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Therapeutic Delight or Cultural Discomfort? Enhancing Receptive Affective Capacity Across Cultures

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Abstract: One of the central practices of AEDP emphasizes making the implicit explicit through direct expressions of appreciation and inter-subjective delight, aiming to expand the client's receptive affective capacity. However, when applied in Israeli[1] cultural contexts, these expressions, so integral to AEDP's therapeutic process, often evoke discomfort, defensiveness, or feelings of inauthenticity for both clients and therapists. This paper explores the cultural dissonance that arises when explicit verbal appreciation, a norm in American therapeutic training, is introduced in Israeli therapy rooms, creating unique barriers to high-intensity affective interventions. The core dilemma addressed is how to distinguish between rejection stemming from personal trauma and resistance rooted in cultural defense. This precise understanding of the source of the resistance determines the corrective relational path, which requires a detailed understanding of the unique culture. Drawing on socio-linguistic research and clinical vignettes, the article demonstrates how Israeli clients' responses often reflect cultural norms rather than trauma-based restricted receptive affective capacity The article proposes diagnostic and interventional strategies, these culturally attuned adjustments serve dual purposes: they bridge the cultural gap while revealing the source of resistance through the speed and quality of the client's response. Clinical vignettes illustrate how these adaptations successfully bypass cultural defenses, maintain AEDP fidelity, and enhance therapeutic safety and bonding.

1. Introduction

The prevalence of cultural gaps between therapists and clients constitutes a significant and well-established challenge in clinical practice. To address this, comprehensive approaches such as the Multicultural Orientation (MCO) framework[2] (Owen et al., 2011; Owen, 2013)

[1] It is crucial to note that Israeli society is heterogeneous, comprising numerous distinct sub-cultures and populations. The cultural analysis presented here is based primarily on socio-linguistic studies and the author's clinical experience, which is centered predominantly on the Israeli Jewish population. Accordingly, the term Israeli is used to refer to this cultural context, as other populations in Israel are likely governed by different cultural scripts regarding the expression and reception of appreciation, affirmation, and delight.

[2] Multicultural Orientation (MCO) is a framework in psychotherapy that focuses on the therapist's and client's cultural worldviews and how they interact during therapy. It is based on three core components: cultural humility (being open and curious about a client's culture), cultural comfort (being at ease discussing cultural

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have been formulated, primarily focusing on enhancing cultural awareness within the therapeutic dyad. The foundational principles of MCO, including cultural humility, reflective self-awareness, and relational respect (Hook, et al., 2017). These principles translate into interventions that are closely related to core elements in the AEDP therapeutic stance and interventions. Since therapy involves not two (client and therapist), but three distinct entities: the therapist, the client, and the therapeutic model, a unique challenge arises when the entire therapy model and its language originate in a different cultural field. In this scenario, the *therapist must proactively translate the model, making the implicit cultural gaps within the local therapeutic dyad (which shares the same cultural space) explicit in order to bridge the structural and linguistic gap with the imported theoretical model itself.* This article specifically addresses the challenge of bridging this therapeutic triad gap (Therapist–Client–Model) by examining the cultural adaptation required when applying the AEDP model with an Israeli therapist and patient.

The foundational, transformative work in AEDP hinges on the therapist's authentic, affirmative presence - utilizing affirmation, appreciation, and inter-subjective delight - to melt defenses and move the client from a place of isolation to therapeutic connection and access to core affective experiences. (Fosha, Thoma, & Yeung, 2023). This relational truth-telling, often starting from the get-go in the very first moments of the encounter, is designed as a dynamic intervention woven throughout the process. It is foundational for establishing safety, thereby facilitating the dismantling of defenses and the reduction of anxiety. This relational presence undoes aloneness and paves the way for processing affect to completion and reaching core state. Concurrently, it enables the internalization of a nurturing and empathic voice - one that sees the client through warm, affirming eyes and replaces maladaptive internal voices of harsh criticism and toxic shame.

While the AEDP therapeutic methodology of affective-somatic tracking is well suited to cross-cultural work (Suber 2025, Sundgren 2025, & Ye-Perman 2025), the primary transformative power of AEDP rests in its therapeutic stance—specifically, the therapist's authentic and affirmative presence, characterized by affirmation, appreciation, and intersubjective delight. Our authentic use of self—conveying our genuine experience of the client's adaptive strivings and reflecting it back to them—guides us throughout the therapeutic process. This stance is foundational for establishing safety, which in turn facilitates the dismantling of defenses and the reduction of anxiety. The client's ability to internalize these authentic expressions from the therapist depends significantly on their receptive affective capacity—the ability to take in the affirming presence and positive regard of a significant other (Fosha, 2004). However, in cross-cultural work, differences in the expression and reception of affirmation, appreciation, and intersubjective delight can present barriers to the internalization of these experiences.

issues), and cultural opportunities (recognizing when to explore cultural themes) (Davis et al., 2018). This approach aims to enhance the therapeutic relationship and improve outcomes by shifting the focus from fixed competencies to a dynamic, relational process (Hook et al., 2017).

In my clinical practice with mostly Israeli Jewish clients, I have frequently encountered situations when the therapeutic language of affirmation, appreciation and warmth, so central to AEDP, is met with rejection, suspicion, or even active pushback. These reactions of clients, so common to all therapeutic work, might carry a different meaning in a cross-cultural context. While the direct expression of appreciation is often the cultural script of authenticity in the American context, for many Israeli clients, this same language can be experienced as inauthentic, performative, or even patronizing, resulting in a defensive rejection of the intervention. We know that cultural comfort is critical in multicultural orientation therapy (Hook et al., 2017). Yet, in this specific clinical situation, the cultural gap does not primarily lie between the therapist and the client; rather, it exists structurally between the local therapeutic dyad (therapist and client, who share the Israeli culture) and the imported therapeutic model (AEDP). This results with a therapeutic dilemma whether the relational rupture was caused by the therapist's inaccurate translation of the model across cultures, or by the activation of the client's internal world. Therefore, posing a crucial clinical question: *How do we discern if a client's rejection of our genuine, affiliative affect stems primarily from a cultural script of emotional guardedness and restraint, or from a constrained restricted receptive affective capacity or personal trauma?* This inquiry is central to effectively leveraging authentic appreciation to expand receptive affective capacities within cultural landscapes where direct appreciation is often met with skepticism. This article will focus on attempting to answer this question specifically within the Israeli context.

2. Cultural Differences – appreciation and inter-subjective delight across cultures

The direct expression of appreciation and inter-subjective delight is foundational to AEDP, serving to consolidate healing and act as an antidote to maladaptive affects (Fosha, & Schneider 2008; Piliero, 2021). This relational act, which deepens the visceral experience of receiving positive material (Lamagna, 2021), requires explicit exploration of the client's response, which falls into two main categories: the first main category of client responses is resistance and defenses. Clients frequently struggle to take in good experiences, viewing them as unfamiliar or scary (Fosha, 2000). This resistance manifests as soft defenses, deflecting the compliment (Piliero, 2021), or as guilt, self-doubt, and intellectualization (Fosha, 2006). This deflection is often tracked non-verbally through hesitation or physical retreat (Prenn, 2011). The second category of response, and the clinical goal of metatherapeutic processing, involves positive and transformational responses. Where successful internalization yields healing and transformational affects (Fosha, 2000). Clients report rich emotional responses (like gratitude or love) that lead to self-affirming states ("reminded of the real me") and profound Somatic Shifts (feeling lighter, stronger) (Fosha & Thoma, 2020). These changes culminate in an assertion of agency and are tracked by nonverbal cues like changed posture, deep smiles, and "truth tears" (Piliero, 2021).

These expressions, however vital to the AEDP transformational process, were often delivered and taught through a distinctly American relational lens, raising immediate questions about

cultural adaptability. I distinctly recall my own reaction to a clinical video presented during the first module of my ES1 training, a torrent of warmth and admiration that quickly morphed into an anxious form of envy, followed by an immediate dismissal of such interventions ever successfully translating to the Israeli culture where I live and work. This visceral response highlighted the tension at the heart of my clinical inquiry, particularly when viewing the explicit, highly positive relational affects central to AEDP.

2.1 The American context

Expressing appreciation and compliments holds high social value in American culture and is performed frequently and openly across a range of interpersonal relationships (Eisenstein & Bodman, 1986). Americans perceive complimenting as relatively easy and regard it as an important cultural custom (Matsuura, 2004). Compliments are highly formalized, with many utilizing a limited vocabulary, particularly adjectives such as nice, good, and great. Moreover, the favored topics for compliments often concern external achievements, possessions, or skills/work, generally focusing on aspects resulting from deliberate effort rather than natural characteristics or personality traits (Wolfson, 1981; Nelson, et al., 2003). In my experience, much of the cultural gap was also related to the intensity of emotional expression. A small meme circulating online defines the differential framing best: while an American might intend "Excellent job!" to mean "You did the job properly," an Israeli might interpret that same phrase as "You're a genius, you did the best job in the team".

This difference in perceived emotional magnitude is reflected not only in the general culture but in the therapeutic language modeled in AEDP, where explicit, abundant affective disclosure is emphasized in training examples. This intense style typically manifests in three ways: first, through high-intensity modifiers, which use linguistic intensifiers to amplify the significance of the moment (e.g., "I feel *really*... when I hear you say this!", "I was *very* moved when you said...", and "I can *really* feel the power of this."); second, through absolute declaratives, which are unqualified statements of positive assessment directed at the client or the process (e.g., "You are doing so well!", "This is a lot. This feels so important...", and "What a good observation, so helpful for us!"); and third, through explicit relational affect, which involves overt statements of relational connection and emotional investment from the therapist (e.g., "I'm so touched by what you're telling me!", "I'm so happy you did that, do you see my big smile?", and "I care for you."). This collective use of high-intensity, explicit, and declarative language stands in stark contrast to the Israeli cultural norm, immediately raising questions of reception and authenticity in a cross-cultural dyad[3]

[3] All examples listed were sourced from various handouts given in experiential exercises in ES modules I experientially assisted in over the years. While acknowledging the existence of other culturally attuned examples, these specific high-intensity phrases were deliberately chosen because they represented the most significant linguistic and affective divergence from my own cultural norms when I initially learned the AEDP model.

2.2 The Israeli context

Expressing compliments and appreciation in Israeli culture is largely characterized by the central socio-pragmatic concept of Dirgun (Danziger, 2018; Katriel, 2018), which means to openly and genuinely support another person's success. This practice is rooted in the Israeli Dugri code, requiring the expression of an evaluative stance to be direct, sincere, and volitional, rather than an obligatory social convention or mere politeness. The essence of Dirgun is in its authenticity (Katriel, 2018), aiming to affirm the recipient's self-image and foster a supportive environment (Danziger, 2018). Therefore, any perceived exaggeration or lack of candor immediately undermines its therapeutic effect. Complimentary topics commonly focus on external and tangible aspects such as performance (e.g., a job promotion or student lecture), possession, or appearance. Conversely, "internal" compliments on personal attributes like talent or personality traits are often perceived as too intimate or unwelcome (Danziger, 2018). Furthermore, because of the cultural value placed on self-reliance, modesty, and skepticism, and a general aversion for overt, exaggerated praise (Katriel, 1986), expression of appreciation is frequently delivered through indirect methods. These indirect relational signals of authentic warmth and concern are often communicated through practical gestures such as practical help or immediate, critical feedback aimed at improvement, rather than through explicit, prolonged expressions of admiration. Another common expiration of positive regard is humor which often serves as a primary relational channel for expressing affection and appreciation, allowing closeness without the perceived heaviness of formal sincerity. Conversely, positive support may be masked by cynicism or light teasing, a form of inverse affirmation. This reliance on directness (Dugri) to ensure authenticity is the core hurdle for translating high-affect interventions.

Another fundamental difficulty in translating affirmative, high-affect AEDP interventions lies in the collision between the model’s encouragement of explicit "delighting in" of the client and the deeply rooted Israeli social norm of "No pampering with compliments" (Katriel, 1986). When I, as an Israeli therapist, utilize the AEDP language of "I really feel you right now" or "You are doing so well!," the high-intensity language, which is often perceived as culturally performative, can trigger an immediate, defensive minimization (e.g., "It was nothing”, "Anyone could have done that"), rejection, or even suspicion. This response stems from a cultural reflex to deflect "fluff," rather than a primary sign of a restricted receptive affective capacity.

These defensive responses are not limited to explicit appreciation or delight; they may also occur when the therapist highlights any feeling or experience as important, difficult, or emotionally significant. An intervention frequently used in AEDP to affirm and validate the client's experience, encourage slowing down, and deepen emotional processing can easily be met with minimization, dismissiveness, and cynicism. This can be understood as a further manifestation of the cultural norm of "No pampering", which is evident in the allocation of emotional public space. Israeli cultural discourse extensively prioritizes national and collective loss, consequently leaving limited space for private grief and virtually none for

other personal hardships that do not involve the loss of life. This emotional hierarchy creates an internal burden. In my work with men coping with trauma, the self-cancellation, minimization, and lack of self-validation of their injury is very prominent because “they are alive and not dead”, or they were “only seriously injured and not fatally.” This pattern of minimizing distress, however, extends beyond men; it is frequently observed with other clients whose genuine emotional experiences, when validated by the therapist or even just highlighted, are met with automatic reduction or dismissiveness. A chilling but representative example that emerged in the treatment of a client who told of an experience she had a difficult interaction:

Therapist: Wow, I feel my chest tightening. That sounds very difficult.

Client: The Holocaust was difficult. This was something that had to be dealt with.

The implementation of AEDP, which relies heavily on explicit relational warmth, affirmation, and the deepening of emotional experience, encounters two significant cultural barriers within the Israeli context. Firstly, the deep-seated "Dugri" code, a cultural value prioritizing directness, honesty, and minimizing verbal embellishment, can cause clients to perceive the therapist's genuine appreciation or positive affect as inauthentic, excessive, or merely a foreign "technique," often leading to immediate suspicion rather than genuine receptivity. Secondly, the intense cultural focus on national trauma and collective loss creates a strict emotional hierarchy, minimizing the public and internal space available for private, non-life-threatening emotional distress or individual suffering. Consequently, AEDP interventions that seek to validate and slow down to process personal affective experiences are often met with rapid dismissal, minimization, or discomfort, as the client implicitly questions whether their private pain is culturally "allowed to take up so much space" compared to the collective narrative.

Clinical vignette: Minimization as a culture gap rooted defense against affect

The client in the following micro-interaction is a man in his early 40s, a successful company owner, married with children, presenting with mild PTSD symptoms following a car accident. He was raised by largely absent but successful parents, leading him to invest heavily in business success to meet perceived expectations, though he had a warm, meaningful connection with his grandmother. Clinically, he also presented with subtle depressive symptoms. From the very first session, he consistently employed emotional minimization and constricted responses whenever the therapist directly affirmed or validated significant emotional events.

Therapist (T): How does it feel to talk about it now?

Client (C): Uncomfortable. (*makes eye contact, looks down, moves upper body slightly uncomfortably*).

T: (*Takes a slow breath and a long exhale, modeling dyadic regulation*) What do you notice happening in your body right now? **[inviting client to notice the body's response to the difficult affect]**

C: Heavy in the chest and stomach, uncomfortable. (*speaks slowly, quieter tone of voice, soft gaze, seems to be shifting his attention inward into the body and the experience*) [**successfully identifies and names a somatic experience, showing a glimmer of self-awareness and emotional connection].**

T: (*Soft, slow tone of voice*) Is it okay if we slow with this? That heaviness sounds important. [**using validation and slowing down to deepen the affective experience, treating the somatic signal as significant core material.]**

C: (*Sits up in chair abruptly, shrugs slightly, makes direct eye contact*) It's not that big of a deal, it was just a fight, it's not like someone died. (*Tone of voice rises, cutting off speech, sounds businesslike and cynical*). **[abruptly retreats from the affective connection and immediately employs Minimization and Cynicism to negate the significance of his internal experience, reflecting the cultural defense against affective 'over-the-top' drama.]**

This vignette starkly illustrates the challenge: when a client deflects my affirmation or validation, I must quickly discern: Is this an expression of a cultural gap or a personal trauma reflected in a restricted receptive affective capacity, shame or guilt? To answer these questions, the subsequent section will provide a framework for differentiating between these crucial sources of client resistance.

3. Cultural Misunderstanding vs. Trauma-based Defense

3.1. The client's response as a diagnostic map: tracking receptive affective capacity, defense, and transformance

The understanding that the unit of intervention is what the therapist does and how the client responds to it is fundamental to the work of AEDP. The client's immediate affective, relational, and cognitive responses serve as the clearest map for understanding the background and meaning of their reaction. We can clearly observe types of defensive and resistant behaviors that emerge when a client struggles to integrate positive relational experiences (known as the challenge of building receptive affective capacity (Piliero, 2021; Frederick, 2021). These reactions are crucial markers indicating the need for therapeutic exploration. The negative responses generally fall into three main categories: affective and emotional resistance, relational anxiety, and behavioral and cognitive defenses.

1) As affective and emotional resistance, where the sudden shift to a positive state is destabilizing and perceived as unfamiliar or scary (Fosha, 2000). This category includes the anxious, disorienting experience of tremulous affects (signaling a healing crisis), alongside reactions of guilt and unworthiness (feeling undeserving), and expressions of shame or

embarrassment (nervous smiles, giggling, or needing to "laugh it off") (Russell & Fosha, 2008).

2) Resistance that manifests as relational anxiety, rooted in the fear that the therapeutic bond will inevitably replicate past injury. This includes compliance fear, where clients worry that accepting affection will lead them to lose authenticity or compromise their integrity to please the therapist (Fosha, 2006), or being hardwired for negativity, defensively expecting criticism and blocking positive input with internal mottos like "Don't set yourself up for disappointment" (Frederick, 2021).

In a sense, with both of these patterns, the client initially allows the intervention to be registered internally, but the subsequent negative reaction, whether it is affective and emotional resistance or compliance fear triggered by the intervention's encounter with the client's deeply ingrained personal history of trauma. Therefore, both patterns are mostly anchored in the client's personal history of trauma, differentiating them from pure cultural deflection.

3) Behavioral and cognitive defenses, whereby the client actively blocks the intervention. This block manifests in several distinct ways. Deflection and dismissal are common: the client immediately minimizes the compliment using a "soft defense" (Piliero, 2021), perhaps shrugging, or explicitly saying, "It's not that big a deal." Clients also engage in intellectualization, retreating to analyze the situation instead of staying with the feeling. Avoidance tactics include looking away when communication becomes personal or using rapid speech as a defense mechanism (Fosha, 2006). These defenses can also be expressed through physical barriers, such as a "puzzled expression," crossing hands (Frederick, 2021) or describing an internal "block" that prevents the positive feeling from sinking in (Pando-Mars, 2016; Fosha & Thoma, 2020). When these strategies are deployed, the therapist's intervention is effectively pushed away or reduced to "take away its sting." While AEDP generally refers to these as defenses against the perceived threat of relational intimacy or positive emotion (Piliero, 2021), I have found that cultural gaps in Israeli clients will often be expressed primarily through these deflective, minimizing, and blocking types of responses.

The critical importance of this diagnostic differentiation lies in the fact that we must tailor our subsequent interventions to the client's underlying emotional question (Figure 1). If a client reacts to an expression of appreciation with discomfort due to a history of personal trauma, they are essentially asking: "Will it be safe for me to allow this pleasant feeling to sink in, or will I be hurt/abandoned again?" (restricted receptive affective capacity). Conversely, an Israeli client may react to effusive appreciation with discomfort because they are asking: "Are you being genuine? Is this affirmation authentic, or just a social script?" (cultural defense). Similarly, when a client minimizes or cancels the validation of their distress, the question being posed might not be rooted in a traumatic history of critical parents, but rather: "Culturally, is my personal emotional experience truly allowed to take up this much space and be treated as significant?". Therefore, a precise understanding of the source of the resistance determines the corrective relational path, which requires a detailed

understanding of the unique culture. In the next section I will expand specifically on Israeli responses to affirmation and appreciation, drawing from both my clinical impressions and relevant existing studies.

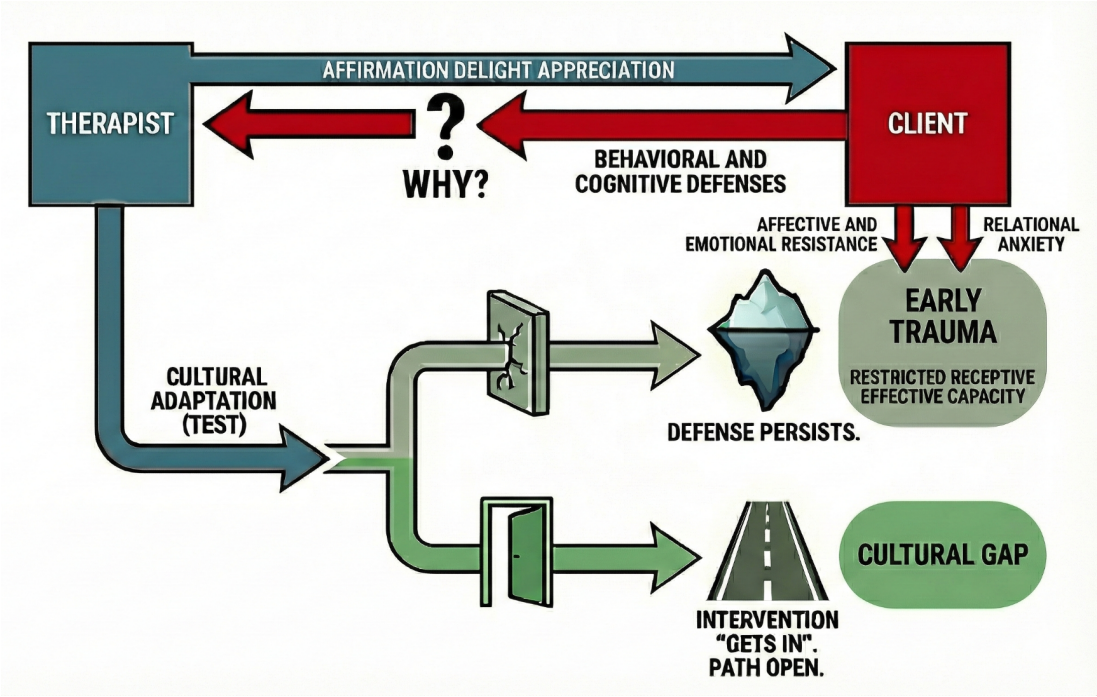

Figure 1. Differential diagnosis of resistance to affirmation, appreciation and inter-subjective delight in cross-cultural therapeutic dyad. *This schematic illustrates the differentiating process of the underlying etiology of client resistance to core relational-affective interventions (affirmation, delight, appreciation). The initial intervention is met with categorized defenses (behavioral/cognitive, affective/emotional, relational anxiety), which necessitates the diagnostic test phase. The model posits that the therapist's subsequent application of a culturally adapted intervention serves as the critical differentiator: The Upper Pathway indicates that if resistance persists (failure of adaptation), the etiology is ascribed to deep-seated early trauma and resultant restricted receptive affective capacity. The Lower Pathway indicates that successful bypassing of resistance via cultural modulation (intervention "gets in") points to a primary cultural gap as the source of misalignment, thereby facilitating the therapeutic path.*

3.2 Examining client responses through the lens of the cultural gap

A study examining Hebrew-speaking students' responses to appreciation or compliments found that they are commonly experienced as inauthentic, or inappropriate. Two guiding cultural principles drive these reactions. First, ambivalence toward politeness reflects the Israeli tendency to perceive conventional politeness negatively. Secondly, the demand for

sincerity reflects both the traditional D*ugri* code (which often involves negative direct evaluation) and the newer concept of Firgun (supportive appreciation) that is rooted in the value of sincerity and the need for an openly expressed evaluative stance (Danziger, 2018; Katriel, 2018). When the sincerity of an act of Firgun is questioned, the appreciation is often perceived as calculated flattery or manipulation serving a self-interest (Katriel, 2018).

Based on observations of Israeli responses to compliments (Danziger, 2018), their rejection strategies generally divide into two modes when appreciation is perceived as inauthentic, threatening, or too intimate: explicit challenge and reinterpretation which involves actively questioning the compliment's sincerity ("Are you serious? Why did you say that?") or function - often deeming it an act of impoliteness - and avoidance, evasion, and conditional acceptance. Rejection is especially common for compliments concerning intimate, internal aspects (e.g., personality or talent), this includes ignoring the comment, rapid topic shift, or offering a ritualistic "thank you" often accompanied by explicit non-verbal cues of discomfort (such as redness, looking down, and shifting quickly). In addition to the overt strategies, another common response expressing cultural gaps in the clinical context is when the client responds verbally in an apparently positive or polite manner to the intervention ("Thank you" or “it feels nice”), but the somatic and non-verbal signs indicate closure, distance, or emotional detachment. It seems this polite response is used strategically to avoid directly contradicting the therapist and thereby maintain the external therapeutic alliance. Simultaneously, however, it serves as a block that prevents the client from internalizing the appreciation, which is experienced as inauthentic, exaggerated, or unrealistic according to the cultural script.

Understanding the range of these unique responses is important, not specifically for understanding Israeli culture, but because every culture has its own unique way of responding to appreciation, affirmation and inter-subjective delight. Becoming intimately familiar with these different modalities can help us as therapists respond in a more tailored way to our clients. Across different cultures, reactions to appreciation experienced as inauthentic or face-threatening often prioritize social norms like modesty over agreement. Persian speakers, for example, frequently resort to strategies driven by *shekasteh-nafsi* (modesty), often denying or downgrading compliments, such as minimizing praise for a child by claiming he is "troublesome and mischievous" (Chen, 2010; Morady Moghaddam, 2019). When receiving a second compliment on the same attribute, they often appraise it as flattery or a prelude to a hidden request, responding confrontationally with questions like "What are you complimenting me for, again?" (Morady, Moghaddam, 2019). Historically, Chinese speakers demonstrate a strong adherence to the modesty maxim, leading to compliment responses characterized by overwhelming rejection and self-denigration, such as outright claiming the object of the compliment is "cheap stuff" (Chen, 1993). Conversely, Arabic speakers often respond to praise for a possession by offering the item through a formulaic expression, a gesture understood as *lip service* that is not meant to be taken seriously (Chen, 2010). Lastly, individuals embedded in individualistic cultures (like U.S.-born Asian Americans) who are targets of appreciation based on a positive stereotype often react negatively, feeling

depersonalized or "lumped together," leading them to derogate the complimenter and experience negative emotions (Siy & Cheryan, 2013). Cultural gaps are also described in the AEDP literature. For example, in the encounter between AEDP and Brazilian culture, with high degree of convergence with Brazilian culture, particularly the *Carioca* culture of Rio de Janeiro, were warmth, relational expansiveness, healing potential, and integration aligns well with the cultural values of *brasilidade* (authentic Brazilian spirit). Despite that, enduring legacies of colonialism and social inequality hinder the affirmation of an authentic self, and while recognition of the conditions for safety and connection exists, there is often a sense of estrangement in accepting the invitation to attune to the subtleties of bodily language (Pontes & Soares, 2025). Another example can be seen in the application of AEDP in Swedish culture, which faces three primary challenges rooted in deep-seated cultural norms. First, the prevailing atmosphere discourages open emotional expression, leading to a tendency toward emotional containment. Second, AEDP's explicit affirmation of patient strengths and success directly contrasts with the "Law of Jante," which critically discourages individual achievement and uniqueness, rendering explicit acknowledgment strange or inappropriate. Third, AEDP's emphasis on intense, intersubjective relational work, self-disclosure, and the full processing of positive affect clashes with traditional Swedish psychotherapeutic training and secularized cultural codes. Consequently, explicit empathy and self-disclosure can be perceived as lacking integrity, feeling overly intimate, or being inauthentic (Sundgren, 2025). All of these examples highlight not only the importance of familiarity with the unique culture, but also of our ability to distinguish between reactions that originate from a cultural gap and reactions that originate from restricted receptive affective capacity or personal trauma.

Vignette 1

This clinical vignette features a client in his second session and serves to illustrate the challenge of affirmation across a cultural divide. My initial expression of appreciation, aimed at establishing security (healing from the get-go) and identifying glimmers of transformation, is met with a polite but culturally-driven rejection.

Client (C): (*Eyes darting, avoids eye contact, his back is hunched over, talking quickly*) ... and then I just found myself yelling at her again. It ended up being a terrible fight. **[State 1: anxiety]**

Therapist (T): It sounds like that might have been a bit difficult for you? (*Uses a soft, questioning tone, leaning in slightly*) **[uses cultural adaptation of minimization to gently invite the client to get closer to the emotional experience in a way that suits him, matching the Israeli preference for less emotional exaggeration.]**

C: Yeah, it was a difficult moment *(he sighs, he gazes*). **[he briefly touches the core affective experience (difficulty)]**

T: (*Listens quietly, giving the client time to sit with the experience that is emerging*)

C: I think I was mostly offended by what she said right before I blew up. (*Voice tightens slightly when saying 'offended,', he then leans back and avoids eye contact)* but it doesn't really matter, I'm the one that yelled at her with no real reason *(harsher, sharper tone of voice*). **[State 1, avoiding vulnerability.]**

Therapist (P): I really appreciate the courage it took for you to share this with me right now (*Uses a warm voice and direct gaze, smiles slightly*). **[therapist identifies glimmers of transformance and uses self-disclosure and appreciation aiming for co-creating safety]**

C: Okay. (*Looks slightly distant, nods politely, shoulders tense up*). **[Client responds with a covert defense, a polite but emotionally detached response that signals evasion and non-integration of the therapist's self-disclosure]**

T: (*Leans slightly forward*) How was it for you to hear me say that?

C: It's fine. (*shoulders are still tense*).

T: *(pauses for a moment, takes a breath)*. I'm noticing your shoulders tense a bit, I'm wondering if what I just shared didn't quite land so well with you. (*Client shifts gaze to a gentle look, openness to joint exploration*). **[Therapist models authenticity and moment-to-moment tracking, identifying the micro-rupture caused by the client's non-verbal avoidance]**

C: (*Hesitates for a moment, looks down, then rubs his neck*) It's... it's just not a big deal. I don't understand what the appreciation is for. **[Clients discloses the defense explicitly, minimizing the significance of the shared content, a common, culturally-influenced attempt to reject intense, generic praise]**

T: (*slow exhalation, soft smile*) Thank you for telling me that, for being able to be honest with me right now. **[therapist expresses appreciation, but this time expresses appreciation more specifically, with a lower intensity of emotion without using words like "very"/ "so"/ "really"]**

C: (*Shoulders soften a little, gaze seems a little curious*)

T: (*body open*) This is only our second meeting and we are just getting to know each other, I appreciate that you were able to be honest with me, I don't take it for granted. Especially when I think about what you shared in the previous session about your parents. In a way you took a risk with me now and I appreciate that. **[Therapist affirms the difficulty of being honest at the beginning of a relationship by talking about the context, explaining the background to the appreciation she feels]**.

C: (*Raises his head and makes eye contact*) Thank you.

T: (takes a few breaths, shared silence) How did it feel now when I said that?

C: I believed you; it felt true.

T: I do see it as a big deal, the fact that you didn't stay silent right now. You chose to tell me that my response felt off. Can you explain a little more what you mean by "not a big deal"?

C: It feels impersonal. Like you appreciate the "sharing" in general, not *me*. I don't understand what I did that relates to "appreciation".

T: (*Soft gaze, takes a slow, long breath*) Thank you so much for telling me that. It makes total sense that you'd feel distant if my response sounded generic and not personal. I understand why "appreciation" is an empty word for you right now. (*Uses validating and containing tone*) **[uses validation of the defense, the perceived lack of sincerity /authenticity, to undo aloneness, reframing the client's truthfulness (Dugri code) as an act of courage.]**

C: (*Softens gaze, makes direct eye contact now with confidence, more open posture*) **[demonstrates a felt security and safety in response to the explicit validation of his discomfort and experience.]**

T: Hey, if it's okay with you, I'd like to try again. To try and truly express what I meant earlier.

C: Yeah, sure. (*Nods, appears relaxed*)

T: When you mentioned that the fight was difficult and that you noticed you were offended by her, I felt a warmth in my chest and a feeling that is hard to explain, that I called it appreciation, but there really isn't a good word to define it. Despite there being so much shame in that story, there is a part of you that agreed to bring it here and share it with me, and that is not at all a given for me. (*Speaks with specific, personal, and somatic language*) **[adapting the affirmation using affective self-disclosure and concrete, personal language, somatic cues, to bypass the client's possible cultural block.]**

T: What happens inside when I say it like that? (*Asks gently, observing C*)

C: I... I didn't expect that reaction. It's a bit strange, but it's pleasant to hear. It did take some courage on my part. I'm not used to this from other therapies I've done.

T: Is it ok to stay with that pleasant strangeness for a moment? (*Client nods*) Can we slow down a bit with that feeling? **[Asks gently, encouraging presence with the transformational affect]**

C: Yes. **[clear green signal]**

The session continued by making space for these feelings, which facilitated initial contact with core emotions of pride and mastery of being able to share with the therapist a piece that felt shameful (State 3) and landing in a place that felt true (State 4). This subsequently allowed for adaptive engagement with mourning of the self and with the original shame later

in the meeting. In subsequent sessions, the word "appreciation" became an internal joke: whenever the therapist wanted to express appreciation or inter-subjective delight, she would say she "felt something in her chest of appreciation, even though I still can't find a better word[4]." This use of shared humor became a more culturally accepted way to express closeness and esteem, significantly strengthening the therapeutic bond and reinforcing the client's confidence in the therapist's genuine intent. This piece relates to how shared cultural knowledge contributes to forming connection and security by allowing for the quick establishment of bonds and providing informed empathic understanding of the client's trauma, context, and the protective, non-blaming intentions of their caregivers (Ye-Perman, 2025). In the following section, I will share the diverse ways I utilize my interventions to successfully distinguish between a history of personal trauma and a cultural gap.

4. The therapeutic adaptations: differentiating, mapping, and addressing resistance through relational adjustments

If accurately understanding the difference between trauma-rooted and culturally-rooted responses is crucial, what tools can aid us in this distinction? One of the most significant tools I find is attempting to decipher the emotional need or question underpinning the resistance itself. When I suspect a cultural gap, particularly with Israeli clients, I aim to answer the inherent need for authenticity (in the case of explicit appreciation) or grant explicit permission and rationalization for the emotional experience being important (in the case of validation). The resulting clinical picture often demonstrates a key differentiator: when the intervention is culturally precise, the "gate opens," defenses drop swiftly, and the path forward becomes smooth, requiring fewer recurring "roadblocks" compared to instances rooted in personal trauma, which typically require multiple iterations to firmly establish a new internal working model (See Figure 1). This insight also informs my work with cultures or subcultures I am less familiar with; here, I use graduated titration of my interventions, adjusting their intensity and explicitness, not only for therapeutic precision but also as an invaluable diagnostic tool to map the client's unique cultural and personal boundaries.

In the next section, I will detail 6 specific multicultural orientation-informed interventions as applied to the "nitty-gritty of day-to-day, moment-to-moment clinical work" (Fosha, 2018). For each example, I will delineate its inherent diagnostic value, the appropriate therapeutic adaptation, and include a mini-vignette to demonstrate its clinical application and the client's responsive shift when utilized specifically within the Israeli cultural context (See Figure 2 for an outline).

1. Dialing the affective volume. *Diagnostic function*: This tests the client's threshold for emotional hyperbole. The Israeli cultural script tends to reject high-intensity emotional displays as inauthentic or exaggerating. By starting with extremely low-intensity

[4] Now, after almost two years in therapy we found a Hebrew phrase that translates to "happy in you" that can capture this specific phenomenon, although it is not commonly used so with new clients it might sound formal and alienating.

affirmations, we can reduce the perceived "risk" of the statement, making it safe to accept. If the client rejects even minimal affirmation, the root cause is more likely rooted in personal trauma. If they accept low-intensity but reject high-intensity, the root is more likely a cultural defense. *Therapeutic adaptation*: Rather than aiming for a "Wow!" moment, the therapist scales the affective volume down, using hesitant language, quieter tone, and smaller gestures.

C: ... and I just kept my mouth shut, even though I knew he was wrong.

T: Hmm. It sounds like there might have been something slightly important for you in choosing to hold back? (*The tone is very quiet and tentative, questioning.*) **[uses minimization and hesitant language "slightly important" to test the client's threshold for intensity, reducing the cultural threat of exaggeration.]**

C: *(Nods slowly, still looking down)* Yeah. It was important. I've never done that before with him.

Therapist offers a minimal invitation to vulnerability. Client accepts the low-intensity affirmation, signaling that the affirmation itself is not the problem, only the cultural exaggeration.

2. Posing Questions over Pronouncements. *Diagnostic function:* This tests the client's need for self-agency and control in defining their experience. Absolute statements ("You are being so brave right now") can be highly validating for clients with significant attachment trauma who need the certainty of external validation. However, for clients operating under the cultural defense, such pronouncements can feel like a premature and inauthentic imposition of a foreign truth. By shifting from a statement to an open-ended question or reflection, the therapist invites collaborative co-creation of the truth. *Therapeutic adaptation*: Replace declarative "You-Statements" with tentative "Could/Might there be" inquiries.

T: I hear what you just shared. Could there be something powerful in the fact that you decided to bring that story into the room today? (*Open, curious, and reflective tone.*)

C: *(Looks up, pauses)* Hmm. Powerful is a strong word. But yeah, maybe there is something significant in me not holding it back. It was important for me to tell you.

Therapist shifts the intervention from an absolute statement which the client would likely challenge to an open invitation. Client is able to accept "significant" and affirms the agency of his action, demonstrating a preference for collaborative truth-telling.

3. Personal Experience vs. Statement About the Client. *Diagnostic function*: Examining the suspicion of insincerity. You-Statements ("You are brave," "You've grown so much") are easily rejected as generic flattery. I-Statements focus on the therapist's genuine, somatic-affective response to the client's action, making the affirmation an undeniable, immediate relational event. The client cannot reject the truth of the therapist's internal experience. Crucially, in implementing this intervention, it is important to note that sometimes

generalized affirmations are hidden within seemingly personal statements. For example, a phrase like, 'I'm so moved by your strength' which still focuses on evaluating the client's behavior rather than sharing the therapist's immediate, subjective experience to a specific behavior like 'When I'm hearing how you handled that, I feel so moved'. *Therapeutic adaptation*: Use explicit somatic and emotional self-disclosure to anchor the appreciation in the real-time interaction.

T: When you just described how you responded to your brother, I felt a genuine, quick surge of warmth and excitement in my chest. *(places a hand briefly on her chest, maintaining eye contact.)*

C: *(Eyes widen slightly, shifts uncomfortably, then relaxes into a small smile)* That's… yes. I felt that warmth myself when I said it.

T: You felt that warmth yourself? Tell me a little more about what that warmth felt like, inside? **[metaprocesses the emerging transformational affect to deepen the experience of the core state and anchor it somatically.]**

Therapist uses affective self-disclosure to demonstrate sincerity and authenticity, bypassing the Dugri barrier. Client mirrors the somatic experience, signaling emotional integration rather than rejection.

4. Specificity and Micro-appreciation vs. Generalizations. *Diagnostic Function*: Generalized appreciation ("I appreciate you") is the easiest to dismiss as generic. Specificity forces the client to acknowledge a tangible, undeniable action of agency. This is vital for clients with restricted receptive affective capacity (who struggle to receive global good feelings) and for those with a cultural defense (who reject generalizations as vague/insincere). Specificity is profoundly helpful in cases where transparent cultural norms dictate that the object of the validation is not worth much (this is reflected in clients' responses to the appreciation "as not a big deal", "everyone does it", "it's nothing special"). Specificity acts as a counter-argument to the unspoken norm, clearly demonstrating why the experience is, in fact, important, authentic, deserving of space, or inherently valuable. This principle is relevant both for appreciation and for validation. *Therapeutic Adaptation:* Connect the appreciation or affirmation directly to a micro-moment of agency, linking it to the client's known internal struggle.

C: *(avoids eye contact, speaks in a quick, low voice)* I'm also doing exposures three times a week; I go to the mall for half an hour each time.

T: *(Warm body language, upright posture, direct gaze, in a clear, open tone)* Wow. That is really impressive **[Therapist offers initial, general affirmation and appreciation.]**

C: *(Shrugs slightly, shifts posture, tone is flat and dismissive)* It's nothing, really. If I don't help myself, who will? **[Client activates the Dugri defense, rejecting the global praise as inauthentic and minimizing the effort.]**

T: *(Leans forward, voice lowers slightly to an earnest, direct tone)* In all honesty, I think it is really not a given. The essence of avoidance is to pull you as far away as possible from touching the wound. To hear that you initiate this yourself, three times a week, you are moving toward the difficulty, truly, that sounds like it demands something of you. It's not just 'no big deal.'" **[Therapist utilizes micro-appreciation and specificity to address the cultural need for authenticity, linking the effort directly to the struggle with trauma.]**

C: *(Lifts head, meets the therapist's eyes, face softens, releases his tightly clasped hands)* Yeee, it really is difficult. Each time is a nightmare, but I know it reduces the flashbacks.

Therapist uses micro-processing to affirm a specific act of agency, linking the external behavior to the internal conflict. Client accepts the appreciation because it is precise and undeniable.

5. Embracing Humor as a Relational Channel. Humor and playfulness serve as highly effective relational regulators in the Israeli context. Playfulness reduces tension, signals safety, and is a culturally sanctioned way to express affection and closeness without the perceived heaviness or insincerity of formal politeness. By transforming a therapeutic intervention into a shared, running joke, the therapist validates the cultural context while achieving the AEDP goal of relational connection, affirmation and even deepening experience. *Diagnostic function:* Introducing shared humor tests the client's capacity for relational flexibility. If the client engages in the humor, it signals trust, a strong alliance, and the successful bridging of the cultural gap. If they remain rigid or confused, the alliance may not be sufficiently robust for this level of play or there might be underlying causes for the defense beyond a cultural gap. *Therapeutic adaptation:* Create a shared, personalized 'code' based on a prior therapeutic challenge (like the "affirmation" reference from the earlier vignette).

T: …when you described how you connected with your sister, I felt some of that "word we don't have yet instead of appreciation?" (*a light smile, referencing their internal joke.*)

C: *(Laughs loudly, nods)* I did! I was feeling so proud!

T: *(beams with the client)* How does it feel to remember that right now?

C: *(Nods, still smiling)* Really good. I feel lighter. It is so different the way I reacted.

Therapist uses relational humor to affirm core emotion (pride) while reinforcing the cultural safety of the therapeutic bond. Client engages in the joke, which enables him to drop down and connect to something new and true.

6. Using Colloquialisms and Vernacular. *Diagnostic function*: In the Israeli context, professional or overly formalized language can be instantly categorized as artificial, distant, or "American politeness," triggering the Dugri defense and subsequent deflection. The judicious use of vernacular, common slang, or non-professional jargon signals that the

therapist is "real" and reduces the perceived relational gap, directly addressing the client's underlying need for authenticity. *Therapeutic adaptation*: Use low-register, genuine colloquialisms (e.g., *walla/truly* , *magniv/cool* , *eizeh siyut/what a night mear*) when delivering metatherapeutic processing or affective interventions that require immediate and sincere connection. This grounds the intervention in the client's authentic emotional register.

C: "I feel so much lighter now, like something just opened up inside of me."

T: *(Pauses for a beat, smiles warmly, speaks slowly and intentionally)* "Wow. That is genuinely cool (*magniv*) to hear."

C: "Yeah, truly." *(A moment of quiet, shared smiling, and deep connection, sharing the experience after a difficult emotion has been processed to completion.)*

T: "What is it like to notice this inside right now?"

The therapist consciously utilized a low-register, highly authentic vernacular term ("magniv" / cool) during the metatherapeutic processing phase. This move reinforced the sincerity of the shared moment of transformation and solidified the relational bond, demonstrating to the client that the therapist's appreciation is "real" and not a formal clinical tool.

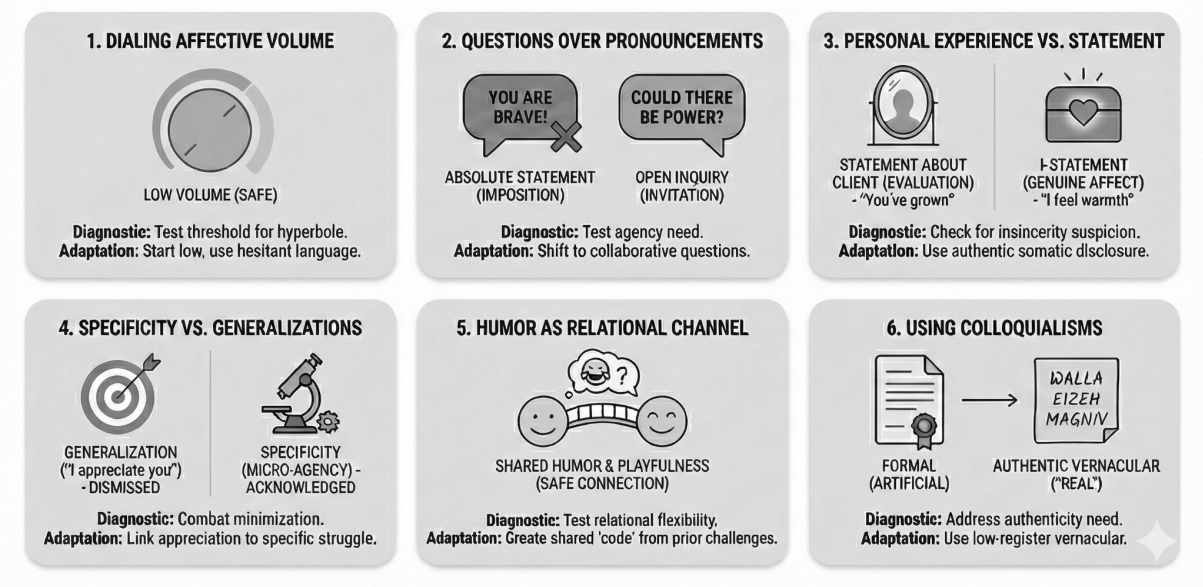

Figure 2: ***The six therapeutic interventions for assessing and adapting in a multicultural therapeutic triad.*** *These interventions include dialing affective volume, questions over pronouncements, personal experience verses statements, specificity versus generalization, humor as a relational channel and using colloquialisms.*

The six interventions described above were developed through the lens of my clinical experience applying AEDP principles in a cross-cultural setting. While these specific

applications are rooted in AEDP's emphasis on affective and relational processing, the core strategies, such as modulating intensity, increasing specificity, and using self-disclosure, are universally shared across various multicultural therapeutic approaches and have been extensively discussed in socio-linguistic and cross-cultural literature. This work, however, makes an attempt to schematically organize and delineate the unique contribution of these adapted interventions within the complex multicultural therapeutic triad (Therapist–Patient–Model).

5. Discussion and clinical implications

I began this inquiry with a core clinical dilemma: Is a client's immediate rejection of an affirmation rooted in a core trauma-based receptive affective capacity limitation, or is it a defensive maneuver driven by the a cultural gap? In this article, I proposed that by utilizing targeted, modulated AEDP relational interventions of adjusting specificity, intensity, and personal disclosure, the therapist could use these very interventions as precise diagnostic tools. This adaptation serves not only as an intervention but as a rapid assessment of the source of the client's resistance. My personal experience suggests a distinct difference in the therapeutic trajectory and pace of change based on the root of the resistance. When the rupture was primarily cultural, and we successfully identified and switched to the correct affective "language" (e.g., humor, specific micro-appreciation), the gates often opened quickly. The path forward in that specific relational dimension became relatively smooth, and we did not encounter further defenses on that route. Conversely, when the root was firmly embedded in trauma, the work was predictably slower. It required repeated interventions, delivered in various ways, to gradually expand the client's restricted receptive affective capacity. This highlights the value of the micro-adjustments as a diagnostic screen: a rapid positive shift suggests a cultural barrier was bypassed; slow, incremental change points toward a deeper, trauma-based limitation.

Many, if not all, of the adjustments mentioned in the article can be used not only to bridge a cultural gap but also in any case of a rupture in the therapeutic process. However, it is important to understand these specific ruptures, locate them, and address them correctly to enable a more tailored therapeutic process. In addition to this question, when organizing and analyzing my clients' recurring responses and connecting these patterns to sociological research, a deeper, crucial question has emerged. To what extent do these responses merely reflect a cultural code that requires simple stylistic adjustments (such as specificity or the use of slang)? And to what extent do they reflect an unspoken collective or intergenerational trauma that demands a more profound therapeutic engagement? I believe that accurately distinguishing this requires a deeper, more nuanced understanding of each culture's history and subcultures. In my work with Israelis[5], it became easier to separate the cultural from the personal once we established enough trust that my sincerity and authenticity were guaranteed, and I was not merely delivering generic "therapist" reactions. After this initial trust was

[5] I acknowledge here that "Israeli" is itself too general; every sub-population carries a slightly different collective narrative.

secured, many Dugri-driven defenses dropped. The defenses that remained often pointed toward characteristics related to the unique collective trauma of this population, a phenomenon that might involve a collective restricted receptive affective capacity that demands guardedness and resilience over explicit vulnerability. This line of thought opens up significant questions regarding how we, in AEDP work, approach collective and transgenerational trauma versus purely individual trauma, and I am highly curious about the future theoretical developments in this area.

On a different note, this inquiry is profoundly rooted in my own evolution as a clinician and as a person. This personal journey was key to navigating the cultural gap and underscores the importance of the therapist's development, not just professionally, but personally, in confronting language and cultural gaps. About 20 years ago, I remember being at an airport, feeling a mix of wonder and dismissiveness as I watched a mother tell her two sons, "GOOD JOB BOYS!," just for sitting down. I dismissed it as American affective hyperbole. Today, having personally changed to be an AEDP therapist, opening my heart and body to feel deeper admiration, awe, pride, and delight with my clients, I find myself authentically saying very similar words to my own daughters. I can genuinely feel enthusiasm for things I would previously have minimized or even dismissed.

Perhaps because of this personal shift, I find myself increasingly curious about the collective restricted receptive affective capacity from which I originate. One of the impacts of this shift is that I can now express appreciation at a higher "volume" with my clients. This level of expression might appear quite similar, even to some of the American-context examples presented here, yet my clients now perceive my authenticity. Consequently, although this high-volume appreciation remains culturally foreign, it elicits significantly less dissonance and resistance compared to the beginning of my clinical journey with AEDP. This evolution highlights a process of cultural diffusion, where the Israeli therapist in me learned and adopted new ways of expressing Firgun (supportive appreciation) in my professional and personal life. Yet, the questions around collective restricted receptive affective capacity remain open, and this is one of the paths I hope AEDP will explore in the future.

While this article focused primarily on the client's cultural defenses, a crucial point largely untouched is the therapist's own learning process and the specific struggles encountered while internalizing the model. The principles and examples discussed are deeply connected to my long, personal search for personal authenticity within a model that speaks profoundly to my human DNA yet many of the actual interventions feel so alien and distancing for me. As an Israeli therapist, I found myself compelled to constantly translate the AEDP model's explicit affective language into expressive modes that felt genuinely true and authentic. My initial difficulties, mirroring those of many Israeli practitioners, included the challenge of emotional self-disclosure, the lack of cultural background in giving and receiving "high-volume" appreciation, and the resulting fear of sounding inauthentic. This is compounded by the fact that the learning period often occurs primarily in the high-stakes therapeutic context due to the lack of appreciative dialogue in Israeli personal lives.

Finally, today I use humor extensively for affirmation and inter-subjective delight. I occasionally wonder if I am fully maintaining AEDP principles or if I am subtly sliding toward avoidance and emotional flattening using humor to bypass the depth of the moment. This connects me to a more general question: How can the core principles of AEDP, particularly the emphasis on deep, explicit emotional processing, be preserved in a culture where direct emotional expression is perceived differently? And how do we execute cultural adaptations without losing the emotional depth central to AEDP interventions? This work emphasizes the profound importance of cultural competency in AEDP training, treating our own interventions as fluid, negotiable elements of the therapeutic process while keeping true to the AEDP model. This relates to previous work arguing that cultural differences should be recognized and managed, as they are generally considered "State one stuff" that must be made explicit and dealt with if they interfere with safety for the patients. While interventions are fluid, the essence of the AEDP model remains intact. The goal is to use genuine presence, spontaneity, and affective vitality to create an attachment-securing environment and undo the client's aloneness. To do this, therapists themselves need to find their own authentic path, which necessarily involves an AEDP encounter and its adaptation to their culture (Sundgren, 2025).

6. Limitations and future research directions

The primary limitation of this paper is its necessary reliance on socio-linguistic theory and personal clinical observations rather than controlled therapeutic outcome studies. While the vignettes offer rich detail, they are experiential and require further systematic investigation to generalize the findings. Ultimately, the open questions regarding the distinction between collective trauma and cultural defense remain a compelling area for future exploration in both training and practice.

Given the complexity demonstrated here, there is a clear and urgent need for research. Specifically, in my work with Israelis, I find a distinct lack of studies on their responses in a therapeutic context, pointing to a broader absence of research on the diverse ways therapists use self-disclosure and affirmation across various cultures and its clinical impact. I hope to see future research that focuses on three key areas: investigating the effectiveness of cultural adaptations and the expansion of receptive affective capacity across different national and ethnic groups; developing models for self-disclosure and authenticity that maintain AEDP fidelity while respecting cultural norms; and creating culturally tailored tools adapted for working with low-affect populations. Furthermore, future research might explore options such as integrating culturally-specific training groups for safe practice, investigating the strategic use of humor and positive cynicism as culturally resonant bridging mechanisms, focusing on the moments of struggle (the therapist's internal experience of cultural collision), and studying the potential for a positive cultural diffusion, where adopting the AEDP approach leads to the welcome integration of more genuine affirmation into the therapist's own personal life.

I will conclude with Diana Fosha's (2018) words, which eloquently frame the continuous challenge: "AEDP, with its motto of "make the implicit explicit, and the explicit experiential," needs to actively keep optimizing its interventions to meet the challenges of the multicultural orientation framework and to do justice to these vital considerations". My personal experience demonstrates that this optimization is not a niche requirement but a constant mandate. As an Israeli therapist applying a model taught primarily out of the life experience and cultural space so different from mine, I find that multicultural thought and work are relevant not only when I am working with clients from a background different from my own, but in every single moment of my practice.

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