Short-Term Intercultural Psychotherapy: Ethnographic Inquiry

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This article examines the challenges specific to short-term intercultural treatments and recently developed approaches to intercultural treatments based on notions of cultural knowledge and cultural competence. The article introduces alternative approaches to short-term intercultural treatments based on ethnographic inquiry adapted for clinical practice. Such approaches allow clinicians conducting short-term intercultural treatments to foreground clients' indigenous conceptions of selfhood, mind, relationship, and emotional disturbance, and thus to more fully grasp their internal, interpersonal, and external worlds. This article demonstrates the uses of clinically adapted ethnographic inquiry in three short-term intercultural cases.

Key words: clinical practice; cross-cultural variation; cultural competence; multicultural clients; psychotherapy

The contemporary clinical environment is marked by two pronounced trends. First, in response to a variety of social and economic factors, short-term psychotherapies are delivered with increasing frequency in many mental health settings. Second, because of the growing cultural, ethnic, and racial diversity of the clientele who seek mental health services, and of the clinicians who provide them, intercultural treatments have become a more common clinical occurrence. The challenges of brief psychotherapies and of intercultural treatments have been discussed in the clinical literature in recent years, but they have been addressed separately. Despite the historic convergence of these two phenomena, the problems specific to treatments that are both short-term and intercultural have received insufficient attention.

This article examines theoretical and technical frameworks that are applicable to short-term intercultural treatments. After discussing difficulties that are common to such treatments, the article describes clinical approaches that allow therapists to conceptualize and explore the psychic and cultural worlds of clients whose cultural and linguistic backgrounds differ from theirs. Three short-term intercultural case vignettes are presented to illustrate these new approaches.

Short-Term Psychotherapies

As managed care makes ever deeper inroads in providing coverage for mental health services, therapists more frequently encounter clients who request brief psychotherapies because of the constraints of their mental health insurance plans. Short-term psychotherapies are also the rule in many institutional settings, including corporations and universities, where therapists commonly have a limited number of sessions to offer their clients. Even therapists who might prefer to provide their clients with open-ended, long-term treatments recognize that short-term treatments have become the norm across a variety of contemporary clinical settings.

The limitations of brief treatments, and the comparative advantages and disadvantages of short-term and long-term treatments, have been widely discussed and are not reviewed here.
For the purposes of this article, it should be noted that short-term psychotherapies have been found especially problematic in clinical work with clients whom psychotherapists categorize as "difficult." This category includes clients who are actively psychotic, clients with severe preoedipal pathologies, clients with histories of trauma and early object loss, and clients with serious physical illnesses (Messer & Warren, 1995). Of central importance to this article is that the category of difficult clients also includes international and ethnic minority clients.

**Short-Term Intercultural Psychotherapies**

The problems characteristic of brief psychological treatments are apt to multiply and deepen in short-term intercultural psychotherapies. Even when client and therapist share linguistic and cultural backgrounds, therapists sometimes find it difficult to make quick diagnostic assessments and to fully grasp their clients' concerns in a limited number of sessions. In brief intercultural treatments, the cultural and linguistic differences between therapist and client may inhibit their communication and mutual understanding profoundly, diminishing the possibility of accurate psychological evaluation and effective therapeutic intervention.

When the usual pressures of working with clients from different cultural and linguistic backgrounds (compare Chin 1993; Ewalt & Mokuau, 1995; Kakar, 1990; Landrine, 1992; Littlewood, 1990; Roland, 1988, 1996; Sabin, 1975; Seeley, 2000) are heightened by limitations of time, the puzzles that commonly characterize intercultural clinical work can seem even more insoluble.

As the population of clients seeking psychotherapy has grown more culturally diverse, clinicians have realized that clients from other societies, as well as clients from various ethnic and racial groups in this society, may not be well served by therapeutic models and techniques designed for the treatment of mainstream Westerners. To address the needs of international clients and clients of color and to improve intercultural psychotherapies, new approaches to intercultural treatments have been developed.

Most of the newly developed approaches to intercultural treatment rely on cultural knowledge—that is, they require therapists to possess preconceived understanding of the basic features of their clients' cultures. These approaches also prescribe the use of "culturally sensitive" clinical techniques tailored to fit clients' cultural, racial, and ethnic backgrounds so that therapists can achieve what is commonly constructed as cultural competence (Castex, 1994; Morones & Mikawa, 1992; Sue, 1998; Weaver, 1999). Knowledge of clients' cultures can enhance intercultural treatments, especially when it is not treated as an end in itself, but as a starting point from which to investigate each client's particular cultural formation and identity. Indeed, therapeutic approaches based on cultural knowledge may be most useful to clinicians who work primarily with specific client populations, and whose familiarity with culturally patterned behaviors, ideologies, and idioms of distress guides them in exploring individual clients' culturally shaped subjectivities.

Yet, intercultural therapeutic approaches that depend exclusively on cultural knowledge pose problems. First, they are frequently grounded in superficial concepts of culture that locate culture in the external environment—as extraneous to the person—and reduce it to collective practices and identities. Because these approaches construct culture as secondary to, and as overlaid onto, psychological processes that are thought to constitute the "universal, timeless dimensions of human experience" (Mitchell, 1993, p. 7), they fail to recognize that culture infuses every aspect of the psyche. Yet, in the words of Indian psychoanalyst Sudhir Kakar (1990), "Cultural ideas and ideals . . . pervade the innermost experience of the self. One cannot therefore speak of an 'earlier' or 'deeper' layer of the self beyond cultural reach" (p. 443). Central to the project of intercultural clinical work is the understanding that cultures provide their members with symbolic meanings that are so deeply internalized that they actually constitute psychic life and the self (Geertz, 1983). Accordingly, cultures shape how people think, feel, fantasize, use language, relate to others, construct their worlds, and experience themselves as individuals. Second, approaches to intercultural treatment based on cultural knowledge are often essentializing, in that they emphasize intracultural homogeneity and overlook intragroup variation. This perspective is especially troubling in clinical theory and practice because it frequently entails reducing the rich world of cultural variation to a
small number of overly inclusive categories, such as "Asian," "Hispanic," and "African American." The category "Asian," for example, includes Laotians and Japanese as well as Indians and Pakistanis, and the category "Hispanic" represents people from dozens of different countries located across North America, Central America, South America, and the Caribbean. These cultural categories are so broad that they obscure the national, ethnic, racial, tribal, linguistic, religious, political, and socioeconomic features of the groups placed within them. By failing to distinguish between different generations of immigrants—for example, between individuals born in China and their Chinese American descendants—these categories erase clients' social histories. By failing to distinguish among different kinds of migrants, such as permanent expatriates, political refugees, and temporary immigrants, they obscure clients' political histories. Such broad categories cannot help therapists understand how their culturally and ethnically diverse clients identify themselves; they do not provide therapists with a means of understanding clients who are multicultural, multiracial, or multilingual, and whose group identifications and self-concepts are plural, and perhaps conflicting, rather than singular.

Because many newly developed approaches to intercultural treatments represent cultural, ethnic, and racial groups as internally undifferentiated, they reinforce cultural stereotypes. Of greater therapeutic concern is that such approaches may discourage clinicians from exploring the specific features of their clients' cultural, racial, and ethnic histories and identities. Although displacing the Eurocentric assumptions embedded in standard models of psychotherapy is a critical task for intercultural practice, replacing one set of preconceived and highly generalized cultural assumptions with another is unlikely to significantly improve intercultural treatments. Rather, delivering more effective intercultural psychotherapies requires the development of alternative models of clinical practice.

**Ethnography and Clinical Practice**

In an earlier work (Seeley, 2000), I explored the problems of intercultural treatments in depth. To better comprehend the incompatibilities between non-Western clients and Western psychotherapeutic models, I interviewed individuals from a variety of cultural and ethnic groups who had been in psychotherapy with white American therapists. These interviews provided a window into international and ethnic minority clients' views of psychotherapeutic treatments in general, and of intercultural clinical treatments in particular. They indicated that for intercultural treatments to be enhanced, new clinical approaches that allow therapists to learn about their clients' culturally shaped subjectivities and worlds in the treatment setting, and as the therapeutic process unfolds, were needed.

How are we to learn about our clients' cultural worlds? There are reasons to doubt that conventional clinical theories and methods provide us with adequate tools. Beginning with classical psychoanalysis's universalizing models of psychopathology and culminating in contemporary psychiatry's neurochemical explanations of mental disturbance, most theories of practice have failed to consider culture as a critical element in the etiology, incidence, and symptomatology of psychological disorder. Although the field of social work promotes integrative models that view clients from biopsychosocial perspectives, it has not emphasized methods of cultural inquiry that give voice to clients' indigenous experiences of disorder and distress. As a result, despite a century of clinical practice, the field of mental health still lacks "phenomenological accounts... which focus(es) on lived experience, on the disturbances of experience of time, space, person, affect, thought, and embodiment, associated with psychopathology in various societies" (Good, 1992, p. 196 [emphasis in the original]). Clearly, if we are to learn about our multicultural clients' varying psychologies and grasp their subjective experiences of suffering, we must bring cultural inquiry into the clinic.

In my view, cultural anthropology's conceptions of selfhood, human development, cognition, emotion, language, and relationship as culturally shaped and as cross-culturally variable are essential to this project. Also essential to this project are anthropology's ethnographic methods. As described by the anthropologist Clifford Geertz (1973), ethnography involves modes of observation and inquiry that produce dense, multilayered, and complex accounts of cultures from the perspectives of those who inhabit them. Ethnographic investigations of indigenous worldviews, languages, and conceptual structures allow anthropologists "first to grasp and then to
render” alternative constructions of the world and of the self (Geertz, 1973, p. 6). Because it illuminates structures of meaning and systems of classification previously unfamiliar to Western anthropologists, and often at odds with their native points of view, ethnography is an invaluable tool of cultural discovery (Shweder, 1997).

When adapted for use in clinical settings, and especially for intercultural treatments, ethnography facilitates the discovery of clients’ culturally shaped psychological landscapes. Clinically adapted ethnographic inquiry provides psychotherapists with tools for exploring the indigenous categories and conceptions of mind, self, relationship, and disorder that structure their clients’ experiences. By doing so it offers clear alternatives not only to treatment approaches based on cultural knowledge, but also to the presumptive Western notions of disorder that are embedded in standard therapeutic procedures and diagnostic categories. Therapists who use ethnographic inquiry gain access to cultural dimensions of clients’ clinical material that might otherwise be obscured, either by conventional models of psychic functioning or by their own cultural worldviews. Included in these cultural dimensions are important insights into international and ethnic minority clients’ strengths, coping skills, and social supports, as well as their difficulties and resistances to therapy. Even in treatments abbreviated by the corporations of managed care or by the institutions in which they are set, an ethnographic approach to clinical practice can yield information that is of significant clinical value and that would be unavailable through conventional therapeutic assumptions and modes of inquiry.

Although ethnography is primarily associated with anthropology, ethnographic inquiry and clinical inquiry have much in common. Psychoanalysis has been characterized as “a certain kind of microethnography” (Herdt & Stoller, 1990), reflecting therapists’ efforts to render thick descriptions of particular clients’ psyches. Practitioners of ethnographic and clinical inquiry seek to grasp the language, rules, and contours of unknown terrains, whether they are anthropologists who study the cultural worlds of their informants or clinicians who explore the intrapsychic and interpersonal worlds of their clients (Chodorow, 1999). There are also similarities between ethnographic inquiry and narrative and social constructivist approaches to practice. All of these approaches generate richly textured and finely detailed understandings of clients’ psychological and social realities (Anderson & Goolishian, 1992; Laird, 1989; Saleebey, 1994). Moreover, the practitioners who use such approaches commonly seek to suspend received theoretical assumptions and lines of questioning to “grant primary importance to the client’s world views, meanings, and understandings” (Anderson & Goolishian, p. 30).

Yet, narrative and social constructivist approaches may not have the desired results in intercultural clinical encounters. Because narratives are culturally contingent, there is extensive cross-cultural variation in their forms, contents, aims, and sequencing (Gergen, 1994). More important, international clients and clients of color, like all individuals, can generate multiple narratives. Their narratives may be presented in different languages; they may contain strikingly variant cultural representations of self and other (Koven, 1998), and widely divergent cultural idioms of distress. In any situation, they must decide which narratives best meet the cultural and interpersonal demands at hand, for as Gergen noted, narrative “serves as vehicles for rendering ourselves intelligible” (p. 186).

In intercultural clinical encounters, many aspects of the therapeutic situation press international and ethnic minority clients to render themselves intelligible to their therapists by telling stories that conform to the cultural demands of the clinic. For example, if clinical intake forms privilege standard Western psychological concepts and diagnostic categories, they may induce culturally diverse clients to suppress indigenous conceptions of distress (Seeley, 2000). Similarly, if their therapist is monolingual, bilingual clients may find it difficult to retrieve early memories and indigenous cultural narratives that are more readily accessible in their native tongue (Amati-Mehler, Argentieri, & Canestri, 1993; Javier, 1995). International clients and clients of color who experience the clinical situation as part of a larger social world that routinely silences and devalues their indigenous narratives may conclude that such accounts are unwelcome. Alternatively, they may regard their therapists as representatives of the dominant society and choose to protect indigenous narratives from their scrutiny (Seeley, 2000).

Because so many dimensions of the clinical situation may discourage international and ethnic
minority clients from disclosing information about their indigenous cultural worlds, we need clinical modes of inquiry that explicitly and consistently ask them to do so. Ethnographic inquiry contributes to intercultural treatments by moving indigenous constructions of person, relationship, disorder, and experience into the clinical foreground and by promoting their systematic investigation. What distinguishes ethnographic inquiry from narrative and social constructivist approaches to treatment is its focused, deliberate exploration of clients’ indigenous cultural concepts and native language categories.

The ethnographic inquiry I recommend for intercultural psychotherapies is not ethnography in the strict sense of the term. I am not suggesting that psychotherapists be required to learn their clients’ native languages, participate in their cultural practices, or enter their social worlds, even though such activities might be therapeutically valuable. Instead, I propose a specialized mode of ethnographic inquiry that is adapted for use in clinical settings, that focuses on understanding the cultural dimensions of clients’ presenting concerns and systematically elicits indigenous accounts of lived experience. Just as anthropologists have deepened their cultural understandings by incorporating clinical perspectives and techniques into their research (Herdt & Stoller, 1990), psychotherapists may enrich their understandings of clients whose cultural and linguistic backgrounds differ from theirs by incorporating ethnographic inquiry into intercultural treatments.

I illustrate the uses of clinically adapted ethnographic inquiry by presenting three brief intercultural treatments drawn from my clinical practice. The work took place in a college mental health service that offers students a maximum of 10 psychotherapy sessions per academic year. The students come from countries all over the world, as well as from various ethnic minority communities; many are multicultural, multiracial, and multilingual. Most students who seek treatment schedule their first psychotherapy appointment by phoning the clinic receptionist, who assigns each student to a therapist on the basis of their mutual availability. Although students are required to complete standard intake forms, they usually do so immediately before their first session. As a result, therapists rarely know the cultural, racial, or ethnic identities of their clients until their first encounter. In the three cases discussed, identifying information has been modified to protect client confidentiality.

Case Number 1

Diane was a 21-year-old woman who was born on the island of Samoa and immigrated to the United States with her family when she was in her teens. Diane sought treatment when she began to feel emotionally destabilized by the psychological problems of an acquaintance. Diane worked off-campus as the assistant manager of a bookstore. One of her employees had developed a severe eating disorder, and Diane had become increasingly distressed as she witnessed her employee’s deterioration. In addition, Diane began to experience a loss of appetite and became convinced that she, too, was developing an eating disorder. In the intake interview, Diane did not present significant anorexic symptoms. At first glance, she seemed to need help differentiating herself from others.

Diane came to her next session feeling tremendously pressured and disturbed following a turn of events at the bookstore. Diane’s employee had informed her that she would be leaving her job immediately to be hospitalized for anorexia. In our meetings over the next few weeks, Diane’s despair intensified. She was preoccupied by feelings of guilt and remorse and was unable to concentrate on her work. It soon became apparent that Diane blamed herself for her employee’s condition. Aware of her employee’s eating disorder, she had repeatedly tried to persuade the employee to eat. Diane felt herself a terrible failure; in her view, she should have been able to lead her employee to recovery.

There seemed to be something excessive about Diane’s sense of responsibility for her employee; it also seemed that her feelings of failure in this regard were central to her collapse. But exploring Diane’s interpersonal expectations and patterns through conventional clinical questioning failed to help us understand her distress. With Diane’s Samoan heritage in mind, I systematically explored the indigenous cultural meanings of her predicament. First, using an ethnographic line of inquiry, I asked Diane to tell me about work relationships in Samoa. She described work relationships that were neither formal nor distant; they resembled family relationships, with supervisors assuming responsibility for the welfare of their employees. When I asked her how she might conceptualize her employee in Samoan cultural
terms, Diane said that she had thought of her employee as her daughter. According to Diane's indigenous cultural narrative, she had failed her employee as a mother fails a daughter, a failing that carried great shame.

Second, because it seemed that the nature of her employee's disorder had been unusually upsetting to Diane, I asked her to tell me stories concerning the practices of eating, and the meanings of food, in Samoa. Diane recounted several anecdotes illustrating the importance of friends and families eating together in her community. She said that in Samoa, to be a good host and to feed others was a primary social obligation. Those who neglected to perform this obligation risked becoming social outcasts.

Once we had elucidated Diane's cultural constructions of relationships and explored her indigenous conceptions of food and eating, we were in a better position to understand and address the ways in which she experienced and responded to her employee's decline. The treatment progressed, and by our final session, Diane's mood and functioning had begun to improve.

Case Number 2

Eighteen-year-old Erica, a first-year college student, had grown up in Korea. Although she was newly arrived in the United States, as the daughter of a North American father and a Korean mother, she considered herself bicultural. In our first meeting, through her Americanized dress and her unaccented, fluent English, Erica appeared perfectly adapted to life in the United States. It soon became apparent, however, that this was not the case.

Erica entered treatment voluntarily, seeking relief from the intensifying loneliness and anxiety that had troubled her since she had come to college. Yet, Erica seemed to feel ill at ease when I asked her to describe her family history and her current concerns. The first few sessions were characterized by Erica's reluctance to speak of personal and emotional matters with me.

It was clear that Erica was resistant to treatment, and given her international background, I suspected that some of her resistances were cultural. Her quietness in sessions suggested that she was not used to putting her worries and her feelings into words, and I wondered whether Korean norms surrounding emotional expression contributed to her silence. To better grasp the nature of Erica's cultural resistance to treatment, I began to explore the norms governing these aspects of language use in Korea. In the next session I told Erica that I had noticed that she felt uncomfortable talking about herself in treatment with me, and I asked her how she would describe her difficulties if she were in a Korean setting. Erica responded that in Korea, as a rule, people did not convey their problems to others directly; that to do so would be considered selfish and antisocial. Keeping in mind that Erica might feel this way about her own participation in treatment, I told her that there seemed to be different rules about disclosing personal issues in Korea and in New York. Erica agreed, and we spent the rest of the session, as well as the next, identifying these rules in general terms.

Following this ethnographic line of inquiry into Korean norms of discussing personal issues, Erica became interested in understanding how these norms applied to her. Although her family was bicultural, in Korea she had learned to talk about herself sparingly and modestly and to voice her opinions indirectly. When she behaved this way at college, her roommates found her passive and meek. They urged her to be more assertive and vocal, but Erica felt uncomfortable speaking in ways that would have marked her as brash, egocentric, and aggressive in Korea. In addition, in Korea Erica had learned that it was unacceptable to express emotions such as sadness and anger openly. In Korea she had received emotional nourishment from others who were attuned to her needs and who responded to them without her having to verbalize them. Failing the responsiveness of others, Erica had learned that these emotions were to be silently endured.

As a consequence of our discussions, Erica began to understand that these Korean norms of emotional expression were at odds with those of other students on campus, who freely complained of their moods and their problems. Erica realized that she could not expect other students to be attuned to her sentiments and needs and that unless she learned to communicate her emotions to them, her isolation would grow. Erica used our final sessions to practice verbalizing her emotional states, and together we addressed the feelings of selfishness and aggression this evoked in her. By the end of the treatment, Erica had become more aware of the conflicting cultural norms surrounding emotional expression and had
become more adept at expressing her feelings to others.

**Case Number 3**

Fatima came to treatment in her third year of college, in the wake of a deepening sense of despair. In her initial session, Fatima told me that her family had come to the United States to escape the war in Afghanistan. Having lived in Afghanistan all of her life, at the time of her family’s migration Fatima had been completely identified with her native language and culture. After being abruptly taken away from her home and from all she had ever known, Fatima had been moved to a U.S. city thousands of miles away.

Fatima was not only traumatized by the war and by her separation from close relatives who had remained in Afghanistan, but her sudden immersion in an unfamiliar world had fragmented her identity. Fatima felt that she had developed two distinct selves in her two different languages. Her first self, which was formed in her native language, was vulnerable to overwhelming emotions, especially to emotions evoked by the memories of events she had witnessed during the war as a child. Fatima’s mastery of English and her academic success represented her second self. This self, which developed after her arrival in the United States, showed a firm emotional grip and a singular focus on personal accomplishment. Because she revealed different selves to her family and to her friends, no one knew her completely. This thrilled and disturbed Fatima. She clearly derived feelings of pleasure and power from keeping parts of herself hidden from others, but at the same time she yearned to be more fully understood.

Unlike time-limited treatments in which a brief course of therapy appears to be adequate for addressing the patient’s concerns, in Fatima’s case it was clear from the outset that the severity of her trauma and fragmentation made short-term treatment inadvisable. Not only would unearthing and working through the many issues she presented require a considerable number of sessions, but also the work involved promised to be too emotionally disturbing to be contained within an abbreviated frame. Given Fatima’s presenting complaints and history, it seemed imperative to place her in an open-ended treatment.

My intentions in this regard were complicated by the fact that at the start of the second session, Fatima expressed her discomfort at being in therapy and her wish to discontinue it. When she characterized psychotherapy as “taboo,” I wondered how mental illness was conceptualized in Afghanistan. I asked Fatima to tell me about the notions of mental illness and the methods for its treatment in her native community. Fatima told me that psychotherapeutic treatment was unknown in her Afghani village. Moreover, mental health was conceptualized as falling into two discrete categories, rather than being seen as a continuum. In her community, Fatima explained, you were either sane or insane. To seek expert intervention was to admit to insanity.

Fatima’s cultural resistances to treatment were clarified by the ethnographic investigation of her indigenous constructions of mental illness. According to such constructions, the emotional difficulties she was experiencing, and her subsequent appeal for psychological help, classified her as “crazy.” Working through these cultural resistances to treatment helped Fatima realize that continuing in therapy could be beneficial to her. When our sessions came to a close, Fatima accepted a referral to an outside practitioner and began long-term psychotherapy.

**Discussion**

The three cases illustrate how ethnographically adapted clinical inquiry can enhance short-term intercultural treatments. In the first case, an ethnographic line of inquiry was used to elicit the client’s indigenous cultural narratives of selfhood, relationship, and specific social activities—all of which are highly variant across cultures. The Samoan beliefs and expectations regarding individual behavior, interpersonal obligation, and the everyday practice of eating that were discovered in the course of this inquiry were found to have significantly shaped the client’s interpretations of her situation, and her emotional responses to it. Only by recontextualizing the client’s distress—by considering it within the stories and norms of her native culture—could it be understood, normalized, and relieved.

In the second case, the client’s bilingualism and biculturalism were ethnographically explored. Although, as a general rule, being bilingual and bicultural requires the translation of emotional worlds, senses of self, and relational patterns across cultural boundaries, the particular difficulties involved in this translation vary from case to case. For this client, the ethnographic analysis of

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the conflicting patterns of emotional expression and self-disclosure in her two languages and cultures was essential in clarifying the shifts in self-presentation and linguistic expression required of her as she moved from one cultural setting to another. This analysis proved beneficial to the treatment in other ways as well, as it made the client more willing to explore the discomfort she experienced in making these shifts. With a surer grasp of the different kinds of communication and relationship that were called for in each cultural setting she inhabited, the client’s treatment became a place in which she felt safe to experiment with new varieties of emotional and verbal expression.

The cases also illustrate the utility of ethnographic inquiry in illuminating key aspects of clients’ indigenous metapsychologies. International clients and clients of color may conceive of the causes and manifestations of mental illness, and of the methods for its cure, in ways that diverge from those embedded in standard clinical theories and nosologies. As this case suggests, such clients may enter conventional clinical treatment even as they conceptualize their difficulties in alternative cultural terms. Their fears of being seriously ill or in some way aberrant may be heightened rather than soothed by their decision to seek psychological help. Using ethnographic inquiry to assist these clients in elaborating their indigenous accounts and constructions of psychopathology can be helpful in such cases as long as such accounts and constructions are not summarily dismissed in favor of standard Western notions of psychological disorder and treatment.

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Finally, although issues of the therapist’s positionality in intercultural treatments cannot be discussed fully here, I briefly consider them in relation to ethnographic inquiry. As the white, middle-class, North American therapist in the cases mentioned earlier, I differed from my clients in culture, nationality, and race, and my personal history and professional formation sharply contrasted with theirs. Yet, by implementing ethnographic lines of inquiry, I indicated my willingness to accept these clients’ accounts and constructions of psychopathology and to engage in dialogues with them about their experiences and interpretations of their lives.
to suspend, to the extent possible, my usual assumptions and values, and to enter my clients’ cultural worlds. When therapists consistently ask their clients to elaborate indigenous notions of personhood, emotional expression, interpersonal relationship, and distress, they legitimate cultural conceptions that are commonly invalidated and silenced; at the same time, therapists implicitly challenge conventional therapeutic narratives and their own cultural authority. Thus, although ethnographic inquiry cannot undo therapists’ positions of power and privilege, it may serve to reposition them in the therapeutic dyad. In all intercultural treatments, issues of positionality merit extensive mutual exploration.

Conclusion

New therapeutic approaches are necessary to improve the delivery of short-term intercultural mental health treatments, which are more and more frequently provided in our current clinical environment. Recently developed approaches that advocate cultural competence and require therapists to possess preconceived knowledge pertaining to their clients’ cultural, ethnic, and racial worlds may not be adequate or practicable in many intercultural clinical situations. Instead, there is a need for therapeutic approaches that incorporate clinically adapted ethnographic inquiry, and that allow the cultural patterns and meanings that are particular to each client, and that inform clients’ specific perceptions of their psychic and social difficulties, to be discovered anew in each case.

The cases presented in this article demonstrate the uses of clinically adapted ethnographic inquiry in uncovering and understanding international and ethnic minority clients’ cultural subjectivities and worlds. Implementing such lines of inquiry in short-term intercultural treatments can quickly illuminate clients’ indigenous conceptions of self, relationships, and emotions, as well as their metapsychologies, ways of speaking, and everyday social practices. These cases indicate that ethnographic inquiry may be especially useful in exploring the plural and sometimes fragmented senses of self that are common among clients who are multicultural, multiracial, or multilingual. Because of the effectiveness of ethnographic inquiry in short-term intercultural treatments, this approach deserves a central role in clinical training programs. In addition, because the benefits of ethnographic inquiry may be maximized when used in conjunction with clinical forms and intake procedures that ask clients to express their presenting problems, strengths, and support systems in indigenous cultural terms, these forms and procedures should be revised to incorporate such information.

The need for ethnographic inquiry may be most apparent in clinical work with clients who do not speak English fluently and are new to mainstream U.S. society. It may also be clearly indicated in intercultural treatments when conventional lines of clinical inquiry prove fruitless, and when clients’ narratives, communicative styles, and emotional responses jar therapists’ own cultural assumptions and worldviews that they begin to feel “at sea” (personal communication with A. Roland, psychoanalyst, November 21, 1999). But ethnographic inquiry is called for in every intercultural treatment, including treatments in which clients present themselves as well adapted to mainstream North American life. In all such clinical encounters, therapists cannot assume that they share conceptions of reality, of selfhood, of relationship, of emotion, or of mental disorder with their clients. Nor can therapists assume that their clients will spontaneously produce indigenous cultural renderings of their material; on the contrary, clients may fail to describe their predicament in indigenous cultural renderings unless their therapists explicitly and repeatedly invite them to do so. Enhancing short-term intercultural treatments requires not only that therapists use the tools provided by clinically adapted ethnography, but also that they cultivate an openness to discovering the precise features of their clients’ indigenous cultural worlds.

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