JOURNAL OF PERSONALITY ASSESSMENT
2016, VOL. 98, NO. 6, 576–584
http://dx.doi.org/10.1080/00223891.2016.1178128

Routledge
Taylor & Francis Group

SPECIAL SECTION: CULTURAL CONSIDERATIONS IN COLLABORATIVE AND THERAPEUTIC ASSESSMENT

Family Traditions, Cultural Values, and the Clinician's Countertransference: Therapeutic Assessment of a Young Sicilian Woman

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ABSTRACT

Despite recent advances in models and instruments to understand the role of a client's cultural background, clinical psychologists are not immune to implicit cultural biases that are potentially damaging to the therapeutic alliance. In this article, I present a Therapeutic Assessment with a young Sicilian woman conducted in a university-based student clinic in Italy. During the assessment, I assumed that because we were both Italians, my client shared my perspective (northern Italian) about family and individual values, which resulted in a therapeutic impasse when I responded on the basis of my individual and culturally shaped view of interpersonal and family relationships without appreciating important differences between my own and my client's microcultures. To overcome the impasse, I had to openly acknowledge such differences and reorient myself to my client's goals. I discuss the core processes involved in such a repair in the context of a cross-cultural psychological assessment.

ARTICLE HISTORY
Received 3 August 2015
Revised 1 March 2016

Macroculture and *microculture* are widely used terms indicating, respectively, the shared cultural perspective of a large (dominant) group in a given society, and the shared cultural perspectives of smaller (minority) groups within the same society (Neuliep, 2012). The terms are also used to differentiate the common overarching culture of a given nation and the way the shared core values of that culture are mediated by specific subgroups (microcultures) and interpreted differently within them (Banks & Banks, 2008). Microcultures might include different types of groups, such as ethnic groups, religious groups, people with disabilities, or women. Microcultures are a result of the different historical paths followed by groups within the same nation.

The wide diffusion of these and similar terms in various fields of the social sciences underscores the importance of the concept of culture and its nuances for understanding interpersonal relationships (Berry, Poortinga, Segall, & Dasen, 2002; Clauss-Ehlers, 2010; Mercer, 2011). In the field of clinical psychology in particular, the increased awareness of the role of the client's and the clinician's cultural backgrounds in shaping the therapeutic relationship and its phenomena (i.e., countertransference, projections, etc.) has led to the development of culturally informed theoretical models (i.e., Berry, 1990) and culturally informed methods of psychological assessment (Dana, 2000) and intervention (i.e., Sue & Sue, 2003). In 2002, the Council of Representatives of the American Psychological Association approved the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (American Psychological Association, 2003). The document was intended to provide psychologists with "the rationale and need for addressing multiculturalism and diversity in education, training, research, practice, and organizational change; … references to enhance on-going education, training, research, practice, and organizational change methodologies; and … paradigms that broaden the purview of psychology as a profession" (American Psychological Association, 2003, p. 1). The guidelines state the importance of psychologists recognizing their own cultural heritage in influencing their perceptions of and interactions with individuals who are ethnically and racially different from themselves (Guideline 1), and of acknowledging multicultural sensitivity, knowledge, and understanding about other cultures (Guideline 2). They also address the application of multiculturalism in education and training (Guideline 3), research (Guideline 4), clinical practice and other applied psychological practices (Guideline 5), and organizational change (Guideline 6).

Increased awareness about the relevance of the differences in the individuals' cultural background has helped psychologists appreciate that our view of the world is related to specific cultural beliefs and values that are equally as relevant as those of our clients even though they might differ. One effective way of managing this situation in the therapeutic context was the development of theoretical and clinical instruments to understand and intervene with specific cultural groups (Carbral & Smith, 2011; Costantino et al., 2012). In the field of psychological assessment, for example, the evaluation of clients from different cultural backgrounds has been enhanced by using culturally sensitive instruments and by framing the assessment results within concepts such as *acculturation strategies* and *ethnic identity* (Dana, 2000). However, such concepts and

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instruments are often developed to address the problems encountered by clinicians working with immigrant clients or clients from cultural minorities, where the differences between the clinician and the client are often quite profound. Less theoretical or practical tools have been created to address the more nuanced and subtle cultural differences existing between members of different microcultures within a shared macroculture. Also, no theoretical model or therapeutic method of intervention in and of itself can ensure that the psychologist will be able to maintain a respectful position toward the clients' different ways of thinking, feeling, and living, and from that position initiate and carry on a therapeutic dialogue (Sue et al., 2007). Even outside the field of multicultural and cross-cultural studies, the difficulties of working therapeutically without assuming that our point of view holds an absolute truth has been stressed by various authors in the systemic, intersubjective, and narrative fields (i.e., Anderson & Goolishian, 1992). For example, among family systems theorists within the Milan school of family therapy, Cecchin (2004) described how insidious the risk for therapists is of assuming the role of teachers or moralists with our clients. This means that instead of keeping alive our curiosity to understand how and why our clients live their lives in ways that we consider problematic, we run the risk of telling them what to do and what they do wrong on the basis of our view of various matters.

Despite the years of training we receive, and the cultural awareness or postmodern thinking we use in therapeutic endeavors, there always remains the risk of falling into the trap of trying to "change" our clients on the basis of our personal and culturally bound beliefs, values, and preferences. This trap becomes especially tempting when clients struggle with issues that hold a strong personal meaning for us and thus activate countertransference dynamics, which can result in a therapeutic impasse. In such cases, we can work through such an impasse by reflecting on our role in creating it. Further, we are aided in addressing the impasse when we are working within a therapeutic approach or model that stresses respect for the client's unique self-narrative and is built on collaborative processes between the clinician and the client to define the goals and tasks of the therapeutic process that align with the client's values and beliefs (Horvath & Greenberg, 1994).

Therapeutic Assessment (TA; Finn, 2007) represents a model of brief psychological intervention that is well suited for working therapeutically with clients who trigger the therapist's desire to change them in predetermined ways based on differing cultural and personal beliefs. TA focuses on the collaboration with clients, the respect of their narratives about themselves and the world, the focus on clients' goals, and the attention to scaffolding clients' new understanding about their difficulties, while respecting their pace in making therapeutic changes (Finn, 2009). Therefore, working within the TA theoretical and clinical framework could help clinicians avoid the risks and pitfalls of presuming to know the truth about their clients' difficulties and about the best ways to solve their problems.

The TA of Maria illustrates some of the traps a clinician can encounter in working with a client whose cultural background is different from the clinician's in ways that are not immediately apparent and who is struggling with issues that activate strong countertransference reactions in the clinician. In the case presentation, I discuss potential solutions to a therapeutic impasse based on the clinician's individual and cultural background and how working within the TA model facilitated repair.

The therapeutic assessment of Maria

Presenting issues and assessment question

Maria was a young woman 22 years of age from Enna, Sicily, in southern Italy. At the time of the assessment she resided in Milan, a large city in northern Italy, where she was completing an undergraduate degree in philosophy. When I first met Maria, relevant cultural differences that might exist between us were not in the forefront of my mind, even though I came from a northern Italian family and she was from a southern Italian family. I had been to Sicily for vacation and my memories of the region were of its beautiful natural areas, delicious food, and very welcoming people. None of my memories, however, would be of real importance to the psychological consultation we were about to undertake, apart from serving as the topic of our opening conversation. In retrospect, the first mistake I made in my work with Maria was assuming that our cultural background was more or less similar.

Maria was self-referred to the Counseling Service for University Students at the Università Cattolica del Sacro Cuore (Milan, Italy) where I served as coordinator, and where, over the previous 2 years, I had enjoyed working with university students, who seem to benefit a great deal from brief psychological consultations. Maria was suffering from a severe lack of self-confidence. She told me that the numerous oral exams that her philosophy courses entailed were a horrible experience for her. On each occasion she felt extremely anxious, even if she was well prepared. The consequence was that, in the best scenario, she would stutter throughout the exam and receive a lower grade than she felt she deserved. In the worst scenario, she would go blank after the professor's first question and fail the exam.

I began a TA with Maria, which is the typical practice in the Counseling Service with university students who are provided brief psychological consultations. Maria's main question for the assessment was, "How can I become more self-confident?"

From the outset, Maria's difficulties strongly triggered my caregiving system, making me feel the desire to help her, support her, and even save her, as I shall explain in more detail. In fact, when I was a university student, no small part of my self-esteem was based on my ability to be successful during exams. I really felt for Maria not being able to do this and imagined what it would have meant for me. I really wanted to help her to feel better about herself.

I started to collect some background information about her assessment question and my caregiving feelings toward her grew even stronger. Maria disclosed that her lack of self-confidence was making her life hard in many ways. For example, in Milan she was sharing an apartment with a girlfriend and often took care of the household chores that her roommate "forgot" to do. Of course, Maria felt absolutely incapable of talking with

her friend about this. Also, her lack of self-confidence limited her to the point that she was not even able to enter a coffee bar and order a coffee, or to ask a waiter at the restaurant to bring more water when it was finished. She always had to rely on friends to do these very simple, everyday life activities.

Maria's testing

The only standardized test I used with Maria was the Minnesota Multiphasic Personality Inventory–2 Restructured Form (MMPI–2–RF; Ben-Porath & Tellegen, 2008/2011) in the second session of the consultation. Among her most significant test scores were low self-esteem (SFD = 67), a high sense of inefficacy (NFC = 77), and signs of an inability to express anger and be assertive with others (AGG = 43, IPP = 69, AGGR-r = 36). Another interesting result was on the Family Problems (FML) scale, which showed the lowest possible score of 39. Maria had not reported any kind of familial discord whatsoever. This was particularly striking to me when, in conducting an extended inquiry into some of her MMPI–2–RF critical items, she started to tell me about her family.

There was one episode in particular that deeply challenged my capacity to contain my reactions. Maria told me that when she was 17, she had been in a romantic relationship with a young man for 4 years, but at one point she kissed someone else. Although she was unsure whether she should have ended the relationship with her long-term boyfriend, she decided she still wanted to be with him. The other young man told the boyfriend about the kiss and the boyfriend told all their friends at school, as well as Maria's parents. The consequence was that many of their common friends (and apparently some teachers as well) began to treat Maria in a very cold, if not hostile, way. Maria's parents also were very angry with her, especially her father, who nearly decided not to show up to her 18th birthday party as previously planned. While telling me about this episode, Maria was a bit critical about her peers' reaction but not at all about her parents' reaction. In fact, she thought that her parents had the right to be angry with her given the way she had misbehaved.

Maria also told me that when she was at home, her mother asked her to do many household chores, and if she did not do them immediately after the request, her mother started a never-ending litany of complaints about her, until Maria would finally obey. Her mother could go so far as to lock Maria in the house until she had done the chores. Arguing with her mother about anything would have meant several days of hostile silence, or complaints and victimization on her mother's part. While talking about this, my impression was that Maria's feelings were mainly of helplessness, not frustration or anger, as I would have expected, or wished for her.

Last, Maria disclosed that her mother had open access to her e-mail account and used it to check all her e-mails and communications from the university, to buy her the flight tickets to go back and forth from Milan to Sicily, and so on. Again, while talking about this arrangement Maria did not show signs of frustration or uneasiness as I would have expected from a college-aged young woman.

Therapist countertransference and the therapeutic impasse

While hearing all this information, I progressively began to feel, without noticing it, a desire to save Maria from her own family. I was seeing her as a victim and her parents as the perpetrators, while I was taking the role of the rescuer. I also began to look at her as if she were in some way defective, and I felt compelled to teach her what she was missing; that is, the capability to be assertive and angry.

In retrospect it is clear to me that this impulse was coming from my own cultural and individual perspective on family relationships. As an Italian, my family of origin had and still has a central importance in my life. From an early age, though, my family supported me in traveling and having experiences abroad. They never wanted or tried to be involved in my romantic life, and I was always given complete privacy and independence regarding e-mails, telephone calls, personal space, and so on. I am very similar to many women of my generation who grew up in Milan, Lombardy, in northern Italy. Also, as a person I can at times struggle with accepting being dependent on others. For example, I rarely delegate to others what I can do myself, both at work and in my private life.

Thus, in my mind, Maria was maintaining an excessive, pathologically dependent relationship with her parents, and my reaction was to focus my work on helping her become more independent from them. I was confident that this would help her to improve her assertiveness in general. In my mind, Maria's psychological dependency on her family had become the primary problem to be targeted.

In the first phase of the consultation, the problem in my case conceptualization was that I was thinking and acting on the basis of strong countertransference feelings emanating from my cultural background and personal history. I was not taking into account any cultural difference that might exist between Maria and me, nor was I aware of the extent to which Maria's struggles were activating thoughts and emotions related to my own struggles. In other words, I was not giving the necessary importance to Maria's narrative of how family relationships should work. Instead I was trying to impose my own.

I began to act as if I had to rescue Maria from a persecutor; therefore, I initially tried to gently challenge the idea that it was okay for her parents to behave in this or that way. Maria was kindly considering my gentle inputs, but my attempts to free her were completely useless. For example, I suggested she could consider changing the password on her e-mail account, and it seemed she did consider doing it, but of course she did not. As I came to understand later, she did not feel this was a priority for her. At this point, I was beginning to feel at an impasse with Maria.

Overcoming the impasse

I had just started to think about asking for clinical supervision to understand what was going wrong in this consultation when a fortuitous coincidence helped me reflect on my cultural and personal assumptions in working with Maria. In the middle of Maria's TA, another Sicilian young woman came to the counseling service seeking consultation. She was having different problems than Maria's but shared some episodes regarding

her family that were incredibly similar to Maria's. For example, she had basically the same experience betraying her boyfriend and experiencing her parents' anger after they learned (from him) what had happened. She also felt this was completely understandable and fair. As a result, I started to wonder if there was something I was missing in my understanding of the world of these young Sicilian women.

I superficially knew, as did every Italian who studied Italian history in school, that Italy is a relatively young nation compared to other European ones, made up of various regions that experienced very different cultural influences in the course of history. These influences produced lingering cultural differences, even after the unification of Italy in 1861. Whereas in the north of Italy the Franks and Austrians transferred their social organization, promoted industrialization, and favored the presence of an educated, organized, and active bourgeoisie, Spanish influences in the south promoted an extensive agricultural model in which the nobility and a nonentrepreneurial aristocracy were taking advantage of the majority of the population working as small farmers (Blok, 1966; Cafiero, 2002; Große &Trautmann 1997; Mastronardi, Marascio, & Pizzi, 2007). The Sicilian population, as other southern Italian populations, historically suffered from lack of infrastructures, welfare services, and reduced access to education (Ginsborg, 2005; Romano, 2005). Such differences persisted long after the unification of Italy.

As I mentioned earlier, I was not aware that the different historical paths might mean, even today, that significant cultural differences existed between a Sicilian young woman and me in terms of family relationships and values. What I came to know after the case was completed is that in the Sicilian socioeconomic context (i.e., in a less mobile society, rooted in agriculture, less educated, lacking support from the central government for individual needs, and with fewer available economic resources), family came to represent a central source of support (Wakenhut & Gallenmueller-Roschmann, 2001) characteristically different from that commonly found in northern Italy. The available literature underscores how, in the 1990s, southern families were still larger, with more children, more religious marriages, fewer divorces, and organized around more traditional gender roles, authoritarian parental styles, and patriarchal structure, compared to northern Italian families (Galasso, 1997). In particular, in Sicilian culture the value of honor and the concept of familism have often been described as central aspects of the local culture. *Honor* could be defined as the assignment of value by the group a person belongs to (Fazio, 2004). Anthropologists in the 1960s still depicted a picture of Sicilian families in which rigorous codes of honor and shame were strictly observed and women's sexual mores in particular were scrutinized (Fazio, 2004). *Familism* is defined as an outlook that binds individuals to their families (Wakenhut & Gallenmueller-Roschmann, 2001). In other words, individuals show and devote higher fidelity and commitment to family rules and family well-being than to external (i.e., social, state, laws) dues and norms, and families supply most of the material, emotional, and social resources to their members. Individuals pay particular attention to being obedient to and to honoring parents and elders, and are prone to limited actions, inclinations, and impulses that might have a negative impact on them (Di Maria, Di Stefano, & Falgares, 2007).

For Maria, taking into account the impact of such cultural aspects in her psychological and family functioning could have meant reframing her commitment to her family demands for being an "honorable" woman and her acceptance of her parents' control over various aspects of her life as culturally appropriate. If I had been aware of this information at the beginning of the assessment, I could have more carefully interpreted Maria's relationship with her family. Despite this, the pull I felt to consider Maria and me as belonging to the same culture might have still been strong; humans tend to accentuate similarities with individuals who we perceive as belonging to our social group based on a salient social category (Turner, Oakes, Haslam, & McGarty, 1994).

At the point in the assessment where I felt at an impasse with Maria, however, I was unable to fill in my knowledge gap about the characteristics of Italian microcultures. I started to wonder, though, if I was excessively pathologizing my client's relationship with her family on the basis of the few episodes she shared. Was it possible that she was just taking a culturally appropriate role as girl and daughter in the Sicilian culture, or at least in the Sicilian community she came from? I realized it was hard for me to simply answer, "Yes." My difficulties in completely endorsing such a hypothesis were in part related to my clinical judgment. That is, a part of me was still thinking that Maria and her family could have elaborated in a unique way the Sicilian traditional cultural values within the context of their personal and family history. In other words, I still considered the possibility that Maria's family-specific way of enacting such values could have resulted in more rigid positions within her family, compared to what would be found in other families in the same community. I also realized that it was particularly hard for me to consider the cultural appropriateness hypothesis because of my desire to "teach" my client how to become more independent from her family, an issue that had a strong personal meaning for me and was activating strong emotional reactions.

Even though such realizations did not give me immediate solutions for my impasse with Maria, they greatly helped me to stop seeing Maria's family as her persecutor and trying to rescue her from them. I had just started to consider the possibility that there was a relevant cultural component in Maria's relationship with her family and to be aware of the importance of my countertransference issues. From that point, I was able to shift to a position where my goal was to try to open a dialogue between my view of a healthy woman and hers, albeit with my countertransference challenges still in place. Until then, I had hoped Maria would understand the truth of my point of view. Metaphorically speaking, instead of helping her to find her voice, I had tried to make her speak my words.

Getting back to TA theoretical and methodological principles

In shifting to this new position, it was fundamental to get back to TA theoretical and methodological principles. In the fourth session of the consultation with Maria, I had come to the TA step called the assessment intervention session (Finn, 2007), a step where the main goal is to give the client an occasion for experiential learning. The assessment intervention session is based on several steps that have been described in detail

elsewhere (Aschieri, Fantini, & Smith, 2016; Finn, 2007). The first step for the clinician is to formulate a clear case conceptualization. Then, the clinician selects a focus for the session; that is, an aspect of the client's problem behaviors he or she wants to work on. This could be either directly or indirectly connected to one of the client's assessment questions. Depending on the choice of the target, the clinician decides how best to elicit the problem behavior in the room. This often includes the use of test materials in nonstandardized ways or other techniques, such as role plays or the empty chair technique. In the next step, after the problem manifests in the room, the clinician and the client observe and analyze its phenomenology together: What are the factors maintaining it? What are the contextual elements that make it easier to manage? In this way it is often possible to come to a new understanding of the client's problems and to coconstruct a new narrative about them. Finally, in some cases, on the basis of what has been learned from the previous steps, the clinician and the client can think together about which solutions the client could adopt to cope more successfully in his or her everyday life with the targeted problem.

In designing and conducting a successful intervention session (and more in general a successful TA), it is fundamental to (a) maintain the focus on the clients' goals; (b) support clients in integrating the new understandings, while respecting their pace in changing the old narrative about themselves and their problems; and (c) maintain a collaborative style of communication based on clinicians constantly asking the clients' input in understanding what is happening in the session. As I illustrate in the following paragraph, such TA principles can successfully guide clinicians in conducting a therapeutic intervention that is cross-cultural in nature. In fact, assessment intervention sessions require the clinician to hold a respectful position toward clients' individual, as well as culturally shaped, narratives and to be constantly aware of one's countertransference. In this way clinicians avoid behaviors driven by a desire to force clients to adhere to our narrative of a healthy individual.

1. Case formulation

Going into the assessment intervention session, the central features of my case formulation were as follows: Maria was dissociating[1] anger and assertiveness (Aschieri et al., 2016). That is, while growing she learned that displaying such aspects of her psychological functioning would have been likely to receive negative responses from her attachment figures and other important people in her environment. In her upbringing, she had many experiences of being punished or ashamed for striving to assertively get what she wanted (e.g., in everyday family life, in romantic relationships). Therefore, as a young woman, she ended up not being in contact with such important aspects of her emotional world and was instead prone to feel intense shame in interpersonal situations where she had to actively negotiate with others for what she wanted (e.g., ordering a coffee in a coffee shop, negotiating a certain behavior from a friend, answering a professor's questions properly to get the grade she felt she deserved even if the professor was not very nice to her). There was clearly a cultural component in the way she had been socialized to be an obedient and respectful young woman and daughter. Nevertheless, moving to another town and meeting other young men and women coming from other parts of Italy and other cultural contexts made it necessary for her to be more assertive, independent, and strong to be successful in her new responsibilities (i.e., university exams, cohabitation with other university students, managing everyday tasks without the support of the strong network of her hometown community). This new context challenged the adaptiveness of core aspects of her individually and culturally shaped identity. That is, her identity of a quiet and respectful young woman, who would not get into conflict with others and especially would be compliant with authority figures, was not helping her to obtain the collaboration of her housemate in household chores as she desired, or to negotiate with the professors concerning grades or the conditions of her exams.

2. Choose a target related to the client's goals

In choosing a target for the assessment intervention session, I decided to explore what was blocking Maria from expressing a bit more anger and assertiveness in situations where this would have helped her to achieve her goals. I planned to role play situations that were difficult for her to manage and reflect on what was happening so that she could gain more insight about her difficulties. From there we could start to look for possible solutions. Because I had previously decided on the behavioral goals to pursue on the basis of my individual and cultural point of view and had failed (i.e., assertiveness within her family), for this session I made sure to focus on what was important for Maria. This is an exchange we had on this issue:

> FF (author): [Talking about changing the password of her e-mail account] Is it possible that a part of you thinks this is not important?
>
> Maria: Not that it is not important … but maybe it's not a priority. Maybe I think I have to do it because it's right, but I can do it later instead of now …
>
> FF: Let's think, … I wonder what other occasions or contexts you feel you could run experiments about making your voice heard by the others? Experiments of sticking to your point, setting limits and so on. Experiments not quite so big as the exams but important enough for you; things that you feel are hard to do now and are more important to you than changing your e-mail account password. I mentioned the password, but I'm different from you. Maybe in your situation I would have felt this was important, but you don't and that's perfectly okay. There isn't just one criterion of importance. I wonder if there are other situations that could be considered occasions to train yourself that are easier to manage than the exams …
>
> M: For example, telling the girl I live with that I don't like things she does—things that have to do with us living together?
>
> FF: Yes.

After I acknowledged that my point of view on her problems was relative, Maria felt free to identify and express which

[1] Readers coming from a psychoanalytic background might wonder why the term *dissociation* is used here instead of the more traditional concepts of repression and denial. I refer the reader to various chapters and articles by Allan Schore (e.g., Schore, 2009a, 2009b). Schore explained how a whole new body of neuropsychological, developmental, and trauma research supports the conclusion that most early-forming strategies for avoiding or minimizing painful affect states are due to dissociation, a natural result of disintegration of the right brain, rather than to later forming repression, which is associated with "left-hemispheric inhibition of affects generated by the right brain" (Schore, 2009b, p. 115). Bromberg (2006), Van der Kolk, van der Hart, and Marmar (1996), and other experts share this conclusion.

problem was a more salient for her—a problem that we could start to work on together.

3. Re-create the problem

With the goal of creating an experience that would help Maria reach more insight in her difficulties, I asked her to role play a situation that was difficult for her to manage involving the girl with whom she was living. My goal was to structure this experience as a collaborative effort to build a shared understanding of Maria's struggles. Previously, I had failed in telling Maria what to do by taking a one-up position based on my individual and cultural point of view. Now, my goal was instead to support her while we explored her difficulties together. I was again curious and open to learning more from my client.

M: For example—a small thing—1 week ago she hand-washed a pullover and left the bottle of the detergent on the sink for a week. The closet where we keep the detergent is right beside the sink … what's the problem?

FF: Okay, let's think about what you could tell her.

M: I don't know, when such things happen, I think that I have to tell her something, but I can't …

FF: Let's try together, first let's think about what to do and then we can try together, I'll be you and you can act out the worst possible scenario that could happen with your friend and then we'll switch roles.

M: Okay.
[We tried the role play]

M: No, I can't …

FF: Why not?

M: I don't know … I'm embarrassed in front of you, too.

As Maria and I moved toward acting out anger, shame was activated. In TA, special attention is given to clients' shame because its emergence hinders the reintegration of previously dissociated affect states (Aschieri et al., 2016; Finn, 2014). There are several techniques that clinicians can use to help reduce clients' shame. One of them is providing clients with a more accurate and compassionate narrative about their problems. Such a new narrative often highlights how the clients' problems and symptoms are the result of an effective adaptation to an early childhood or adolescent environment where the dissociated affect state was not acceptable. Dissociation was therefore necessary for the clients' survival (Aschieri et al., 2016).

4. Observe the problem

When the problem manifested and shame was activated, we began to observe it together and try to understand more about it. The framework continued to be collaborative. I was curious about Maria's experience of her difficulties and asked her to give inputs so that we could reach a common goal, understanding more about her problem. In this phase, whatever individual or cultural differences existed between Maria and me, they were the targets of a conjoint observation.

FF: Okay, good! What is making you feel embarrassed?

M: I don't know …

FF: What is making you feel embarrassed here and now?

M: I feel that I'm being watched
…

M: If you touch my cheeks now they are burning, I feel … not as much as if I was in the real situation, but … I shouldn't feel like this …. I always have this experience. What I am actually able to do is much less than what I want to do. I'm aware of the things you're telling me and I agree, but when I have to act …

FF: That's why I wanted to try it here, but it's difficult to do it here, too.

M: Yes.

FF: And since we are in a safer context, let's try to explore together what makes it so difficult to do it here. It's a smaller goal. It's okay. That's great; we start from where it's possible to start … What makes it so difficult to try this experiment here with me?

M: I feel stupid.

FF: What makes you feel stupid?

M: I don't know … doing these little scenes … because I keep on thinking about what's going to happen in the real situation. How is it possible that I have such difficulties in doing these things that should be natural?

FF: How do you answer this question?

M: I don't know. I really don't understand it … because if I think about my friends who live with other girls, I see them when they tell the other girl that there's a problem. Looking at them, it doesn't seem so difficult.

FF: If you think about your history, why do you have such great difficulty doing this?

M: Because I don't feel self-confident; just a few words are enough to make me back off, and since I'm not confident … not that I'm not confident but I constantly have doubts about myself …

FF: Where did you learn to doubt yourself?

M: I don't know, maybe because I never had anything or anybody helping me grow stronger.

FF: Was there a person in your life standing beside you and constantly sending you messages like, "Good, great, that's perfectly okay"; "Tell me more about how you're feeling, I'm really interested, good"; "Wow! You're able to do that"; "Are you sad? Tell me more"; "Are you angry? I understand this might be frustrating, I'm sorry but …"?

M: You. Really, nobody else … [long silence] … but why? … I mean, is it because there's something wrong with me? I think that everybody receives a little bit of that during their life.

FF: This is what happens—that you feel there's something wrong with you. Why? Because, especially when you were younger, it was hard to be able to reach the awareness that the adults near you have their own personal difficulties that prevented them from being able to support you as you needed.

M: In fact, I always feel judged, even if the others are not even thinking about me, because … yes … I feel there's something wrong with me.

While exploring her difficulties together and addressing her shame and its causes, Maria and I could work on one of her core pathogenic beliefs: the belief of being fundamentally flawed because of her problems, despite having had a perfect nurturing environment to grow in (Weiss, 1993). Contextualizing the origin of her difficulties helped her find more compassion for herself and her problems in living.

The end of the TA

After the assessment intervention session, Maria and I started developing the metaphor of "training." We discussed how the context she lived in did not train her to be able to make her voice heard as much as she felt she needed now. At the time of the TA, Maria was facing a dilemma of change: To overcome her current difficulties she would have to (metaphorically) raise her tone of voice, making it more audible to others, at the risk of re-experiencing hostile reactions or withdrawal by others. Those experiences had made the possibility of raising her voice terrifying and thus impossible. Also, she was still in part dependent on her family and context of origin, meaning that the best adaptation to her environment she had found in the past was still important for her current life. On the other hand, never raising her tone of voice would have meant not being able to reach some important personal goals (i.e., finishing university with the grades she felt she deserved).

As we started to work together on the task of trying to raise her voice in situations that she felt were priorities for her, Maria became able to make significant shifts with her peers and professors. For example, she was eventually able to negotiate with a professor the evaluation of an exam and felt very satisfied at the end. While we worked together, nothing changed in her relationship with her family as far as I know. At the end of the TA, she said that what really helped her was understanding that she had a lack of "training" in raising her voice, when she previously thought she was born without this capacity. This seemed to significantly reduce her shame and open her up to the possibility of exploring new ways of being.

Conclusions

When we work as clinicians, it is hard to balance the expert role attributed to us by a context in which the clients are paying us to solve their problems and the need to be aware of the limitations of our knowledge and the influences of our own cultural and personal backgrounds and current contexts. Such limitations become apparent when we acknowledge that neither our clients nor we can be objective observers of a clinical situation, but we both contribute to creating what happens in the sessions by acting and interacting on the basis of our individual and culturally shaped point of view. Also, with clients who activate strong countertransference reactions, because they are struggling with issues that hold a relevant personal meaning for us, this becomes even more challenging. In such clinical situations, our capacity to reflect on our own assumptions and relative position in the clinician–client system is essential. Further, it is fundamental to rely on a therapeutic model of intervention that limits the possibility of assuming a one-up position with our client.

TA is well suited to this kind of clinical situation due to several features of the model. First, in TA, clinicians attempt to involve clients as collaborators throughout the process. This begins with selecting the goals of the assessment and continues by inviting the client to give personal context to test scores and assessment events. To participate in a truly collaborative process, clinicians are in many ways forced to step outside of the expert role and acknowledge their clients' expertise in coconstructing what is going to be therapeutic for them. In this way, clients' individual as well as cultural inputs become an important part of the process and clinicians learn to be open and to keep their curiosity alive, instead of falling into a teacher or moralist role (Cecchin, 2004).

Second, the entire TA process is focused on the client's goals. The assessment questions collected in the first session become the framework of the TA, and each of the clinician's choices (from selecting which tests to use to planning the intervention session and the feedback) should be related to those goals. This becomes an especially important aspect of the therapeutic work when individual or cultural differences between clinicians and clients would tempt the clinician to use his or her own criteria of importance in choosing other goals to pursue and imposing some other cultural representation of health on the client. In these clinical situations, the risk of the clinician acting from an ethnocentric or self-centered point of view is high. Therefore, maintaining the focus on the client's goals is a way to respect what the client feels is important and what she or he is open to changing, based on their personality features as well as by their cultural backgrounds.

Third, in TA, the client's narrative about the self and the world assumes a high relevance, as does the goal of understanding his or her narrative and scaffolding the new understandings. This is done by maintaining a balance between the clinician's input and respect for the client's pace in integrating new information. Such balance is of the utmost importance when the client's narrative is created on the basis of cultural backgrounds different from that of the clinician. Again, striving for ongoing collaboration with the client furthers this goal because the client can be explicitly asked to teach the clinician about his or her culture, or more implicitly, the client is given the opportunity to colead the process at his or her pace. This also means that therapeutic impasses are viewed as occasions for clinicians to reflect on their own role in creating the impasse, not simply viewing them as manifestations of client resistance.

Fourth, one of the aims of TA is to reduce clients' shame, which is often prominent in clients from nondominant cultures (Finn, 2013). In Maria's case, the presence of shame might be seen both as a by-product of her psychological functioning, characterized by dissociation of anger and assertiveness, and as a consequence of her feeling different from her new friends and colleagues, as well as from the clinician, each of whom were from other cultural backgrounds. This dynamic was difficult to detect early in the TA because my sense of belonging to the same overarching Italian culture shaded the importance of the microcultural differences existing between Maria and I and many of her new colleagues. In TA, reducing clients' shame, while highlighting their dilemmas of change and creating alongside them new narratives, opens up new behavioral possibilities. These new possibilities are not defined a priori by the clinician. Instead, they are cocreated and adopted by the clients and often reflect a (individually experienced) balance between the novelty (e.g., for Maria new ways of managing conflicts and showing assertiveness) and maintaining coherency (e.g., still behaving

as respectful and "honorable" in front of her parents) with the clients' cultural framework.

In conclusion, this case presentation illustrates how the use of the theoretical and methodological principles of TA can help clinicians avoid the risks of endorsing an ethnocentric or self-centered attitude in conducting a cross-cultural psychological consultation, even when the cultural differences are not immediately apparent, as is true with microcultural groups within the same overarching national culture. This is possible due to TA being a collaborative, client-centered therapeutic intervention that highlights the importance of the client's individually and culturally shaped narrative about themselves and the world; focuses on the client's goals in entering into a psychological consultation; and constantly involves gathering their input as the process unfolds and evolves. This, in turn, enables clients to find new ways of looking at their difficulties and identifying behavioral solutions that can be new and useful, as well as coherent to their individual and cultural background.

Besides the usefulness of this kind of work for the client, there is also the potential for it to be very valuable for the clinician; that is, the possibility to come to a deeper understanding of ourselves, of our strengths, and our potential struggles. Using Finn's (2005) words, "to do our jobs well, we must continuously confront our inner shadows" (p. 31). The TA of Maria taught me something important about my personal issues around dependence and independence, and I am confident that this will help me to be a better clinician in the next consultation in which these issues will be meaningfully involved and a more balanced individual when relating to others on such dimensions.

Acknowledgment

I am thankful to Rodan Di Maria, PhD, at the Universitá di Palermo, Italy, for sharing his expertise of traditional Sicilian social and microcultural features.

References

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *The American Psychologist*, *58*, 377.

Anderson, H., & Goolishian, H. (1992), The client is the expert: A not-knowing approach to therapy. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 25–39). London, UK: Sage.

Aschieri, F., Fantini, F., & Smith, J. D. (2016). Collaborative/Therapeutic Assessment: Procedures to enhance client outcomes. In S. Maltzman (Ed.), *The Oxford handbook of treatment processes and outcomes in psychology: A multidisciplinary, biopsychosocial approach* (pp. 241–269). New York, NY: Oxford University Press.

Banks, J. A., & Banks, C. A. (2008). *Multicultural education: Issues and perspectives* (7th ed.). Hoboken, NJ: Wiley.

Ben-Porath, Y. S., & Tellegen, A. (2011). *MMPI–2–RF (Minnesota Multiphasic Personality Inventory–2 Restructured Form): Manual for administration, scoring, and interpretation*. Minneapolis: University of Minnesota Press. (Original work published 2008)

Berry, J. W. (1990). Acculturation and adaptation: A general framework. In W. H. Holtzman & T. H. Bornemann (Eds.), *Mental health of immigrants and refugees* (pp. 90–102). Austin, TX: Hogg Foundation for Mental Health.

Berry, J. W., Poortinga, Y. H., Segall, M. H., & Dasen, P. R. (2002). *Cross-cultural psychology* (2nd ed.). New York, NY: Cambridge University Press.

Blok, A. (1966). Land reform in a west Sicilian Latifondo village: The persistence of a feudal structure. *Anthropological Quarterly*, *39*(1), 1–16.

Bromberg, P. M. (2006). *Awakening the dreamer: Clinical journeys*. Mahwah, NJ: Analytic Press.

Cafiero, S. (2002). *Questione meridionale e unità nazionale: 1861–1995* [Southern issue and national unification: 1861–1995]. Rome, Italy: Carocci.

Carbral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, *58*, 537–554.

Cecchin, G. (2004). Ci relazioniamo dunque siamo: Curiosità e trappole dell'osservatore [We relate therefore we are: Observer's curiosity and pitfalls]. *Connessioni*, *15*, 57–61.

Clauss-Ehlers, C. S. (Ed.). (2010). *Encyclopedia of cross-cultural school psychology*. New York, NY: Springer.

Costantino, G., Cardalda, E. B., Dana, R. H., Martínez, J. V., Fantini, F., Aschieri, F., & Bevilacqua, P. (2012). TEMAS (Tell-Me-A-Story) multicultural assessment in the new millennium. In R. G. Malgady (Ed.), *Cultural competence in assessment, diagnosis, and intervention with ethnic minorities: Some perspectives from psychology, social work, and education* (pp. 28–37). Sharjah, UAE: Bentham Science.

Dana, R. H. (Ed.). (2000). *Handbook of cross-cultural and multicultural personality assessment*. Mahwah, NJ: Erlbaum.

Di Maria, F., Di Stefano, G., & Falgares, G. (2007). *Psiche e Società: la Polis Siciliana tra Conservazione e Trasformazione* [Psyche and society: Sicilian polis between preservation and transformation]. Milan, Italy: Franco Angeli.

Fazio, I. (2004). The family, honour and gender in Sicily: Models and new research. *Modern Italy*, *9*, 263–280.

Finn, S. E. (2005). How psychological assessment taught me compassion and firmness. *Journal of Personality Assessment*, *84*, 29–32.

Finn, S. E. (2007). *In our clients' shoes: Theory and techniques of Therapeutic Assessment*. Mahwah, NJ: Erlbaum.

Finn, S. E. (2009). Core values in Therapeutic Assessment. Retrieved from www.therapeuticassessment.com.

Finn, S. E. (2013, June). *Live Therapeutic Assessment of an adolescent and his family*. Continuing education workshop sponsored by the European Center for Therapeutic Assessment, Milan, Italy.

Finn, S. E. (2014, March). *Working with shame in psychotherapy and psychological assessment*. Continuing education workshop sponsored by the Society for Personality Assessment, Arlington, VA.

Galasso, G. (1997). *L'Altra Europa: per un'Antropologia Storica del Mezzogiorno d'Italia* [The other Europe: Hystorical anthropology of south Italy]. Lecce, Italy: Argo.

Ginsborg, P. (2005). *L'Italia del Tempo Presente: Famiglia, Società Civile, Stato. 1980–1996* [The Italy of the present time: Family, society, state: 1980–1996]. Turin, Italy: Einaudi.

Große, E. U., & Trautmann, G. (1997). *Italien Verstehen* [Understanding Italy]. Darmstadt, Germany: Wissenschaftliche Buchgesellschaft.

Horvath, A. O., & Greenberg, L. S. (1994). *The working alliance: Theory, research, and practice*. New York, NY: Wiley.

Mastronardi, V. M., Marascio, F., & Pizzi, A. (2007). *Psicologia degli italiani del Centro-Nord: Tipi, vizi, pregi e difetti* [The psychology of north and central Italians: Types, faults, qualities and flaws]. Turin, Italy: CSE.

Mercer, B. L. (2011). Psychological assessment of children in a community mental health clinic. *Journal of Personality Assessment*, *93*, 1–6.

Neuliep, J. W. (2012). *Intercultural communication: A contextual approach*. Thousand Oaks, CA: Sage.

Romano, R. (2005). *L'Emergere di un'Economia Dualistica* [The emergence of a dualistic economy]. In M. L. Cicalese, *L'Italia delle Cento Città: dalla Dominazione Spagnola all'Unità Nazionale* [One hundred cities in Italy: From the Spanish domination to the national unification] (pp. 104–114). Milan, Italy: Franco Angeli.

Schore, A. N. (2009a). Attachment trauma and the developing right brain: Origins of pathological dissociation. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders: DSM–V and beyond* (pp. 107–141). New York, NY: Routledge.

Schore, A. N. (2009b). Right-brain affect regulation: An essential mechanism of development, trauma, dissociation, and

psychotherapy. In D. Fosha, M. Solomon, & D. Siegel (Eds.), *The healing power of emotions: Integrating relationships, body, and mind. A dialogue among scientists and clinicians* (pp. 112–144). New York, NY: Norton.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, *62*, 271–286. doi:10.1037/0003-066X.62.4.271

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). New York, NY: Wiley.

Turner, J. C., Oakes, P. J., Haslam, S. A., & McGarty, C. (1994). Self and collective: Cognition and social context. *Personality and Social Psychology Bulletin*, 20, 454–463.

Van der Kolk, B., van der Hart, O., & Marmar, C. R. (1996). Dissociation and information processing in posttraumatic stress disorder. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience of mind, body, and society* (pp. 303–327). New York, NY: Guilford.

Wakenhut, R., & Gallenmueller-Roschmann, J. (2001). *Kulturelle Identitaet: Einfuehrung und Sozialwissenschaftliche Beitraege zur Entwicklung Kultureller Identitaeten in Italien* [Cultural identity: Introduction and social science contributions about the development of a cultural identity in Italy]. In J. Gallenmueller-Roschmann, *Kulturelle Identitaeten in Italien* [Cultural identity in Italy] (pp. 11–56). Frankfurt, Germany: Peter Lang.

Weiss, J. (1993). *How psychotherapy works: Process and technique*. New York, NY: Guilford.