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Introduction to Commentaries on Sociocultural Identity, Trauma Treatment, and AEDP Through the Lens of Bilingualism in the Case of "Rosa"

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ABSTRACT

The papers in this collaborative commentary explore the importance of engaging issues of sociocultural identity in trauma treatment in general, and specifically in the AEDP treatment of Nicole Vigoda Gonzalez's (2018) case of Rosa. Issues addressed include the role of language, bilingualism and language switching in therapy in general, and *a fortiori* when trauma or relational trauma is involved. After brief autobiographical sketches of the contributors, organized around each author's personal bilingualism story, there are three separate commentaries: Raymond Rodriguez (2018) begins by elaborating on the construct of sociocultural identity, exploring clients' identification around their native language, and emphasizes how crucial it is to address those concerns in therapy. Next, Yamilka Urquiza Mendoza (2018) introduces the importance of specificity in addressing multicultural issues, proposing that overly broad categories risk cluelessness, just at a higher level of magnification. Taking off from Rosa's being born on a Spanish Caribbean Island, Urquiza Mendoza illustrates how applying the term *Hispanic* to all Spanish speakers misses the huge ethnic and cultural diversity contained within that overly broad term. In the third commentary, referencing some neurobiological findings on how the traumatized brain processes language, Huan Jacquie Ye-Perman (2018) discusses how choosing to speak in one's non-native language in treatment is not always about distancing and can often be a vehicle for differentiation and exploring new aspects of self-identity. My concluding reflections are on the specific aspects of stance and intervention that allow AEDP to embody fundamental elements, as described by Owen (2013), of the multicultural therapist's paradigm—i.e., cultural humility, benefitting opportunities, and developing cultural comfort—and to seamlessly manifest them in the nitty gritty of day-to-day, moment-to-moment clinical work. I end with some reflections on what AEDP, with its motto of "make the implicit explicit, and the explicit experiential," needs to do to actively keep optimizing its interventions to meet the challenges of the multicultural orientation framework and to do justice to these vital considerations.

Key Words: multicultural orientation; sociocultural identity; bilingualism; language; trauma treatment; complex PTSD; AEDP; experiential therapy; attachment trauma; experience; trauma; experiential psychotherapy; language processing in trauma; right brain; clinical case study; case study.

INTRODUCTION

AEDP is a mind-body therapy that assumes a healthy core within all people and emphasizes the importance of experiential work with attachment, emotion, and transformational experiences (Fosha, 2003, 2009, 2013, 2017a; Russell, 2015). It leverages safety and connection within the therapist-client relationship to support the emergence of healing, facilitating experiential work with the potential to transform attachment trauma and emotional suffering. AEDP seeks to put positive neuroplasticity into action, both moment-to-moment, and session-to-session: first undoing the patient's aloneness by entraining, that is by engaging, experiences of secure attachment that allow trauma processing, and then proceeding to rigorously process those experiences. AEDP works with the *experience* of the patient-therapist attachment directly, explicitly, and experientially, moment-to-moment tracking it and processing it as rigorously as any other experience (Fosha, 2017b; Lamagna, 2011; Lipton & Fosha, 2011; Prenn, 2011).

Guided by an orientation to healing (rather than by a focus on psychopathology) and by a rigorous precise moment-to-moment transformational phenomenology (see Fosha, 2018, 2017a), AEDP has specific intervention strategies for working *explicitly*, *dyadically*, and *experientially* with intense unresolved traumatic emotions in a way that transforms suffering and fosters patients' feeling safe, as well as recognized and understood. Quintessential to AEDP are its *metaprocessing* intervention techniques for systematically processing transformational experience to enhance resilience, expand relational capacity, and deepen receptive affective experiences of feeling safe, seen, helped, and changed (Fosha, 2017a; Russell, 2015). With aloneness undone, traumatic emotions processed, and transformational emotions metaprocessed, AEDP's transformational process culminates in vitality, energy, and the positive-affect transformational spirals that are so highly correlated with health, resilience, creativity, and well-being (Fosha & Yeung, 2006; Russell & Fosha, 2008).

Alan Schore has written extensively about the importance of right-brain-to-right-brain communication between client and therapist in therapy (2009, 2012). In line with Schore's ethos, in AEDP, right-brain-to-right brain communication—the communicative non-verbal and paraverbal exchange that happens through tone, gaze, facial expression, bodily posture, and rhythm of speech, and that underlies attunement (Tronick, 2009)—is entrained to co-create safety and connection. This contributes to the establishment of the therapeutic alliance and of a secure attachment relationship, within which difficult emotions can be processed. It is also used to bypass left-brain mediated or language-based defenses, and to track and access bodily-based emotional experience. Moment-to-moment tracking of bodily based emotional relational and transformational experience, the *sine qua non* of all AEDP interventions, is achieved through this right-brain-mediated way of attuning and connecting.

Yet, even in an experiential mind-body therapy like AEDP, language is important inasmuch as it is the actual medium through which the therapy happens. Language both reflects and affects the state of the individual and the therapeutic process, and has the potential to alter it, i.e., transform it, for better or worse (Fosha & Gleiser, in press).

Trauma, as it does everything else, affects language processing (Fosha & Gleiser, in press). There is increasing neurobiological evidence that acute trauma shuts down Broca's area, i.e., the spoken language center of the brain (Bremner, 1999, 2006; Liberzon et al., 1996; Rausch, et al., 1996; Shin et al., 1999; van der Kolk, 2015). This creates a split in the self: there is a non-verbal part of the self that retains a record of the trauma ("the body keeps the score" [van der Kolk, 2015]), though this part can be literally "speech-less," i.e., Broca's area is offline; and there is another part of the self that speaks, but knows little of the trauma. Even when trauma does not totally shut down the capacity for language, there is ample evidence of state-specific memory encoding. Here, language and memory surround a particular event, reflecting the state of the organism at the time of the emotionally charged event, including the individual's developmental level. When that obtains, it is easier to access memories in state-specific circumstances. When different languages are involved, it is easier to retrieve memories encoded in a particular language when speaking that language. When the dominant language of one's childhood is different from the dominant language of the culture one inhabits as an adult, as is the case for most immigrants, there is potential for further splits in the psyche. While right-brain-to-right-brain communication is just one tool of many that the AEDP therapist has, the more tools a therapist has to address these splits, the better.

The issue of the different languages spoken by an individual bears not only upon developmental level and trauma processing. The issues of bilingualism go way beyond the psyche of the individual and open into the larger culture. Language is both a window into, and a deep manifestation of, culture, identity, class, ethnicity, socioeconomic factors, and so much more. Language is not only part of sociocultural identity; language is, in and of itself, a sociocultural identity (Rodriguez, 2018, in this issue). In interaction with a specific culture, language reflects the very rhythms and flavor of a culture, its heart and soul (Urquiza Mendoza, 2018, in this issue). In addition, language, because of its flexibility and versatility, has the ability to differentially reflect an individual's various sociocultural identities, both as they co-exist simultaneously, and as they shift over time (Ye-Perman, 2018, in this issue). In light of our profession's growing awareness of the importance of multicultural issues operating in each therapy, and the necessity of adding multiculturally competent strategies to the repertoire of each therapist, bilingualism is an important issue to address and to explore how it is handled within an AEDP therapy.

In Nicole Vigoda Gonzalez's treatment of Rosa, all of these strands—trauma, bilingualism, and AEDP—are woven together. Rosa is a 63 year old professional woman, divorced, the mother of one (now adult) son. Born in a Spanish Caribbean island, she immigrated to the United States with her family when she was a three year old child. Her native language is Spanish. When she comes to seek therapy, she presents with severe major depression, significant anxiety, as well as many of the signs and symptoms of complex PTSD. In addition, she has few, if any, friends or interests; has stressful, fraught relationships with her family members; is socially isolated; and, despite her professional success, has a noteworthily low self-esteem. As the therapist soon learns, Rosa's history, early and subsequent, is replete with both *big T* and *small t* trauma—paternal alcoholism and violence; rejection, humiliation and ostracism of Rosa by mother, father and siblings; and racial oppression in her own family in the form of *colorism* (persecution based on the color of her skin), with bullying by her siblings.

After an initial failed attempt to use a different therapy, Vigoda Gonzalez adopts AEDP as her treatment of choice, as Rosa's response to the AEDP therapeutic stance and interventions is unequivocally positive. At the end of 23 sessions of AEDP, there is a marked improvement in Rosa, changes for the better which are well maintained at a 3-month follow up.

An important moment occurs early in the treatment: Rosa, ambivalent at best about whether to tackle her early trauma or avoid doing so at all costs, is struggling with the painfulness of the emotions evoked by her traumatic experiences. Expressions come to her in Spanish, which she translates for her therapist. It is at this point that the therapist discloses to her client that she too speaks Spanish, and that the client, therefore, need not worry about translating for her and should feel free to speak whatever language comes naturally to her at any given moment. This evokes a highly positive and highly emotional response from Rosa—surprise and delight. And from that point forth, with the therapist attuning to the client, language-switching becomes a fact of the therapy, with both client and therapist fluently going back and forth between Spanish and English throughout the therapy. Vigoda Gonzalez carefully tracks when Rosa uses which language throughout the therapy. Furthermore, she discusses the disclosure of her own bilingualism and the use of bilingualism in the therapy as evidence of her use of a multiculturally competent strategy and explores its role in AEDP.

THE PAPERS IN THIS ISSUE

Vigoda Gonzalez's case of Rosa affords us the opportunity to address some inextricably intertwined important issues in terms of language, bilingualism, multicultural orientation, trauma treatment, and AEDP. To address these and other issues from a multicultural orientation framework (Davis et al., 2018; Owen, 2013), I invited three guest contributors: Raymond Rodriguez, Yamilka Urquiza Mendoza, and Huan Jacquie Ye-Perman. All three work with trauma, all three address multicultural issues in their own clinical practices, and all three are practitioners of experiential therapies, with two of them, i.e., Urquiza Mendoza and Ye-Perman, actively involved in AEDP. In addition, for all three –as for me—English is not our first language. Thus, issues of bilingualism are addressed not only from the vantage point of a professional orientation, but are also informed by personal experience. Finally, all of us identify as members of non-dominant ethnic/racial/cultural groups.[1]

Raymond Rodriquez's paper focuses on the construct of a sociocultural identity, and explores language as one kind of sociocultural identity, or *social location*, as he phrases it. His reflections on AEDP are from the vantage point of a non-AEDP, yet also experiential, trauma-focused therapist, brand new to AEDP.

Yamilka Urquiza Mendoza takes on the importance of specificity when addressing multicultural issues. She emphasizes that using overly broad, overly general categories runs the risk of repeating the oversights of not addre2ssing multicultural issues at all, just reproduced at a

[1] Until recently, despite being Jewish, given that I am Caucasian, I thought it presumptuous to identify myself as a member of a "non-dominant ethnic/racial/cultural" group. However, more so than ever, events in the last two years in the United States make it clear that there is no presumption involved.

different level of magnification. In the case of Rosa, Urquiza Mendoza discusses the problems that result from lumping together, under the term "Hispanic," so many different cultural, linguistic, and ethnic minorities, each with its own distinct character.

Huan Jacquie Ye-Perman, an experienced therapist, supervisor, and teacher of AEDP, addresses different aspects of bilingualism and of AEDP in the case of Rosa. She discusses how the use of one's native language in therapy is not always something a client welcomes: using personal and clinical examples, she illustrates how the use of one's non-native language, the language of the culture/country the individual is living in, can be a vehicle for healthy differentiation, especially when there is a lot of cultural trauma associated with one's language/country/family of origin. She raises the quintessentially AEDP-sensitized possibility that for Rosa, English, her second language, is also the language of transformation and exploration.

My concluding reflections address the specific mechanisms of therapist stance and therapist interventions. These are explored through the vantage point of AEDP, which allow us to translate the elements of the multicultural orientation paradigm (Davis et al., 2018; Owen, 2013)— cultural humility, benefitting opportunities, and developing cultural comfort—into the nitty gritty of day-to-day, moment-to-moment clinical work to do justice to these vital considerations.

Below, just prior to our commentaries, we share our respective autobiographical sketches, told through the lens of experiences with bilingualism. This sharing is grounded in the values of cultural humility advocated by Owen (Davis et al., 2018; Owen, 2013); the importance of self-disclosure elaborated by Hill (Hill & Knox, 2002; Hill, Knox & Coelho-Pinto, 2018); see also Prenn, 2009); and adopting a practice similar to that of Chang and Berk (2009).

AUTOBIOGRAPHICAL PORTRAITS THROUGH THE LENS OF BILINGUALISM

In a "commentary," particularly one addressing multicultural issues, it is important for each of the voices to be personal and speak in the first person "I," as opposed to assuming the appearance of authority and neutrality of a third person voice. Furthermore, this showing up as oneself is congruent with the values of AEDP, where the genuine presence of the therapist co-creates, with each client, a unique dyad, where the distinct contribution of each voice is honored, as is what results from their dyadic co-creation. So here we go (in the order of the commentaries).

Raymond Rodriguez

I was born and raised in Puerto Rico (PR). My entire immediate and extended family lives in PR to this day. The official language of PR is Spanish, a legacy of the many years of Spanish colonialism. In the history of PR, the island went from being a colony of Spain to a colony of the U.S. I grew up with implicit and explicit messages about how the mainland was "better," how staying in the island was backward, how those that moved to the mainland had

more opportunities, and most importantly, that learning "good" English was a prerequisite to upper mobility, better employment, a good education, and so forth.

My family bought into these notions, and with their best efforts to set me up for a better future, enrolled me in a preparatory, English-only high school. This was my first experience in *otherness*, with a school in which I didn't fit for so many reasons: because I came from a working class background and my classmates came from rich families; because I didn't speak "good" English and my classmates were fully bilingual; because my parents drove a 10-year-old car while my classmates' parents had the latest BMWs, Mercedes, and the like; because I spent the summer watching TV at home and working in my father's small business while my classmates were traveling the world in exotic locations; and because during winter break, I was home having a traditional Puerto Rican Christmas dinner while my friends were skiing with their families in Vail and Tahoe.

One very specific form of otherness I experienced at that time was language. Before entering this English-only prep school, I spoke Spanish like everyone else and had only been exposed to English at school in the required English reading and writing courses. When I entered the prep school, it was very clear that I spoke "broken" English and my wealthy bilingual peers spoke "good" English. My broken English meant that I had an accent, that I didn't have a wide vocabulary, that I didn't fully understand or make good use of all the many rules and exceptions of the English language. Back then, and even sometimes today, words like "thought," "though," and "through" were my enemy. For years I couldn't differentiate these words in writing or even properly pronounce them. Thus, starting with high school, I became aware of socio-cultural differences and their profound psychological impact.

Back then, however, I didn't have a language to understand or articulate experiences where I felt othered, marginalized, ostracized, and discriminated. It wasn't until years later that I began to make sense of these formative experiences.

I moved to the U.S. at 20 to pursue a college degree. Moving to the mainland was expected of me by my family and peers. I was also ready to leave the island. I wanted to see the world but most importantly, I was ready to come out as a gay man away from a largely homophobic family and PR culture.

In the U.S., I tried hard to fit in and assimilate. I was looking and hoping for the mythical "melting pot" experience that never happened. The harder I tried to be like them, to speak like them, to fit into the larger U.S. cultural fabric, the more experience I had that told me I was different and I didn't belong. In time I began to find others who shared similar experiences of migration and who affirmed my sexual orientation. These friends became my chosen family, and their support guided me and allowed me to channel the struggles I experienced as an immigrant gay Latin into a passion and a career.

Yamilka Urquiza Mendoza

As a Caribbean, born and raised in Cuba, I have my individual history with the Spanish language, with Lucumí, and with Yoruban Afro-Cuban. I too am an immigrant and I identify as

Cuban, not Hispanic. Thinking of myself as Cuban is deeply meaningful to me, as my identity has history and emotions connected to the Island. I migrated to the United States at the age of 17. I learned the language post-migration and I still struggle with pronunciation and with grammar.

Fortunately, I do not have the struggles I faced during the first three years of my migration, when speaking my native tongue was not welcomed by everyone. Then, I experienced a lot of curiosity and excitement from people on the West coast, even from those with whom I thought of as having equal or similar background. Soon I found out that "we" were not as similar as I thought and that our Spanish did not have the "sameness" I thought it would have. In fact, sometimes I struggled understanding the "Spanglish" and other colloquialisms of other Spanish speaking people; and in turn, they would comment on the uniqueness of my "Cubanismo."

I spent many years struggling to fit into a country in which I never felt I belonged. As I immersed myself in the culture and language of my new country, trying to find a place where I felt that I belonged, I started to lose some of my Cubanismo. And yet within me, I carried a deep feeling that I was missing something. Later on I moved to Florida where for the first time, I had a felt sense of belonging: there and then I realized that the "something" I was looking for was the *musicality* of the Cuban language, accent, and phrases. Now, every time I go "home" to Cuba, I feel that I recharge my spirit with the musicality of the accents, Cubanismo and Lucumí.

Huan Jacquie Ye-Perman

I am myself a bilingual, bi-cultural psychotherapist, born and educated in China before moving to Canada and then to the U.S. at age 24 to pursue graduate study in psychology. To relate to my professors, peers, and clients—most of them non-Chinese, of course—I immersed myself in mastering English and studying North American culture.

My identity and connection with the Chinese world reduced to conversing a few times a week with family and friends and, occasionally, reading Chinese literature. As my way of thinking about and relating to the world changed drastically and rapidly, at times I would feel awkward in my identity, as if I were somehow "caught" between two worlds. But both time and my doctoral training in counseling psychology—with its consistent attention to social justice and multicultural issues—helped integrate my dual identities. I grew to feel "legitimate" in this historically Westernized discipline and I relaxed my earlier impulse to hide my cultural difference. I also learned to navigate a professional space where almost every encounter was visibly cross-cultural. My post-graduate AEDP training further enabled me to feel effective with clients from a wide range of backgrounds.

At the same time, when I see a client in some way affiliated with Chinese culture, I notice how our shared surface-level cultural affiliation curiously does not automatically enhance the therapeutic alliance. With continued interest in understanding the impact of cultural similarities and differences, and an interest in utilizing the power of emotions in therapy, I gravitated towards AEDP as my path of growth. I have noticed that on this path, both my clients and myself

have been more and more at ease with each other and the work, regardless of our cultural backgrounds.

In recent years, I have begun to work closely with the Chinese therapeutic community in China in therapy and training. While translating AEDP methods and the emotion work from English to Chinese, I am often surprised and delighted at how well my Chinese clients and trainees receive me. I am convinced that AEDP is highly adaptable across cultures, and this commentary will identify some factors that I believe make it so.

Diana Fosha

I was born in Romania, where I lived until I was 12. To escape anti-Semitism and Communism, my family sought to immigrate to the United States; we were able to do so [2] when I was 12, when I arrived in the US with only a smattering of English. With a good ear and a strong multi-determined dynamic motivation to distance myself from my first language, within a couple of years of my arrival in the United States, not only was I speaking English fluently and with little or no accent, but I was also dreaming in English and doing calculations in my head in English (dreaming and arithmetic are usually done in one's native tongue—they tend to persist longer than most language-based cognitive functions).

Before I started high school, my family moved to a new neighborhood in New York City, different from the one we had lived in since my arrival in the United States. At my new high school, I lost my automatic identity as the "immigrant kid": I sounded like everyone else, and whether I revealed my history of otherness or not was discretionary, my choice. At that time, that made me very happy.

Fast forward to just a few years ago. (In between then and the incident I am about to relate, I went to college and graduate school, wrote a dissertation, developed AEDP, and had a life.) As it is hard for me to have an AEDP therapy for myself, much as I desire one, I went to have a consultation with a therapist trained in *brainspotting* (brainspotting, which initially grew out of EMDR, is a model of trauma therapy developed by David Grand [2013]). The processing work I was doing was moving along, when the therapist noticed there was a "blank spot" in the space we were exploring. When he asked me about it, nothing much happened. Then, in a moment of inspiration, he asked me to say what came to mind when focusing there, but this time to do so in Romanian (even though he didn't speak the language). Whoa! Suffice it to say, it wasn't blank!

[2] In light of recent events in the United States (October, 2018), it seems important to mention that, until my parents and grandfather were able to obtain employment in our new country, my family was supported by HIAS, an American Jewish philanthropic organization committed to helping immigrants to the United States.

CONCLUDING REMARKS

There are clearly two overarching themes in these three commentaries. The first includes the importance of honoring the client's bilingualism in the therapist-client relationship and the importance of the treatment-enhancing effects of incorporating aspects of the client's cultural identity into the treatment. The second, related theme includes how crucial it is that the therapist remain exquisitely attuned to the particularities of a client's multiple and non-fixed ethnic, racial, gender, sexual orientation, and other sociocultural identities— these are always more nuanced than meets the eye and ear, even when the therapist is from a similar background as the client; and furthermore, sociocultural identities can shift over time, and even from session to session.

Rodriguez, Urquiza Mendoza, and Ye-Perman raise important questions about Vigoda Gonzalez's case of Rosa.[3] Indeed, we do not know if the racism and colorism so painfully evident in Rosa's history were explored in the treatment; and if they weren't, what the impact of so doing upon outcome would have been. Similarly, we do not know what the impact would have been had Vigoda Gonzalez opted to disclose more fully her own ethnic and racial background, and explored it as thoroughly –similarities and/or differences—as she did her own bilingualism and having Spanish as her first language.

However, what we do know is that Rosa walks away from her 23 sessions of AEDP treatment with Vigoda Gonzalez transformed, grateful, and feeling deeply seen. Chang and Berk's (2009) tremendously important work on how multicultural issues, especially around ethnicity and race, relate to treatment outcome is resonant and deeply relevant here. Practicing the "mixed methods" (Datillio et al., 2010) or "multimethod" (Davis, et al., 2018) research approach, Chang and Berk's 2009 study combined quantitative data with the specificity of a phenomenological exploration of *each* client's subjective experience, conducted through an in-depth individual interview. Their subjects were all racial or ethnic minority clients who had each completed a "cross-racial therapy" with "White, European" therapists. What Chang and Berk (2009) discovered is that the importance clients accorded multicultural concerns differentiated *satisfied clients*, i.e., those with successfully completed treatments, from *dissatisfied clients*, i.e., those who did not feel helped by their treatment experience. The authors' conclusions are fascinating: "Along these lines, we were surprised to find that therapist cultural competence was not associated with treatment satisfaction, whereas cultural *in*competence—e.g., behavior

[3] The case raised some questions for me as well. In addition to the ones raised by Rodriguez, Urquiza Mendoza, and Ye-Perman, for myself, I would also have appreciated some further elaboration of why she was such a sscapegoat in her own family. Was it only because colorism and internalized racism in the family? Were there other reasons, e.g., her paternity? There were many siblings: Was her skin the darkest and was she the only one with darker skin? Were there other reasons for the scapegoating, either heightened vulnerability of some sort, or heightened excellence, like her excelling in school in a way that by comparison shamed the others? One can make up many stories in the absence of information, and thus more dynamic/historical specifics would have helped.

suggesting lack of cultural awareness, knowledge, or therapeutic skill—was associated with treatment *dis*satisfaction only" (Chang & Berk, 2009, page 532).

Chang and Berk investigated what minority clients deemed important in their therapists: four factors emerged. In their order of importance, these factors were: (i) the therapist's "affective involvement in the relationship;" (ii) "therapist caring, respect, and acceptance (e.g., unconditional positive regard), congruence (genuineness), and validation of and responsiveness to expressed needs;" (iii) therapist self-disclosure[4]; and (iv) "the ability of the client and therapist to productively communicate and negotiate ruptures in the relationship, … [i.e.,] therapists' responsiveness to clients' expressions of dissatisfaction, communications of needs, and attempts to cultivate the therapy relationship. " Their results echo and are congruent with earlier work by Sue et al. (2009) and Owen et al. (2011).

When the satisfied clients were explicitly asked about multicultural issues, there were a variety of answers: some said those issues had been addressed with sensitivity; for others, it didn't matter that issues of race and/or ethnicity differences weren't addressed, since the benefits of the therapy far outweighed any problems; and for a few, and reflecting an important point that Ye-Perman (2018, in this issue) also makes, they actually welcomed their therapist's difference, given their own attempts to differentiate from racial/ethnic aspects of their own sociocultural background. When people suffer trauma at the hands of their own people, the leaving of one's native tongue, race, and/or culture can be an act of liberation.

The story was quite different for dissatisfied clients. They placed sociocultural issues, and their therapists' insensitivity and cluelessness in that realm, as central in their dissatisfaction, and thus as central factors in the ineffectiveness of the therapy.

This seems quite congruent with Rosa's experience with Vigoda Gonzalez. Her therapist's self-disclosure that she too speaks Spanish and that it too is her native tongue was extremely important to Rosa. The sharing of two languages, Spanish and English, and language switching, contributed to the success of the therapy in two ways. First, it allowed Rosa to use her native tongue, the language she felt most at ease in, to process the painful memories of her early traumatic experiences, making that very difficult process a little easier, and a little more natural; And secondly, it made her feel deeply seen, validated, and understood, as well as joined, further solidifying the already strong bond between client and therapist.

The four factors identified by Chang and Berk—the therapist's affective involvement; therapist care, respect, and genuineness; self-disclosure; and a valuing of the repair of ruptures

[4] The strong relationship Chang and Berk (2009) found between self disclosure, despite only 50% of it being related to racial and/or ethnic topics, and treatment satisfaction validates Hill's work on the beneficial effects of self disclosure (Hill & Knox, 2002; Hill, Knox & Pinto-Coelho, 2018), Chang and Berk report that clients found it very meaningful: "Results confirm that therapist self-disclosure is an effective strategy for bridging perceived social and power distance" (p. 534). See also Prenn's 2009 article on the importance of self disclosure in AEDP.

and misunderstandings—could very well be taken from the basic manual on the AEDP's therapist's therapeutic stance.

I wish to go beyond the case of Rosa, and beyond Chang and Berk's (2009) AEDP-congruent findings to more general concerns. I wish to explore what allows AEDP to be simultaneously effective and congruent with a multicultural orientation. Towards that end, I want to bring in the core constructs identified by Owen (2013) and his colleagues (Davis et al., 2018; Owen et al., 2017, 2018) as central in the multicultural orientation framework. I also want to bring into the discussion two other published systematic case studies of successful AEDP therapies with clients identified as belonging to oppressed minorities (Medley, 2018; Simpson, 2016).

Emphasizing *orientation* language to complement the competence language of previous writing on multicultural competencies, Owen (2013) and his colleagues proposed a *multicultural orientation* (MCO) framework, its core constructs being "*values*," or as they call them, "*virtues*" that can be used to inform various the therapeutic practices of different therapeutic models (Hook et al. 2017; Owen, Drinane et al., 2017; Owen, Tao, Drinane et al., 2016; Owen, Tao, Leach et al., 2011).[5] "The overarching value or virtue of the MCO framework is *cultural humility*" (Davis et al., 2018, p. 91). A distinctive aim of the MCO framework is the attempt to delineate specific constructs that indicate potentially positive or negative processes within intercultural therapy relationships. "First, culturally humble therapists strive to take advantage of *cultural opportunities* that arise in session. Second, culturally humble therapists strive to develop *cultural comfort* for engaging various cultural identities of clients" (Davis et al., 2018, p. 91).

Thus to Chang and Berk's (2009) four crucial factors—affective involvement of the therapist; therapist attitudes of respect, care, genuineness, and responsiveness; therapist self-disclosure; and the importance of the therapist's actively working to repair misunderstandings and ruptures—we can add the also crucial factors of embodying the stance of *cultural humility; seizing cultural opportunities;* and *striving to develop cultural comfort* with as many aspects of the sociocultural identities of one's client as possible.

A multicultural orientation needs to go beyond race and ethnicity, and be true to the meaning of "culture" that is in the name "multicultural" in a way that it is ideographically attuned to the individual. It needs to address the different constituents of each individual's sociocultural identity, i.e., the therapist needs to adopt an idiographic perspective specific to each client. Furthermore, it is important to remember that it is the individual who deems the relative importance of each aspect of their identity (see also Rodriguez, 2018, this issue; Urquiza Mendoza, 2018, this issue; and Ye-Perman, 2018, this issue). In agreement with a similar point made by Sue et al (2009), Chang and Berk aptly assert:

> Clients are particularly sensitive to acts of cultural incompetence. Such acts to be avoided include applying either generic or textbook interventions that do not take clients' lived experiences into account, addressing only particular facets of clients' complex cultural

[5] I deeply resonate with the ideas of "values" or "virtues" to inform clinical practice. For many years, my handouts on AEDP have begun with articulating its *credo*.

> selves, and invalidating the social realities of being a racial or cultural minority. These findings affirm the importance of adopting an *idiographic perspective*, conceptualizing the client as a whole person with multiple and intersecting cultural identities (including gender, family role, immigration history, religion, age, socioeconomic status, race, and sexual orientation) and choosing interventions that are tailored yet that do not stereotype the client on the basis of normative assumptions about cultural group (2009, p. 534; *emphasis added*).

Rodriguez, Urquiza Mendoza, and Ye-Perman all deeply embody the above and elaborate it with rich detail and texture in their commentaries[6].

To further evaluate AEDP from within a multicultural orientation framework, in addition to Vigoda Gonzalez's case of Rosa, we have two other published, systematic case studies documenting effective AEDP therapies with clients who are members of oppressed minorities: Simpson's (2016) successful AEDP treatment of an African American man and Medley's (2018) successful AEDP therapy with a male client self-identified as gay. In both therapies, the application of AEDP techniques informed by its fundamentally healing orientation and affirmative ethos allowed corrective emotional experiences for both clients. In addition to offsetting whatever attachment traumas each of these clients had suffered in their own respective families of origin, these corrective emotional experiences countered, and were reparative of, experiences of minority stress, discrimination, and oppression that each client had suffered.

Both Simpson and Medley address what about AEDP made the treatments particularly effective in treating their respective clients. Simpson (2016) emphasizes the importance of AEDP's methodology for working with recognition and its impact. The receptive affective experience of *feeling seen*, especially for minority clients who have suffered the effects of the invisibility syndrome, is something she sees as being particularly relevant to her client and the experience of African American men in general. She specifically identifies the importance of her acts of both "explicit and implicit recognition" in that therapy, and her explicit acknowledgment of race and its impact on the client's experience. Medley (2018) emphasizes AEDP's attachment orientation, and its embrace of explicit affirmation as being particularly powerful to counter the shaming of males identified as gay by both the dominant masculinity ideology, as well as by the rejection from their fathers often faced by male gay children. In his treatment, Medley specifically sees his affirmation of his client, his open and explicit expression of delight, as well as the self- disclosure of his own experiences similar to the client, as having a powerful anti-shaming and transformative effect.

It is as if the therapists in these three systematic case studies (Medley, 2018; Simpson, 2016; Vigoda Gonzalez, 2018, this issue) serve two masters, MCO and AEDP, with one stance. And this despite the fact that the principles of the MCO—cultural humility, seizing cultural opportunities, and developing cultural comfort—were articulated well after AEDP came of age. However, these virtues are resonant and congruent with AEDP's own *values* or *virtues*, to use Owen's soulful terminology The therapeutic stance of the AEDP therapist includes all those elements. In addition, AEDP contains many different specific techniques, as reflected in Vigoda

[6] That point is also reflected in the personal experiences related in the autobiographical sketches of all four of us.

Gonzalez's case of Rosa (as well as in the cases of Simpson and Medley), for "making the nonspecific factors of treatment-specific" (Fosha, 2000, p. 222). The AEDP ethos, stance, and practice, as embodied by Vigoda Gonzalez, Simpson, and Medley, allows us to witness these three AEDP therapists in their attuned use of multiculturally competent strategies; in their seizing of cultural opportunities; and in their demonstration of cultural comfort with exploring and affirming their clients' experiences. Furthermore, in all three cases we see evidence of the four factors, including the affective involvement of the therapist and self- disclosure, which Chang and Berk (2009) reported were particularly valued by clients who were members of oppressed minorities.

In these treatments, the AEDP model was able to produce, as it seeks to do, remarkable transformations in "Rosa," Vigoda Gonzalez's client born in a Spanish Caribbean island whose first language was Spanish; in Simpson's unnamed African American male client; and in "Mitchell," Medley's male self-identified as gay client. AEDP also simultaneously and seamlessly embodies the principles of the MCO put into direct clinical action in a fashion completely congruent with the ethos and stance of the AEDP therapist. This is separate from the conscious and deliberate use of multiculturally competent strategies Vigoda Gonzalez refers to in her title and case write-up.

However, before we get overly confident of the rightness of AEDP as a valid, multiculturally informed treatment, one *caveat* about these three cases: Much as the effectiveness of ethnic matching does not seem to pass the test of significant contribution to therapeutic outcome (see reviews by Vigoda Gonzalez, 2018; Rodriguez, 2018; Urquiza Mendoza, 2018; and Ye-Perman, 2018, this issue), nevertheless we cannot ignore the fact that matching is precisely what we have in the three cases under consideration. The native language of both Vigoda Gonzalez and Rosa is Spanish, and self-disclosure of that is a hugely important moment in the case. While of different genders, Simpson and her client are both African American. What Simpson calls the "implicit recognition" of their shared experiences as African Americans in the United States is communicated through "the nod" taking place in the opening minutes of the therapy, and this is deemed by her to be of essential significance. Similarly, Medley, like his client, Mitchell, is a male self-identified as gay. Medley's self-disclosure of "getting" his client based on his own similar experiences, allows the therapy to drop down to a much deeper place. In a way, these therapists do not need to be culturally humble: if attuned, which all three are, they can afford to be culturally confident as there is a huge overlap in the sociocultural identities of both members of each of these three therapeutic dyads, as is explicitly validated by each client and is reflected in the fine details of the client-therapist interaction.

In the future, it will be important to systematically investigate the effectiveness of AEDP in cross-racial and cross-cultural therapies, inquiring into how the virtues or values of the MCO framework come into play in those therapies. There are many such AEDP therapy cases, and we have both videotaped records of them as well as quantitative data from them. Thus, the "mixed methods" approach can be applied. These cases, with qualitative and qualitative data available, exist, but to date, have not yet been the focus of systematic study.

Given AEDP's motto, "make the implicit explicit and the explicit experiential," with respect to multicultural concerns, it behooves us to not be complacent and to keep striving to learn and to further articulate—explicitly and experientially—what we must strive to do in order to be better at addressing these fundamental issues that have everything to do with healing the trauma that our culture visits upon so many individuals. One very important action that we can immediately take is to teach the three virtues of the multicultural orientation framework along with the other aspects of AEDP's credo as a matter of course in all AEDP courses and training.

Especially at this moment in time in the history of the United States, I am deeply grateful to be asked to do this commentary and humbled by having the opportunity, together with Rodriguez, Urquiza Mendoza, and Ye-Perman, my three colleagues in this endeavor, to engage these all-important concerns.

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