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From ancestral knowledge to clinical practice: The case of *agonias* and Portuguese clinicians in America

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ABSTRACT. Cultures have varying notions about symptom expression and the treatment of mental health issues. Consequently, clients and psychotherapists may or may not share a similar worldview. In the psychotherapy literature there has been increased attention to these complex processes. This survey descriptive study aims to understand how therapists working with culturally diverse clients incorporate sensitivity to cultural differences. Fifteen culturally sensitive mental health care providers working with the Portuguese immigrant community were interviewed about their practices. Specifically, we investigated their understanding of the symptoms, causes and cures for *agonias*, a culture specific phenomenon. It was found that even though the providers are all Portuguese themselves, the meaning that they ascribed to *agonias* (anxiety and/or depression) was very different than the meaning ascribed to *agonias* by community members. The community member's meanings ranged from indigestion to being on the brink of death. A cluster analysis revealed that clinicians who stated that *agonias* is anxiety, conducted cognitive behavioral therapy or psychopharmacology, and those that stated *agonias* had a depressive component tended to use family therapy or psychoanalysis.

KEYWORDS. Portuguese. Immigrants. Agonias. Therapy. Cultura. Survey descriptive study.

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RESUMEN. Este estudio descriptivo mediante encuestas trata de conocer como los terapeutas que trabajan con clientes de diferentes culturas incorporan a su práctica profesional la sensibilidad a estas diferencias culturales. Con este objetivo, se entrevistaron quince profesionales del área de salud mental considerados hábiles con respecto a cuestiones culturales, los cuales trabajaban con la comunidad de inmigrantes portugueses. En concreto, se trata de identificar el conocimiento de estos profesionales sobre los síntomas, posibles causas y tratamientos del fenómeno "agonias", específico de la comunidad de inmigrantes portugueses. Incluso tratándose de profesionales de nacionalidad portuguesa, se identificó que el significado que le atribuyen al fenómeno "agonías" (como sinónimo de ansiedad y depresión) es diferente al descrito por los individuos de la comunidad de inmigrantes. El significado que estos le atribuyen varía entre el término de indigestión a una denominación que indica proximidad de la muerte. Un análisis global revela que los clínicos que identifican "agonías" con ansiedad habían aplicado terapia de conducta cognitiva o psicofarmacológica; por su parte, los que identifican las "agonías" como un componente de la depresión habían empleado la terapia familiar o el psicoanálisis.

PALABRAS CLAVE. Portugueses. Inmigrantes. Agonías. Terapia. Cultura. Estudio descriptivo mediante encuestas.

RESUMO. Este estudo descriptivo mediante inquéritos tem como objetivo a compreensão de como terapeutas que trabalham com clientes de culturas diversas, encorporam à sua prática profissional a sensibilidade às diferenças culturais. Para tanto, fora entrevistados quinze profissionais da área de saúde mental, considerados hábeis em relação a questões culturais, os quais trabalham com a comunidade de imigrantes portugueses. Mais especificamente, procurou-se identificar o entendimento destes profissionais sobre os sintomas, possíveis causas e curas do fenomono "agonias", específico à comunidade de imigrantes portugueses. Mesmo tratando-se de profissionais de nacionalidade portugueza, foi identificado que o significado por eles atribuído a "agonias" (como sinônimo de ansiedade ou de depressão) foi diferente do descrito pelos indivíduos da comunidade de imigrantes. O significado atribuído pelos imigrantes, varia de um sinônimo de indigestão, a uma denominação que indica proximidade da morte. Uma análise do conjunto revelou que os clínicos que identificaram "agonias" como ansiedadade, haviam aplicado terapia de comportamento cognitivo (cognitive behavioral therapy) ou psicofarmacologia (psychopharmacology); aqueles que identificaram "agonias" como um componente de depressão, por sua vez, haviam empregado a terapia de família ou o psicanalise.

PALAVRAS CHAVE. Imigrantes. Portugueses. Agonias. Terapia. Cultura. Estudo descriptivo mediante inquéritos.

Introduction

Notions of mental health regarding symptoms, diagnosis, and intervention are culture-specific. Not surprisingly, various frameworks about the nature and treatment of disorders emerge from a variety of worldview perspectives. Consequently, at times

there is a discrepancy between the culture of the client and the culture of the therapist. Sometimes, the culture of the client has a worldview that strongly encompasses the social and religious domains. This worldview can include such things as the centrality of spirituality, strong ties to the family, lack of materialism, and a determination to retain culture and language. The culture of psychotherapy, on the other hand, has a worldview that tends to emphasize personal agency (as opposed to Divine agency), individuation from the family, commodification of empathy, and promotion of the language of psychology (Mail, McKay, and Katz, 1989; Tanaka-Matsumi and Higgingotham, 1996). The worldviews held by both the therapist and the client play an important role in the expression of symptoms, diagnosis and intervention, especially if they are at odds with one another. Specifically, the culture of the client, at times, attributes what psychologists label a 'disorder' to external forces rather than internal, personal characteristics. For instance, contemporary Native American societies attribute the cause of illness to disequilibrium in their universe, whether it is social, spiritual, physical and/or emotional (Mail *et al.,* 1989). This finding is consistent with Richeport-Haley (1998) who describes non-native American clients with schizophrenia who attributed their symptoms to supernatural forces. Another study (Krause, 1995) examined a Punjabi immigrant client who assaulted his son. The Punjabi concepts of personhood suggest a sociocentric basis for the client's maladaptive behaviour. The Punjabi client believed that mental states and physical symptoms were due to the external world rather than in inherent personal qualities.

The culture of psychotherapy, on the other hand, attributes illness to individual, rather then sociocentric causes. According to the DSM-IV-TR (American Psychiatric Association, 2000) biological factors and internal personal issues are often considered to be the etiology of the disorder. This notion is often the result of the prevalent belief in a medical model that attributes maladaptive behaviours as symptomatic of an internal disorder (Kendall, 1975). Although the DSM-IV-TR has been translated into a number of languages, this attempt at universality does little more than account for language differences. The symptoms and diagnoses of the DSM-IV-TR are still bound to the perceptions of the culture of psychology.

Beliefs about healing and intervention are also culture specific and consistent with the etiology of the disorders. Often, the culture of the client aims at resolving problems on a larger scale, such as in the community or, in some cases, the client's universe. The goal of treatment is often to restore a sense of balance to the individual, again, addressing the external cause. These cultures provide treatment that largely encompasses a community-centred and/or spiritual component. For instance, healers may perform rituals and prayers to rid the individual of the external force that is causing his or her suffering (Mail *et al.,* 1989). In the culture of psychotherapy, the therapist's treatment goals are related to curing the individual and giving him/her a new view of him or herself. Treatment is often directed at curing the client at an individual or family level. Contained within this process is the expectation that the client will develop, and use, the language of therapy in sessions.

These different notions of diagnosis and intervention present many potential problems for the therapist-client interaction and can result in misunderstanding and ineffective

intervention (Jackson, 1983; Wilson and Calhoun, 1974). Mail *et al.* (1989) and Roll, Millen, and Martinez (1980), indicate that it is common for North American practitioners to treat disorders, regardless of the clients' culture, within their own defined notion of the disorder. The American Psychological Association (2002) has responded to this situation by publishing a manual that addresses multicultural counselling and therapy issues aimed at making North American therapists more sensitive to culturally diverse clients. This manual provides ethical guidelines for therapists providing treatment for culturally diverse clients by calling for cultural competence within the therapeutic setting. Research on symptom expression and conceptualization of members of other cultural groups is also important because it may reveal specific facets of Western symptom expression and conceptualization that may have been understudied or gone unnoticed by Western social scientists (Butcher, 2005).

While striving for cultural competence a couple of global questions arise. First, "Can therapists working with culturally diverse clients successfully incorporate sensitivity to cultural differences?" Secondly, "How do they accomplish this?" To explore these questions we investigated the practices of culturally sensitive therapists to see what we could learn.

The Massachusetts Department of Mental Health (1994) reported that there are approximately 650,000 Portuguese immigrants living in Massachusetts. Initially, the lure of fishing companies brought many Portuguese immigrants to the New England area. During the 1950's and 1960's one factor instrumental in Portuguese emigration to the United States, was the danger of volcanic eruption in the Azores. Adjustment issues for many Portuguese immigrants arose out of the lack of correspondence between rural (fishing communities in Portugal) and metropolitan existence in America (Moitoza, 1982). Discrimination existed for the Portuguese in multiple spheres. Financially, the Portuguese were burdened with the necessity of several semi- or unskilled jobs due to their lack of English literacy. The workplace atmosphere echoed the American dislike of Portuguese immigrants. Reeve (1998) intimated that American prejudice in the factory resulted in a lack of advancement for the Portuguese worker. The negative social climate in the factory led to amplified tension for the Portuguese, because of inept management, lack of job security, an unsafe workplace, and the inability to engage in social discourse with the American workers. The social sphere was also difficult as the dominant society sometimes felt that the Portuguese immigrants did not measure up to American education standards. As a consequence, the Portuguese as a community were feeling the effects of ethnic bias.

There are a number of mental health professionals who work almost exclusively with this population. Their colleagues consider these mental health providers as authorities in cross-cultural therapy, often teaching other clinicians how to be culturally sensitive while working with Portuguese clients. These mental health providers also act as advocates for the Portuguese community by setting up and staffing Portuguese health clinics.

While working with Portuguese clients, James encountered a phenomenon called *agonias* by the clients (James and Prilletensky, 2002). *Agonias* literally translates as "the agonies," which is a culture specific-disorder within the Portuguese community. To investigate this phenomenon a study was conducted with members of the Azorean

immigrant community. James, Navara, Clarke, and Lomotey (2005) found that, while the definition and manifestation of *agonias* varied greatly from client to client (everything from an asthma attack to a premonition of death), a cohesive and systemic understanding of the phenomenon emerged. The symptoms, causes and potential cures that the participants in the study identified coalesced into three clusters: *agonias* of illness, *agonias* of premonition, and *agonias* of death. The researchers also demonstrated a link between the somatic symptoms, psychological processes, the social context and systems of religious beliefs of the clients. After examining *agonias* from the clients' perspectives, the next logical step in research was to explore how clinicians label and treat *agonias*.

Generally, we wanted to see if the clinicians' understanding of *agonias* was similar or different to those of the general community. It was fortunate that the clinicians mentioned above, were both trained in providing culturally sensitive interventions and themselves members of the Portuguese community. Thus, we wanted to investigate these culturally sensitive mental health providers to see what we could learn. This survey descriptive study (Montero and León, 2005) examined whether the mental health providers, although trained in cross-cultural sensitivity and Portuguese heritage, classified and labelled the symptoms and etiology of *agonias* using the criteria laid out in the DSM. Further, we wondered whether the treatment of *agonias* would follow from the disorder that they ascribed using the DSM. For drawing up this article, we followed the proposal by Ramos-Álvarez and Catena (2004).

Method

Participants

Fifteen mental health care providers (9 women, 6 men) who primarily treat Azorean clients were interviewed through the use of a semi-structured interview about their professional experiences working with this community. As mentioned, all of the care providers in this study are of Portuguese descent (6 Azoreans and 9 from the Continent). The participants represent numerous mental health professions, including clinical psychologists, social workers, physicians, and nurses. The average age of the participants was 41 years (SD = 8) and they have been providing mental health services for an average of 15 years (SD = 6). The median income of these care providers was $40,000 to $50,000.

Procedure

The mental health care providers were contacted through notices posted at their Portuguese Health Clinics. Those interested in participating in the study were asked to contact the researchers. The interviews took place at Portuguese Health Clinics. A modified ethnographic style interview, Kleinman's (1988) Explanatory Model, was used, as this model addresses relevant issues such as the significance of symptoms (including etiology, treatment options and prognosis), whether symptoms are a normative expression of distress, and the significance of the symptoms. Participants were asked: "What is *agonias*?" "What is the cause of *agonias*?" "What method of treatment do you prescribe?" "What method of psychotherapy do you prescribe for *agonias*?" and "How effective

is the treatment for *agonias*?" The interviews conducted with the mental health care providers were similar in format and content with those carried out with local community members (see James, 2002). By using similar methods of gathering information, it was hoped that meaningful comparisons between practitioner and community members' views on *agonias* could be made. The conversations with the mental health providers were audio recorded and transcribed with the permission of the participants. The conversations lasted approximately one hour.

Statistical analysis of the interview

To determine if there were patterns within the narratives collected in the interviews, a cluster analysis was conducted on the data. Shweder, Much, and Mahapatra (1997) have demonstrated that cluster analyses can be used as an effective tool when analyzing cross-cultural data, as the methodology allows the researcher to investigate indigenous categories or local meanings, without relying on non-indigenous assessment tools. Every symptom, cause, form of treatment, etc. mentioned by the mental health care provider during the interview was recorded and subsequently underwent cluster analysis.

Results

Overview

Most service providers who participated in this research described *agonias* as a general sense of not being well or some form of anxiety attack. Others described the symptoms as resembling a variety of illnesses. As one physician explained, *agonias* in Portuguese language seems to translate roughly to "feeling agonized." According to him, "it [*agonias*] sometimes seems to relate to panic attack but it's much broader than that...." Another physician who has worked with Portuguese immigrants for about 15 years concurred with this description saying, "It is similar to panic attack." The physicians generally associated the illness with feelings of anxiety. According to one of them, people who complain of *agonias* appear very dramatic and helpless, saying things like "Oh life is horrible" and "Oh! I can't do anything." One clinician further described it as, "Feelings of anxiety in which the person feels overwhelmed." According to another service provider, "Some of the patients seem to have a sense of some impending danger - some impending doom." In a sense the sufferer seems to experience some kind of premonition. "Some patients feel like they are going to die," according to one of the physicians who also described *agonias* as a word used by the Portuguese to describe both physical and emotional symptoms. According to him, "There is always something emotional going on, some [kind of] emotional disturbance."

Service providers interviewed in this study identified several symptoms associated with *agonias*. One therapist describing *agonias* as "somatic and pathological" said that when people say they have *agonias,* they would actually be experiencing feelings of anxiety or depression. According to the physicians who participated in this study, clients express "a general sense of being unwell." One physician explained that, "the Portuguese describe *agonias* as nerves, and to them, nerves explains everything including anxiety and depression." Other common symptoms the mental health care providers identified

were feelings of tightness in the chest, heart palpitations, breathing difficulties, sadness, worrying and nausea/vomiting. Sometimes sufferers feel dizzy and generally complained of being upset about something. *Agonias* was also accompanied by feelings of a lack of control of one's life.

All the providers linked *agonias* to anxiety and/or depression. In the words of one of the physicians, "for some people, depression is a precursor whilst for others the precursor is anxiety." Another said, "[*agonias*] has to do with a lot of anxiousness, which emanate from imagining the worst." According to one of the therapists, precipitants of *agonias* can be both internal and external. Internal precipitants could be something upsetting that preoccupies a client, while external precipitants could range from an argument with a spouse, to the muggy oppressive weather characteristic of the Azores. He also pointed out that Portuguese immigrant families are exposed to many social problems like domestic violence, alcoholism and financial difficulties in addition to their inability to speak English, which could be very stressful and could precipitate the condition they describe as *agonias*.

Treatment

How the health care providers treated *agonias* varied with the symptoms and their own therapeutic orientation. When asked what methods were used in treating *agonias*, one physician responded, "I am eclectic. It depends on who they are." Choice of method was also sometimes difficult because the clients lacked the psychology vocabulary to describe their condition. In the words of one practitioner, "In order to work with them [*agonias'* clients] one needs to teach them how to put the symptoms into words like anxiety and depression, [but] it takes a while for the new vocabulary to develop." Therapeutic methods used by the health care providers involved psychoanalytic and behavioural as well as bio-medical models. Some health care providers utilized only one intervention model, others two and others all three. According to the participating practitioners, the model employed usually depended on what modality they had personally adopted. One said that she had employed cognitive techniques when the version of *agonias* the client experienced translated into something like a panic attack. In other cases, she had used breathing as well as relaxation techniques, especially when she identified the cause as anxiety. These techniques, according to her, were not useful when the person was just feeling overwhelmed and "frozen." In such instances, she would try to sort through and untangle the root causes of the condition through a kind of talk therapy.

Another practitioner, in response to the same question stated, "I think you will treat it as you [would] treat anxiety." This physician said he would ask the client to describe his or her illness or give examples of what the problem was. After this he worked with him or her to find a way to "help or deescalate the situation." Another practitioner who had used behaviour modification and relaxation techniques described her methods as "active therapy." According to her, the techniques are active on the part of the client and therefore do not work when the client is too depressed. Depressed clients, she noted, are more appreciative of medication than such therapeutic treatment as breathing exercises.

All the providers were also aware of some of their clients seeing *bruxas* (witches/mediums) and *curandeiros* (healers) for treatment to compliment their medical treatment. According to one practitioner, "...for *agonias* and whatever else comes with *agonias*, several of our clients have gone to see a *bruxa*. And usually when they go it is because they are not getting from us what they need to get – they don't feel better." When further asked how he viewed the clients seeking out *bruxas* and *curandeiros* to get help, he responded "I think for many of our clients, especially the older clients, it is a way of trying to get some control over their care." However, another physician indicated the opposite, where clients come to seek orthodox treatment only after going to the *bruxas* and *curandeiros* and finding no improvement in their condition.

Statistical analysis of the interview (cluster)

As already discussed, all interviews were coded and from them every symptom, cause and possible cure for *agonias* was identified. In total, 6 symptoms, 5 causes and 3 cures were identified (see Table 1). Using Ward's (1963) method of hierarchical cluster analysis, two distinct clusters emerged: depression and anxiety. In a final, confirmatory step, using k-means, the number of possible clusters was limited to two. The 14 variables clustered together in similar ways through all procedures.

TABLE 1. Symptoms, causes and cures for *agonias*.

Symptom	*Cause*	*Cure*
Headaches	Depression	Psychoanalysis
Nausea	Stress	Family therapy
Not sleeping	Asthma	
Light-headed	Premonition	
Difficulty breathing	Anxiety/panic	CBT/relaxation
Heart/chest pain		Medication

Discussion

The health care providers all acknowledged that their understanding of *agonias* differed from those of their clients. The providers also recognized that their clients' understanding of *agonias* was not a monolithic construct – there was great variety in causes, symptoms and cures for *agonias* from the clients' perspective (ranging from premonitions to asthma). It appears that although the clinicians were well aware of their clients understanding of *agonias*, their conception of *agonias* reflected a biomedical approach. They all said that *agonias* was an "anxiety disorder." Several mental health providers were more specific and identified the anxiety disorder to be a panic attack. Two mental health providers labelled *agonias* as an anxiety disorder, which was sometimes accompanied by depression. The treatments they prescribed for *agonias* were also consistent with the culture of psychology, often recommending, either singularly or in combination, cognitive behavioural therapy, medication and relaxation techniques. Even though the mental health providers were aware that their clients went to other healers as well, they never made referrals or contacted healers to learn how they treat *agonias*.

Mental health providers' notions of the meaning and treatment of *agonias* differed considerably from those held by community members (James and Clarke, 2001). The meaning ascribed to *agonias* by the Azorean immigrant community members varied from participant to participant and included, inter alia, indigestion, a premonition, one's final breath, and asthma. Community members' treatments for the ailment also varied considerably and included water, sugar water, smelling salts and prayer.

Richeport-Haley (1998) suggests that it is important to label clients in a culturally acceptable manner. Guarnaccia, Parra, Deschamps, Milstein, and Argiles (1992) found that Puerto Rican clients disagreed with psychiatrists' diagnosis and prognosis of schizophrenia more than Euro-Americans'. They also found that families had more tolerance for seriously mentally ill family members when labelled with *nervios*, a culture-specific idiom of distress. Puerto Rican clients often perceive *nervios* as less serious and more transient than mental illness.

The difference between the lay and mental health providers' meaning of the disorder represents a collision of two culturally bounded positions - *agonias* and anxiety disorder -. *Agonias* is easily seen as a culture-bound phenomenon, as there are similar exotic disorders listed in the appendix of the DSM-IV-TR, such as, *"ataques de nervios"* and *"amok."* We contend, however, that DSM categories and biomedicine are also culture bound, although this is more difficult to recognize when you are from within the culture. Perhaps this is why researchers tend to conceptualize culture-bound syndromes as occurring elsewhere and not among one's own people (Cassidy, 1982). Cassidy (1982) suggests that like other culture-bound positions, biomedicine has its own language, assumptions and models; but, we behave as if these of assumptions of biomedicine (future orientation, activism, individualism, power of science) are culture-free and universal. These notions occur even though they are culture-specific and are not readily transferable between cultures. Cassidy (1982) also points out that in North America we tend to believe that scientific biomedical knowledge is uniquely powerful and valuable.

Guarnnacia's (1992) finding with Puerto Rican immigrants, as described above, argues that categorizing commonplace symptoms, such as *agonias*, as a biomedical disease can cut off communication with the target population and lead to a misunderstanding between mental health provider and client. The question then arises, why are Portuguese mental health providers using a language different for *agonias* from the one that they were brought up with? In consideration of this complex question, it became evident that many mental health providers do this regardless of culture. One grows up hearing people say that their "nerves are bad" or that a relative had a "nervous breakdown," but in training these colloquial terms are replaced with scientific ones. Thus, when clients use culturally appropriate idioms of distress, such as *agonias* or bad nerves, many therapists "educate" clients to replace their experience with a scientific reality. For the person that holds the power, their interpretation becomes the reality, which thereafter acts to organize the responses in an encounter (Cassidy, 1982).

During training, clinicians learn to reconstruct their world in compliance with the culture of psychology. Some of the things they knew previously emerge and others are silenced or forgotten (Bacigalupe, 1998). The culture of psychology encourages clinicians

to assume that its categories are sufficient and exclusive, whereby ideas that do not fit into these categories are not given equal consideration. As one Portuguese therapist noted, "I teach them the language of therapy so that we have a common language." It would seem that clinicians sometimes believe that the language commonly used by the client to navigate the complexities of their local world is somehow lacking in a clinical setting, and as such, the language of psychology should be adopted. The language used by clients often connects mind, body, spirit, and community (Clauss, 1998; Farnsworth, 1975). We would argue that, in an effort to make the language more "objective," the therapist strips away notions of spirit and community, making "objectivity" equal to, or less than, the reality of the community member.

The culture of psychotherapy demands acculturation of its members, regardless of one's own cultural background. There is a language and a protocol one needs to adopt, just as you would when traveling in a foreign land. In this land, where people pay for compassion and an hour is really 50 minutes, one uses the DSM (much like a foreign language dictionary) to translate your mother tongue into the language of psychology. As therapists, we expect acculturation of those whom we are trying to help, regardless of how culturally distant the client's experiences are from ours.

We cannot forget that the therapeutic milieu is a microcosm of the wider political reality (Seedat and Nell, 1990). Thus, acculturation and education to American values provides a way for the Portuguese mental health professionals to avoid the usual trades that the Portuguese hold in North America, such as cleaning or factory work. Also, in the Portuguese male dominated family, where verbal or physical abuse sometimes occurs, Portuguese clinicians are finding solutions for Portuguese women. This action is consistent with Holland's (1990; as cited in Lloyd and Bhurga, 1993) suggestion that the oppression of ethnic minority women by society and class-related factors contributes to a feeling of helplessness and depression that should be addressed in therapy.

For some people, self-shaping can be empowering (Rose, 2000). It must have been for the women who adopted the culture of psychology and became clinicians. Perhaps it freed them from feelings of powerlessness in a world full of illness and male dominance. These women wanted careers where they could compassionately care for others. Their gender prevented them from becoming priests but they could fulfill that mandate by becoming clinicians. Also, an anxiety disorder is something that therapists feel we can predict and control, *agonias* is not. After sitting through the interviews and hearing about the tremendous amount of suffering, I (James), as a clinician, felt the urge to help. Thus, labelling clients' distress as something manageable gives hope to the clinicians. Additionally, younger, second generation relatives would be more likely to offer support if the client has a medical condition.

There are also structural factors that force therapists to use the language of the therapeutic to describe their clients. Firstly, on hospital forms, it is expected that clients be given a DSM diagnosis rather than a culturally appropriate diagnosis. Secondly, the insurance companies do not cover cultural idioms, such as *agonias*. Thus, if the client is not given a DSM diagnosis the client has to pay out of pocket. This situation would lead to the termination of treatment with this community, as most of these clients cannot afford therapy without financial assistance.

The findings have lead us to wonder, Is the clients' enculturation (adoption of the language and values of the dominant society) sometimes an implicit goal of therapy? Do therapists contribute to this goal by teaching clients the language of psychology rather than using the clients' idioms? If this happens in sessions with ethnic minority clients, we need to take this situation seriously and learn if it is the clients' value on acculturation or our own that is the driving force in therapy. We also we wonder if it is the intolerance for folk idioms in North America that leads the therapists to teach their clients scientific idioms. For instance, one participant (who had not completed grade school) said that, …this talking about *agonias* shouldn't happen. *Agonias* doesn't exist in any books, and it isn't talked about by people who are educated. So this talking about *agonias* is only for people that never went to school. A lot of things don't exist but people keep saying it. They hear other uneducated people saying it and they keep using it. I didn't study much but *agonias* comes from people who are very old. And then other people hear the word and they start using it too. They hear it from their grandparents, from their parents, and they continue using the word the same way. But in school, they don't use the word '*agonias*' anymore. I didn't go to school much and I sometimes say the wrong thing, but whoever, goes to school shouldn't say '*agonias*' anymore.

The participant's reaction appears to be one of embarrassment. For him, the use of the Azorean language is somewhat parochial, and is devalued in his new "scientific" society. *Agonias*, to the extent that individuals identify with this scientific society, becomes a very powerful image; an image, as Taussig (1980) describes, illuminates a culture's self-consciousness of the threat posed to its integrity. Perhaps the clinicians had experienced similar feelings of delegitimization and consequently taught their clients the acceptable, scientific language so that they too can avoid similar experiences of delegitimization. Thus, the therapist is unwittingly acting as a mediator between the client and their adopted culture but this act also, potentially, delegitimizes Portuguese idioms and experiences.

After identifying a similar mismatch between therapist and client, some clinical solutions have been suggested by other researchers (Guarnaccia *et al.,* 1992; Richeport-Haley, 1998). It has been suggested that clinicians: a) allow clients to present the problem; b) clinicians present the problem and then dialogue for a mutually acceptable language (Seedat and Nell, 1990; Tanaka-Matsumi and Higginbotham, 1996). It is laudable that the clinician's framework is given after the client's framework. With Portuguese clients, however, it would be difficult to create a "shared" language because once the therapist presents his/her framework; the clients would adopt the therapist's language and ideas saying "*voce que sabe*" (you are the one that knows). Perhaps the clinician should suspend their framework of understanding the situation and first explore the clients' framework, discovering their meaning and solution for the problem. It could also be beneficial for the clinician to learn about other traditional healers, to see if their knowledge about the situation could aid the client. Only after having a good understanding of the clients' worldview, should one think about whether the therapists' culture-bounded system of diagnosis and treatment can be useful.

There are also structural barriers to clients using cultural idioms. Insurance agencies need to be educated about culture specific phenomenon and pressed for those categories to be included for reimbursement if they want to provide competent care for all of their clients. Similarly, clinicians, translators and hospital administrators need to be informed about these categories and encouraged to use them if appropriate. A further structural barrier for therapists using culturally appropriate idioms is the lack of tolerance for diverse expressions, thoughts and beliefs within the American society. At first this goal appears well beyond the realm of psychology. However, psychologists can offer themselves as consultants for diversity training in the workplace, schools and religious institutions.

Another level of intervention could be contained within our training programs. Bacigalupe (1998), a Chilean therapist, feels that the clinical psychology trainee is sometimes similar to a colonial subject because knowledge is not created in a collaborative way and there is no place for reflexivity. As trainees, clinicians are often not taught social theory or critical thinking skills that allow them to situate our profession and our diagnostic/therapeutic models in an historical or cultural context. For instance, realizing that our position is also culturally bound. This realization is particularly relevant for cultural competence training. It is difficult for students and therapists, who have learned the psychiatric categories and therapy models as the only truth, to later learn that this framework does not fit for a large percentage of the population. Without critical thinking tools it is hard for clinicians to think about these issues in anything more than a superficial manner. Consequently, what often occurs is the storing of 'facts' and the creation of diagnostic heuristics, "Asian families are like this … African American clients are like this …" Often clinicians do not grapple with the difficult theoretical issues raised by a deeper cultural awareness. To aid people in thinking about these questions Bacigalupe (1998) has developed an accountability guide for trainers in the land of others to aid in recognizing colonial practices. The following questions have been reformulated from Bacigalupe's guide to fit therapists conducting cross-cultural therapy. Several additional questions have also been included.[2]

– Who defines the problem and intervention? What and whose knowledge is privileged?
– What content of the client's narrative do I emphasize? What parts of the client's narratives do I overlook? *
– What methods/techniques do I use? Are they appropriate for the client that I am working with? *
– How do I negotiate my cultural identity?
– How do I respond to larger system constraints? Am I trying to intervene at multiple levels? *
– If clients accept my ideas without questioning them, what do I conclude from that position? If clients "rebel" what rhetorical devices do I find myself using the most?

[2] * indicates the additional questions.

– How does the client's empowerment develop in the session?*
– How do I evaluate the outcome of therapy? How do the clients evaluate the outcome of therapy? Who am I accountable to?

The questions highlight the need for the accountability of clinicians to their own biases and practices. Training in anti-racism, critical psychology and critical thinking are pivotal for identifying power relations in sessions and in the client's experience. Clinicians also need to understand how these power relations are related to interlocking systems of oppression and the process of globalization for a more complete understanding of the culture of the client (Heron, 2004).

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