press; 2001.
4. Cross T, Bazron B, Denals K. Towards a culturally competent system of care. Washington (DC): CASSP Technical Assistance Center; 1989.
5. Kleinman A. Patients and healers in the context of culture. Berkeley (CA): University of California Press; 1980.
6. Cheung FM. Conceptualization of psychiatric illness and help-seeking behaviour among Chinese. Cult Med Psychiatry 1987;11:97–106.
7. Sue S. Community mental health services to minority groups: some optimism, some pessimism. Am Psychol 1977;32:616–24.
8. Sue S. In search of cultural competence in psychotherapy and counseling. Am Psychol 1998;53:440–8.
9. Quastel A, Lo HT. Cultural considerations in psychiatric assessment. In: Rummens A, Beiser M, Noh S, editors. Immigration, health and ethnicity. Toronto: University of Toronto Press. Forthcoming.
10. Dyche L, Zayas L. The value of curiosity and naivete for the cross-cultural psychotherapist. Fam Process 1995;34:389–99.
11. Lee E. Assessment and treatment of Chinese-American immigrant families. In: Saba GW, Karrer BM, Hardy KV, editors. New York: Haworth Press; 1990. p 99–122.
12. Engel GL. The need for a new medical model: a challenge for biomedicine. Science 1977;196:129–36.
13. Larson D, Milano M, Lu F. Religion and mental health: the need for cultural sensitivity and synthesis. In: Okpaku S, editor. Clinical methods in transcultural psychiatry. Washington (DC): American Psychiatric Press; 1998.
14. Hayano D. Ethnic identification and disidentification: Japanese-American views of Chinese Americans. Ethnics Groups 1981;3:157–71.
15. Uba L. Ethnic identity. Asian Americans. New York: The Guilford Press; 1994. p 89–118.
16. Berry JW, Poortinga YH, Segall MH, Dasen PR. Cross-cultural psychology: research and applications. New York: Cambridge University Press; 1992.
17. Berry JW, Sam D. Acculturation and adaptation. In: Berry JW, Segall MH, Kagitcibasi C, editors. Handbook of cross-cultural psychology. Volume 3. Social behavior and applications. Boston: Allyn and Bacon; 1996. p 291–325.
18. Rabkin JG. Ethnic density and psychiatric hospitalization: hazards of minority status. Am J Psychiatry 1979;136:1562–6.
19. Halpern D, Nazroo J. The ethnic density effect: results from a national community survey of England and Wales. Int J Soc Psychiatry 2000;46(1):34–46.
20. Sue S, Zane N. Therapists' credibility and giving: implications for practice and training in Asian American communities. In: Miranda MR, Kitano HHL, editors. Mental health research and practice in minority communities: development of culturally sensitive training programs. Rockville (MD): National Institute of Mental Health; 1986. p 157–75.
21. Acosta F, Yamamoto J, Evans LA. Effective psychotherapy for low-income and minority patients. New York: Plenum Press; 1982.
22. Reis BF, Brown LG. Reducing psychotherapy dropouts: maximizing perspective convergence in the psychotherapy dyad. Psychotherapy Theory 1999;123–36.
23. Sue DW, Sue D. Counselling the culturally different: theory and practice. 3rd ed. New York: John Wiley and Sons; 1999.
24. Leung P, Lee P. Psychotherapy with the Chinese. In: Bond M, editor. The handbook of Chinese psychology. Hong Kong: Oxford University Press; 1996. p 441–56.
25. Marcos LR, Alpert M. Strategies and risks in psychotherapy with bilingual patients: the phenomenon of language independence. Am J Psychiatry 1976;133:1275–8.
26. Marcos LR, Urcuyo L. Dynamic psychotherapy with the bilingual patient. Am J Psychotherapy 1979;33:331–8.

27. Cheng LY, Lo HT. On the advantages of cross-culture psychotherapy: the minority therapist/mainstream patient dyad. Psychiatry: Journal for the Study of Interpersonal Processes 1991;54:386–96.
28. Comas-Diaz L, Jacobsen FM. Ethnocultural transference and countertransference in the therapeutic dyad. Am J Orthopsychiatry 1991;61:392–402.
29. Pinderhughes E. Understanding race, ethnicity, and power: the key to efficacy in clinical practice. New York: Free Press; 1989.
30. Pinderhughes EB. The interaction of difference and power as a basic framework for understanding work with African Americans: family theory, empowerment and educational approaches. Smith Coll Stud Soc Work 1997;67:323–47.
31. Jilek WG. Traditional medicine relevant to psychiatry. In: Sartorius N, de Girolamo G, Andrews G, editors. Treatment of mental disorders: a review of effectiveness. Washington (DC): American Psychiatric Press; 1993. p 341–83.
32. Attneave CL. Therapy in tribal settings and urban network intervention. Fam Process 1969;8:192–210.
33. Attneave CL. Therapeutic effectiveness of social network interventions compared to groups of "intimate strangers." Journal of Group Psychotherapy 1979;32:173–7.
34. Attneave CL. Core network intervention: an emerging paradigm. Journal of Strategic and Systemic Therapies 1990;9(1):3–10.
35. Kinzie D. Lessons from cross-cultural psychotherapy. Am J Psychotherapy 1978;32:510–20.
36. McGolderick M, Giordano J, Pearce J. Ethnicity and family therapy. New York: Guilford; 1996.
37. Mezzich J. Cultural formulation and comprehensive diagnosis. Psychiatr Clin North Am 1995;18:649–57.
38. Lin K, Smith M. Psychopharmacotherapy in the context of culture and ethnicity. In: Ruiz P, editor. Ethnicity and psychopharmacology. Washington (DC): American Psychiatric Press; 2000. p 1–36.
39. Gabbard GO. Psychodynamic psychiatry in clinical practice. 3rd ed. Washington (DC): American Psychiatric Press; 2000.
40. Mitchell SA, Black MJ. Freud and beyond: a history of modern psychoanalytic thought. New York: Basic Books; 1995.
41. Russell JA, Yik MSM. Emotion among the Chinese. In: Bond MH, editor. The handbook of Chinese psychology. New York: Oxford University Press; 1996. p 166–88.
42. Kitayama S, Markus H. The cultural construction of self and emotion. In: Kitayama S, Markus H, editors. Emotion and culture: empirical studies of mutual influence. Washington (DC): American Psychological Association; 1994.
43. Armon-Jones C. The thesis of constructionism. In: Harre R, editor. Social construction of emotions. Oxford: Basil Blackwell; 1986. p 32–56.
44. Abu-Lughod L, Lutz CA. Introduction: emotion, discourse, and the politics of everyday life. In: Lutz CA, Abu-Lughod L, editors. Language and the politics of emotion. New York: Cambridge University Press; 1990. p 1–23.
45. Ekman P. Biological and cultural contributions to body and facial movements in the expression of emotions. In: Rorty AO, editor. Explaining emotions. Berkeley (CA): University of California Press; 1980. p 73–101.
46. Mesquita B, Frijda NH, Scherer KR. Culture and emotion. In: Berry JW, Dasen PR, editors. Handbook of cross-cultural psychology. 2nd ed. Volume 2. Basic processes and human development. Needham Heights (MA): Allyn and Bacon; 1997. p 255–97.
47. Koevecses Z. The concept of anger: universal or culture specific? Psychopathology Special Issue: anger and fury: from philosphy to psychopathology 2000;33:159–70.
48. Eid M, Diener E. Norms for experiencing emotions in different cultures: inter- and intranational differences. J Pers Soc Psychol 2001;81:869–85.
49. Stipek D. Differences between Americans and Chinese in the circumstances evoking pride, shame, and guilt. J Cross-Cult Psychol 1998;29:616–29.
50. Beiser M, Hyman I. Refugees' time perspective and mental health. Am J Psychiatry 1997;154:996–1002.
51. Cheung FM, Lau BW, Waldmann E. Somatization among Chinese depressives in general practice. Int J Psychiatry Med 1980;10:361–74.
52. Simon GE, VonKorff M, Piccinelli M, Fullerton C, Ormel J. An international study of the relation between somatic symptoms and depression. N Engl J Med 1999;341:1329–35.
53. Ramirez MI. Multicultural psychotherapy: an approach to individual and cultural differences. 2nd ed. Boston (MA) : Allyn and Bacon; 1999.
54. Cheung F. Facts and myths about Somatization among the Chinese. In: Lin TY, Tseng WS, Yeh EK, editors. Hong Kong: Oxford University Press; 1995. p 156–66.
55. Ryder AG, Alden LE, Paulhus DL. Is acculturation unidimensional or bidimensional? A head-to-head comparison in the prediction of personality, self-identity, and adjustment. J Pers Soc Psychol 2000;79(1):49–65.
56. Hsieh T, Shybut J, Lotsof E. Internal versus external control and ethnic group membership: a cross-cultural comparison. J Consult Clin Psychol 1969;33:122–4.
57. Chiu L-H. Locus of control differences between American and Chinese adolescents. J Soc Psychol 1988;128:411–3.
58. Ho M. Family therapy with ethnic minorities. Newbury Park: Sage; 1987.
59. Gao G, Ting-Toomey S, Gudykunst WB. Chinese communication process. In: Bond MH, editor. Handbook of Chinese psychology. New York: Oxford University Press; 1996. p 280–93.
60. Draguns JG. Resocialization into culture: the complexities of taking a worldwide view of psychotherapy. In: Brislin RW, Bochner S, Lonner WJ, editors. Cross-cultural perspectives on learning. Beverly Hills (CA): Sage Publications; 1975. p 273–89.

Manuscript received and accepted February 2003.

[1]Assistant Professor, Department of Psychiatry, University of Toronto; Consultant, Culture, Community, and Health Studies, Centre for Addiction and Mental Health, Toronto, Ontario.
[2]Lecturer, Department of Psychiatry, University of Toronto; Clinical Director, Asian Initiative in Mental Health, University Health Network, Toronto, Ontario.
Address for correspondence: Dr K Fung, Toronto Western Hospital, Department of Psychiatry EC-3C, 399 Bathurst Street, Toronto ON M5T 2S8

Résumé : Psychothérapie compétente sur le plan culturel

Pour fournir une psychothérapie efficace aux patients de différentes cultures, les thérapeutes doivent acquérir une compétence culturelle, qui peut se diviser en 2 grandes dimensions entrecroisées de compétences culturelles génériques et spécifiques. Les compétences culturelles génériques comprennent les connaissances et l'ensemble des aptitudes nécessaires pour travailler efficacement dans toute rencontre thérapeutique interculturelle. À chaque phase de la psychothérapie, y compris le pré-engagement, l'engagement, l'évaluation et la rétroaction, le traitement et la cessation, nous discutons de questions culturelles génériques pertinentes sur le plan clinique, dans les catégories suivantes : thérapeute, patient, famille ou groupe, et technique. Les compétences culturelles spécifiques permettent au thérapeute de travailler efficacement auprès d'une communauté ethnoculturelle spécifique et influent aussi sur chaque phase de la psychothérapie. Une approche détaillée de l'évaluation et du traitement est nécessaire pour prendre en compte les effets particuliers de la culture sur le patient. L'analyse culturelle (AC) développe la formulation en fonction de la culture du *DSM-IV* et l'adapte à la psychothérapie; c'est un outil clinique mis au point pour aider les thérapeutes à étudier systématiquement et à produire des hypothèses concernant les influences culturelles sur l'univers psychologique du patient. L'AC examine les questions de 3 domaines : le soi, les relations et le traitement. Nous présentons un cas pour illustrer l'influence de la culture sur la présentation du patient, le diagnostic, l'AC et le traitement psychothérapeutique. Une thérapie réussie exige que les thérapeutes recourent à des buts, des processus et du contenu appropriés sur le plan culturel. Le cas démontre aussi diverses techniques relatives à la culture, y compris des stratégies contre-culturelles, renforçant la culture ou congruentes à la culture ainsi que l'utilisation de croyances culturelles contradictoires. En résumé, l'acquisition de compétences culturelles tant génériques que spécifiques accroîtra l'efficacité clinicienne en psychothérapie, ainsi que dans d'autres rencontres thérapeutiques interculturelles.