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Commentary on: "The Commitment of a Lifetime": The Role of Emotionally Focused Couple Therapy in Strengthening Attachment Bonds and Improving Relationship Health in Later-Life Couples—The Teletherapy Case of "Alice" and "Steve"

The Successful Integration of Emotionally Focused Couple Therapy (EFCT) and Multicultural Theory: Drew Mendelson's Psychotherapy with "Alice" and "Steve"

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ABSTRACT

In reading Drew Mendelson's case study, I am inspired and hopeful about the possibilities for our field to address diversity. Although there are many things to admire and discuss about Mendelson's work, and many implications that it has for clinicians, I am choosing to focus this commentary solely on aspects of diversity, something that Mendelson clearly thinks and cares about, and something that the field is still learning how to integrate into treatment. I will discuss how Mendelson shared his knowledge of the challenges that later-life couples face, recognizing age as an aspect of diversity that needs more attention. Then I will discuss the couple that Mendelson treated and analyze how Mendelson used cultural competence to assess the role of diversity in their lives and to bridge differences between him and the couple and between the two partners. Given that Mendelson used Emotionally Focused Couple Therapy (EFCT) with this case, I will review the aspects of EFCT that appear to be quite useful for working with diverse couples, as well as a set of fatal flaws that hinder the ability of EFCT and other Western treatments to address diversity fully. Based upon those observations, I conclude with the reasons why I believe that Mendelson successfully integrated EFCT and multiculturalism to tailor treatment to the couple, "Alice" and "Steve."

Key words: couple therapy; multiculturalism; multicultural theory; diversity; Emotionally Focused Couple Therapy (EFCT); older adults; aging; geropsychology; case study; clinical case study

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MY EXPERIENCE IN SUPERVISING THERAPIST DREW MENDELSON AND WATCHING HIS SKILLS DEVELOP

I found Drew Mendelson's therapeutic work in the case of "Alice" and "Steve" exceptional. His performance in the therapy was consistent with three long term experiences I

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have had with him while he has been a graduate student in the clinical psychology department at the Graduate School of Applied and Professional Psychology at Rutgers. Specifically, I supervised Drew's emotionally focused treatment of two couple therapy cases for about a year. It occurred early in his development as a therapist, in a small group setting with one other student therapist. Right away it stood out to me that Drew is a natural therapist, with very strong empathy, validation, and reflective listening skills that lent themselves to building a strong rapport and made the members of his couples feel heard and understood. He also was a master at eliciting the primary emotion that is necessary for helping couples gain therapeutically from EFCT.

Moreover, despite how tough Drew's cases were, such as dealing with suicidality, intercultural clashes, and developmental disabilities, he had a constant focus on self-improvement, enthusiastically engaging in role plays and "deliberate practice" (Chow et al., 2015) to facilitate the work. I saw Drew continue to grow in the video clips and thoughtful comments that he shared over time within the large group supervision that we provide in our Rutgers Couple Therapy Clinic, and it was clear then that he had found his calling as a therapist developing expertise with couples. Thus, as a member of his dissertation committee, I found that the therapeutic work that he presented within his dissertation case study that forms the basis of the present paper in *PCSP* (Mendelson, 2023) is but a natural extension of his passion and developing expertise.

A FOCUS ON DIVERSITY

In reading Mendelson's case presentation, I am particularly impressed and encouraged for the field of psychotherapy to address the challenges of diversity.

Addressing the "ADDRESSING" Model

Mendelson's article begins with an educational primer on common issues faced by later-life couples, wherein he impressively weaves in attention to multiple areas of diversity. Hays' (2008) ADDRESSING model is an acronym that highlights many of the areas of diversity that therapists may attend to in therapy. These include a consideration of Age, developmental Disabilities, acquired Disabilities, Religion, Ethnicity, Sexual orientation, Socioeconomic status, Indigenous group membership, Nationality, and Gender. Given that Mendelson focuses on a later-life couple, it would make sense and be acceptable for him to only focus on that aspect of diversity. And Mendelson does engage readers with the important work of attending to development and later-life stage issues of dealing with illness and mortality, which can lead to caregiving burdens, stress, social isolation, loneliness, and cumulative relational trauma. He also unites two important theories in outlining how Erikson's individual later-life stage of integrity versus despair is complemented by the family life-cycle concept of mutual aid among family

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members versus uselessness during the period between retirement and death (McGoldrick & Shibusawa, 2012).

Mendelson also recognizes that the intersectionality among the ADDRESSING categories of diversity is inherent in each of us. That is, every couple has multiple identities that shape each other, impact their lives and deserve clinical attention. For example, clinicians need to learn about normative cultural variations in aging. Mendelson outlines a cultural variation in the later-life stage, wherein mutual aid can involve communal coping that shifts the problem from an individualistic "I" perspective to a "we/our" perspective. This we/our perspective is more consistent with a collectivist orientation (Cohen, Shengtao Wu, & Miller, 2016) that may yield an expansion of resources, support, and mutuality. Similarly, contrary to our individualistic society's emphasis on nursing homes for caregiving of those in the later-life stage, an alternate perspective considers the benefits of caretaking for partners, such as the inherent satisfaction that many may experience in the caregiver role; the moral satisfaction and reciprocation of past kindnesses; and the opportunities for the partners to deepen friendship and companionship. For example, just as with an infant, helping to bathe, lotion, and dress an ill partner can be a loving act that both partners can enjoy, and therapists can assist them in attending to and savoring those moments.

Mendelson also cites Viktor Frankl's (1985) comments concerning Western society's emphasis on achievement and usefulness in the present. This emphasis may become the focus in reminiscing about and reviewing the past and make it hard to cope or find integrity with the advent of physical and mental decline. Mendelson highlights Frankl's essential point that another cultural variation could involve feeling a sense of dignity from having experienced life. From this alternate perspective, those in later-life have developed valuable wisdom, irrespective of their current ability to contribute to society (Frankl, 1985). While that cultural variation may sound reasonable and logical and common, it is not. Western society tends to focus on problem solving and mastery of the physical and social environment (e.g., Smith, 2010), and in line with that cultural value, only recently has the field of psychology recognized the value of non-Western approaches such as mindfulness, and the value of being rather than doing (Atkinson, 2013). Religion also can play a role in fostering greater acceptance of the situation. Each of these variations can be considered as cultural strengths for many communities.

As those who value diversity might expect, those with more experience and training may fail to decrease their own ageist stereotypes, likely due to a lack of focus on diversity in most settings. What was illuminating was that just as with racism and other "isms," Mendelson noted that the experience of doing more treatment as usual can make clinicians apply even more stereotypes, such as disregarding issues related to sexual dysfunction and relationship conflict. It is a diversity concern because clients' age prevents their complaints from being seen as

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legitimate; therapists may have false notions that sex is no longer important as one ages. Or therapists may lack knowledge and simply fail to check to see if surgery, illness, or some of the medications that are given as one ages frequently can contribute to erectile dysfunction or other sexual problems (e.g., McCarthy, 2008). They also may falsely believe that it is "normal" to complain and bicker with one's partner towards the end of one's lifespan due to a stereotype that one should naturally be unhappy when one is older. Instead, Mendelson identifies that the "angry older couple" often suffers from interlocking depressions and a long history of hurting each other deeply without having forgiven each other, both of which can be ameliorated with couple therapy. Rather than believing in the adage that one can't teach an old dog new tricks, his review shows that having realistic hope can lead to growth and greater intimacy late in life. This realistic hope can include mourning losses and accepting realities of the couple relationship, of nearness to death, and of the existential despair that accompanies it.

Alice and Steve: A Later-Life Intercultural Couple

Mendelson worked with Alice and Steve, an intercultural couple in their mid-70s. She is a cisgender Chinese American woman raised Buddhist and with traditional gender roles in Taiwan. He is a cisgender Polish American man who began working at a young age and was raised Catholic in the United States. They met in graduate school and have one adult daughter who is married with a son. They sought treatment due to Steve's advanced Parkinson's Disease and the challenging role that it played in their marriage.

Mendelson foregrounds the diversity aspects of his couple, Alice and Steve, showing how it is integral to their presentation and includes some of the foregoing important factors experienced by later life couples. Alice's analogy for her relationship with Steve was that of a "real estate situation," where as an immigrant graduate student, she was granted land by him sharing his privilege as a third-generation American with her, enabling him to live "rent-free" as a "tenant" while she "toiled to build a life together," disproportionately investing in the relationship during their years together (Mendelson, 2024, p. 22). Thus, she felt "simmering" resentment at again having to bear the burden of caring for him later in life, rather than feeling a sense of mutual aid.

Alice's resentment also seemed to be compounded by how she grew up. First, she was raised with "traditional Chinese values" involving prioritization of the family and patriarchy in the form of traditional gender roles. But beyond traditional cultural values, she also grew up idiosyncratically experiencing the trauma of physical and emotional abuse by her father as "king of the castle" and she experienced her mother as subservient and thus unable to protect her. She immigrated to the US as a student to escape her family life. Yet having only had her parents as role models, Alice tended to submit to Steve's needs, and thus felt just as "trapped" in the marriage as she had in her family of origin. Due to his stoic Polish upbringing and lack of

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experience dealing with emotions, Steve tended to be inactive or focus on solutions, such that she felt like Steve had withdrawn from her emotionally, and thus she felt exploited and lonely. Moreover, it seemed like Alice's reminiscence over her life led to despair.

The Use of Cultural Competence with Alice and Steve

In the field of psychology, scholars and therapists agree that it is essential for therapists to have (a) *cultural humility*; (b) *cultural sensitivity*; or (c) to aspire to the never fully achieved goal of *cultural competence* towards successful cross-cultural practice (e.g., Danso, 2018). Danso (2018) notes that despite the tremendous overlap of these terms, which all reflect care about culture and diversity, the terms tend to have different emphases as well as some degree of construct fragmentation wherein their meanings have changed over time, so sometimes therapists prefer one of the terms and disavow the others. As a researcher and therapist who has long worked in this field, my experience is that the term "cultural humility" tends to highlight therapists' stance of being humble and learning from our clients rather than pushing dominant cultural assumptions onto them. "Cultural sensitivity" tends to highlight being aware and embracing rather than overlooking cultural factors in treatment. While it contains attitudinal components, "cultural competence" tends to highlight being able to address cultural factors in treatment.

Among the three terms, I prefer the term cultural competence due to my belief that therapists' interventions can address diversity, and that one's stance is merely a part of addressing diversity, albeit an essential part. Multicultural scholars and therapists tend to agree that cultural competence includes knowledge of clients' diverse backgrounds; diversity-related intervention skills; and awareness of the biases in the field and one's own idiosyncratic cultural biases (Sue, 2006; Sue, Zane, Hall, & Berger, 2009). Some of us also believe that another important facet of cultural competence is "dynamic sizing," that is, the ability to know when to generalize cultural information to one's clients or to individualize and see their uniqueness (Sue et al., 2009).

What is impressive about Mendelson's work with Alice and Steve is how thoroughly he used cultural competence to bridge differences not only between himself and the couple, but also between Alice and Steve, especially given their cultural differences from one another. Having knowledge of a cultural group can mean having a lot of experience with those at or above one's own status level to ensure that we don't build our competence on clients who by definition have problems that could possibly extend into their relationship with their culture. Knowledge can stem from having read about our clients' cultures, or consulting with or being supervised by those with competence or expertise on our clients' backgrounds, just as we would do with any new diagnosis or area of concern. Mendelson clearly displayed this knowledge in his discussion of Alice and Steve. For example, he noted that, "As is common in Chinese upbringings, Alice

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relied on her education to strive for independence, leading her to relocate to the U.S. as an immigrant" (Mendelson, 2024, p. 26). Similarly, he stated, "As is typical in Polish households, Steve assumed work responsibilities at an early age, maintaining emotional safety and connection with his parents so long as he worked and contributed to the family" (p. 26). These kinds of statements show that Mendelson had developed a sense of what was normative for both of Alice's and Steve's backgrounds.

Moreover, Alice and Steve's case study is rife with Mendelson exemplifying skill in asking the couple about their backgrounds as well. This is a crucial aspect of couple assessment. Not only should therapists assess aspects of presenting problems and diagnoses, but also, they need to assess core contexts, such as those involving culture and family (American Psychiatric Association, 2013; Kelly & Omar, 2017). Towards this end, Mendelson stated:

> Because Alice and Steve were an intercultural couple, I discussed cultural differences with them to better enable their grasp of their negative cycle together. These conversations illuminated which attachment needs and fears were more or less acceptable to express due to early cultural messaging and clarified their positions in the cycle. Alice's upbringing in a Chinese household, characterized by high parental control and filial piety, influenced her tendencies to criticize and pursue. Meanwhile, Steve's upbringing in a Polish-American household emphasized stoicism in the face of pain and independence, shaping his inclinations to stonewall and withdraw. By acknowledging and validating their cultural disparities, Alice and Steve developed a greater awareness of how they habitually disconnected from each other in moments of emotional distress (Mendelson, 2024, p. 34).

This is but one example of Mendelson showing multiple facets of the skill of raising and assessing diversity. First, he took a stance of cultural humility with the couple, as he discussed how he listened and made it safe for Alice to express her concerns about the therapist's age and for the couple to express their concerns about using technology without fear of judgment. Many cultures respect and value elders and ancestors highly (Suzuki, Wong, Mori, & Toyama, 2017), so Mendelson being open to age differences mattering to Alice and letting Alice's concerns drive treatment was important. Alice already had raised diversity herself in making a metaphor for their relationship of Steve granting land to her, the immigrant, while in being an American, he lived on it rent-free as a tenant. But Mendelson went further.

Not only did Mendelson let Alice and Steve tell him about diversity as it arose for them, but also, he asked about early cultural messaging that influenced their cycle, to increase their "awareness of how they habitually disconnected from each other in moments of emotional distress" (Mendelson, 2024, p. 34). I believe that these disclosures also may have increased the couple's mutual understanding and connection around their cultural differences. Clearly, Mendelson's approach to the couple shows that he understands that culture is inextricably interwoven into people's lives and that it influences their approach to their own problems and to

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therapeutic tasks. The success of Mendelson's interventions of this type also suggests the importance of developing the skills to assess the how, what, when, where, and why of cultural influences on behavior.

Like Mendelson, many well-intentioned clinicians often tell me that they are open to including diversity, but unlike Mendelson, they leave it to the partners to raise it if it is important to them. What this means is that due to the power differential in therapy between therapists and clients, therapists might miss that clients may not feel comfortable raising culture if the clinician does not do so first, thinking that it may not matter to the therapist, particularly when the therapist does not share their own background. Also, clients may only talk about one aspect of culture that occurs to them in the moment when they have to raise it on their own, such that the discussion is not comprehensive nor systematic, preventing a full assessment.

The fact of many clinicians' failures to raise or look for the influence of culture and identity with their clients and themselves speaks to the importance of awareness. Each clinician needs to be aware of cultural biases in the field. What many well-intentioned clinicians don't know is that culture is important to all of us, but our treatment tends to be tailored to all of the dominant-group identities, so we do not always notice the presence of those cultural components in our treatments. For example, our treatments tend to lean towards Western ideals of rational thinking, individualism, and independence (Smith, 2010), which many assume are the only "normal" ways to address issues. Studies show that men are listened to more and women are interrupted more in work and treatment settings (e.g., Werner-Wilson, Price, Zimmerman, & Murphy, 1997), which suggests that because it is taught to all of us to yield more power to men, all genders tend to do and accept it. The American Psychological Association (APA) has recently acknowledged the history of how the field has not served minority groups well, due to factors such as structural racism and psychologists' cultural limitations (APA, 2013, 2021).

Therapists must do self-reflection regarding our own idiosyncratic biases as well, as each of our backgrounds and upbringings made us familiar with certain identity groups and not others, as well as some approaches and not others, mostly oriented to dominant groups, whose values and ways of being are prominently displayed. Thus, we may not be aware of cultural variations and strengths such as those which Mendelson referred to in his literature review, which allow differing normal cultural instantiations of universal processes. Mendelson (2024) took the first step of self-reflection in acknowledging his own "countertransference of helplessness" (p. 33) in the face of Alice's pain surrounding the inequities in her relationship with Steve.

Dynamic sizing complements having knowledge of various cultures and identities; the skills needed to raise and assess their importance in our clients' lives; and our awareness of biases against non-dominant groups. Sue (1999) discusses being scientifically minded by having a hypothesis-testing stance in therapy. This means that therapists should test both the hypothesis

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that treatment as usual applies to our clients, and the hypothesis that culture and non-dominant identities matter and apply as well. Like any good scientist, Sue argues that we should not just look for evidence that each of these hypotheses fits our clients, but we should look for evidence that they *do not* fit our clients as well, in line with scientific skepticism.

Mendelson approached the task of dynamic sizing in a different but no less effective way in using EFCT. He discussed how in EFCT, "reflection captures ongoing emotional processing by bringing attention to the internal experience and articulating it vividly and accurately," such as with focusing on the partners' "felt sense" of embodied experience (2024, p. 33). Within that approach, it appears that Mendelson was able to access the couple's identity of being in the later-life stage in a very poignant way. His use of reflection also revealed that much of the knowledge in his literature review about later-life challenges was appropriate to apply to this couple and resonated quite strongly with them. As Alice said,

> But ultimately, the picture is death. So, when you do the marriage counseling, it's not just general run-of-the-mill issues, like my husband has no more interest in me. You know, he has a wandering eye. He visits pornography. Blah, blah, blah. Those are run-of-the-mill issues. But for us, it's the termination of life (2024, p. 34).

Those and other statements of Alice's left no doubt that for this couple, the later-life stage challenges of reminiscence in developing integrity and a sense of mutual aid were very real.

Bridging Differences with Cultural Competence

Given the consensus on the usefulness of cultural competence, I developed a model of Bridging Differences to help clinicians focus their application of cultural competence (Kelly, 2017). I theorize that differences in four arenas—(a) worldviews, (b) power, (c) experiences and contexts, and (d) the felt sense of distance in the room—are core diversity-related cultural differences that therapists need to bridge among themselves and both members of the couple. I also show how various multicultural experts' work with diverse couples and families naturally bridge differences in these areas (Kelly, 2017). Each of these areas of difference can overlap and influence each other, but they are each named for their heuristic importance. Moreover, any or all of the aspects of cultural competence can be used towards bridging differences. Next, I will show Medelson's impressive use of the elements of the Bridging Differences model.

Worldviews

Worldviews can include components like religious and cultural beliefs, racial identity, and other broad perspectives, such as the etiology of problems and how to treat them. Indeed, meta-analysis shows that therapists' ability to culturally adapt their psychotherapy—that is, to bridge differences between their own worldviews and those of psychology with the worldviews of each client—significantly increases effect sizes in treatment (Benish et al., 2011). Given client

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Steve's Parkinson's diagnosis, Mendelson noticed that client Alice felt powerless in the face of his eventual death while still "being left to deal with a wellspring of bitterness and anguish stemming from their relationship" (2024, p. 33). For example, in response to Alice's pain and anger at the power differential between her and Steve, Mendelson first tried to offer hope that the couple could create a different narrative about their relationship. He noted how Alice quickly dismissed that attempt with "a more realistic interpretation of her goals" (2024, p. 33). She told him,

> You know, what is hope? I am a survivor. I'm an immigrant. I am very, very practical, and I'm a survivor. I don't, you know, expect a unicorn or something. But really, just my main goal is that with whatever time remains, I don't want the past to poison it. But, like I explained, the scar is there, and the puss never really healed (2024, p. 33).

Mendelson then changed his approach, concluding,

> When working with those approaching the end of life, offering a safe space to express the "ugly" truths about death is crucial. In aligning with the Chinese notion of fate, focusing on how to coexist with these truths rather than overcoming or problem-solving around them was helpful. While certain boundaries and truths exist in life, one can transcend these constraints by dispelling their illusions about reality (2024, p. 33).

This excerpt shows how Mendelson had knowledge of traditional Chinese beliefs held by Alice, and bridged differences with her in accepting and including Alice's fatalistic worldview in treatment, rather than trying to problem-solve or change it. He joined with her in mirroring her upset about the unfairness of life, repeating her words, saying, "You start to ask, 'What the hell is all this for?'" (2024, p. 35). He also validated her going to a "very dark place" (2024, p. 36) due to that pain.

Power

Power is another area of difference to bridge, particularly with this couple, due to Alice's anger at Steve's disproportionate power as an American male. This is represented in her core metaphor about Steve having granted her land and then lived rent free on it as she toiled to make it better. Power refers to the influence and privilege that dominant group membership yields—such as being White, male, cisgender, heterosexual, rich, American, and able-bodied—where society is geared towards supporting dominant group members at the expense of minority or non-dominant group members (APA, 2017).

The foregoing example of how Mendelson bridged worldviews also is an example of how he leveled some of the power between him and the couple by providing treatment consistent with not just Alice's worldview, but also consistent with her preferences, thus empowering her. Another way that he helped to limit the influence of their power differentials in treatment was by

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(a) being a compassionate witness to Alice's pain regarding doing the lion's share of the work in the marriage due to her immigrant and gender status, and (b) genuinely hearing the microaggressions and related fears that she shared with him. It can be immensely empowering for the client to have the therapist, usually a holder of privilege, to witness the pain of minority clients and not try to explain the pain away or defend against clients' perceptions of discrimination or oppression (e.g., Watson, 2019).

Experiences and Contexts

We clinicians need to recognize that the onus is on us to bridge differences between the varied experiences and contexts among ourselves and our clients. Experiences and contexts refer to the lived experiences and environments that minority groups are subjected to that can be traumatic and sometimes unfathomable to dominant group members who may never even see such contexts. Thus, it is no wonder that Mendelson felt the "transference of helplessness" as Alice spoke to the pain of her female and immigrant statuses leading to her doing the "lion's share" of work in the relationship in the past, and again in the present as Steve begins succumbing to the ravages of Parkinson's disease. It is likely that Steve was unfamiliar with Alice's type of pain and wasn't sure how to help her with it, as Steve had grown up with differing experiences and contexts than Alice.

Given the degree of difference that experiences and contexts can have on people's lives, Kelly and Omar (2017) noted how researchers often examine risk and protective factors related to clients to better predict how to tailor treatment to them. These experiences and contexts also can encourage different ways of engaging with the world. For example, when some minority immigrant women experience trauma, they may be at risk of fusing the trauma with their culture of origin, leading them to disavow their heritage and find a refuge in American culture (Yi, 2014). Indeed, Alice reported that she came to the United States to escape her family life. Yet it is a strength of Alice's that she did not associate her trauma with her culture. She remains firmly attached to her culture, and even wants her daughter to develop a connection to her Chinese heritage like she has.

In alignment with the idea of Alice's experiences and contexts possibly affecting the spouses' approach to each other, Mendelson had wisdom in considering how culture affected Alice's notion of softness. Mendelson noted that,

> Alice and I spoke about the meaning of 'soft' to her and how to express softness in alignment with her familial, cultural, and spiritual experiences. (As Alice aptly put it, Steve did not choose to marry an "opera singer"). By facilitating Steve's understanding of Alice's cultural framework for softness, I could de-escalate tension due to missed bids for connection and foster greater empathy between them (2024, p. 39).

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What I like about Mendelson's discussion of Alice's notion of softness is that he showed cultural awareness in noticing that "she clearly possessed a deep reservoir of tender, soft emotions" (2024, p. 39). We all are influenced by multiple experiences and contexts. Culturally, "traditional Chinese values" tend to involve traditional and patriarchal notions of gender roles, just as "traditional gender roles" in the United States also involve patriarchy. While patriarchy, an orientation towards group harmony, prioritizing the needs of the group, and filial piety are aspects of traditional Chinese culture, Alice's father's abuse was *not* the cultural norm.

Consistent with Mendelson's observations around Alice's softness, every human being has the capacity for the full range of human emotions, and each culture prioritizes which ones are acceptable or not and under which circumstances they can or should be expressed or repressed. Moreover, each individual, couple, and family has a varying capacity to live up to their cultural ideals. While we do not know Alice's father's story, we do know that men's endorsement of traditional masculine ideologies is associated with the use of violence to gain or maintain control (Mahalik, Good, & Englar-Carlson 2003). And it is a very important role of the therapist to make those distinctions between which experiences and contexts are normative and useful for clients, and which ones are not.

Thus, when Mendelson helped Alice to reflect on her anger from the pain of abuse from her family of origin and disproportionate work/adversity as compared to Steve, Alice was able to realize that

> it doesn't mean, whatever Steve did to me, my father did to me is right. It's not right. It's just never right. But why punish yourself? (2024, p. 41).

In this way, Mendelson helped Alice to continue valuing her culture and her marriage, but still let herself process and heal from oppressive experiences.

The Felt Sense of Distance

Felt distance is the final major area that is important to bridge with clients, and the notions of cultural humility and sensitivity tend to focus on addressing this area of diversity. Felt distance refers to that palpable sense of feeling like someone is the "other," dissimilar, not close, and disconnected (Kelly et al., 2014). Notably, the United States has a history of "othering" Asian Americans, and as Alice experienced with post-Covid microaggressions, these types of discrimination have been on the rise (Gover, 2020).

Mendelson made the therapy sessions safe from that type of oppression with many of his foregoing efforts to improve the therapeutic alliance, such as making a safe space for Alice to complain without judgment, being a compassionate witness as she gave voice to her suffering, demonstrating that he was beside her in her peaks and valleys, focusing on capturing her felt sense of internal experience throughout, and asking and caring about culture. He even discussed

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her vulnerability and criticism compassionately, such as when he stated, "that feeling of dissatisfaction and wanting more has allowed you to never give up and to ask for more in your relationships, even thinking about you growing up with your father and getting out of that situation and coming to the United States and leaving that family that hurt you so much? You always had to ask for more for yourself." This is a great use of dynamic sizing, as Mendelson drew out and accurately reflected Alice's experiences and how she coped with them in a positive and validating way, ensuring that her cultural experiences were understood, towards developing a level of closeness with Alice through their differences.

Additional Ways to Use Cultural Competence

Despite my belief that Mendelson did an excellent job in addressing culture with Alice and Steve, it also can be helpful to show other ways that therapists can use the skills of cultural competence to treat this couple. Note that due to EFCT's focus on emotions in stages one and two of the therapy and problem solving in stage three, they all likely would be done in that final stage of EFCT because they are active and concrete interventions.

One strengths-based approach that therapists can always explore is to link their clients with positive community models. These models are people who share the type of diversity that our clients bring, who also are coping well with whatever issues that they face (Kelly et al., 2014). For example, Alice and Steve could be asked to identify other intercultural couples that they know, or other later-life couples who have a partner with a disabling or deadly illness and have one or more conversations with them about their shared or similar challenges.

These community "models" are likely to have had similar experiences and been in similar contexts. This suggests that their chosen coping methods might be particularly applicable to our diverse clients' challenges. For example, they may cope using their own cultural strengths or in other ways not considered by many dominant group members who do not face similar challenges, such as that of being an intercultural couple. For example, Maynigo (2017) has highlighted the common ways that intercultural couples successfully address differences between them. In this way, community couples who are similar to Alice and Steve could serve as role models for positive coping, and Alice and Steve might benefit from conversations with other couples about their shared or similar challenges. Not only does this intervention help to tailor solutions to our clients' specific problems around their specific cultural experiences and contexts, but also it can bridge differences in power between the therapist and the couple because the therapist is demonstrating the belief that there are solutions from the clients' backgrounds that are valuable and useful.

A second intervention skill is to label the problems between Alice and Steve as being due to cultural clashes and be their "cultural broker" in helping the couple to mutually decide what

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aspects of each of their cultures to keep and what aspects to let go of in their remaining lives together (e.g., Kelly, 2017). Labeling differences as due to culture is not only honest and true, but also it externalizes the problem to prevent it from getting in between the members of the couple in therapy. Moreover, this intervention also decreases the power imbalance between the therapist and the couple, as it makes the couple the deciders of what to keep, rather than the therapist, who merely facilitates the conversation and keeps the partners focused on sharing their cultural values with each other and jointly making decisions on what to keep or not.

The issue of what cultural values to keep or reject also touches on the elephant in the therapy room with Alice and Steve: there has long been a need to address the patriarchal aspects of their relationship that Alice accepted but never wanted. Knudson-Martin (2017) has developed interventions to help couples to make their relationships more egalitarian, with a more even power balance between the genders. Ironically, and likely consistent with Steve's presentation, Knudson-Martin notes how many couples report that they want to enact egalitarian gender roles but don't know how to do so, and thus they continue to replicate patriarchal patterns, particularly after having children. Knudson-Martin teaches them to look for patterns of interaction that show a gendered imbalance of power according to (a) relative status, such as whose interests determine what is expressed, what happens, and who does the low-status work in the home; (b) attention, such as whose needs and emotions and needs receive attention; (c) accommodation, such as which partner organizes their life around the other and how do they justify it; and (d) well-being, such as whose well-being is supported at the expense of the other. Then her interventions lead the couple through steps of changing the power balance across the genders (Knudson-Martin, 2017).

What is important to note about Knudson-Martin's framework is that she does not accept patriarchy as a done deal; this is an issue that can be addressed within the couple relationship towards building a stronger and more equitable bond. Towards this end, more assessment of Steve and the cultural influences leading him to utilize his privilege in the relationship could be done. This would prevent a disproportionate focus on Alice as the minority partner, which can reify the false notion of deviance and that Steve's stance throughout their marriage is the normal, best way to be in marriage. Even though Alice and Steve are a later-life couple, and Steve is facing the end of life, there are still aspects of how gender is enacted in their relationship that do not rely on his physical functioning.

Moreover, Mendelson already was seeking to rebalance the amount of attention given to Alice or Steve's emotions and needs. Mendelson got Steve to discuss how he wants to be "more responsive and demonstrative" and "more reflective of what I should be in her life" (2024, p. 38). Then Mendelson asked Alice, "Can you see how he is trying to show up for you right here and right now?" Alice replied, "I am surprised he has been more affectionate." She referred to her extreme care in stopping Steve's bleeding after he had fallen down multiple times. She said,

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"I suppose that made him much more demonstrative" (2024, p. 39). While Mendelson's interventions seemed to be getting them in a direction of more mutuality of emotional expression, the couple also might have benefitted from Knudson-Martin's interventions that could show them where and how they can reverse their gendered power imbalance.

Notably, while they may also touch upon other differences between couples that need to be bridged, each of the foregoing potential interventions deals with bridging power differences in therapy. It is unsurprising, in that one issue with addressing diversity is that dominant groups tend not to want to give up their power, as gaining power at the expense of others is the main reason why oppression exists. While this is not an issue for Mendelson as a therapist, at times those who do not want to give up their power can include therapists and the members of the couple. Thus, it is important for therapists to be vigilant for an overreliance on awareness and understanding, wherein they seek connection and reduction of felt distance without trying to bridge differences in power and other differences in the model that can sometimes be attached to power differentials. Moreover, the field of psychology needs to do better at concepts such as addressing power differentials, removing oppression, increasing social justice, and decolonializing (e.g., APA, 2013, 2021; Comas-Díaz, Adames, & Chavez-Dueñas, 2024; Watson, 2019).

Emotionally Focused Couple Therapy: Diversity Strengths and Weaknesses with Alice and Steve

What extends Mendelson's article beyond that of a solid primer and an excellent example of addressing diversity is his masterful EFCT conceptualization and interventions that show how he helped Alice and Steve turn their relationship around. First, Mendelson gives a thorough and convincing presentation of how and why EFCT is an approach well-suited to this later-life couple, such as how it aids useful reminiscence on the attachment bond over time in the partners' family of origin and in the marriage. He convincingly outlines many of the strengths of EFCT and its interventions, and thus I will refrain from repeating them. But I will focus on a few core EFCT interventions that help with addressing diversity with the couple, and then the factors that I believe hinder EFCT's ability to address diversity with couples.

One of the strengths of EFCT is what Mendelson calls "emotional validation and perspective-taking." Similar to Carl Rogers' unconditional positive regard, EFCT enables the therapist to join with all clients by meeting them where they are and accepting their points of view with kindness, understanding, and validation, to the extent that those of us who use it joke about its use of "validation on steroids." But EFCT goes beyond validation to "catching the bullets" of negativity, such as Alice's criticisms, and raising alternative positive nuggets of one's experience with the partner that often get overlooked. For example, Mendelson asks Alice, "Wow…this is something you have yearned for so long. So can we stay with this for just a

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moment longer?" "Can you let in *just a little bit* that this is really how he really feels about you?" (2024, p. 32). This was an invitation to "seed attachment" or notice aloud some aspect of the yearning for each other or positive bond between them and have them sit with it to ensure that it is received. In sum, EFCT espouses a loving approach to increase loving between the partners. Moreover, this loving-kindness approach of EFCT fits with cultural humility and cultural responsiveness, as the therapist is always on the side of each partner and always supporting them both. That is powerful for people with significant experience with being oppressed and unaccepted or seen through a deficit-focused lens.

Another positive diversity-related aspect of EFCT is its focus on all of the soft, vulnerable emotions. As previously stated, every culture prioritizes some emotions and forms of emotional expression over others. Rather than prioritizing Western male stoicism or any culture-bound emotional expression, EFCT pushes for all soft and vulnerable emotions to be shared, some of which are deemed as a plus and some of which might be suppressed or not valued in any given culture. These emotions are reframed in terms of attachment fears and needs, and the therapist uses the resulting enactments or disclosures of these emotions and longings to help the couple to develop more satisfying interactions and a secure bond (Johnson, 2008).

EFCT also has been adapted to fit with non-Western cultures. Parra-Cardona, Cordova, Holtrop, Escobar-Chew, and Horsford (2009) discussed cultural adaptations of EFCT with Latinx couples. They highlight how therapists using EFCT can attend to cultural identity issues and reframe couple problems around emotions pertaining to cultural issues. They suggest that EFCT can help couples to identify and feel entitled to their cultural needs, and also accept those needs as well as cultural differences together. Similarly, Mendelson was able to use EFCT while attending to Alice and Steve's cultural needs and differences.

WEAKNESSES OF EFCT AND ALL WESTERN TREATMENTS

Unfortunately, the weaknesses of EFCT surrounding diversity are the weaknesses of all mainstream therapy approaches to couple therapy (Kelly et al., 2014). First, they all are assumed to be universally applicable despite being developed by, for, and with the dominant group in the United States. That is, all other groups are not typically included in clinical trials (e.g., Chambless & Ollendick, 2001), and the WEIRD (Western, Educated, Industrial, Rich, Democratic) societies, where most mainstream approaches are developed. are a minority but are presented as the norm worldwide.

Second, therapists of any background who solely use these mainstream treatments erroneously apply a "color-blind" or "value-free" approach while ignoring White privilege, heterosexism, and other forms of oppression. This mainstream approach often leads to the

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development of deficit perspectives concerning diverse couples because the couples are assessed against dominant group norms that do not always apply to them.

Third, and most importantly, EFCT and all mainstream treatments fail to train therapists on how to address diversity. While I acknowledge that each of our major treatments like EFCT can be tailored to diverse couples, the issue is that developers of these approaches assume that therapists can identify, understand, and address diversity automatically without specific training. Moreover, therapy model developers assume that work with the dominant group alone is sufficient to be generalizable to everyone, despite the broad range of diversity that exists in the world. Per Sue (1999), this is a selective use of scientific skepticism, because the reverse is not deemed to be true: researchers and clinicians tend not to believe that treatments developed on minority groups are applicable to everyone else.

CONCLUSION: INTEGRATION IN MENDELSON'S THERAPY

In line with the above, Mendelson's exceptional ability to consider and work with culture in treating Alice and Steve is not derived from EFCT. Rather, I assert that the couple was lucky to have someone who has developed the cultural competence to bridge differences and treat them effectively, while also applying EFCT well.

There is a long rich history of advocacy for culture-focused treatment as a means to enhance treatment as usual. Sue, Ivey, and Pedersen (1996) discuss multicultural theory as a metatheory that supplements the major treatment approaches to enable them to address diversity. Multicultural theory is based on six theoretical propositions: (1) all theoretical orientations are grounded in a cultural context biased towards the population on which they are developed; (2) the complex interrelationships of the client-therapist relationship and dynamic changing contexts must be considered; (3) clients' cultural identities influence their approach to problems, their goals, and the process for reaching them; (4) culture-centered approaches can enhance treatment by expanding the repertoire of "helping responses" available to clinicians; (5) many alternative "helping roles" exist from a variety of cultural contexts; and (6) multicultural theory legitimizes liberation of consciousness and social justice as therapeutic goals (Pederson, 2002; Sue, et al., 1996).

In line with having attended to many of these six propositions, I have concluded that rather than just doing EFCT with Alice and Steve, Mendelson's treatment was integrative, drawing both from EFCT and aspects of multicultural theory to successfully tailor treatment to their unique needs.

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