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A Case Study of Multicultural Counseling: Clinical Issues in Ethnic Match

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In the field of multicultural counseling, client-clinician ethnic match has been widely advocated for better outcomes in treatment. There is, however, a dearth of studies that address specifically how and why ethnic match facilitate the therapeutic process. This study examined important issues based on a clinical case of ethnic match of Korean therapist and Korean client conducted in the U.S.A. Clinical issues surrounding languages, titles, self-disclosure, and gift-giving were discussed. Results indicated that ethnic match in multicultural counseling tend to facilitate the therapeutic process by cultivating common understanding of subtle cultural nuances in the client-clinician relationship, when the clinician approaches the treatment with a heightened sense of cultural awareness and a willingness to examine the clinician's own biases. Clinical implications based on the results were made.

Key words : Multicultural Counseling, Ethnic Match

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Introduction

There have recently been a great influx of international population into the Republic of Korea (hereafter Korea). Many multicultural families and individuals face mental health issues due to various issues such as cultural adjustment, the need for multicultural counseling is rapidly growing. Unfortunately, most clinicians are monolingual Koreans, creating cultural and linguistic barriers between clients and clinicians. As a way to facilitate the therapeutic process in multicultural counseling, ethnically matching clients and clinicians by utilizing immigrant population has been proposed. Thus, it will be very meaningful to explore and understand issues surrounding ethnic match in the field of multicultural counseling.

People regard ethnicity match positively. When the therapist and the client are ethnically matched, there are many advantages: they can speak the same language. For immigrants in particular, being able to speak in the mother tongue facilitates not only communication but also working alliance. In addition, the therapist and the client share the same cultural heritage, which likely further cultivate mutual understanding and capture subtle nuances in communication and behaviors. For those reasons, ethnic match is commonly practiced in a multicultural society such as the United States of America (Hereafter America or the States).

Empirical studies conducted in America tend to support ethnic match. Some studies concluded lower dropout rates after the first session among ethnically matched groups between the therapist and the client, compared to nonmatched groups (Maramba & Hall, 2002). Clients showed up for more sessions when they had therapists of their own ethnicity and reported higher working alliance (Chao, Steffen, Heiby 2012; Sue, 1998). Additionally, there was evidence that ethnic match brought about better treatment outcomes. For example, compared to their GAF scores at the intake, ethnically matched clients exhibited greater improvement in their GAF scores (as evaluated by their therapists) upon discharge than did nonmatched clients (Gamst, Dana, Der-Karabetian, & Kramer, 2001).

Other studies, however, demonstrated the complexity of ethnicity match. For example, Gamst et al. (2001) asserted that the effect of ethnicity match could vary depending on the given diagnosis of the client. In their study, when groups were classified according to the given diagnosis, nonmatched anxiety disorder clients showed higher GAF evaluations than their ethnically matched counterparts. Sue (1998) suggested that ethnicity match matters to certain ethnicity groups. She found that treatment outcomes for African Americans and Whites were not related to ethnicity match while the converse was true for Asian Americans and Mexican Americans. She concluded that ethnicity match is important for less acculturated groups.

By and large, it appears that existing

empirical studies support the notion that ethnic match facilitates therapeutic progress, especially for less acculturated groups and Asian populations. However, those studies are quantitatively conducted and fall short in explaining why and how ethnicity match works and/or does not work at times. Do ethnically matched clients show up for more sessions only because they find their therapists more understanding? Or do they show up because they expect their therapists to be more understanding? Do they receive more positive GAF evaluations because their therapeutic gain is greater? Or is it because ethnically matched therapists normalize or minimize clients' symptoms from their cultural perspective? What kinds of transference and countertransference issues come up? In order to address those questions and deepen the understanding of clinical implications of ethnic match in multicultural counseling, a clinical case between a Korean therapist and Korean client in American setting was qualitatively analyzed.

Method

Among various types of qualitative research, the present study employed case study method. This is a type of qualitative research which focuses on intensive description and analysis of the individual case (Merriam, 2009; Pak, 2006). The credibility of qualitative research depends on the credibility of the researcher and rigorous methods for systematically analyzing the data (Patton, 2002).

In the present study, I, as the primary researcher and therapist, served the primary instrument for data collection and analysis. While conducting this study, I was a female therapist in my early 30s, born and raised in Korea. I was pursuing a doctoral degree in clinical psychology and had received several years of clinical training in the States. The participant as the client called "M" was a Korean male immigrant. He was in his early 50s and immigrated to the States when he was 19 years old. He had been diagnosed with schizoaffective disorder for the past 20 years and had been hospitalized every other year on average. Psychotherapy between the therapist and client took place at a regional mental health clinic in North California and lasted a year. The qualitative analysis of clinical issues surrounding this case proceeded under the supervision of and consultation from a group of multiple clinicians: two licensed clinical psychologists, one licensed social worker, and two doctoral students in clinical psychology. The primary researcher with the Korean origin was able to interpret the meaning and cultural context of therapeutic process from the insider perspective. Other researchers provided a variety of perspectives from different angles: one is Korean American who was born and raised in the States; another was from a South Asian country; another has a

similar originality, yet was born and raised in the States; still another had the Eurasian background; the last one was an European American. They all provided valuable insights from their clinical and personal experience. The case was analyzed on a weekly basis.

The results were summarized surrounding a series of questions surrounding ethnic match raised by the primary researcher during the course of treatment: the first question was how the language of choice in therapy influence the therapeutic process. Although Korean was M's primary language, he initially refused to speak Korean. Over the course of treatment, both Korean and English was spoken in session. I noted how the language interacted with transference/countertransference issues as well as therapeutic progress. The second question was related to finding the right title for the client. In Korean culture, there is an emphasis on relational hierarchy between the young and the elderly. Finding the right honorifics depending on one's status in relation to the other is extremely important. As I, as a young woman, counseled him, the elder, it created a complex relational dynamic. The third one dealt with self-disclosure and boundary issues. I often had to ask myself where and how I drew my boundaries as M frequently asked about my personal life. Koreans build relationships usually by sharing personal information. In contrast, being neutral and setting the boundaries is emphasized in psychotherapy. Related to the third, the last question was: what shall I do with the client's gifts? From an early stage in therapy, M brought me a gift, which raised a question of what is culturally appropriate and what is therapeutic. Exploring these issues led to a cultural formulation of this case.

Results

Flowing with Languages

When the client speaks more than one language, the therapist needs to pay attention to which language the client chooses to use in the therapeutic dyad. Each language contains a specific set of affects, memories, and traumas, contains some affect states that are not necessarily translatable from one language to another, and contains self and other representations formulated during its acquisition and use (Rapoport, 2008). Thus, it is possible that a client use a secondary language defensively; by switching to a secondary language, the client may use intellectualization, isolation of affect, and splitting off of anxiety-ridden internal fantasy. This tendency was noted in my work with M.

First, I would like to describe how M's language choice and our language negotiation took place over time. When I first received his chart, I noted that his name was an English name. Although I was informed that he was a

Korean-speaking client, in my first phone call, I asked if he would prefer to speak in Korean. He responded: "No! Only English!" In our first session, his English was observed to be poor. It was baffling for me to understand his insistence on English. Toward the end of the session, he questioned my ethnicity. When I revealed that I am Korean, he looked disappointed and expressed his unwillingness to see a Korean therapist. I sensed that his refusal to speak Korean was related to his unpleasant previous experience with Korean. As I suggested that he try a trial period of therapy, he agreed to see me.

In the early stage of treatment, however, I was careful to use only English in order to relieve M from his anxiety of relating to a Korean therapist. Speaking English served me as a young therapist as well: it relieved me from hassling with finding the right respectable words which would have been required if we spoke in Korean. During this phase, he tended to share world knowledge that he had found valuable as if he wanted to give me important lessons. As mentioned earlier, his English was poor. His thought process was tangential. Naturally, I played a role of language tutor, providing him with the proper English words and helping him connect his ideas. It was as if he traded his knowledge for my English skills. Therapeutic rapport was well established. He appreciated my attentive attitude, and showed up to every session punctually. After a couple of months, however, the stagnant phase arrived: he was running out of topics of his world knowledge, and I became bored with my tutoring job.

My consultation with other clinicians raised a possibility that I had colluded with M in speaking English, thus avoiding dealing with anxiety-provoking issues in our relationship. I examined my countertransference: not only did I not want to shame him by reminding him that I was younger, yet successful enough to counsel someone like him, but I was also afraid to accurately assess his debilitating condition if he spoke in his mother tongue. He was a middle-aged man, a little bit younger than my father. I always respected men in my father's generation for working hard and creating the economic miracle in Korea. I hated men of my father's generation to look pitiful and sick. It would be as if my Korean pride collapsed. Nonetheless, I had to admit that focusing on his knowledge and English skills left us little room for therapeutic work.

After exploring potential problems in speaking only English, I decided to try to speak Korean in sessions. First, I greeted M in Korean. He tended to greet me in Korean. Whenever he utilized some Korean words, I attempted to converse in Korea for a longer time. In response, he spoke more Korean. Gradually we became more and more Korean; he started to share some traumatic events that had occurred to him in sessions. In the following session after we spent most time speaking in Korean, he

spoke mostly in English as if he needed some break from his affect-laden issues. I respected his choice of language. English and Korean started to flow naturally together without much tension, facilitating our therapeutic progress. As Rapoport (2008) noted, the therapist's choices regarding language must derive not from rigid formulas but from the specific ebb and flow of the analytic material and the emotional ambience both of the relationship and of the particular session. One should neither encourage nor discourage the patient's use of his mother tongue.

Natural flow of language negotiation revealed a more accurate clinical picture of M's condition. His level of psychotic symptoms was observed to be severe: he exhibited various delusional beliefs and irrational thoughts. Nonetheless, he became more sincere toward sessions and willing to share his personal stories, especially when speaking in Korean. I realized that his traumatic events resided within a Korean-speaking context. I also learned that when he seemed under greater stress, he spoke English more, probably as a way to distance himself from his emotional experience. On those occasions, he rather talked about topics that would not involve his affect such as trees, flowers, animals, and coins. When he seemed less distressed, he engaged more in the therapeutic process, sharing his memories that were emotionally loaded. When the pain was too intense, however, I noticed that he switched to speaking English and tried to lighten up the atmosphere. I realized that our language negotiation finally had reached a stage where the ebb and flow of the language change came and went very smoothly.

Finding the Right Titles

In the context of speaking Korean, I noticed some different relational dynamics from what I had become used to in my western training. When we spoke in English, our relationship felt more equal. As soon as we spoke in Korean, relational hierarchy became more salient for me. Honorifics are special nouns and verbal endings that indicate the listener's superiority. People use honorifics when talking about someone superior in status. In Korean cultural context, it is extremely important for one to find the right honorific, because it informs one of how to relate to the other person. Age itself plays a significant role when one tries to figure out how to relate. With M, as we conversed in Korean, contemplated on finding the right title for him. The first title that I tried with him was "sunsang-nim." The literal meaning of "sunsang" is someone who was born earlier. In Korean context, it is mostly associated with a "teacher" at school. "Nim" is a suffix to acknowledge the other's superiority. Thus, "sunsang-nim" means the "respectable teacher." In Korea, the word "teacher" is rather loosely used. It often refers to someone who is more knowledgeable and experienced than oneself. For example, if you are

a doctor, you are a doctor "sunsang-nim." If you are a counselor, you are a counselor "sunsang-nim."

When I first called M "sunsang-nim," he smiled. I was delighted, thinking that I had found the right honorific. After a couple of sessions in which I called him "sunsang-nim", he raised a question about my choice of his title. He explained that he did not deserve to be called "sunsang-nim." When asked, he expressed his desire to be called "Mr. M." Although I attempted to use the title as he requested, I noticed my discomfort with calling him "Mr. M." I sensed his sadness and despair when he said that he did not deserve to be called "sunsang-nim." For the following few sessions, I shuttled between "sunsang-nim" and "Mr. M" as I felt confused between respecting his desire to be called "Mr. M" versus following the Korean cultural norm of calling the elderly "sunsang-nim".

My consultation with multiple clinicians directed me to examining the level of comfort in me seeing this elderly man as my client. When seeing elderly clients of a different cultural background, I felt relatively comfortable without being too conscious of the age factor. When it came to Korean culture and Korean clients, however, I found myself increasingly conscious of age difference. I had to ask myself if I could play his therapist given that he was much older than I.

In order for me to comfortably identify myself as his therapist, it took some work on my countertransference. What helped me most was to examine my own biases about what I, as a Korean woman, should or could be. I realized that growing up, I had unconsciously and consciously aspired to become *HyungMoYangChu*. The literal translation of *HyungMoYangChu* is the wise mother and good wife. It is the ideal image of a Korean woman that used to be most highly regarded in the traditional society. Importantly, as a good wife, a woman is supposed to be "proper, submissive, passive, and enormously patient" in relation to her husband (Choi, 2005, p.69). This principle between the husband and wife applies to any hierarchical relationship. A subordinate should know how to behave in a proper and submissive manner, so that he or she can make his or her superiors feel good about themselves.

Growing up as a girl, I had learned to show respect and be obedient to elderly people. It was a very important virtue, especially for girls. It certainly makes the other person feel respected and highly regarded. In the initial phase of our treatment, I approached him with the kind of cultural attitude. I carefully listened to what he had to say and treated his knowledge as something from a knowledgeable and wise man. The limitation with this approach was that it made it very difficult for me to challenge him. I was ignoring the simple fact that my client came to receive benefits from my expertise.

I started to wonder if *HyungMoYangChu* was the only archetype of the Korean woman. Soon after, I realized that I paid little attention to the wise mother part in *HyungMoYangChu*. Probably because I had less experience with being a mother, I simply thought that the wise mother is a compassionate mother. However, the wise mother needs not only to be compassionate, but also strict. Even in the traditional society, the mother was the primary force within the home. She ran the household, and nurtured, supervised, and sanctioned children (Roland, 1996). She was not just passive and submissive. In the relational dyad between the client and the therapist, the client often experiences the therapist as a maternal figure. In that sense, I realized that I, as a therapist, could be strict and challenge my clients.

Examining the Korean woman's images that I was not so aware of, I encountered another important figure, the shaman. The shaman was the healer in the traditional Korean society. Nowadays there are male and female shamans, but traditionally shamans used to be mostly female. Everyone in the village – male and female, the old and the young – came to a shaman for healing. A shaman shared their clients' sorrows as if they were their own, verbalized the clients' repressed sense of injustice, sang for their clients, and gave direction and homework (Kim, 2005). Their role was very similar to what therapists do in the contemporary society. In my relationship with my clients, I did not have to be just a girl in the village who was young and inexperienced, but I could be the powerful woman of healing who was outside of the ordinary relational hierarchy.

The *kumiho* (literally "nine tailed fox") was another figure that freed me from being just a docile and proper woman toward my clients. The kumiho is a creature that appears in the oral tales and legends of Korea. According to those tales, a fox that lives a thousand years turns into a *kumiho*. It can freely transform, mostly into a woman, especially into a beautiful woman who is often sent out to seduce men. It is associated with a character who is cunning, powerful, and scary. A supervisor of mine had mentioned *kumiho* several times to me, but my initial response was, "What do I have to do with the *kumiho*?" Reflecting on my relationship with M, I realized that at times I was like the *kumiho*. I transformed into various forms of a woman - mother, wife, sister, and daughter. I realized that as a therapist, I could be experienced as seducing, cunning, and powerful. As I became more comfortable identifying myself with different female characters in Korean mythology, I found myself a lot more at ease with being my aged Korean client's therapist. What I had learnt over time was that as much as I struggled, my Korean client who was older than me also struggled to accept me as his therapist. As I become more comfortable with being his therapist, he seemed to feel more

comfortable accepting me as his therapist.

Finally, I started to call him "Mr. M" consistently. Actually his requested address for himself matched with his address of me, because he called me "Ms. A." Interestingly, as we matched our honorifics, the relational hierarchy between us did not feel rigid. I found our rapport strengthened. Challenging and confronting him became a natural part of our treatment. He was above me in hierarchy because he was older and more experienced with life in general. I was above him because I was a therapist who provided him with nurturance, comfort, and insight. Interestingly, this dual hierarchy equalized our power and position in our relationship as we successfully negotiated our titles for each other.

Drawing Boundaries and Disclosing oneself

McWilliam (1994) mentioned that she utilizes self-disclosure usually with a psychotic client in order to help the patient become at ease with the therapist as an ordinary human being. Nonetheless, the therapist generally approach the client's questions directed at the therapist's personal life with caution. The therapist is encouraged to discover the meanings behind each question first before deciding whether to answer it. In practice, however, many therapists may have come across situations where some clients are incapable of or unwilling to participate in the meaning-finding process.

Certainly, in my practice, I have encountered some clients who indicated their interest in my personal life. M was rather too invasive in that he asked personal questions in almost every single session, especially after he happened to see me with my daughter (who was a toddler at that time) outside of the clinic. He persistently tried to know more about my daughter by asking such questions: "How old is she?," "What's her name?," "Is she counting?," and "How is she doing?" I felt very uncomfortable and intruded upon, so I rarely answered his questions. Instead, I prompted him to think over where the question came from. My attempts to discover the meanings or intentions of his questions were mostly unsuccessful: he responded by continuously switching topics. It felt as if he was determined not to reveal his internal world because I refused to share my personal life.

Our interaction repeated itself: he asked questions, and I asked him what made him curious about that particular subject. He became less persistent with his questions as if he knew that I was not going to answer him. Then, I started to notice some pattern in him questioning me about my daughter: he asked about my daughter when he became emotional about the content at hand, or right before he was going to share emotionally charged memories. I commented on the process, and he laughed as if he agreed with me. Nevertheless,

he continued to be very curious about my daughter. I often sat with this question: “Why should it be about my daughter, of all things?”

In the middle phase of our treatment, I had an opportunity to visit a Korean community where I used to be a member of. This provided me with an opportunity to deepen my understanding of his curiosity about my daughter. Many Korean friends that I met on the trip, threw similar questions to those that M had for me: “How old is she[my daughter]?,” “Is she walking and running?,” “Can she talk?,” “When are you going to have the second baby?” In Korean households, the family is centered on the children (Roland, 1996). Social conversations typically revolve around topics on children. All of sudden, I realized that my client had related to me as a Korean to a Korean; in contrast, I had focused on acting as a therapist. I hypothesized that some of his questions about my daughter were his way of asking, “How are you?” Upon resuming our work, I was better able to discern intrusive questions from benign and social ones. As I answered some benign and social questions, he shared his life events and various emotions in a more sincere manner.

Dealing with Gifts

From a very early stage of therapy, M brought me a gift. One of his first gifts was dimsum (chinese dumpling) with soda. Our session was scheduled around noon, so it felt as if he intended to socialize with me over the meal. I was truly uncomfortable with his gift because he pushed my boundaries by confusing therapeutic relationship with casual social one. I believed that receiving such gift would be ethically problematic. At the same time, I was afraid to reject his gift because I was keenly aware of his vulnerability to social rejection. I felt frozen not knowing what to do, and simply ignored the fact that he put dimsum in front of me. I presented this dilemma to one of my consulting members and expected her to help me come up with ways of stopping him from bringing such gifts. Betraying my expectation, she simply emphasized the importance of talking about the gift instead. She added that some clients like to bring gifts.

M continued to bring gifts including a bag, a whistle, an apron, a flail, and coins. I became increasingly curious if there were any cultural and/or personal meanings behind his gifts. While I was reflective of cultural nuances surrounding his gifts, I recalled what I had done in college in Korea. When I went to see a professor for extra help, I brought him some snack with a drink. It was my token of appreciation for his time and help. It is a rather common practice in Korean culture. In fact, that was exactly what my client did in the beginning: his gift was dimsum with soda.

After communicating my understanding of his gifts, I attempted to discourage him from

presenting gifts for various reasons (e.g., his economic situation, or the potential loss of therapeutic gain). Nonetheless, he insisted that he should bring in gifts; thus, I insisted that we should talk about them. Gradually, I realized that he communicated his dreams, fantasies, and memories through his gifts. Pieces of his memories and feelings surrounding each gift were shared. Due to his tangential thought process, it was often difficult to make sense of those pieces. At times, however, those pieces were weaved together and emerged as a sensible story. I felt as if I worked out a puzzle: sometimes it was enjoyable, yet other times frustrating.

My confusion about M's gifts led me to further explore the general topic of gift giving and receiving. Freud (1917/1961) regarded gift-giving as an expression of transference whereby the gift represents the client's attempt to win favor with the therapist, much as the client would do with his or her parents. From a more conservative perspective, gifts are viewed as unconsciously motivated representations of symbolic desires (e.g., to please the therapist and be more intimate with the therapist outside of therapy) (Kritzberg, 1980). In this context, gifts may reflect the client's personality characteristics and interpersonal problems. From this perspective, M's gifts were interpreted as his difficulty with interpersonal boundaries and his fear of rejection. Sue and Zane (1987) assert that gift-giving is common and culturally appropriate in many Asian communities to show gratitude, respect, and the sealing of a relationship. Taking this angle, M's gifts could be his cultural expression of gratitude and respect.

As I speculated on the potential meanings of his gifts based on our interactions, multi-layered meanings attached to his gifts were unfolded. First of all, it was definitely his expression of gratitude. One day, he articulated this by saying, "you give me strength, so I give you gifts." Secondly, it was his attempt to enhance his self-esteem. He alluded that gift-giving was his way of contributing to someone's life. Thirdly, it seemed as if he was building his "familial self" through our relationship. According to Tang (1997), most Asians have different self-concepts than Caucasians. While for many Caucasians, it is more important to have a distinctive sense of individual self, many Asians feel secure about themselves through who they are in their family. In our relationship, M seemed to play the uncle figure who tried to contribute to my family. Fourthly, gift-giving sometimes served as his communication of how he had been for the past week. I noticed that his gift was more benign, ordinary, and likable when he had a better week, while his gift was too heavy, too big, or breakable (probably indicating his aggressive impulse) when he had a worse week.

Lastly, M seemed to utilize my ego function to discern what to trash and what to keep

through my response to his gifts. He gave me permission to throw them away if I disliked his gifts. He further revealed that he had hoarded up stuff in his room. I associated his stuff with psychotic parts of himself. Although he knew that he had a rather irrational part, he was attached to it because it had the surviving value. He had lost a sense of what to keep and what to trash. He needed me to do that. There could be more meanings to his gifts than those I listed above. What I believe was more important for us was that my empathy for and understanding of him had increased in the process of finding meanings behind his gifts. As I was able to uncover more meanings behind his gifts, he presented his intentions and thoughts in a more organized manner.

Formulating the Case from the Cultural Perspective

A further cultural formulation of M's case was attempted. I paid particular attention to his immigration experience. He was born and raised in Korea and of a generation before mine. He grew up in Korean traditional society which was largely governed by rules and obligations of Confucianism. Although it may have been very burdensome, Confucianism provided a *deeply felt sense of security*: "everyone knew their exact place in the social schema, the precise path that they were assigned to tread, and the specific personal parameters that existed for them. Nothing was left to chance or improvisation" (Slote, 1996, p. 197). Based on his reports, his position was secured in Korea. He was the adored first-born of a wealthy family. He had servants who were subservient to him, and neighbors who recognized his family's reputation. When he became a late teen, he immigrated to the States. What happened to his life after the immigration?

Rapoport (2008) compared the immigrant's struggle to Laing's (1960, as cited in Rapoport, 2008) notion of "*ontological insecurity* - the sense of confusion, isolation, and terrifying lack of certainty characterizing psychotic experience." The immigrant's experience is similar to that of the psychotic patient in that things are unknown and unknowable as if he or she were in an unfamiliar country. One is never sure who one is, who the other is, or what is to come. More than anything else, his immigration experience challenged and confused his sense of self. If he had been comfortable with his sense of we-self, the new culture challenged him with individualistic values and perspectives. Roland (1996) distinguished we-self (or family self) from individual self: we-self is a self that is primarily experienced in relation to others. An experiential sense of a we-self includes the inner image of others of the extended family and community as part of the self to a much greater degree than the highly individualistic, more self-contained American I-self.

The years M had been in the States

corresponded with the years that he had been mentally ill. He expressed his regret coming to the foreign country by remarking that if he were in Korea, even though he would be somewhat odd and weird, he would have been recognized as the heir of a wealthy family. I also imagined that his family would have been there to taken care of him even in his illness. In a new country, he lost all the bases that had secured him before. He had a low level of English proficiency and was a person of color. He was no longer seen as the first-born of a wealthy family. His way of socialization may have been seen as clumsy and awkward. Back then, for him, the country, not he, might have felt as confusing and strange. This kind of cultural case formulation helped me view his symptoms as more understandable.

Discussion

After exploring the above-mentioned issues, I went back to the original question: Does ethnic match facilitate the therapeutic progress? Overall, the therapeutic progress of the presented case was positive. M remained consistent and cooperative with his treatment for the first time ever since he started receiving psychological services more than 20 years ago. He used to be hospitalized once every two years due to his psychotic breakdown. The beginning point of our treatment was when his previous clinicians expected him to decompensate: however, he stayed stable throughout the year and managed to cope with daily stress. Can we conclude that ethnic match brought about this positive outcome? It did help, but the outcome was not given. In the beginning of treatment, ethnic match played a role in increasing the client's level of resistance. M exhibited hypervigilence due to his negative previous experience with those who shared his ethnic background: he refused to speak in Korean and was reluctant to see a therapist of his own ethnicity. As the treatment proceeded, however, ethnic match provided with a sense of 'us' and common ground to understand nuanced meanings behind certain words and behaviors.

The effect of ethnic match largely depends on the degree to which the therapist is aware of his/her cultural biases about his/her own culture and therapy. The therapist needs to sensitively normalize the clients' cultural behaviors and at the same time challenge them in a way that helps them adapt well to their given environment within the dominant culture. The therapist's familiarity with the client's culture can easily overshadow therapeutic issues at hand. Based on the presented case study, the following recommendations are made for those who consider ethnic match in the field of multicultural counseling: first, the therapist should examine his/her own cultural biases and remain open to the possibility that the client may have different ideas and assumptions about

their shared culture. Secondly, the therapist needs to continuously seek supervision and consultations so that the therapist be sensitively aware of his/her biases about the dominant culture as well as psychotherapy. Finally, the therapist should be able to bring flexible lens in understanding normality/psychopatholgy from the cultural perspective, yet help the client develop adaptive coping skills in the given cultural milieu. When the therapist makes continuous effort to remain culturally and clinically sensitive, the ethnic match in the multicultural counseling is likely to greatly facilitate the therapeutic progress.

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다문화 상담 사례 연구: 상담자-내담자 간 동일 민족성의 문제 고찰

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다문화 상담에서 상담자와 내담자의 민족성이 같으면 상담이 더 효과적일 것이라고 보는 경향이 있다. 본 연구에서는 미국의 상담장면에서 한국인 상담자가 한국인 내담자를 상담했던 사례를 중심으로 상담장면에서의 상담자-내담자 간 민족성 일치를 둘러싸고 나타나는 몇 가지 임상적 이슈-언어의 문제, 호칭의 문제, 상담자-내담자간 경계의 문제-를 다루었다. 본 연구를 통해 다문화 상담에서 상담자-내담자 간 민족성이 일치할 경우 상담자가 높은 수준의 문화적 자각을 가지고 상담에 접근하면 내담자가 언어적 혹은 비언어적으로 전달하는 메시지의 미묘한 문화적 의미를 이해하기 용이해지기 때문에 상담 과정을 촉진할 수 있음을 알 수 있었다. 결과를 중심으로 다문화 상담에서 상담자-내담자 간 민족성 일치를 통한 상담효과를 제고하기 위한 방안을 논했다.

주요어 : 다문화 상담, 민족성 일치