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Multiculturalism and Group Therapy in the United States: A Social Constructionist Perspective

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Multiculturalism encourages the inclusion of the broad range of cultural differences that exist in society into our therapeutic dialogues. This paper examines multicultural group therapy through the perspective of social constructionism. Emphasis is given to the unacknowledged and unspoken imbalance of power that exists in psychotherapeutic contexts. The concepts of multiple individual identity and cultural representation are discussed and illustrated with case examples. Clinical considerations for the multicultural group therapist are provided.

KEY WORDS: multiculturalism; group psychotherapy; privilege; social constructionism; absent standard.

Group therapy in the United States has evolved from a treatment modality that focused exclusively on individual psychodynamics (Slavson, 1950; Wolf & Schwartz, 1962) to one that also embraces the exploration of interpersonal (Leszcz, 1994; Yalom 1970), group-as-a-whole (Horwitz, 1977), and intersubjective (Cohen, 2000; Cohen & Schermer, 2001; Harwood, 1992; Harwood and Pines, 1998) dynamics. In recent years, group therapists have begun to appreciate the importance of contextual issues and their effect on group treatment. Context includes many factors, such as ecological, social, cultural, and political influences. These influences can be both current and historical (Hopper, 1996). An example of a current influence is existing Board of Education policies that label some children "at

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risk" and other children as "gifted and talented." Historical influences are the sociohistorical factors that existed at the time of a patient's development and still have an effect on the individual and the culture. Growing up as an African-American in the segregated South is an example of such an influence. Historically, the United States has held the professed belief in the inherent worth and dignity of all people, who have the right to pursue their own self-determined goals (Declaration of Independence, Bill of Rights of the U.S. Constitution). In practice, however, the road to inclusiveness for all Americans has been blocked by slavery, selective suffrage, oppression of indigenous peoples, racism, sexism, ageism, able-body-ism, homophobia, and ethnic, class, and religious discrimination. In the past fifty years, political movements and social legislation, such as the civil rights movement, the women's and gay liberation movements, and the Americans with Disabilities Act of 1990, have fought against blatant and legal discrimination in the workplace, the voting booths, in housing, and in schools. As a result, progress has been made in limiting institutionalized oppression. However, it is only through an increased awareness of the subtle forms of oppression that operate interpersonally that individuals can begin to understand the complex forces affecting their position in the world and their psychological well-being.

Toward this end, multiculturalism has developed as a social-intellectual movement that values diversity as a core principle and insists that all individuals and cultural groups be treated with respect and as equals (Flowers & Richardson, 1996). Multiculturalism encourages the inclusion in our therapeutic dialogues of the broad range of significant differences (race, gender, sexual orientation, ability and disability, religion, class, etc.) that often hinder communication and understanding among people (Sue et al., 1999).

Most individuals are unaware of contextual influences and how their identities have been formed, at least partially, by social and political forces (Hayes, 2001; Hopper, 1996). This type of awareness, however, is necessary for individuals to develop and exercise their personal agency, defined as "the realized capacity of people to act upon their world and not only to know about or give intersubjective significance to it" (Holland et al., 1998, p. 42).

STUDIES ON MULTICULTURAL GROUP THERAPY

Early studies on multicultural group therapy focused on those cultural groups that were targets of discrimination: racial minorities (Addison, 1977; Burke, 1984; Davis, 1984; Fenster, 1996; Jenkins, 1990; Smith & Gundlack, 1974), ethnic minorities (Delgato, 1983; Hynes & Werbin,1977; McKinley, 1987; Olarte & Masnik, 1985; Tylim, 1982; Werbin and Hynes, 1975), religious minorities (Silverstein, 1995), immigrants and refugees (Dunkas & Nikelly, 1975; Kinzie et al., 1988), indigenous peoples (McDonald, 1975; Wolman, 1970), social class (Heitler, 1974), elders (Lesczc, 1990; Leszcz et al., 1985; Lieberman & Gourash Bliwise, 1985),

gays and lesbians (Conlin and Smith, 1985; Frost, 1990, 1996, 1998; Hawkins, 1993; Schwartz and Hartstein, 1986), and women (Brabender, 1992; Brody, 1987; DeChant, 1996; McWilliams and Stein, 1987; Nobler, 1992).

In recent years the focus of investigation has shifted to those who unintentionally profit from racism, sexism, and homophobia and other forms of discrimination (Hayes, 2001; Matsukawa; 2001, McIntosh, 1998). Therapists are now being encouraged to pay special attention to the role of privilege, defined as the advantages one holds as a result of membership in a dominant group (McIntosh, 1998).

The overwhelming majority of psychotherapists and group therapists in the U. S. are White Euro-Americans (Hammond and Yung, 1993). Sue and colleagues (1999) observed that racial and ethnic minorities appear to be much more in touch with their racial and cultural heritage, whereas White Euro-Americans often have difficulty perceiving themselves as racial beings. It is this "invisibility of whiteness" that makes those who enjoy the advantages it confers oblivious and unaware. For these reasons, Euro-American psychotherapists are likely to have difficulty viewing themselves as advantaged and privileged and their minority counterparts as disadvantaged and marginalized (Hays, 2001; Helms, 1990; McIntosh, 1998; Robinson, 1999). In addition they are also likely to experience their worldview as normative and universal, resulting in biases in their understanding and interpretation of individual behaviors and group dynamics. Consequently, Euro-American therapists need to pay special attention to the influence of privilege on their understanding of cultural issues and hence on their work with clients in groups. Privilege, nevertheless, is a complex and multidimensional concept. Although White Euro-American therapists have to make a concerted effort to understand their own position of privilege, all therapists need to consider how the multidimensional aspects of privilege contribute to biases, gaps in their knowledge base about clients, and reenactments in their therapy groups. Hays (2001) points out that a therapist's knowledge and experience is greater in those areas in which he or she is a member of a nondominant group, but that this specific knowledge does not necessarily generalize to an understanding of the issues faced by all disadvantaged groups. For example, Hays suggests that a Euro-American lesbian therapist is likely to be more aware of subtle sexist and heterosexist biases, but the same therapist may be less aware of the array of prejudices that affect people of color, people with disabilities, or people of lower socioeconomic status, the elderly, immigrants, religious minorities, or indigenous peoples.

To bring attention to the multidimensional aspects of privilege, Hays (2001), using the acronym "ADDRESSING," provides us with a method of identifying privilege in the United States. Listing nine cultural influences, she locates positions in society where members can be privileged or disadvantaged.

Using Table I, Hays suggests that therapists go through each of the categories of privilege and put a star next to a category in which they are privileged. This exercise can be a first step in the therapist's self-exploration of the influence of culture on one's belief system and worldview. Secondly, therapists can view each

Table I. Cultural Influences and Related Privileged and Disadvantaged Groups

Cultural influences	Privileged groups	Disadvantaged groups
Age and generational differences	Between the ages of 30 and 60	Children, adolescents, elders
Developmental and Acquired Disabilities	No acquired or developmental disabilities	People with acquired or developmental disabilities
Religion and spiritual orientation	Raised in a secular or Christian home	Religious minorities
Ethnicity	Euro-American heritage	Ethnic minority cultures
Socioeconomic status	Raised in a middle or upper class family or currently middle or upper class	People of lower status by class, education, occupation, income, rural or urban habitat, family name
Sexual orientation	Heterosexual	Gay, lesbian, bisexual
Indigenous heritage	Not belonging to an Indigenous people	Indigenous people
National origin	Born or grew up in the United States	Refugees, immigrants, international students
Gender	Males	Females, transgendered people

From *Addressing cultural complexities in practice: A framework for clinicians and counselors* by Hays, P.A. (2001), Washington, D.C.: American Psychological Association. Copyright 2001 by American Psychological Association. Adapted with permission.

of their clients in relation to the same nine categories and see how any particular client may be either in a privileged or disadvantaged category. This should alert therapists to the need to educate themselves about their clients' cultures and to begin to appreciate the obstacles that some clients encounter on a daily basis. It should be emphasized that the purpose of this exercise is not to categorize individuals, but rather to generate curiosity regarding the impact of race, religion, ethnicity, and other factors on one's own identity and worldview and the identities and worldviews of clients. We must remember that the significance of cultural influences is person-specific and context-specific. The framework in Table I tells us little about how each cultural factor affects any given individual. It does, however, remind therapists to consider how these factors may influence their perceptions of clients and the resulting therapeutic interactions. It is also important for therapists to be aware of the distinction between identity constructs and oppressive practices. Robinson (1999) gives an example of a therapist who assesses a gay, working-class, Latino man with a physical disability as "having multiple oppressions." It is not the personal characteristics of the client that oppress him, if in fact the client feels oppressed, but rather the discriminatory and exclusionary practices of the society. If the therapist fails to make this distinction, she or he may see the client as an "oppressed person," and fail to see "the creative and resourceful ways in which he [the client] connects with, empowers, and is empowered by his community, cultivates his spiritual life, enjoys a fulfilling relationship with his partner, and

acknowledges and resists acts of oppression with his soul and spirit still intact" (Robinson, 1999, p. 77).

With these considerations in mind, it is the intention of the multicultural group therapist to develop an expanding cultural awareness through continuous self-exploration and multicultural education. This type of personal learning is seen as a prerequisite for developing an understanding of how complex and oppressive forces in society are socially constructed, and how these forces can limit the personal agency of clients both within our therapy groups and in their everyday lives.

A SOCIAL CONSTRUCTIONIST PERSPECTIVE ON MULTICULTURAL GROUP THERAPY

The social construction of reality is derived from the philosophical tenets of Derrida (1984) and others (Gergen, 1994) who hold that our way of being is formed by the language that is created around it. More importantly, certain voices are inevitably left out of our social constructions. Accordingly, that which we believe we know and that on which we shape our actions are products of the lens used by a limited but powerful sector of the world. Akin to the adage that "the victors write the history," socially constructed reality is seen as deriving from the perspective of the dominant groups of any society. When applied to the American context, those who are empowered to do so unconsciously shape the socially constructed reality in which we live and work.

The social constructionist view of psychotherapy holds that reality is a function of the language used to create the therapeutic exchange. From this perspective, the patients and therapists in group therapy are co-actors in the creation of the field of clinical activity. Implicit in this process is the construction of social location in the group. Based on each group member's relative perceptions of power, privilege, and capacity for personal agency, as well as the mutual projections that come to exist as members interact, an intersubjective matrix is created and sustained that may differ substantively from the issues explored in the group. The role of the therapist is key in bringing to consciousness the layer of work that social construction may play in the group dynamic, ever mindful that the therapist contributes to and is part of the reality that is being formed.

In a multicultural context, social construction is an important variable in group psychotherapy. Sampson (1993) contends that an *absent standard* is present in most therapeutic situations where the therapist and the patient are operating in a system of meaning that is imported from the larger society. Sampson (1993) developed the construct of the absent standard to describe the unseen and unspoken imbalance of power that exists in psychotherapeutic contexts. In his theory, the absent standard is one that is absent by virtue of the fact that those who possess it also have the privilege of not acknowledging its presence. This process, which is often thought to be "objectivity" by those who practice it, Sampson terms *viewlessness*.

According to Sampson, this perspective has a particular hold in the United States. He specifically identifies this American stance as part of the absent standard that includes being male, white, Christian, heterosexual, and able-bodied. This process imposes an often unconscious and unacknowledged use of norms of hierarchy and power that act to construct the shared reality in the psychotherapy. According to Sampson, much as with Hays (2001) and Robinson (1999), those who are privileged in the larger society hold the absent standard. More importantly, those who hold the standard have the privilege of denying that it is present. As her seminal article on white and male privilege suggests, McIntosh (1998) contends that the privilege of not having to view one's experiences as privileged is its own privilege. As such, therapists who may have been trained to believe in the objectivity of their own stance are complicit in using an absent cultural standard in their work.

In group psychotherapy, social construction comes through the use of an absent standard. It is through this standard that the discursive framework in which we function is set. In other words, the language or voice one has in a social context determines the reality that is constructed. Furthermore, the discursive determines one's social location in such a context, not unlike a pecking order. Those who most reflect the absent standard in a group are those who have a transformative voice and can shape the course of events. Those who less conform to the absent standard are relegated to having accommodative voice, not unlike tokenism, where their presence and contributions do little to influence the social praxis. Accordingly, a person of color or a gay member of group, in addition to whatever psychological issues they may bring, is on some level dealing with psychic imposition of the absent standard. Even in those instances where a group psychotherapist may be sensitive to such matters, the patient is apt to import this lived reality into the group. Part of determining whether the group is safe for such a member will be the degree to which he or she must work through the absent standard, which is often more visible to those outside of it than those within. Such a group member may terminate treatment prematurely and can even become a casualty of the process when the socially constructed reality is left unexamined and the absent standard is allowed to reign. The critical issue in the therapy group is whether the patient believes she or he has access to a transformative voice. If the discursive framework being used does not acknowledge that gender, race, social class, ability, and sexual orientation, etc. are at play in the group dynamic, then the voice of those who experience themselves as less privileged in any of these dimensions are likely to hold a view that they are being silenced by the process. This can be a result of a group process where intrapsychic, interpersonal and family dynamics are considered, but the sociohistorical context and larger societal praxis are not.

To fully understand the influence of contextual issues in group psychotherapy, we need to expand our understanding of the concept of *identity*. Erickson (1954) posited that identity comes through a feeling of what he termed *selfsameness*, as

well as the sharing of salient characteristics with others. In a multicultural context a greater complexity emerges due to the presence of multiple identities within the group and within each individual member. The process shifts the therapeutic boundary to a location where identity is simultaneously held: 1) as within the individual; 2) as a function of the group; and 3) as a representation of societal interaction. While this would appear to be an obvious observation, the practice of this form of systems thinking is often at odds with unexplored absent standards that permeate a psychotherapy group. Therapists may unconsciously act to create discursive frameworks that support their preferred constructions of reality. The most apparent manifestation of this process is the use of a primary theoretical orientation. By definition, any theoretical model is socially constructed and carries with it the framework and social context of the original theoreticians. What we "see" as group psychotherapists comes through the lens of this constructed framework, which may filter out key elements of the group dynamics in ways that we may not recognize. This process in a group can be particularly pernicious when the therapists do not attend to the power of representation. In hip-hop music culture, "to represent" speaks to the degree that one has not fallen prey to being co-opted by the larger society. If you are representing, you have maintained the integrity of your identity and have managed to keep yourself "real." Smith and Berg (1987) used the term in a somewhat different fashion to describe a group process where singletons in a group come to represent a salient identity group, whether they want to or not. In this way, group members who are gay, or Islamic, or Latino, or disabled become the voice of the community they represent. While this concept may seem to contradict Sampson's (1993) notion that these members do not have a transformative voice, it does not. Through this type of representation, a group member is given a voice precisely because he or she does not reflect some aspect of the absent standard. (She or he is not white, heterosexual, able-bodied, etc.) This particular member's voice is functionally restricted by the other group members, who are attempting to see his or her diverse culture through a limiting lens. The group member is left with the paradox of needing to represent a community, in the hip-hop sense, while at the same time recognizing he or she does not represent the multidimensional aspects of that same community. The implicit dominance of the other members of the group plays into the challenge of representation, as such group members who are singletons often must offer some part of their identity in order to be considered a part of the whole. All too often the part that such members are asked to offer, as well as to leave behind, is precisely what they represent. To do so means no longer to "keep it real," and thereby creates a different challenge than those personal issues that brought such a patient to group psychotherapy.

In a similar fashion, our cultural identities as group psychotherapists are also imported into our sessions with patients. When our groups are increasingly diverse, the realm of the cultural unknowns and their importance in creating the discursive framework of the group expands exponentially with each individual and

each identity present. The assumption by group members that two women who are white, Jewish, of the same educational background, and share similar experiences of abuse may find allegiance with each other may be accurate along those particular dimensions. Yet differences in social class and nationality may present sufficient divergence in how reality is constructed that there may be few parallels in their psychological resiliency or even their interpretations of experience.

Therapists should realize that each exchange in a psychotherapy group is likely to be experienced in multiple ways through the multiple identities of each individual patient. For example, if a group is working on issues of sexual orientation, a member who is a fundamentalist Christian and is in an active gay relationship may experience the exploration of this dynamic differently through the lenses of his different social identities. Within the individual there may be rejection of his homosexuality as a fundamentalist Christian and an acceptance of his homosexuality as a partner in a loving relationship. Nevertheless, there may be a relative absence of specific conflict about his experience of self. Such an experience should not be thought of as a form of fragmentation or akin to a dissociative state (DuBois, 1903). More accurately, the process is the paradoxical concurrent presence of multiple states of being. It is a temporal illusion and limitation that permits only one aspect of the self to be expressed at one time. Those who have a social location outside these expressions of identity may feel that the client's stance is contradictory and conflicted and may even act to repudiate the holding of the multiple identities in this manner. The ideal of integration, which is itself a Western and psychodynamic construction, does not take into consideration other cultural contexts where multiple identity is a given. An alternative construction allows for there to be fluidity and ambiguity in identity.

THE CHALLENGE OF INTEGRATING MULTICULTURAL PERSPECTIVES IN GROUP PSYCHOTHERAPY

The value of attending to the social construction of reality in group psychotherapy is that it provides for a greater equity of voice for patients. Those who come from cultural backgrounds different from our own are afforded the opportunity to educate fellow group members and the therapists about nuances of experience that may influence their clinical presentation. When multiculturalism is introduced as a norm of the group by the therapist, those who may otherwise silence their "differences" are invited to find ways to share them.

The challenge of integrating socially constructed perspectives into group psychotherapy is noteworthy. The most important and perhaps the most difficult issue to address in a therapy group is the self-sealing nature of the dominant philosophical orientation. By taking the position that reality is socially constructed, group participants are encouraged to question any implied perspective that is seen as

dominant or oppressive to a marginalized member or subgroup. When patients construct an alternative reality, it also suggests that some standard that we use as therapists is being put to the test. As group psychotherapists, we are placed in the precarious position of being arbiters of a potential array of socially constructed realities that are brought to life over the course of treatment. Accordingly, group therapists must hold on to a therapeutic culture, ever vigilant to the clinical implications of what is being presented, while concurrently allowing the opportunity for differing perspectives to emerge.

The following case example illustrates how an empathic rupture can occur when cultural issues are not addressed.

In an ongoing psychotherapy group, Carlos has been an active member for two years. He entered the group, composed of a number of professionals in their 30s and 40s, to examine issues he experiences in intimate relationships. As a child of Cuban immigrants, Carlos is the only "person of color" in the group, although he has never raised this as a concern. During a particular session, while lamenting the break-up of his most recent relationship, he commented, "If not for the closeness of my family, I do not think I could endure this pain again." A female member who had been in the group as long as Carlos then suggested, "Maybe it is because of your closeness to your family that you never really let yourself commit to anyone. You always seem to run back to them." At that moment Carlos bristled in a way that he had not before in the group. "My family is not the problem," he said behind angry tears, "I am the problem. They have done nothing but love me. And what I do to show this love is try to find women like you who want to take me away from them." Another woman in the group then confirmed, "I can see this is painful for you, but if you as a grown man can't stand up to your family I would not have anything to do with you." Carlos then mumbled something in Spanish and fell silent. The group psychotherapist then spoke to Carlos with great empathy about his anger and his pain. Carlos turned the therapist and simply said, "I now see you don't get it either."

In this case example, clinical issues are interwoven with cultural issues. The decision by the therapist is to allow the group to focus solely on the clinical dynamic related to separation-individuation while ignoring cultural nuances regarding the meaning and importance of an extended family. The consequence is that the patient experiences an empathic failure. It is possible that if the therapist intervened by engaging the group in a discussion of the cultural relativism of family structure, boundaries, and obligations, the patient might have felt that he was better understood by the group and more willing to explore separation-individuation issues in the context of his own cultural milieu.

A second example is taken from a group that had been meeting for two months. The group consisted of six members. Two of the group members, Karen and Betty, identified themselves as African-American. Each woman's biological father is African-American and each women's mother is Caucasian. The remainder of the

group consists of two Caucasian men and two Caucasian women. The therapist is a caucasian male. In the group session preceding this one, Karen told the group that her biological mother, who is White, abandoned her. She was then adopted by an African-American family who raised her. At the beginning of this session, Karen told the group that she had ended her long-term relationship with a married African-American male. She was very attracted to this man but he was neglectful and frequently threatened to end the relationship if she didn't do what he wanted. The other group members were supportive of her decision to leave this man, having worked with her on fears related to separation and abandonment. Bo, a White male member, then told the group that he and his wife were offered the opportunity to adopt a baby this past week, but they were waiting for a Caucasian baby. The other group members, including the African-American females, offered support to Bo around his plans to adopt. Shirley, one of the White women, began to talk about having wanted to adopt a child when she was younger but never having done so. When asked by the other White female if she regretted her decision, she denied any regret and said, "I probably wouldn't have been a good mother anyway." At this point, the therapist, being aware that the two African-American women had withdrawn from actively participating in the group discussion, asked the group members if they had any reaction to Bo's announcement that he and his wife would only adopt a Caucasian baby. The White members said they felt a surge of anxiety when he said it. Each of the African-American women expressed their hurt and anger toward Bo accusing him of being a racist. Bo initially denied that he had any racist feelings, saying that he felt that it would just be easier to raise a child that looked like him and his wife. Karen challenged him further, saying, "So you don't think it has anything to do with racism?" Bo was quiet for a minute and then told the group that his family is racist and his grandmother refused to attend Bo's wedding because his best man was African-American. Bo admitted that he fears that if he adopts a non-White baby he will be further rejected by his family. This acknowledgment by Bo allowed Karen and Betty to talk about the personal experiences of rejection. Karen discussed how her own biological mother rejected her because she is dark-skinned. Betty told the group that her mother's White Jewish family rejected her mother when she married an African-American man. The other members joined in and talked about their own experiences of rejection and fears of abandonment. The group ended with a renewed sense of solidarity.

In this example, similar to the first case example, clinical issues are interwoven with cultural issues. The therapist in this second group, being aware that the two African-American women withdrew from the session, felt that it was imperative to address the racial issues before the clinical issues could be dealt with in an atmosphere of safety and support.

With the changing demographics in our nation, group therapists will be faced increasingly with challenges presented by sociocultural diversity. In the face of such challenges, it is imperative that the group psychotherapists adeptly speak to the range of issues in the room. In groups where mirroring is needed, the group

psychotherapist might find the most clinical efficacy in naming both the cultural and clinical issues that are present in an interpersonal exchange. In more developed groups, it may be possible to bring in the multiple realities and to speak from a group-as-a-whole perspective, so as to allow each member an opportunity to participate in the learning potential present in such exchanges. What remains paramount, however, is the balance between clinical presentations and idiosyncratic constructions of reality resulting from differing cultural experiences. The group psychotherapist's skills in discerning the location of emphasis is an art that may become increasingly easy to recognize but will take ongoing practice to master.

CONCLUDING CONSIDERATIONS FOR MULTICULTURAL GROUP PSYCHOTHERAPISTS

Working in the multicultural context requires the group psychotherapist to consider the unique population of his or her clinical practice. The degree to which issues of social identity are a part of the dialogue and discourse of the group may depend on a number of variables, such as:

1) the competence and the experience of clinicians in working with multicultural issues;
2) the composition of the therapy group in terms of clinical presentation and social identities;
3) the balance of dynamics in the group in terms of their psychological and identity dimensions.

One important area of ongoing skill development for group psychotherapists is in the ability to discern the relative importance of social identity issues over clinical presentation. There is the possibility that an overemphasis on cultural issues could obscure significant psychological concerns. It is not that social identity is ever absent, but that it may be secondary or complementary to the overall clinical presentation. The challenge for any group psychotherapist is to be attuned to the emotional "hot moment" to which the group most needs to speak. When multicultural dimensions are kept in consciousness, the salient issue at such a moment is multiply determined. Creating the atmosphere for exploration of the varied perspectives in the group is essential.

A further challenge for the group psychotherapist is the avoidance of complacency about competence on multicultural issues. There may be a tendency to generalize from single experiences of different others or to rely heavily on materials such as this article and similar ones to create a false illusion of competence. Such a stance is itself an act of privilege and serves to perpetuate the value of one's own constructions over direct experience with different others who may challenge our essential views of what is most important. The process of continuous education,

therefore, includes at least three elements:

1) ongoing self-examination of one's own experiences and biases concerning different others;
2) gathering a network of resources on multicultural dimensions of group psychotherapy, including direct training experiences;
3) developing professional relationships with mental health professionals who are experienced with and represent those populations that may be present in our practices but are less culturally familiar to us.

The authentic experience of integrating the multicultural context into group psychotherapy is more than a process of gathering resources, it must become a lived experience for clinicians. The validation that can come from supervision and consultation may well need to come from sources that are less familiar, where the encounter with different others is more direct and our comfort is a bit more challenged. In this way, the circle that is a part of who we become can be reflected in the circles we call group psychotherapy.

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