Co-creating Culture Through Relationship with Individuals of Asian Indian Origin

Mohan Krishna Vinjamuri

Introduction

This chapter discusses potential applications of relational theory to clinical social work practice with individuals in the United States of Asian Indian origin. Social workers may come into contact with Asian Indians for many reasons, such as parent–child conflicts, stresses created by taking care of aging family members, couple difficulties, work-related difficulties, family violence, and challenges related to sexual orientation, immigration, death, or illness (Almeida 2005). Second-generation Asian Indian immigrants in particular may be struggling with issues of identity and separation and individuation from their families of origin. A relational framework helps practitioners recognize the emotional and interpersonal needs that may be encoded in their client's presenting problems and respond to these needs in ways that make aspects of the client's culture amenable for exploration in the clinical social work process. As Tosone (2004), Berzoff (2011), Goldstein (2001), and other social work clinicians have pointed out, attention to the manifest and pragmatic concerns of clients must be matched with a deeper understanding of the internal dynamics that guide their capacities to adapt and their ways of using the practice process.

This chapter reviews findings about experiences of Asian Indians in the United States and clinical literature on therapeutic work with this population. Application in direct practice is presented in the case example of Naresh, a client of Asian Indian origin, and his social worker Jessica, who is Caucasian (English and German). Naresh is a gay-identified Asian Indian legal immigrant from a Hindu family who moved to the United States voluntarily with significant educational and meager economic resources. His case illustrates how the practitioner can use a relational framework to co-construct with the client a space of curiosity, mutuality,

M.K.Vinjamuri, Ph.D., LMSW (✉)
Department of Social Work, Lehman College, City University of New York, New York, USA
e-mail: mohanvinjamuri@gmail.com

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and possibility. In this space, the client can unlock his potential for transforming his relationship to self, his family of origin, and his cultural identities and thereby live more fully in the world.

Clinical Work with Asian Indian Immigrants

The Term "Asian Indian": Illuminating and Obscuring

"Asian Indian" refers to individuals whose country of origin is India. More than 20 million South Asians – that is, people whose country of origin is India, Pakistan, Bangladesh, Sri Lanka, Nepal, or Bhutan – have migrated throughout the world, some for several generations (Guzder and Krishna 2005). Most South Asian immigrants in the United States are Asian Indians. They are the fourth largest immigrant community in the United States (Khanna et al. 2009) and are one of the fastest-growing immigrant groups (Baptiste 2005).

Discussion of a particular population always must acknowledge its diversity within diversity. Homogenizing people's experiences by group not recognizing intragroup differences can run "the risk of flattening out complexity and…in doing so, [increase] the potential for reproducing wider forms of essentialism, stereotyping and racism" (Gunaratnam 2003 as cited in Singh 2009, p. 363). "Asian Indian," for example, includes multiple religious traditions (Hindu, Muslim, Buddhist, Christian, Jain, and Sikh) and any of the 22 official languages of India (Almeida 2005; Baptiste 2005). Akhtar (1995) suggests caution about "essentializing" immigration: differences in immigrants' experiences include the circumstances (voluntary, under duress, legal, or not) and reasons (economic, familial, educational) they immigrated to the United States (Guzder and Krishna 2005; Baptiste 2005). Additionally, immigrants come to the United States with a variety of social, economic, and occupational resources (Baptiste 2005). Practicing within a relational framework helps the practitioner with this tension by applying the principle of not knowing and thereby using mutuality and co-construction of meanings to illuminate how presenting problems and symptoms may reflect vastly different internal experiences.

Fortunately for both the clinician and the client, human relationships, by their very nature, are creative spaces. In speaking about the origins of the therapeutic alliance, Bollas (1998) poignantly describes the clinical therapeutic process as one that

> evoke[s] some of the mysteries of human life…[and] could evoke the transfer of so many different if interconnected alliances: of fetus inside womb, infant inside maternal world, child inside the law of the father, child inside family complexity, self inside the dream, addressee inside the textures of the "I's" discourses. (p. 29)

The evolving relationship between clinician and client, by reproducing aspects of these past relationships, gives the client and clinician opportunities to see how her definitions of "me" and "not me" have been constructed and can be re-envisioned.

In these spaces for exploration, the clinical social work practitioner can become empathically attuned to culturally specific experiences while continually letting go of assumptions about the meanings of these experiences. Relational practice puts the clinical social worker into the heart of this dialectic of knowing and not knowing. In order to accomplish this engagement, the practitioner must encounter the transferences and countertransferences evoked by the very concept of a relationally engaged clinical social work relationship.

Barriers to Help Seeking

Asian Indians may be reluctant to seek services from providers whom they see as culturally alien from them, anticipating dissonance between basic cultural positions (Baptiste 2005). Western clinicians may view personal problems and responses in diagnostic terms (APA 1994). An example being what Western thinking classifies as depression (Leung et al. 2011) found that Asian Indians experience the hallmarks of what is called depression, like loss of motivation, concentration, appetite changes, and loss of hope, but not see these conditions as psychological in nature. The relational clinician's assessment is focused less on symptoms and categories and more on mutual articulation of the client's explanation of suffering and dysfunction. McWilliams (2011) stresses understanding the key dynamics in the client's distress, and relational social work stresses inquiry and dialogue to co-construct this understanding (Greenberg and Mitchell 1983). To do so, the practitioner must be aware of the lens through which she is viewing the experiences of the client and how holding on to this paradigm can impede the therapeutic process (Bromberg 2011).

Seeking clinical services is controversial for Asian Indians (Almeida 2005) who are averse to speaking to strangers, and thus seek advice from friends or relatives. Stigma is attached to people with mental health problems (Leung et al. 2011), so professional consultation is especially threatening because it is a sign of failure (Almeida 2005). Issues such as domestic abuse and homosexuality evoke denial, shame, and social anxiety (Guzder and Krishna 2005). The relational social worker can express understanding through mutual empathy with these sentiments, incorporating this understanding into constructing a mutually viable representation of the problem that includes psychodynamic aspects in a form that is congruent with cultural imperatives. For example, a client's avoidance of feelings about a shamefully experienced problem can be introduced in terms of expressed empathic attunement about this difficulty and its role in engaging possible remedies. Another example is that Asian Indian clients may express somatic complaints that mask challenges related to racial and cultural identity (Almeida 2005), or, conversely, use "cultural camouflage" (Guzder and Krishna 2005, p. 135), blaming their cultural background to mask emotional processes and avoid personal agency or responsibility for change. In keeping with relational theory, these authors ask the clinician to "widen the bedrock questions of counter transference, neutrality, identity, and psychotherapy processes to accommodate cross-cultural realities" (Guzder and Krishna 2005, p. 121).

Immigration and Acculturation Experiences

The not-knowing stance for creating a more open and inviting space of mutuality wherein the therapeutic relationship can grow (Tosone 2004) nonetheless requires the practitioner to be aware of the cultural imperatives that may be impinging on the client's individual process of handling difficulties and relieving suffering. Not knowing is individual; a clinical awareness that there is much cultural knowledge *to know* spurs the mutual exploration and co-construction of meanings at the heart of relational social work practice. Many constructs of Asian Indians, particularly those brought up in India, are in stark contrast to dominant individualistic Western values (Baptiste 2005) about identity, family, community, life meaning, and personal growth. Acknowledging these contrasts requires surfacing and challenging norms and values clinicians themselves may take for granted and perpetuate in the culture of the dominant society. Authenticity as a relational principle invites open communication about perceptions in order to explore in direct interpersonal dialogue what would constitute healthy change. This may take a non-Western form, requiring the relational clinician to embrace the potential of "a collective psychology [in which] the social and familial contexts are central to individual development" (Almeida 2005, p. 389). Intergenerational fealty and the role of religious and spiritual beliefs are equally significant, as will be illustrated in the case example. Oyserman and Lee (2008) explain:

> Within individualism, the core unit is the individual; societies exist to promote the well-being of individuals. Individuals are seen as separate from one another and as the basic unit of analysis. Within collectivism, the core unit is the group; societies exist, and individuals must fit into them. Individuals are seen as fundamentally connected and related through relationships and group memberships. (p. 311)

Kakar (2006) posits that "[t]he high value placed on connection does not mean that [Asian] Indians are incapable of functioning by themselves or that they do not have a sense of their own agency" (p. 34). Rather, the yearning for autonomy and the yearning for relationships coexist, which in fact confirms the relational theory emphasis on connection as the primary human drive (Greenberg and Mitchell 1983).

Viewing the experiences of Asian Indians through the lens of transitions can be useful (Rastogi 2007). Migration, immigration, and acculturation bring transitions and losses which may include lowered social class and status and loss of economic power (Khanna et al. 2009). Less visible but more psychologically painful are losses of moving away from families of origin. Many immigrant Asian Indians lived very closely and were continuously involved with their families of origin. They may prioritize maintaining and strengthening these ties by bringing family members to this country and being vigilant in keeping their cultural values front and center in everyday life (Inman et al. 2007). Asian Indian immigrants tend to idealize their culture, which makes it possible to distinguish themselves from and within a racist mainstream society (Patel 2007; Almeida 2005). Women may preserve gendered roles and hierarchies (Patel 2007). Children and adolescents being reared in this country may, in particular, experience conflicts with elder generations (Farver et al. 2002; Khanna et al. 2009).

Intergenerational Conflicts

A common presenting problem of Asian Indians in clinical social work practice is intergenerational conflicts (Inman et al. 2007). Normative life cycle transitions including separation–individuation of adolescents occur in "an unfamiliar context under different cultural rules" (Baptiste 2005, p. 364). Asian Indian families are often referred for clinical social work services because of mental health and behavioral concerns about their children (Almeida 2005). Parents fear losing their children to mainstream American culture, losing parental authority, and losing face within their Asian Indian communities because of their child's behaviors (Baptiste 2005). The children speak about the stress and strain brought about by their parents' focus on educational and financial success as a model minority syndrome (Lee et al. 2009). This is a classic example of where relational social work practice can help reach for the deeper emotional pain about change and transition presenting as a behavioral issue. The empathic attunement to emotional challenges, the "me" and "not-me" dilemma, does not require discrediting of cultural representations. Rather, the relational practitioner enlarges the culturally explicated problem, validating its diversity roots and reaching for mutual exploration of more deeply felt individual experience of the client. Opening up a singular cultural explanation in an interpersonally respectful exploration requires the social work clinician to monitor her own reductive tendencies; resolution in the individual of conflict between cultural preservation and individual needs and goals requires "standing in spaces" (Bromberg 1996) where mutual validation can occur.

Case Example: Naresh and Jessica

Naresh is a 34-year-old male of Asian Indian origin who was being seen by Jessica, a 28-year-old clinical social worker in a small outpatient mental health clinic. Jessica is Caucasian (English and German) and was brought up in the United States in a Protestant family. When Naresh began seeing Jessica, he had a boyfriend of 2 years who was 36 years old, Caucasian (Irish), and brought up in the United States in a Catholic family. He and his boyfriend did not live together. Naresh came voluntarily to this clinic seeking help for what he described as relationship difficulties with his boyfriend and recurring anxiety. His difficulties getting emotionally and sexually closer to his boyfriend reflected experiences in previous relationships with both men and women. In the work described below, Jessica had been seeing Naresh once a week for approximately 4 months.

Many Mothers

Naresh, an only child, came to the United States from India with his parents when he was 3 years old. The traditions of extended family and Mother India remained central. Expressing feelings, particularly difficult ones like sadness, anger, and being hurt,

was actively discouraged as self-indulgent and threatening family unity. Naresh either suppressed or became dissociated (Bromberg 2011) from emotional experience, leading to functional adequacy but internal dissatisfaction. This reserve and remoteness was apparent among his small United States circle of friends, who encouraged Naresh to, like them, work on personal issues with a professional clinician, despite its incongruence with family and cultural norms. Harlem (2009) notes a special benefit of addressing diversity practice in clinical social work is that it "serves as an intimate point of contact" (p. 274) between host country realities and the fixed idealization or denigration of a culture of origin. In the same way, the relational clinician is a potential point of contact between disparate self-aspects: her tolerance of ambiguity and ambivalence, as well as facility in bringing dissociated self-states together (Bromberg 1996, 2011). Naresh's need to feel connected to his mother country, as well as his mother herself, required a space in which to formulate and relate intimately with the values of both present and past environments (Akhtar 1995).

The relational model, stressing process of connection over implications of specific content, embraces all forms of diversity as ultimately aspects of individuality in search of coherence. When Naresh came out as gay at age 30 years, and told his parents shortly thereafter, he was not surprised, but was distressed, by their visceral negative reactions to him. Shame, guilt, behavioral demands, invoking extended family pressure, and the like were their tools to try to "fix" him. Naresh felt great affection for and had a profound need to please and be close to his parents, in keeping with his Asian Indian identity. Their emphatic refusal to know about his personal life was wounding. At the same time, they said that they would be there for him if he ever needed help financially or fell ill. Overtly less abandoned than might be the case for other homosexual Asian Indians, Naresh nonetheless struggled with the disconnection between demonstrated care and emotional connection. This problem, a state of mixed signals, shows the importance of understanding diversity in clinical social work practice: clients bring all kinds of variations of divided self-identities, with powerful organizing self-experiences in primary relationships being incongruent with prevailing social messages. The relational practitioner is especially well equipped to engage this confusion: the relationship of practice itself is the forum for reconciliation of these kinds of conflicts. Through exploration, mutuality, attunement, collaboration, and all the relational practice skills, the social work practitioner guides the self-integration process, the specific contents of which fuse individual characteristics with cultural values and expectations.

Engagement, Assessment, and Core Problem

Self-differentiation from the "mother" country, particularly for Indians, invariably leads to internal and interpersonal conflict. For Naresh, recognizing and eventually being open to his parents about his homosexuality was a catalyst for accepting himself as an individual while striving to preserve the collectivist values of his

family and culture of origin. Jessica, his clinical social worker, was familiar with homosexuality as a family conflict issue and had resolved her initial Protestant, Anglo countertransference to homosexuality. Thus prepared for mutually empathic engagement with Naresh's core conflict of how to reconcile personal and familial/community differences, her assessment included co-created appraisal of how this interpersonal conflict was causing him intrapsychic pain. On another level, however, the culturally specific meanings that interpersonal relations had for Naresh were beyond Jessica's experience. Therefore, she was mindful of invoking the stance of not knowing, inquiry, and pursuing mutual definitions of issues rather than translating Naresh's core problem into her familiar constructs. Taking time to read about Asian Indian culture was part of her charge, but the engagement with her client as a clinical social work practitioner rested most heavily on her authenticity as a learner of cultural meanings as she reflected on how to relate her understanding of individual experience with the turbulence her client experienced.

The Treatment Process: Reflective Listening and Functional Exploration

Naresh practiced his Hindu faith until age 28. By the time he began seeing Jessica, he did not subscribe to any organized religion but described himself as spiritual. Nevertheless, Naresh understood deeply and identified strongly with the worldview he grew up with in a Hindu household, particularly family lineage and children's duties to their parents. He explained to Jessica that he did not see himself as a good son. While he was feeling freer and happier overall after having come out and beginning to have intimate relationships with men, he felt guilty that he did not perform his duty to get married and provide grandchildren. He was failing in his duty to give them pleasure in this life and to passing on to the next life his father's family name, which represented continuity in lineage proudly traced back to Hindu saints and scholars. This sense of continuity was becoming increasingly important to Naresh's father as he aged and reflected on his own mortality and the cycle of birth, death, and rebirth that is central to Hindu beliefs.

Naresh's parents felt embarrassed in their extended families about their son being gay, which caused them to withdraw from various social activities. This was a crisis, as continuous involvement with extended family was both culturally expected and personally very meaningful for his parents. Naresh felt responsible for this problem. Nevertheless, Naresh came out to several relatives, which posed another threat to his parents' sense of being part of a stable and respectable family. Some relatives tried to pressure him, telling him that he was being selfish, and others who did not know he was gay said that he needed to fulfill his duties as a son. Though Naresh was living life as an openly gay man, he knew that his sexuality was shameful and disgraceful to his family.

For the relational practitioner, the treatment process involved helping Naresh express his grief about his family's disapproval and deal with the conflicted internal

feelings this engendered. Jessica was stymied about a remedy, based on her limited cultural understanding of the Asian Indian complexity of family, so different from her own nuclear family experience. Her relational technique required forthright authenticity about not knowing, seeking clarification for herself and facilitating conscious explication for Naresh to assist in his own reflective process. Try as he might, Naresh was focused on feelings of failure and inadequacy, could not see his own beauty and strengths, and easily felt criticized and diminished. He had great difficulties feeling good enough and often equated what he did and what he experienced as either right or wrong. Jessica could help Naresh recognize the repercussions of his conflict in terms of his own self-state and his disrupted functioning, but a resolution required an internal reconciliation of self-states that was demonstrable, not just psychological.

A Critical Clinical Moment

A pivotal moment in the clinical process and its impact on Naresh's striving for resolution arrived when Naresh told Jessica that he had decided to travel back to India with his parents to participate in a ceremony to initiate him as a Brahmin male, which is the highest caste in the Hindu caste system. His parents had indicated that they would like him to have this ceremony, even though he had stopped practicing as a Hindu and in many ways opposed the hierarchies of the caste system. This affirmation of cultural identity was important to Naresh's parents independent of their dismay about his avowed homosexuality. Deciding to fulfill their wishes so that he would be allowed to perform the prescribed and required religious rituals as a Brahmin son upon the death of his parents, Naresh felt he could provide a compromise between his individuality and his affiliation with his culture in a way that did not constitute a violation of his personal identity.

Jessica's response was to be annoyed and angry with Naresh, protective of his partner, and in competition with his parents. Jessica's countertransference, rooted in Western individuality, was to pathologize Naresh's need to satisfy his parents' wishes as a failure of individuation. As a Caucasian, she struggled to grasp the cultural significance of Naresh's relationship to his shared familial bond to Mother India. Holding to her relational theory convictions, Jessica recognized the issue might be her own inability to fully understand the nuances of the issues Naresh was presenting from his population's perspective and that it was she who was constricted by a parent/child conflict point of view.

In their interpersonal linkage, Naresh recognized Jessica's struggle. He often downplayed how hurt he felt by his parent's behaviors toward him out of fear of being misunderstood and blamed Jessica for trying to turn him against them. This was challenging for Jessica who did not want to "enable Naresh in buying into the shame and guilt that his parents were projecting onto him," assuming that these emotions were somehow psychologically universal. Reducing a client's individual

struggle to terms with which the clinician is familiar, rather than using the relational skills of co-construction of meaning and acknowledgement of not knowing, represents the clinical social worker's challenge in working with a culturally different population: misunderstanding can arise from trying to understand on the clinician's experiential terms that are unconsciously assigned universal validity. Harlem (2009) suggests, instead, that emotional life is culturally constructed. Rosaldo (1984), as cited in Harlem (2009), writes that "feelings are not substances to be discovered in our blood but social practices organized by stories that…are structured by our forms of understanding" (p. 143). Therefore, although Jessica was not incorrect in understanding Naresh's core issues as expressing separation and attachment conflicts, she was out of alignment with the culturally specific dimensions of how separation and attachment can be negotiated in a different cultural context.

Jessica projected her own beliefs about religion as controlling and judgmental onto how she thought his Hindu upbringing was contributing to Naresh's struggles, even though she knew very little about Hinduism and was apprehensive about asking Naresh religious questions. This apprehension may have stemmed from the fact that the clinical social work literature has virtually ignored, at least until very recently, the impact of Eastern spirituality or religious influences on clients' lives (Kakar 2003; Streets 2009). Because of the lack of openness about religion as part of the clinical discourse, when Jessica occasionally suggested to Naresh that his Hindu upbringing could be contributing to his current conflictual feelings, he responded by avoiding the topic and diverting the conversation to other matters. Though he did not practice the Hindu faith anymore, Naresh was proud of his religious upbringing, saying it gave him a sense of belonging, identity, and stability.

When Naresh told Jessica that he had decided to have his caste initiation ceremony, she felt taken aback, because Naresh had not brought up this topic in previous sessions. She was surprised and angry that he did not involve her in making this decision. She felt protective and worried that Naresh would be "pulled back into his parents' vortex of shame and guilt." She could not understand why he would want to go through with this ceremony when he had expressed such strong philosophical, moral, and emotional objections to what it represents. Looking at the familial relationship with Western ideas of parity, Jessica did not feel Naresh's parents had earned his respect since they did not show respect toward his own life choices. She also saw his parents' continual focus on what will happen after they die as a way of manipulating Naresh to remain enmeshed with them, again displaying cultural myopia about death and its aftermath. Self-awareness of feelings such as anger, surprise, confusion, disapproval, protectiveness, and the like is a valuable signpost of countertransference. For a relational clinician, they signal the need for active inquiry and openness to not understanding, as a version of not knowing. The achievement of relational connection thus reflects mutual regard and tolerance for uncertainty, rather than all-knowing clinical expertise. In this manner, Jessica could use this opportunity to engender greater compassion for herself and for Naresh by reaffirming the core value of the client's subjective experience (Bean and Titus 2009).

Leaning into Uncertainty: The Need for Constant Self-Reflection

One of the key tenets of relational social work (Tosone 2004) is that the therapeutic relationship is a primary catalyst for client change. A nurturing therapeutic relationship enlists the powers of client and clinician as individuals, with individual histories, and the in-the-moment transformative powers of the therapeutic dyad. Tosone (2004) describes these elements as the aspects of the actual relationship, the working alliance, and the "transference-countertransference matrix as it operates in the intersubjective field" (p. 482). The intersubjective field encompasses both empathic attunement and the role of mentalization through the dialogic exchange (Allen et al. 2008).

Seeking the guidance of a supervisor or peer is a natural step in relational practice. It confirms the unending process of experiential learning and the centrality of interpersonal exploration as sources of growth in client and clinician alike (Baker Miller 2012). "Starting where the client is" (Woods and Hollis 1999) should be replaced by starting where the client and clinician are (Jordan 2004). Urdang (2010) notes that social workers, motivated to find the best solutions for their clients or to empower them to improve their lives, can feel pressured to apply time-limited and outcome-focused treatments and may "tend to reinforce [workers'] own tendencies towards 'omniscience, benevolence, and omnipotence', without a need to reflect upon or alter them" (Urdang 2010, p. 524). A relationally informed clinical practice stance could allow a social work clinician like Jessica to see her countertransference not as something problematic or to be avoided, but rather as something vital for engaging more deeply with Naresh. Countertransference "result[s] from dynamics with a client that are both inevitable and essential for meaningful change to occur…[and] is a way to feel in one's bones that which the client cannot convey through language alone" (Berzoff and Kita 2010, p. 342). In her strong desire to have the therapeutic relationship of her fantasy, however, Jessica unwittingly engaged in a power struggle with Naresh and his cultural legacy. She was bringing into her work European American notions of personal agency, pride, and parent–child relationships, concepts that may be the product of her own personal experiences and reinforced through Western psychological, psychoanalytic, and psychosocial theories. The relational perspective of individual agency (Bennet and Nelson 2011; Berzoff et al. 2008) recognizes rather than disregards the unique culturally congruent features of individuality. Perhaps reflecting the invisibility of culture as an aspect of self due to membership in a dominant population, Jessica attributed her own experiences of being overwhelmed or pressured to intra-familial conflicts with her nuclear family. Thus her preconceived notions reproduced the power struggle that existed between Naresh and his parents and that played out within Naresh himself. Jessica felt that as she was trying to build a relationship with Naresh, she was in competition with his parents. This competition may have paralleled the competing forces in Naresh – one urging him toward greater autonomy and individuality and another pulling him toward familiar patterns of relationship in his family of origin. The struggle between developing autonomy and maintaining

interpersonal relatedness can be a central theme for some clients, particularly those who came from family environments that did not encourage expressing one's emerging competency or one's desire and need for connection (Safyer et al. 1997).

Co-creating Culture and Connection Through Relationship

Just as Naresh was creating splits between right and wrong, or choosing his own life versus choosing his parents/family, Jessica also was making a sharp distinction between Naresh's culture and his presenting problems. His presenting problems were his relationship with his boyfriend and anxiety. His former troubles with intimacy were linked to feeling withdrawn and defensive about being truly understood. In this way, there was a parallel process between Naresh's struggles in connecting with his partner and family and his ability to form an open and authentic dialogue with his clinical social worker. The relationally attuned practitioner needs to recognize, embrace, and work with this parallel process as a here-and-now modification of what is a reality-based struggle for the client to exist authentically in the present in a culturally divergent and uncomprehending society.

In addition to trying to view the presenting problem within the client's cultural context, the practitioner needs to attune herself to how aspects of his culture get *enacted* through the presenting problem. In this way, "the problem contextualizes the relationship between clients and [clinician] and organizes possibilities and limitations for counseling" (Bean and Titus 2009, p. 42). Aspects of Naresh's culture (relationships with parents and extended family, religious upbringing, caste, etc.) and his presenting problems (anxiety, struggles with intimacy, conflictual relationships, feelings about himself/his own sexuality, etc.) shape and transform each other. Neither is static. The reported presenting problem may allow the client the opportunity to acknowledge and face struggles that are either downplayed or silenced in his culture and/or family.

Often, culture is seen as already existing properties residing in the individual; the individual brings these qualities into the clinical encounter and the clinical social worker must then orient her work so as to understand, become aware of, and respond to these properties as they get revealed. Rather than seeing her reactions as stemming from something inside Naresh that she needs to understand but is avoiding for her own defensive reasons, Jessica can "question whether or not there is ever anything objective of the client's that the [clinical social worker] can grasp" (Berzoff and Kita 2010, p. 343). This more dynamic relational perspective suggests that the client's culture and the presenting problem get enacted by and through each other in the vessel that is the therapeutic relationship. Berzoff and Kita (2010) describe the possibilities for growth that these enactments present:

> The hope is that by getting *into* an enactment, the [clinician] can then *get out* and, in the process of doing so, make the enacted material available for conscious reflection. This requires that the [clinician] get emotionally involved with the client…From this perspective, [clinicians] and their clients will inevitably enact parts of the patient's mental life and parts of the [clinician's] mental life, creating what Ogden (1994) has called the "third space" in which something new can be understood between them. (p. 342)

Both the clinician and the client then have an opportunity to participate and construct this enactment in ways that can shift the client's views of both the presenting problem and his experiences of his own culture. This is the essence of applying constructivist theory to clinical social work practice through the relational model. Instead of relying on gaining detailed knowledge of a client's culture, which can be a form of maintaining the dominant control of the narrative by becoming more expert rather than by valuing the client's expertise, the clinician can see this pressure as a signal to "becom[e] aware of [her own] culture's fundamental propositions about human nature, human experience, and the fulfilled human life and….then [see] them as cultural products, embedded in a particular place and time" (Kakar 2006, p. 41). In doing this, Jessica could join with Naresh around these life journeys and thereby co-construct with her client what Winnicott (1967) has called "the potential space between baby and mother, between child and family, between individual and society or the world…[which is] sacred to the individual in that it is here that the individual experiences creative living" (p. 372). This is the space, according to Winnicott (1967), where "cultural experience" (p. 371) is located and is also what he called "the place where we live" (Winnicott 1971, p. 104). Thus, culture in the clinical encounter is a location of creative experiences that gives the person a sense of his past, present, and future as a human being living in this world, a space where he can discover or rediscover himself in relation to his cultural and familial history.

What Separates Us Joins Us

In describing the possibility and impossibility of communicating human experience in the therapeutic alliance, Bollas (1998) writes that "there is a 'strangeness' between people, an 'interruption escaping all measure' (Blanchot 1993, p. 68), an infinite separation, that is the outcome of that difference between any two persons" (p. 33). Both the clinician and the client may become starkly aware of this strangeness at any moment in the clinical encounter. In sharing with her his decision to have his caste initiation ceremony, a ritual that is rich with cultural, familial, and historical meaning, Naresh took an important step to let Jessica further into his world, a world to which she feels she cannot relate. Jessica has an opportunity to invite, rather than shut out, her feelings of disconnection with Naresh as he speaks with her about his decision to perform a very important rite in his life. In fact, her feeling shut out presented an opportunity to empathize with how shut out Naresh may feel from her and from others in his life, as well as how shut out he and his parents may feel from each other. Difference between the clinician and the client can thereby become not an obstacle to engagement but a catalyst for growing a trusting, more open relationship. Cultural dissimilarities need not be barriers and, in fact, may be openings for identifying with our clients' pain (Lobban 2011).

Engaging with one's feelings and experiences of disconnection is the very vehicle for healing, as well as individual and societal change (Comstock et al. 2008). Opening herself up to the pain of disconnection and being misunderstood may allow

Jessica to genuinely respect Naresh's need and wish to fulfill certain cultural and familial obligations. Engaging with Naresh around all of his thoughts and feelings about having his caste initiation ceremony, be they of social, familial, cultural, or developmental origins, can open the door to expand how he thinks about his own and his parents' happiness, norms which may have been passed down through generations. Perhaps Naresh's decision to go to India for the ceremony was his attempt to connect more with himself and his parents and develop what Akhtar (1995) has called a "good-humored ambivalence" (p. 1060) toward himself, his parents, his country of origin, and the country he grew up in and adopted for his adult life.

Recognizing that while there will always be an unbridgeable separation between them, Jessica may find new ways to engage with Naresh around the many meanings religion and spirituality may have for him. His disavowal of the importance of reflecting on his Hindu upbringing illustrates that the inquiry process for the social work clinician who is bold enough to pursue it may not always be met with ready acceptance. Beginning clinicians often struggle with what they perceive as negative reactions from their clients, such as clients not appreciating or accepting their help in the ways they may have envisioned or wished (Urdang 2010). Clients from populations labeled as diverse, and therefore marginalized, may be reluctant, as was Naresh, to be open with clinicians who are diverse from themselves about their deepest cultural convictions.

Conclusion

Dharma is an unwritten and often unexpressed code or law in Hindu thought that helps one know if one is acting in accordance with right action and the truth of things (Kakar 2006). Dharma, however, is not a prescriptive code and may lead to what may seem incongruent actions. The right action depends on the context in which this action is taking place. Thus, contained within the concept and enactments of dharma in people's lives is the realization that truth is all encompassing, not by limiting or predetermining but by creating a space where multiple potentialities can emerge. Dharma, like co-constructing meaning through relationship with one another, is constantly creative and evolving. This Asian Indian (Hindu) construct can be understood as a version of the relational space that can cradle what Winnicott (1967) describes as paradoxes between separateness and union, between originality and tradition, and between the individual and the shared (communal). In the potential space where cultural experience is located (Winnicott 1967), all of these exist and, in fact, are necessary for one another. Allowing for these paradoxes is important in working with Asian Indian clients, particularly second-generation immigrants like Naresh, who want to connect even more deeply with their familial and cultural histories while transforming them and adopting new ways of living in the world.

Kakar (2006) states, "the relativism of dharma supports both tradition and modernity, innovation and conformity" (p. 30). In the realm of relational theory's

endorsement of construction and found meaning rather than prescription and validated meaning, dharma is a useful principle that may be central to working with Asian Indian clients and more broadly with clients who are culturally different. Transformation requires being able to hold multiple truths, to let oneself be pulled toward the past while reaching for the future, and to embrace new ways of being while honoring the collective wisdom of tradition. To embark on such a journey can be frightening and unsettling. Transformation cannot happen in isolation, but rather in relationship with others. Clinical social workers have the precious opportunity to build these relationships, and doing so requires both knowing and not knowing how to be with another human being.

Study Questions

1. Discuss the impact of immigration on the lives of Asian Indian families and individuals. How might these impacts be similar and/or different for other immigrant groups in the United States with whom you are familiar?
2. How might the concepts – collectivism and individualism – be useful to you in working with an Asian Indian client? How might these concepts be limiting?
3. What are some of the reasons Asian Indian clients may be reluctant to seek services or engage in therapy? Choose one of these reasons and discuss whether this is a common theme when it comes to hesitations that clients may have when reaching out?
4. Choose one of the following terms: family, identity, community, self-determination. Discuss any countertransference this concept evokes that may influence relational work with an Asian Indian client.
5. Earlier in this chapter, it was stated that "a relational framework can help practitioners recognize the emotional and interpersonal needs that may be encoded in their client's presenting problems and then respond to these needs in ways that make aspects of the client's culture amenable for exploration in the therapeutic process." Discuss this statement using an example from your own practice.
6. Reflect on a core idea or value from any religious or spiritual tradition, not limited to Asian Americans. Discuss how this core idea might inform your practice as you explore presenting issues in their daily life.

References

Akhtar, S. (1995). A third individuation: Immigration, identity, and the psychoanalytic process. *Journal of the American Psychoanalytic Association, 43*, 1051–1084.

Allen, J. G., Fonagy, P., & Bateman, A. (2008). *Mentalizing in clinical practice*. Washington, DC: American Psychiatric Publishing.

Almeida, R. (2005). Asian Indian families. In M. McGoldrick, J. Giardano, & N. Garcia-Preto (Eds.), *Ethnicity and family therapy* (pp. 377–394). New York: Guilford Press.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Arlington, VA: American Psychiatric Association.

Baker Miller, J. (2012). *Five good things*. *Jean Baker Miller Training Institute at the Wellesley Centers for Women*. New Hampshire: Wellesley.

Baptiste, D. A. (2005). Family therapy with East Indian immigrant parents rearing children in the United States: Parental concerns, therapeutic issues, and recommendations. *Contemporary Family Therapy, 27*(3), 345–366.

Bean, R. A., & Titus, G. (2009). Cultural intersection of Asian Indian ethnicity and presenting problem: Adapting multicultural competence for clinical accessibility. *Journal of Multicultural Counseling and Development, 37*, 40–51.

Bennett, S., & Nelson, J. (2011). *Adult attachment in clinical social work*. New York: Springer.

Berzoff, J. (2011). *Falling through the cracks: Psychodynamic practice with at risk and vulnerable clients*. New York: Columbia Press.

Berzoff, J., & Kita, E. (2010). Compassion fatigue and countertransference: Two different concepts. *Clinical Social Work Journal, 38*, 341–349.

Berzoff, J., Flanagan, L., & Hertz, P. (2008). *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts* (2nd ed.). New York: Jason Aronson.

Blanchot, M. (1993). *The infinite conversation*. Minneapolis: University of Minnesota Press.

Bollas, C. (1998). Origins of the therapeutic alliance. *Scandinavian Psychoanalytic Review, 21*, 24–36.

Bromberg, P. (1996). Standing in the spaces: The multiplicity of self and the psychoanalytic relationship. *Contemporary Psychoanalysis, 32*, 509–535.

Bromberg, P. (2011). *The shadow of the tsunami and growth of the relational mind*. New York: Taylor and Francis.

Comstock, D. L., Hammer, T. R., Strentzsch, J., Cannon, K., Parsons, J., & Salazar, G., II. (2008). Relational-cultural theory: A framework for bridging relational, multicultural, and social justice competencies. *Journal of Counseling and Development, 86*, 279–287.

Farver, J. M., Narang, S. K., & Bhadha, B. R. (2002). East meets west: Ethnic identity, acculturation, and conflict in Asian Indian families. *Journal of Family Psychology, 16*(3), 338–350.

Goldstein, E. (2001). *Object relations theory and self psychology in social work practice*. New York: The Free Press.

Greenberg, J., & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory*. Cambridge: Harvard University Press.

Gunaratnam, Y. (2003). *Researching 'race' and ethnicity: Methods, knowledge, and power*. London: Sage.

Guzder, J., & Krishna, M. (2005). Mind the gap: Diaspora issues of Indian origin women in psychotherapy. *Psychology and Developing Societies, 17*(2), 121–138.

Harlem, A. (2009). Thinking through others: Cultural psychology and the psychoanalytic treatment of immigrants. *Psychoanalysis, Culture and Society, 14*(3), 273–288.

Inman, A. G., Howard, E. E., Beaumont, R. L., & Walker, J. A. (2007). Cultural transmission: Influence of contextual factors in Asian Indian immigrant parents' experiences. *Journal of Counseling Psychology, 54*(1), 93–100.

Jordan, J. V. (2004). Toward competence and connection. In J. V. Jordan, M. Walker, & L. M. Hartling (Eds.), *The complexity of connection* (pp. 11–27). New York: The Guilford Press.

Kakar, S. (2003). Psychoanalysis and Eastern spiritual healing traditions. *Journal of Analytic Psychology, 48*, 659–678.

Kakar, S. (2006). Culture and psychoanalysis. *Social Analysis, 50*(2), 25–44.

Khanna, A., McDowell, T., Perumbilly, S., & Titus, G. (2009). Working with Asian Indian American families: A Delphi study. *Journal of Systemic Therapies, 28*(1), 52–71.

Lee, S., Juon, H.-S., Martinez, G., Hsu, C. E., Robinson, E. S., Bawa, J., & Ma, G. X. (2009). Model minority at risk: Expressed needs of mental health by Asian American young adults. *Journal of Community Health, 34*, 144–152.

Leung, P., Cheung, M., & Tsui, V. (2011). Asian Indians and depressive symptoms: Reframing mental health help-seeking behavior. *International Social Work*, 1–18. doi:10.1177/0020872811407940.

Lobban, G. (2011). Li-an: Wounded by war. In M. Dimen (Ed.), *With culture in mind: Psychoanalytic stories* (pp. 25–30). New York: Routledge.

McWilliams, N. (2011). The psychodynamic diagnostic manual: An effort to compensate for the limitations of descriptive psychiatric diagnosis. *Journal of Personality Assessment, 93*(2), 112–122.

Ogden, T. H. (1994). The analytic third: Working with intersubjective clinical facts. In B. Rothschild & M. Rand (Eds.), *Help for the helper: The psychophysiology of compassion fatigue, vicarious traumatization, and self care*. New York: W.W. Norton.

Oyserman, D., & Lee, S. W. S. (2008). Does culture influence what and how we think? Effects of priming individualism and collectivism. *Psychological Bulletin, 134*(2), 311–342.

Patel, N. R. (2007). The construction of South-Asian-American womanhood: Implications for counseling and psychotherapy. *Women and Therapy, 30*(3/4), 51–61.

Rastogi, M. (2007). Coping with transitions in Asian Indian families: Systemic clinical interventions with immigrants. *Journal of Systemic Therapies, 26*(2), 55–67.

Rosaldo, M. Z. (1984). Toward an anthropology of self and feeling. In R. A. Schweder & R. Levine (Eds.), *Culture theory: Essays on mind, self, and emotion* (pp. 137–157). Cambridge: Cambridge University Press.

Safyer, A. W., Brandell, J. R., & Atwood, R. (1997). The autonomous self versus the relational self: A developmental perspective. *Smith College Studies in Social Work, 67*(2), 137–158.

Singh, R. (2009). Constructing 'the family' across culture. *Journal of Family Therapy, 31*, 359–383.

Streets, F. (2009). Overcoming a fear of religion in social work education and practice. *Journal of Religion and Spirituality in Social Work: Social Thought, 28*(1/2), 185–199.

Tosone, C. (2004). Relational social work: Honoring the tradition. *Smith College Studies in Social Work, 74*(3), 475–487.

Urdang, E. (2010). Awareness of self – A critical tool. *Social Work Education, 29*(5), 523–538.

Winnicott, D. W. (1967). The location of cultural experience. *The International Journal of Psychoanalysis, 48*, 368–372.

Winnicott, D. W. (1971). *Playing and reality*. London: Tavistock Publications.

Woods, M., & Hollis, F. (1999). *Casework: A psychosocial therapy*. New York: McGraw-Hill.