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TREATMENT APPROACHES FOR OBESE AND OVERWEIGHT AFRICAN AMERICAN WOMEN: A CONSIDERATION OF CULTURAL DIMENSIONS

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It is important to understand how individual factors interact with environmental and sociocultural factors for a client in treatment. The purpose of this article is to acknowledge the utility of an Afrocentric systems approach to treating obese or overweight African American women. It is suggested that a treatment program should address and integrate the strengths and supports of the culture into the development of interventions. African American beliefs about psychotherapy and family, cognitive and coping styles, religiousness and spirituality, and body satisfaction and body image, as well as current approaches to treating obesity and overweight, are considered. This literature is used to frame guidelines for helping African American women with eating problems, body dissatisfaction, or weight management in ways that do not dismiss the experience of multiple oppressions (i.e., racism, sexism, and the stigma of obesity and overweight).

Treatment Approaches for Obese and Overweight African American Women: A Consideration of Cultural Dimensions

Epidemiology

Restrictive eating disorders (i.e., anorexia, bulimia nervosa) are known to be associated with young females of an upper to upper-middle socioeconomic status and are thought to be rare in African American women. Recent studies, however, have called into question the generalizability of such findings. The majority of studies have drawn subjects from student or inpatient populations. Recent results suggest that the number of African American women who suffer from eating disorders, particularly bulimia, may be increasing. Regardless of this increase in restrictive eating disorders, significant concerns related to obesity and overweight in African American women have repeatedly emerged in the literature. For example, epidemiological studies of eating behaviors and weight concerns (e.g., obesity, binge eating) reveal that females, African Americans, and individuals in the middle and lower socioeconomic status percentiles tend to exhibit these problems at a higher rate (Abrams, Allen, & Gray, 1993; Langer, Warheit, & Zimmerman, 1991). Further, researchers at the University of Florida College of Medicine interviewed 2,115 African American and White adults (aged 18–96 years) on weight and weight concerns as part of a health survey and found significant age, gender, race, and social class differences. They found that 46% of 306 African American women, 28% of 144 African American men, 18% of 905 White women, and 16% of 743 White men were overweight and discussed these findings in relation to cultural acceptance of overweight. That is, the significantly greater percentage of overweight African American women and men may, in part, be due to the greater acceptance of diverse body types in this culture rather than the idealization of thinness that is typical in the dominant White culture (Rand & Kuldau, 1990). Another study noted that obesity is a health problem for 30% of middle-aged White women and 60% of middle-aged African American women in the United States (Wing, 1993). Finally, Malina (1973) pre-

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sented several studies reporting a greater incidence of obesity among adolescent African American girls and among lower socioeconomic groups.

Defining Obesity and Overweight

The methods for classifying individuals as obese, overweight, or normal weight in the research have varied. This poses some difficulties in making comparative statements across studies. Much of the data relating health and obesity have been obtained and analyzed with reference to overweight, meaning a weight that deviates from some recommended standard for a particular height or a calculated body mass index (BMI). An individual may be overweight, however, yet not obese. This may be most evident in athletes who may exceed the standard normal weight for a given height due to increased muscle mass. Generally, overweight refers to a BMI (wt/ht) of 25 to 30 or a body weight between the upper limit of normal and 20% above that limit. Obesity refers to a BMI of 30 or greater or a body weight more than 20% above the upper limit for height (Bray, 1986). Although the health risks (e.g., heart disease, gall bladder disease, diabetes mellitus, hypertension) may be significantly greater for individuals who fit the classification of obese, there are also some health risks and certainly psychological and social ramifications related to being an overweight woman. Yet, it is important to note that, regardless of whether these objective defining criteria are met, an individual's subjective perception of being obese or overweight must be considered when planning treatment strategies. For instance, body dissatisfaction, a low ideal weight, and restrained eating are primary cognitive and behavioral characteristics of binge eating, anorexia nervosa, bulimia nervosa, and some types of obesity (Agras, 1987). From a treatment perspective, it is crucial to obtain a comprehensive understanding of how such individual factors interact with environmental and sociocultural factors for any given client.

Body Satisfaction and Acculturation

Authors examining eating disorders, obesity, or overweight in African American women have typically discussed their findings in terms of etiological factors relating to cultural differences, such as attitudes toward body size, styles of coping and responding to trauma, and degree of assimilation into mainstream, dominant culture that has embraced a standard of thinness as attractive for women (Rozin & Fallon, 1988; Rucker & Cash, 1992). Harris (1994) notes that this thin standard of mainstream culture's ideal body has been the impetus for a myriad of weight reducing activities (e.g., dieting, purging, excessive exercising) that may ultimately lead to increased body dissatisfaction. African American women may be impacted even more seriously because "thinness is only one criterion among several Euro-American features (e.g., hair, skin color, lip size) used to determine attractiveness" in the mainstream culture (Harris, 1994, p. 90).

Several cultural differences may affect African American women's evaluations and images of their physical bodies. For instance, studies have demonstrated that African American men may view overweight women less negatively than their White counterparts (e.g., Harris, Walters, & Waschull, 1991), which may influence African American women's acceptance of higher body weights. In addition, some researchers have found that, for a subset of African American women, obesity, along with eating "right" (i.e., not engaging in restrictive dieting), and engaging in stress-reducing activities, was associated with a perception of health (e.g., Keller & Hargrove, 1992). One study of 100 African American female and 100 White female college students provides evidence suggesting that anorexia and bulimia in African American female college students is associated with the extent of their assimilation into mainstream culture and their acceptance of mainstream culture ideals of attractive as thin (Abrams et al., 1993). Thus, identification with African American culture and its ideals, rather than with mainstream Euro-American culture, may be a protective factor for overweight or obese African American women. The extent of assimilation into the mainstream Euro-American culture versus identification with African American culture seems to influence both the acceptance and internalization of the mainstream thin standard and the likelihood of engaging in restrictive, disordered dieting behaviors (Harris, 1994; Klem, Klesges, Benet, & Mellon, 1990). Differences in acceptance of and identification with mainstream standards and culture, socioeconomic status, as well as individual characteristics may influence the degree to which African American women internalize mainstream dominant standards for thinness and beauty.

As noted by Harris (1994), clearly neither African American women in general nor obese/over-

weight African American women are a homogeneous population. Many obese or overweight African American women may be content with their physical selves and may not experience any significant obesity-related health problems. Despite Harris' (1994) finding that African American women reported greater overall body satisfaction than Euro-American women, Hsu (1987) suggests that restrictive eating disturbances among African American women may be increasing. African American women who experience significant health problems or concerns related to obesity or overweight and/or who internalize the thin ideal standard, evaluate themselves negatively in comparison to the ideal, and may experience body dissatisfaction and considerable personal distress concerning the management of their weight and appearance. Although several authors have proposed alternative conceptual frameworks and treatment strategies for understanding and treating African American women in general (e.g., Greene, 1993; McNair, 1992), African Americans in substance abuse treatment programs (e.g., Rowe & Grills, 1993), and African Americans seeking health care (e.g., Taylor & Jackson, 1991a, 1991b), no one is known to have written about alternatives to traditional conceptualizations and treatment approaches for obesity and overweight. The purpose of this article is to acknowledge an Afrocentric systems approach to treating obese and overweight African American women. A treatment program needs to address and integrate the strengths and supports of the culture into the development of treatment strategies for overweight and obese African American women. The literature concerning African American beliefs about psychotherapy and family, cognitive and coping styles, religiousness and spirituality, and body satisfaction and image, as well as current approaches to treating obesity and overweight, may offer useful strategies for helping obese or overweight African American women who experience body dissatisfaction or who have concerns about health issues due to being obese or overweight.

African American Cultural Dimensions in Treatment

As Sampson (1993) states, most psychologists and mental health providers approach treatment not "ready to encounter other's unique specificity, but to reduce them to one of our discipline's categories" (p. 1227), failing to thoroughly consider and incorporate an individual's social, cultural, political, and historical experiences and strengths into intervention and treatment strategies. This is no less true in the specific approaches that have been used to treat obesity and overweight. In this particular area, there are at least two relevant issues to be addressed with each individual client or group of clients: (a) the not-so-invisible standard of thinness as desirable and attractive, and (b) the formation of a discursive partnership with a client to "co-author" objectives for treatment. Depending on the client(s) and on the context of the initial meeting (e.g., church or community-based group versus individual client), the construction of a working conceptual model of the individual's reality, specifically an understanding of the client's experience of overweight or obesity, is essential because it will have direct implications for treatment. It is important not to assume that thinness or weight loss is the objective. A client who has not internalized the dominant, mainstream standard of thin as ideal, and is not distressed about being overweight or obese, may require assistance, not in weight reduction strategies, but in acceptance of her body and physical self as they exist in the present. The latter goal might require lifestyle changes directed at improving the experience of the client's current self (e.g., improved nutrition, social support, self-esteem, exercise regimes modified for obese or overweight persons) rather than changing her body (e.g., via a cognitive behavioral or very low-calorie diet program aimed at weight reduction). By beginning to integrate Afrocentric and feminist models as they pertain to the experience and treatment of African American women, treatment professionals may begin to develop guidelines for working with obese and overweight African American women that do not dismiss the experience of multiple oppressions (e.g., racism, sexism, stigma of obesity, overweight), and that incorporate individual and cultural strengths in the conceptualization of useful treatment approaches and settings.

Knowledge and sensitivity to cultural differences are important, but are not sufficient. This conceptual knowledge and sensitivity must be incorporated into practice (Stevenson & Renard, 1993). Several components of African American culture may be useful in treating the African American woman who has eating problems, who seeks weight loss, or who seeks to maintain her weight while enhancing her self-esteem and qual-

ity of life and coping with the multiple oppressions she may experience as an obese or overweight African American woman.

Helms (1992), in discussing the implications of African culture for cognitive ability testing, and Stevenson and Renard (1993) adapted several dimensions of culture from Boykin and Toms's (1985) characteristics of African American life. Helms's and Stevenson and Renard's work modified versions of Boykin and Toms' cultural components to include factors related to spirituality, harmony, movement, affect, communalism, expression, orality, and social time, and speculated about the manner in which these variables may influence test responses. Similarly, Jones (1991) highlighted related dimensions and devised a model of culture/personality adaptation with psychotherapeutic implications. He referred to this as the TRIOS model representing five dimensions of human experience (i.e., time, rhythm, improvisation, oral expression, and spirituality) and reflecting the "basic ways in which individuals and cultures orient themselves to living" (p. 38). These same components or dimensions of culture may provide a framework for the development of guidelines for the clinician working with overweight and obese African Americans. Specifically, spirituality and religiosity, cognitive, affective, and behavioral communication style (including harmony, movement, affect), communalism, or social network and support (e.g., family values and structure) may have unique implications for prevention and treatment. Although these dimensions may also be relevant to individual white women struggling with these issues as well, the theoretical and empirical findings suggest that they may be particularly useful to consider when working with African American women.

Incorporating Spirituality and Religion

Many authors (e.g., Block, 1984; Jones, 1984; McNair, 1992; Watkins-Duncan, 1992) have addressed the fact that most African Americans are "uneasy and unsure" (Block, 1984, p. 51) of the mental health field as a result of clinicians' failures to acknowledge and understand cultural differences the client may bring to therapy. Any means by which the field can be responsive to this voice and transform the intervention setting, context, or approach to meet and match the needs and concerns of clients should be employed. For example, studies have shown that religion plays an important role in the development and continuity of identity for many African Americans and contributes to a sense of social support and well-being (Nye, 1993; Walls & Zarit, 1991). Walls and Zarit's (1991) research, examining the influence of informal support from Black churches on the well-being of elderly Blacks, suggests that "social service agencies might work within the organizational structures of Black churches to provide more services to elderly individuals living in Black communities" thereby enhancing medical and mental health care (p. 493). In efforts to develop existing client resources and strengths, Hatch and Derthick (1992) explored the ways that Black churches may be incorporated in the promotion of health and wellness in African American communities. They recommend empowering Black churches to develop and implement prevention programs in health promotion and disease prevention. Church-based efforts focused on prevention and early intervention would reach a large subset of obese or overweight African American women who might not otherwise seek support or assistance with their eating problems or concerns about body image. Structured twelve-step approaches to treating overeating (i.e., Overeater's Anonymous) might be another useful approach because they complement thinking styles that reflect a belief or emphasis on the power of spiritual forces in the universe to influence everyday life, and they support the belief that functioning is optimal when in synchronicity with this spiritual life force.

Alternatively, community-oriented clinical psychologists might actively cultivate relationships with Black church groups in order to develop independent nutrition-and-fitness and body-image programs within the church community that would shape specific goals and objectives according to the needs of the individuals and group. Jones noted that it is conceivable that differences between individual and social etiology and spiritual or religious beliefs could be interpreted by a "traditional" therapist as an inclination to externalize, suggesting denial on the part of the client. Instead, Jones suggested this "externalizing" may simply reflect a spiritual and religious affiliation rather than resistance to accept personal responsibility. Ultimately, as Jones (1991) expressed, "to the extent that therapy is seen as a context for increasing or restoring personal control and efficacy in clients, certain adjustments may need to be made when dealing with clients who are highly spiritual" (p. 40).

Cognitive, Behavioral, and Affective Styles

Several authors have pointed to a tradition of African culture that reflects a quality of expressive individualism or improvisation (e.g., Boykin & Toms, 1985; Jones, 1991; Stevenson & Renard, 1993). Expressive individualism "assumes that people are interdependent but that they can demonstrate a style that others may not be able to replicate or use efficiently" (Stevenson & Renard, 1993, p. 435) and focuses on personal artistry and spontaneity rather than methodological, systematic planning. The creation of one's own unique solutions is valued. Encouraging the client's participation in designing effective interventions is one way to incorporate this aspect of culture, provided that it is appropriate with a given individual. The following excerpt from the introduction to a group-based cognitive-behavioral program that has resulted in good outcomes for clients with mild to moderate obesity may be a particularly pertinent example of an approach that encourages individualism based on the client's knowledge of herself and her lifestyle. This therapeutic style might provide a basic introduction to identifying problem areas in a client's eating behavior while encouraging creative, individualized problem solving.

> No one is in a better position to identify and resolve your weight problems than yourself. Everyone is unique, and there are many different ingredients that lead to a particular weight problem. You will need to identify your own difficulties during this course. Some people, for example, eat too many sweets, or big meals, or eat regular meals but just nibble; others may be inactive. Any of these difficulties, singly or in combination, or others may be contributing to your particular problem. With proper training anyone can identify their problem areas and work to change them. You can also identify your strengths and work to enhance them (Agras, 1987, p. 33).

Another unique characteristic of African American culture is "orality" (Stevenson & Renard, 1993, p. 435). Orality refers to the value that speaking and hearing are the preferred modes of communication, and that writing or the written word alone may not be sufficient to capture attention. This dimension of African American culture may have implications for self-monitoring methods for clients who desire weight loss. Perhaps a client is more comfortable or more motivated to monitor food intake orally using a tape-recording device. Another alternative is to develop "buddy" or sponsor relationships with other individuals whose goals are similar. The "sponsor check-in system," similar to that employed in the twelve-step approaches (i.e., Overeaters Anonymous and Alcoholics Anonymous), allows a client to orally and aurally monitor and process her experience or difficulties in implementing treatment strategies. Finally, verve and movement reflect the importance of newness and deviation from customary, often mechanically performed, procedures. Reinforcement of continued self-monitoring and the development of creative, customized problem-solving strategies should serve to maintain a sense of versatility and flexibility in the treatment program.

Family Values and Community Structure

Nobles (1981) noted that racism and assumptions of the inferiority of African Americans have fueled research on the African American family system as one that is permeated with "problems and inadequacies" (p. 78). The prototypical Black family is not a reality. Individual Black families exist, and they may have experiences that are unique to the family as well as experiences that are typical of many families, both Black and White. The "Black family" is a type of social organization whose structure changes with social class, geographical location, and culture as do other families. The often shared experience across these dimensions, however, is a past and present of oppressive racism. This latter factor makes it virtually impossible to objectively compare Black and White families (Staples, 1971). Much of the literature purporting to investigate Black families has studied only seriously deprived families and has inappropriately generalized findings in support of arguments for the existence of inherent pathology within Black families. Staples (1971) called for researchers to obtain and propagate the knowledge needed to develop a "relevant sociology of the Black family" (p. 4); one that will facilitate the determination of the Black family's strengths in survival and adaptation and the role of the Black woman.

Recent researchers emphasize capitalizing on the inherent strengths of the African American family (e.g., Stevenson & Renard, 1993). Harmony, a sense that oneself and one's environment are not separate, disconnected entities, and communalism, a value of one's participation in and support of the group that surpasses one's individual needs, are two familial and communal dimensions of Boykin and Toms's African American cultural characteristics (cited in Stevenson & Renard, 1993). These may be important to incorporate into the treatment of obese and overweight

African American women. It is useful to determine the extent to which the family and social network will support treatment objectives of clients. It is possible, for example, that a woman may experience difficulties following her eating or lifestyle-change program if she perceives that it takes time from responsibilities to family or community. For instance, time taken for an individual exercise regime or for personal reflection and journaling may be viewed as time taken from children and family. In such a case, ideas may be generated with the client for incorporating children into the physical activity or into having their own "quiet time." Further, treatment providers need to extend their consideration of what constitutes family beyond the conventional nuclear family to incorporate extended and adopted family. Utilizing this unique expanded system of supports that constitutes the African American family might involve additional nontraditional frameworks for treatment. That is, social network therapy that incorporates kinship relations or paraprofessional supporters, such as parent aides or twelve-step sponsors as mentioned earlier, or that involves the establishment of multiple family or neighborhood reinforcement support groups may be helpful (Boyd, 1982).

Treatment Strategies

The extent to which a woman has become acculturated may affect her willingness to accept a larger or smaller body size as ideal and, consequently, as a goal for treatment. Working with an individual's expectations, for instance, to raise an unrealistic weight goal by reviewing her, and possibly her family's, history of obesity; reevaluating successful and unsuccessful attempts at reaching and maintaining particular weights; reviewing healthy ranges for her frame; and working on acceptance of moderate or high-end weight goals may be useful. Conversely, an approach such as motivational interviewing may be useful with a client whose health is seriously compromised by obesity, but who is resistant to accepting weight loss as a goal and/or making changes necessary for weight loss. In either situation, however, self-acceptance and maintaining or increasing self-esteem will be important, because change in either direction may prove difficult if the client feels she is not worth the effort required to make those changes. Therefore, it is important for the therapist to recognize that goals will vary with individuals, not with weight-chart recommendations, and that reaching those goals may involve laying the groundwork for change in phases. Addressing the experiences and negative emotions or beliefs associated with the multiple oppressions a woman may have experienced with regard to gender, ethnicity, and obesity is also recommended. Overall, it may be useful to consider the guidelines that follow to evaluate the extent to which a client has experienced negative reactions or treatment from others. Also important to consider are negative beliefs a client may hold about herself concerning gender, ethnicity, or body image and the ways in which these three may intertwine to adversely affect self-image and self-worth.

Draguns (1981) captured an overarching question that is particularly relevant to working with this population of women: How does one "balance the culturally unique with the humanly universe" (p. 3)? Recognizing that within-group variation may be greater than between-group variation (Jones, 1991), Jones stated that issues of trust are fundamental to the psychotherapy and treatment situation, and that race is tied to issues of trust due to a history of stereotyping and devaluing African Americans. He proposed examining adaptations to problems related to race as clues to the types of interventions that may be most likely to be successful. Jones drew attention to the utility of measures of acculturation, mistrust, and identity in evaluating adaptation to racially related variables that affect day-to-day responses as well as life-cycle and developmental processes. He noted the need for research examining these issues and their applications to psychotherapy and treatment. Considering these issues and the various dimensions of African American culture outlined above, the following guidelines may be useful in establishing the beginnings of a conceptual model for working with obese and overweight African American women in treatment and, to some extent, in framing research questions.

Considerations and Guidelines for Developing a Treatment Framework

1. Develop a sense of credibility with the client and bridge any trust-mistrust issues by acknowledging and addressing directly that feelings of uneasiness or mistrust are not uncommon. Inquire as to the extent to which this may be the experience of the client. At intake, use information gleaned from measures such as the Cultural Mis-

trust Inventory (CMI), the Counselor Effectiveness Rating Scale (ERS), and the Personal Problem Inventory (PPI) in addition to a measure of acculturation or Black identity development to evaluate the extent to which these issues may impact the client-therapist relationship and the course of treatment.

2. As Draguns (1981) suggests, approach the client as an important, irreplaceable conveyer of her cultural and community experience and the ways these cultural dimensions may or may not impact her attitudes toward eating, food, and her body and physical self. Respect and utilize her cultural strengths and self-knowledge in guiding treatment goals. Regardless of cultural experience, educate the client concerning options for treatment goals such as weight management, addressing particular problematic eating patterns (e.g., binge eating), self-esteem, body acceptance, and self-awareness and self-efficacy, or some combination of these.

3. Ascertain the client's personal history of weight loss, dieting, eating behavior, and the severity and duration of problematic eating behaviors. This information will have implications for the appropriateness of weight loss as a treatment goal. For instance, an individual with a family history of eating and weight problems, and years of biweekly binge-eating episodes would have a less favorable prognosis for weight loss than an individual with adult-onset obesity, no family history of eating problems, and no history of binge eating.

4. Facilitate the client's discovery of her personal stance with regard to treatment objectives (e.g., Are her goals to accept herself and to improve physical and mental health at her current weight or to reduce her weight?). As mentioned in #3, the treatment should be tailored to the individual according to the relevance of cultural factors and specific prognoses related to her history or current psychological, emotional, and physical status. For instance, a client who reports a lifelong history of obesity and repeated failed attempts at dieting may conclude that her treatment objectives could involve (a) working toward acceptance of her present self as an obese woman; (b) incorporating of activities/interests that might lessen her preoccupation with food and eating; and (c) lifestyle changes, such as increased physical activity, with an emphasis on improving the quality of her life and health, as opposed to goals of dramatic weight loss that may set her up for failure. In addition, treatment strategies that reflect cultural dimensions relevant to the particular client should be incorporated. Regardless of the client's profile concerning weight loss and dieting history, the client's degree of acculturation, level of trust/mistrust, and the cultural dimensions outlined above should be considered in devising treatment strategies. These factors, combined with relevant data concerning the individual's level of dietary restraint, food preoccupation, weight-loss history, and disordered eating patterns, should be integrated and considered in formulating a treatment plan that reflects an appropriate balance between cultural considerations and the universal for a client.

5. Evaluate and use social support networks including church (e.g., spiritual networks), immediate family, and extended kinship support. Determine with the client whether and how these systems might be integrated into her treatment program. For example, a client may know of other church members seeking to improve their mental and physical health and fitness through healthier eating, exercise, or weight loss, and could initiate a church-based prayer, meditation, or support group with the encouragement or assistance of the therapist. Also, a therapist should be alert to whether partners, children, or other important family members of the client might assist the therapeutic endeavor. The therapist should be prepared to invite such individuals to individual or group sessions, with the client's permission, to explore what they can offer the client in simple support or active involvement (e.g., providing specific reinforcements to the client for positive, health-promoting behavior changes).

6. Continue to evaluate and use cognitive style, extent of acculturation, and impact of body satisfaction.

7. Continue to monitor and evaluate the extent to which relevant cultural components apply to a particular client or group. Obtain feedback from the client(s) and adjust the treatment plan accordingly. Maintain open communication with the client(s) regarding the "goodness of fit" as they experience the treatment program, and evaluate and adjust strategies according to the client's feedback.

8. Finally, consider etiological as well as maintaining variables in the environment regardless of whether the treatment emphasis is self-acceptance or self-change. That is, work with the client to identify strengths in her environment that will

be helpful in maintaining psychological and/or physical changes versus those that may have a negative impact (such as the ongoing experience of racism, sexism, or obesity related discrimination).

Summary and Conclusions

"Words devoid of action or meaning in an action context may be rejected. Thus the therapy session may need to be more behavior-based or 'action oriented' than conceptual and thought oriented" (Jones, 1991, p. 40). Given this strong statement, a behavioral treatment approach, which by its very nature acknowledges learning histories and culturally embedded contingencies and responses, may on the surface appear to be the preferred mode of treatment for obese and overweight African American women. Yet treatment planning is unlikely to be so simple. As Jones (1984) noted the majority of African American women function in their own culture and community as well as in the dominant White, mainstream culture. This reality may confound the usefulness of assuming that treatment strategy, whether grounded in a dimension of African American culture or not, will be helpful with an African American client. In light of this biculturalism and in light of recent findings suggesting that the degree of acculturation may be associated with particular levels of body satisfaction, evaluation of the degree of acculturation and level of Black identity development must be an integral, ongoing aspect of treatment for the obese or overweight African American woman. Although cultural dimensions discussed here are important, the unique experience and individuality of the woman in treatment will affect the extent of her appropriateness for incorporation into a client's treatment. A client's unique experience of her culture should be considered in choosing treatment interventions and in establishing the therapeutic framework. An individual's experience may or may not closely reflect the cultural dimensions previously noted, but it is crucial to explore the extent to which these factors may facilitate or impede the course of treatment.

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