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A Person-Centered Approach to Multicultural Counseling Competence

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Abstract

This article examines current and historical trends in psychotherapy research and practice with racial/ethnic minority populations. Initially, research on Derald Sue's multicultural counseling competencies is provided as a foundation to further examine the evidence regarding effective cultural adaptations to mainstream treatment approaches, such as cognitive-behavior therapy and interpersonal psychotherapy. Next, a brief outline of Carl Rogers's psychotherapy research tradition is presented, with a focus on both past and present evidence suggesting that person-centered therapy may be effective across diagnoses, as well as cultures. Using psychotherapy evidence from both the latter half of the 20th century and the initial decades of the 21st century, cultural adaptations to previously hypothesized person-centered therapy mechanisms of change are proposed. In particular, this culturally adapted person-centered approach is suggested to provide a competent and effective treatment system for racial/ethnic minority clients and families.

Keywords

person-centered, client-centered, Carl Rogers, multicultural counseling competence, Derald Sue, cultural competencies, mechanisms of change, racial/ethnic clients, families, facilitative conditions

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During the final decades of the 20th century, the multicultural (MC) counseling competence movement emerged as a primary topic of concern in the helping professions, acquiring the status of a "fourth force" in counseling and psychology (P. B. Pedersen, 1991). In particular, Derald Sue and colleagues' work (e.g., D. W. Sue, Arredondo, & McDavis, 1992; D. W. Sue et al., 1982; S. Sue, 1977; S. Sue & Zane, 1987) toward developing a cross-cultural counseling competencies framework had a substantial impact on theory, research, and policy at the turn of the century. As a result, a wealth of contributions toward the training and practice of the culturally competent counselor have proliferated the field, possibly comparable to the effect that Rogers (1957) and Bordin (1979) had on research and practice in the helping professions.

During the same time period, the stewards of counseling and psychotherapy research evidence (e.g., the American Psychiatric/Psychological Associations) put forth rigorous practice guidelines and validation criteria against which psychotherapy efficacy could be measured (e.g., Chambless et al., 1998). However, the U.S. Department of Health and Human Services (HHS) Surgeon General's report (HHS, 2001) later issued a stark analysis of the research studies cited by these mental health organizations. The report concluded that definitive MC research evidence demonstrating psychotherapy's relevance for minority populations was nonexistent. Since then, however, MC counseling research has emerged suggesting that culturally adapted psychotherapy may be effective compared to both unadapted forms and to no treatment. Therefore, the first section of this article will review Sue and colleagues' MC competencies, as well as historic and modern MC research trends in general.

During the formative years of Carl Rogers's person-centered therapy (PCT; ca. 1954-1974), evidence that PCT was an effective treatment for racial/ethnic minority clients was absent from the empirical literature. However, in the early 1970s a modest body of research emerged from this tradition, answering certain clinically meaningful questions regarding the effects of psychotherapy with minority clients in community settings. For reasons presented in this article, neither MC nor general PCT research would proceed further. Instead, the Rogerian research tradition receded into the annals of psychotherapy history in the United States. Remarkably, since the 1990s PCT has reemerged demonstrating equivalence to other psychotherapies across a range of Axis I and, potentially, Axis II disorders (e.g., Elliott, Greenberg, & Lietaer, 2004; Quinn, 2011). Moreover, recent MC research studies in both the United States and countries worldwide suggest that PCT is an effective and acceptable treatment for clients from collectivist-oriented cultures-of-origin. Therefore, the latter half of this article provides (a) a brief historical review of the factors contributing to the delay of a person-centered MC research tradition; (b) evidence of this

reemergence, despite considerable researcher allegiance bias, marking PCT's return to the status of an effective treatment approach across client populations; and (c) cultural adaptations to previously hypothesized PCT mechanisms of change, thus providing a competent and effective treatment system for racial/ethnic minority clients and families.

As of 2010, according to the Office of Minority Health (HHS, 2012b), African Americans composed approximately 14% of the U.S. population: Latinos(as), 16%; Asian Americans, 6% (including Pacific Islanders); Native Americans, 2%; and White Americans of European descent, 62% of the population (U.S. Census Bureau, 2011). Moreover, the Office of Minority Health (HHS, 2012a) also estimated that 7% of African Americans in the United States received mental health treatment in 2006: 7% of Latinos(as); 6% of Asian Americans; and 11% of Native Americans—compared to nearly 15% of the White population. In addition, during the same period, these four minority groups had a higher incidence of psychological distress and suicide than their White counterparts, and as expected, income level appeared to be a substantial protective factor. Specifically, distress decreased as an average minority person's income rose above two times the poverty level, which was approximately $10,500 for an individual and $21,000 for a household of four (HHS, 2012a; U.S. Census Bureau, 2010).

In comparison to their clients, when mental health counselor demographic data are examined (Manderscheid & Berry, 2006), of 361,525 therapists surveyed, an estimated 87% of clinically trained psychiatrists, psychologists, social workers, mental health counselors, and marriage and family therapists in the United States report being White; 3% report being African American; 3% Latino(a); 2% Asian American; 0.5% Native American; and approximately 5% did not specify.

Intuition suggests that knowledge of historical trends make possible a better approximation of the emerging future. In this respect, the unique potential of a MC person-centered approach in the 21st century will not likely be understood without locating in history the context in which this quiet, humanistic revolution emerged, receded, and is now entering a period of resurgence as suggested by Kirk Schneider's (2011a) recent forecast of psychology's imminent return to its existential/humanistic roots. Furthermore, evidence of this resurgence can be found in the work of humanistic psychologists Rubin (2011), Bargdill (2011), Hoffman (2009), Robbins (Olfman & Robbins, 2012), and others (see Hoffman, 2011; Schneider, 2011b). These leaders are in the process of forging the way toward the next great period in the helping professions—reminding a new generation of professionals that their full potential resides in their way of being as helping practitioners.

Consequently, this article attempts to provide both a window to the past and a vista of one possible future by contributing relevant clinical information for the case worker, counselor, and therapist working in the field. Whether the helping professional provides office and outreach therapy at a MC community mental health agency, works in a culturally diverse hospital setting, or is a private practice therapist who sees minority clients across a range of income levels, a specific, therapeutic way of being is suggested to bridge these different situations. In all, the effectiveness of a culturally adapted person-centered approach is dependent on the therapist and his or her willingness to be a person, flawed yet genuine, in the presence of the client.

The Multicultural Counseling Competencies

Multicultural counseling competence, in a broad sense, suggests a type of therapist skillfulness when helping a person, family, group, or community that struggles as a result of discriminatory and oppressive practices of the dominant group of a given culture. To clarify, culture has been defined as "the belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes . . . and organizations" (American Psychological Association [APA], 2002, p. 8) and referred to as "the totality of ways being passed on from generation to generation" (National Association of Social Workers, 2007, p. 10). Specifically in the United States, along a cultural/political spectrum, a person possessing, for example, membership in all the domains of the dominant group is thought to be of White, European American descent, middle-class, male, heterosexual, Christian, young, able-bodied (mentally, physically, and emotionally), and English-speaking (Robinson, 1999). And as a result, by virtue of this dominant group membership, an individual, family, or group inherently has a higher probability, as it were, of experiencing life, liberty, and the potential pursuit of happiness across the lifespan.

According to the updated MC counseling model developed by D. W. Sue et al. (1992), a therapist's MC *competence* is dependent on the degree to which he or she can learn, develop, and demonstrate specific MC *competencies*. These MC competencies are thought to extend beyond a therapist's general counseling competence (i.e., counseling microskills; see Ridley, Mollen, & Kelly, 2011) when contributing to client outcome (Constantine, 2002). In addition, the MC competence model suggests certain competencies that extend beyond "micro-level" work, focusing on advocacy and change practices at the organizational and institutional levels (National Association of Social Workers, 2007; D. W. Sue et al., 1992). Therefore, the MC competence

model centers on a therapist's ability to recognize his or her membership in one or more dominant cultural groups and to acknowledge the subsequent effects of this membership on the intra- and extratherapy relationship with a MC client, family, or community. In other words,

> A major obstacle in getting our profession to understand the negative implications of monoculturalism is that White culture is such a dominant norm that it acts as an invisible veil that prevents people from seeing counseling as a potentially biased system . . . what is needed is for counselors to become culturally aware, to act on the basis of a critical analysis and understanding on their own conditioning, the conditioning of their clients, and the sociopolitical system of which they are both a part. (D. W. Sue et al., 1992, p. 480)

Therapist Knowledge, Awareness, and Skills. In brief, the MC counseling competencies, as put forth by D. W. Sue et al. (1992), include three characteristics that apply to the development of the competent therapist. The therapist must develop (a) an understanding or *knowledge* of the client's experience as a culturally different person, (b) an *awareness* of his or her own assumptions about culturally diverse people, and (c) culturally appropriate therapeutic interventions and *skills*.

Knowledge of the client's worldview. As the therapist develops an understanding of the client's worldview, potentially rigid beliefs and attitudes toward the client's culture are unearthed. The therapist facilitates this exploration by obtaining knowledge about the client's cultural group, including the culture-specific attitudes toward mental health issues, help-seeking behavior, and appropriateness of counseling approaches. The therapist supplements this knowledge through experiential immersion in culturally different settings so that his or her "perspective of minorities is more than an academic or helping exercise" (D. W. Sue et al., 1992, p. 482).

Awareness of own assumptions. As the therapist develops cultural knowledge he or she becomes more aware of the relativity of cultural assumptions. The therapist's attitudes about his or her own culture, as well as beliefs about other cultures, move from a state of rigidity toward a more dynamic viewpoint. In tandem, the therapist develops a deeper, more accurate understanding and subsequent ownership of ways in which dominant group membership has benefited and affected him or her personally. The therapist also becomes aware of the effects that these socially constructed power differentials have on the relationship with culturally different clients—at times communicated through interpersonal style, office décor, therapy orientation, and so on. Moreover, the

therapist realizes his or her own limitations and seeks out further training and education to develop culturally competent clinical skills and to understand him or herself as a racial and cultural being.

Culturally adapted interventions. The therapist's attitudes toward helping and healing practices are extended beyond a mainstream, Westernized counseling approach. He or she moves toward respect and understanding of religious/spiritual values relating to mental and physical functioning, as well as indigenous, culturally specific healing practices, including the importance of family and community resources. As the therapist delves further into culturally different perspectives, he or she acknowledges the cultural bias affecting mainstream therapy practice, including monocultural diagnostic assessment procedures that may perpetuate barriers to mental health services.

A Racial/Ethnic Focus. D. W. Sue et al. (1992) address an ongoing difficulty with which MC theorists struggle: the rank order of oppressions. Although D. W. Sue et al. (1992) suggest the above MC counseling competencies could likely be relevant to counseling other oppressed groups (e.g., GLBTQ [gay/lesbian/bi/transsexual/queer] groups, physically disabled people, etc.), they state that these competencies, as they are hypothesized, focus on the four "visible racial ethnic minority groups" in society: African Americans, Latinos(as), Asian Americans, and Native Americans. Moreover, Arredondo et al. (1996) include a Caucasian/European group in their operational definition of the MC competencies.

Similarly, a number of social justice and critical race theorists caution against creating an "equality of oppressions" paradigm that may dilute the legacy and ongoing effects of racial oppression persistent in racial/ethnic minorities' lives (Abrams & Moio, 2009). That is, to suggest equivalency may perpetuate a color-blind mentality that threatens to perpetuate the idea of a "universal human experience" and, as a result, would enable the continuation of oppression in the helping professions in particular. In contrast, however, some have argued that to deny a universal helping system creates a stereotype-based counseling system (Patterson, 2004) in which the counselor acts less like a genuine helper and more like a "chameleon . . . to meet the presumed characteristics of clients from varying cultures" (Patterson, 1996, p. 230). As a result, therapists may rely on theory and techniques that are generally unproven (Weinrach & Thomas, 2002). In response, others have stated that to disregard the MC competencies is equivalent to an unethical psychotherapy practice (Arredondo & Toporek, 2004).

Moving forward, Arredondo et al. (1996) observe that "an assumption is often made, although not verbalized, that MC counseling is for poor persons of color who use public services. Not only is this erroneous but it does lump

all persons of color into one economic class" (p. 7). However, Bonilla-Silva and Ray (2009) balance this view

> as the research traditions of laissez-faire racism . . . symbolic racism . . . and . . . colorblind racism shows, whites have learned how to talk the talk, without walking that walk. Ignoring all evidence of the profoundly racialized system affecting most areas of social life and the fact that most blacks are still at the bottom of the well, whites have pointed to several token black figures as evidence that the long arc of white racism is indeed tilting towards justice. (p. 177)

Historical Multicultural Counseling Research Traditions

The evolution of a culturally sensitive approach to working with clients of diverse backgrounds has at minimum a 60-year history (Heine, 1950); though the late 1960s and early 1970s marked a significant movement forward in theory and initial research (Lorion, 1978), with person-centered researchers visible at the forefront (e.g., G. Banks, Berenson, & Carkhuff, 1967; Carkhuff & Banks, 1970; Lerner, 1972). However, with the Rogerian research tradition in the beginning stages of decline (at the time, arguably the oldest evidence-based research tradition in the profession), an empirical vacuum emerged into which experimental MC therapy research would not enter for two decades.

On Building a Multicultural Research Foundation. The year 1954 marked the beginning of the Rogerian research tradition, with the publication of Rogers and Dymond's (1954) experimental volume, *Psychotherapy and Personality Change*. Subsequently, during the next 20 years psychotherapy research became increasingly concerned with studies not only relating PCT but also the facilitative conditions (Rogers, 1957) of empathy, warmth, and genuineness, to outcome (e.g., Beutler, Johnson, Neville, Workman, & Elkins, 1973; Garfield & Bergin, 1971; Halkides, 1958; Truax, 1963; Truax & Carkhuff, 1967)—continuing in part the research tradition begun by Rogers and colleagues at the University of Chicago (see D. S. Cartwright, 1957). Moreover, approximately 20 years after the Rogers and Dymond volume, experimental research measuring therapeutic change with culturally diverse populations emerged from the Rogerian tradition (e.g., Lerner, 1972; Redfering, 1975). However, the apparent ascent of this PCT MC research paradigm—which appeared to be building on inquiries begun by Rogers and colleagues in Chicago and Wisconsin—would be short-lived. That is, the research methodologies generally employed in the numerous studies demonstrating the effectiveness of the facilitative conditions had come under sharp criticism (e.g., Chinsky & Rappaport, 1970),

and by the mid-1970s, the Rogerian research tradition had receded from the literature.

During the same period, psychoanalytic and behavior therapy research was in its infancy (Luborsky & Spence, 1978; Marks, 1978), with virtually no empirical evidence contributed by the analytic tradition, and mostly applied learning studies contributed by the behaviorists (Bergin, 1966; Bergin & Strupp, 1970). Sloane, Staples, Cristol, Yorkston, and Whipple's (1975) book *Psychotherapy versus Behavior Therapy* represents one of the first controlled, well-designed psychotherapy outcome studies using actual clients to be completed outside the influence of the Rogerian research tradition: The authors found the effects of behavior therapy versus psychoanalytic psychotherapy to be comparable. Going forward 2 years, Beck's cognitive therapy entered the evidence-based domain with an initial study comparing cognitive therapy with an antidepressant (Rush, Beck, Kovacs, & Hollon, 1977). By the early 1980s, a research tradition, combining the randomized clinical trial design with advanced statistical procedures using computer software, held the promise of a coming age in which social science research would no longer be subjected to bias from the effects of unique, nonspecific personal qualities inherently introduced by the client and the therapist (Krause & Lutz, 2009; Stiles, 2009)—qualities that had previously "invalidated" Rogerian research findings (Bergin & Suinn, 1975).

By the early 1990s, interest in culturally diverse psychotherapy outcome research was again reaching prominence in therapy journals and handbooks (D'Andrea & Heckman, 2008). Accordingly, if the growth of the Rogerian research tradition were used as a timeline, hypothetically one could predict that the newer psychoanalytic and behavior therapy research traditions would begin publishing experimental MC research following a similar 20-year foundation-building time period. Therefore, using Sloan, Staples, Cristol, Yorkston, and Whipple's (1975) book as the initial marker, a post-Rogerian MC research tradition could be predicted to begin in 1995. Remarkably, a review of the literature supports this hypothesis.

In Bergin and Garfield's 1994 edition of *Psychotherapy and Behavior Change*, Stanley Sue and colleagues' chapter on the state of psychotherapy research with culturally diverse populations concluded that "there are virtually no studies comparing the outcomes of treated and untreated groups of ethnic minority clients" (S. Sue, Zane, & Young, 1994, p. 785); that is, no studies using actual clients in which the findings can be generalized to larger populations. However, in 1995, Muñoz et al. (1995) reported findings from a major randomized, controlled comparison study examining the effects of a culturally adapted, cognitive-behavioral depression prevention treatment with

low-income, racial/ethnic minority clients (notably, Miranda et al.'s [2005] comprehensive literature review corroborates a general date of 1995 as marking the inception of modern experimental MC research as well).

Modern Multicultural Research

By the beginning of the 21st century, all forms of psychotherapy and psychosocial interventions had come under attack for assuming equal therapeutic effectiveness across racial/ethnic groups despite a lack of appropriate research evidence (Miranda et al., 2005). The 2001 Surgeon General's report (HHS, 2001) demonstrated this bleak situation in the mental health field. Miranda et al. (2005) further reviewed the data and found that of 9,266 participants in mental health care efficacy studies, only 561 (6%) African American, 99 (1%) Latino, 11 (0.1%) Asian American/Pacific Islanders, and zero Native Americans were included, severely limiting the clinical significance of any conclusive findings. Specifically, the research that was examined in the report of the Surgeon General (HHS, 2001) were those studies cited in the American Psychiatric Association's "Practice Guidelines" for bipolar disorder, major depression, and schizophrenia, and in the Agency for Healthcare Research and Quality's "Evidence Report/Technology Assessment" for attention-deficit/hyperactivity disorder in children. Also included in the report's analysis was the APA's "empirically-validated therapies" research evidence. After reviewing the literature cited by these three organizations, the Surgeon General's report concluded that "specific information about the efficacy of these interventions for racial and ethnic minority populations is unavailable" (HHS, 2001, p. 172).

Notably, following a decade of negative reactions (see Freire, 2006), the APA (2006) broadened the definition of an empirically validated treatment. At the request of 2005 APA president, and person-centered veteran, Ronald Levant (Levant, 1978), a new task force was formed to reevaluate the APA's treatment efficacy standards. As a result, the APA (2006) developed a new evaluative framework called "evidence-based practice in psychology," validating the importance of clinical observation and naturalistic and qualitative research designs in psychotherapy research.

Modern Culturally Adapted Psychotherapy Research. Since Muñoz et al.'s (1995) early study and the Surgeon General's report (HHS, 2001), reviews by Miranda et al. (2005) and Cardemil, Moreno, and Sanchez (2011) of racial/ethnic minority psychosocial intervention research report that culturally adapted mainstream treatments *can* improve outcome. In particular, two therapy orientations have shown success with predominantly Latino(a)

and African American clients and to a lesser extent Asian Americans: (a) culturally adapted cognitive behavior therapy (e.g., Hinton, Hofmann, Rivera, Otto, & Pollack, 2011; Miranda, Chung, et al., 2003; Muñoz et al., 1995; Tandon, Perry, Mendelson, Kemp, & Leis, 2011; Wells et al., 2004) and (b) culturally adapted interpersonal psychotherapy (e.g., Grote et al., 2009; Krupnick et al., 2008). In contrast, both approaches, or variants of them, have reported less favorable outcomes as well (culturally adapted cognitive behavior therapy: Foster, 2007; Le, Perry, & Stuart, 2011; culturally adapted interpersonal psychotherapy: Crockett, Zlotnick, Davis, Payne, & Washington, 2008). Moreover, unadapted motivational interviewing (Miller & Rose, 2009) has shown favorable results with Native American clients.

On closer inspection of these studies, though, treatment effects tend to diminish as the research migrates from the highly controlled efficacy settings to the naturalistic community settings that treat the "hardest-to-serve" clients who face multiple treatment barriers (e.g., Miranda, Chung, et al., 2003). Furthermore, naturalistic research suggests that additional case management services may be required in conjunction with culturally adapted treatment to mitigate substantial engagement and attrition problems (e.g., Miranda, Azocar, Organista, Dwyer, & Areane, 2003). Likewise, Beck and colleagues have reported similar problems in studying CBT effects in naturalistic settings (Gibbons et al., 2010; 83% White client sample reported).

Modern Multicultural Competence Research. As interest in MC counseling research reemerged in the 1990s, multiple instruments were developed to measure therapist, client, and observer ratings of Sue's (D. W. Sue et al., 1992) therapist MC competencies (Constantine, Juby, & Liang, 2001; Worthington, Mobley, Franks, & Tan, 2000). Furthermore, process-outcome studies using primarily survey, analog, and retrospective designs have been carried out to assess relationships between training, MC competence, client satisfaction, and symptom-reduction using mostly White therapists and mixed samples of racial/ethnic college student clients (i.e., predominantly African American, Latino(a), and Asian American).

Therapist self-ratings. In studies assessing therapists' own ratings, the therapist tends to rate his or her MC skill level as higher than, and subsequently unrelated to, the client's and judge's ratings (Constantine, 2001b; Fuertes et al., 2006; Worthington et al., 2000). Adding to this dilemma, therapist self-report MCC ratings tend to be positively related to socially desirable responding (Constantine et al., 2001; Constantine & Ladany, 2000; Worthington et al., 2000).

In terms of training and education, however, a therapist self-reported MC knowledge component, though not the awareness component, has been repeatedly found to correlate with the therapist's previous MC education (Constantine, 2001a; Constantine et al., 2001; Constantine & Ladany, 2000). One study has found both self-reported knowledge *and* awareness components to be positively associated with previous MC education (Chao, Wei, Good, & Flores, 2011). In contrast, therapist MC competence has consistently been found unrelated to his or her cross-cultural case conceptualization skill set (Constantine, 2001a; i.e., competence was unrelated to therapist ability to formulate a treatment plan).

Previous MC education, then, may predictably influence a White therapist's MC knowledge but may be less predictable in affecting his or her awareness and choice to take ownership of racial disparities that may affect the MC counseling situation. Interestingly, verbally demonstrating knowledge/awareness to the client as "proof" that the therapist owns his or her "Whiteness" may *not* be necessary or helpful in therapy (Thompson & Alexander, 2006). Troubling, though, is the finding that less therapist MC awareness is related to both increased color-blindness (i.e., lack of awareness, or denial of the existence of racism; Gushue & Constantine, 2007) and more rigid White racial identities (Constantine et al., 2001). Moreover, Chao et al. (2011) found that more trained, less color-blind White therapists had significantly higher MC knowledge scores than their more color-blind, but equivalently trained, counterparts.

Taken together, these findings tentatively demonstrate that White therapist *knowledge* of a MC world is easier or more readily attained than *awareness* of that world, but color-blind pretenses and rigid racial attitudes can obscure that knowledge. Nonetheless, despite this latter qualification a therapist will likely struggle less with MC knowledge assessment statements, such as "I am knowledgeable of acculturation models for various ethnic minority groups," versus an MC awareness statement, such as "I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face" (Chao et al., 2011, p. 75). Furthermore, this discrepancy may be related to differences between cognitive (e.g., perspective taking) and affective (e.g., concern or sympathy) components of a culturally empathic understanding system (Constantine, 2001a). For instance, once social desirability effects were controlled, Constantine (2000) found higher levels of therapist affective empathy alone to be significantly related to higher MC knowledge and awareness self-reports, whereas cognitive empathy alone was unrelated. Despite these findings, however, therapist self-reported MC competence is not specifically related to outcome, such as client satisfaction with therapy (Fuertes et al., 2006).

Client ratings. In comparison, racial/ethnic minority clients' ratings of their predominantly White therapists' MC competencies *have* correlated significantly with client satisfaction and symptom reduction but are possibly confounded with client ratings of general competence/credibility ratings of the therapist (i.e., expertness, attractiveness, trustworthiness). Further support for this latter finding comes from studies by Owen, Leach, Wampold, and Rodolfa (2011) and Constantine (2007) suggesting that client-rated MC competence ratings and satisfaction may be influenced by the therapist's personal qualities, such as likeability. However, client MC competence ratings have been found to account for an additional amount of client satisfaction, beyond therapist general competence and likeability (Constantine, 2002; Fuertes & Brobst, 2002). Interestingly, client ratings of therapist general and MC competence have consistently been found interrelated with client perception of the working alliance (Constantine, 2007; Fuertes et al., 2006; Owen, Tao, Leach, and Rodolfa, 2011; Wang & Kim, 2010) demonstrating that a client's perceptions of the therapist's general as well as MC competence may be substantially dependent on the particular client–therapist relationship that is formed.

In addition, client–therapist racial/ethnic match has been found unrelated to both client perception of therapist MC competence (Owen, Leach, et al., 2011) and satisfaction with therapy (Fuertes et al., 2006). Looking beyond racial/ethnic match, Stanley Sue and colleagues (Zane et al., 2005) investigated client–therapist "cognitive match" (i.e., congruence between client/therapist perceptions of how a person relates to others, copes with problems, and the purpose of therapy). The authors found these factors to play a significant role in session impact and symptom outcome. Previously, the authors (S. Sue & Zane, 1987) had suggested that therapist credibility and a giving nature may be important components in minority clients' (a) attitudes toward therapy, (b) their inspiration for attending therapy, and (c) the overall perceived benefit from therapy.

On the whole, a minority client's satisfaction with therapy may substantially depend on a general positive regard toward, and trust in, the therapist, and is also modestly related to the therapist's particular MC competence. Corroborating recent research reviews (Zane et al., 2005), client–therapist racial/ethnic match similarity appears to be less important for some types of outcome criteria than previously thought.

Observer ratings. Fewer studies have reported observer-rated therapist MC competence. Among these, Constantine (2001b), using audiotaped recordings, found that observers rated the MC competence of African American and Latino counselors higher compared to White counselors. These observer ratings were neither influenced by the client's race/ethnicity nor by client/therapist racial/ethnic similarities.

In addition, observers' ratings of therapist MC competence have been found to significantly correlate with both MC-oriented verbal content and therapist attribution of client problem causation. In other words, the therapists who were rated more competent also tended to use more MC-oriented speech content and demonstrated increasingly sympathetic attitudes toward the client's problem (Worthington et al., 2000). Paralleling these findings, observer-rated empathy has also been found related to verbal content frequency (Wenegrat, 1974). For empathy, a substantial factor was found to explain this relationship: a therapist's assertiveness in approaching the client's emotions. Drawing a parallel, Worthington et al.'s (2000) finding could be interpreted as a therapist's assertiveness in approaching the client's multiculturalism. Mentioned earlier, however, Thompson and Alexander's (2006) study moderates this finding: White therapists that were instructed to initiate a discussion of race were rated no more effective by their African American clients than were White therapists instructed not to initiate a discussion. Therefore, the extent to which a therapist should intentionally demonstrate MC competence by initiating a "race discussion" is questionable.

Multicultural empathy. A number of theorists and researchers have found empathy to be a necessary therapist attribute in general (Elliott, Bohart, Watson, & Greenberg, 2011) and potentially important in MC counseling as well. P. Pedersen (2009) reviews empathy within an MC framework and suggests an "inclusive cultural empathy" paradigm through which the therapist reframes the therapy relationship into MC categories in order to "accept the counseling relationship as it is—ambiguous and complex" (p. 147). Furthermore, the author recommends developing a balance of meaningful knowledge and accurate assumptions as a means to develop appropriate social action skills (i.e., interventions).

Regarding research evidence, MC competence studies have found therapist self-reported empathy to positively affect MC case conceptualization skills (Constantine, 2001a), and client-perceived empathy is positively related to client satisfaction (Fuertes & Brobst, 2002). In addition, Miville, Carlozzi, Gushue, Schara, and Ueda (2006) found empathic therapists more likely to embrace cultural diversity and to score high on emotional intelligence tests. Conversely, therapists with high color-blind scores were found to be less empathic when compared to low color-blind therapists (Burkard & Knox, 2004). Furthermore, client-perceived therapist MC competence was positively associated with client-perceived therapist empathy across both racially matched and racially unmatched therapy dyads (Fuertes et al., 2006). Taken together, these findings suggest that therapist empathy may be a primary ingredient in MC counseling competence.

Meta-Analytic Research: The Culturally Adapted Illness Myth. Bruce Wampold and colleagues (Benish, Quintana, & Wampold, 2011) performed a meta-analysis of select comparison studies that compared "bona fide" culturally adapted therapies to comparable but unadapted therapies (bona fide therapies are considered to be treatments that possess specific, hypothesized mechanisms of change). The findings are provocative: The effectiveness of the culturally adapted therapies (beyond that of the unadapted general effects) was moderated solely by the degree to which the therapies possessed an accurate "illness myth" or culturally congruent explanation and perception of the clients' problems or illnesses. Therefore, as the types of studies analyzed are distilled to the most competitive comparisons, culturally adapted therapies remain moderately more effective because of the presence of an accurate illness myth, a concept similar to Stanley Sue's (Zane et al., 2005) cognitive match and Derald Sue's (D. W. Sue et al., 1992) skills competencies.

With the MC research in mind, the following section will examine PCT's current and historical contributions and then suggest hypothesized cultural adaptations to a person-centered approach.

A Person-Centered Approach to the Treatment of Multicultural Clients

As is generally known, Carl Rogers is the figurehead of the person-centered movement, which, from the 1940s to 1970s, explored the effects of certain facilitative therapist conditions on personality and behavior change with individuals, families, groups, students, schools, in corporate culture, and in large groups as well. These facilitative, or core, conditions were originally defined as congruence, unconditional positive regard, and empathic understanding (Rogers, 1957). Moreover, from the early 1970s until his death in 1987, Rogers and colleagues devoted substantial time and resources toward clarifying a cross-cultural definition of the person-centered approach, providing a future foundation for therapeutic work in culturally diverse settings (e.g., Rogers, 1977; Rogers, Farson, & McGaw, 1968; Rogers & Sanford, 1987).

Remarkably, in the first decade of the 21st century, results of a survey of practicing helping professionals found Rogers to be the most influential figure of the previous quarter-century, replicating findings from two decades prior (Cook, Biyanova, & Coyne, 2009; D. Smith, 1982). Furthermore, in 2007 a prominent psychotherapy journal devoted a special section of the Fall volume to the 50-year publication anniversary of Rogers's (1957) renowned necessary and sufficient facilitative conditions article (Gelso, 2007). Paradoxically,

though, across the 11 articles published in this bicentennial, celebratory volume the verdict was: probably facilitative but not sufficient—save for one-half of one article. Most support for the *necessity* of Rogers's theory seemed to be provided only within the context of correcting it; by adding novel components primarily related to the therapeutic orientation held by the author of each article (e.g., psychodynamic, behavioral, process-experiential, feminist, etc.).

Despite the ambivalence of professional opinion toward Rogers's contributions, the facilitative conditions tend to be regarded as the necessary preconditions for therapy to occur—that is, necessary to build a therapeutic relationship. Once this is accomplished, the helping professions have then historically focused on specific therapist techniques and interventions thought to ultimately result in client symptom reduction, or as Gordon Paul (1967) asked in his well-known question, "*what* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances?" (Paul, 1967, p. 111).

Person-Centered Research in the 1970s

Arguably, the Rogerian traditions of research and evidence-based practice concurrently ended in the United States in 1974. A number of methodological issues had been raised about the final 10 years of facilitative conditions research (ca. 1964-1974), spearheaded, for better or worse, by Charles Truax (Truax & Mitchell, 1971). Not by chance, this hypothesized end date corresponds with Truax's death (December 1973; Bergin & Suinn, 1975; Kirschenbaum, 1979), John M. Butler's death in 1975 (Wexler & Butler, 1976), and, in a broader sense, the deaths of Maslow in 1970 and Buhler and Jourard in 1974 (Greening, 2007). Consequently, by the time Rogers (1975) published his well-known article entitled "Empathic: An Unappreciated Way of Being," Bergin and Suinn (1975) had performed a quick and cursory review of the arguments on both sides of the ongoing methodological dispute (e.g., Bozarth & Krauft, 1972; Chinsky & Rappaport, 1970; Gurman, 1973b; Mintz & Luborsky, 1971; Rappaport & Chinsky, 1972; Truax, 1972) and had concluded, "These findings may invalidate much of this program of research [including the Wisconsin schizophrenia project (Rogers, Gendlin, Kiesler, & Truax, 1967)]" (p. 515). However, Bergin and Suinn (1975) had overlooked evidence contradicting much of the criticism leveled at Truax and colleagues' use of observer-rated research measures (Beutler, Johnson, Neville, & Workman, 1973; Gurman, 1973a; Wenegrat, 1974). Later, additional clarification and evidence supporting Truax emerged as well (Beutler, 1976; Friedlander et al., 1988).

Despite evidence to the contrary, literature published in the late-1970s continued to rely on the negative reviews and research findings published earlier that decade (e.g., Parloff, Waskow, & Wolfe, 1978). Finally, the proverbial nail-in-the-coffin came from the PCT camp. Mitchell, Bozarth, and Krauft (1977) found no correlation between the conditions and measurable change in clients, though the finding emerged from a therapist sample possessing minimal abilities to provide sufficient facilitative conditions, as rated by trained observers. Surprising, though understated, were findings that client-perceived facilitative condition measures were consistently related to positive outcome (Barrett-Lennard, 1981; Bergin & Suinn, 1975; Gurman, 1977).

Though debatable, the Rogerian practice tradition was discredited along with research on the facilitative conditions. Looking back, interpersonal conflict stemming from events that took place during the "Wisconsin years" may have largely contributed to PCT's decline rather than overwhelming evidence disproving Rogers's theory and the effectiveness of PCT (Kirschenbaum, 1979). To be clear, despite unfavorable reviews (e.g., Parloff et al., 1978), the evidence did not conclusively demonstrate the alleged inadequacies of either the research or the practice—though an exhaustive review of the numerous articles supporting this point is beyond the scope of this article. However, after reviewing Parloff et al.'s (1978) influential chapter, C. H. Patterson (1984) exemplifies the general trend: "they recognize that there are positive findings, but emphasize the negative, failing to note that there are more positive than negative studies, or to note that the negative studies are not without serious problems or flaws" (p. 433). Furthermore, when the studies cited by Parloff et al. (1978), in particular, are examined in detail, a researcher allegiance bias comparable to "necessary, *not* sufficient" becomes apparent (e.g., Bergin & Jasper, 1969; Garfield & Bergin, 1971; Mintz, Luborsky, & Auerbach, 1971; Sloane et al., 1975). As a result—and given recent concessions that allegiance *does* affect outcome (McLeod, 2009)—this bias may have seriously affected the intentions of both the researchers and the non-PCT therapists in these studies, resulting in their unequivocal conclusions of "no relationship" between the conditions and outcome. In retrospect, why substantial time, book, and journal space were devoted to dismantling 20 years of empirical support for Rogers's facilitative conditions—and the subsequent affect on the helping professions and on society in general—is grounds for consideration.

Historical Multicultural Research. Noted in the previous section of this article, although the Rogerian tradition was ending, research influenced by the PCT tradition was accumulating that examined the effects, for example, of person-centered and egalitarian therapist attitudes on racial/ethnic minority clients

from a variety of backgrounds (including college students and clients living in impoverished communities). Moreover, these initial studies contributed meaningful empirical findings, such as "both race and social class of both patient and counselor appear to be significant sources of effect upon the depth of self-exploration of patients in initial clinical interviews" (Carkhuff & Pierce, 1967, p. 634) and "the evidence thus suggests that counselor experience *per se* may be independent of counseling effectiveness with [African American] counselees . . . race and type of orientation and training appear more relevant variables" (G. Banks et al., 1967, p. 71), and furthermore, "systematic training in interpersonal skills, then, was effective in 'shaping' higher and more effective levels of communication . . . between races" (Carkhuff & Banks, 1970, p. 417).

Furthermore, in addition to the work of Banks, Carkhuff, and colleagues (e.g., Redfering, 1975), Barbara Lerner published the well-known book *Therapy in the Ghetto*, as well as follow-up studies, on differential therapist attitudes in relation to outcome with low-income, African American clients (Lerner, 1972, 1973; Lerner & Fiske, 1973). A few years later, in a major review of psychotherapy with disadvantaged populations (a previous version of Stanley Sue's pivotal chapter cited earlier [S. Sue et al., 1994]), Lorion (1978) referred to Lerner's work as "a single systematic evaluation of insight-oriented psychotherapies for ghetto residents" (p. 920). Lerner, who began her work in the person-centered research tradition (R. Cartwright & Lerner, 1963), received further praise and criticism from Stanley Sue (1973). In particular, echoing the critique he would make 20 years later of psychoanalytic and behavior therapy research (S. Sue et al., 1994), Sue pointed out that Lerner's naturalistic research design lacked a comparable control group against which the positive outcomes could be further substantiated. Sue's criticisms were answered by Lerner (1974) in which she referred to her companion study (Lerner, 1973) that supported her original findings of a positive relationship between White therapists' nonauthoritarian, "democratic" values and improved outcomes with African American clients. Despite these early empirical precedents being set, little culturally diverse experimental therapy research was carried out in subsequent years, though Stanley Sue (along with Derald Sue, as already cited) would continue to demonstrate evidence of severe disparities in racial/ethnic minority mental health treatment over the years (e.g., S. Sue, 1977; S. Sue et al., 1994; S. Sue & Zane, 1987; Zane et al., 2005). Similarly, the humanistic/person-centered movement would also become dormant in the United States for the next few decades. In writing about the revival of meaning in psychology, Kirk Schneider (1999) substantiates this view: "Since about 1975 . . . the humanistic psychology movement

. . . has been relegated to a quaint afterthought in the curriculum of most APA-accredited doctoral programs in psychology" (p. 14).

The person-centered movement never fully achieved Sue's (S. Sue, 1973; S. Sue et al., 1994) recommendations regarding the use of research methods that would allow for further generalization of results with racial/ethnic minority clients. However, the likelihood of the Rogerian tradition executing additional MC research using control/comparison groups was substantially stronger than that of other research traditions still in the beginning phases of building a research base (e.g., Di Loreto, 1971; Kernberg, 1973; Mintz et al., 1971). That is, from its inception, Rogerian research had been engaged in scientific inquiry and the use of rigorous and meaningful control conditions (i.e., the two Rogerian research volumes were practically graduate-level methodology courses unto themselves; see Rogers & Dymond, 1954; Rogers, Gendlin, Kiesler, & Truax, 1967). Therefore, the Rogerian group would have had a 20-year foundation of experience, training, and know-how to contribute toward the implementation of further randomized, controlled MC research projects. However, the published literature in the 1970s suggests that PCT researchers, rather than pursuing novel avenues of empirical inquiry, devoted substantial time in defending—what now appear to be—unfounded claims made by a group of social scientists who held significant professional interest in seeing through the dismantling of the person-centered approach.

Modern Person-Centered Research

According to the original APA standards for empirically validated therapies (Chambless et al., 1998), PCT meets criteria as a well-established treatment intervention for depression (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998; Teusch, Bohme, Finke, Gastpar, & Skerra, 2003; Teusch, Bohme, & Gastpar, 1997; Ward et al., 2000) and meets criteria as a potentially efficacious treatment for panic and anxiety disorders (Cottraux et al., 2008; Teusch et al., 1997) and for personality disorders (Cottraux et al., 2009; Teusch, Bohme, Finke, & Gastpar, 2001; Turner, 2000). Furthermore, Elliott et al.'s (2004) meta-analysis found that PCT—once researcher allegiance was controlled—was equivalent in effect size to both process-experiential therapies (i.e., PCT plus process-direction) and cognitive, behavioral, and psychodynamic approaches, across a range of Axis I disorders. Unfortunately, PCT is also comparable to modern established treatments by merit of an insubstantial MC research base (HHS, 2001).

Multicultural Studies. However, a number of 21st-century research studies have provided strong support for the person-centered approach as an effective and

equivalent treatment for culturally diverse populations, despite probable researcher allegiance bias in some. The following studies report findings from Brazil, Malaysia, Iran, and the United States.

Brazil. Freire, Koller, Piason, and da Silva (2005) reported on a program in Southern Brazil that provided PCT to impoverished children and adolescents living at either a residential shelter or attending day treatment. The authors observed that a nondirective, person-centered therapist intention toward promoting client autonomy and self-determination resulted in notable symptom and behavior change. After 6 months, the children and adolescents who received or were receiving counseling had demonstrated observable improvements in their relationships with the shelter staff, their peers, and their families (with whom many of the children were able to visit on the weekends). Surprisingly, this pattern of change was reportedly independent of the children's particular use of time in therapy: positive outcomes were observed in those children who chose only to play cards and games with their therapists, those children who openly discussed their feelings and experiences, and those who talked only about sports and movies. Confirming these clinical observations, Teusch and Bohme (1999) provide quantitative evidence of client change in PCT, despite an absence of a specific symptom-reduction treatment plan: "Our findings underline the hypothesis that client-centered treatment influences the reduction of anxiety symptoms using other mechanisms than would behavioral exposure treatment" (p. 119).

Malaysia. Mohamad, Mokhtar, and Samah (2011) provide findings from a qualitative study of four PCT clients' perceptions of their inner experiences and personal growth. After 12 sessions, the clients reported constructive change as assessed by interpersonal process recall methods; in particular, increased openness to exploring spiritual, cultural, and moral issues in their lives.

For example, one young woman reported improved personal understanding of the teachings of the Qur'an, which paralleled a closer connection to and understanding of her mother's life experiences. Another client, dissatisfied with her religion, had lost her faith in prayer prior to starting therapy. However, shortly after therapy began, she renewed her morning prayer routine:

> That day after the counseling session. . . . I went home . . . then I thought and thought about all those things. . . . I still did not pray. . . . I came back here . . . suddenly it was like . . . I don't know, it came naturally . . . that morning when I woke up at 5.30, I performed my prayers again. (Mohamad et al., 2011, p. 2121)

In addition, Din, Noor, and Kahn's (2008) quantitative study provides further support for PCT's effectiveness in Southeast Asia. Moderately educated, predominantly married, and depressed Malay women reported symptom improvement after receiving four sessions of PCT during an 8-week period. Clients receiving PCT reported a large decrease in depression (assessed by the Malay version of the Beck Depression Inventory [BDI]) at posttreatment (BDI = 13.93) and follow-up (BDI = 9.80), and compared to a waitlist control. Moreover, the clients' clinical improvement is substantial, particularly when compared to nondepressed Malay samples (BDI = 12.4; Muhktar & Oei, 2010). The authors concluded,

> The three necessary therapeutic conditions, namely, congruence, unconditional positive regards [*sic*] and empathy provided without any directed intervention during the therapy resulted in significant positive outcome. Beck's hypothetical statement that the therapist's qualities as '*necessary but not sufficient*' . . . to produce positive outcome was not observed in most of the participants in this experimental study. (Din et al., 2008, p. 12)

Iran. Yoosefi (2011) compared change in client self-differentiation scores among a sample of divorced Muslim men and women in Iran, randomly assigned to PCT, rational-emotive behavior therapy (REBT), or a control group condition. The women, whose sample size was twice the men's, tended to be predominantly unemployed and living with their parents, whereas the men tended to be employed, living alone. Furthermore, compared to the men, the women were less educated, earning one sixth the income.

Briefly, self-differentiation has been defined as "the capacity of a family system and its members to manage emotional reactivity, remain thoughtful in the midst of strong emotion, and experience both intimacy and autonomy in relationships" (Skowron, Stanley, & Shapiro, 2009, p. 4). Specifically, higher scores on Skowron and Friedlander's (1998) Differentiation of Self Inventory (DSI) relate to higher client self-differentiation, and vice versa. Skowron et al. (2009) have found that greater self-differentiation was positively related to interpersonal and psychological well-being in White samples. Furthermore, the DSI has shown relevance in cross-cultural and marital relationship studies as a measure of emotional reactivity, ability to take the "I" position, and degree of emotional cut-off/fusion with others (Yoosefi, 2011). Select normative comparison scores have been reported for the following: (a) White, married men and women in the United States ($M = 3.9$ and $M = 3.6$, respectively; Skowron & Friedlander, 1998), (b) married Iranian men and women ($M = 3.5$

and $M = 3.3$, respectively; Yousefi [*sic*] et al., 2009), and (c) college students in Tehran ($M = 3.4$, men and women combined; Gharehbaghy, 2011). Moreover, in Gharehbaghy's (2011) latter study, higher self-differentiation scores were positively associated with greater family harmony.

Going forward, Yoosefi (2011) found no significant differences between PCT and REBT treatment effects on client self-differentiation scores. Surprisingly, self-differentiation scores for both therapies had decreased about three points from pretreatment (PCT: $M = 5.0$; REBT: $M = 4.7$) to posttreatment (PCT: $M = 2.0$; REBT: $M = 1.9$) remaining stable at follow-up, while control group scores held at pretreatment levels across time.

Examined through a Western cultural lens, Yoosefi's (2011) findings are startling. First, the divorced clients, on average, were found to possess a higher individuated self-concept at pretreatment compared to both the demographically similar sample of married Iranians and the sample of Iranian college students (Gharehbaghy, 2011; Yousefi [*sic*] et al., 2009). Furthermore, the cognitive-behavior therapy variation (i.e., REBT) and the PCT were found to equally change client self-differentiation scores, though in an unexpected direction when viewed from an individualistic, Western perspective.

Drawing from a MC perspective, however, these findings may be easier explained. It is reasonable to assume that, within a more collectivist-oriented culture, holding status as a divorcee might result in a defensive reaction within the individual—particularly the women—that would presumably be related to an unusually strong individualistic client stance (i.e., higher than "culturally normal" self-differentiation scores). As a result of therapy, the person becomes less defensive over time, returning to a more balanced self-concept that would include both individual and collectivist attributes (i.e., a lower self-differentiation score). Partially explaining this phenomenon, early psychotherapy research (Butler & Haigh, 1954) provided evidence of a convergent relationship between clients' actual-self and ideal-self scores after receiving PCT. Across a predominantly White client sample, Butler and Haigh (1954) found that PCT facilitated equilibrium between the client's self-concept and the client's ideal of who he or she should or could be, assumed to be partly influenced by the client's culture. Depending on the point of view, this correlation was referred to as "congruence" or "discrepancy," but the degree of self-ideal match was suggested to measure a client's self-esteem (Shlien, 1962).

Likewise, Yoosefi's (2011) research may demonstrate convergence between a client's personal view of self and a collective-influenced ideal. Specifically, in a person-centered therapeutic climate, where the therapist's intent is toward a nonjudgmental attitude, the client will likely be encouraged

to explore individually chosen aspects of his or her worldview. Within a MC context, the tendency toward self-actualization—hypothesized to be the meta-mechanism of change within a person-centered relationship (Quinn, 2011)—may operate within a client by moving him or her toward individual–collective equilibrium. In the process, the client accommodates and embraces various aspects of his or her culture-of-origin, while also retaining unique personal qualities as well. In this way, the client can remain a unique person, but within the context of relationship with and responsibility to/for others. Thus, increased self-esteem will not always predict increased individuation. Rather, self-esteem will be the outcome of an increased sense of personal choice.

United States. Szapocznik et al. (2004; Feaster, Brincks, et al., 2010; Feaster, Burns, et al., 2010) reported a study assessing change among a sample of low-income, HIV-positive, African American mothers randomly assigned to one of three conditions: (a) structural ecosystems therapy (SET; an adaptation of a brief family therapy), (b) a PCT attention-control condition, and (c) a community referral control. Specifically, PCT "was incorporated in the study to control for common factors . . . in therapy such as attention, supportiveness, and empathy" (Szapocznik et al., 2004, p. 291).

Previously, I reported on the tendency of research studies to provide PCT in a diluted format as a TAU or minimal treatment control condition. Despite these handicaps, PCT demonstrated results comparable to the experimental treatment conditions (Quinn, 2011). In contrast, the current study provides a less-diluted version of the PCT condition. Specifically, PCT training and adherence measures were instituted, including an initial PCT workshop and monthly adherence checks provided by the late Barbara Brodley, a well-known person-centered therapist (e.g., Brodley, 2006b). However, a substantial bias likely remained because of constraints placed on the PCT therapists' choice of responses and the subsequent outcome criteria against which PCT was measured. The PCT condition "was included to compare the family and systems-oriented SET to a person-oriented therapeutic modality that did not address the family or other systems in which the women are embedded" (Feaster, Burns, et al., 2010, p. 206). Presumably, the researchers wished to assess additional effects of their approach (i.e., SET), beyond the effects of an individualized, non-technique-oriented treatment. However, when the researchers formulated their subsequent conclusions, they failed to account for the substantial advantage given to the SET treatment on family assessment measures, in particular due to the PCT constraints, which may have produced spuriously inflated differences between treatments. However, despite this apparent researcher partisanship, PCT demonstrated comparable results on most measures.

The initial study published by Szapocznik et al. (2004) found that clients receiving SET demonstrated significantly better retention rates on average (M = 12.45, SD = 12.85) compared to PCT clients (M = 5.74, SD = 5.23), though initial engagement rates were the same (i.e., at least two sessions attended). Related to these retention rates, the authors state: "Assessors and therapists contacted each woman to set and confirm appointments for each assessment or therapy session," however, "for women in the SET condition, therapists also contacted family members to remind them to be available for therapy sessions" (Szapocznik et al., 2004, p. 292). In comparison, "[PCT] methods were limited to contact with the woman only and nondirected attempts to build empathy, unconditional positive regard, and congruence" (Feaster, Burns, et al., 2010, p. 208).

Statistical analysis indicated that all three conditions were found to significantly decrease psychological distress over time, though overall decrease in the clients' distress was small for each of the three conditions. Moreover, the PCT condition was more effective with the most severely distressed clients, whereas SET was more effective with the least distressed. Specifically, no difference in distress was found between the active treatment conditions at the 3-month and 6-month postbaseline assessments. However, SET clients compared to their PCT counterparts reported a significant improvement in distress at the 9-month assessment, whereas PCT client distress rose slightly. Unexpectedly, SET and PCT clients reported no difference in overall distress improvement at the final 18-month assessment, as PCT clients' distress subsequently decreased over the final period. Of interest, the above findings parallel reports by Greenberg and Watson (1998), Teusch and Bohme (1999), and Cottraux et al. (2008). In these studies, the more directive therapy condition demonstrated stronger midtreatment and/or posttreatment effects but at follow-up assessments these differences between treatments had disappeared.

Differences between treatment conditions were also reported for client-perceived family hassles scores. In brief, an adapted version of the Hassles Scale (L. Smith et al., 2001) was used by Szapocznik et al. (2004) to assess the extent to which clients reported family hassles occurring daily, for example, in relation to their children, parents, ex-spouse, neighbors, money for health care, another's smoking or drinking, their children's future, social/support services, and transportation (L. Smith et al., 2001). A hassles score "was obtained by counting the number of family-related hassles items that the woman had endorsed" (Szapocznik et al., 2004, p. 292). No difference between conditions was reported at the 3- and 6-month assessments. However, clients who had received PCT reported an increase in family hassles at both 9 months (compared to both SET and the control) and 18 months (compared to SET only).

Last, Szapocznik et al. (2004) assessed changes in client-perceived family support across time. The family support measure sums the number of reported family relationships on whom the client feels she can depend. No differences were found across conditions: all three conditions demonstrated declines in reported family support over time, stabilizing between 9- and 18-month assessments.

Six years later, a subsequent study analyzing the same data (Feaster, Brincks, et al., 2010) reported a significant difference between the SET and PCT conditions relating to HIV medication adherence. Though client-reported "percentage of pills taken" in the PCT condition was significantly greater compared to SET at first (i.e., at 3- and 6-month assessments), and comparable after 9 months, clients in the PCT condition had a significantly lower medication adherence at 18 months compared to the SET and the control groups, which had similar adherence rates.

A third analysis of a subset of the data was undertaken by Feaster, Burns, et al. (2010), examining differences in substance use relapse. PCT clients demonstrated a significantly greater relapse rate compared to the SET and control groups—which is surprising given the impact of therapist empathy on substance users treated with motivational interviewing (Miller & Rose, 2009). A mediational analysis was performed to assess the impact that psychological distress scores, family hassles, and extra-therapy service usage had on the differences between treatments. Overall, none of these variables were found to mediate relapse, though, conspicuously, change in client-reported family hassles were reported to have partially explained the SET/PCT relapse difference. In addition, Feaster, Burns, et al. (2010) found that therapy attendance significantly accounted for the differences in relapse between SET and PCT. Like medication adherence, the SET relapse rates were not significantly better than the control group.

A "Constraint Effect" in Psychotherapy Research. The final cluster of studies by Szapocznik (2004); Feaster, Brincks, et al. (2010); and Feaster, Burns, et al. (2010) adds to a group of psychotherapy studies (Quinn, 2011) demonstrating comparable results between a "showcased" treatment and PCT, despite consistent and overwhelming advantage given to the former. In this case (Szapocznik et al., 2004), researcher allegiance bias was introduced, not by providing a PCT condition with minimally trained therapists, but by constraining the PCT therapists' range of responses (e.g., instructions to focus solely on individual client characteristics). Statistically speaking, this bias or "constraint effect" would then theoretically lead to nonrandom, or systematic, error being introduced into the data. For example, the effect of systematically constraining PCT therapist response would likely lead to a significant correlation between the

PCT treatment condition and a unidirectional outcome measure that is sensitive only to an increase of client problems (i.e., family hassles scale). The inflated client-perceived family hassles scores found for the PCT condition substantiates this hypothesis. To be clear, the above bias is analogous to asking a 7-foot tall athlete to crouch, then measuring the athlete's height under these conditions, and subsequently cutting him or her from the basketball team for being too short. In a similar way, after instructing the PCT therapists to avoid family issues (i.e., rendering the therapists less effective with their clients) the researchers proceeded to evaluate PCT using a family assessment measure that would predictably favor the family therapy (SET). Therefore, drawing conclusions from this data set regarding differences in treatment effects is ill-conceived at best. Remarkably, however, the authors would conclude that PCT was a harmful treatment approach (Szapocznik & Prado, 2007).

In a separate article regarding harmful effects in family therapy, Szapocznik and Prado (2007) employ broad strokes in presenting their conclusions: that PCT, in particular, is an iatrogenic psychosocial treatment. To build their case, the authors first cite a number of research studies, primarily depending on Allen Bergin's research from the 1960s, which suggested that psychotherapy could produce a "deterioration effect" (Barlow, 2010; Bergin, 1966, 1971). In brief, Bergin had originally developed his conception of a deterioration effect by attending a meeting of Rogers's schizophrenia research project at the University of Wisconsin in the early 1960s. Moreover, Truax—who, at the time, was the administrative coordinator for this research project—is reported to have presented evidence during this meeting suggesting that some clients might get worse from psychotherapy (see Lambert, Bergin, & Collins, 1977; notably, Truax's conclusions supported tentative evidence found a decade prior [see Rogers & Dymond, 1954]). In short, Truax would go on to provide substantial evidence (e.g., Truax, 1963) that psychotherapy could be "for better or for worse"—and the primary protective factors against deterioration, bridging treatment approaches, were found to be high levels of Rogers's facilitative conditions (Truax & Carkhuff, 1965, 1967; Truax & Mitchell, 1971). Later, Bergin (1966, 1971) would cite Truax's research in support of his similar and historically more popular concept (see Barlow, 2010).

Next, Szapocznik and Prado (2007) state,

> There was a transitory iatrogenic effect . . . with the person-centered approach having significantly more family stressors than either the experimental family condition or the community control. However, the

> significance of these differences was not sustained at the 18-month follow-up [to be accurate, the SET advantage remained significant at 18-months, as reported by Szapocznik et al. (2004)]. (p. 474)

Similarly, others have found their voices as well. Berk and Parker (2009) interpret these findings as follows: "Szapocznik and Prado detailed how interventions may have adverse effects on families and friends . . . particularly if the individual undergoing therapy becomes more self-absorbed or self-centered" (p. 789). Likewise, Moos (2005) states "person-centered treatment also may engender an individualistic and self-centered world-view, which may be associated with deterioration in social and family functioning" (p. 600).

Redfering (1975). Consequently, the potential inaccuracies and broad generalizations contained in the above conclusions are particularly troubling given that previous PCT research has demonstrated positive effects on African American women's attitudes toward their families. Briefly, Redfering (1975) conducted a 1-year follow-up study of the differential effects of person-centered group therapy (using White therapists) on personal meanings that young African American and White institutionalized, juvenile-delinquent females placed on their concepts of "father," "mother," "myself," and "peers." Remarkably, following PCT treatment the African American women placed significantly greater positive meanings on these family concepts, at posttreatment, at a 1-year follow-up, and compared to their White counterparts after 1 year. Moreover, significantly more of the African American clients had been released from incarceration within the year, living with their parents and gainfully employed. Surprisingly, Redfering (1975) found that "with the exception of 'myself,' the black group's mean scores on the experimental concepts improved" (p. 534). In other words, according to the criteria of improvement suggested by Szapocznik and Prado (2007), Berk and Parker (2009), and Moos (2005), these African American women were significantly freed from their "self-absorbed" and "self-centered" attitudes as a result of a PCT treatment.

Hypothesized Mechanisms of Change in the Treatment of Multicultural Clients

Like all psychotherapies and psychosocial interventions (Kazdin, 2009), a causal relationship between Rogers's hypothesized mechanisms of change (Rogers, 1957, 1959) and outcome criteria have yet to be definitively proven. Similarly, as the field of psychotherapy currently begins the process

of demonstrating that orientation-specific mechanisms of change are causally linked to temporary or lasting symptom reduction, the results become ambiguous. For example, the effectiveness of adherence to techniques, such as therapist prescription of homework, is questioned (Strunk, Brotman, & DeRubeis, 2010), and more difficult patients have been found to be less treatable, regardless of therapist competence in providing specific techniques (Strunk, Brotman, DeRubeis, & Hollon, 2010). Furthermore, a meta-analysis of mechanisms of change research found therapist adherence and therapist competence unrelated to outcome, concluding that "it may be that a more important set of factors are those that are common to most or all forms of psychotherapy, such as the quality of the therapeutic alliance" (Webb, DeRubeis, & Barber, 2010, p. 207).

Previously, hypothesized mechanisms of change in PCT (Quinn, 2011) were described in the context of treating a client population that possessed two primary characteristics: (a) the likelihood of experiencing trauma and (b) low trust of the therapist (i.e., put coarsely, possessing a "sensitive bullshit meter"; Quinn, 2008, p. 464). Furthermore, a plausible predictive relationship has been suggested to exist between a client's experience of trauma and a subsequent decrease in trust toward the therapist (Quinn, 2008). Given that many racial/ethnic minority clients will also possess these characteristics, as a result of racism and oppression in particular (Pole, Gone, & Kulkarni, 2008), the remainder of this article will use MC research evidence to develop a set of MC mechanisms of change.

The Facilitative Mechanisms. Rogers (1957, 1959) suggested that when a client and therapist are in psychological contact, and the client is incongruent (e.g., the client's illness myth is incongruent with societies' illness myth), then the therapist facilitative mechanisms of congruence, unconditional positive regard, and empathic understanding will likely result in a process of positive client change. However, these mechanisms must be both communicated by the therapist and perceived by the client. As stated earlier, research has consistently found Rogers's facilitative mechanisms to be predictive of client outcome when provided by PCT therapists (Barrett-Lennard, 1981; Truax & Mitchell, 1971) and nonpredictive when provided by non-PCT therapists (Parloff et al., 1978).

The MC research reviewed in this article supports Rogers's hypothesis. The evidence suggests that two necessary facilitative mechanisms of change are needed for the therapist to provide a culturally competent therapy experience: (a) therapist self-congruence (e.g., emotional intelligence) and (b) an accurate empathic understanding of the client's internal frame of reference (i.e., empathy was earlier found related to client satisfaction, therapist case

conceptualization, and a pro-diversity therapist stance). However, if mechanisms (a) and (b) describe the competent PCT therapist, then a final mechanism must be included for the therapist to be effective, which is hypothesized to be (c) a therapist's tendency for unconditional positive regard toward the client, also referred to as radical acceptance (Linehan, 1993). Therefore, assuming the conditions of psychological contact, client incongruence, and minimal communication and perception are met, then, if the PCT therapist can provide these three facilitative mechanisms within a culturally adapted framework (described shortly), these mechanisms are hypothesized to be sufficient to facilitate a process of positive change for MC clients and families.

Accordingly, these hypothesized mechanisms of change are integrative with D. W. Sue et al. (1992) MC competencies. That is, the effective person-centered therapist must possess MC *knowledge* (cognitive empathy) and *awareness* (affective empathy plus self-congruence) to sufficiently provide the *skills* (communication of unconditional positive regard) necessary for a process of change to occur with racial/ethnic minority clients. However, these competencies are not suggested to be mandates within the PCT framework: much of the MC knowledge and awareness that a PCT therapist acquires is invariably from a personal/professional motivation toward further self-congruence and unconditional positive self-regard. In support, MC research suggests that an empathic therapist (presumably, a more integrated, self-accepting, emotionally intelligent person) is less color-blind and has a more fluid racial identity.

However, these facilitative mechanisms are hypothesized to be effective only if the therapist provides them with a genuine, unconditional intention (Quinn, 2011). Others (Brodley, 2006b; Merry & Brodley, 2002) have referred to this intention as "nondirective," which is equivalent, though typically misconceived by the field at large as "indirectness" or "indifference" on the part of the therapist. Nonetheless, if the therapist does not possess this type of intention in providing these mechanisms, then these mechanisms will fail to be sufficient. Moreover, this "genuinely unconditional" therapist intention likely differentiates the PCT therapist from other therapists who may view or use the facilitative mechanisms for contingent purposes, such as a means by which the client will more readily engage in a therapist-prescribed course of treatment, or to more willingly accept the therapist's transference interpretations (e.g., J. S. Beck, 1995; Gabbard, 2004; Linehan, 1993). Thus, for PCT to be effective, it is hypothesized that

> the therapist wants to understand for no other reason but to understand. If the therapist is motivated to understand solely to be a change agent

> for the client [e.g., by using a reflective listening technique], then the facilitative mechanisms may not be sufficient because a tendency toward unconditional acceptance will not effectively emerge. (Quinn, 2011, p. 482)

Of note, this last point may explain why the motivational interviewing research group includes a "spirit of MI" component in their mechanisms theory and in their therapist competence measure (Miller & Rose, 2009).

The Process Mechanisms. Rogers (1959) outlines a comprehensive process theory of change hypothesized to occur within the client as a result of experiencing the facilitative mechanisms. This process has been distilled into six mechanisms: (a) an increase of an accurate awareness of experience, both internal and external; (b) an increase of an internal locus of control and decrease of an external locus of control; (c) an ability to assimilate previously threatening experience into the self-concept; (d) decreased defensiveness and reactivity, increased self-acceptance; (e) increased acceptance of others; and (f) an increased reliance on an internal locus of evaluation of experience (Quinn, 2011). Briefly, research has consistently found a positive relationship between higher levels of the therapist facilitative mechanisms, higher levels of the client process mechanisms, and improved client outcome (Kiesler, 1971; van der Veen, 1967). However, the findings from studies investigating the relationship between *change* in process levels during therapy and subsequent outcome have been equivocal, due in part to nonlinear trends found during the process of therapy (D. S. Cartwright, 1955). In other words, assumptions of a linear, or straight-line, model of client process change related to outcome have led to ambiguous and inconclusive findings, due to client change measures tending to be curvilinear over time, for instance, U-shaped in form (Kiesler, 1971; see Pachankis & Goldfried, 2007, for a critique of historical linear assumptions related to process research).

Of importance, MC research has found a relationship between higher levels of therapist empathy and increased process depth with African American clients, but only when provided by racially matched therapists in the study (W. M. Banks, 1972). In contrast, Redfering (1975) demonstrated cross-racial PCT effectiveness, but did not provide data regarding specific characteristics of the person-centered therapists or measures of the mechanisms of change. Therefore, the question remains: How can PCT be adapted to achieve effectiveness when provided to culturally diverse client populations by nonracially matched therapists, in particular?

Culturally Competent Adaptations to Person-Centered Therapy. Two cultural adaptations to the facilitative mechanisms of change are hypothesized: (a) therapist congruence with the client's (or family's) illness myth (Benish et al., 2011) and (b) therapist empathic understanding of the client's emerging perceptions of, and attitudes toward, the therapist. In other words, the former adaptation focuses on entering the client's world, whereas the latter adaptation focuses on understanding the client's perception of the therapist. These adaptations, when met, are hypothesized to account for the suggested MC deficiencies in PCT (MacDougall, 2002; Usher, 1989) and are also hypothesized to result in a sufficient MC PCT treatment approach. Although specific in-session therapy phenomena (e.g., anger, "projective identification," self-harming, homework, etc.) are not addressed at length because of space considerations, therapist response patterns have previously been discussed (see Bozarth, 1984; Brodley, 2006a; Merry & Brodley, 2002; Quinn, 2011).

Adaptation (a). The therapist must accurately understand the client's illness myth, that is, his or her perception of and solution to the particular reason for treatment (i.e., by modern Western standards, the dominant culture's illness myth is called a *disorder*, such as depression or anxiety, and can be treated, for example, by controlling one's automatic thoughts [J. S. Beck, 1995] as well as taking psychotropic medications). Furthermore, the therapist develops this understanding through the use of Sue's (D. W. Sue et al., 1992) MC knowledge and awareness guidelines and, in tandem, by developing an individualized understanding of the client by accurately listening to and communicating with the client. Specifically, in order for therapist listening and communicating to result in accurate understanding, a therapist's internal frame of reference, or awareness, must become increasingly congruent with the events taking place in the external environment (e.g., client verbal and nonverbal communication), resulting in accurate knowledge of the client's moment-to-moment experience (Quinn, 2008). By frequently checking or testing his or her perceived and subceived understanding of the client's experience, the therapist's knowledge of the client will accumulate, resulting in a steady increase of accurate conceptualizations of the client's cultural worldview. This recursive process of understanding, in the context of Sue's recommendations, will become the medium through which the therapist perceives the client's illness myth and, gradually, as a result of this nonjudgmental intention to create a client–therapist cognitive match (Zane et al., 2005), the therapist will communicate unconditional positive regard to the client. As a result, it is hypothesized that this genuine positive regard and unconditional communication of acceptance and understanding of the client, or family, will become increasingly integrated into the client's self-concept, or each family

member's "self-in-group" concept, resulting in a tendency toward unconditional positive self-regard: "It is the therapist's genuine congruence in the relationship that authenticates this positive regard as real and something the client is able to own and believe in" (Quinn, 2011, p. 485).

Adaptation (b). The focus of Adaptation (b) rests within Rogers's sixth condition, which states that both therapist communication of (Rogers, 1957) and client perception of (Rogers, 1959) the facilitative mechanisms must be minimally achieved—hypothesized here to be the "bridge" between the facilitative and process mechanisms of successful culturally adapted PCT. The therapist's consistent intention to accurately understand the client's perceptions of the therapist, with increasing precision, is this adaptation's purpose; though taking care to realize that the therapist, whether he or she be Carl Rogers, Barbara Brodley, or a graduate student, may initially appear quite fake and incongruent through the eyes of the client or family. Adaption (b), then, could be thought of as the "here-and-now" aspect of the therapeutic encounter that addresses and resolves barriers between the therapist and client as the therapist continues to develop further precision in understanding the client's worldview informed by Adaptation (a).

Hypothetically, a racial/ethnic minority client may experience difficulties in trusting that a PCT therapist's genuine and prizing way of being is *real* and not a façade through which the therapist will attempt to gain leverage or control of the client's behaviors. Moreover, research suggests that some clients who are less acculturated to Western living may perceive the therapeutic relationship differently than their more acculturated counterparts (Wang & Kim, 2010). Therefore, when therapy begins, a minority client may not believe or trust that a White therapist, in particular, genuinely holds the client's best interests in mind. That is, the client's perception of the therapist may not match the therapist's more benign self-perception, as MC competence research has shown. When possessing genuine intention, if the PCT therapist recognizes client distrust or suspicion, he or she does *not* switch to a more analyzing, advice-giving, or coaching therapeutic stance which, at minimum, may result in avoidance of important issues in the client's life (e.g., developing hope, reuniting with family, building community supports by attending church or other social functions, setting limits with others, pursuing higher education, etc.) and, at worse, promote racial microaggressions to emerge (Constantine, 2007). Rather, the therapist is asked to accept the ambivalence and "stay in the muck" by remaining within the client's frame of reference, tentatively addressing the therapist's feeling with the client, and allowing the client to move the moment forward.

To reiterate, as MC research suggests the therapist's self-perception means little in terms of the client's perceptions of the therapist. Thus, for the facilitative mechanisms to be sufficient, the therapist must engage in a reciprocal return to the core question regarding how the client is perceiving the therapist at all emerging points in time. Constantine's (2007) findings clearly support this position. The author found that client perceptions of therapist general and MC competence, as well as the working alliance, failed to mediate the negative relationship between perceived therapist racial microaggressions and satisfaction with therapy. Furthermore, since an intention to provide sufficiently high levels of the facilitative mechanisms are hypothesized to facilitate a change process in PCT, and if, according to Truax (Truax & Carkhuff, 1965; Truax & Mitchell, 1971), high levels of the facilitative mechanisms likely mediate therapist-induced client deterioration (presumably, therapist racial microaggressions as well), a therapist's primary intention must be to provide these facilitative mechanisms continually, thereby providing maximal levels of these attitudes, in the client's presence, across the course of treatment. In other words, a consistent and genuine intention to provide these mechanisms will likely preclude actions such as agenda setting, Socratic questioning, or homework assigning (see Brodley, 2006a, on PCT homework). If these directive actions are taken, the PCT therapist will likely fail to monitor his or her emerging behaviors, as well as the client's reactions to the therapist's behaviors, which will likely increase the prevalence of client-perceived racial microaggressions. Therefore, to be therapeutically effective, a PCT therapist must consistently adhere to the facilitative mechanisms, as opposed to a therapist using a different treatment approach, such as cognitive therapy, which may require more directive therapist responses:

> Let me interrupt you for a moment. It's important to me to understand the big picture of your week and to get the details later in the session. For right now, could you just tell me about your week in two or three or four sentences? . . . It sounds to me like you're saying, "I had a pretty hard week. I had a fight with a friend, and I was really anxious about going out, and I had trouble concentrating on my work." That's the big picture I was talking about that helps me get a sense of what's really important to put on the agenda and find out more about later. (J. S. Beck, 1995, pp. 64-65)

Furthermore, Adaptation (b) does not suggest that the therapist should somehow convince the client to trust him. Rather, the focus for the therapist

to be continually open to the potential for client feelings of distrust, whether or not verbalized, may be illustrated by the following:

> Well, I guess I'd like to say that, "I'm here to be of help" . . . I'd like to hear about your life, but I also suspect that it would be hard to say things to me . . . because, who am I to act like I know who you are and what you've been through. . . . I guess I usually think I'm pretty trustworthy, but it's up for you to decide, really . . . but I'd like to hear about what's on your mind. . . . .Or, if you'd like we could go for a walk for our time together, and see how that is—if you'd like to, I'd like to do that too.

To briefly clarify: this is not to say that, when meeting with a family, a therapist will take a walk with a whole family, though possibly this could occur; or, similar to other approaches, the therapist might meet the client or family at home occasionally; or the individual client will wish to walk and talk sometimes, and talk in the office at other times. This *is* to illustrate the intention of the therapist to accept that the client may not like or trust the therapist (particularly during initial sessions), but will not usually verbalize this. Thus, the therapist must continue to provide high levels of the facilitative mechanisms, "roll with resistance," and wait for the client to gradually perceive the mechanisms as being real and not a facade.

In providing this hypothesized facilitative climate that allows the client to gradually feel trusting toward the therapist, the therapist may feel as though little if any "progress" is happening. Again, the PCT therapist does not switch therapy orientations. Rather, he or she trusts in the process that results from providing these facilitative mechanisms consistently, genuinely, and with an unconditional intention. Furthermore, given higher attrition rates found in MC treatment settings (Cardemil et al., 2011), if the client continues to return to therapy each week, therapy is likely progressing in a positive direction, though it may not always seem so to the therapist.

Consequently, the therapist will know that a minimally sufficient client trust has been reached when a new and meaningful "familiarity" in his or her relationship with the client emerges; sometimes merely from the client consistently attending therapy over time, or sometimes from a specific event or experience while together. For example, Dave Mearns' concept of "meeting at relational depth," which also happens gradually, may be equivalent (Mearns & Cooper, 2005). Similarly, MC consultants frequently refer to this familiarity as "breaking bread" with the client or family; though this concept arguably leads to a technique and, consequently, an item on a therapist's checklist:

"Ok . . . breaking bread, check . . . now let us proceed with the therapy." In contrast to the latter concept, a culturally adapted PCT approach anticipates that the process of facilitating this familiarity or trust happens gradually, in a variety of ways which, research suggests, is due to the unique characteristics inherent in each client–therapist dyad (Moos & MacIntosh, 1970, Owen, Leach, et al., 2011; Truax et al., 1966).

Once this familiarity is achieved, the process mechanisms of change are hypothesized to proceed, though the therapist does not go on autopilot. The therapist's manner or way of being with the client—which resulted in their relationship reaching this point of familiarity—is assumed to continue because, according to research evidence, therapist-provided facilitative mechanisms tend to be predictably stable across time, after a slight instability during the early sessions (Gurman, 1973a; Rogers et al., 1967; Truax et al., 1966). However, the client or family may ebb and flow in their levels of trust toward and familiarity with the therapist, which substantiates the ongoing need for the therapist to adhere to the facilitative mechanisms, thereby consistently attending to the client's emerging perceptions as therapy progresses.

A concluding transcript (Rogers, 1977) demonstrates this nonjudgmental adherence to the client's perspective. Rogers exemplifies the use of Adaptation (b) in reciprocally facilitating a climate of unconditional acceptance of the client's anger, which, arguably, resulted from incongruence between the client's illness myth and that of society's:

Client: You know, [. . .] what has happened to me didn't just start when I found out that I, you know, was going to die. (T: Mmm.) Kind of thing.

Therapist: Let me see if I understand that. That you feel as though, um, what the culture and people and so on have . . . have done to you . . . that's really caused you more suffering than the leukemia. Is that what you're saying?

Client: I think so [. . .] I don't know what would have happened if I had died or if I will or whatever, but I certainly know what's happening now and what happened [. . .]

Client: And to some extent that . . . that kind of leukemia, that kind of deterioration of the body is the same kind of thing that happened to my mind [. . .]

Therapist: So really, what the culture did to you was give you a cancer of the mind.

Client: Yeah [. . .] I really . . . I think, I really want to say that [. . .] my culture [. . .] is saying that it's not all that good to be angry, you

know, because [. . .] traditionally, you know, when blacks become angry they're, they're not angry . . . they're militant. (T: Mmm.) You know what I mean (slight laughter)?

Therapist: I know. Another label [. . .] I get what you're saying and I also feel quite strongly that I want to say, "it's OK with me if you're angry here" . . .

Client: (Pause) . . . But I don't, you know . . . it's hard to know how to be angry, you know . . . hard to . . .

Therapist: Sure, sure, I'm not saying you have to be. (C: Sure). I'm just saying it's OK with me. [. . .] If you feel like being angry, you can be angry.

Client: You really believe that?

Therapist: Damn right.

Client: (12 second pause.) Well. (15 second pause.) (Sigh.) I'm not sure how to respond to that at all, you know, because a part of that anger is, you know, the . . . the hurt, and maybe if I'm . . . maybe what's happening is that if I'm . . . if I become angry and I really let it hang out, that I really will see how hurt I am [. . .]

Therapist: Perhaps at a deeper level you're afraid of the hurt that you may experience if you let yourself experience the anger. [. . .]

Client: [agreeing] (Small laugh. Pause.) Um, whew . . . (Pause.) I keep getting these blocks, you know . . . these, you know . . . when I come to something like that, you know, because, you know, to me that's a revelation and I'm not really sure that, uh, risking being angry I guess . . . (T: Mmm.) or something like that, you know [. . .]

Therapist: I really do get that . . . that this . . . this realization that, "Maybe what I'm most afraid of is the hurt that I might experience," um, makes you more cautious about whether you should, whether you should or could really let go of the . . . of the anger (Rogers, 1977, pp. 86-89).

Conclusion

If a therapist can be a person that possesses a genuine and accepting way of being, then he or she will likely move toward providing these person-centered, culturally adapted facilitative mechanisms of change for the client or family. If the MC client or family perceives these mechanisms to be a genuine aspect of the therapist's way of being, then trust and familiarity will likely occur, resulting in a process of change to occur, which is hypothesized to resemble the process mechanisms. Though these mechanisms are not a magic bullet,

they are sufficient for this process of change to occur both during and beyond therapy. The client or family may return to therapy someday, or these therapy experiences may have been sufficient to continue a process of "becoming" for the rest of their lives. Ultimately, in the process of becoming one's own person, or in becoming "their own family," so to speak, the client may choose the family, and the family may choose its members, but this valuing process lies beyond the scope of the therapist's personal and clinical judgments. Rather, this process emerges from within the client.

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Bio

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