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Intercultural Communication Between Forensic and Clinical Psychologists

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BY
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Abstract

While working in clinical and forensic psychology settings, a communication difficulty between the two professions became apparent. Forensic psychologists often appeared cold and callous from the clinical psychologist’s perspective, while clinical psychologists often appeared naïve or too client centered from the forensic psychologist’s perspective. I wondered if viewing each subfield of psychology as a culture could facilitate better communication through intercultural communication. Guided by *Intercultural Communication in Contexts* (Martin & Nakayama, 2010) in approaching intercultural communication between the two professions, I explored factors contributing to each profession’s cultural identities. Once this was established, I attempted to explore the different ways each culture could communicate more effectively. By recognizing and utilizing the strengths from each profession and understanding the possible pitfalls of one’s own, we may become competent in intercultural communication.

*Keywords*: intercultural communication, cultural competence, clinical psychology, forensic psychology
Intercultural Communication Between Forensic and Clinical Psychologists

Upon finishing my master’s degree in forensic psychology, I pursued my doctorate in clinical psychology, while maintaining a forensic emphasis. As I began to navigate the personalities and communication styles of my cohort and other professionals I worked with, I noticed a divergence between the more clinically focused students and those forensically focused. I began to discuss these differences with professionals and wondered if they too had noticed the different unspoken, but ever present attitudes and thoughts between the two groups when they were in the same room. I also began to wonder if some of these differences were impeding our abilities to be better psychologists in our field of practice. How could recognizing and communicating these differences help to improve both areas of practice, while allowing each specialty to maintain its distinct professional identity?

According to the American Psychological Association, forensic psychologists possess skills like clinical assessment, interviewing, report writing, and strong verbal communication skills. With these skills forensic psychologists perform such tasks as threat assessment for schools, child custody evaluations, competency evaluations of criminal defendants and of the elderly, counseling services to victims of crime, death notification procedures, screening and selection of law enforcement applicants, the assessment of post-traumatic stress disorder and the delivery and evaluation of intervention and treatment programs for juvenile and adult offenders. (Ward, 2013)

The American Psychological Association defines clinical psychology as follows: The field of Clinical Psychology integrates science, theory, and practice to understand, predict, and alleviate maladjustment, disability, and discomfort as well as to promote human adaptation, adjustment, and personal development. Clinical Psychology focuses
on the intellectual, emotional, biological, psychological, social, and behavioral aspects of 
human functioning across the life span, in varying cultures, and at all socioeconomic 
levels. (American Psychological Association, n.d., para. 1)

While reading about forensic psychologists’ work, many words were more significant 
than others: threat, competency, criminal, victim, crime, death, and offenders. In reviewing the 
definition of clinical psychology, certain words are more prominent to understanding how the 
identity or perceptions of a clinical psychologist is formed. For example, alleviate, 
maladjustment, discomfort, adaptation, and personal development imply a greater focus on 
helping a person feel better. Perhaps the descriptions alone begin to highlight the differences 
between these two professions.

One of the many differences I have noticed between the two professions is the stance or attitude 
toward testifying in court. In general psychologists came much later to testifying in court, and 
more specifically in forensic cases. I have noticed that this is part of the forensic psychologist’s 
identity and thus, part of their profession as a badge of honor. Usually, when on the stand, they 
appear confident and comfortable with speaking to the court about their area of expertise. 
Perhaps this is because forensic psychologists must always keep in mind the possibility of having 
to stand in court. By contrast, this does not appear to be as true for most clinical psychologists. 
Some research has opined, that clinical psychologists have tended to rely on theoretical 
formulations and techniques of data gathering in which validity has not been scientifically 
established either for general clinical purposes or for specific use in addressing the questions 
often asked of clinical psychologists by the courts (Rotgers & Barett, 1996). Usually, clinical 
psychologists are tasked with working with a client for the client’s own benefit or outcome. 
Even with assessments, clinical psychologists are tasked to uncover what impedes their clients
and address ways to help the client grow. Most clinical psychologists’ first thoughts upon meeting a client do not involve thinking about legal ramifications or expert testimony. They are not listening for key words or phrases to later quote their client regarding risk. When a clinical psychologist is then called to court to testify, he or she may feel less comfortable, if not used to working from the frame of mind of how his/her work will stand in court. Thus, when the idea of court is presented, the usual response is fear and anxiety. The anxiety and fear can stem from a feeling of betraying their client’s trust or the therapeutic relationship in general. Such fear or reluctance to testify may impede the clinical psychologist from fully demonstrating his or her own expertise.

I have also noticed that the way the client is defined and understood varies between the two professions. As mentioned before, most clinical psychologists are client-focused, meaning that they help guide their clients to a better understanding of themselves and also improve their psychological functioning. In clinical psychology training, there is more emphasis on believing a client’s story and how they have experienced the world within the context of their life. This is very useful in learning how to understand and communicate with clients in an effective way and meet them where they are, not where the psychologist thinks they should be. By contrast, the “client” a forensic psychologist is usually working with, whether for an evaluation or for treatment, is usually not the person in front of them. Rather, the forensic psychologist’s client is most often a legal entity or considered in its entirety the community. Weiner describes the relationship between the examiner and the examinee as “detached, neutral, and objective,” (Weiner, 2003 p.6). A forensic psychologist is thus, more prone to look at actuarial information, given their familiarity with risk assessments, and overlook some of the client’s strengths. For a forensic psychologist, risk management and exercising caution are salient, perhaps making it
difficult to view a case or client from a more clinical lens. Clinical psychologists may often feel that forensic psychologists struggle to understand and view a client as an individual, rather than a category of risk. By not acknowledging some of the client’s personal strengths and weaknesses that are not found in the understanding a person. This could be detrimental for a client when long-term planning is applied. A forensic psychologist focused mainly on risk may only look at placement restrictions when determining the best placement for a person, overlooking some of their strengths that could help them flourish in a different environment. Just as clinical psychologist more focused on the relational peace with their client may struggle with what feels like punitive decisions regarding placing a client in a higher level of care.

Another difference between the two professions is the use of language and dark humor. Some research suggests from a cognitive perspective, a sense of humor may mitigate the adverse effects of stress in at least two ways. First, those who respond to life in a generally humorous manner may be less likely to appraise their environments threatening, and therefore may experience less stress in their lives. Second, in situations that are experienced as stressful, individuals with a sense of humor may be able to cope more effectively by making more benign reappraisals of the stressors (Kuiper & Olinger, 1993). The majority of the forensic psychologists I have worked with have heard some horrific stories about the dark, despicable acts people are capable of committing. At times, they are hearing or reading these accounts on a daily basis. For example, running a treatment program in a room full of child rapists or working in a prison with those that have taken lives or traumatized others can be daunting. Perhaps as a defense mechanism and a way to distance themselves from the ugliness of their profession, they have developed a sardonic sense of humor. This can be a sense of humor that is largely misunderstood or sometimes appears inappropriate to clinical psychologists. Perhaps, clinical
psychologists view forensic psychologists as insensitive or cold because of their dark sense of humor or the ability to laugh when discussing a heinous offender. However, this type of coping skill may shield forensic psychologists from suffering vicarious trauma and allow him/her to continue to treat a group of sex offenders with more objectivity and concern for the community. Yet, if forensic psychologists are unaware of the distress their humor can cause clinical psychologists a professional rift can occur causing miscommunication, lack of trust, or inability to work together as a team. Conversely, clinical psychologists are also exposed to trauma via their patients, but it is usually a mutually beneficial process. With this process, the psychologist can better understand the client’s experiences and work to help the client process and understand how these experiences have contributed to his or her identity as an individual. A clinical psychologist may view humor about a client perpetuating a trauma as disrespectful to their relationship with the client.

I once had a conversation with another forensic student about—from our vantage point—the most ridiculous excuse we had heard from clients that were sex offenders. As I finished my story about a man claimed that his victim fell down the stairs and landed on his genitals, my colleague erupted in laughter at the absurdity. Then, I noticed another group of both clinical and child-focused students staring at us in horror. We had failed to be aware of our surroundings and the disturbance it would cause others to hear our conversation. In our minds we thought most psychologists would find humor in this. Upon experiencing this interaction my colleague and I felt embarrassed and ashamed that we were portraying ourselves in a light that seemed uncaring or dismissive of those that have been victims of sexual abuse. Conversely, our colleagues were probably puzzled and questioning our competence on a therapeutic level. This interaction may have led my colleagues and myself to place restrictive boundaries on further communication
with each other. Since beginning my training as a clinical psychologist, I have experienced these differences from a clinical perspective and a forensic perspective.

One of my last classes in graduate school was a class focused on supervision. One of our assignments was to break off into groups of 6 to 8 people to discuss and share our experiences consulting first year doctoral students. My group was divided evenly between forensic and clinical students. One of my peers was sharing her experience and some difficulties that had arisen with her consultee. Almost automatically, all of the forensic students, including me, began discussing how it appeared that this student was personality disordered and was in no shape to provide psychotherapy to others. We discussed what the diagnostic criteria of these personality disorders were, and gleaned from the information provided by our peer that this student should not be in a clinical psychology program. The clinical students, possibly feeling the need to protect the consultee, began discussing the strengths this person could have, if perhaps given the right guidance. My forensic peers and I rolled our eyes at these suggestions and commented that these strengths should already be present prior to entering this program, given the possible risk this student could be inflicting upon psychotherapy clients. We struggled in removing our forensic lens or even dimming it, and my clinical peers struggled to understand the possible risk this student could impose on others or herself. This situation is a perfect example of how both clinical and forensic psychologists steeped in their own identities missed the chance to develop guidelines on how to help this student navigate their professional identity as a client. If both sides were able to take their own lenses off perhaps we could have seen that although there were red flags that needed to be addressed, if addressed, and support was provided to the student perhaps that student could develop into a professional psychologist.
Currently at my internship, I work with clients that were found incompetent to stand trial or not guilty by reason of insanity. In order for these clients to be released into the community, the hospital takes many precautions. A risk assessment is performed by a psychologist and psychiatrist, recommendations are made, and both are brought to a special status committee. The case is discussed, and recommendations are made for a judge’s ultimate decision. I had been conducting intensive psychotherapy with a client found incompetent to stand trial, and although he appeared to be on the higher end of the actuarial risk assessments, the team ultimately recommended discharge planning. The special status committee could only look through the lens of risk, as this client had committed a serious violent crime. I remember working to understand his mental health symptoms, the importance of self-care, and in exploring the trauma he had experienced that contributed to his psychotic break. I discussed the progress he had made verbalizing and coping with distressing emotions, his ability to express empathy, and his concrete and coherent plans for his future. I proposed what I thought would be the appropriate community supports and restrictions for him to be successful in the community. Ultimately, the client’s scores on a risk assessment were enough for the committee to decline his discharge planning and review his case in another year. I, as a clinician, was dumbfounded. Did they not hear how much progress he had made, some of the mitigating factors contributing to his violent crime, and the strengths he could contribute to society when mentally stable? For once, the tables had been turned. This is yet another example of the ramifications when forensic and clinical psychologists fail to communicate effectively, and ultimately a client suffers.

These differences can be seen vividly in even the smallest testing interpretation, with the Rorschach Inkblot Test as a good example. If both types of psychologists view some of these results and one particular result shows the possibility that the client was deprived of his or her
early childhood needs (an FD response), a clinical psychologist may conceptualize the manner by which the client can get these needs met or validated later in life. A forensic psychologist, on the other hand, may interpret this same score as a risk factor to predict future antisocial behavior. How can we look at these two professions from a different viewpoint in an attempt to enhance communication in the field with the end goal to improve both practices? Perhaps, examining these two professions from an intercultural perspective would be helpful. Just as research has explored ways for Western and Eastern cultures to communicate, so too can psychologists. I will explore some of the different ideas contributing to intercultural communication using Martin and Nakayama’s (2010) *Intercultural Communication in Contexts*.

**Culture**

What is culture? Williams (1983) noted that culture is “one of the three most complicated words in the English dictionary” (p. 89). Culture has been defined in a multitude of ways for the benefit of different purposes and professions throughout time. Culture is considered a fundamental concept when examining how people in a community function, why people behave in certain ways, and how it influences a professional environment. For the purposes of this paper, broadly, culture can be viewed from the lens of “the shifting tensions between the shared and the unshared” (Collier, Hedge, Lee, Nakayama, & Yep, 2002, p. 219). Using this perspective, we can better understand the cultural rift between the professionals in the fields of forensic and clinical psychology. As professionals of psychology, forensic and clinical psychologist’s share certain common goals, adhere to the same ethical code, and hopefully work to improve quality of life. However, they have many unshared differences and goals, such as the protection of the community versus the individual client, diagnostic implications versus treatment, and even the expectations of their roles of psychologists.
From a social sciences perspective, culture is viewed as a “set of learned, group-related perceptions” (Hofstede, 1984, p. 87). While reflecting upon the beginning of this paper, what perceptions are considered culturally acceptable in the forensic and clinical psychological world? For clinical psychologists, one of the perceptions is that the work involves improving the client’s quality of life and accepting clients’ life experiences. Forensic psychologists, by contrast, work with a goal to unveil the facts rather than focusing on clients’ beliefs or experiences. This helps them to understand the underlying psychopathology of their behaviors, and determine, what, if any, their role in society can be. Although possessing some shared similarities, ultimately each psychology subspecialty has different goals. However, is it possible to yoke the differing perceptions of people from each field? Is it possible to understand the shared and unshared differences of these perspectives, and somehow use them both to cultivate a better understanding of people, and succeed in our role of becoming better psychologists? If forensic and clinical psychologists can view each profession as a culture, then communication between the two could be addressed more from an intercultural communication perspective rather than a dialogue between two types of psychologists with different beliefs.

Hofstede (1984) also described culture as “collective experiences because it is shared with people who live in and experience the same social environments” (p. 87). Perhaps the experiences of clinical and forensic psychologists have contributed to the differences in these groups’ cultures. Most forensic psychologists work in forensic settings, which may be less than conducive to the therapeutic process. Some of the environments that forensic psychologists practice include prisons, jails, and psychiatric facilities, all places that require one to be vigilant most times. Perhaps these rough atmospheres contribute to the sometimes “rough around the edges” impression of forensic psychologists, whereas many clinical psychologists often work in
environments designed to facilitate intimate conversation and rapport with the client. When psychologists are taken out of their environment, communication messages become misdirected or awkward in an environment that is discordant with their duties and values. Martin and Nakayama (2010) proposed that the “stronger your identification with a particular space/cultural situation, the more difficult it might be to change spaces without experiencing a lot of discomfort” (p. 293). In concordance with Martin and Nakayama (2010), I have noticed this in my own observations while completing a class project, which required all students to perform an assessment at a jail. I arrived alongside my classmate, who specializes in child therapy, to a county jail to meet with a social worker that could lead us to the inmate we would be testing. The social worker informed us that there were two spots for testing and, as she was speaking, the door slammed and locked behind us. My classmate jumped, appearing terrified at the possibility that she could be locked in a pod with other inmates. I volunteered to go onto the pod so my colleague could stay closer to the front, making her visibly calmer. In contrast, if you placed me in a child therapy play room, I would likely feel uncomfortable and be apt to joke.

Identity

Our identities indelibly influence our cultural perspectives. From a social sciences perspective, identity can be viewed as the perception of the self in relation to “the various communities to which a person belongs: nationality, race, ethnicity, religion, gender and so on,” (Martin & Nakayama, 2010, p. 162). For the sake of this paper, let us primarily consider identity in terms of the profession of psychology. Modern definitions of professional identity seem to revolve around three ideas: self-labeling as a professional, incorporation of skills, and outlooks as a professional, and a perception of context in a professional community (Gibson, Dollarhide,
& Moss, 2010). By examining these three themes, it can become apparent how the professional identities of forensic and clinical psychologists diverge.

Reflecting upon the definitions for each profession in the beginning of the paper, many words seem salient in the identity formation of forensic psychologists: threat, competency, criminal, victim, crime, death, and offenders. This makes it easier to understand how some of the attitudes and perceptions form within forensic psychologists. Forensic psychologists define the “client” as the courts, law enforcement, and ultimately the community. It is easy to comprehend that from this perspective, they may feel like more of a gatekeeper and protector of society rather than one tasked to help a person understand themselves, their behaviors, and how they function in the world. Conversely, clinical psychologists’ professional identity is more intertwined with alleviating maladjustment and personal development. If the clinical psychologist’s role is to support human adaptation and functioning, it can be easy to see how such a person might value empathy, understanding, and trust as integral tools to successfully work with clients. One may also take on a protective role; however, it is more on a micro level, improving upon a couple’s communication, helping a family adjust when tragedy arises, or helping someone understand that he or she is capable of forming interpersonal relationships with others.

A forensic psychologist, on the other hand, portrays himself/herself through the identity mentioned above, just as a clinical psychologist does. They are, in a sense, announcing themselves as professionals; for example, I am currently working as a forensic psychologist assessing the risk of civilly committed sexually violent predators and striving to understand the threat potential if released to the community. As a clinical psychologist, I am counseling a client to adjust to the symptoms of his/her mental illness after his/her first psychotic break, and
working to help him/her adapt to his/her current level of functioning. Thus, the professional identity to which I subscribe more in any given situation contributes to my style and approach as a psychologist.

Furthermore, it is important to understand a professional’s identity while communicating with him/her. For example, a supervisor and I were discussing another clinical psychologist’s decision to remove a client from her therapy groups because the client informed her that he had masturbated while thinking of her in the past. My supervisor and I began to discuss how “lucky” this psychologist was because she had not been actually exposed to this self-gratifying act. I then stopped for a second and said to my supervisor, “I think we really missed the boat on acknowledging that this experience for most people would be quite uncomfortable and possibly traumatizing,” and we failed to express that empathy to a fellow colleague. Our own identities as forensic psychologists therefore impeded our ability to empathize with this psychologist’s experiences.

**Language and Communication Style**

Language may also contribute to the difficulty of intercultural communication among these two groups of professionals. As mentioned earlier, forensic psychologists use a sardonic sense of humor while communicating about topics others find appalling. Clinical psychologists are concerned with maintaining rapport with their clients and can creatively tailor their communications to the client. A forensic psychologist often times is neither in the position to do so, nor feels the need to tailor an answer to alleviate a client’s distress; he or she is just stating facts. *Code-switching* is a communication term referring to the switching of languages, dialects, or accents. People switch codes to accommodate others, avoid communication with others, or express an aspect of their own cultural identity (Martin & Nakayama, 2010). In terms of
communication between the two professions, perhaps code switching should be applied more thoughtfully. For example, I once overheard a forensic psychologist discussing a patient with the clinical psychologist and psychiatrist. The patient had recently reported two separate sexual assaults on incapacitated patients. The psychiatrist and clinical psychologist had taken the patient off of 1:1 observation by staff because they felt this patient was no longer a high risk to others. The forensic psychologist began to list off the reasons this patient was indeed a high risk, and by the end of the conversation, the psychiatrist was crying. Now, could the forensic psychologist have practiced code-switching and have altered her approach to get her message across without having the conversation end in tears? She probably could have. By contrast, I have called many clinical psychologists for background information regarding a client on whom I am performing a risk assessment. When calling, I usually have very specific information I am trying to obtain and thus, I do not necessarily need to hear one’s approach to therapy. I am ultimately not assessing one’s clinical skills; I simply want to know if the client has expressed remorse in the context of therapy. If both professions could become more adept at code-switching, perhaps our messages would be both communicated more effectively and received more sanguinely.

Dugan Romano (1997) studied couples where the partners came from two distinct cultural backgrounds and identified four styles of intercultural interaction depending on the context: the submission style, whereby one partner submits to the other partner’s culture; the compromise style, where each partner gives up a little of their cultural beliefs to accommodate the other; the obliteration style, in which both partners attempt to erase the other’s cultural identity; and, finally, consensus style. The consensus style is based on give and take from both partners; it is not a tradeoff, but rather a win–win proposal (Martin & Nakayama, 2010). Clinical
and forensic psychologists both fall into these communication style pitfalls. For example, the forensic psychologist that had the psychiatrist in tears came mostly from an obliteration style. Additionally, often times when I am in a forensic setting as a clinician, I notice that I may not bring up a point that I may think is relevant during a case conceptualization with other forensic psychologists, because their style of communication suggests their presumed expert status. If both professional groups were more flexible and approached communication with the idea of how both parties can “win,” then they might foster a collaborative environment focused on using their specialized training for the greater benefit of the client.

These styles of communication often arise amidst conflict. Martin and Nakayama (2010) proposed that “intercultural conflict may be characterized by ambiguity, which causes us to resort quickly to your default style” (p. 427). Resorting to our default style impacts the way we communicate as professionals. As mentioned earlier, a clinical psychologist can view testing in court as an anxiety-invoking experience, and may regress to the communication style he or she feels most comfortable using, as opposed to the style that would be most adaptable in that environment. If we were truly self-aware regarding our professional cultures, we could work to understand the other’s style of communication, and possibly be flexible in ours to obtain an outcome in which both professions are agreeable. If we are able to understand our own preferred style of communication and work to understand others’ communication styles, we could then focus on similarities as well as differences regarding the two professions.

Intercultural Competence

If we are to adapt our view of communication as an interplay between the cultures of clinical and forensic psychologists, we must strive for intercultural competence as it applies to our professions. After studying how CEOs arrive at decisions, Howell (1982), an intercultural
researcher, identified four levels of intercultural communication competence. The first, *unconscious incompetence*, occurs when one is not conscious of differences and therefore, does not need to act in a particular way (Howell, 1982). This could be applied to the brash jokes forensic psychologists make in front of clinical psychologists, not necessarily acknowledging or knowing that this sense of humor may be markedly offensive to others. The second, *conscious incompetence*, occurs when one understands that a conversation may not be going well, but fails to recognize why this is. An example would be when the forensic psychologist continues to make jokes, even after the first few were not received well.

*Conscious competence* focuses on analytic thinking and learning and is deemed a necessary level in the communication process to be an intercultural communicator (Martin & Nakayama, 2010). The final level is *unconscious competence*, when communication goes well, but it is not a conscious process. Martin and Nakayama (2010) described it as “being well prepared cognitively and attitudinally, but knowing when to let go and rely on your holistic cognitive processing” (p. 473). Most of us only achieve this level of communication in more intimate relationships. For professional dialogue between the two groups of psychologists, unconscious competence is probably difficult to achieve. However, there is a chance of achieving this level of competence through the frequent process of conscious competence.

There are some individual areas psychologists can work on to be more interculturally competent in their communication. Martin and Nakayama (2010) suggested one of these components is motivation. It is simple: If we are not motivated to improve and enhance our intercultural communication, then there is no desire to change. Psychologists must be aware of some basic hindrances to motivation. Members of one group often think that they do not need to know about the practices of another group. A good example would be of the colleague who was
upset about the patient masturbating to thoughts of her. The way my supervisor and I communicated with her at the time lacked empathy or thought regarding her own personal experience with this situation. This could lead to the colleague assuming that forensic psychologists are callous or not empathic, which could lead to feeling uncomfortable or fearful to bring this topic up again, only creating more intercultural conflict. Another component that contributes to motivation involves who is considered the dominant party in the relationship. Those that consider themselves to be more dominant are usually less motivated intrinsically and extrinsically. Thus it is important for psychologists to be aware of what group they are a part of and how that role can be influencing their motivation to communicate effectively.

Another individual component to becoming interculturally competent in communication is knowledge tied into the professional identities that I defined earlier. Psychologists must be more self-aware of how they are perceived as communicators and what strengths and weaknesses they have when communicating with other groups (Martin & Nakayama, 2010). They should also be familiar with “other-knowledge,” which involves how others think and behave while communicating (Martin & Nakayama, 2010). Thus, as psychologists begin to understand the identities and values assigned to the other group with whom they are communicating, their communication style may change to ensure a better outcome for both parties.

Additionally, attitudes also comprise an individual component of competency. Two areas highlighted concerning attitudes are empathy and nonjudgmentalism. Both parties must work to empathize with the other’s position by integrating not only what the other says, but also how the other feels (Martin & Nakayama, 2010). The communication between my supervisor, another colleague, and I lacked the second component of consideration concerning how the other feels. If we were able to keep that in mind in the beginning of the conversation, the interaction may have
gone differently, and we could have discovered even more information about our patient’s behavior toward other women. Martin and Nakayama (2010) defined nonjudgmentalism as the freedom from evaluating according to one’s own cultural frame of reference. On the surface, this concept appears easy enough, but applying it can require knowledge and a high level of self- and other-awareness. One exercise that can be applied to achieving nonjudgmentalism is the D.I.E. exercise (Wendt, 1984). This exercise involves making distinctions among description, interpretation, and evaluation while processing information (Martin & Nakayama, 2010). Descriptive statements convey factual information, while interpretative descriptions attach meaning to the description, and evaluation attaches how one feels to the description. In effect, descriptive statements are the only statements that are nonjudgmental (Martin & Nakayama, 2010).

**Conclusion**

Csibra and Gergely (2009) argue that human communication is an evolutionary product of the necessity to diffuse cognitively dense cultural knowledge: generic knowledge that is robust to interference, is kind-generalizable, and becomes experienced as shared, in the sense that it immediately creates an expectation that others belonging to the same social group possess the same knowledge (Csibra & Gergely, 2009). If we as psychologists can view basic communication through this definition we can begin to understand the greater benefit of communicating interculturally. By viewing communication between forensic and clinical psychologists from an intercultural lens, the two groups are able to enhance communication and foster a better understanding of each other’s professional identity. As a generality, psychologists strive to communicate effectively with their clients. They attune to how their communication style is being received by the client and adjust as needed to elicit the best outcome, whether that
be establishing rapport for a therapeutic relationship or for the means of information gathering for an assessment. Sometimes, when communicating with others that are “in the field,” psychologists forget their analyst cap regarding their communication style. Awareness of self and others is key to intercultural competency in communication between the two subspecialties. Checking in with themselves regarding their own cultural attitudes and identities and working to better understand the other’s own cultural identity and attitudes can only help facilitate effective communication.

Psychologists must understand that people seeking clinical help for their mental or emotional difficulties need a psychologist who can not only take their pain in stride, but also be able to think critically while simultaneously being emotionally moved. Often times, clinical psychologists can find themselves too close to their client and are unable to step back and re-analyze what the client needs most because they can often feel “in it” with them. By taking a tool from the forensic psychologists and critically analyzing the client’s discomfort, clinical psychologists may be able to provide better interventions while still capitalizing on the therapeutic relationship.

There is much emphasis and pressure for forensic psychologists to categorize a client. They are frequently focused on risk level, dangerousness, and competency. Unfortunately, while assessing and treating their clients, forensic psychologists forget that there is an individual in front of them, not just a sex offender. If forensic psychologists could use some of the skills clinical psychologists commonly use, such as empathy and looking at the psychology of a situation, perhaps interventions and prevention of recidivism would become more idiographic. Offender or not, people want to be treated as humans and want to feel as though the psychologist is trying to help them. I have been trying this while assessing civilly committed offenders.
Rather than just being callous and punitive, I introduce cognitive testing as a tool to help them. I might say, “This will help me understand your strengths and weaknesses—how you learn—so that way we can tailor your treatment to really fit you and your learning style.” By doing so, I am presenting myself as more of an ally while still keeping my boundary and position as a forensic psychologist.

Some may question why it is important to consider viewing communication interculturally for psychologists. By continuing to be interculturally competent amongst ourselves as professionals, it open up yet another path of how to enhance our communication. Enhancing our communication between professionals allows us to be more forthcoming with each other in a direct manner while being aware of our differences and communication styles. By being able to curtail our communication to be more culturally appropriate hopefully we can avoid the communication pitfalls mentioned above and work as a stronger team. As we begin to work as a more effective team our clients and the community will begin to benefit. Regardless of our subspecialty, didn’t most of us venture into the field of psychology to help people? By using the knowledge about intercultural communication we have another tool in our tool box to help our clients navigate their journeys.

There has not been previous research on how communicating effectively interculturally amongst subspecialties in psychology could be beneficial. It would be important to explore the validity of these core concepts that contribute to intercultural communication such as identity. It would be interesting to survey clinical and forensic psychologists regarding their own professional identity and how they view the other subspecialties’ identity. By truly understanding where psychologists see themselves and others one can begin to work on how their communication style should be curtailed to communicate effectively. As people grow in their
professional identities it is easy to forget some of the fundamentals of our identity as a
psychologist. Perhaps it would be beneficial for psychologists to attend a lecture highlighting the
roles and ethical concerns for each subspecialty. If we are reminded why our colleagues practice
or conceptualize the way they do we would be more culturally sensitive. Although there is no
research regarding intercultural communication in the psychology field, we have learned through
the history of intercultural communication amongst Eastern and Western civilizations that being
culturally sensitive only fosters more effective communication.

In short, often clinical psychologists are too close to their clients, while forensic
psychologists are too far away. By recognizing and utilizing the strengths and understanding the
possible pitfalls of each profession, we can all become better psychologists and even possibly
competent in intercultural communication.
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