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The Role of Culture and Cultural Techniques in Psychotherapy: A Critique and Reformulation

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This article examines the role of cultural knowledge and culture-specific techniques in the psychotherapeutic treatment of ethnic minority-group clients. Recommendations that admonish therapists to be culturally sensitive and to know the culture of the client have not been very helpful. Such recommendations often fail to specify treatment procedures and to consider within-group heterogeneity among ethnic clients. Similarly, specific techniques based on the presumed cultural values of a client are often applied regardless of their appropriateness to a particular ethnic client. It is suggested that cultural knowledge and culture-consistent strategies be linked to two basic processes—credibility and giving. Analysis of these processes can provide a meaningful method of viewing the role of culture in psychotherapy and also provides suggestions for improving psychotherapy practices, training, and research for ethnic-minority populations.

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For nearly two decades research has been devoted to the investigation of the adequacy of psychotherapeutic services and treatment practices for ethnic-minority populations. Yet clinical and community psychologists continue to be perplexed by the problem of how to increase the effectiveness of mental health services to these populations. Although it can be legitimately argued that much more research is needed in order to address this problem, perhaps our efforts need to be redirected to some basic issues that have been overlooked.

This article examines the principles underlying attempts to develop effective psychotherapy with ethnic-minority groups. Several points are made. First, investigators have been remarkably consistent in offering recommendations or suggestions for improving the relationship between therapists and ethnic-minority clients. These recommendations typically involve therapists' knowledge of culture and specific techniques based on this knowledge. Second, the suggestions raise problems for therapists. Third, in order to resolve these problems, research and practice should be redirected to two key processes involving therapist credibility and giving. Fourth, by focusing on these processes, guidelines for therapy, training, and research can be more adequately specified. Although these four points are illustrated primarily with Asian Americans in this article, they have direct relevance to other ethnic or cultural groups.

Problems in Providing Effective Services

The research and clinical literature on the delivery of mental health services to ethnic-minority populations has been quite consistent in drawing attention to inadequacies in the provision of services. For example, in summarizing the work of its Asian/Pacific-American, Black-American, Hispanic-American, and Native-American/Alaska-Native subpanels, the Special Populations Task Force of the President's Commission on Mental Health (1978) concluded that ethnic minorities "are clearly underserved or inappropriately served by the current mental health system in this country" (p. 73). The first author (Sue, 1977) studied nearly 14,000 clients in 17 community mental health centers in the greater Seattle area. Results indicated that Blacks and Native Americans were overrepresented in the centers, whereas Asian Americans and Hispanics were underrepresented. The disturbing finding was that regardless of utilization rates, all of the ethnic-minority groups had significantly higher dropout rates than Whites.

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About half of the ethnic-minority clients failed to return for treatment after one session, compared to the 30% dropout rate of Whites. Without belaboring the point, we believe that there is ample evidence that ethnic minorities are not faring well in our mental health system.

How can these problems be explained? Again, researchers and practitioners exhibit remarkable agreement about the reasons for the inadequacies in mental health services. Some of these reasons include the lack of bilingual therapists, stereotypes therapists have of ethnic clients, and discrimination. However, the single most important explanation for the problems in service delivery involves the inability of therapists to provide culturally responsive forms of treatment. The assumption, and a fairly good one, is that most therapists are not familiar with the cultural backgrounds and life-styles of various ethnic-minority groups and have received training primarily developed for Anglo, or mainstream, Americans (Bernal & Padilla, 1982; Chunn, Dunston, & Ross-Sheriff, 1983; Wyatt & Parham, 1985). Consequently, therapists are often unable to devise culturally appropriate forms of treatment, and ethnic-minority clients frequently find mental health services strange, foreign, or unhelpful. Szapocznik, Santisteban, Kurtines, Hervis, and Spencer (1982) argued that Hispanic Americans in contrast to Anglo Americans value linearity (i.e., role-structured rather than egalitarian relationships) and a present-time orientation in therapy. They believe that failure to recognize and utilize these values in treatment is an impediment to effective psychotherapy. Similarly, Nobles (1980) delineated several Black-American cultural traditions including group identification and collectivity, spirituality, and a flexible concept of time. These traditions, along with reactions to racial oppression, must be understood by psychotherapists working with Black Americans (Jones, 1985). The need to appreciate the cultural values of Native-American (Attneave, 1984; Manson & Trimble, 1982) and Asian-American (Kim, 1985) groups has also been emphasized. The Special Populations Task Force of the President's Commission on Mental Health (1978) recommended that "services to be provided for the special populations should be delivered, again with a view toward the best possible of worlds, by persons who share the unique perspective, value system and beliefs of the group being served" (p. 732).

New Issues Raised by Contemporary Strategies

Because of the unresponsiveness of services to the needs of ethnic minorities, researchers and practitioners advocated changes in the mental health system. The changes had to do with the process of match, or fit: Treatment should match, or fit, the cultural life-style or experiences of clients. Otherwise, ethnic-minority clients would continue to underutilize services, prematurely terminate, or fail to show positive treatment outcomes. Modifications were deemed important at the system level and at the face-to-face, client–therapist level.

At the system level several policy recommendations were made (S. Sue, 1977). First, existing mental health services were urged to hire bilingual/bicultural personnel who could work with ethnic-minority clients. The continuing education of current staff through seminars, workshops, and lectures on various cultural groups was also deemed important. Indeed, many mental health centers developed continuing education programs on ethnic issues. Second, the initiation of parallel services was necessary in areas where a large ethnic community existed. These services included the creation of mental health centers or sections of mental hospitals that specialized in treating these ethnic clients. Finally, nonparallel services for ethnic-minority clients were advocated. For example, because of the stigma attached to the use of mental health services, new means of delivering such services were needed. Some communities organized multiservice centers where mental health programs could be embedded within legal, social service, and language programs.

There is evidence that these three recommendations are being implemented (see Snowden, 1982; Uba, 1982) and that structural changes have been made in the service delivery sector. We are not implying that newly formed programs are sufficient to meet the needs of ethnic-group populations. The main point is that research and the concept of match have played important roles in influencing system changes.

Applying the concept of match, or fit, at the client–therapist level has generally meant that (a) more ethnic therapists who presumably are

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bilingual or are familiar with ethnic cultural values should be recruited into the mental health field, (b) students and therapists should acquire knowledge of ethnic cultures and communities, and (c) traditional forms of treatment should be modified because they are geared primarily for mainstream Americans. These tasks have been difficult and problematic to achieve. For example, it can be difficult to recruit Hispanics who are fluent in Spanish because graduate programs are often reluctant to admit students if their English verbal skills are low. Another problem is that few training programs offer courses in ethnicity or cultural diversity, as mentioned earlier.

Perhaps the most difficult issue confronting the mental health field is the role of culture and cultural techniques in psychotherapy. We believe that cultural knowledge and techniques generated by this knowledge are frequently applied in inappropriate ways. The problem is especially apparent when therapists and others act on insufficient knowledge or overgeneralize what they have learned about culturally dissimilar groups. This is illustrated in the following situations:

> One of our colleagues conveyed the following story to us. His daughter's fourth-grade teacher had just returned from a human relations workshop where she had been exposed to the necessity of incorporating "ethnicity" into her instructional planning. Since she had a Japanese American student in her class, she asked the child to be prepared to demonstrate to the class how the child danced at home. When the child danced in typical American fashion on the following Monday, the teacher interrupted and said, "No! No! I asked you to show the class the kinds of dances you dance at home." When the child indicated she had done just that, the teacher said, "I wanted you to show the class how you people dance at the *Bon Odori*" (a Japanese festival celebrated in some Japanese American communities at which people perform Japanese folk dances).
>
> Obviously, the teacher was looking for a dance which would be different and which she could use to demonstrate that in a pluralistic society there are many forms of dance. (Mizokawa & Morishima, 1979, p. 9)

A similar effect can be seen in clinical practice. Years ago when one of the authors was a clinical intern, a case conference was held concerning a Chinese-American client. The person presenting the case contrasted Chinese and American cultures and proceeded to apply the contrast to the client in a literal and stereotypic fashion, despite the fact that the client was a fourth-generation American. The point is that in working with ethnic-minority groups, no knowledge of their culture is detrimental; however, even with this knowledge, its application and relevance cannot always be assumed because of individual differences among members of a particular ethnic group.

Other issues are raised by the match, or fit, concept. Is it not impossible to gain sufficient knowledge of the different ethnic groups? If traditional forms of treatment should be modified, does this mean that popular forms of Western treatments such as psychoanalysis, gestalt therapy, humanistic approaches, and behavior modification are inappropriate? In what ways should therapy be modified? If match is important, should not therapists be ethnically similar to their clients? The notion of match brings forth a whole host of problems and issues.

The inability to fully address the problems concerning match, or fit, resulted in technique-oriented recommendations. Rather than simply advocating the necessity for therapists to be culturally sensitive and to know the cultural background of clients, some investigators began to specify intervention strategies to use with ethnic clients. For example, Asian Americans tend to prefer counselors who provide structure, guidance, and direction rather than nondirectedness in interactions (Atkinson, Maruyama, & Matsui, 1978). They are presumably more culturally familiar with structured relationships. Therapists are therefore advised to be directive. Ponce (1974) recommended that mental health workers treating Philipinos avoid approaches that emphasize communications, interpersonal feelings, feeling-touching maneuvers, or introspections. At least in the initial stages, an authoritative as opposed to egalitarian therapist role is more consistent with the helper–helpee relationship that Philipino Americans expect.

Recommendations for conducting psychotherapy with other ethnic groups have also appeared. In working with Hispanics, therapists have been advised to reframe the client's problems as medical ones in order to reduce resistance (Meadow, 1982) and to deemphasize the necessity for self-disclosure (Cortese, 1979). In the case of Black clients, Calia (1966) suggested that therapists use an action-oriented and externally focused (as opposed to intrapsychic) approach.

The implications are that therapists should be structured, authoritarian, and surface-problem oriented in working with ethnic-minority clients. Although these suggestions for the role of the therapist may, indeed, be more culturally consistent with certain groups such as Asian Americans, they raised difficulties. First, individuals who developed a theoretical style or orientation found problems in adopting a different style. Psychoanalytic or client-centered therapists would have to abandon to some extent insight or reflective techniques. Second, many Asian-American clients who were unacculturated seemed quite willing to talk about their emotions and to work well with little structure. Third, and most important, these technique-oriented suggestions were distal to the goal of effective therapy.

Distal Nature of Contemporary Strategies

The major problem with approaches emphasizing either cultural knowledge or culture-specific techniques is that neither is linked to particular processes that result in effective psychotherapy. In the case of cultural knowledge, therapists assume that it enables them to more accurately understand and assess clients and to develop treatment strategies that result in positive outcomes. In actuality, therapists' knowledge of the culture of clients is quite distal to therapeutic outcomes, in the sense that the knowledge must be transformed into concrete operations and strategies. This is why recommendations for knowledge of culture are necessary but not sufficient for effective treatment. That is, given knowledge of clients' culture, what should therapists do?

As mentioned previously, the need for concrete suggestions on how to conduct therapy with ethnic-minority clients stimulated recommendations for culturally specific forms of intervention. However, these intervention approaches are also distal to the outcome of psychotherapy. Let us imagine the following dialogue between an advocate and a skeptic of culturally specific techniques for Asian-American clients:

> **Advocate**: "Therapists need to be directive and structured in their interactions with Asian clients."
>
> **Skeptic**: "Why?"
>
> **Advocate**: "Because the roles are more consistent with Asian cultures."
>
> **Skeptic**: "Why is it important to be culturally consistent?"
>
> **Advocate**: "There are probably many reasons. Clients do not find therapy so strange. They believe that therapists understand them and can appropriately relate to them. Therapy and therapists become more meaningful to clients. Also, with a knowledge of the cultural background of clients, therapists are in a better position to assess, understand, and facilitate change in clients."
>
> **Skeptic**: "Then, being directive and culturally responsive are means to another end. That is, certain therapy strategies enhance the credibility of therapists and therapies to clients. This enhancement facilitates positive outcomes in treatment."
>
> **Advocate**: "Yes."

As indicated in Figure 1, the recommendations can be placed on a continuum of distance from the goal of positive outcomes. Knowledge of culture is the most distal. It leads to formulations of culturally consistent tactics such as providing structure to clients. These tactics occupy an intermediate distance because they do not magically lead to effective therapy. Rather, they presumably result in a process such as increased therapist credibility. Therefore, it may be wiser to focus on the proximal process of therapist credibility than on the more distal techniques. Instead of learning how to be authoritarian, directive, or structured with Asian-American clients, we should learn how to become credible with clients.

Perhaps these issues can be illustrated by reversing the situation. Let us imagine that an Anglo-American client seeks treatment from a

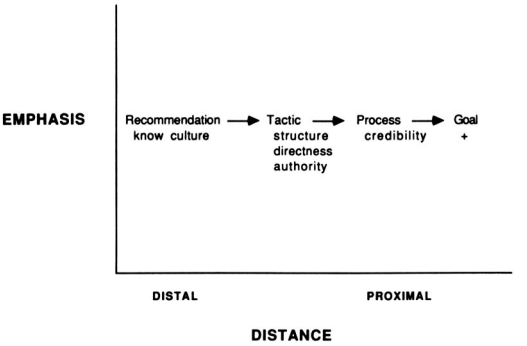

Figure 1. Relationship between therapeutic emphasis and distance from the goal of treatment.

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therapist in Taiwan who has had little contact with Americans. The therapist knows that compared to Chinese, Americans are individualistic, self-disclosing, assertive, and expressive. From this knowledge, how should the therapist conduct psychotherapy? Is the client a simple caricature of American values? Let us now assume that the therapist is given culturally specific techniques to use. Because Americans value insight into personal problems and insight-oriented treatment is still a predominant approach (Korchin, 1976), the therapist uses psychoanalysis in working with the client. Undoubtedly, many Americans would object to this "cookbook" technique as the culturally appropriate form of therapy for Americans.

We are not implying that knowledge of culture and the formulation of culturally consistent techniques are unnecessary or unimportant. They have been necessary and valuable in the attempts to provide more adequate services for ethnic-minority groups. However, as noted by Rappaport (1981), today's solutions often become tomorrow's problems, and psychology must continually strive to devise new paradigms and practices.

A Reformulation

The field of cross-cultural therapy has reached the point where it is necessary to review current practices and suggest recommendations for the future. We would like to reinterpret some of the research findings in an attempt to distill two basic processes (i.e., credibility and giving) that are important to consider in working with ethnic-minority clients. These two processes are not the only ones that are important in treatment; nor are they important only for ethnic minorities. Rather, credibility and giving are *particularly* relevant considerations in working with culturally diverse groups. Credibility refers to the client's perception of the therapist as an effective and trustworthy helper. Giving is the client's perception that something was received from the therapeutic encounter. The client has received a "gift" of some sort from the therapist. Credibility and giving are not new concepts in treatment. They are related to the much-discussed notions of expectancy, trust, faith, and effectiveness in therapy. The purpose in discussing these two concepts is to show how they are especially relevant to ethnic minorities and how they can be goals for training programs. For discussion purposes we have drawn examples relevant to Asian Americans.

Credibility

Many investigators have noted the critical role of therapist credibility in treatment. Frank (1959) stated,

> Expectancy of benefit from treatment in itself may have enduring and profound effects on his (the patient's) physical and mental state. It seems plausible, furthermore, that the successful effects of all forms of psychotherapy depend in part on their ability to foster such attitudes in the patient. (p. 36)

Phares (1984) maintained that outcomes for clients are better when clients believe in their therapists and in the methods being employed.

How do ethnic-minority clients come to believe in therapists or therapeutic methods? At least two factors are important in enhancing credibility: ascribed and achieved status. *Ascribed* status is the position or role that one is assigned by others. In the case of Asian Americans, Shon (1980) argued that communication patterns are often governed by factors such as age, expertise, and sex. In traditional Asian cultures, the youth is subordinate to the elder, the woman to the man, the naive person to the authority, and so on (Bodde, 1957; Kim, 1985). These role patterns, of course, are not true of all Asians, nor are they always desirable (such as the male–female roles). But these patterns generally exist in traditional Asian cultures. Status, or credibility, can also be *achieved*. Achieved credibility refers more directly to therapists' skills. Through the actions of therapists, clients come to have faith, trust, confidence, or hope. These actions may involve culturally consistent interventions and general therapeutic skills such as empathic understanding, ability to accurately assess clients, and so on.

The focus on the process of credibility also allows for an analysis of potential problems such as the following: (a) A nationally renowned psychotherapist is perceived by a client as being effective for Caucasians but not for Asians (perceived cultural difference in ascribed credibility); (b) A young female therapist is perceived as having expertise but low status because of her age and sex (discrepancy between ascribed credibility characteristics); (c)

Table 1
Factors in Credibility

Ascribed credibility	Achieved credibility	
	Low	High
Low	Client avoids treatment; if already in treatment, premature termination likely.	Client avoids treatment; if in treatment, expectations exceeded and may stay in treatment.
High	Client likely to enter treatment; high expectations are not realized so may terminate prematurely.	Client likely to enter treatment; high expectations are realized by skills of therapist.

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An older, mature expert in psychotherapy fails to be effective with an Asian client (high ascribed credibility but low achieved credibility), or (d) A client who is skeptical of therapy and of the therapist's training is pleasantly surprised that the therapist is quite skilled and helpful (low ascribed credibility but high achieved credibility).

Many other possibilities can be generated. The main point is that by analyzing credibility, we can begin to break the processes related to therapeutic effectiveness into components that can serve to direct our efforts in treatment and training. Ascribed and achieved credibility are related to one another. However, the lack of ascribed credibility may be the primary reason for underutilization of therapy, whereas the lack of achieved credibility may better explain premature termination. Many Asian Americans believe that therapists in the mental health system cannot help them (Root, 1985). They avoid services because of low ascribed credibility. Once in treatment, clients will drop out if therapists do not achieve credibility. Jenkins (1985) also argued that Black clients tend to "size up" therapists and to be wary of them. Credibility and a treatment relationship must be established within two to three sessions. In general, if therapists lack certain aspects of credibility with clients, other aspects must be strengthened. This will be illustrated later in a case example. Table 1 shows the two types of credibility and their consequences for clients.

Achieved credibility can be examined in terms of three areas in which cultural issues are important. These are stated as hypotheses

1. *Conceptualization of the problem.* If the client's problems are conceptualized in a manner that is incongruent with the client's belief systems, the credibility of the therapist is diminished. Directly or indirectly, therapists often convey their understanding or conceptualization of the causal links in the problems or situation of clients. If these are antagonistic to clients, credibility may not be achieved.

2. *Means for problem resolution.* If the therapist requires from the client responses that are culturally incompatible or unacceptable, the achieved credibility of the therapist is diminished. For example, a therapist may encourage an Asian client to directly express anger to his or her father in family therapy. The response (expression of anger to father) may be quite ego dystonic because of cultural values.

3. *Goals for treatment.* If the definitions of goals are discrepant between therapist and client, credibility of the therapist will be diminished. D. W. Sue (1981) cited the example of an Asian-American client who saw a counselor for vocational information. The counselor's goal in working with the client was to facilitate insight into deep underlying dynamics concerning motives and decisions. This was not the goal of the client, who felt extremely uncomfortable in the session. In such situations, the therapist and client tend to judge the effects of treatment on different criteria. One may feel treatment is successful; the other, unsuccessful.

These three hypotheses are not intended to imply that therapists should simply strive to match clients. At times, the client's belief systems may be inappropriate; he or she may need to learn new and (previously considered) incompatible responses. The client may hold inappropriate goals or the therapist may have to define other goals in order to address the client's primary problem. Nevertheless, therapists should realize that incongruities in conceptualization, problem resolution, or goals often reduce credibility. This diminished credibility needs to be restored or increased by demonstrating the validity of the therapist's perspective.

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Moreover, the incongruities should alert the therapist to the need to reexamine treatment strategies. For example, are the treatment decisions guided by the therapist's limitations in understanding the culture and context of the client or by well-thought-out outcome considerations for this client?

The role of cultural knowledge is to alert therapists to possible problems in credibility. Without knowing the cultural values of an ethnic-minority group, therapists would have to assess their credibility on a case-by-case basis. They would be unprepared to deal with possible cultural discrepancies in conceptualizing the problem, finding means to resolve problems of the client, and setting goals for treatment. On the other hand, because of the link between cultural knowledge and the process of credibility, therapists can avoid confounding the cultural values of the client's *ethnic group* with those of the *client*. The knowledge is used in the service of developing credibility. Because credibility is the central process of interest, it remains the focal point even when the client may be quite acculturated and Anglo American in perspective.

The role of culture-specific techniques is also influenced by the consideration of credibility. As indicated in the dialogue between the advocate and the skeptic, these techniques have been used to facilitate credibility. By focusing on credibility, therapists may be less likely to use culture-specific approaches for those ethnic clients who would not benefit from them.

Giving

In one way or another, clients often wonder how talking about problems to psychotherapists can result in the alleviation of emotional and behavioral distress. In response to clients' uncertainties, therapists often resort to the explaining of the treatment process: Clients should not expect immediate resolution of problems, talking about emotional difficulties results in greater insight and control of these difficulties, alternative causes of action to alleviate problems may be generated, the sharing of problems with another person is often helpful, one can learn better ways of dealing with crises, and so on. Explanations of treatment are intended to provide a rationale and to alter clients' expectations so that they fit the therapy process. In other words, we attempt to change their expectations to match our form of treatment. Such a strategy is needed in order to deal with clients who do not understand the treatment process. Nevertheless, explanations of therapy should be viewed as necessary but not sufficient to maintain the involvement and motivation of clients.

Almost immediately, clients need to feel a direct benefit from treatment. (We have called this benefit a "gift" because gift giving is a ritual that is frequently a part of interpersonal relationships among Asians.) The therapist cannot simply raise the client's expectations about outcomes. Direct benefits must be given as soon as possible. These are needed because of (a) the high dropout rate from treatment, (b) the need to demonstrate the achieved credibility of the therapist (and of therapy), and (c) the skepticism toward Western forms of treatment on the part of many Asian Americans. Gift giving demonstrates to clients the direct relationship between work in therapy and the alleviation of problems. Providing a gift is difficult, particularly in the initial session, because the therapist may be interested in gathering information for assessment purposes.

What kinds of gifts can be given in therapy? Depending on the client and situation, the therapist can strive to provide certain benefits. For example, clients who are depressed or anxious will perceive gains in therapy if there is an alleviation or reduction of these negative emotional states. For clients in a state of crisis and confusion, the therapist frequently helps clients to develop cognitive clarity or a means of understanding the chaotic experiences these clients encounter. Such a technique is often used in crisis intervention.

S. Sue and Morishima (1982) advocated normalization in work with Asian clients. Normalization refers to a process by which clients come to realize that their thoughts, feelings, or experiences are common and that many individuals encounter similar experiences. The purpose is not to deny unique experiences or to make trivial the client's problems. Rather, it is intended to reassure clients who magnify problems and who are unable to place their experiences in a proper context because of a reluctance to share thoughts with others.

Gift giving does not imply short-term treatment or even the necessity of finding quick solutions. However, it does imply the need for

attaining some type of meaningful gain early in therapy. The process of giving, of course, can be conceptualized as a special case of building rapport or establishing a trusting relationship, and cultural factors may influence whether a gift is actually a gift. Our central argument is that therapists should focus on gift giving and attempt to offer benefits from treatment as soon as possible, even in the first session. Some of the gifts (immediate benefits) that the therapist can offer include anxiety reduction, depression relief, cognitive clarity, normalization, reassurance, hope and faith, skills acquisition, a coping perspective, and goal setting.

In our analysis of the importance of credibility and giving, several features are apparent. First, the concepts of credibility and giving are not new. What we have tried to do is argue their particular relevance for ethnic minorities in general and Asian Americans in particular. These concepts should be the initial focal point of therapists. It may be wise for therapists to address some questions such as the following: What is my level of ascribed credibility with this client? How can I enhance my ascribed/achieved credibility? What kind of gift is important to provide? How can I offer this gift? Second, the two concepts are not limited to any particular therapeutic orientation. They cut across different approaches such as gestalt, psychoanalytic, client centered, and behavioral treatment. Third, credibility and giving are viewed as necessary but not sufficient ingredients for positive treatment outcomes. Long-term client changes are influenced by a variety of other therapist, client, and situational factors. However, we believe that the mental health profession, in its attempts to find effective means of treatment, has lost sight of some basic processes that are crucial. Most investigators have focused on distal considerations (e.g., knowledge of culture or culturally consistent tactics) rather than on the processes that underlie these considerations. Fourth, credibility and giving provide more specific targets for our intervention and training efforts than notions of cultural responsiveness, match or fit, therapeutic flexibility, cultural sensitivity, and so forth. Cultural knowledge is necessary, but if we have erred, it has been in the direction of ignoring therapeutic processes in favor of abstract admonishments to know culture. A balance between the two is needed.

A Case Example

We will now present an example case of a client and then discuss the issues it raises concerning credibility and giving. The case is taken from S. Sue and Morishima (1982) and was selected not because it neatly illustrates the processes of credibility and giving, but because the treatment raises issues relevant to the processes.

> At the advice of a close friend, Mae C. decided to seek services at a mental health center. She was extremely distraught and tearful as she related her dilemma. An immigrant from Hong Kong several years ago, Mae met and married her husband (also a recent immigrant from Hong Kong). Their marriage was apparently going fairly well until six months ago when her husband succeeded in bringing over his parents from Hong Kong. While not enthusiastic about having her parents-in-law live with her, Mae realized that her husband wanted them and that both she and her husband were obligated to help their parents (her own parents were still in Hong Kong).
>
> After the parents arrived, Mae found that she was expected to serve them. For example, the mother-in-law would expect Mae to cook and serve dinner, to wash all the clothes, and to do other chores. At the same time, she would constantly complain that Mae did not cook the dinner right, that the house was always messy, and that Mae should wash certain clothes separately. The parents-in-law also displaced Mae and her husband from the master bedroom. The guest room was located in the basement, and the parents refused to sleep in the basement because it reminded them of a tomb.
>
> Mae would occasionally complain to her husband about his parents. The husband would excuse his parent's demands by indicating, "They are my parents and they're getting old." In general, he avoided any potential conflict; if he took sides, he supported his parents. Although Mae realized that she had an obligation to his parents, the situation was becoming intolerable to her. (pp. 76–77)

Mae's ambivalence and conflict over entering psychotherapy were apparent. On the one hand, she had a strong feeling of hopelessness and was skeptical about the value of treatment. Mae also exhibited an initial reluctance to discuss her family problems. On the other hand, she could not think of any other way to address her situation. Then, too, her friend had suggested that she see me because I (S. Sue) had experience with Asian-American clients. In retrospect, I realize that my ascribed credibility with Mae was suspect. I was an American-born Chinese who might not understand her situation; furthermore, her impression of psychotherapy was not positive. Mae did not understand how "talking" about her problem could help. She, as well as

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her close friend, was unable to think of a solution, and she doubted a therapist could help. My age was probably an advantage—too young to be considered a parental figure (who might be an ally of her parents-in-law) and old enough to have experience in working with clients. The sex difference did not seem to matter.

In such a situation, achieving credibility is critical. I wanted to demonstrate that I understood her conflict and would not adopt the position of her in-laws. I attempted to reflect and to occasionally summarize her feelings of anger at her in-laws for their demands (and at her husband for not helping her) and of her failure to act as an ideal daughter-in-law and wife in fulfilling obligations. These attempts were somewhat successful judging by her progressive openness in detailing her problems and by her emotional reactions (e.g., crying) when summaries of her problems were verbalized to her. Unlike many Asian Americans, Mae seemed willing to self-disclose as long as I did not do anything to reduce my credibility. That is, the task was to avoid mistakes rather than to find means of drawing her out. I believe that had I defined Mae's problem as her lack of assertiveness and suggested assertiveness training as a goal, my credibility would have been diminished.

Toward the end of the first session, I also wanted to provide Mae with some gifts—normalization and hope. I indicated that conflicts with in-laws were very common, especially for Chinese, who are obligated to take care of their parents. I attempted to normalize the problems because she was suffering from a great deal of guilt over her perceived failure to be the perfect daughter-in-law. I also conveyed my belief that in therapy we could try to generate new ideas to resolve the problem—ideas that did not simply involve extreme courses of action such as divorce or total submission to the in-laws (which she believed were the only options).

I discussed Mae during a case conference with other mental health personnel. It is interesting that many suggestions were generated: Teach Mae how to confront the parents-in-law; have her invite the husband for marital counseling so that husband and wife could form a team in negotiation with his parents; conduct extended family therapy so that Mae, her husband, and her in-laws could agree on contractual give-and-take relationships. The staff agreed that working solely with Mae would not change the situation. However, these options entailed extreme response costs. Confronting her in-laws was discrepant with her role of daughter-in-law, and she felt very uncomfortable in asserting herself in the situation. Trying to involve her husband or in-laws in treatment was ill-advised. Her husband did not want to confront his parents. More important, Mae was extremely fearful that her family might find out that she had sought psychotherapy. Her husband as well as her in-laws would be appalled at her disclosure of family problems to a therapist who was an outsider.

We are not implying that these strategies would have failed. There is no a priori way of knowing their effectiveness. What is known is that Mae would have found these means for resolving the problem unacceptable. Urging her to adopt these strategies might have reduced the credibility of the therapist (he does not understand Chinese role relationships, he is not aware of the situation, and so on) and might have resulted in her termination of treatment.

How could Mae's case be handled? During the case conference, we discussed the ways that Chinese handle interpersonal family conflicts, which are not unusual to see. Chinese often use third-party intermediaries to resolve conflicts. The intermediaries obviously have to be credible and influential with the conflicting parties.

At the next session with Mae, I asked her to list the persons who might act as intermediaries, so that we could discuss the suitability of having someone else intervene. Almost immediately, Mae mentioned her uncle (the older brother of the mother-in-law), whom she described as being quite understanding and sensitive. We discussed what she should say to the uncle. After calling her uncle, who lived about 50 miles from Mae, she reported that he wanted to visit them. The uncle apparently realized the gravity of the situation and offered to help. He came for dinner, and Mae told me that she overheard a discussion between the uncle and Mae's mother-in-law. Essentially, he told her that Mae looked unhappy, that possibly she was working too hard, and that she needed a little more praise for the work that she was doing in taking care of everyone. The mother-in-law expressed surprise over Mae's unhappiness and agreed that Mae was doing a fine job. Without directly confront-

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ing each other, the uncle and his younger sister understood the subtle messages each conveyed. Older brother was saying that something was wrong and younger sister acknowledged it. After this interaction, Mae reported that her mother-in-law's criticisms did noticeably diminish and that she had even begun to help Mae with the chores.

Our intent in presenting Mae's case is not to illustrate the appropriateness or inappropriateness of certain techniques. The purpose is to demonstrate how credibility and giving should be relevant *processes* to consider in working with ethnic minorities. We believe that therapist credibility and giving are important processes that have implications for treatment, training, and research.

Implications

Treatment

It could be argued that credibility and giving are important in working with any client—so why emphasize these in the treatment of ethnic-minority individuals? Granted credibility and the importance of giving are salient issues even with a Caucasian client who is naive about or distrustful of psychotherapy. However, such issues are dealt with in a sociocultural context in which the client and therapist frequently share common values, attitudes, norms, patterns of communication, and language. This situation is less prevalent for many Asian-American or ethnic-minority clients. Outcome in therapy is the *cumulative* product of many discrete dynamics between client and therapist. For example, we doubt that an ethnic-minority client prematurely terminates solely because he or she may be ashamed of seeking help or unfamiliar with psychotherapy. He or she leaves after a series of frustrations, misunderstandings, disappointments, and defensive reactions on his or her part that combine to create a poor response to treatment. For many ethnic clients, language problems, role ambiguities, misinterpretations of behavior, differences in priorities of treatment, and so forth occur in conjunction with one another to produce a rapidly accelerating negative process in therapy. Viewed in this context, credibility and gift giving become all the more important because they can either exacerbate or help reverse this process.

Although it would be ideal to maximize both credibility and giving in treatment, our clinical experience suggests a more realistic objective in working with ethnic-minority clients: to minimize problems in credibility while maximizing gift giving. In essence, ascribed credibility and the three aspects of achieved credibility can be seen as marker areas for potential cultural problems in therapy. Gift giving, on the other hand, represents a potential positive force in treatment. In this framework both cultural problems as well as constructive solutions become salient foci in treatment.

Minimization of cultural problems does not imply that treatment should always match cultural expectations and norms. The primary purpose of therapy is to provide clients with new learning experiences. Often these involve prescriptions that run counter to cultural beliefs and/or accepted patterns of behavior. For example, a therapist working with a depressed Black woman may want her to become more self-disclosing, especially in expressing her feelings about certain problems she is having with her husband. Given that extensive self-disclosure of negative feelings and the focus on negative thoughts may be culturally incongruent means of problem solving for the client, the therapist must decide whether this decrement in credibility is offset by other perceived gains in treatment. A gift may involve agreeing to help the client arrange for an intermediary to talk with her husband, as in Mae's case. The point is that cultural incongruities are often unavoidable and at times are necessary. However, by being knowledgeable of issues of credibility and giving, therapy proceeds in a more systematic manner toward handling these incongruities, with an emphasis on producing constructive benefits.

Training

Culturally responsive problem conceptualization, means for problem solving, goals for evaluating progress, and gift giving constitute specific clinical tasks that must be undertaken in the treatment of ethnic-minority clients. Training can be conceptualized as a program for developing skills in each of these areas. In this way, the diffuse concept of cultural sensitivity is transformed into a set of meaningful operational objectives for the development of skilled therapists.

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By using this model it becomes apparent why simply imparting knowledge of different cultures was insufficient in the past. Such knowledge often involved very general and abstract concepts. More important, few training programs offered explicit guidelines for the application of these concepts to the specific clinical tasks of therapy.

Trainees working with clients can be videotaped, and evaluations can be made of credibility and gift-giving effectiveness; or therapist–client role playing situations can be created whereby the person adopting the role of client can provide the therapist-trainee with feedback on these skills. We have reached a point where innovative training practices must be found if we are to respond to ethnic-minority groups.

Research

The reformulation of the role of culture and the two processes we have identified suggest areas of clinical research. An interesting line of investigation would be to test the hypotheses proposed earlier: Do therapist–client discrepancies in problem conceptualization, means for problem resolution, and goals for treatment reduce therapist credibility and positive outcomes? Previous research has largely focused on therapeutic outcomes as a function of clients' expectancies about the value of treatment (Weiner & Bordin, 1983) and as a function of client–therapist match on global characteristics (e.g., race, social class, sex, general personal constructs, or personality characteristics; Berzins, 1977; Ivey & Simek-Downing, 1980; Phares, 1984). By specifying those discrepancies that may be important in the therapeutic endeavor, we more precisely test and understand the significance of client–therapist match. Furthermore, Greenberg (1986) pointed out that

> particular processes occur at different times in therapy and have different meanings in different contexts. It is more the occurrence of a particular pattern of variables than their simple presence or frequency of occurrence that indicates the therapeutic significance of what is occurring in therapy. (p. 7)

Given the complexity of therapeutic processes, it is important to investigate the relative significance of the three aspects of achieved credibility, the influence of one aspect on another, and the critical time periods that may exist in developing these aspects of credibility.

In the gift-giving process, we need to determine the kinds of gifts that are effective and the method by which gifts can be delivered. Here again, knowledge of culture can be used in the service of the process. Although gift giving may be a simple idea, its simplicity is more apparent than real. For example, we know that by providing a reward after the occurrence of a behavior, the frequency of that behavior often increases. Many Chinese offer gifts (i.e., rewards) first, in order to control the behavior of others. That is, an implicit obligatory relationship is created. Although this gift-giving procedure does not run counter to the principle of operant conditioning (e.g., the gift can be seen as a stimulus rather than a consequence of the behavior), it does point to the complexities that need to be addressed in research.

Another aspect to consider is the interaction between credibility and the effectiveness of a particular gift-giving action. Whether an action is perceived or experienced as a gift may be a function of the level of credibility. For instance, if therapists succeed in conceptualizing their clients' problems in a manner consistent with the clients' world view, clients may be more likely to "accept" reassurance from the therapist. On the other hand, clients who feel that their therapists do not understand them and their problems may perceive attempts at reassurance as condescending or pro forma gestures. Research examining the interaction between the various components of credibility and the gift-giving process may make significant contributions toward the development of effective treatment strategies for ethnic minorities.

References

Atkinson, D. R., Maruyama, M., & Matsui, S. (1978). The effects of counselor race and counseling approach on Asian Americans' perceptions of counselor credibility and utility. *Journal of Counseling Psychology, 25,* 76–83.

Attneave, C. L. (1984). Themes striving for harmony: Conventional mental health services and American Indian traditions. In S. Sue & T. Moore (Eds.), *The pluralistic society: A community mental health perspective* (pp. 149–166). New York: Human Services Press.

Bernal, M. E., & Padilla, A. M. (1982). Status of minority curricula and training in clinical psychology. *American Psychologist, 37,* 780–787.

Berzins, J. I. (1977). Therapist–patient matching. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy* (pp. 124–139). New York: Pergamon Press.

Bodde, D. (1957). *China's cultural tradition.* New York: Holt, Rinehart & Winston.

Calia, V. F. (1966). The culturally deprived client: A reformulation of the counselor's role. *Journal of Counseling Psychology, 13,* 100–105.

Chunn, J. C., Dunston, P. J., & Ross-Sheriff, F. (Eds.). (1983). *Mental health and people of color: Curriculum development and change.* Washington, DC: Howard University Press.

Cortese, M. (1979). Intervention research with Hispanic Americans: A review. *Hispanic Journal of Behavioral Sciences, 1,* 4–20.

Frank, J. P. (1959). The dynamics of the psychotherapeutic relationship. *Psychiatry, 22,* 17–39.

Greenberg, L. S. (1986). Change process research. *Journal of Consulting and Clinical Psychology, 54,* 4–9.

Ivey, A. E., & Simek-Downing, L. (1980). *Counseling and psychotherapy.* Englewood Cliffs, NJ: Prentice-Hall.

Jenkins, A. H. (1985). Attending to self-activity in the Afro-American client. *Psychotherapy, 22,* 335–341.

Jones, A. C. (1985). Psychological functioning in black Americans: A conceptual guide for use in psychotherapy. *Psychotherapy, 22,* 363–369.

Kim, S. C. (1985). Family therapy for Asian Americans: A strategic-structural framework. *Psychotherapy, 22,* 342–348.

Korchin, S. J. (1976). *Modern clinical psychology.* New York: Basic Books.

Manson, S. M., & Trimble, J. E. (1982). American Indian and Alaska Native communities: Past efforts, future inquiries. In L. R. Snowden (Ed.), *Reaching the underserved: Mental health needs of neglected populations* (pp. 143–164). Beverly Hills, CA: Sage.

Meadow, A. (1982). Psychopathology, psychotherapy, and the Mexican-American patient. In E. E. Jones & S. J. Korchin (Eds.), *Minority mental health* (pp. 331–361). New York: Praeger.

Mizokawa, D. T., & Morishima, J. K. (1979). The education for, by, and of Asian/Pacific Americans. *Research Review of Equal Education, 3,* 1–33.

Nobles, W. (1980). Extended self: Rethinking the so-called Negro self-concept. In R. L. Jones (Ed.), *Black psychology* (pp. 99–105). New York: Harper & Row.

Phares, E. J. (1984). *Clinical psychology.* Homewood, IL: Dorsey.

Ponce, D. (1974). The Filipinos in Hawaii. In W. S. Tseng, J. F. McDermott, & T. W. Maretzki (Eds.), *People and cultures in Hawaii* (pp. 34–43). Honolulu: University Press of Hawaii.

Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. *American Journal of Community Psychology, 9,* 1–25.

Root, M. P. (1985). Guidelines for facilitating therapy with Asian American clients. *Psychotherapy, 22,* 349–356.

Shon, S. (1980). The delivery of mental health services to Asian and Pacific Americans. In U.S. Commission on Civil Rights (Ed.), *Civil rights issues of Asian and Pacific Americans: Myths and realities* (pp. 724–733). Washington, DC: U.S. Government Printing Office.

Snowden, L. R. (Ed.). (1982). *Reaching the underserved: Mental health needs of neglected populations.* Beverly Hills, CA: Sage.

Special Populations Task Force of the President's Commission on Mental Health. (1978). *Task panel reports submitted to the President's Commission on Mental Health: Vol. 3.* Washington, DC: U.S. Government Printing Office.

Sue, D. W. (1981). *Counseling the culturally different: Theory and practice.* New York: Wiley.

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist, 32,* 616–624.

Sue, S., & Morishima, J. K. (1982). *The mental health of Asian Americans.* San Francisco: Jossey-Bass.

Szapocznik, J., Santisteban, D., Kurtines, W. M., Hervis, O. E., & Spencer, F. (1982). Life enhancement counseling: A psychosocial model of services for Cuban elders. In E. E. Jones & S. J. Korchin (Eds.), *Minority mental health* (pp. 296–330). New York: Praeger.

Uba, L. (1982). Meeting the mental health needs of Asian Americans: Mainstream or segregated services. *Professional Psychology, 13,* 215–221.

Weiner, I. B., & Bordin, E. S. (1983). Individual psychotherapy. In I. B. Weiner (Ed.), *Clinical methods in psychology* (pp. 333–388). New York: Wiley.

Wyatt, G. E., & Parham, W. D. (1985). The inclusion of culturally sensitive course materials in graduate school and training programs. *Psychotherapy, 22,* 461–468.

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