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CROSS-CULTURAL EMPATHY AND TRAINING THE CONTEMPORARY PSYCHOTHERAPIST

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ABSTRACT: The diversity of today's client population has required that psychotherapy training confront the importance of cultural competence in graduates. Approaches in this area of education create dynamic tensions between stressing therapist openness to diversity and therapist knowledge of clients' cultures. This paper proposes that this attitude-knowledge dilemma in psychotherapy education can be reconciled by helping trainees develop an empathic response capable of transcending cultural differences. Cross-cultural empathy helps provide the therapist with a coherent and familiar means of maintaining affective receptivity in the therapeutic encounter with clients while making use of a repository of information about clients' cultures. Such empathy can also be a base for building the skills needed to develop collaborative relationships with clients who are often disempowered and distrustful. The paper examines approaches and resources for training psychotherapists in cross-cultural empathy.

KEY WORDS: cross-cultural empathy; therapy training; urban practice.

Attention to the area of cultural competence has become an essential aspect in training psychotherapists to work with the diverse populations found throughout this country. Yet, the components of this competency involve attitudes, knowledge, and skills that can be difficult to integrate (Falicov, 1995; Sue & Zane, 1987). As educators, we seek to prepare clinicians who are knowledgeable about the specifics of particular cultures but who are able to suspend this knowledge when with a client in order to listen openly and without assumptions. We want to see clinicians who

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think critically but who do not lose their sense of wonder and curiosity about the great variability in human lifeways.

The difficulty of integrating knowledge about specific cultures, therapeutic techniques, and therapists' stance with clients often propels training programs into divergent directions. Programs which are organized around psychodynamic models tend to emphasize general impediments to therapist receptivity such as countertransference (Zaphiropoulos, 1982), while family system's training literature has focused on knowledge of specific cultures (McGoldrick et al., 1996). This paper proposes that using cross-cultural empathy as an overarching concept can bring coherence to the task of teaching cultural sensitivity. We contend that when therapists develop this capacity, they are well-prepared to practice psychotherapy with a diverse clientele. With cultural empathy as a goal of training in this field, educational objectives can be clarified, curricula developed, and appropriate skills taught. We approach the discussion of cultural empathy by focusing on therapist *receptivity* (affective component), *knowledge* (cognitive component), and *collaborative* skills (clinical-political components). These three important components give cultural empathy its shape and can be used to inform curricula on cross-cultural therapy.

CONCEIVING CROSS-CULTURAL EMPATHY

Cultural empathy is a concept evolved by several of the psychotherapy disciplines in a search to address the complexities of cross-cultural work. Cultural empathy has been defined as a general skill or attitude that bridges the cultural gap between therapist and client, one that seeks to help therapists integrate an attitude of openness with the necessary knowledge and skill to work successfully across cultures. It involves a deepening of the human empathic response to permit a sense of mutuality and understanding across the great differences in value and expectation that cross-cultural interchange often involves (Ridley & Lingle, 1996). Cultural empathy allows psychotherapists to employ their skills in situations where the usual clues that they rely on for understanding and communication are absent.

Understanding cultural empathy requires clarity about the concept of empathy as it occurs in life and in psychotherapy. Empathy is an integrated expression of our intellectual and emotional selves in our relations with others. It involves an emotional resonance with another, but is different from other relationship orientations such as sympathy or enmeshment. It is distinguished from these by the presence of cognitive activity; in empathy the intellect reaches for an understanding of the others feeling while maintaining a clear perception of the boundary between self and other, thus allowing a full and balanced engagement of both

affect and cognition. The empathic response permits one to experience the contagion of another's affect while maintaining a effort to grasp the meaning of that person's experience.

Empathy has particular significance in psychotherapy. It is accepted as curative or, at least, facilitative by practitioners of wide-ranging perspectives and is empirically associated with positive treatment outcome (Wachtel, 1993). Empathy is essential as both a diagnostic tool and a route to client trust. It is arguably the therapist's greatest recompense since it can reward a potentially tedious activity with sudden, electric moments of shared human experience and reassurance that unity does underlie the human condition.

This concept, sometimes referred to as "cross-cultural empathy," or "transcultural empathy" has been discussed in the literature. While most agree that cultural knowledge about a client's culture is a necessary element in cross-cultural therapy, many point out that cultural knowledge alone is not sufficient for successful engagement and therapeutic work (Draguns, 1995; Dyche & Zayas, 1995; Parson, 1993; Ridley & Lingle, 1996). Besides the potential for leading the therapist to inaccurate conclusions about a client, cultural knowledge skirts the realm of affective connection and interpersonal relatedness. It does not help the therapist examine the socioemotional world of the client nor elicit the individuality that distinguishes this particular client from other in his or her ethnocultural group.

Parson (1993) refers to "ethnotherapeutic empathy" as the cross-cultural therapist's capacity for introspection and willingness to disclose information, when helpful, about themselves. Empathy and empathic qualities are manifested differently in different cultures and what may be empathic in one culture may not be so in another (Parson, 1993). This form of empathy requires therapists to relinquish the traditional psychotherapeutic stance of asking complete openness of the client while maintaining the privilege of self concealment. Parson (1993) holds that judicious self-disclosure can be an interpersonal glue that bonds therapist and client in a working alliance. However, Parson's conceptualization relies heavily on cognitive processes and under-emphasizes the affective elements of the client's experience, such as those found in memory traces and familiar words.

At the affective level, empathy in cross-cultural therapy requires an effort to see the world through another's eyes, hearing as they might hear and experiencing their internal world (Ivey, Ivey, & Simek-Morgan, 1993). In their work on cultural empathy, Ridley and Lingle (1996) emphasize the importance of therapists' commitment to integrating cultural factors into all phases of their clinical work. Ivey et al. (1993) describes the basic steps toward cultural empathy in the psychotherapy process as listening to and observing client responses, deriving the client's message, building

a response from the client's main words and constructs, and asking the client to confirm or disconfirm the impression.

Normative information about cultural groups can only be useful to a therapist if it leads to a personal construction of a particular client. The therapist must seek to discover the ways in which a client experiences her or his culture that deviate from the universal model of culture (Ridley & Lingle, 1996). Dyche and Zayas (1995) have proposed a therapist stance of "cultural naivete" as a means to elicit this. Klein (1995) speaks of "empathic imagination," in which therapists abandon the search for certainty, accept ambiguity, and suspend attention to themselves and the natural inclination to pursue safety. Empathic imagination invites therapist to look into the lives of clients who are culturally different from them, to accurately imagine their world, and to allow themselves to be touched by clients' experiences.

The following excerpt from a therapy session between two persons of different genders and cultures illustrates the essential aspects of receptivity, understanding, and collaboration that underpin the concept of cross-cultural empathy.

A white male therapist in his late twenties is beginning therapy with a recently immigrated, 39-year-old West Indian woman. The client is concerned about her adolescent daughter who has been behaving in an angry, hostile way toward her mother's fiancee. The woman is well dressed and is somewhat abrupt, seeming to be impatient with the therapist. Though not a parent himself, the therapist recognizes the distress behind his client's sternness, and thinking of the struggles he had with his own father, responds to the woman's obvious discomfort with "I imagine that must hurt you." This intuitive response from the therapist reduces the woman's embarrassment, and she pauses from the angry story of her daughter's ungratefulness to wipe a tear.

The therapist is able to find an emotional resonance with the woman despite their differences, helping the client feel safe enough to share feelings and permitting the endeavor of therapy to begin.

Empathy, however, is a function of intellect as well as emotion, and therapy relies on therapist sensitivity that is disciplined by awareness and reflection. In this case, the therapist feels a sense of compassion and identification with his client but recognizes that his role as her therapist may be other than to give consolation. He also knows that vast differences stand between them and their ability to develop a shared vocabulary. The history, culture, and diaspora of West Indian peoples was part of the therapist's studies, and this leads him to frame questions perceptively and sensitively.

Exploring a hypothesis that the conflict is related to the daughter's feelings about her mother's immigrating to the U.S. before her, he inquires about the period of time after the daughter's arrival. The mother confirms that this was a turbulent time, and emotionally recalls having to leave her daughter behind in St. Thomas.

Without the tools of cultural knowledge, the therapist's helpfulness could have been limited to sympathy. Although an emotional link has begun and the process of understanding is underway, an empathy that is equal to the therapeutic task may not yet be fashioned. The therapist who has worked with clients from backgrounds of oppression and marginalization has learned that trust is often elusive, that many clients will censor their experiences, and that discrepancies of power and status exert a quiet but substantial hold on the growth potential of therapy. This therapist recognized that if he wanted his client to feel safe enough to be candid with him, she must feel a sense of control of the process. He begins negotiating a collaborative contract.

He apologizes for his relative lack of experience with West Indian culture and asks his client to help him with areas he might not understand adequately. He indicates that he thought it might be useful to include the daughter in an upcoming session but wants the mother's opinion. When she seems chagrined by his apparent uncertainty, he simply assures her that together they will work this out. The woman confesses to apprehension about facing the daughter's anger in front of him, and they agree to postpone this for another meeting.

CROSS-CULTURAL RECEPTIVITY

The most fundamental capability of the psychotherapist is that of listening, of being receptive to another. We feel that well-developed receptivity is made up of a genuine, respectful curiosity, and of the capacity to tolerate uncertainty or ambiguity (Dyche & Zayas, 1995). Receptive listeners prefer to experience and describe another's world rather than to define or assess it. They look for narrative coherence instead of truth.

Educators frequently use group approaches to help student clinicians build receptivity to cultural diversity. Diversity training groups are small and heterogeneous in composition and they are professionally facilitated to create an environment where personal differences can be safely shared. The model pioneered by Pinderhughes (1989) emphasizes the sharing of participant's family histories and cultural biases. These groups were initially developed in a context of professional training, but they have proved so effective that the approach is now used by corporations as a means to enhance employee relationships. Affinity groups are sometimes used adjunctively with diversity training groups. Since receptivity to diversity requires a secure sense of self, affinity groups, which are homogeneous in composition can help build awareness of the barriers to cross-cultural dialogue and help build a readiness for such a conversation.

Narrative therapy is an approach well suited to working across cultures, especially with clients who have recently undergone immigration and are grappling with an unfamiliar culture (Reichelt & Sveass, 1994; Sluzki, 1992). Culture itself can be seen as a narrative epic, with innumer-

able scripts, that exists to preserve continuity in a social order. It is written not by us but for us, so that the act of altering it through the adoption of another culture tests our deepest loyalties. Employing a narrative approach with a client who is experiencing acculturation stress can facilitate a therapeutic conversation that allows the voices of the old world to be heard. The therapist, unfamiliar with these voices but curious about them, inquires respectfully from the point of view of the new world, providing a process that can honor the past while remaining pragmatic about the present.

Empathy requires a certain surrender of self, of one's own self involvement, and one's own preferences. It is the act of listening with openness, not entirely unlike the stance that can lead to aesthetic appreciation of a work of art. There is a substantial body of cross-cultural narratives in the popular literature, both fiction and memoirs, which can be fruitfully employed in psychotherapy training. These are not only informative in themselves, but by seeking to portray the universally human element in an unfamiliar culture they can help expand receptivity through the aesthetic experience.

Educators should note that the heightened receptivity needed in cross-cultural psychotherapy is parallel to the process of psychoanalytic listening—a listening that, when done effectively, embraces ambiguity and gives up certainty, memory, desire and understanding. Yet, though listening is a cornerstone of psychoanalytic technique, its explication and implications for analytic training receive limited attention in the literature, perhaps due to the fact that this fundamental human activity is elusive in nature. In the literature of psychoanalysis and religion, several authors have examined the similarity between psychoanalytic listening and the meditative practices of Buddhism (Epstein, 1986). In both, the practitioners are attempting to remain one step removed from their own cognitive activity while identifying the distortions introduced by the mind. The Buddhist concern with attachment and the analyst's with countertransference are both attention to aspects of culture's effect on perception and receptivity. Most approaches to helping people develop cross-cultural receptivity involve some type of desensitization to the anxiety about differences that is native to the human condition. They allow the trainee exposure to cultural dissonance in a context of safety and support.

CROSS-CULTURAL UNDERSTANDING

Empathy leads us not only to experience the feelings of another but also to reflect on these feelings and compare them to our own. Whether we discover similarity or difference, empathy leads us to recognize that we are all separate individuals sharing a common humanity. Empathy

is a uniquely human capacity because it involves the intellectual and linguistic as well as the affective. Sometimes it is our intellectual understanding of another that precedes the development of affective empathy. The successful therapeutic engagement of an angry adolescent would be all but impossible were the clinician not emotionally sustained by an understanding that rejecting behavior often covers fear, an easier emotion to embrace.

The "accuracy" of empathic understanding is considered to be essential to positive therapeutic outcome. But such accuracy is not always immediate, particularly as in cross-cultural work, when life experiences and values diverge. Such accuracy necessitates a process in which impressions are reflected back to the client for confirmation, as process similar in form to the client-centered approach of Carl Rogers (1951).

For several decades the primary vehicle for helping clinicians develop cross-cultural understanding has been that of cultural knowledge, the presentation of historical and anthropological information pertaining to a particular ethnic group and of recommendations regarding treatment approaches from clinicians from these same backgrounds. This approach has effectively served the dual agendas of promoting attention to client diversity in psychotherapy education as well as teaching students about cultures.

There has recently been a sounding of caveats regarding the cultural knowledge approach (Dyche & Zayas, 1995; Falicov, 1995; Sue & Zane, 1987), particularly regarding the potential of the concept of culture, an abstract notion, to be inadvertently taken by psychotherapists to be a description of specific client traits, ostensibly creating a stereotype in the very effort to avoid it. The implication is that cultural knowledge should be taught only along with careful direction as to its use, that it is a source of hypotheses for thoughtful exploration with the individual client.

Anthropology has much to offer the cross-cultural psychotherapist, though it has yet to find a recognized place in the training of contemporary clinicians. Ethnography and other qualitative methods provide tools for acquiring and interpreting information across a cultural divide. The ethnographic approach also avoids the problems of using the abstract construct "culture" to predict particular individual behavior and in so doing miss the variability and the evolutionary nature of a culture. Ethnography seeks instead to derive cultural understanding inductively beginning with observed patterns of individual behavior. These data allow the formation of conclusions that apply primarily to individuals and their families, secondarily to their immediate social and community context, and only tentatively and indefinitely to the larger cultural grouping.

Kleinman and Eisenberg (1978) provide physicians who work cross-culturally with an approach to eliciting the culturally based health beliefs of their patients. Kleinman and Eisenberg have developed a set of ques-

tions to help ascertain the meaning that patients give to their illness and to understand the expectations they have of the doctor. Falicov (1995) sends her students to interview healthy families. The authors of the present paper have experimented with having psychology graduate students interview experienced cross-cultural practitioners, and having primary care physicians in training make home and neighborhood visits to better understand their patients. Each of these approaches is an adaptation of anthropological fieldwork.

Our teaching has also been informed by qualitative methodologies such as those employed by the Carol Gilligan group in their studies of adolescent girls (Brown & Gilligan, 1992; Dyche & Zayas, 1995). Ethnocentrism in the parlance of research is a type of interviewer bias, and the Gilligan group's process of rigorous daily self scrutiny helped them uncover hidden bias in their own approach that was inadvertently silencing their interviewees. This recognition helped them make changes that added depth and richness to their findings. Communication failures in a cross-cultural dialogue easily go unnoticed, and consistent success requires the development of routines and structures to support vigilance.

The cross-cultural therapist needs to acquire a knowledge base relevant to the population served, but accurate empathic understanding also involves the ability to recognize that which one does not know and an awareness of how to obtain relevant information. The quest for cultural understanding will take the student to both the library and the field.

CROSS-CULTURAL COLLABORATION

The empathic therapist is inclined to build collaborative relationships in treatment, as shown in the vignette. The sharing of power is both a facilitator and a consequence of empathy. An egalitarian stance is sensitive to a client's vulnerability, and it encourages the sharing and self disclosure necessary for developing empathy. Likewise, felt empathy inhibits dominating behaviors by sensitizing the therapist to a client's experience of helplessness.

However, therapists' resistance to developing collaborative psychotherapeutic relationships involves more than simply the universal reluctance to yield power. Psychotherapy privileges the practitioner and, in cross-cultural treatment, the therapist is commonly of the dominant culture. The structuring of egalitarian roles and leveling of the playing field in treatment presses against the grain of medical tradition, client assumptions and social reality; to succeed the entire therapeutic system must swim upstream like the salmon. Collaboration demands skill as well as intention.

Scientific literature regarding the issue of power in psychotherapy

should be essential reading for students of cross-cultural work. Franz Fanon (1963) and Thomas Szasz (1964) saw psychotherapy inherently bound in the politics of colonial oppression and social control. Their solutions called for a revision in the existing social order, a challenge seeming at odds with the daily work of the psychotherapist. Yet the work of Freire (1982) on language and of Alinsky (1971) on community participation press forth the notion that radical intention can often be expressed in the subtleties of a therapist's daily activity.

Mutual goals can be the basis for sharing power in a collaborative psychotherapy relationship. In work with people who have suffered oppression, the distribution of power assumes a particular significance and complexity; the therapist who retains too much therapeutic control replicates oppression, but the one who relinquishes too much abdicates therapeutic responsibility. Pinderhughes (1989) emphasizes the importance of therapist self-awareness in work with descendants of slavery. Therapists, particularly those with no experience with oppression, must learn to recognize their own privilege and at the same time manage the accompanying feeling of guilt or shame. These can distort therapist perceptions, skew judgement, and promote the unconscious acting out of anxiety. A key tool in Pinderhughes' approach involves the use of sensitivity training groups geared specifically to addressing this issue.

Access to knowledge and information is a primary source of power. Psychotherapy, with its roots in the medical model, has a long history of sequestering information from clients. Despite laws to the contrary, diagnoses, working theories, and professional communications continue to be withheld from the consumers of mental health services, disguising hegemony beneath seeming benevolent intent. A series of innovative practitioners within the field of family therapy have revised their approach to the management of information and its accruent power. Anderson and her colleagues (1980) turned the disclosure of diagnosis and treatment information into an effective joining intervention with the families of the mentally ill. Andersen (1987) used the one way mirror to new therapeutic advantage by reversing it in order to bring the consulting activities of therapist and colleagues into the view of families. In cross-cultural therapy, the power differential tends to be so substantial and significant that the effective therapist needs to develop skill in working in an untraditionally open style.

Some recent efforts to manage the deleterious impact of therapist privilege on cross-cultural treatments has been spurred by the work of White (1995) on accountability. White advocates that therapists learn to position their work so that their therapeutic prerogatives can be illuminated by feedback from sources not aligned with the therapist. He will seek consultation with former clients regarding work with a client with similar problems, or he will invite an adolescent to bring a peer to the

session. The mental health agency that involves community representatives in setting agency policy is employing a similar approach.

The field of education contains a literature referred to as radical pedagogy that can be valuable reading for the teacher as well as the student of cross-cultural therapy. Friere (1982), Hooks (1994), and Korin (1994) demonstrate that education can be repressive or liberating activity, and much hinges on the stance assumed by the instructor. Hooks in particular considers the classroom dynamics with students who have experienced marginalization, and the specific tasks involved in bringing their voices into the mainstream dialogue.

A collaborative approach in psychotherapy requires combinations of conviction, self awareness, and skill. It is divergent enough from mainstream approaches that it needs to be taught through role modeling as well as instruction, and effective student-teacher collaboration is a critical feature of this learning process.

TRAINING FOR CROSS-CULTURAL THERAPY

In addition to curriculum, there are a number of structural features of a psychotherapy training program that influence its potential for helping trainees develop cultural empathy. Racial, cultural, and disciplinary diversity are all friends to cross-cultural empathy. When programs provide a diverse interpersonal environment among students, faculty, and support staff, the opportunities for cross-cultural learning experiences are greatly expanded.

Program location also has a strong influence on the ability of a training program to impart cross-cultural empathy. Location not only affects a program's accessibility to consumers, but also makes clients' homes, neighborhoods, and communities more immediate and available to trainees. When programs maintain a community base and permeable boundaries, they promote an exchange that can allow community members to serve in instructional roles and program members to provide community service.

The organization and exercise of power in a psychotherapy training institution will have significance for the trainee's development of cultural empathy. Decision making that maintains openness and gives students and community members appropriate levels of participation will model the process of collaboration. The fact that many training programs carry the responsibility of sanctioning psychotherapists for practice means that ways must be found to carry out this authority without disempowering the trainees.

VIGNETTE

Justin, a 24-year-old psychology intern in his second year of study, was assigned to the first author for supervision. One client Justin was treating proved to be a particular challenge: Ms. C, a 44-year-old woman from Cambodia being seen in our medical clinic for recurrent headaches. Ms. C had admitted to her doctor that she was episodically abused by her husband. Ms. C lived with a large family that had immigrated in the early 90's; she and her three teenagers were supported by the husband's supplemental security income check. She was dutiful in following her doctor's recommendations, but was unclear about the purpose of the referral to a psychological services provider or even of its value.

Justin was a bright, single man of Italian background who entered graduate school directly after completing his undergraduate studies at a prestigious Ivy League university. In supervision, a quick rapport was established. The supervisor admired Justin's quick mind and insightfulness, and Justin seemed to appreciate the breadth of his supervisor's experience. Justin was excited to have a client of such a "different" background from his own. However, needing a case to present in class, he was becoming frustrated with Ms.C's reticence in sessions, making it exceedingly difficult for him to present a compelling case with clear psychodynamic and family systems features, or with pithy quotes, dreams, or comments provided by the client. She met most of his questions with a downward glance or one word answers, and Justin was finding himself slipping into an interrogative mode, eliciting basically "yes" or "no" replies from Ms. C.

The supervisor sensed that Ms. C's formality and deference to Justin felt very dissonant to the assertive interpersonal style he had learned from his own family. Rather than offer a lecture, the supervisor supported Justin's discomfort, "that really can make a therapist feel unhelpful." The supervisor encouraged Justin to seek out a Cambodian community worker, Suni, who acted as an interpreter for the clinic to see if she had any suggestions. This helped put the cultural behavior in a healthy frame, and it encouraged Justin to do some "field work." Moreover, it reduced the hierarchical frame of professional expert and lay paraprofessional, offering Justin the opportunity to appreciate that learning and therapeutic abilities do not come only with university degrees.

This suggestion proved even more fruitful than the supervisor had hoped. Suni's low key but competent style made the Cambodian manner more easily understandable for Justin and, in addition, she told Justin about some of Cambodia's's history of political violence of which he was only partially aware. She suggested that he rent a copy of the movie, "The Killing Fields" and read the book *To Destroy You is No Loss* (Criddle & Mam, 1987).

Justin found the discussion with Suni exciting. He watched the movie and read the book. He was quite taken with both, now understanding that the person he knew, Ms. C, had lived through such extraordinary events. The empathy for Ms. C that grew in Justin was remarkable, allowing him to set aside the worries of presenting a case in class full of psychotherapeutic insights.

When he saw Ms. C next, he felt more relaxed and perhaps because of this she shared some of her own experiences about living in refugee camps in Cambodia and about leaving her family behind when she came to the U.S. But she remained unwilling to discuss her marriage, indicating that the doctor must have misunderstood her. Her one concern besides her headaches was her 14-year-old son who had been skipping school.

Justin was flustered by his inability to get to the domestic violence issue.

The supervisor encouraged him to stick with his client's agenda and to try to make her an expert for him, perhaps regarding how to help an immigrant teenager connect with both worlds of family and of peers. Maybe in the effort to help her son, Justin might convey to Ms. C his alliance with her and the recognition that, though different in culture and gender, they could work together to make some improvements in her life.

In the following supervision session, Justin described experiencing an insight regarding his client's feelings about her husband's abuse. In learning how Ms. C had lost so many relatives in her life, he imagined that physical abuse might be a preferable alternative to the possibility of losing another. In some way, she was tentative with her son as well: if she pushed him to go to school or punished him for not attending, he might run away. The thought of any further family abandonment or fracture was intolerable to Ms. C.

Justin seemed to have found a connection with his client, they had been discussing her dilemma with her son, but he was feeling stymied by her passivity and habit of waiting for him to initiate suggestions. The supervisor sensed that he had yet to validate her power and initiative in their relationship. He suggested that Justin invite her to bring in someone from her family as a way to provide her with an ally. Justin learned that Ms. C's older sister was the family matriarch but she had been too ill to travel. She told Ms. C that she would speak with her doctor if he could come to the home.

Though the home visit raised Justin's apprehension, he found it quite productive. In the familiar confines of her home, Ms. C became a much more active, assertive person—making Justin feel comfortable, offering beverage, managing her children. She displayed a competency and self-confidence Justin has not seen in the sterile environment of a hospital clinic. Ms. C.'s sister emphasized that her nephew was a good boy but needed stronger limits. But the most valuable development was meeting the husband, who proved friendly and concerned about his son. The husband agreed to come to the next clinic session.

Justin's work in this case continued, although not without challenges: Ms. C's son was struggling with acculturative pressures brought from family and peers, and challenged by academic pressures to perform in English which he was acquiring rapidly in conversation but to a lesser extent in reading. Ms. C's medical presentation improved. In sessions with Justin, she remained essentially reticent but more accessible than before. Justin's empathy for her situation was extended, and he felt less pressured to secure the psychological insights expected by his teachers. The comfort of the sessions was helped by Justin's conscious awareness of the extreme conditions Ms. C had faced in her life.

CONCLUSION

This paper has proposed the concept of cultural empathy as a bridge for integrating the disparate and sometimes contradictory elements of a cultural competency curriculum for training psychotherapists for practice with ethnic populations. Using the model of the human empathic response as applied to persons of widely divergent backgrounds and beliefs, can

provide the psychotherapy practitioner a familiar paradigm for integrating the requisite knowledge and skills with the essential attitude of oneness for practice with a client population that is exploding in its diversity.

Cross-cultural psychotherapy places the clinician at the center of a dilemma central to all psychotherapy practice: that of knowing how to know without knowing or of listening without the need to understand. If all psychotherapy encounters can be seen to have elements of the cross-cultural, given the diversity inherent in the human experience, it is the ultimate challenge of an effective therapist to be able to balance competency of craft with openness and receptivity to the client's point of view. Empathy may in fact be the trait most essential to the human situation, at least in our global community. The capacity to face others with openness to their reality while simultaneously maintaining coherence in our own beliefs and sense of self is the dialectic process behind human attachment and social contract.

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