EIGHTH EDITION

Counseling the Culturally Diverse

THEORY AND PRACTICE

Derald Wing Sue

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Laura Smith

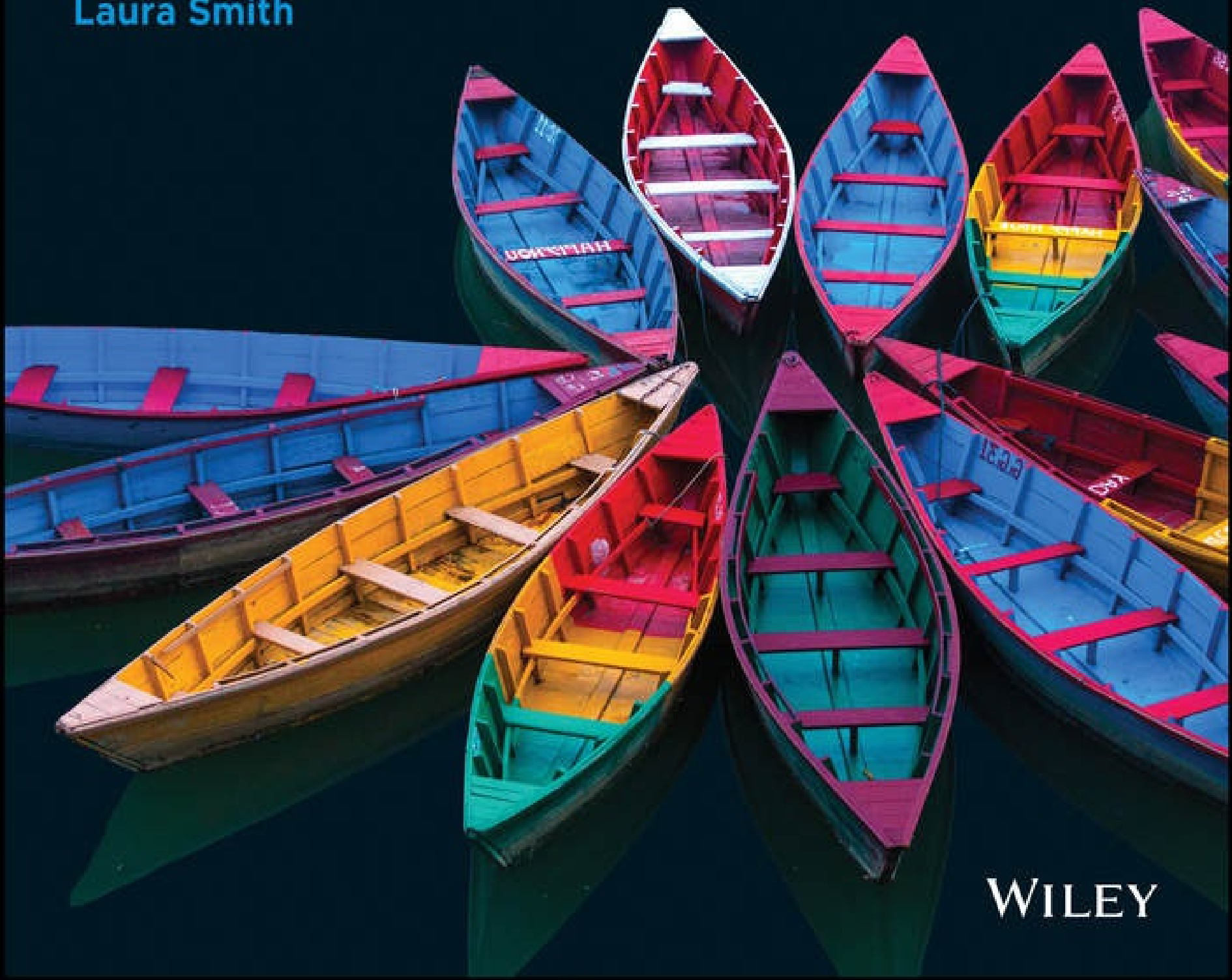

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Table of Contents

List of Tables

List of Illustrations

EIGHTH EDITION

Counseling the Culturally Diverse

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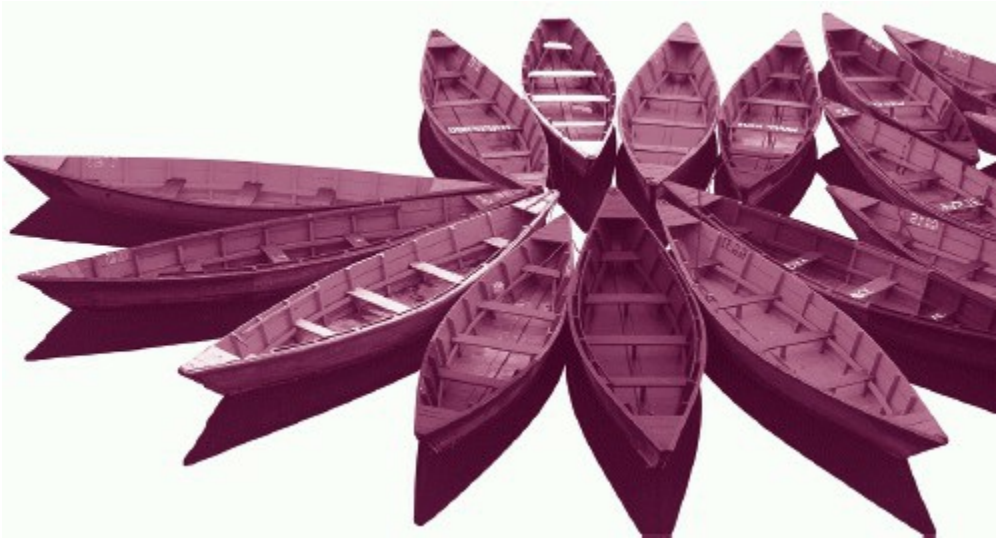

Derald Wing Sue | David Sue | Helen A. Neville | Laura Smith

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Preface

For nearly four decades, *Counseling the Culturally Diverse: Theory and Practice* (*CCD*) has been the cutting‐edge text in multicultural counseling and mental health, used in an overwhelming majority of graduate training programs in counseling and clinical psychology. It now forms part of the multicultural knowledge base of licensing and certification exams at both the master's and the doctoral levels. In essence, it has become a “classic” in the field, and continues to lead the profession in the research, theory, and practice of multicultural counseling and therapy (MCT). *CCD* upholds the highest standards of scholarship and is the most frequently cited text in multicultural psychology and ethnic minority mental health.

With the addition of two new co‐authors, Dr. Helen Neville and Dr. Laura Smith, to the eighth edition, instructors will note a fresh, new, and exciting perspective to the content of *CCD*, and their scholarly input guarantees it will continue to rank as the most up‐to‐date text in the field. Both have been foremost leaders in multicultural psychology, and their voices become obvious in this revised edition.

CHANGES TO *CCD*

Much new research has been conducted in multicultural counseling, cultural competence, social justice advocacy, new roles of the helping professional, White allyship, and culture‐specific interventions over the past few years. In essence, the topical areas covered in each chapter continue to be anchors for multicultural counseling coverage. As a result, while the chapters remain similar, each has undergone major revisions; some are quite extensive in the updating of references, introduction of new research and concepts, and discussion of future directions in counseling, therapy, and mental health.

We maintain our two‐part division of the book, with 12 separate chapters in Section One: The Multiple Dimensions of Multicultural Counseling and Therapy, and 13 population‐specific chapters in Section Two: Multicultural Counseling and Specific Populations. We introduce Section Two by providing a chapter, “Culturally Competent Assessment” (Chapter 13), that outlines the many variables that influence assessment, diagnosis, and case conceptualization—which, hopefully, guide the reader's understanding of each specific population presented. All have been thoroughly updated using common topical headings (when possible) that allow better cross‐comparisons between and among the groups.

EFFICIENT UP - TO - DATE COVERAGE

We have heard from textbook adopters that the breadth and depth of coverage has made it very difficult for instructors and students to digest the amount of material in a single course. Although reviewers suggested that *CCD* be shortened, they did not recommend eliminating topics, but rather condensing, summarizing, streamlining, or eliminating certain subtopics. We have tried our best to do so without violating the integrity of the content. Each of the major chapters 1 through 12) has been shortened by an average of 10%, but the special population chapters have maintained their original length. This latter decision was based on our belief that further shortening would result in the chapters having a "checklist" quality. Further, we are also aware that most instructors do not assign all special population chapters, but rather pick and choose the ones most relevant to their classes.

Despite shortening major sections of the text, new advances and important changes in multicultural counseling suggest additional areas that need to be addressed. These include building on the previous groundbreaking edition, which has become the most widely used, frequently cited, and critically acclaimed multicultural text in the mental health field, and updating concepts to be consistent with *Diagnostic and Statistical Manual of Mental Disorders* (*DSM - 5*) categories and principles, the multicultural guidelines of the American Psychological Association, the American Counseling Association's (ACA) multicultural and social justice competencies, and Council for Accreditation of Counseling & Related Educational Programs (CACREP) standards.

We also include the most recent research and theoretical formulations that introduce and analyze emerging important multicultural topics. These include the concept of "cultural humility" as a domain of cultural competence; the important roles of White allies in the struggle for equal rights; the emerging call for social justice counseling; the important concept of "minority stress" and its implications in work with marginalized populations; greater focus on developmental psychology that speaks to raising and educating children about race, gender, and sexual orientation; reviewing and introducing the most recent research on lesbian, gay, bisexual, transgender, and queer (LGBTQ) issues; major research developments in the manifestation, dynamics, and impact of microaggressions; and many others.

PEDAGOGICAL STRENGTHS

One of the main goals of the eighth edition has been to better engage students in the material and allow them to actually become active participants in digesting multicultural counseling concepts. We have increased our focus on pedagogy by providing instructors with exercises and activities to facilitate experiential learning for students. We open every chapter with broad *chapter objectives*, followed by more specific—and oftentimes controversial—*reflection and discussion questions* interspersed throughout, which allow for more concentrated and detailed discussion by students on identifiable topical areas.

Further, every chapter opens with a *clinical vignette*, *longer narrative*, or *situational example* that previews the major concepts and issues discussed within. Many of these are new and serve to anchor the multicultural issues to follow. They add life and meaning to the chapter concepts and research. The *chapter focus questions* serve as prompts to address the opening "course objectives," but instructors and trainers can also use them as discussion questions throughout the course or workshop. As in the previous edition, we have retained the "Implications for Clinical Practice" and "Summary" sections at the end of every chapter.

There are two other major resources available for instructor use:

1. A series of brief simulated multicultural counseling videos that can be used in the classroom or viewed online. Each video relates to issues presented in one of the first 13 chapters. They are excellent training aids that allow students to witness multicultural blunders by counselors, identify cultural and sociopolitical themes in the counseling process, discuss and analyze what can go wrong in a session, and suggest culturally appropriate intervention strategies.

   Following each video, Dr. Derald Wing Sue and Dr. Joel M. Filmore discuss and analyze each session in the context of the themes of the chapter. Instructors have many ways to use the videos to stimulate classroom discussion and understanding.

2. In keeping with the importance of applying research and theory to work with client and client systems, we encourage instructors to use *Case Studies in Multicultural Counseling and Therapy*, edited by Sue, Gallardo, and Neville (2014), alongside *CCD*.

APPRECIATION

There is an African American proverb that states, “We stand on the head and shoulders of many who have gone on before us.” Certainly, this book would not have been possible without their wisdom, commitment, and sacrifice. We thank them for their inspiration, courage, and dedication, and hope they will look down on us and be pleased with our work. We would like to acknowledge all the dedicated multicultural pioneers in the field who have journeyed with us along the path of multiculturalism before it became fashionable. We also wish to thank the staff of John Wiley & Sons for the enormous time and effort they have placed in obtaining, evaluating, and providing us with the necessary data and feedback to produce this edition of *CCD*. Their help was no small undertaking, and we feel fortunate in having Wiley as our publisher.

Working on this eighth edition continues to be a labor of love. It would not have been possible, however, without the love and support of our families, who provided the patience and nourishment that sustained us throughout our work on the text. Derald Wing Sue wishes to express his love for his wife, Paulina, his son, Derald Paul, his daughter, Marissa Catherine, and his grandchildren, Caroline, Juliette, and Niam. Helen A. Neville wishes to express her deepest love and appreciation for her life partner, Sundiata K. Cha - Jua, her daughters, and the memory of her parents. Laura Smith expresses love and appreciation for the support of her partner, Sean Kelleher, as well as her extended family. David Sue wishes to express his love and appreciation to his wife and children.

We hope that *Counseling the Culturally Diverse: Theory and Practice*, eighth edition, will stand on “the truth” and continue to be the standard bearer of multicultural counseling and therapy texts in the field.

Derald Wing Sue
David Sue
Helen A. Neville
Laura Smith

REFERENCE

1. Sue, D. W., Gallardo, M., & Neville, H. (2014). *Case studies in multicultural counseling and therapy*. Hoboken, NJ: Wiley.

About the Authors

Derald Wing Sue is Professor of Psychology and Education in the Department of Counseling and Clinical Psychology at Teachers College, Columbia University. He served as president of the Society for the Psychological Study of Culture, Ethnicity and Race, the Society of Counseling Psychology, and the Asian American Psychological Association. Dr. Sue continues to be a consulting editor for numerous publications. He is author of more than 160 publications, including 21 books, and is well known for his work on racism/antiracism, cultural competence, multicultural counseling and therapy, and social justice advocacy. Three of his books, *Counseling the Culturally Diverse: Theory and Practice*, *Microaggressions in Everyday Life*, and *Overcoming our Racism: The Journey to Liberation* (John Wiley & Sons), are considered classics in the field. Dr. Sue's most recent research on racial, gender, and sexual orientation microaggressions has provided a major breakthrough in understanding how everyday slights, insults, and invalidations toward marginalized groups create psychological harm to their mental and physical health and create disparities for them in education, employment, and health care. His most recent book, *Race Talk and the Conspiracy of Silence: Understanding and Facilitating Difficult Dialogues on Race* promises to add to the nationwide debate on racial dialogues. A national survey has identified Derald Wing Sue as "the most influential multicultural scholar in the United States," and his works are among the most frequently cited.

David Sue is Professor Emeritus of Psychology at Western Washington University, where he has served as the director of both the Psychology Counseling Clinic and the Mental Health Counseling program. He is also an associate of the Center for Cross‐Cultural Research at Western Washington University. He and his wife, Diane M. Sue, have coauthored the books *Foundations of Counseling and Psychotherapy: Evidence‐Based Practices for a Diverse Society*, *Understanding Abnormal Psychology* (12th edition), and *Essentials of Abnormal Psychology* (2nd edition). He is coauthor of *Counseling the Culturally Diverse: Theory and Practice*. He received his PhD in Clinical Psychology from Washington State University. His writing and research interests revolve around multicultural issues in individual and group counseling and the integration of multicultural therapy with evidence‐based practice. He enjoys hiking, snowshoeing, traveling, and spending time with his family.

Helen A. Neville is Professor of Educational Psychology and African American Studies at the University of Illinois at Urbana‐Champaign. Before coming to Illinois in 2001, she was on the faculty in Psychology, Educational and Counseling Psychology, and Black Studies at the University of Missouri‐Columbia, where she cofounded and codirected the Center for Multicultural Research, Training, and Consultation. Dr. Neville has held leadership positions on campus and nationally. She was a Provost Fellow and participated in the CIC/Big 10 Academic Alliance Academic Leadership Academy. Currently, she serves as president for the Society for the Psychological Study of Culture, Ethnicity, and Race (2018), which is a division of the American Psychological Association (APA). She has co‐edited five books and (co)authored nearly 90 journal articles and book chapters in the areas of race, racism, racial identity, and diversity issues related to well‐being. Dr. Neville has been recognized for her research and mentoring efforts, including receiving the Association of Black Psychologists' Distinguished Psychologist of the Year Award, the APA Minority Fellowship Award, Dalmas Taylor Award for Outstanding Research Contribution, APA Graduate Students Kenneth and Mamie Clark Award, the APA Division 45 Charles and Shirley Thomas Award for mentoring/contributions to African American students/community, and

the Winter Roundtable Janet E. Helms Mentoring Award.

Laura Smith is Professor of Psychology and Education and Director of Clinical Training in the Counseling Psychology Program at Teachers College, Columbia University. Laura was formerly the Training Director of Pace University's American Psychological Association (APA) ‐ accredited predoctoral internship program and later the founding Director of the Rosemary Furman Counseling Center at Barnard College. She was subsequently Director of Psychological Services at the West Farms Center in the Bronx, where she provided services, training, and programming within a multifaceted community ‐ based organization. Laura's research interests include social inclusion/exclusion and emotional well ‐ being, the influence of classism and racism in psychological theory and practice, whiteness and white antiracism, and participatory action research (PAR) in schools and communities. She is the author of the book *Psychology, Poverty, and the End of Social Exclusion* and the former Chair of the APA Committee on Socioeconomic Status, and she was awarded the 2017 APA Distinguished Leadership Award on behalf of that committee.

SECTION ONE

The Multiple Dimensions of Multicultural Counseling and Therapy

Becoming culturally competent in working with diverse populations is a complex interaction of many dimensions that involve broad theoretical, conceptual, research, and practice issues. This section is divided into four parts (each part contains a number of chapters) that describe, explain, and analyze necessary conditions that mental health practitioners must address on issues related to multicultural counseling and therapy, cultural competence, and sociopolitical influences that cut across specific populations.

PART I

The Affective and Conceptual Dimensions of Multicultural Counseling and Therapy

1
Obstacles to Developing Cultural Competence and Cultural Humility: Understanding Resistance to Multicultural Training

Chapter Objectives

1. **1. Acknowledge and understand personal resistance to multicultural training.**
2. **2. Identify how emotional reactions to topics of prejudice, discrimination, and oppression can act as obstacles to developing *cultural competence* and *cultural humility*.**
3. **3. Understand *worldview* differences between majority and socially devalued group members in U.S. society.**
4. **4. Make sense of why majority group members often react differently from marginalized group members when issues of racism, sexism, or heterosexism are discussed.**
5. **5. Be cognizant of how *worldviews* may influence the ability to understand, empathize, and work effectively with diverse clients.**
6. **6. Realize that becoming an effective multicultural counselor is a lifelong journey.**

Reading and digesting the content of this book may prove difficult and filled with powerful feelings for many of you. Students who have taken a course on multicultural counseling and therapy (MCT) or multicultural mental health issues have almost universally felt both positive and negative feelings that affect their ability to learn about diversity issues. It is important not to allow those emotions to go unacknowledged, or to avoid exploring the psychological meanings they may have for you. As you begin your journey to becoming a culturally competent or *culturally responsive* counselor/mental health professional, the road will be filled with obstacles to self - exploration, to understanding yourself as a racial/cultural being, and to understanding the *worldview* of those who differ from you in race, gender, ethnicity, sexual orientation, and other sociodemographic characteristics.

The subject matter in this book and course requires you to explore your biases and prejudices, a task that often evokes defensiveness and resistance. It is important to recognize personal resistance to the material, to explore its meanings, and to learn about yourself and others. Sometimes what is revealed about you may prove disturbing, but having the courage to continue is necessary to becoming a culturally competent counselor or therapist. This chapter is specifically written to help readers understand and overcome their emotive reactions to the substance of the text, and the course you are about to take. Let us begin by sharing reactions from four past students to reading *Counseling the Culturally Diverse: Theory and Practice* (*CCD*) and discuss their meaning for them, and the implications for mental health practice.

Video 1.0: Introduction

Introduction to the book and videos.

REACTIONS TO READING *COUNSELING THE CULTURALLY DIVERSE*

Reaction #1

White Female Student:

> *"How dare you and your fellow caustic co‐author express such vitriol against my people? You two are racists, but of a different color … I can't believe you two are counselors. Your book does nothing but to weaken our nationalism, our sense of unity and solidarity. If you don't like it here, leave my country. You are both spoiled hate‐mongers who take advantage of our educational system by convincing others to use such a propagandistic book! Shame on you. Your book doesn't make me want to be more multicultural, but take ungrateful people like you and export them out of this great land of mine."* (Name withheld)

Analysis: This response reveals immense anger at the content of *CCD*, and especially at the authors, whom she labels "hate‐mongers" and "racists." It is obvious that she feels the book is biased and propagandistic. The language of her words seems to indicate defensiveness on her part as she easily dismisses the material covered. More important, there is an implicit suggestion in the use of "people like you" and "land of mine" that conveys a perception that only certain groups can be considered "American" and that others are "foreigners." This is similar to statements often made to people of color: "If you don't like it here, go back to China, Africa, or Latin America." Likewise, the implication is that this land does not belong to persons of color who are U.S. Citizens, but only to White Americans.

Reaction #2

White Male Student:

> *"I am a student in the field of Professional Counseling and feel compelled to write you because your text is required reading in our program. I am offended that you seem to think that the United States is the only perpetrator of prejudice and horrific acts. Excuse me sir, but racism and oppression are part of every society in the world ad infinitum, not just the United States. I do not appreciate reading biased material that does not take into account all forms of prejudice including those from minorities. You obviously have a bone to grind with White people. Minorities are equally racist. Why do you take such pleasure in attacking whites when we have done so much to help you people?"* (Anonymous)

Analysis: Similar to the first response, the male student is also angry and offended about the content. There is a strong feeling of defensiveness, however, that emanates from his narrative. It appears he feels unjustly accused of being bigoted and that we are implying that only U.S. society and not others are racist. To make himself feel less guilty, he emphasizes that "every society" oppresses "minority" constituents and it is not Whites alone who are prejudiced. These are actually accurate statements, but they mask the defensiveness of the student, and have the goal of exonerating him and other Whites for being prejudiced. If he can get other groups to admit they too are racist, then he feels less guilt and responsibility for his own beliefs and actions.

Reaction #3

Latina Student:

> *"I am currently embarking on the journey of becoming a Marriage and Family*

> *Therapist at a California State University. I just want to thank you for writing Counseling the Culturally Diverse. This book has spoken to me and given me so much knowledge that is beyond words to express. Finally, there is someone willing to tell it like it is. You have truly made an impact in my life because, being an ethnic minority, I could empathize with many of the concepts that were illustrated. Although some White classmates had difficulty with it, you truly validated much of my experiences. It reaffirmed how I see the world, and it felt good to know that I am not crazy! Once again thanks for writing the book."* (Name withheld)

Analysis: The reaction from the Latina student is diametrically opposite to that of her White counterparts. She reacts positively to the material, finds the content helpful in explaining her experiential reality, feels validated and reaffirmed, and realizes that she is "not crazy." In other words, she finds the content of the book truthful and empathetic to her situation. The important question to ask is, "Why does she react so differently from the two White students?" After all, the content of the book remains the same, but the perceptions appear worlds apart.

Reaction #4

African American Male Student:

> *"When I first took this course (multicultural counseling) I did not have much hope that it would be different from all the others in our program, White and Eurocentric. I felt it would be the typical cosmetic and superficial coverage of minority issues. Boy was I wrong. I like that you did not 'tip toe' around the subject. Your book Counseling the Culturally Diverse was so forceful and honest that it made me feel liberated … I felt like I had a voice, and it allowed me to truly express my anger and frustration. Some of the white students were upset and I could see them squirming in their seats when the professor discussed the book. I felt like saying 'good, it's about time Whites suffer like we have. I have no sympathy for you. It's about time they learned to listen.' Thank you, thank you, and thank you for having the courage to write such an honest book."* (Name withheld)

Analysis: Like the Latina student, the African American male finds the book compelling, honest, and truthful. He describes how it makes him feel liberated, provides him with a voice to describe his experiences, and taps into and allows him to express his anger and frustration, and he thanks the authors for writing *CCD*. He implies that most courses on multicultural psychology are taught from a EuroAmerican perspective, but the book content "tells it like it is." Additionally, the student seems to take pleasure in observing the discomfort of White students, expresses little sympathy for their struggle in the class, and enjoys seeing them being placed on the defensive. (We will return to the meaning of this last point shortly.)

Reading *CCD* is very likely to elicit strong emotions among readers. These four reactions, two by White students and two by readers of color, reveal the range of emotions and reactions likely to be expressed in classes that use the text. For nearly four decades, we have received literally hundreds of emails, letters, and phone calls from students, trainees, professors, and mental health professionals reacting strongly to the content and substance of *CCD*. Many of the readers praise the book for its honest portrayal of multicultural issues in mental health practice. Indeed, it has become the most widely used and cited text in multicultural psychology, considered a classic in the field (Ponterotto, Fingerhut, & McGuinness, 2013; Ponterotto & Sabnani, 1989), and now forms the knowledge base of licensing and certification exams for counseling and mental health professionals.

Despite the scholarly status that *CCD* has achieved, some readers (generally those from the majority group) find the substance of the book difficult to digest and have reacted very strongly to the content. According to instructors of MCT classes, the powerful feelings aroused in some students prevent them from being open to diversity issues, and from making classroom discussions on the topic a learning opportunity. Instead, conversations on diversity become “shouting matches” or become monologues rather than dialogues. These instructors indicate that the content of the book challenges many White students about their racial, gender, and sexual orientation realities, and that the book's writing style (passionate, direct, and hard‐hitting) also arouses deep feelings of defensiveness, anger, anxiety, guilt, sadness, hopelessness, and a multitude of other strong emotions in many. Unless properly processed and understood, these emotions act as roadblocks to exploring issues of race, gender, and sexual orientation. Learning about multicultural psychology is much more than an intellectual exercise devoid of emotions.

It would be a mistake, however, to conclude from these examples that White students and students of color respond uniformly in one way. As we will explore in future chapters, many White students react positively to the book and some students of color report negative reactions. But, in general, there are major *worldview* differences and reactions to the material between the groups. For example, many socially marginalized group members find solace in the book; they describe a deep sense of validation, release, elation, joy, and even feelings of liberation as they read the text. What accounts for these two very different reactions?

For practicing professionals and trainees in the helping professions, understanding the differing *worldviews* of our racially, ethnically, and culturally diverse clients is tantamount to effective multicultural counseling. But understanding our own reactions to issues of diversity, *multiculturalism*, oppression, race, gender, and sexual orientation is equally important to our development as counselors/therapists (Collins, Arthur, & Brown, 2013; Todd & Abrams, 2011). As we will shortly see, that understanding can be quite anxiety‐provoking, especially when we are asked to confront our own biases, prejudices, and stereotypes. The old adage “counselor or therapist, know thyself” is the basic building block to *cultural competence* and *cultural humility* in the helping professions. Let us take a few moments here to dissect the reactions of the four readers in our opening narratives and attempt to make meaning of them. This is a task that we encourage you to personally take throughout your educational journey as well. Likewise, as a counselor or therapist working with culturally diverse clients, understanding differences in *worldviews* is an important first step to becoming culturally competent.

Video 1.1: Reacting to Race and Racism

Select the video link to view a conversation with the author about reacting to race and racism.

EMOTIONAL SELF‐REVELATIONS AND FEARS: MAJORITY GROUP MEMBERS

It is clear that the two White students are experiencing strong feelings in reaction to the content of *CCD*. As you will shortly see, the book's subject matter (a) deals with prejudice, bias, stereotyping, discrimination, and bigotry; (b) makes a strong case that counseling and psychotherapy may serve as instruments of cultural oppression rather than therapeutic liberation (Sue, 2015; Wendt, Gone, & Nagata, 2015); (c) indicates that well‐intentioned mental health professionals are not immune from inheriting the racial, gender, and other biases of the larger society; and (d) suggests therapists and trainees may be unconsciously biased toward clients from marginalized groups (Ratts & Pedersen, 2014).

Although supported by the research literature and by clinical observations and reports, these assertions can be quite disturbing to members of the majority group. If you are a majority group member and beginning the journey to developing *cultural competence* and *cultural humility*, it is possible that you may share similar reactions to those of the students. Both White students, for example, are reacting with anger and resentment; they believe that the authors are unjustly accusing U.S. society and White Americans of racism, and claim the authors are themselves "racist" but of a different color. They have become defensive and are actively resisting and rejecting the content of the book. If these feelings persist throughout the course unabated, they will act as barriers to learning and further self‐exploration. But what do these negative reactions mean to the students? Why are they so upset? Dr. Mark Kiselica (Sue & Sue, 2013, pp. 8–9), a White psychologist and now provost of a college in New York, writes about his own negative emotional reactions to reading the book during his graduate training. His personal and emotional reactions to the book provide us with some clues.

I was shaken to my core the first time I read Counseling the Culturally Different *(now* Counseling the Culturally Diverse*) … At the time, I was a doctoral candidate at The Pennsylvania State University's counseling psychology program, and I had been reading Sue's book in preparation for my comprehensive examinations, which I was scheduled to take toward the end of the spring semester…*

I wish I could tell you that I had acquired Sue's book because I was genuinely interested in learning about multicultural counseling … I am embarrassed to say, however, that that was not the case. I had purchased Sue's book purely out of necessity, figuring out that I had better read the book because I was likely to be asked a major question about cross‐cultural counseling on the comps. During the early and middle 1980s, taking a course in multicultural counseling was not a requirement in many graduate counseling programs, including mine, and I had decided not to take my department's pertinent course as an elective. I saw myself as a culturally sensitive person, and I concluded that the course wouldn't have much to offer me. Nevertheless, I understood that … the professor, who taught the course, would likely submit a question to the pool of materials being used to construct the comps. So, I prudently went to the university bookstore and purchased a copy … because that was the text … used for his course.

I didn't get very far with my highlighting and note‐taking before I started to react to Sue's book with great anger and disgust. Early on in the text, Sue blasted the mental health system for its historical mistreatment of people who were considered to be ethnic minorities in the United States. He especially took on White mental health professionals, charging them with a legacy of ethnocentric and racist beliefs and practices that had harmed people of color and made them leery of counselors, psychologists, and

> *psychiatrists. It seemed that Sue didn't have a single good thing to say about White America. I was ticked off at him, and I resented that I had to read his book. However, I knew I had better complete his text and know the subject matter covered in it if I wanted to succeed on the examinations. So, out of necessity, I read on and struggled with the feelings that Sue's words stirred in me.*

Developing culturally competence and cultural humility in counseling/mental health practice demands that nested or embedded emotions associated with race, culture, gender, and other social identity differences be openly experienced and discussed. It is these intense feelings that often block our ability to hear the voices of those most oppressed and disempowered (Sue, 2011). How we, as helping professionals, deal with these strong feelings can either enhance or impede a deeper understanding of ourselves as racial, ethnic, and cultural beings and our understanding of the *worldviews* of culturally diverse clients. Because Mark did not allow his defensiveness and anger to get the best of him, he was able to achieve insights into his own biases and false assumptions about people of color. The following passage reveals the internal struggle that he courageously fought and the disturbing realization of his own racism.

> *I tried to make sense of my emotions—to ascertain why I was drawn back to Sue's book again and again in spite of my initial rejection of it. I know it may sound crazy, but I read certain sections of Sue's book repeatedly and then reflected on what was happening inside of me … I began to discover important lessons about myself, significant insights prompted by reading Sue's book that would shape the direction of my future … I now realized that Sue was right! The system had been destructive toward people of color, and although my ancestors and I had not directly been a part of that oppressive system, I had unknowingly contributed to it. I began to think about how I had viewed people of color throughout my life, and I had to admit to myself that I had unconsciously bought into the racist stereotypes about African Americans and Latinos. Yes, I had laughed at and told racist jokes. Yes, I had used the "N" word when referring to African Americans. Yes, I had been a racist.*
>
> *Sue's book forced me to remove my blinders. He helped me to see that I was both a product and an architect of a racist culture.*
>
> *(Sue & Sue, 2013, pp. 9–10)*

Years after first reading the book, Mark Kiselica (1999) talks about his racial awakening and identifies some of the major fears many well - intentioned Whites struggle with as they begin studying racism, sexism, or heterosexism on a personal level. This passage, perhaps, identifies the major psychological obstacle that confronts many Whites as they process the content and meaning of the book.

> *You see, the subjects I [White psychologist] am about to discuss—ethnocentrism and racism, including my own racism—are topics that most Whites tend to avoid. We shy away from discussing these issues for many reasons: We are racked with guilt over the way people of color have been treated in our nation; we fear that we will be accused of mistreating others; we particularly fear being called the "R" word—racist—so we grow uneasy whenever issues of race emerge; and we tend to back away, change the subject, respond defensively, assert our innocence and our "color blindness," denying that we could possibly be ethnocentric or racist. (p. 14)*

It is important to note Mark's open admission to racist thoughts, feelings, and behaviors. As a White psychologist, he offers insights into the reasons why many White trainees fear open

dialogues on race; they may ultimately reveal unpleasant secrets about themselves. In his own racial awakening, he realizes that discussing race and racism is so difficult for many Whites because they are racked with guilt about how people of color have been treated in the United States and are fearful that they will be accused of being a racist and be blamed for the oppression of others. Rejecting and avoiding racial topics are major strategies used to hold on to one's self‐image as a good, moral, and decent human being who is innocent of racial bias and discrimination.

Mark's honesty in confronting his own racism is refreshing, and his insights are invaluable to those who wish to develop culturally competence and become allies in the struggle for equal rights (Chao, Wei, Spanierman, Longo, & Northart, 2015; Spanierman & Smith, 2017). He is a rarity in academic circles, even rarer because he was willing to put his words on paper for the whole world to read as a means to help others understand the meaning of racism on a human level. Mark's courageous and open exploration of his initial reactions to *CCD* indicates what we have come to learn is a common, intensely emotional experience for many readers.

Video 1.2: Same Material, Different Reaction

The different reactions to the material that majority students may have compared to their minority counterparts.

EMOTIONAL INVALIDATION VERSUS AFFIRMATION: MARGINALIZED GROUP MEMBERS

It is clear that the same subject matter in *CCD* often arouses a different emotional response from marginalized group members; for the two students of color, for example, they felt heard, liberated, and validated. They describe the book content as "honest" and "truthful," indicating that their lived experiences had finally been validated rather than silenced or ignored. One of the more interesting comments is made by the Latina student: "it felt good to know that I am not crazy." What did she mean by that? Many people of color describe how their thoughts and feelings about race and racism are often ignored, dismissed, negated, or seen as having no basis in fact by majority group members. They are told that they are misreading things, overly sensitive, unduly suspicious, or even paranoid when they bring up issues of bias and discrimination; in other words, they are "crazy" to think or feel that way.

As can be seen from the students of color, many marginalized group members react equally strongly as their White counterparts when issues of oppression are raised, especially when their stories of discrimination and pain are minimized or neglected. Their reality of racism, sexism, and homophobia, they contend, is relatively unknown or ignored by those in power because of the discomfort that pervades such topics. Worse yet, many well‐intentioned majority persons seem disinclined to hear the personal stories of suffering, humiliation, and pain that accrue to persons of color and other marginalized groups in our society (Sue, 2015). The following quote gives some idea of what it is like for a Black man to live his life day in and day out in a society filled with both covert and overt racist acts that often are invisible to well‐intentioned White Americans.

> *I don't think white people, generally, understand the full meaning of racist discriminatory behaviors directed toward Americans of African descent. They seem to see each act of discrimination or any act of violence as an "isolated" event. As a result, most white Americans cannot understand the strong reaction manifested by blacks when such events occur … They forget that in most cases, we live lives of quiet desperation generated by a litany of daily large and small events that, whether or not by design, remind us of our "place" in American society. [Whites] ignore the personal context of the stimulus. That is, they deny the historical impact that a negative act may have on an individual. "Nigger" to a white may simply be an epithet that should be ignored. To most blacks, the term brings into sharp and current focus all kinds of acts of racism—murder, rape, torture, denial of constitutional rights, insults, limited opportunity structure, economic problems, unequal justice under the law and a myriad of … other racist and discriminatory acts that occur daily in the lives of most Americans of African descent.*
>
> *(Feagin & Sikes, 1994, pp. 23–24)*

The lived experience of people of color is generally invisible to most White Americans, as this quotation portrays. As we will discuss in Chapter 6, racial, gender, and sexual orientation *microaggressions* are experienced frequently by people of color, women, and lesbian, gay, bisexual, transgender, and queer (LGBTQ) persons in their day‐to‐day interactions with well‐intentioned members of the dominant society (Nadal, Griffin, Wong, Davidoff, & Davis, 2017; Velez, Moradi, & DeBlaere, 2015). *Microaggressions* are the everyday slights, put‐downs, invalidations, and insults directed to socially devalued group members by well‐intentioned people who often are unaware that they have engaged in such biased and harmful behaviors. A lifetime of *microaggressions* can have a major harmful impact on the

psychological well‐being of victims. Note the following narratives provided by American Indians as they describe day‐to‐day experiences with *microaggressions* that serve to undermine their humanity through exposure to racial hostility and assumptions of inferiority.

> *I know my dad has a lot of white friends, and they get comfortable with him and they say really insulting things. They call us wagon burners, dirty Indians. And, it's, it's, it's when they get, when they start getting out of line 'cause my dad wouldn't say anything. I would, start saying stuff and then they'd come back to my dad and be like "oh, what's wrong with your son? Can't he take a joke?" Well it's not funny when, when someone insults you to your face and then they just expect you to laugh at it like they do. (name withheld)*
>
> *…so I filled out the little form and I took it up to the girl behind the glass and said "I've got this thing for the parking permit" [at the local university] And she looked at it and looked at me, and she said "So are you delivering this for Dr. X?" and I said "No, actually I am Dr. X." And she got really red and embarrassed, you know, but I don't really know what was in her mind. You know, maybe I just don't look professorial or something like that.*
>
> *(Senter & Ling, 2017, pp. 266, 269)*

Here, it is important to note the emotional toll of having to listen to racially hostile name calling among "so‐called" friends or to have to continually prove your legitimacy as a professional. These narratives are part of a larger study on racial microaggresions against American Indians (Senter & Ling, 2017). People retold stories of being assumed to be poor, addicted to alcohol or drugs, lazy, and dirty. Narrators described costs associated with microaggressions including being followed, receiving poor service, and getting overcharged. Over time, these experiences left people with hurt and anger; some people coped by distancing themselves from non‐Natives or trying to hide. But, people of color are also strong. Like so many others who experience racial microaggressions, many used these moments as an opportunity to educate others.

Given the fact that the majority of people of color have experienced microaggressoins in their lifetime, covering these topics in class can serve to validate their lived realities. Dr. Le Ondra Clark, now an African American psychologist in California, describes her experiences of being one of the few Black students in a graduate program and the feeling of affirmation that flooded her when taking a multicultural counseling course and using *CCD* as the textbook.

> *I, a native of Southern California, arrived at the University of Wisconsin, Madison, and was eager to learn. I remember the harsh reality I experienced as I confronted the Midwest culture. I felt like I stood out, and I learned quickly that I did. As I walked around the campus and surrounding area, I remember counting on one hand the number of racial and ethnic minorities I saw. I was not completely surprised about this, as I had done some research and was aware that there would be a lack of racial and ethnic diversity on and around campus. However, I was baffled by the paucity of exposure that the 25 members of my master's cohort had to racial and ethnic minority individuals. I assumed that because I was traveling across the country to attend this top‐ranked program focused on social justice, everyone else must have been as well. I was wrong…*
>
> *I did not begin to feel comfortable until I attended the Multicultural Counseling course later that week. Students were assigned a number of textbooks as part of this course, including* CCD *… I never imagined a textbook would bring me so much comfort. I vividly remember reading each chapter and vigorously taking notes in the margins. I also remember the energy I felt as I wrote about my reactions to the readings each week.*

> *I felt like the book legitimized the experiences of racial and ethnic minorities and helped me understand what I was encountering in my Midwest surroundings. It became a platform from which I could explain my own experience as a racial and ethnic minority from Southern California who was transplanted to the Midwest. The personal stories, concepts, and theories illustrated in* CCD *resonated with me and ultimately helped me overcome my feelings of isolation.* CCD *provided me with the language to engage in intellectual discourse about race, ethnicity, social class, privilege, and disparities. I remember the awareness that swept over the class as we progressed through the textbook … I felt that they were beginning to view things through my cultural lens, and I through theirs. We were gaining greater understanding of how our differing cultural realities had shaped us and would impact the work we conducted as therapists.*
>
> *(Sue & Sue, 2013, pp. 17–18)*

Le Ondra's story voices a continuing saga of how persons of color and many marginalized individuals must function in an ethnocentric society that unintentionally invalidates their experiences and enforces silence upon them. She talks about how the text provided a language for her to explain her experiences and how she resonated with its content and meaning. To her, the content of the book tapped into her experiential reality and expressed a *worldview* that is too often ignored or not even discussed in graduate‐level programs. Le Ondra found comfort and solace in the book, and she has been fortunate in finding significant others in her life that have validated her thoughts, feelings, and aspirations and allowed her to pursue a social justice direction in counseling. As a person of color, Le Ondra has been able to overcome great odds and to obtain her doctorate in the field without losing her sense of integrity or racial/cultural identity.

A Word of Caution

There is a word of caution that needs to be directed toward students of marginalized groups as they read *CCD* and find it affirming and validating. In teaching the course, we have often encountered students of color who become very contentious and highly outspoken toward White classmates. A good example is provided in the reaction of the African American student in the fourth scenario. It is clear that the student seems to take delight in seeing his White classmates “squirm” and be uncomfortable. In this respect, he may be taking out his own anger and frustration upon White classmates, and his concern has less to do with helping them understand than having them feel some of the pain and hurt he has felt over the years. It is important to express and understand one's anger (it can be healing), but becoming verbally abusive toward another is counterproductive to building rapport and mutual respect. As people of color, for example, we must realize that our enemies are not White Americans, but White supremacy! And, by extension, our enemy is not White Western society, but racism and ethnocentrism.

Second, because the book discusses multicultural issues, some students of color come to believe that multicultural training is only for White students; the implicit assumption is that they know the material already and are the experts on the subject. Since many students of color have not explored their beliefs about other groups, and sometimes their own, such a perspective prevents self‐exploration and constitutes a form of resistance. As will be seen in Chapter 3, people of color, for example, are not immune from prejudice, bias, and discrimination. Further, such a belief prevents the exploration of interracial and interethnic misunderstandings and biases. Multicultural training is more than White–African American, White–Latinx American, White–Asian American, White–Native American, and so on. It is also about African American–Asian American, Asian American–Native American, and

Latinx–Native American relationships; and it includes multiple combinations of other social identity differences, like gender, sexual orientation, disability, religious orientation, and so forth. Race, culture, ethnicity, gender, and sexual orientation/identity are about everyone; it is not just a "minority thing."

REFLECTION AND DISCUSSION QUESTIONS

Look at the opening quotes by the four students, then answer these questions.

1. In what ways are the reactions of the White students different from those of the students of color? Why do you think this is so?
2. Which of the four reactions can you relate to best? Which reaction can you empathize least with? Why?
3. As you continue reading the material in this text, you are likely to experience strong and powerful reactions and emotions. Being able to understand the meaning of your feelings is the first step to *cultural competence*. Ask yourself, why am I reacting this way? What does it say about my *worldview*, my experiential reality, and my ability to relate to people who differ from me in race, gender, and sexual orientation?
4. As a counselor working with clients who are racially or ethnically different from yourself, would you be able to truly relate to their *worldviews*?
5. What do you think "understanding yourself as a racial, ethnic, cultural being" means?

RECOGNIZING AND UNDERSTANDING RESISTANCE TO MULTICULTURAL TRAINING

As a counselor or therapist working with clients, you will often encounter psychological resistance or, more accurately, client behaviors that obstruct the therapeutic process or sabotage positive change (Ridley & Thompson, 1999). Clients may change the topic when recalling unpleasant memories, externalize blame for their own failings, fail to acknowledge strong feelings of anger toward loved ones, or be chronically late for counseling appointments. All of these client behaviors are examples of resistance or avoidance of acknowledging and confronting unpleasant personal revelations. Oftentimes, these represent unconscious maneuvers to avoid fearful personal insights, to avoid personal responsibility, and to avoid painful feelings. In most cases, resistance masks deeper meanings outside the client's awareness; tardiness for appointments is unacknowledged anger toward therapists, and changing topics in a session is an unconscious deflection of attention away from frightening personal revelations. In many respects, multicultural training can be likened to "therapy" in that trainees are analogous to clients, and trainers are comparable to therapists helping clients with insights about themselves and others.

As we shall see in Chapter 2, the goal of multicultural training is *cultural competence*. It requires trainees to become aware of their own *worldviews*, their assumptions of human behavior, their misinformation and lack of knowledge, and, most importantly, their biases and prejudices. Sometimes, this journey is a painful one, and trainees will resist moving forward. For trainers or instructors, the job is to help trainees in their self‐exploration as racial/cultural beings, and the meaning this has for their future roles as multicultural counselors. For trainees, being able to recognize, understand, and overcome resistance to multicultural training is important in becoming a culturally competent counselor or therapist.

In the next few sections, we focus upon identifying how resistance manifests itself in training and propose reasons why many well‐intentioned trainees find multicultural training disconcerting and difficult to undertake. By so doing, we are hopeful that trainees will attend to their own reactions when reading the text or when participating in classroom dialogues on the subject. Ask yourself the following questions as you continue reading in the next sections and throughout the book.

REFLECTION AND DISCUSSION QUESTIONS

1. What type of reactions or emotions am I feeling as I study the material on multicultural counseling? Am I feeling defensive, angry, anxious, guilty, or helpless? Am I feeling affirmed, valued or engaged? Where are these feelings coming from? Why am I feeling this way, and what does it possibly mean?
2. In what ways may these emotions affect my ability to understand the *worldview* of clients who differ from me, and how might that affect my work?
3. Does having a different point of view mean I am resisting the multicultural material? List all those reasons that support your stance. List all those reasons that do not support it.
4. How applicable are the resistances outlined in the following sections to me?

In work with resistance to diversity training, research reveals how it is likely to be manifested in three forms: *cognitive resistance*, *emotional resistance*, and *behavioral resistance* (Sue,

2015). Recognizing the manifestation and hidden meanings of resistance is one of the first priorities of multicultural training for both trainees and trainers. For trainees, it is finding the courage to confront their own fears and apprehensions, to work through the powerful emotions they are likely to experience, to explore what these feelings mean for them as racial/cultural beings, to achieve new insights about themselves, and to develop multicultural skills and behaviors in their personal lives and as mental health professionals. For trainers, it means understanding the nature of trainee resistance, creating a safe but challenging environment for self‐exploration, and using intervention strategies that facilitate difficult dialogues on race, gender, sexual orientation, and other topics in the area of diversity.

Cognitive Resistance—Denial

> *To date, my biggest discovery is that I didn't really believe that people were being discriminated against because of their race. I could hear them say it, but in my head, I kept running a parallel reason from the White perspective. A Chinese lady says that her party had to wait longer while Whites kept getting seated in front of them. I say, other people had made reservations. A black man says that the receptionist was rude, and made him wait longer because he's Black. I say she had a bad day, and the person he was there to see was busy. A Puerto Rican couple says that the second they drove into Modesto … a cop started tailing them, and continued to do so until they reached their hotel, which they opted to drive right on by because they didn't feel safe. I say, there's nothing to be afraid of in Modesto. It's a nice little town. And surely the cop wasn't following you because you're Puerto Rican. I bet your hotel was on his way to the station. I know that for every story in which something bad happens to someone because of their race, I can counter it with a White interpretation. And while I was listening with a sympathetic ear, I silently continued to offer up alternative explanations, benign explanations that kept my world in equilibrium.*
>
> *(Rabow, Venieris, & Dhillon, 2014, p. 189)*

This student account reveals a pattern of entertaining alternative explanations to the stories told by persons of color about their experiences of prejudice and discrimination. Although the author describes “listening sympathetically,” it was clear that he or she silently did not believe that these were instances of racism; other more plausible and “benign” explanations could account for the events. This is not an atypical response for many White trainees when they listen to stories of discrimination from classmates of color (Sue, 2015; Young, 2003). Because of a strong belief that racism is a thing of the past, that we live in a post‐racial society, and that equal access and opportunity are open to everyone, people of color are seen as exaggerating or misperceiving situations. When stories of prejudice and discrimination are told, it directly challenges these cherished beliefs. The student's quote indicates as much when he says that his “benign explanations” preserves his racial reality (“kept my world in equilibrium”).

The fact that the student chose not to voice his thoughts is actually an impediment to learning and understanding. In many classrooms, teachers have noted how silence is used by some White students to mask or conceal their true thoughts and feelings about multicultural issues (van Dijk, 1992; Sue, 2010; Sue, Torino, Capodilupo, Rivera, & Lin, 2010). Denial through disbelief, unwillingness to consider alternative scenarios, distortion, fabrication, and rationalizations are all mechanisms frequently used by some trainees during racial conversations to prevent them from thinking about or discussing topics of race and racism in an honest manner (van Dijk, 1992; Feagin, 2001; Sue, Rivera, Capodilupo, Lin, & Torino, 2010). In our teaching in multicultural classes, we have observed many types of denials that

work against honest diversity discussions. There are denials that students are prejudiced, that racism still exists, that they are responsible for the oppression of others, that Whites occupy an advantaged and privileged position, that they hold power over people of color, and even denial that they are White (Feagin & Vera, 2002; McIntosh, 2002; Sue, 2010; Tatum, 1992; Todd & Abrams, 2011). This latter point (Whiteness and White privilege) is an especially "hot topic" that will be thoroughly discussed in Chapter 12. As a trainee in this course, you will be presented with opportunities to discuss these topics in greater detail, and explore what these denials may mean about you and your classmates. We hope you will actively participate in such discussions, rather than passively dealing with the material.

Emotional Resistance

Emotional resistance is perhaps the major obstacle to multicultural understanding, because it blocks a trainee's ability to acknowledge, understand, and make meaning out of strong and powerful feelings associated with multicultural or diversity topics. The manifestation and dynamics of *emotional resistance* are aptly described by Sara Winter (1977, p. 24), a White female psychologist. She also provides some insights as to why this occurs: it serves to protect people from having to examine their own prejudices and biases.

> *When someone pushes racism into my awareness, I feel* **guilty** *(that I could be doing so much more);* **angry** *(I don't like to feel like I'm wrong);* **defensive** *(I already have two Black friends … I worry more about racism than most whites do—isn't that enough);* **turned off** *(I have other priorities in my life with guilt about that thought);* **helpless** *(the problem is so big—what can I do?). I HATE TO FEEL THIS WAY. That is why I minimize race issues and let them fade from my awareness whenever possible.*

The Meaning of Anxiety and Fear

Anxiety is the primary subjective emotion encountered by White trainees exposed to multicultural content and its implications. In one study, it was found that when racial dialogues occurred, nearly all students described fears of verbal participation because they could be misunderstood, or be perceived as racist (Sue, Rivera, et al., 2010). Others went further in describing having to confront the realization that they held stereotypes, biases, and prejudices toward people of color. This insight was very disturbing and anxiety‐provoking to them because it directly challenged their self‐image as good, moral, and decent human beings who did not discriminate. Facing this potential awareness creates high levels of anxiety, and often results in maneuvers among students to avoid confronting their meanings.

> *I have a fear of speaking as a member of the dominant group … My feelings of fear stem from not wanting to be labeled as being a racist. I think that fear also stems from the inner fear that I do not want to know what happens to people of color every day. I may not directly be a racist, but not reacting or speaking up to try to change things is a result of my guilt … This is a frightening prospect because I do not want to see the possibility that I have been a racist. Awareness is scary.*
>
> *(Rabow et al., 2014, p. 192)*

In the preceding quote, the student talks about "fear" being a powerful force in preventing him or her from wanting to learn about the plight of people of color. The strong emotions of guilt and fear, and possibly "being racist," are too frightening to consider. For many students, these feelings block them from exploring and attempting to understand the life experience of people of color. In one major study, for example, silence or not participating in diversity discussions, denials of personal and societal racism, and physically leaving the situation were

notable avoidant ploys used by students. The apprehensions they felt affected them physically as well (Sue, Rivera, et al., 2010; Sue, Torino, et al., 2010). Some students described physiological reactions of anxiety like a pounding heart, dry mouth, tense muscles, and perspiration. One student stated, “I tried hard to say something thoughtful and it's hard for me to say, and my heart was pounding when I said it.” Others described feeling intimidated in the discussions, stammering when trying to say something, being overly concerned about offending others, experiencing a strong sense of confusion as to what was going on, censoring thoughts or statements that could be misunderstood, feeling reluctant in expressing their thoughts, being overwhelmed by the mix of emotions they felt, and hearing constriction in their own voices.

These thoughts, feelings, and concerns blocked participants from fully participating in learning and discussing diversity issues, because they became so concerned about themselves (turning inward) that they could not freely be open and listen to the messages being communicated by socially devalued group members. Indeed, their whole goal seemed to be to ward off the messages and meanings being communicated to them, which challenged their *worldviews*, and themselves as racial beings, and highlighted their potential roles as oppressors.

For those who are able to listen to stories about racial and other forms of oppression, some allow their anxiety and fear to immobilize them: “I think sometimes I'm afraid to say things because I don't want to offend people, and so I just decide … to sit and be quiet” (Linder, 2015, p. 545). One's fear of appearing racist or offensive thus undermines learning because one remains silent in discussion and allows others to do the difficult work of self‐exploration; oftentimes, the brunt of the work is then unduly put on the shoulders of the people of color or other marginalized group members in the class.

The Meaning of Defensiveness and Anger

Although defensiveness and anger are two different emotions, studies seem to indicate a high relationship between the two (Apfelbaum, Sommers, & Norton, 2008; Sue, Torino, et al., 2010; Zou & Dickter, 2013). One represents a protective stance and the other an attempt to strike back at the perpetrator (in many cases, statements by people of color). In the opening quotes for this chapter, note that both White students became angry at the authors and accused them of being racist and propagandistic. In absorbing diversity content, many White students describe feeling defensive (unfairly accused of being biased or racist, blamed for past racial injustices, and responsible for the current state of race relations). “I'm tired of hearing ‘White people this … White people that’ … why are we always blamed for everything?”

When the text discusses bias and bigotry, or when classmates of color bring up the issue, for example, some White students seem to interpret this as a personal accusation, and rather than reach out to understand the content, respond in a defensive and protective posture. In many cases, even statements of racial facts and statistics, such as definitions of racism, disparities in income and education, segregation of neighborhoods, hate crime figures, and so forth, arouse defensiveness in many White students. Their defense response to a racial dialogue is seen as protection against (a) criticism (“You just don't get it!”), (b) revealing personal shortcomings (“You are racist!”), or (c) perceived threat to their self‐image and ego (“I'm not a racist—I'm a good person.”). Because of this stance, we have observed that many White students who feel attacked may engage in behaviors or argumentative ploys that present denials and counterpoints because they view the racial dialogue as a win–lose proposition. Warding off the legitimacy of the points raised by people of color and maintaining their tightly guarded

color‐blind racial perspective becomes the primary goals, rather than listening and attempting to understand the material or point of view.

When White students feel wrongly accused, they may respond with anger and engage in a counterattack when a racial topic arises. It appears that anger stems from three sources: (a) feeling unfairly accused, (b) being told the substance or stance they take is wrong, and (c) confronting information suggesting they have benefited from racial privilege. Many White students may feel offended and perceive the allegations as a provocation or an attack that requires retaliation. Anger may be aroused when students feel offended (“How dare you imply that about me?”), wronged (“I am deeply hurt you see me that way”), misunderstood (“You make it seem like I didn't work hard for everything I have”), or that their good standing is denied (“Don't associate me with racists!”). Defensiveness is designed to uphold one's own stance. Sometimes, we see students in class searching the Internet for information to refute data documenting racial disparities or a story about someone's experiences with discrimination. Anger, on the other hand, turns its attention to attacking the threatening behavior of others. Given the choice of the fight‐or‐flight response, some White students' anger turns to rage; they make a choice to take action in stopping the threatening accusations (Spanierman & Cabrera, 2015). The strategy used is to discredit the substance of an argument and/or to derogate the communicator, often through a personal attack (“He or she is just an angry Black man or woman”). Sometimes, White rage lies beneath the surface as students seethe in silence, and sometimes it leads to hostile actions, like making official complaints about the teacher for covering the material in class. In many respects, anger, rage, and defensiveness may become so aroused that one loses control of one's self‐monitoring capacities and the ability to accurately assess the external environment. These latter two abilities are extremely important for effective multicultural counseling.

The Meaning of Guilt, Regret, and Remorse

When discussing diversity issues, many White trainees admit to feeling guilty, although most tend to say that they “are made to feel guilty” by people of color, especially when unjustly accused (Sue, 2003). This statement actually suggests a distancing strategy in localizing guilt as external to oneself rather than as rightfully residing and being felt internally. Guilt as an emotion occurs when we believe we have violated an internal moral code, and have compromised our own standards of conduct. The question becomes, why should White trainees feel guilty when topics of race, racism, or Whiteness are discussed? If indeed they are not racist, not responsible for the racial sins of the past, and not responsible for current injustices, then why should they feel guilt and how could they be made to feel guilty?

Some have coined the term “White guilt” to refer to the individual and collective feelings of culpability experienced by some Whites for the racist treatment of people of color, both historically and currently (Goodman, 2001; Spanierman, Todd, & Anderson, 2009; Tatum, 1992). In diversity discussions, many White trainees find guilt extremely uncomfortable, because it means that they have violated a moral standard and are disinclined to acknowledge their violation. What is that moral standard? Being a good, moral, and decent human being who does not discriminate, being a *nonracist*, living a life that speaks to equality and justice, and being a humane person who treats everyone with respect and dignity are the positive standards that are being breached. Compromising these moral standards and beliefs and acting in ways that violate them bring on bad feelings of guilt and remorse.

Behavioral Resistance

White racial guilt involves realizing one's potential culpability over past deeds; guilt is

compounded by the knowledge that continued inaction on one's part allows for the perpetuation of racism in oneself and others. Thus, taking action is a means to alleviate feelings of guilt. The emotions of helplessness and hopelessness make themselves felt in two different arenas: one is internal (personal change) and the other is external (system change). In becoming aware of their racial/cultural identity, for example, White students at this juncture of development may begin to ask two primary questions.

First, “How does one change?” What needs to be changed? How does one become a *nonracist* **or an unbiased person**? How does one break the shackles of social conditioning that have taught one that some groups are more worthy than others, and that other groups are less worthy? Many trainees often make these comments: “I don't know where to begin.” “If I am not aware of my racism, how do I become aware of it?” “Tell me what I must do to rid myself of these prejudices.” “Should I attend more workshops?” “I feel so confused, helpless, impotent, and paralyzed.”

Second, “What must I do to eradicate racism in the broader society?” While self‐change requires becoming a *nonracist* person, societal change requires becoming an *antiracist* one. Impacting an ethnocentric mental health delivery system falls into this category. This role means becoming an advocate and actively intervening when injustice makes its presence felt at the individual level (for example, objecting to a racist joke or confronting friends, neighbors, or colleagues about their prejudices) and at the institutional level (for example, opposing biased mental health practices, supporting civil rights issues, making sure a multicultural curriculum is being taught in schools, or openly supporting social justice groups).

The helplessness that is felt by White students in diversity studies, unless adequately deconstructed, can easily provide an excuse or rationalization for inaction. “What good would it do?” “I'm only one person, how can I make any difference?” “The problem is so big, whatever I do will only be a drop in the bucket.” Feeling helpless and hopeless is legitimate unless it is used as an excuse to escape responsibility for taking any form of action. Helplessness is modifiable when students are provided options and strategies that can be used to increase their awareness and personal growth, and when they are provided with the tools to dismantle racism in our society. Hopefully, this course and the readings will provide you with suggestions of where to begin, especially in mental health practice.

Hopelessness is a feeling of despair and of giving up, a self‐belief that no action will matter and no solution will work. Helplessness and hopelessness associated with the need for change and action can be paralytic. The excuse for inaction, and thus the avoidance of racial exploration, resides not simply in not knowing what to do, but in some very basic fears eloquently expressed by Tatum (2002).

> *Fear is a powerful emotion, one that immobilizes, traps words in our throats, and stills our tongues. Like a deer on the highway, frozen in the panic induced by the lights of an oncoming car, when we are afraid it seems that we cannot think, we cannot speak, we cannot move … What do we fear? Isolation from friends and family, ostracism for speaking of things that generate discomfort, rejection by those who may be offended by what we have to say, the loss of privilege or status for speaking in support of those who have been marginalized by society, physical harm caused by the irrational wrath of those who disagree with your stance? (pp. 115–116)*

In other words, helplessness and hopelessness are emotions that can provide cover for not taking action. They allow many of us to not change for fear that our actions will result in the negative consequences previously outlined. Becoming a multiculturally competent counselor

or therapist requires change.

Video 1.4: Worldviews and Dominant Narratives

The majority worldview and narrative can become a hindrance to minority populations.

CULTURAL COMPETENCE AND EMOTIONS

There are many other powerful emotions often experienced by students during the journey to developing *cultural competence*. They include sadness, disappointment, humiliation, blame, invalidation, and so on. These feelings, along with those already discussed, can make their appearance in dialogues on *multiculturalism* or diversity.

The unpleasantness of some emotions and their potentially disturbing meanings makes for avoidance of honest multicultural dialogues and hence a blockage of the learning process. Rather than seeing emotions as a hindrance and barrier to mutual understanding, and rather than shutting them down, allowing them to bubble to the surface actually frees the mind and body to achieve understanding and insight. The cathartic relationship between memories, fears, stereotypic images, and the emotional release of feelings is captured in the following passage, which describes the racial awakening of Reese, a White male social justice advocate.

> *I remember when I was first introduced to [intergroup dialogue] … I thought it was the most bullshit pedagogy … And, I fought it so hard … I don't know why I would ever sign up for another course … I really thought it was stupid … [L]ike the taking in a circle with the whole dialogue pedagogy was a huge hang‐up … [Later, reading about Friere] was a really important moment in my life when I think about development.*
>
> *(Ford, 2017, p. 124)*

Years after his work as an intergroup dialogue facilitator, Reese reflected that the experience had a "big impact" on his development and influenced his "perspectives." He also recognized that his journey was influenced by his varying levels of racial awareness as a White male along the way.

We are aware that the content of this chapter has probably already pushed hot emotional buttons in many of you. For trainees in the dominant group, we ask the following questions: Are you willing to look at yourself, to examine your assumptions, your attitudes, your conscious and unconscious behaviors, the privileges you enjoy as a dominant group member, and how you may have unintentionally treated others in less than a respectful manner? For socially marginalized group members, we ask whether you are willing to confront your own biases and prejudices toward dominant group members, be honest in acknowledging your own biases toward other socially devalued group members, and work to build bridges of mutual understanding and respect for all groups.

Trainees who bravely undertake the journey to developing *cultural competence* and *cultural humility* eventually realize that change is a lifelong process, and that it does not simply occur in a workshop, classroom, or singular event. It is a monumental task, but the rewards are many when we are successful. A whole body of literature supports the belief that encountering diverse points of view, being able to engage in honest diversity conversations, and successfully acknowledging and integrating differing perspectives lead to an expansion of critical consciousness (Gurin, Dey, Hurtado, & Gurin, 2002; Jayakumar, 2008). On a cognitive level, many have observed that cross‐racial interactions and dialogues, for example, are necessary to increase racial literacy, expand the ability to critically analyze racial ideologies, and dispel stereotypes and misinformation about other groups (Bolgatz, 2005; Ford, 2012; Pollock, 2004; Stevens, Plaut, & Sanchez‐Burks, 2008). On an emotional level, trainees of successful diversity training report less intimidation and fear of differences, an increased compassion for others, a broadening of their horizons, appreciation of people of all colors and cultures, and a greater sense of belonging and connectedness with all groups (American Psychological Association, 2017; APA Presidential Task Force, 2012; Bell, 2002;

President's Initiative on Race, 1999; Sue, 2003).

In closing, we implore you not to allow your initial negative feelings to interfere with your ultimate aim of learning from this text as you journey toward *cultural competence*. Sad to say, this empathic ability is blocked when readers react with defensiveness and anger upon hearing the life stories of those most disempowered in our society. We have always believed that our worth as human beings is derived from the collective relationships we hold with all people; that we are people of emotions, intuitions, and spirituality; and that the lifeblood of people can be understood only through lived realities. Although we believe strongly in the value of science and the importance psychology places on empiricism, *CDC* is based on the premise that a profession that fails to recognize the heart and soul of the human condition is a discipline that is spiritually and emotionally bankrupt. As such, this book not only touches on the theory and practice of multicultural counseling and psychotherapy, but also reveals the hearts and souls of our diverse clienteles.

IMPLICATIONS FOR CLINICAL PRACTICE

1. Listen and be open to stories of those most disempowered in U.S. society. Counseling has always been about listening to our clients. Don't allow your emotional reactions to negate their voices because you become defensive.
2. Know that although you were not born wanting to be racist, sexist, or heterosexist, or to be prejudiced against any other group, your cultural conditioning has imbued certain biases and prejudices in you. No person or group is free from inheriting the biases of U.S. society.
3. Understand and acknowledge your intense emotions and what they mean for you. *CCD* speaks about unfairness, racism, sexism, and prejudice, making some feel accused and blamed. The “isms” of our society are not pleasant topics, and we often feel unfairly accused.
4. It is important that helping professionals understand how they may still benefit from the past actions of their predecessors and continue to reap the benefits of the present social/educational arrangements.
5. Understand that multicultural training requires more than book learning. In your journey to developing *cultural competence*, it is necessary to supplement your intellectual development with experiential reality.
6. Don't be afraid to explore yourself as a racial, ethnic, and cultural being. An overwhelming number of mental health practitioners believe they are good, decent, and moral people. Because most of us would not intentionally discriminate, we often find great difficulty in realizing that our belief systems and actions may have oppressed others.
7. Open dialogue—to discuss and work through differences in thoughts, beliefs, and values—is crucial to becoming culturally competent. It is healthy when we are allowed to engage in free dialogue with one another. To a large extent, unspoken thoughts and feelings serve as barriers to open and honest dialogue about the pain of discrimination and how each and every one of us perpetuates bias through our silence or obliviousness.
8. Finally, continue to use these suggestions in reading throughout the text. What emotions or feelings are you experiencing? Where are they coming from? Are they blocking your understanding of the material? What do these reactions mean for you personally and as a

helping professional?

Video 1.5: Cultural Conditioning

Societal conditioning and socialization impacts all of us regardless of race/ethnicity and culture.

Video Lecture: Emotional Roadblocks to Counseling the Culturally Diverse

SUMMARY

Students who take a course on multicultural counseling and mental health issues have almost universally felt both positive and negative feelings that affect their ability to learn about diversity issues. Those from marginalized groups often feel validated by the content while majority group members often feel a range of emotions like defensiveness, anxiety, anger, and guilt. It is important not to allow these nested or embedded emotions to go unacknowledged, or to avoid exploring the psychological meanings they may have for trainees. The journey to becoming culturally competent therapists is filled with obstacles to self‐exploration, to understanding oneself as a racial/cultural being, and to understanding the *worldview* of those who differ from others in terms of race, gender, ethnicity, sexual orientation, and other sociodemographic dimensions. The subject matter in this book requires students to explore their biases and prejudices, a task that often evokes strong resistance from both majority and oppressed group members.

It is important to recognize personal resistance to the material, to explore its meaning, and to learn about yourself and others. Sometimes, what is revealed about you may prove disturbing, but having the courage to continue is necessary to becoming a culturally competent counselor or therapist. Recognizing the manifestation and hidden meanings of resistance is one of the first priorities of multicultural training for both trainees and trainers. For trainees, it is finding the courage to confront their own fears and apprehensions, to work through the powerful emotions they are likely to experience, to explore what these feelings mean for them as racial/cultural beings, to achieve new insights about themselves, and to develop multicultural skills and behaviors in their personal lives and as mental health professionals. For trainers, it means understanding the nature of trainee resistance, creating a safe but challenging environment for self‐exploration, and using intervention strategies that facilitate difficult dialogues on race, gender, sexual orientation, and other sociodemographic dimensions. This chapter is specifically written to help readers understand and overcome their emotive reactions to the substance of the text and the course they are about to take.

GLOSSARY TERMS

- Antiracist
- Behavioral resistance (to multicultural education)
- Cognitive resistance (to multicultural education)
- Cultural competence
- Cultural humility
- Culturally responsive
- Emotional affirmation
- Emotional invalidation
- Emotional resistance (to multicultural education)
- Emotional self‐revelation
- Microaggressions
- Multiculturalism
- Nested/Embedded emotions
- Nonracist
- Self‐reflection
- Worldview

REFERENCES

1. American Psychological Association. (2017). Multicultural guidelines: An ecological approach to context, identity, and intersectionality. Retrieved from http://www.apa.org/about/policy/multicultural - guidelines.pdf

2. American Psychological Association (APA) Presidential Task Force on Preventing Discrimination and Promoting Diversity (2012). *Dual pathways to a better America: Preventing discrimination and promoting diversity*. Washington, DC: American Psychological Association.

3. Apfelbaum, E. P., Sommers, S. R., & Norton, M. I. (2008). Seeing race and seeming racist: Evaluating strategic colorblindness in social interaction. *Journal of Personality and Social Psychology, 95,* 918–932.

4. Bell, L. A. (2002). Sincere fictions: The pedagogical challenges of preparing White teachers for multicultural classrooms. *Equity and Excellence in Education, 35,* 236–244.

5. Bolgatz, J. (2005). *Talking race in the classroom*. New York, NY: Educators College Press.

6. Chao, R. C., Wei, M., Spanierman, L., Longo, J., & Northart, D. (2015). White racial attitudes and White empathy: The moderation of openness to diversity. *The Counseling Psychologist, 43,* 94–120.

7. Collins, S., Arthur, N., & Brown, C. (2013). Critical incidents in graduate student development of multicultural and social justice competency. *Academic Journal of Interdisciplinary Studies, 2*(9), 105.

8. Feagin, J. R. (2001). *Racist America: Roots, current realities, and future reparations*. New York, NY: Routledge.

9. Feagin, J. R., & Sikes, M. P. (1994). *Living with racism*. Boston, MA: Bacon.

10. Feagin, J. R., & Vera, H. (2002). Confronting one's own racism. In P. S. Rothenberg (Ed.), *White privilege* (pp. 121–125). New York, NY: Worth.

11. Ford, K. A. (2012). Shifting White ideological scripts: The educational benefits of inter - and intraracial curricular dialogues on the experiences of White college students. *Journal of Diversity in Higher Education, 5,* 138–158.

12. Ford, K. A. (2017). A White male's post - college reflections on race, resistance, and social change. In K. A. Ford (Ed.), *Facilitating change through intergroup dialogue: Social justice advocacy in practice* (pp. 123–129). New York, NY: Routledge.

13. Goodman, D. J. (2001). *Promoting diversity and social justice: Educating people from privileged groups*. Thousand Oaks, CA: Sage.

14. Gurin, P., Dey, E. L., Hurtado, S., & Gurin, G. (2002). Diversity and higher education: Theory and impact on educational outcomes. *Harvard Educational Review, 72,* 330–366.

15. Jayakumar, U. M. (2008). Can higher education meet the needs of an increasingly diverse and global society? Campus diversity and crosscultural workforce

competencies. *Harvard Educational Review*, *78*, 615–651.

16. Kiselica, M. S. (1999). Confronting my own ethnocentrism and racism: A process of pain and growth. *Journal of Counseling and Development*, *77*, 14–17.

17. Linder, C. (2015). Navigating guilt, shame, and fear of appearing racist: A conceptual model of antiracist White feminist identity development. *Journal of College Student Development*, *56*(6), 535–550.

18. McIntosh, P. (2002). White privilege: Unpacking the invisible knapsack. In P. S. Rothenberg (Ed.), *White privilege* (pp. 97–101). New York, NY: Worth.

19. Nadal, K. L., Griffin, K. E., Wong, Y., Davidoff, K. C., & Davis, L. S. (2017). The injurious relationship between racial microaggressions and physical health: Implications for social work. *Journal of Ethnic & Cultural Diversity in Social Work*, *26*(1–2), 6–17.

20. Pollock, M. (2004). *Colormute: Race talk dilemmas in an American high school*. Princeton, NJ: Princeton University Press.

21. Ponterotto, J. G., Fingerhut, E. S., & McGuinness, R. (2013). Legends of the field: Influential scholars in multicultural counseling. *Psychological Reports*, *111*(2), 364–382.

22. Ponterotto, J. G., & Sabnani, H. B. (1989). “Classics” in multicultural counseling: A systematic five‐year content analysis. *Journal of Multicultural Counseling and Development*, *17*, 23–37.

23. President's Initiative on Race (1999). *Pathways to one America in the 21st century*. Washington, DC: U.S. Government Printing Office.

24. Rabow, J., Venieris, P. Y., & Dhillon, M. (2014). *Ending racism in America: One microaggression at a time*. Dubuque, IA: Kendall Hunt.

25. Ratts, M. J., & Pedersen, P. B. (2014). *Counseling for multiculturalism and social justice*. Alexandria, VA: American Counseling Association.

26. Ridley, R. R., & Thompson, C. E. (1999). Managing resistance to diversity training: A social systems perspective. In M. S. Kiselica (Ed.), *Prejudice and racism* (pp. 3–24). Alexandria, VA: American Counseling Association.

27. Senter, M. S., & Ling, D. A. (2017). “It's almost like they were happier when you were down”: Microaggressions and overt hostility against Native Americans in a community with gaming. *Sociological Inquiry*, *87*(2), 256–281.

28. Spanierman, L. B., & Cabrera, N. L. (2015). The emotions of White racism and antiracism. In V. Watson, D. Howard‐Wagner, L. Spanierman, N. L. Cabrera, A. Garman, A. Fofiu, et al. (Eds.), *Unveiling Whiteness in the twenty‐first century: Global manifestations, transdisciplinary interventions* (pp. 9–28). New York, NY: Lexington Books.

29. Spanierman, L. B., & Smith, L. (2017). Roles and responsibilities of White allies: Implications for research, teaching, and practice. *The Counseling Psychologist*, *45*(5), 606–617.

30. Spanierman, L. B., Todd, N. R., & Anderson, C. J. (2009). Psychosocial costs of racism

to Whites: Understanding patterns among university students. *Journal of Counseling Psychology*, *56*, 239–252.

31. Stevens, F. G., Plaut, V. C., & Sanchez‐Burks, J. (2008). Unlocking the benefits of diversity. *Journal of Applied Behavioral Science*, *44*, 116–133.

32. Sue, D. W. (2003). *Overcoming our racism: The journey to liberation*. San Francisco, CA: Jossey‐Bass.

33. Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, NJ: Wiley.

34. Sue, D. W. (2011). The challenge of White dialectics: Making the “invisible” visible. *The Counseling Psychologist*, *39*, 414–423.

35. Sue, D. W. (2015). *Race talk and the conspiracy of silence. Understanding and facilitating difficult dialogues on race*. Hoboken, NJ: Wiley.

36. Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). Hoboken, NJ: Wiley.

37. Sue, D. W., Rivera, D. P., Capodilupo, C. M., Lin, A. I., & Torino, G. C. (2010). Racial dialogues and White trainee fears: Implications for education and training. *Cultural Diversity and Ethnic Minority Psychology*, *16*, 206–214.

38. Sue, D. W., Torino, G. C., Capodilupo, C. M., Rivera, D. P., & Lin, A. I. (2010). How White faculty perceive and react to classroom dialogues on race: Implications for education and training. *The Counseling Psychologist*, *37*, 1090–1115.

39. Tatum, B. D. (1992). Talking about race, learning about racism: The application of racial identity development theory in the classroom. *Harvard Educational Review*, *62*, 1–24.

40. Tatum, B. D. (2002). Breaking the silence. In P. S. Rothenberg (Ed.), *White privilege* (pp. 115–120). New York, NY: Worth.

41. Todd, N. R., & Abrams, E. M. (2011). White dialectics: A new framework for theory, research and practice with white students. *The Counseling Psychologist*, *39*, 353–395.

42. van Dijk, T. A. (1992). Discourse and the denial of racism. *Discourse and Society*, *3*, 87–118.

43. Velez, B. L., Moradi, B., & DeBlaere, G. (2015). Multiple oppressions and the mental health of sexual minority Latina/o individuals. *The Counseling Psychologist*, *43*, 7–38.

44. Wendt, D. C., Gone, J. P., & Nagata, D. K. (2015). Potentially harmful therapy and multicultural counseling: Bridging two disciplinary discourses. *The Counseling Psychologist*, *43*, 334–358.

45. Winter, S. (1977). Rooting out racism. *Issues in Radical Therapy*, *17*, 24–30.

46. Young, G. (2003). Dealing with difficult classroom dialogues. In P. Bronstein, & K. Quina (Eds.), *Teaching gender and multicultural awareness* (pp. 360–437). Washington, DC: American Psychological Association.

47. Zou, L. X., & Dickter, C. L. (2013). Perceptions of racial confrontation: The role of color blindness and comment ambiguity. *Cultural Diversity and Ethnic Minority*

Psychology, *19*, 92–96.

2
Multicultural Counseling and Therapy (MCT)

Chapter Objectives

1. **1. Compare and contrast similarities and differences between "traditional counseling/clinical practice" and *culturally responsive* counseling.**
2. **2. Understand the *etic* and *emic* orientation to *multicultural counseling*.**
3. **3. Become cognizant of differences between counseling/clinical competence and *multicultural counseling* competence and *cultural humility*.**
4. **4. Identify Eurocentric assumptions inherent in our standards of clinical practice.**
5. **5. Discuss and understand the characteristics of the three levels of personal identity.**
6. **6. Develop *awareness* of possible differences in counseling culturally diverse clients who differ in race, gender, sexual orientation, and other group identities.**
7. **7. Provide examples of ways that other special populations may constitute a distinct cultural group.**
8. **8. Define *multicultural counseling and therapy, cultural competence,* and *cultural humility*.**
9. **9. Explain how *cultural humility* is different from *cultural competence*.**

The following is the third counseling session between Dr. D. (a White counselor) and Gabriella, a 29 - year - old single Latina, who was born and raised in Brazil but came to the United States when she was 10 years old.

Dr. D:

So how did it go last week with Russell [White boyfriend of six months].

Gabriella:

Okay, I guess. [seems withdrawn and distracted]

Dr. D:

You don't sound too sure to me.

Gabriella:

What do you mean?

Dr. D:

Well, from the last session, I understood that you were going to talk to him [Russell] about your decision to live together, but that you wanted to clarify what moving into his apartment meant for him.

Gabriella:

I didn't get a chance to talk about it. I was going to bring it up, but I had another attack, so I didn't get a chance. It was awful! [begins to fidget in the chair] Why does this always happen to me?

Dr. D:

Tell me what happened.

Gabriella:

I don't know. I had a disagreement with him, a big stupid argument over Jennifer Lopez's song “Booty.”

Dr. D:

“Booty”?

Gabriella:

Yeah, he kept watching the video over and over on the computer. He loves the song, but I find it vulgar.

Dr. D:

Lots of songs press the limits of decency nowadays … Tell me about the attack.

Gabriella:

I don't know what happened. I lost control and started screaming at him. I threw dishes at him and started to cry. I couldn't breathe. Then it got really bad, and I could feel the heat rise in my chest. I was scared to death. Everything felt unreal and I felt like fainting. My mother used to suffer from similar episodes of *ataques*. Have I become like her? … God, I hope not!

Dr. D:

Sounds like you had another panic attack. Did you try the relaxation exercises we practiced?

Gabriella:

No, how could I? I couldn't control myself. It was frightening. I started to cry and couldn't stop. Russell kept telling me to calm down. We finally made up and got it on.

Dr. D:

I'm glad things got smoothed over. But you always say that you have no control over your attacks. We've spent lots of time on learning how to manage your panic attacks by nipping them in the bud … before they get out of control. Maybe some medication might help.

Gabriella:

Yes, I know, but it doesn't seem to do any good. I just couldn't help it.

Dr. D:

Did you try?

Gabriella:

Do you think I enjoy the attacks? [shouts] How come I always feel worse when I come here? I feel blamed … Russell says I'm a typical emotional Latina. What am I to do? I come here to get help, and I just get no understanding. [stated with much anger]

Dr. D:

You're angry at me because I don't seem to be supportive of your predicament, and you think I'm blaming you. But I wonder if you have ever asked yourself how you contribute to the situation as well. Do you think that fighting over a song is the real issue here?

Gabriella:

Maybe not, but I just don't feel like you understand.

Dr. D:

Understand what?

Gabriella:

Understand what it is like to be a Latina woman dealing with all those stereotypes. My parents don't want me living with Russell … they think he benefits from having sex with no commitment to marriage, and that I'm a fool. They think he is selfish and just wants a Latina … like a fetish…

Dr. D:

I think it's more important what *you* think and want for yourself, not what your parents would like you to do. Be your own person. And we've talked about cultural differences before, in the first session, remember? Cultural differences are important, but it's more important to recognize that we are all human beings. Granted, you and I are different from one another, but most people share many more similarities than differences.

Gabriella:

Yes, but can you really understand what's it like to be a Latina, the problems I deal with in my life? Aren't they important?

Dr. D:

Of course I can. And of course they [differences] are … but let me tell you, I've worked with many Latinos in my practice. When it comes right down to it, we are all the same under the skin.

Gabriella:

[period of silence]

Dr. D:

Now, let's go back and talk about your panic attacks and what you can do to prevent and reduce them.

REFLECTION AND DISCUSSION QUESTIONS

1. What are your thoughts and feelings about the counseling encounter between Dr. D. and Gabriella?
2. Do you think that Dr. D. demonstrated cultural awareness? Is this an example of “good counseling”? If not, why not?

3. When Gabriella described her episodes as *ataques*, do you know what she meant?
4. What are the potential counseling and cultural issues in this case?
5. Is it important for the counselor to know what the song “Booty” is about?
6. When the parents suggest that their daughter might be a “fetish,” what could they possibly mean? Is it important?
7. What images of Latinas exist in our society? How might they affect Gabriella's relationship with Russell?
8. If you were the counselor, how would you have handled the situation?

Video 2.0: Introduction

Introduction to counseling session by Dr. Joel Filmore.

Culturally competent care has become a major force in the helping professions (American Psychological Association, 2003, 2017; Arredondo et al., 1996; CACREP, 2015; Cornish, Schreier, Nadkarni, Metzger, & Rodolfa, 2010; Sue, Arredondo, & McDavis, 1992). The therapy session between Dr. D. and Gabriella illustrates the importance of cultural awareness and sensitivity in mental health practice. There is a marked *worldview* difference between the White therapist and the Latina client. In many cases, such differences reflect the therapist's (a) belief in the universality of the human condition, (b) belief that disorders are similar and cut across societies, (c) lack of *knowledge* of Latinx culture, (d) task orientation, (e) failure to pick up clinical clues provided by the client, (f) lack of awareness of the influence of sociopolitical forces in the lives of marginalized group members, and (g) lack of openness to professional limitations. Let us briefly explore these factors in analyzing the preceding transcript.

CULTURE‐UNIVERSAL (*ETIC*) VERSUS CULTURE‐SPECIFIC (*EMIC*) FORMULATIONS

First and foremost, it is important to note that Dr. D. is not a bad counselor per se, but like many helping professionals is culture‐bound and adheres to EuroAmerican assumptions and values that encapsulate and prevent him from seeing beyond his Western therapeutic training (Comas‐Diaz, 2010). One of the primary issues raised in this case relates to the *etic* (culturally universal) versus *emic* (culturally specific) perspectives in psychology and mental health. Dr. D. operates from the former position. His training has taught him that disorders such as panic attacks, depression, schizophrenia, and sociopathic behaviors appear in all cultures and societies; that minimal modification in their diagnosis and treatment is required; and that Western concepts of normality and abnormality can be considered universal and equally applicable across cultures (Arnett, 2009; Howard, 1992; Suzuki, Kugler, & Aguiar, 2005). Many *culturally responsive* psychologists, however, operate from an *emic* position and challenge these assumptions. In Gabriella's case, they argue that lifestyles, cultural values, and *worldviews* affect the expression and determination of behavior disorders (Ponterotto, Utsey, & Pedersen, 2006). They stress that all theories of human development arise within a cultural context and that using the EuroAmerican values of normality and abnormality may be culture‐bound and biased (Locke & Bailey, 2014). From this case, we offer five tentative cultural/clinical observations that may help Dr. D. in his work with Gabriella.

Cultural Concepts of Distress

It is obvious that Dr. D. has concluded that Gabriella suffers from a panic disorder and that her attacks fulfill criteria set forth in the *Diagnostic and Statistical Manual of Mental Disorder*s (*DSM‐5*) (American Psychiatric Association, 2013). When Gabriella uses the term *ataques* to describe her emotional outbursts, episodes of crying, feeling faint, somatic symptoms (“heat rising in her chest”), feeling of depersonalization (unreal), and loss of control, a Western‐trained counseling/mental health professional may very likely diagnose a panic attack. Is a panic attack diagnosis the same as *ataques*? Is *ataque* simply a Latin American translation of an anxiety disorder? We now recognize that *ataque de nervios* (“attack of the nerves”) is a cultural syndrome, occurs often in Latin American countries (in individuals of Latinx descent), and is distinguishable from panic attacks (American Psychological Association, 2013). Cultural syndromes that do not share a one‐to‐one correspondence with psychiatric disorders in *DSM‐5* have been found in South Asia, Zimbabwe, Haiti, China, Mexico, Japan, and other places. Failure to consider the cultural context and manifestation of disorders often results in inaccurate diagnosis and inappropriate treatment (Sue, Sue, Sue, & Sue, 2016). Chapter 10 will discuss these cultural syndromes and treatments in greater detail.

Acknowledging Group Differences

Dr. D. seems to easily dismiss the importance of Gabriella's Latinx culture as a possible barrier to their therapeutic work together. Gabriella wonders aloud whether he can understand her as a Latina (being a racial, ethnic, cultural being), and the unique problems she faces as a person of color. Dr. D. attempts to reassure Gabriella that he can, in several ways. He stresses (a) that people are more similar than different, (b) that we are all “human beings,” (c) that he has much experience in working with Latinx individuals, and (d) that everyone is the “same under the skin.” Although there is much truth to these statements, he has unintentionally negated Gabriella's racialized experiences, and the importance that she places on her

racial/ethnic identity. In *multicultural counseling*, this response often creates an impasse to therapeutic relationships (Arredondo, Gallardo‐Cooper, Delgado‐Romero, & Zapata, 2014). Note, for example, Gabriella's long period of silence following Dr. D.'s response. He apparently misinterprets this as agreement. We will return to this important point shortly.

Being Aware of Collectivistic Cultures

It is obvious that Dr. D. operates from an individualistic approach and values individualism, autonomy, and independence. He communicates to Gabriella that it is more important for her to decide what she wants for herself than to be concerned about her parents' desires. Western European concepts of mental health stress the importance of independence and "being your own person," because this leads to healthy development and maturity, rather than dependency (in Gabriella's case, "pathological family enmeshment"). Dr. D. fails to consider that in many collectivistic cultures, such as Latinx and Asian American cultures, independence may be considered undesirable and interdependence as valuable (Ivey, Ivey, & Zalaquett, 2014; Kail & Cavanaugh, 2013). When the norms and values of Western European concepts of mental health are imposed universally upon culturally diverse clients, there is the very real danger of cultural oppression, resulting in "blaming the victim."

Attuning to Cultural and Clinical Clues

There are many cultural clues in this therapeutic encounter that might have provided Dr. D. with additional insights into Latinx culture and its meaning for culturally competent assessment, diagnosis, and treatment. We have already pointed out his failure to explore more in depth Gabriella's description of her attacks (*ataques de nervios*), and her concern about her parents' approval. But many potential sociocultural and sociopolitical clues were present in their dialogue as well. For example, Dr. D. failed to follow up on why the song "Booty" by Jennifer Lopez precipitated an argument, and what the parents' use of the term "fetish" shows us about how Russell may view their daughter.

The four‐minute music video "Booty" shows Jennifer Lopez and Iggy Azalea with many anonymous women shaking their derrieres ("booties") in front of the camera while chanting "Big, big booty, big, big booty" continuously. It has been described as provocative, exploitative, and "soft porn." Nevertheless, the video has become a major hit. And while Dr. D. might be correct in saying that the argument couldn't possibly be over a song (implying that there is a more meaningful reason), he doesn't explore the possible cultural or political implications for Gabriella. Is there meaning in her finding the song offensive and Russell's enjoying it? We know, for example, that Latinas and Asian women are victims of widespread societal stereotyping that objectifies them as sex objects. Could this be something that Gabriella is wrestling with? At some level, does she suspect that Russell is only attracted to her because of these stereotypes, as her parents' use of the word "fetish" implies? In not exploring these issues, or worse yet, not being aware of them, Dr. D. may have lost a valuable opportunity to help Gabriella gain insight into her emotional distress.

Balancing the Culture‐Specific and Culture‐Universal Orientations

Throughout our analysis of Dr. D., we have made the point that culture and life experiences affect the expression of abnormal behavior and that counselors need to attune to these sociodemographic variables. Some have even proposed the use of culture‐specific strategies in counseling and therapy (American Psychological Association, 2017; Ivey et al., 2014; Parham, Ajamu, & White, 2011). Such professionals point out that current guidelines and

standards of clinical practice are culture‐bound and often inappropriate for racial/ethnic minority groups. Which view is correct? Should treatment approaches be based on cultural universality or *cultural relativism*? Few mental health professionals today embrace the extremes of either position.

Proponents of cultural universality focus on disorders and their consequent treatments and minimize cultural factors, whereas proponents of *cultural relativism* focus on the culture and on how the disorder is manifested and treated within it. Both views have validity. It would be naive to believe that no disorders cut across different cultures or share universal characteristics. Likewise, it is naive to believe that the relative frequencies and manners of symptom formation for various disorders do not reflect the dominant cultural values and lifestyles of a society. Nor would it be beyond our scope to entertain the notion that various diverse groups may respond better to culture‐specific therapeutic strategies. A more fruitful approach to these opposing views might be to address the following three questions: (a) What is universal in human behavior that is also relevant to counseling and therapy? (b) What is the relationship between cultural norms, values, and attitudes, on the one hand, and the manifestation of behavior disorders and their treatments, on the other? and (c) Are there ways to both examine the universality of the human condition and acknowledge the role of culture in the manifestation of both the presenting concern and the treatment approach? Recently, researchers have systematically addressed the last question. Mounting evidence supports the superiority of culturally adaptive treatment interventions compared to culturally universal ones (Hall, Ibaraki, Huang, Marti, & Stice, 2016; Smith & Trimble, 2016).

Video 2.1: We Are All the Same, We Are All Unique

When to apply etic and emic views based on race/ethnicity as well as culture, and how they differ based on culture.

THE NATURE OF MULTICULTURAL COUNSELING COMPETENCE

Clinicians have oftentimes asserted that “good counseling is good counseling” and that good clinical practice subsumes *cultural competence*, which is simply a subset of good clinical *skills*. In this view, they would make a strong case that if Dr. D. had simply exercised these therapeutic *skills*, he would have worked effectively with Gabriella. Our contention, however, is that *cultural competence* is superordinate to counseling competence. How Dr. D. worked with Gabriella contains the seeds of a therapeutic bias that makes him susceptible to cultural errors in therapy. Traditional definitions of counseling and psychotherapy are culture‐bound because they are defined from a primarily White Western European perspective (Gallardo, 2014). Let us briefly explore the rationale for our position.

The Harm of Cultural Insensitivity

Although there are disagreements over the definition of *cultural competence*, many of us know cultural insensitivity when we see it; we recognize it by its horrendous outcomes or by the human toll it takes on our marginalized clients. For some time now, multicultural specialists have described Western‐trained counseling/mental health professionals in very unflattering terms: (a) they are insensitive to the needs of their culturally diverse clients; do not accept, respect, and understand cultural differences; are arrogant and contemptuous; and have little understanding of their prejudices (Ridley, 2005); (b) clients of color, women across race and ethnicity, and lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals frequently complain that they experience microaggressions in counseling (Hook et al., 2016; Sue, 2010); (c) discriminatory practices in mental health delivery systems are deeply embedded in the ways in which the services are organized and in how they are delivered to minority populations, and are reflected in biased diagnoses and treatment, in indicators of dangerousness, and in the type of people occupying decision‐making roles (Cross, Bazron, Dennis, & Isaacs, 1989; Parham et al., 2011); and (d) mental health professionals continue to be trained in programs in which the issues of ethnicity, gender, and sexual orientation are ignored, regarded as deficiencies, portrayed in stereotypic ways, or included as an afterthought (Ponterotto et al., 2006; Ratts & Pedersen, 2014).

Good Counseling Is Culturally Responsive Counseling

As we have discussed, values of individualism and psychological mindedness, and the use of rational approaches to solve problems, have much to do with how competence is defined. Many of our colleagues continue to hold firmly to the belief that “good counseling is good counseling,” dismissing in their definitions the centrality of culture. The problem with traditional definitions of counseling, therapy, and mental health practice is that they arose from monocultural and ethnocentric norms that excluded other cultural groups. Mental health professionals must realize that “good counseling” uses White EuroAmerican norms that exclude most of the world's population. In a hard‐hitting article, Arnett (2009) indicates that psychological research, which forms the *knowledge* base of our profession, focuses on Americans, who constitute only 5% of the world's population. He concludes that the *knowledge* of human behavior neglects 95% of the world's population and is an inadequate representation of humanity. It is clear to us that good counseling takes into consideration the cultural context in which counseling occurs and the cultural realities of the client and counselor. Standards of helping derived from such a philosophy and framework are inclusive. Thus, clinical or “counseling competence is multicultural counseling competence” (Ridley, Mollen, & Kelly, 2011, p. 841).

Video 2.2: Good Counseling Is Good Counseling

Focusing on your client's needs by addressing specifics related to identity and culture.

A TRIPARTITE FRAMEWORK FOR UNDERSTANDING THE MULTIPLE DIMENSIONS OF IDENTITY

All too often, counseling and psychotherapy seem to ignore the group dimension of human existence. For example, a White counselor who works with an African American client might intentionally or unintentionally avoid acknowledging the client's racial or cultural background by stating, “We are all the same under the skin” or “Apart from your racial background, we are all unique.” We have already indicated possible reasons why this happens, but such avoidance tends to negate an intimate aspect of the client's group identity (Apfelbaum, Sommers, & Norton, 2008; Neville, Gallardo, & Sue, 2016). Dr. D.'s responses toward Gabriella seem to have had this effect. These forms of microinvalidation will be discussed more fully in Chapter 6. As a result of these invalidations, a client of color might feel misunderstood and resentful toward the helping professional, hindering the effectiveness of the counseling. Besides unresolved personal issues arising from counselors, the assumptions embedded in Western forms of therapy exaggerate the chasm between therapists and culturally diverse clients.

First, the concepts of counseling and psychotherapy are uniquely EuroAmerican in origin, as they are based on certain philosophical assumptions and values that are strongly endorsed by Western civilizations. On the one side are beliefs that people are unique and that the psychosocial unit of operation is the individual; on the other side are beliefs that clients are the same and that the goals and techniques of counseling and therapy are equally applicable across all groups. Taken to its extreme, this latter approach nearly assumes that persons of color, for example, are White, and that race and culture are insignificant variables in counseling and psychotherapy (Sue, 2010). Statements such as “There is only one race, the human race” and “Apart from your racial/cultural background, you are no different from me” are indicative of the tendency to avoid acknowledging how race, culture, and other group dimensions may influence identity, values, beliefs, behaviors, and the perception of reality (Lum, 2011; Sue, 2015).

Second, related to the negation of race, we have indicated that a most problematic issue deals with the inclusive or exclusive nature of *multiculturalism*. A number of psychologists have indicated that an inclusive definition of *multiculturalism* (one that includes gender, ability/disability, sexual orientation, and so forth) can obscure the understanding and study of race as a powerful dimension of human existence (Carter, 2005; Helms & Richardson, 1997). This stance is not intended to minimize the importance of the many cultural dimensions of human identity, but rather emphasizes the greater discomfort that many psychologists experience in dealing with issues of race as compared to other sociodemographic differences (Sue, Lin, Torino, Capodilupo, & Rivera, 2009). As a result, race becomes less salient and allows us to avoid addressing problems of racial prejudice, racial discrimination, and systemic racial oppression. This concern appears to have great legitimacy. We have noted, for example, that when issues of race are discussed in the classroom, a mental health agency, or some other public forum, it is not uncommon for participants to refocus the dialogue on differences related to gender, socioeconomic status, or religious orientation. In fact, even when asked to define racism, many people will avoid mentioning the word “race” and instead talk about gender or other forms of discrimination.

On the other hand, many groups often rightly feel excluded from the multicultural debate and find themselves in opposition to one another. Thus, enhancing multicultural understanding and sensitivity means balancing our understanding of the sociopolitical forces that dilute the importance of race, on the one hand, and our need to acknowledge the existence of other

group identities related to social class, gender, ability/disability, age, religious affiliation, and sexual orientation, on the other (Anderson & Middleton, 2011; Sue, 2010).

There is an East Asian saying that goes something like this: “All individuals, in many respects, are (a) like no other individuals, (b) like some individuals, and (c) like all other individuals.” Although this statement might sound confusing and contradictory, many East Asians believe these words to have great wisdom and to be entirely true with respect to human development and identity. We have found the tripartite framework shown in Figure 2.1 (Sue, 2001) to be useful in exploring and understanding the formation of personal identity. The three concentric circles illustrated in Figure 2.1 denote individual, group, and universal levels of personal identity.

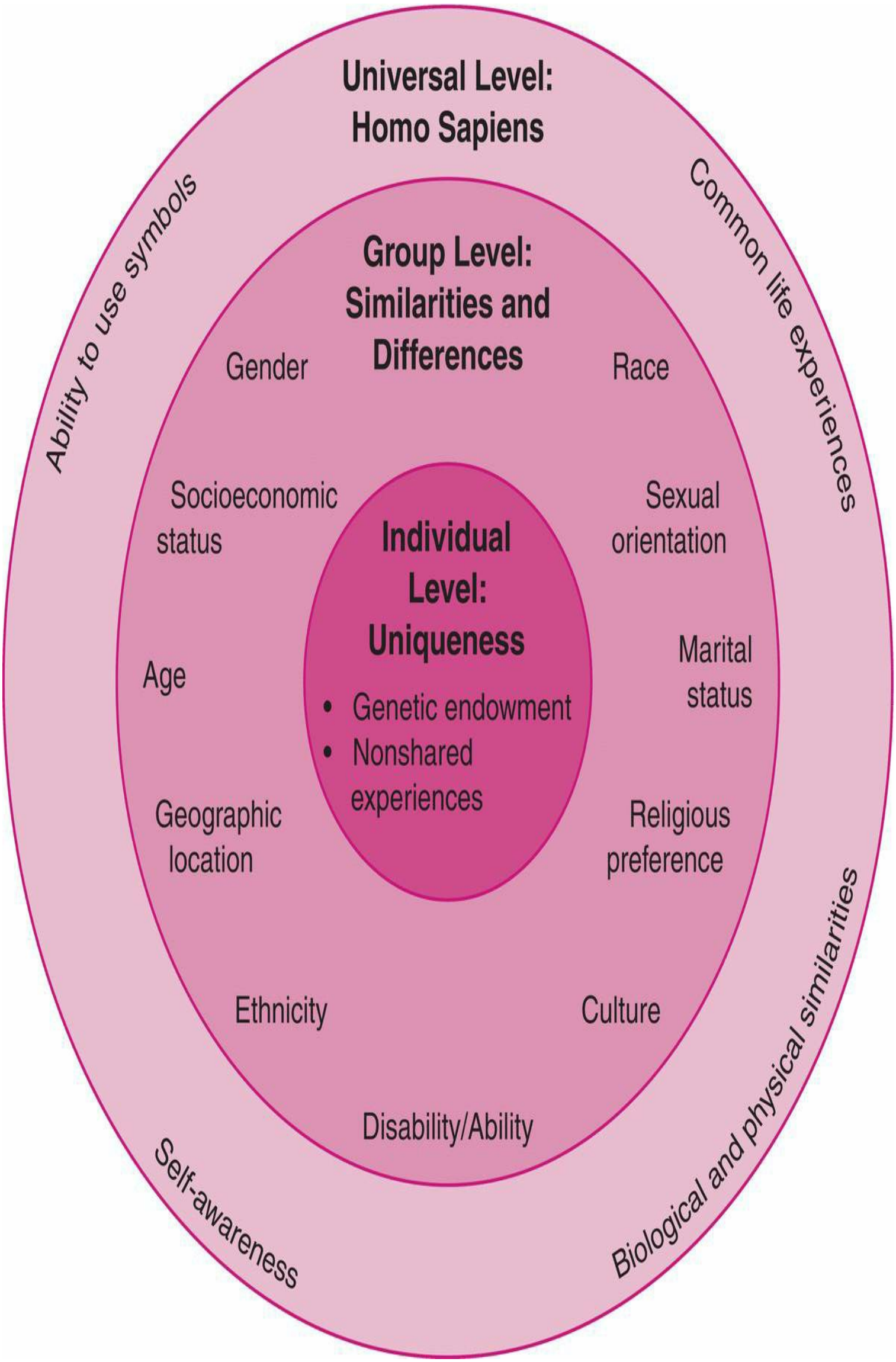
Universal Level:
Homo Sapiens
Ability to use symbols
Common life experiences
Group Level:
Similarities and
Differences
Gender
Race
Socioeconomic
status
Sexual
orientation
Individual
Level:
Uniqueness
• Genetic endowment
• Nonshared
experiences
Age
Marital
status
Geographic
location
Religious
preference
Ethnicity
Culture
Disability/Ability
Self-awareness
Biological and physical similarities

FIGURE 2.1 Tripartite Development of Personal Identity

Select this link to open an interactive version of Figure 2.1.

Individual Level: "All Individuals Are, in Some Respects, Like No Other Individuals"

There is much truth in the saying that no two individuals are identical. We are all unique biologically, and recent breakthroughs in mapping the human genome have provided some startling findings. Biologists, anthropologists, and evolutionary psychologists had looked to the Human Genome Project as potentially providing insights into comparative and evolutionary biology that would allow us to find the secrets to life. Although the project has provided valuable answers to many questions, scientists have discovered even more complex questions. For example, they had expected to find 100,000 genes in the human genome, but only about 20,000 were initially found, with the possible existence of another 5,000—only two or three times more than are found in a fruit fly or a nematode worm. Of those 25,000 genes, only 300 unique genes distinguish us from the mouse. In other words, human and mouse genomes are about 85% identical! Although it may be a blow to human dignity, the important question is how so relatively few genes can account for our humanness.

Likewise, if so few genes can determine such great differences between species, what about within the species? Human inheritance almost guarantees differences, because no two individuals ever share the same genetic endowment. Further, no two of us share the exact same experiences in our society. Even identical twins, who theoretically share the same gene pool and are raised in the same family, are exposed to both shared and nonshared experiences. Different experiences in school and with peers, as well as qualitative differences in how parents treat them, will contribute to individual uniqueness. Research indicates that psychological characteristics, behavior, and mental disorders are more affected by experiences specific to a child than are shared experiences (Bale et al., 2010; Foster & MacQueen, 2008).

Group Level: "All Individuals Are, in Some Respects, Like Some Other Individuals"

As mentioned earlier, each of us is born into a cultural matrix of beliefs, values, rules, and social practices. By virtue of social, cultural, and political distinctions made in our society, perceived group membership exerts a powerful influence over how society views sociodemographic groups and over how its members view themselves and others. Group markers such as race and gender are relatively stable and not very subject to change. Some markers, such as education, socioeconomic status, marital status, and geographic location, are more fluid and changeable. Although ethnicity is fairly stable, some argue that it can also be fluid. Likewise, debate and controversy surround discussions about whether sexual orientation is determined at birth and whether we should be speaking of sexuality or sexualities (Sue et al., 2016). Nevertheless, membership in these groups may result in shared experiences and characteristics. Group identities may serve as powerful reference groups in the formation of *worldviews*. On the *group level of identity*, Figure 2.1 reveals that people may belong to more than one cultural group (e.g., an Asian American female with a disability), that some group identities may be more salient than others (e.g., race over religious orientation), and that the salience of cultural group identity may shift from one to the other depending on the situation. For example, a gay man with a disability may find that his disability identity is more salient among the able‐bodied but that his sexual orientation is

more salient among those with disabilities. We are drawn to exploring experiences based on our social identities; we often read books, listen to music, watch TV shows or movies by or about people who are similar to us in terms of race, gender, sexual orientation, or any combination thereof.

Universal Level: "All Individuals Are, in Some Respects, Like All Other Individuals"

Because we are members of the human race and belong to the species *Homo sapiens*, we share many similarities. Universal to our commonalities are (a) biological and physical similarities, (b) common life experiences (birth, death, love, sadness, and so forth), (c) self‐awareness, and (d) the ability to use symbols, such as language. In Shakespeare's *Merchant of Venice*, Shylock attempts to acknowledge the universal nature of the human condition by asking, "When you prick us, do we not bleed?" Again, although the Human Genome Project indicates that a few genes may cause major differences between and within species, it is startling how similar the genetic material within our chromosomes is and how much we share in common. However, that we are similar at a broad human level does not erase our individual and cultural uniqueness.

REFLECTION AND DISCUSSION QUESTIONS

1. Select three group identities you possess (e.g., race, gender, sexual orientation, disability, religion, socioeconomic status, and so forth). Of the three you have chosen, which one is most salient to you? Why? Does it shift or change? How aware are you of other social group identities?
2. Using the tripartite framework just discussed, can you outline ways in which you are unique, share characteristics with only certain groups, and share similarities with everyone?
3. Can someone truly be color‐blind to race? What makes seeing and acknowledging differences so difficult? In what ways does a color‐blind approach hinder the counseling relationship when working with diverse clients?

Video 2.3: It's Not Always About Being a Minority, but Sometimes It Is

Maintaining self-awareness during the counseling session so that you aren't dismissive of your client's unique, lived experience.

INDIVIDUAL AND UNIVERSAL BIASES IN PSYCHOLOGY AND MENTAL HEALTH

Psychology—and mental health professionals in particular—has generally focused on either the *individual* or the *universal levels of identity*, placing less importance on the group level. There are several reasons for this orientation. First, our society arose from the concept of rugged individualism, and we have traditionally valued autonomy, independence, and uniqueness. Our culture assumes that individuals are the basic building blocks of our society. Sayings such as “Be your own person (à la Dr. D.),” “Stand on your own two feet,” and “Don't depend on anyone but yourself” reflect this value. Psychology and education represent the carriers of this value, and the study of individual differences is most exemplified in the individual intelligence testing movement that pays homage to individual uniqueness (Suzuki et al., 2005).

Second, the universal level is consistent with the tradition of psychology, which has historically sought universal facts, principles, and laws in explaining human behavior. Although this is an important quest, the nature of scientific inquiry has often meant studying phenomena independently of the context in which human behavior originates. Thus, therapeutic interventions from which research findings are derived may lack external validity (Chang & Sue, 2005).

Third, we have historically neglected the study of identity at the group level for sociopolitical and normative reasons. As we have seen, issues of race, gender, sexual orientation, and disability seem to touch hot buttons in all of us because they bring to light issues of oppression and the unpleasantness of personal biases (Lo, 2010; Zetzer, 2011). In addition, racial and ethnic differences have frequently been interpreted from a deficit perspective and have been equated with being abnormal or pathological (Guthrie, 1997; Parham et al., 2011). We have more to say about this in Chapter 4.

Disciplines that hope to understand the human condition cannot neglect any level of our identity. For example, psychological explanations that acknowledge the importance of group influences such as gender, race, ethnicity, sexual orientation, socioeconomic class, and religious affiliation lead to a more accurate understanding of human psychology. Failure to acknowledge these influences may skew research findings and lead to biased conclusions about human behavior that are culture‐bound, class‐bound, and gender‐bound.

Thus, it is possible to conclude that all people possess *individual*, *group*, and *universal levels of identity*. A holistic approach to understanding personal identity demands that we recognize all three levels: individual (uniqueness), group (shared cultural values, beliefs, and experiences), and universal (common features of being human). Because of the historical scientific neglect of the *group level of identity*, this text focuses primarily on this category.

Although the concentric circles in Figure 2.1 might unintentionally suggest a clear boundary, each level of identity must be viewed as permeable and ever‐changing in salience. In counseling and psychotherapy, for example, a client might view his or her uniqueness as important at one point in the session and stress commonalities of the human condition at another. Even within the *group level of identity*, multiple forces may be operative. As mentioned earlier, the *group level of identity* reveals many reference groups, both fixed and nonfixed, that might impact our lives. Being an elderly gay male Latino, for example, represents four potential reference groups operating on the person; the cultural groups also includes membership in multiple social identities, such as American Indian queer woman and White heterosexual man. The *culturally responsive* helping professional must be willing and

able to balance understanding the three levels of personality without negating any aspect of their identity, particularly at the group level.

Video 2.4: Victim Blaming

Staying attentive to your minority clients in order to utilize the most effective and relevant therapies to address their needs.

THE IMPACT OF GROUP IDENTITIES ON COUNSELING AND PSYCHOTHERAPY

Accepting the premise that race, ethnicity, and culture are powerful variables in influencing how people think, make decisions, behave, and define events, it is not far‐fetched to conclude that such forces may also affect how different groups define a helping relationship (Herlihy & Corey, 2015). *Culturally responsive* psychologists have long noted, for example, that different theories of counseling and psychotherapy represent different *worldviews*, each with its own values, biases, and assumptions about human behavior (Geva & Wiener, 2015). Given that U.S. schools of counseling and psychotherapy arise from Western European contexts, the *worldview* that they espouse as reality may not be shared by racial/ethnic minority groups in the United States, or by those who reside in different countries (Parham et al., 2011). Each racial, ethnic, or cultural group has its own perspective on the nature of people, the origin of disorders, standards for judging normality and abnormality, and therapeutic approaches.

Among many Asian Americans, for example, a self‐orientation is considered undesirable, whereas a group orientation is highly valued (Kim, 2011). The Japanese have a saying that goes like this: “The nail that stands up should be pounded back down.” The meaning seems clear: healthy development is considering the needs of the entire group, whereas unhealthy development is thinking only of oneself. Likewise, relative to their EuroAmerican counterparts, many African Americans value the emotive and affective qualities of interpersonal interactions as qualities of sincerity and authenticity (West‐Olatunji & Conwill, 2011). EuroAmericans often view the passionate expression of affect as irrational, impulsive, immature, and lacking objectivity on the part of the communicator. Thus, the autonomy‐oriented goal of counseling and psychotherapy and the objective focus of the therapeutic process might prove antagonistic to the *worldviews* of some Asian Americans and African Americans, respectively.

It is therefore highly probable that different racial and ethnic minority groups perceive the competence of the helping professional differently than do mainstream client groups. Further, if race and ethnicity affect perception, what about other group differences, such as gender and sexual orientation? Minority clients may see a clinician who exhibits therapeutic *skills* that are associated primarily with mainstream therapies as having lower credibility. The important question to ask is, “Do such groups as racial/ethnic minorities define *cultural competence* differently than do their EuroAmerican counterparts?” Anecdotal observations, clinical case studies, conceptual analytical writings, and some empirical studies seem to suggest an affirmative response (Fraga, Atkinson, & Wampold, 2002; Garrett & Portman, 2011; Guzman & Carrasco, 2011; McGoldrick, Giordano, & Garcia‐Preto, 2005).

Video 2.5: Switching Up the Game

Emphasizing the counseling relationship as a two-way street, rather than a one-way tunnel, in counseling minority populations.

WHAT IS MULTICULTURAL COUNSELING AND THERAPY (MCT)?

In light of the previous analysis, let us define *multicultural counseling and therapy* (MCT) as it relates to the therapy process and the roles of the mental health practitioner:

> *Multicultural counseling and therapy can be defined as both a helping role and a process that uses modalities and defines goals consistent with the life experiences and cultural values of clients; recognizes client identities to include individual, group, and universal dimensions; advocates the use of universal and culture‐specific strategies and roles in the healing process; and balances the importance of individualism and collectivism in the assessment, diagnosis, and treatment of client and client systems.*
>
> *(Sue & Torino, 2005)*

This definition often contrasts markedly with traditional views of counseling and psychotherapy. A more thorough analysis of these characteristics is described in Chapter 7. For now, let us extract the key phrases in our definition and expand their implications for clinical practice.

1. *Helping role and process*. MCT broadens the roles that counselors play and expands the repertoire of therapy *skills* considered helpful and appropriate in counseling. The more passive and objective stance taken by therapists in clinical work is seen as only one method of helping. Likewise, teaching, consulting, and advocacy can supplement the conventional counselor or therapist role.
2. *Consistent with life experiences and cultural values*. Effective MCT means using modalities and defining goals for culturally diverse clients that are consistent with their racial, cultural, ethnic, gender, and sexual‐orientation backgrounds. Advice and suggestions, for example, may be effectively used for some client populations.
3. *Individual, group, and universal dimensions of existence*. As we have already seen, MCT acknowledges that our existence and identity are composed of individual (uniqueness), group, and universal dimensions. Any form of helping that fails to recognize the totality of these dimensions negates important aspects of a person's identity.
4. *Universal and culture‐specific strategies*. MCT believes that different racial and ethnic minority groups might respond best to culture‐specific strategies of helping or culturally adaptive interventions. Such counseling takes into consideration how the client defines or understands their concern over and incorporation of culturally relevant concepts such as intergenerational stress, face‐saving, cultural mistrust, and racial and ethnic socialization.
5. *Individualism and collectivism*. MCT broadens the perspective of the helping relationship by balancing the individualistic approach with a collectivistic reality that acknowledges our embeddedness in families, relationships with significant others, communities, and cultures. A client is perceived not just as an individual, but as an individual who is a product of his or her social and cultural context.
6. *Client and client systems*. MCT assumes a dual role in helping clients. In many cases, for example, it is important to focus on individual clients and to encourage them to achieve insights and learn new behaviors. However, when problems of clients of color reside in prejudice, discrimination, and racism of employers, educators, and neighbors or in organizational policies or practices in schools, mental health agencies, government,

businesses, and society, the traditional therapeutic role appears ineffective and inappropriate. The focus for change must shift to altering client systems rather than individual clients.

Video 2.6: Unlearning How to Counsel Cultural Minorities

Analysis of counseling session by Drs. Derald Wing Sue and Joel Filmore.

WHAT IS CULTURAL COMPETENCE?

Consistent with the definition of MCT, it becomes clear that *culturally responsive* healers are working toward several primary goals (American Psychological Association, 2003, 2017; Sue et al., 1992, 1998). First, culturally competent helping professionals are ones who are actively in the process of becoming aware of their own values, biases, assumptions about human behavior, preconceived notions, personal limitations, and so forth. Second, culturally competent helping professionals are ones who actively attempt to understand the *worldview* of their culturally diverse clients and the sociohistorical context in which that worldview develops. In other words, what are the client's values and assumptions about human behavior, biases, and so on? Third, culturally competent helping professionals are ones who are in the process of actively developing and practicing appropriate, relevant, and sensitive intervention strategies and *skills* in working with their culturally diverse clients. These three attributes make it clear that *cultural competence* is an active, developmental, and ongoing process and that it is aspirational rather than achieved. Specifically, we define *cultural competence* in the following manner.

> Cultural competence is a lifelong process in which one works to develop the ability to engage in actions or create conditions that maximize the optimal development of client and client systems. Multicultural counseling competence is aspirational and consists of counselors acquiring awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds), and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups.
>
> (Sue & Torino, 2005)

This definition of *cultural competence* in the helping professions makes it clear that the conventional one‐to‐one, in‐the‐office, objective form of treatment aimed at remediation of existing problems may be at odds with the sociopolitical and cultural experiences of clients. Like the complementary definition of MCT, it addresses not only clients (individuals, families, and groups) but also client systems (institutions, policies, and practices that may be unhealthy or problematic for healthy development). Addressing client systems is especially important if problems reside outside rather than inside the client. For example, prejudice and discrimination such as racism, sexism, and homophobia may impede the healthy functioning of individuals and groups in our society.

Second, *cultural competence* can be seen as residing in three major domains: (a) attitudes/beliefs component—an understanding of one's own cultural conditioning and how this conditioning affects the personal beliefs, values, and attitudes of a culturally diverse population; (b) knowledge component—understanding and knowledge of the *worldviews* and cultural contexts of culturally diverse individuals and groups; and (c) *skills* component—an ability to determine and use culturally appropriate intervention strategies when working with different groups in our society. Cultural humility is a key component of cultural competence, as it serves as the conduit in which awareness, knowledge, and skills are expressed. Box 2.1 provides an outline of *cultural competencies* related to the three major domains; cultural humiliation is discussed later.

BOX 2.1 MULTICULTURAL COUNSELING COMPETENCIES

1. *Awareness*
    1. Moved from being culturally unaware to being aware and sensitive to their own cultural heritage and to valuing and respecting differences.
    2. Aware of their own values and biases and of how they may affect diverse clients.
    3. Comfortable with differences that exist between themselves and their clients in terms of race, gender, sexual orientation, and other social identity variables. Differences are not seen as deviant.
    4. Sensitive to circumstances (personal biases; stage of racial, gender, and sexual orientation identity; sociopolitical influences; etc.) that may dictate referral of clients to members of their own social identity group(s) or to different therapists in general.
    5. Aware of their own racist, sexist, heterosexist, or other detrimental attitudes, beliefs, and feelings.
2. *Knowledge*
    1. Knowledgeable and informed on a number of culturally diverse groups, especially groups with whom therapists work.
    2. Knowledgeable about the sociopolitical system's operation in the United States with respect to its treatment of marginalized groups in society.
    3. Possessing specific *knowledge* and understanding of the generic characteristics of counseling and therapy.
    4. Knowledgeable about the institutional barriers that prevent some diverse clients from using mental health services.
3. *Skills*
    1. Able to generate a wide variety of verbal and nonverbal helping responses.
    2. Able to communicate (send and receive both verbal and nonverbal messages) accurately and appropriately.
    3. Able to exercise institutional intervention *skills* on behalf of clients, when appropriate.
    4. Able to anticipate the impact of one's helping styles and of their limitations on culturally diverse clients.
    5. Able to play helping roles characterized by an active systemic focus, which leads to environmental interventions. Not restricted by the conventional counselor/therapist mode of operation.

    Sources: Sue et al. (1992, 1998). Readers are encouraged to review the original 34 multicultural competencies, which are fully elaborated in both publications.

Third, in a broad sense, this definition is directed toward two levels of *cultural competence*: the personal/individual and the organizational/system levels. The work on *cultural competence* has generally focused on the micro level: the individual. In the education and training of psychologists, for example, the goals have been to increase the level of self - awareness of trainees (potential biases, values, and assumptions about human behavior); to impart knowledge of the history, culture, and life experiences of various minority groups; and to aid in developing culturally appropriate and adaptive interpersonal *skills* (clinical work,

management, conflict resolution, etc.). Less emphasis is placed on the macro level: the profession of psychology, organizations, and the society in general (Lum, 2011; Sue, 2001). We suggest that it does little good to train culturally competent helping professionals when the very organizations that employ them are monocultural and discourage or even punish psychologists for using their culturally competent knowledge and *skills*. If our profession is interested in the development of *cultural competence*, then it must become involved in impacting systemic and societal levels as well.

Fourth, our definition of *cultural competence* speaks strongly to the development of alternative helping roles. Much of this comes from recasting healing as involving more than one - to - one therapy. If part of *cultural competence* involves systemic intervention, then such roles as consultant, change agent, teacher, and advocate supplement the conventional role of therapy. In contrast to this role, alternatives are characterized by the following:

- Having a more active helping style
- Working outside the office (home, institution, or community)
- Being focused on changing environmental conditions, as opposed to changing the client
- Viewing the client as encountering problems rather than as having a problem
- Being oriented toward prevention rather than remediation
- Shouldering increased responsibility for determining the course and the outcome of the helping process

It is clear that these alternative roles and their underlying assumptions and practices have not been historically perceived as activities consistent with counseling and psychotherapy.

Last, *cultural competence* incorporates an orientation of *cultural humility* (American Psychological Association, 2017; Gallardo, 2014). The concept of *cultural humility* was first coined in medical education, where it was associated with an open attitudinal stance or a multicultural open orientation to diverse patients (Tervalon & Murray - Garcia, 1998). The term has found its way into the MCT field, where it also refers to an openness to working with culturally diverse clients (Hook, Davis, Owen, Worthington, & Utsey, 2013; Owen et al., 2014). As more counselors and psychologists have begun to study *cultural humility*, it has become clear that this concept is a “way of being” rather than a “way of doing,” which characterizes *cultural competence* (Owen, Tao, Leach, & Rodolfa, 2011). Cultural humility as an orientation or disposition is thus necessary to facilitate cultural awareness, knowledge, and skills. A counselor must adopt an open, inquisitive orientation in order to engage in self - reflection and to learn from clients and marginalized communities, which are key ingredients of cultural competence. In a therapeutic context, *cultural humility* of therapists (a) is considered very important to many socially marginalized clients, (b) correlates with a higher likelihood of continuing in treatment, (c) strongly relates to the strength of the therapeutic alliance, and (d) is related to perceived benefit and improvement in therapy (Hook et al., 2016). Thus, *cultural humility* as a dispositional orientation may be equally important as three major *cultural competence* domains (awareness, knowledge, and skills) in MCT. We further discuss the relevance of cultural humility in Chapter 4 and throughout the text.

SOCIAL JUSTICE AND CULTURAL COMPETENCE

Building on the multicultural counseling competencies devised by D. W. Sue et al. (1992), the American Counseling Association (ACA) developed Multicultural and Social Justice Counseling Competencies (MSJCC) (Ratts, Singh, Nassar‐McMillan, Butler, & McCullough, 2015). As indicated in Chapter 4, at the heart of the MSJCC is the integration of *social justice* competencies with multicultural competencies. Acknowledging that *multiculturalism* leads to *social justice* initiatives and actions, the MSJCC propose a conceptual framework that includes *quadrants* (privilege and oppressed statuses), *domains* (counselor self‐awareness, client *worldview*, counseling relationships, and counseling and advocacy interventions), and *competencies* (attitudes and beliefs, knowledge, skills, and action).

Perhaps the most important aspect of the proposed MSJCC is seen in the *quadrants* category, where they identify four major relationships between counselor and client that directly address matters of power and privilege: (a) a privileged counselor working with an oppressed client, (b) a privileged counselor working with a privileged client, (c) an oppressed counselor working with a privileged client, and (d) an oppressed counselor working with an oppressed client. When applied to racial/ethnic counseling/therapy, various combinations can occur: (a) a White counselor working with a racial or ethnic minority client, (b) a White counselor working with a White client, (c) a racial or ethnicity minority client working with a White client, and (d) a racial or ethnic minority counselor working with a racial or ethnic minority client. Analysis and research regarding these dyadic combinations have seldom been carried out in the multicultural psychology field. Further, little in the way of addressing counseling work with interracial/interethnic combinations is seen in the literature. We address this topic in the next chapter. We will also cover the issues raised in the MSJCC framework more thoroughly in Chapters 3–5. In Chapter 3, we focus on enumerating the quadrants of power and privilege relationships between counselor and client, in Chapter 4, we address the importance of *social justice* advocacy and action on behalf of the client, and in Chapter 5, we deal with individual and systems‐level work.

REFLECTION AND DISCUSSION QUESTIONS

1. If the basic building blocks of acquiring *cultural competence* in clinical practice are *awareness, knowledge*, and *skills*, how do you hope to develop competency? Can you list the various educational and training activities you would need in order to work effectively with a client who differed from you in terms of race, gender, or sexual orientation?
2. What are your thoughts about the basic building blocks of *cultural competence*? What are your thoughts regarding *cultural humility*, especially as a conduit to developing cultural awareness, knowledge, and skills? How would you define cultural competence?
3. Look at the six characteristics that define alternative roles for helping culturally diverse clients. Which of these roles are you most comfortable playing? Why? Which of these activities would make you uncomfortable? Why?

IMPLICATIONS FOR CLINICAL PRACTICE

1. Know that the definition of *multiculturalism* is inclusive and encompasses race, culture,

gender, religious affiliation, sexual orientation, age, disability, and so on.

2. When working with diverse populations, attempt to identify culture - specific and culture - universal domains of helping.
3. Be aware that persons of color, LGBTQ people, women, and other groups may perceive mental illness/health and the healing process differently than do EuroAmerican men.
4. Do not disregard differences and impose the conventional helping role and process on culturally diverse groups, as such actions may constitute cultural oppression.
5. Be aware that EuroAmerican healing standards originate from a cultural context and may be culture - bound. As long as counselors and therapists continue to view EuroAmerican standards as normative, they may judge others as abnormal.
6. Realize that the concept of *cultural competence* is more inclusive and superordinate than is the traditional definition of *clinical competence*. Do not fall into the trap of thinking "good counseling is good counseling."
7. If you are planning to work with the diversity of clients in our world, you must play roles other than that of the conventional counselor.
8. Use modalities that are consistent with the lifestyles and cultural systems of your clients, as well as with your training.
9. Understand that one's multicultural orientation (*cultural humility*) is very important to successful multicultural counseling.

Video Lecture: Cultural Competence in the Helping Professions

SUMMARY

Traditional definitions of counseling, therapy, and mental health practice arise from monocultural and ethnocentric norms that may be antagonistic to the lifestyles and cultural values of diverse groups. These Western worldviews reflect a belief in the universality of the human condition, a belief that disorders are similar and cut across societies, and a conviction that mental health concepts are equally applicable across all populations and disorders. These *worldviews* also often fail to consider the different cultural and sociopolitical experiences of marginalized group members. As a result, counseling and therapy may often be inappropriate to marginalized groups in our society, resulting in cultural oppression. The movement to redefine counseling/therapy and identify aspects of *cultural competence* in mental health practice has been advocated by nearly all multicultural counseling specialists.

MCT is defined as both a helping role and a process that uses modalities and defines goals consistent with the life experiences and cultural values of clients; that recognizes client identities to include individual, group, and universal dimensions; that advocates the use of universal and culture‐specific strategies and roles in the healing process; and that balances the importance of individualism and *collectivism* in the assessment, diagnosis, and treatment of clients and client systems. Thus, *cultural competence* is the ability to engage in actions or create conditions that maximize the optimal development of clients and client systems.

On a personal developmental level, *multicultural counseling competence* is defined as a counselor's acquisition of the *awareness*, *knowledge*, and *skills* and the *cultural humility* needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds); on an organizational/societal level, it is defined as advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups. Another attribute, *cultural humility*, seems central to effective *multicultural counseling*. *Cultural humility* appears more like a “way of being” than a “way of doing.” The attitudinal components of respect for others, an egalitarian stance, and diminished superiority over clients mean an “other‐orientation” rather than a self‐focus. Finally, it appears that there is a strong need to integrate social justice competencies with *cultural competence*. Becoming culturally competent is a lifelong journey but promises much in providing culturally appropriate services to all groups in our society.

GLOSSARY TERMS

- Awareness
- Collectivism
- Cultural competence
- Cultural humility
- Cultural relativism
- Culturally responsive
- Culture bound syndromes
- Emic (culturally specific)
- Etic (culturally universal)
- Group level of identity
- Individual level of identity
- Knowledge
- Multicultural counseling and therapy (MCT)
- Multiculturalism
- Skills
- Social justice
- Universal level of identity
- Worldview

Video 2.10: Counseling Session Analysis

Introduction to the counseling session.

REFERENCES

1. American Psychological Association (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, *58*, 377–402.

2. American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.

3. American Psychological Association. (2017). Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality. Retrieved from http://www.apa.org/about/policy/multicultural‐guidelines.pdf.

4. Anderson, S. H., & Middleton, V. A. (Eds.) (2011). *Explorations in diversity: Examining privilege and oppression in a multicultural society* (2nd ed.). Belmont, CA: Thomson Brooks/Cole.

5. Apfelbaum, E. P., Sommers, S. R., & Norton, M. I. (2008). Seeing race and seeming racist: Evaluating strategic colorblindness in social interaction. *Journal of Personality and Social Psychology*, *95*, 918–932.

6. Arnett, J. J. (2009). The neglected 95%: Why American psychology needs to become less American. *American Psychologist*, *63*, 602–614.

7. Arredondo, P., Toporek, M. S., Brown, S., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). *Operationalization of the multicultural counseling competencies*. Alexandria, VA: Association of Multicultural Counseling and Development.

8. Arredondo, P., Gallardo‐Cooper, M., Delgado‐Romero, E. A., & Zapata, A. L. (2014). *Culturally responsive counseling with Latinas/os*. Alexandria, VA: American Counseling Association.

9. Bale, T. L., Baram, T. Z., Brown, A. S., Goldstein, J. M., Insel, T. R., McCarthy, M. M., … Nestler, E. J. (2010). Early life programming and neurodevelopmental disorders. *Biological Psychiatry*, *68*, 314–319.

10. Carter, R. T. (Ed.) (2005). *Handbook of racial‐cultural psychology and counseling*. Hoboken, NJ: Wiley.

11. Chang, J., & Sue, S. (2005). Culturally sensitive research: Where have we gone wrong and what do we need to do now? In M. G. Constantine, & D. W. Sue (Eds.), *Strategies for building multicultural competence in mental health and educational settings* (pp. 229–246). Hoboken, NJ: Wiley.

12. Comas‐Diaz, L. (2010). On being a Latina healer: Voice, conscience and identity. *Psychotherapy Theory, Research, Practice, Training*, *47*, 162–168.

13. Cornish, J. A. E., Schreier, B. A., Nadkarni, L. I., Metzger, L. H., & Rodolfa, E. R. (2010). *Handbook of multicultural counseling competencies*. Hoboken, NJ: Wiley.

14. Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) (2015). *2016 CACREP Standards*. Fairfax, VA: CACREP.

15. Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of care*. Washington, DC: Child and Adolescent Service System

Program Technical Assistance Center.

16. Foster, J. A., & MacQueen, G. (2008). Neurobiological factors linking personality traits and major depression. *La Revue Canadienne de Psychiatrie, 53*, 6–13.

17. Fraga, E. D., Atkinson, D. R., & Wampold, B. E. (2002). Ethnic group preferences for multicultural counseling competencies. *Cultural Diversity and Ethnic Minority Psychology*, *10*, 53–65.

18. Gallardo, M. E. (2014). *Developing cultural humility*. Thousand Oaks, CA: Sage.

19. Garrett, M. T., & Portman, T. A. A. (2011). *Counseling Native Americans*. Belmont, CA: Cengage.

20. Geva, E., & Wiener, J. (2015). *Psychological assessment of culturally and linguistically diverse children and adolescents*. New York, NY: Springer.

21. Guthrie, R. V. (1997). *Even the rat was White: A historical view of psychology* (2nd ed.). New York, NY: Harper & Row.

22. Guzman, M. R., & Carrasco, N. (2011). *Counseling Latino/a Americans*. Belmont, CA: Cengage.

23. Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta‐analysis of cultural adaptations of psychological interventions. *Behavior Therapy*, *47*(6), 993–1014.

24. Helms, J. E., & Richardson, T. Q. (1997). How multiculturalism obscures race and culture as different aspects of counseling competency. In D. B. Pope‐Davis, & H. L. K. Coleman (Eds.), *Multicultural counseling competencies* (pp. 60–79). Thousand Oaks, CA: Sage.

25. Herlihy, B., & Corey, G. (2015). *Boundary issues in counseling*. Alexandria, VA: American Counseling Association.

26. Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*, 353–366.

27. Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., Van Tongeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. *Journal of Counseling Psychology*, *63*(3), 269.

28. Howard, R. (1992). Folie à deux involving a dog. *American Journal of Psychiatry*, *149*, 414.

29. Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2014). *Intentional interviewing and counseling* (8th ed.). Belmont, CA: Brooks/Cole.

30. Kail, R. V., & Cavanaugh, J. C. (2013). *Human development: A life‐span view* (6th ed.). Belmont, CA: Brooks/Cole.

31. Kim, B. S. K. (2011). *Counseling Asian Americans*. Belmont, CA: Cengage.

32. Lo, H.‐W. (2010). My racial identity development and supervision: A self‐reflection. *Training and Education in Professional Psychology*, *4*, 26–28.

33. Locke, D. C., & Bailey, D. F. (2014). *Increasing multicultural understanding*. Thousand

Oaks, CA: Sage.

34. Lum, D. (2011). *Culturally competent practice*. Belmont, CA: Cengage.

35. McGoldrick, M., Giordano, J., & Garcia‐Preto, N. (2005). *Ethnicity and family therapy*. New York, NY: Guilford Press.

36. Neville, H. A., Gallardo, M. E., & Sue, D. W. (2016). *The myth of racial color blindness: Manifestation, dynamics, and impact*. Washington, DC: American Psychological Association.

37. Owen, J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy*, *48*, 274–282.

38. Owen, J., Jordan, T. A., Turner, D., Davis, D. E., Hook, J. N., & Leach, M. M. (2014). Therapists' multicultural orientation: Client perceptions of cultural humility, spiritual/religious commitment, and therapy outcomes. *Journal of Psychology and Theology*, *42*, 91–98.

39. Parham, T. A., Ajamu, A., & White, J. L. (2011). *The psychology of Blacks. Centering our perspectives in the African consciousness*. Boston, MA: Prentice Hall.

40. Ponterotto, J. G., Utsey, S. O., & Pedersen, P. B. (2006). *Preventing prejudice: A guide for counselors, educators, and parents*. Thousand Oaks, CA: Sage.

41. Ratts, M. J., & Pedersen, P. B. (2014). *Counseling for multiculturalism and social justice*. Alexandria, VA: American Counseling Association.

42. Ratts, M. J., Singh, A. A., Nassar‐McMillan, S., Butler, K., & McCullough, R. J. (2015). Multicultural and social justice counseling competencies. The Multicultural Counseling Competencies Revision Committee of the American Counseling Association, Draft Report.

43. Ridley, C. R. (2005). *Overcoming unintentional racism in counseling and therapy* (2nd ed.). Thousand Oaks, CA: Sage.

44. Ridley, C. R., Mollen, D., & Kelly, S. M. (2011). Beyond microskills: Toward a model of counseling competence. *The Counseling Psychologist*, *39*, 825–864.

45. Smith, T. B., & Trimble, J. E. (2016). *Foundations of multicultural psychology: Research to inform effective practice*. Washington, DC: American Psychological Association.

46. Sue, D., Sue, D. W., Sue, D. M., & Sue, S. (2016). *Understanding abnormal behavior*. Stamford, CT: Cengage.

47. Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist*, *29*, 790–821.

48. Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, NJ: Wiley.

49. Sue, D. W. (2015). *Race talk and the conspiracy of silence: Understanding and facilitating difficult dialogues on race*. Hoboken, NJ: Wiley.

50. Sue, D. W., & Torino, G. C. (2005). Racial cultural competence: Awareness, knowledge and skills. In R. T. Carter (Ed.), *Handbook of racial‐cultural psychology and*

counseling (pp. 3–18). Hoboken, NJ: Wiley.

51. Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural competencies/standards: A call to the profession. *Journal of Counseling and Development, 70*(4), 477–486.

52. Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., & Vazquez‐Nutall, E. (1998). *Multicultural counseling competencies: Individual and organizational development*. Thousand Oaks, CA: Sage.

53. Sue, D. W., Lin, A. I., Torino, G. C., Capodilupo, C. M., & Rivera, D. P. (2009). Racial microaggressions and difficult dialogues on race in the classroom. *Cultural Diversity and Ethnic Minority Psychology, 15*, 183–190.

54. Suzuki, L. A., Kugler, J. F., & Aguiar, L. J. (2005). Assessment practices in racial‐cultural psychology. In R. T. Carter (Ed.), *Handbook of racial‐cultural psychology and counseling* (pp. 297–315). Hoboken, NJ: Wiley.

55. Tervalon, M., & Murray‐Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*, 117–125.

56. West‐Olatunji, C. A., & Conwill, W. (2011). *Counseling African Americans*. Belmont, CA: Cengage.

57. Zetzer, H. A. (2011). White out: Privilege and its problems. In S. H. Anderson, & V. A. Middleton (Eds.), *Explorations in diversity: Examining privilege and oppression in a multicultural society* (pp. 11–24). Belmont, CA: Cengage.

3
Multicultural Counseling Competence for Counselors and Therapists of Marginalized Groups

Chapter Objectives

1. **1. Learn the importance of cultural competence and cultural humility for trainees of color, and other marginalized group trainees.**
2. **2. Identify the major obstacles that prevent honest dialogue between and among groups of color and other *socially marginalized group* members.**
3. **3. Describe the common stereotypes that people of color have toward one another.**
4. **4. Learn how the historical relationships between groups of color affect their current attitudes toward one another.**
5. **5. Identify group differences that may serve as barriers to *multicultural counseling*.**
6. **6. Become aware of how attitudes and beliefs between groups of color can interfere with interracial and interethnic counseling.**
7. **7. Identify therapeutic barriers likely to arise between a counselor of color and a White client.**
8. **8. Identify therapeutic barriers likely to arise between a counselor of color and a client of color.**

As a professor of color who has taught many courses on *multicultural counseling* and therapy (MCT) and conducted numerous workshops on race relations, I [Derald Sue] have always been aware that my teaching and training were primarily directed at educating White trainees and counselors to their own biases and assumptions about human behavior. I operated from the assumption that people of color knew much of the material on oppression, discrimination, and stereotyping. After all, I reasoned, we were members of the oppressed group and had experiential knowledge of how racism harmed us.

Additionally, there is legitimacy as to why greater emphasis has been placed on the education of White trainees: (a) the majority of counseling and mental health providers are White or members of the majority group; (b) the theories and practices of counseling/therapy arise from a predominantly White, Western perspective and form the educational foundations of our graduate programs; and (c) White, male, and straight EuroAmericans continue to control and hold power in being able to determine the definitions of normality and abnormality and to define mental health reality for marginalized groups. Even if counselors and therapists of color work with other culturally diverse groups, they are generally educated in White, Western ways of describing, explaining, diagnosing, and treating mental disorders. Thus, there is great justification for continuing to focus primarily upon the education and training of those who control the gateways to the delivery of mental health services to socially devalued client populations.

Yet, even in the face of these legitimate reasons, in the back of my mind, I knew that I was shortchanging my trainees of color. I knew that although they most likely had experiential knowledge about the harms of racism, they had biases and prejudices toward one another. I also knew that oftentimes their strong negative reactions toward White fellow students (albeit often justified) could prevent their development toward cultural competence (Ratts & Pedersen, 2014). I understood that much of my trepidation in addressing interracial and interethnic relations had to do with presenting a united front among people of color, and I erroneously operated from a “common enemy” perspective (Sue, 2015). I recognized that by taking this stance, I was perpetuating the belief that only Whites needed to change. It was clear that avoiding broader discussions of interethnic relations blocked the ability of people of

color to more deeply explore their own biased beliefs about their own group and one another. With this realization, I became more active in addressing these issues in my classes and workshops, often pushing emotional hot buttons in some participants of color. The following journal entry made by a former African American student, “Briana,” illustrates this point.

> *I've been angry at Professor Sue for this whole semester. I wish that they would have had a Black professor teach the class. How could he possibly have given me a B− in the midterm [racial counseling lab course]? I'll bet the White students got better grades. As a Black woman I know racism firsthand. They [White students] don't get it and still get better grades. And then we have to keep this stupid journal so he [the professor] can have the TA help us process our feelings. I don't care if you read this stupid journal or not … I know what I feel and why … Well, I'm angry and furious that you gave me a low grade … I'm angry at the White students who hide their racism and just say the right things in class. They are phonies. They are scared to death of me … I just won't put up with their lies and I don't care if I make them cry …. I'm sure they think I'm just an angry Black woman …*
>
> *Why am I not getting an A in the course? I know why. It has to do with our role‐play last week. The class thought I should have been more empathetic with Sandy [Asian American female who played the role of a client]. They said I couldn't relate to her and didn't explore her feelings of discrimination as an Asian. Well, I did. But you can't tell me that she suffers like Blacks do. I felt like saying … good, now you know what it feels like!!!! …*
>
> *Then, Dr. Sue had to stop us from continuing and made process observations. He said I seemed to have difficulty being empathic with the client and believing her. What does he know? How does he know what's going on inside my head? But truth be told, Sandy doesn't have anything to complain or whine about. She doesn't understand what discrimination really is … maybe she has been treated poorly … but … but … well, I don't consider Asians people of color anyway. How can they claim to be oppressed when they are so successful? On this campus, they are everywhere, taking slots away from us. Sometimes I think they are whiter than Whites. I'll probably get an even worst grade because of what I'm saying, but who cares.*

Video 3.0: Introduction

Select the video link to view an introduction to the counseling session by Dr. Joel Filmore.

INTERRACIAL AND INTERETHNIC BIASES

It took much class time and several individual meetings to finally get the student to begin examining her reactions to White students and her images and prejudices toward Asians and Asian Americans. I [Derald Sue] tried to focus the discussion on the meaning of her extreme reactions to other group members and what significance it would have if they were her clients. Although the student did not change significantly because of her classroom experience, the lessons that came out from that role - play provided an opportunity for the entire class to enter a discussion of interracial and interethnic counseling topics. Some important themes are the following.

IMPACT ON INTERRACIAL COUNSELING RELATIONSHIPS

First, we must contextualize Briana's views and her strong feelings of anger, resentment, and bitterness. It is important to understand and be empathic to the fact that these reactions are most likely the result of cumulative years of prejudice and discrimination directed toward her as a socially devalued group member (Parham, Ajamu, & White, 2011; Ridley, 2005); these experiences also might be compounded by other life traumas. Is Briana justified in her anger? The answer is probably “yes.” But is her anger and bitterness misdirected and likely to cause her difficulty in working with Asian American and White clients? Again, the answer is probably “yes.”

In working with White clients, members of oppressed groups might (a) be unable to contain their anger and rage toward their clients, as they view them as the oppressor, especially those with relative privilege; (b) have difficulty understanding the worldview of their clients; (c) be hindered in their ability to establish rapport with their clients; (d) have difficulty empathizing with their clients; and (e) be guilty of imposing their racial realities upon their clients. The following quote illustrates the complexity of this type of dilemma.

> *The challenge for me lately has been empathizing with my male clients who have been triggered by the #MeToo campaign. They—mostly White heterosexual males—are coming into therapy and wanting to process their anxieties about whether they may be guilty of sexually harassing women in the past. I am having a hard time being patient and empathic listening to their stories. (Latino male therapist)*

STEREOTYPES HELD BY SOCIALLY MARGINALIZED GROUP MEMBERS

Second, Briana possesses many stereotypes and inaccurate beliefs about Asian Americans. She seems to operate from the assumptions that Asian Americans "are not people of color," that they know little about racism and discrimination, and that they are like Whites. These statements and her desire that a Black professor should teach the course rather than an Asian American reflect these beliefs. As you will see in Chapter 16, headlines in the national press such as "Asian Americans: Outwhiting Whites" and "Asian Americans: The Model Minority" have perpetuated the success myth and belief that Asians are a "model minority" and somehow immune to prejudice and racism (Kiang, Huynh, Cheah, Wang, & Yoshikawa, 2017; Sue, 2010b).

These false stereotypes of Asian Americans and of African Americans have often played into major misunderstandings and conflicts between these communities (Kim & Park, 2013). The issue here is the stereotypes that various racial and ethnic groups hold toward one another. For example, in one study, it was found that more than 40% of African Americans and Hispanics believe that Asian Americans are unscrupulous, crafty, and devious in business (National Conference of Christians and Jews, 1994). How do these beliefs affect interethnic relations, and how do they affect the counseling/therapy process? No racial or ethnic group is immune from inheriting biased beliefs, misinformation, and stereotypes of other groups. This is a reality often not discussed in courses on diversity and multiculturalism.

THE WHO - IS - MORE - OPPRESSED GAME

Third, we have some flavor of the “who's more oppressed?” trap being played out in Briana's narrative. She believes that Sandy can in no way equate her experiences of discrimination and prejudice with the Black experience. And perhaps she is right! There is little doubt that a racial hierarchy exists in our society in which various groups can be ordered along a continuum. The fact that African Americans have historically been and continue to be in the national forefront of the civil rights debate must be acknowledged and appreciated by all.

There is also, however, little doubt that each group—Native American, African American, Latinx American, and Asian American—can claim that it has suffered immensely from racism. What we need to realize is that all oppression is damaging, whether experienced through occupation and genocide, slavery, labor exploitation on railroads and plantations, internment camps, or in some other form. Even today, the plurality of people of color report being discriminated against in public and private spaces, including in their interactions with police and in applying for jobs (Neel, 2017a, 2017b). The lack of understanding and respect for our unique histories and contemporary experiences serve to separate rather than unify. Playing the “who's more oppressed?” game is destructive to group unity and counterproductive to combating racism. If we understand our own group's oppression, shouldn't it be easier to recognize the oppression of another? To use one group's oppression to negate that of another group is to diminish, dismiss, or negate the claims of another. This leads to separation rather than mutual understanding.

COUNSELORS FROM MARGINALIZED GROUPS WORKING WITH MAJORITY AND OTHER MARGINALIZED GROUP CLIENTS

Counseling the Culturally Diverse has never shied away from tackling controversial issues and topics, especially when they are central to the education and training of culturally competent mental health professionals. Persons of color, for example, have major hesitations and concerns about publicly airing *interracial and interethnic conflicts*, differences, and misunderstandings, because of the possible political ramifications for group unity. But it appears that cultural competency and cultural humility objectives are equally applicable to therapists of color and to other clinicians from marginalized groups.

It is clear that all groups can benefit from learning to work with one another. Being a helping professional or trainee of color does not automatically denote cultural competence in working with other clients of color or with White clients. Being a member of an oppressed or marginalized group (e.g., a gay man or a woman therapist) does not mean you are more effective in treating other culturally diverse clients than if you were a straight or male therapist. It is important to recognize that in the area of racial interactions, MCT is more than White–Black, White–Asian, or White–Latinx. To be a truly multicultural discipline, we must also recognize that MCT involves combinations such as Asian–Black, Latinx–Native American, Black–Latinx, and so on.

The American Counseling Association (ACA) has begun to recognize in their Multicultural and Social Justice Counseling Competencies (MSJCC) that the dimensions of privilege and oppressed statuses vary in the therapeutic relationship between counselors and clients (Ratts, Singh, Nassar ‐ McMillan, Butler, & McCullough, 2015). Most discussions of *multicultural counseling* focus upon White therapists (privileged status) and clients of color (oppressed status), and little emphasis is placed on other combinations: counselors of color (oppressed status) working with White clients (privileged status) or counselors of color (oppressed status) working with clients of color (oppressed status).

REFLECTION AND DISCUSSION QUESTIONS

1. How does a counselor of color work with a White client who expresses racist thoughts and feelings in the therapeutic session? Should he or she confront the client about these biased attitudes? Is this therapeutic?
2. What biases and prejudices do people of color have toward one another?
3. What advantages and disadvantages do you foresee in counselors of color working with people of color from a different racial or ethnic background than the one(s) to which they belong?

Video 3.1 Cultural Competence and Marginalized Groups

Awareness of cultural competence as a universal necessity in counseling and not just a majority requirement.

We address these issues from a number of perspectives: sociopolitical group relationships, cultural differences, *racial identity* attitudes, and practice implications. We start with the assumption that people in the United States, regardless of race and ethnicity, are exposed to the racial, gender, and sexual orientation socialization processes of this society and also inherit racial, gender, and sexual orientation biases about various populations. We focus

primarily on racial/ethnic combinations, but similar analyses using gender, sexual orientation, disability, social class, and other combinations are also important to consider. We are hopeful that these other relationships may be explored further in your classes and workshops.

THE POLITICS OF INTERETHNIC AND INTERRACIAL BIAS AND DISCRIMINATION

People of color generally become very wary about discussing interethnic and interracial misunderstandings and conflicts between various groups for fear that such problems may be used by those in power to

- assuage their own guilt feelings and excuse their racism—"People of color are equally racist, so why should I change when they can't even get along with one another?"
- divide and conquer—"As long as people of color fight among themselves, they can't form alliances to confront the establishment," and
- divert attention away from the injustices of society by defining problems as residing between various racial minority groups.

Further, readers must understand that prejudice toward other groups occurs under an umbrella of White racial superiority and supremacy; although members of socially devalued groups may discriminate, they do not have the systemic power to oppress on a large‐scale basis (Steinberg, 2007; Sue, 2015). In other words, although they may be able to hurt one another on an individual basis and to individually discriminate against White Americans, they possess little power to cause systemic harm, especially to White Americans. Some people of color have even suggested that interethnic prejudice among minorities serves to benefit only those in power.

As a result, people of color are sometimes cautioned not to "air dirty laundry in public." This admonition speaks realistically to the existence of miscommunications, disagreements, misunderstandings, and potential conflicts between and among groups of color. When they constituted a small percentage of the population, it was to their advantage to become allies in a united front against sources of injustice. Avoiding or minimizing interethnic group differences and conflicts served a functional purpose: to allow them to form coalitions of political, economic, and social power to effect changes in society. Although this solidarity may have been historically beneficial on a political and systemic level, the downside has been neglected in dealing with interracial differences that have proven to become problematic. This issue is even more pressing when, for example, one considers that people of color are rapidly becoming the numerical majority. In 2020, more than half of the children in the United States will be a person of color (U.S. Census Bureau, 2015), and the number of majority minority states and cities is growing—so much so that most estimates indicate that by 2050, people of color will be the majority in the United States as a whole (U.S. Census Bureau, 2012).

As the United States becomes more diverse and people of color are placed in close proximity to and often pitted against one another through a system of White supremacy, a pattern of misunderstandings and mistrust emerges. In the early 1990s, the racial discourse in urban America was dominated by African American boycotts of Korean mom‐and‐pop grocery stores, which was followed by looting, firebombing, and mayhem that engulfed Los Angeles (Chang, 2001). Many in the Black community felt that Koreans were exploiting their communities as had White businesses. Instances of Hispanic and Black conflicts in the inner cities have also been reported throughout the country. As Latinx individuals have surpassed Blacks in numbers, they have increasingly demanded a greater voice in communities and in the political process. Since Latinx and Black individuals tend to gravitate toward the same

inner‐city areas and compete for the same jobs, great resentment has grown between the groups (Wood, 2006).

In essence, the discourse of race that once was confined to Black–White relations has become increasingly multiethnic and multiracial. It is not surprising that most Americans believe that race relations have worsened with the election of Donald Trump as President of the United States and that there was a significant increase in Blacks' and Latinx' perception of race relations getting worse between 2016 and 2017 (Pew Research Center, 2017). Several national surveys (Jones, 2013a, 2013b; National Conference of Christians and Jews, 1994; Pew Research Center, 2008, 2012) have found the following:

- More than 40% of African Americans and Hispanics, and one of every four Whites, believe that Asian Americans are “unscrupulous, crafty, and devious in business.”
- Nearly half the Hispanic Americans surveyed and 40% of African Americans and Whites believe Muslims “belong to a religion that condones or supports terrorism.”
- Blacks think they are treated far worse than Whites and worse than other minority groups when it comes to getting equal treatment in applying for mortgages, in the media, and in job promotions.
- Although an overwhelming number of people rate racial/ethnic relations between racial group combinations as positive, the most favorable ratings are Whites–Asians (80%), with Blacks–Hispanics in last place.
- Nearly 50% of African Americans believe Latinx immigrants reduce job opportunities for them, while fewer than 40% of Latinx Americans agree.
- Approximately 70% of Asian Americans rate their relations with Hispanics as good, and 60% say that of Blacks. Interestingly, and consistent with our earlier analysis, 50% of Korean Americans have negative views of their relations with Blacks.
- Only 10% of African Americans—a staggeringly low number—believe the police treat them as fairly as other groups.
- There is tremendous resentment of Whites by all minority groups.
- Two‐thirds of minorities think Whites “believe they are superior and can boss people around,” “are insensitive to other people,” “control power and wealth in America,” and “do not want to share it with non‐Whites.”

Three primary conclusions are noteworthy here: First, racial/ethnic groups harbor considerable mistrust, envy, and misunderstandings toward one another. Surprisingly, African Americans and Latinx Americans held stronger negative beliefs about Asian Americans than did White Americans (40% versus 25%). Second, and not surprisingly, people of color continue to hold beliefs and attitudes toward Whites that are very negative and filled with resentment, anger, and strong mistrust. Third, dialogue between people of color must come out of the closet in order to make important and long‐lasting progress toward mutual respect and understanding, rather than a relationship simply based upon political convenience.

REFLECTION AND DISCUSSION QUESTIONS

1. What effect does interracial or interethnic bias on the part of therapists of color have upon their culturally diverse clients?

2. Think of an interracial or interethnic people of color dyad (for example, African American therapist and Korean American client). What therapeutic issues are likely to arise in the dyad you selected?
3. Likewise, in light of the strong negative feelings expressed by all groups of color against Whites, how might a therapist of color react intentionally and unintentionally toward a White client?

Some might argue that a therapist of color working with a White client might be different from a therapist of color working with a client of color because power differentials still exist on a systemic level for White clients. Little in the way of research or conceptual scholarly contributions has addressed these issues. It may not be far‐fetched, however, to surmise that these racial combinations may share some similar dynamics and clinical issues to White therapist/client of color dyads. Some increased understanding of these issues may come from a brief review of the historical analysis of interracial and interethnic relationships between groups of color in other venues of their lives.

Video 3.2 Roadblocks and Resistance

How transference and countertransference can negatively impact the counseling relationship.

THE HISTORICAL AND POLITICAL RELATIONSHIPS BETWEEN GROUPS OF COLOR

There is a paucity of literature that focuses specifically on interracial interactions between counselors and clients of different racial/ethnic minority groups (e.g., Asian, Black, Latinx, or American Indian). This may falsely convey that there is limited tension between groups of color and that discrimination and stereotyping does not occur between these groups. Given the history of the United States, it is apparent that discrimination and stereotyping does occur between all racial groups.

During the civil rights movement, people of color banded together to combat economic and social injustices that were against them. As a result, people of color have avoided public dialogue (on both individual and group levels) about historical and existing tensions among their groups. Because individuals of color have experienced racism throughout their lives, it may prove difficult for them to understand the biases they hold toward other groups. Some people of color believe that they would not be able to discriminate, stereotype, or pass judgment on others because they themselves have been racially victimized. Other people of color may recognize their biases but believe that because they do not have any systemic power, these biases are excusable or insignificant. Regardless of these perspectives, examining the history of interracial and interethnic relations may prove enlightening.

African Americans and Asian Americans

The conflicting relationships between African Americans and Asian Americans remained relatively unspoken until the Los Angeles Riots in 1992, in which some Black Americans looted Korean American businesses. The tensions were brewing for quite a long time, but came to a head with the killing of 15 - year - old LaTasha Harlins, who was shot in the head by a Korean storeowner for allegedly stealing a carton of milk in 1991. The riot occurred when African Americans became outraged by the years of perceived injustices symbolized by the acquittal of four White officers from the Los Angeles Police Department in the beating of Rodney King, a Black motorist. Of the 4,500 stores that were looted and burned, however, 2,300 were Korean - owned (Yoon, 1997). Although hard feelings existed prior to the riots, this experience led to overt tension between the groups throughout the United States (Kim, 1999).

In interviews with several Korean American business owners, it was clear that they stereotyped Black American customers as likely to steal or become violent; likewise, some Black Americans who acted out against Korean businesses stereotyped Asian Americans as being racist and hostile toward them and thought that they took economic advantage of their communities. This may have even led to overt racist behaviors between the groups, with Asian American store owners blatantly refusing business from Black American patrons or following them around their stores, and Black Americans blatantly using racial slurs such as “Chinaman” and “chink” when speaking to Korean workers (Myers, 2001).

Asian Americans and Latinx Americans

The historical relationship between Asian Americans and Latinx Americans is almost never discussed and is usually invisible in discussions of race (De Genova, 2006). However, there are several ways in which these two groups may share a sense of camaraderie with one another, along with divisive tension. Both groups share the experience of immigration; the majority of Asian Americans and Latinx Americans are first - or second - generation

Americans (De Genova, 2006; Kim, 2011). This shared history may lead to similar experiences of biculturalism (maintaining both Asian or Latinx and American values) and culture conflicts, similar linguistic concerns (bilingualism), and similar experiences of pursuing the American dream. One of the dominant similarities between the two groups is their shared experience of being treated like foreigners in their own country (particularly those who were born and raised in the United States); another is that both groups are often left out of the Black–White racial paradigm debate.

When issues or matters of race are discussed in the news media, for example, the dialogue is usually Black–White and seldom includes Asian Americans or Latinx Americans. This invisibility as groups of color in the racial debate has often created hard feelings in these two groups toward African Americans. Because these groups can feel invisible, they may compete with each other in order to have their voices heard. Historically, there was a moment, during the Chicano ‐ Filipino United Farm Workers Movement in the 1930s, in which Mexican and Filipino Americans worked cohesively for farm workers' rights in California. Yet, they disbanded when the two groups could not agree upon common interests (Scharlin & Villanueva, 1994). Currently, this may be exemplified in U.S. politics, in which Asian and Latinx Americans may run against each other in local elections instead of working harmoniously to form a unified alliance.

Latinx Americans and Black Americans

The history between Latinx Americans and Black Americans also has both solidarity and discord. Historically, there has been solidarity between the two groups, particularly in their quest for equality during the civil rights era (Behnken, 2011). Traditionally, both groups recognized each other as oppressed minority groups, understanding that the other may experience racism, be subjected to widespread stereotyping, and be denied equal access and opportunities to White people. However, there are also points of contention between these two groups.

First, similar to the relationships between Asian and Latinx Americans, there may be tension between Latinx and Black Americans as a result of each group fighting for its own sociopolitical issues and needs. In recent years, Latinx Americans have overwhelmingly exceeded Black Americans in regard to population; this has led to Latinx Americans gaining more visibility in politics and education (Wood, 2006). The rise of Latinx demands has also created tension amongst Latinx and Black Americans because they now find themselves competing for jobs, which has forced some Black Americans to oppose many Latinx Americans in the immigration debate (Behnken, 2011). This competition for jobs has often resulted in problems related to a lack of alliance between the two groups, particularly when it comes to advocacy in government, education, and community organizing (Samad et al., 2006).

Second, it is important to recognize that racism within the Latinx community has historical roots as a result of Spanish colonialism in Latin America. The term *Latinx* is an ethnic designator and not a racial one. Hence, Latinx people may be members of any racial grouping. As a result, they may range phenotypically from Black to White, with many appearing to be somewhere in between (Bautista, 2003). However, because of the colonial mentality, *mestizos*, or light ‐ skinned Latinx people, are valued more highly than darker ‐ skinned Latinx people, who may be viewed as inferior, unintelligent, or unattractive (*colorism*) (Adames, Chavez ‐ Dueñas, & Organista, 2016). This may lead to a hierarchy within the Latinx community, in which light ‐ skinned groups, such as Argentineans, Colombians, and Cubans, may view themselves as superior to darker ‐ skinned groups, such

as Dominicans and Mexicans. This colonial mentality may transcend a Latinx individual's view of a Black American; this observation is supported by studies showing that Latinx Americans hold negative stereotypes of Black Americans as being lazy and untrustworthy, whereas Black Americans do not feel the same way about Latinx Americans (McClain et al., 2006).

American Indians and Black, Latinx, and Asian Americans

The relationship between American Indians and Black, Latinx, and Asian Americans may not be discussed or known, due to the small numbers of American Indians in the United States. Black, Latinx, and Asian Americans may have little interaction with American Indians, which may lead to less obvious tensions or dynamics between American Indians and another racial group. Concurrently, because 40% of the American Indian population may be of mixed racial background (U.S. Census Bureau, 2005), many American Indians may physically look like members of other racial groups, causing others to perceive them and treat them in different ways. However, an American Indian interacting with members of these racial groups may share similarities or experience tensions with individuals of other races, perhaps empathizing with a Black American's experiences of oppression or bonding with a Latinx or Asian American's feelings of being an invisible minority. At the same time, a Black, Latinx, or Asian American individual who does not recognize the American Indian's *racial identity*, realities, history, or experiences may cause the American Indian to feel dismissed, ignored, or invalidated.

Video 3.3 Biases and Belief Systems

Historical biases and their impact on our beliefs, both consciously and unconsciously, within the counseling session.

DIFFERENCES BETWEEN RACIAL/ETHNIC GROUPS

To further understand interracial and interethnic dynamics, it is important to recognize that groups of color may hold values, beliefs, and behaviors unique to their cultures. Many of these differences in *cultural values* are addressed in Chapter 7. Specifically, previous literature has found that racial/ethnic groups have differences in worldviews and *communication styles*. These groups may have different views of therapy, based on cultural stigma and the group's historical experiences with mental health institutions. Knowledge of these cultural differences may aid mental health practitioners to better understand the types of dynamics that occur in a therapeutic relationship. Let us explore a few of these differences.

Cultural Values

Shared and nonshared values held by groups of color may lead to an experience of camaraderie or to one of tension and antagonism. For example, although many White Americans typically believe that people have mastery and control over the environment, persons of color typically believe that people and nature are harmonious with one another (Chen, 2005; McCormick, 2005). Additionally, whereas Whites adhere to the value of individualism, Asian, Native, Black, and Latinx Americans may maintain the values of collectivism, in which the needs of the group/family/community are paramount. Within collectivism, emphasis is placed on the family, what Latinx people call *familialism* or *familismo*; a high value is placed on family loyalty and unity (Arredondo, Gallardo‐Cooper, Delgado‐Romero, & Zapata, 2014; Guzman & Carrasco, 2011). If a Latinx counselor ascribes to *familismo* and works with a client of color who does not place the same central importance on the family, the counselor may inadvertently interpret this person to be emotionally disconnected and isolated.

Although sharing a cultural value may lead to a therapeutic working relationship between two different individuals of color, its expression may potentially cause a misunderstanding in therapy as well. For example, respect for elders is a value traditionally held by people of color (Evans, 2013; Kim & Park, 2013). However, expression of this value may differ among members of different racial groups. In some Asian American and American Indian cultures, respect is shown by not talking unless spoken to and by averting one's eyes and thus not making direct eye contact with the elder or respected person (Nadal, 2011). An African American counselor may misinterpret an avoidance of eye contact by an American Indian client to be a sign of disrespect, avoidance, or disengagement.

Communication Styles

The previous examples lead to our discussion of differences in *communication styles* between various racial/ethnic groups. Communication style differences (see Chapter 8) displayed by therapists can impact the expectations or responsiveness of clients from different backgrounds. American Indians, for example, are more likely to speak softly, use an indirect gaze, and interject less frequently, whereas White Americans are more likely to speak louder, have direct eye contact, and show a direct approach (Duran, 2006). These same characteristics may be displayed by therapists when they interact with clients. Hence, therapists need to be aware of their verbal and nonverbal styles and to determine how they may either facilitate or act as a barrier to the formation of a therapeutic alliance.

Communication styles may include overt verbal communication that may occur between two people (the content of what is said), but may also include nonverbal communication (body

language, tone of voice, volume of speech, what is not said, and the directness of speech), which is equally as important as the spoken word. African American communication style tends to be direct, passionate, and forthright (an indication of sincerity and truthfulness) (Kochman, 1981; Parham et al., 2011). However, Asian cultures highly prize subtlety and indirectness in communication, as it is considered a sign of respect to the person one is talking to (Kim, 2011). Even when disagreements are present, differences are discussed tactfully, avoiding direct confrontation.

American Indians and Latinx Americans may be nonconfrontational like Asian Americans, but their communication styles may change depending on the varying levels of authority between the people involved (Garrett & Portman, 2011). For example, Latinx children are expected to respect their parents, to speak only when spoken to, to have younger siblings defer to older ones, and to yield to the wishes of someone with higher status and authority. Latinx students, thus, may feel uncomfortable challenging or speaking directly to their teachers (Santiago‐Rivera, Arredondo, & Gallardo‐Cooper, 2002). This value may also conflict with the White American value of egalitarianism, where children are encouraged to freely express their thoughts and feelings. Although African American *communication styles* may be egalitarian as well, they are likely to be more animated and interpersonal, generating affect and feeling (Hecht, Jackson, & Ribeau, 2002; Weber, 1985). Given this, if an African American counselor communicates in a more animated and passionate fashion, it may negatively impact the willingness of Latinx or Asian American clients to open up in therapy.

Issues Regarding Stage of Ethnic Identity

The processes of assimilation and acculturation for various racial and ethnic minority groups in the United States are powerful forces in the development of identity. Studies continue to indicate that as groups of color are exposed to the values, beliefs, and standards of the larger society, many become increasingly Westernized. This process is described more fully in Chapter 11, so we will not elaborate here. People of color who are born and raised in the United States may continue to value their traditional racial/ethnic group heritage, actively reject it in favor of an “American identity,” or form an integrated new identity. Depending on where they fall on this continuum, their reactions to other people of color (both within and outside their own group) and to majority individuals may differ considerably. The stage of identity of ethnic minority therapists is likely to affect their work with clients.

Video 3.4 Differences Don't Have to Be Detrimental

Client and therapist differences as a way to enrich the conversation instead of hindering or blocking rapport.

COUNSELORS OF COLOR AND DYADIC COMBINATIONS

The analysis in this chapter indicates how important sociopolitical factors, historical relationships between racial and ethnic minority groups, differences in *cultural values*, and the racial identity of counselors and clients can serve either to enhance or to undermine the counseling process (Comas‐Diaz & Jacobsen, 1995; Greenberg, Vinjamuri, Williams‐Gray, & Senreich, 2017; Ratts & Pedersen, 2014). Little actual research has been conducted on the challenges and difficulties that counselors of color face when working with other culturally diverse groups. Less yet has been done on the subject of cultural competence as it relates to therapists of color. Nevertheless, the foregoing analysis would imply several situational challenges that therapists and trainees of color might expect on their journey to cultural competence. Table 3.1 outlines five common challenges therapists of color encounter as they work with White clients and five for working with clients of color.

TABLE 3.1 Ten Common Challenges Counselors of Color Face When Working with White Clients and Clients of Color

Counselor of color and White client dyads
1. Challenging the competency of counselors of color
2. Needing to prove competence
3. Transferring racial animosity toward White clients
4. Viewing the counselor of color as a super minority therapist
5. Dealing with client expressions of racism
Counselor of color and client of color dyads
1. Overidentifying with the client
2. Encountering clashes in cultural values
3. Experiencing clashes in communication and counseling styles
4. Receiving and expressing racial animosity
5. Dealing with the racial identity status of the client or counselor

Challenges Associated with Counselor of Color and White Client Dyads

When working with White clients, a counselor of color is likely to operate in a situation of power reversal (Comas‐Diaz, 2012; Comas‐Diaz & Jacobsen, 1995). When the counselor

is White and the client is a person of color, the power relationship is congruent with historical and sociopolitical racial roles and structures in our society. The roles of colonizer–colonized, master–slave, and oppressor–oppressed have defined relationships of who are leaders and followers, who is superior and inferior, and who is given higher or lower status (Ratts & Pedersen, 2014). When the counselor is a person of color, however, it fosters a role reversal, because the status of therapist denotes a person who possesses a set of expertise that surpasses that of the White client. In this case, the White client is in need of help, and the counselor of color is in a position to provide it (to diagnose, treat, advise, teach, and guide). Many White clients may find this dependent role very disturbing and manifest it in various ways. Some may, however, find the new relationship exotic or even a positive development. Counselors of color may also misuse the power reversal to harm or to deny appropriate help to their White clients.

Situation 1: Challenging the Competency of Counselors of Color

Whether White clients are conscious of it or not, they may directly or indirectly engage in maneuvers that challenge the credibility of the counselor of color, question the counselor's competence, negate the counselor's insights and advice, and undermine the therapeutic process (Sue, 2010a). Such challenges are not necessarily conscious to the client or expressed overtly. They may be manifested through an excessive interest in seeking greater information about the counselor's training and background, types of degree received, place of training, and number of years in clinical practice. Or, they may be expressed through a tendency to be hypercritical of even the smallest omissions, oversights, and mistakes of the counselor. Behind these resistant behaviors is a presumption that therapists of color are less qualified than White ones—that therapists of color achieved their positions not through their own internal attributes (intelligence and abilities) or efforts (motivation and actions) but through external circumstance, such as attending lesser qualified schools or being recipients of affirmative action programs. A study exploring both White and African American therapists' experiences in working with White clients supports these observations. Ethnic minority therapists consistently reported being the recipient of greater hostility, resistance, and mistrust in cross‐racial practice than their White counterparts (Davis & Gelsomino, 1994).

For counselors of color, there are no easy answers or solutions to dealing with challenges to their credibility. A decision to explore or confront a White client's resistance to the counselor of color depends on many internal and contextual factors: (a) the counselor of color's comfort with his or her racial/ethnic identity, (b) the clinical significance of the behavior, (c) the timeliness of the intervention, (d) the strength of the relationship, and (e) the form in which the intervention would take place. Regardless, several overarching guidelines may prove helpful here. First and foremost, a challenge to one's competence is not a pleasant thing, especially if it is tinged with racial overtones, especially for new counselors. Although the counselor may become upset with the client, become defensive, and allow the defensiveness to dictate actions in the therapeutic session, these reactions are counterproductive to helping the client. Second, before an effective intervention can take place, a counselor must recognize the resistance for what it is. This means an accurate diagnosis separating out behaviors such as questioning one's qualifications from other clinical motivations. Third, a decision to intervene must be dictated by timeliness: it should occur at an opportune time that will maximize the insight of the client. Last, as the therapist of color will need to address racial issues, he or she must feel comfortable with engaging in a difficult dialogue on race.

Situation 2: Needing to Prove Competence

The fact that some Whites may consciously and unconsciously harbor beliefs that persons of color are less capable than Whites may affect counselors of color; the counselors may internalize these beliefs and stereotypes about themselves and their own group. In such cases, counselors of color may be trapped in the need to prove their competence and capabilities; unfortunately, this proof must come from White society, other White helping professionals, and even White clients. In the counseling session, this type of conflict may be played out in seeking affirmation from White clients and in the counselor abdicating their role as expert in the relationship. Counselors of color may also have a disinclination to see clients of color because it may bring to mind their own internalized racism and create discomfort for them. In such instances, they may be paralyzed in discussing racial dynamics, experience extreme anxiety when racial issues arise, and allow their clients to take the lead in the sessions. Alternatively, some counselors may overcompensate by talking too much in an attempt to demonstrate to the client that they are knowledgeable and competent.

Situation 3: Transferring Racial Animosity toward White Clients

This situation is likely to arise through a process of countertransference, where the counselor of color transfers feelings of resentment, anger, and antagonism toward White society to the client. In general, the therapist of color is unable to separate out the experiences of racism, discrimination, and prejudice experienced through years of oppression from their feelings toward the client. The White client may become a symbol of the inherent mistrust that exists in majority–minority interpersonal relationships; thus, the counselor/therapist may harbor negative feelings that infect and distort the counseling relationship. In most cases, these grudges do not operate at a conscious level, but they are likely to present themselves in various forms: (a) dismissing or diluting the pain and suffering of the White client, (b) being unable to form a working alliance, (c) having difficulty in being empathetic to the client's plight, (d) being ultrasensitive to potential racial slights, (e) distorting or misinterpreting the client's actions to include a racial motivation, and in rare cases (f) possessing an unconscious desire to harm rather than help the client. This is potentially a toxic situation and is best resolved early in clinical training.

Situation 4: Viewing the Counselor of Color as a Super Minority Counselor

It may appear contradictory, but evidence exists, in the form of counselor preference studies and clinical narratives, that some White clients actually prefer a therapist of color over a White one (Sue & Sue, 2013). It has been found, for example, that some White college students indicate a preference for seeing a Black helping professional. The reason behind such a preference flies in the face of traditional race relations and is difficult to explain. In our own work with White clients and in speaking to colleagues of color, however, several possibilities have arisen.

First, many White clients may possess an exaggerated sense of the therapist of color's qualifications, reasoning that to have achieved the status of therapist must have required a nearly superhuman effort against the forces of discrimination. The therapist's accomplishments could have come only from high intelligence, outstanding abilities, and high motivation. Thus, the therapist of color is seen as immensely superior and likely to better help the client. Second, many clients, regardless of race, often feel rejected, invalidated, misunderstood, and put down, and suffer from pangs of inferiority and feelings of worthlessness. White clients may possess a mistaken notion that a therapist of color (who him‐ or herself has suffered from racism and stigmatization) may better be able to sympathize and empathize with them. Third, the therapist of color may be perceived as an

expert on race relations, and some Whites may be consciously or unconsciously attempting to deal with their own racial attitudes. At times, the White client may be coping either with a conscious interracial relationship (e.g., dating a person of another race) or with more subtle unconscious personal dilemmas (e.g., White guilt and issues of privilege).

There is certainly a seductive quality to being perceived in such a favorable light, being viewed as an expert, and being accorded such high respect. This challenge is particularly difficult for therapists of color who in their daily lives outside of therapy sessions are not easily accorded the respect and dignity given to others. Yet, to allow the "super minority counselor" image to persist is to perpetuate a false illusion of the White client and to potentially harm therapeutic progress. In this situation, the White client may abdicate responsibility for their own improvements and become overly dependent on the counselor for answers to their problems. Counselors of color need to have a good sense of themselves as racial, ethnic, and cultural beings and to not fall into the all‐omnipotent trap.

Situation 5: Dealing with Client Expressions of Racism

It goes without saying that counselors/therapists of color often encounter racist, sexist, and heterosexist statements and reactions from their clients. Whereas many White lesbian, gay, bisexual, transgender, and queer (LGBTQ) people may remain invisible, people of color represent a visible racial/ethnic minority with distinguishable physical features. Counselors of color, through appearance, speech, or other characteristics, generate reactions. These perceived differences may influence the development of a therapeutic relationship. As Asian American therapists, we've had clients make statements such as, "I like Chinese food" or "The Chinese are very smart and family‐oriented," or exhibit some discomfort when meeting us for the first time. In one study (Fuertes & Gelso, 2000), male Hispanic counselors who spoke with a Spanish accent were rated lower in expertise by EuroAmerican students than those counselors without an accent. This phenomenon may also exist for therapists with other accents and may need to be discussed in therapy to allay anxiety in both the therapist and the client. One graduate student from Bosnia would discuss her accent and would let clients know that English was her second language. Although her command of English was good, this explanation helped establish a more collaborative relationship.

Acknowledging differences or investigating the reasons for client reactions is important, since they may affect the therapeutic process. In one instance, an American Indian psychology intern working with a woman in her 40s noticed that upon learning she was American Indian, the client began to tell stories about her daughter being "part Native." After one such story, the client asked, "What special power do you have?; My daughter has extra‐ordinary hearing." Without missing a beat, the intern matter‐of‐factly responded to the question. This led to a discussion of client concerns that she was being judged for her "Whiteness" and also about what it meant to have a younger American Indian woman therapist.

White counselors facing an ethnic minority client often struggle with whether to ask, "How do you feel working with a White helping professional?" This situation is also faced by counselors of color working with White clients. When differences between therapist and client are apparent (e.g., ethnicity, gender, ability, age) or revealed (e.g., religion, sexual orientation), acknowledging them is important (Zane & Ku, 2014). Culturally responsive counselors are encouraged to *broach* the topic of race, ethnicity, and culture during therapy (Day‐Vines et al., 2007). *Broaching* these issues can strengthen the working relationship. Both African American and White American students revealed a preference for openness and self‐disclosure when asked to imagine a counselor of a different ethnicity (Cashwell, Shcherbakova, & Cashwell, 2003). Self‐disclosure, or the acknowledgment of differences,

may increase feelings of similarity between therapist and client and reduce concerns about differences. The same applies when both therapist and client are persons of color but are from different racial or ethnic groups (Sanchez, del Prado, & Davis, 2010).

Challenges Associated with Counselor of Color and Client of Color Dyads

Many of the challenges facing therapists of color working with White clients can also make their appearance in counseling dyads where both are from marginalized groups. Like their White counterparts, people of color are socialized into the dominant values and beliefs of the larger society. As a result, they may inherit perceptions and beliefs about other racial/ethnic minority groups. In this case, the biases and stereotypes held about other groups of color may not be all that different from those held by White Americans. A Latinx American client can harbor doubts about the qualifications of an American Indian counselor; an Asian American client can act out racist attitudes toward an African American counselor; and an African American counselor may downplay the role that prejudice and discrimination play in the life of Asian Americans. Other interracial and interethnic specific challenges may also make their appearance in the counseling dyad.

Situation 1: Overidentifying with the Client

Overidentification with clients of color, whether with in‐group or out‐group dyadic counseling racial relationships, is often manifested through countertransference.

Although it is accepted that the transference of symbolic feelings, thoughts, and experiences of the client of color can occur in relation to the counselor, an equally powerful countertransference can occur from therapist to client, especially in interracial and interethnic dyadic combinations.

> *Sometimes when I had Black clients, I identified with them and invested in them so much that I might not have pushed them in the way they needed to be pushed. Or I might not have helped them develop something they may have needed to develop. Because I was so busy caring about … being helpful (Black male therapist with Black clients).*
>
> *(Goode‐Cross & Grim, 2016, p. 42)*

In reflecting on his early clinical experiences, this therapist noted that his overidentification with clients may have actually hindered the therapy process. Thus, while there may be potential rewards in working with someone with a similar racial or ethnic background, especially if they also share another social identity such as gender or sexual orientation, there are also pitfalls, which sometimes remain outside of one's awareness. This speaks to the importance of having culturally responsive supervisors working with beginning trainees.

It is said that people of color share a sense of peoplehood in that, despite cultural differences, they know what it is like to live and deal with a monocultural society. They have firsthand experience with prejudice, discrimination, stereotyping, and oppression. It is a constant reality in their lives. They know what it is like to be “the only one,” to have their thoughts and feelings invalidated, to have their sons and daughters teased because of their differences, to be constantly seen as inferior or lesser human beings, and to be denied equal access and opportunity (Sue, 2010a). For these reasons, countertransference among counselors of color working with clients of color is a real possibility. Thus, although therapists of color must work hard not to dismiss the stated experiences of their clients, they must work equally hard to separate out their own experiences from those of their clients.

Situation 2: Encountering Clashes in Cultural Values

As we have mentioned earlier, cultural differences can impact the way we perceive events. This was clearly seen in a study involving Chinese American and White American psychiatrists (Li‐Repac, 1980). Both groups of therapists viewed and rated recorded interviews with Chinese and White patients. When rating White patients, White therapists were more likely to use terms such as *affectionate*, *adventurous*, and *capable*, whereas Chinese therapists used terms such as *active*, *aggressive*, and *rebellious* to describe the same patients. Similarly, White psychiatrists described Chinese patients as *anxious*, *awkward*, *nervous*, and *quiet*, whereas Chinese psychiatrists were more likely to use the terms *adaptable*, *alert*, *dependable*, and *friendly*. It is clear that both majority and minority therapists are influenced by their ethnocentric beliefs and values.

Many cultural value differences between groups of color are as great and prone to misinterpretation and conflict as are those among groups of color and White Americans. In the previous study, it was clear that both the Chinese and the White psychiatrists made such evaluations based upon a number of *cultural values*. Chinese psychiatrists saw the more active and direct expressions of feeling as aggressive, hostile, and rebellious and the more controlled, sedate, and indirect expressions of emotion as indicative of dependable and healthy responding. A prime example of how different cultural dictates affect interpersonal behavior and interpretation is seen in the ways that emotions are expressed among Asian, Latinx, and Black Americans. Restraint of strong feelings is considered a sign of maturity, wisdom, and control among many Asian cultures. The wise and mature “man” is considered able to control feelings (both positive and negative). Thus, Asian Americans may avoid overtly displaying emotions and even discussing them with others (Kim & Park, 2013). This is in marked contrast to African Americans, who often operate from a cultural context in which the expression of affect and passion in interpersonal interactions is a sign of sincerity, authenticity, and humanness (Parham et al., 2011). Likewise, many Latinx Americans value emotional and physical closeness when communicating with each other (Guzman & Carrasco, 2011).

Therapists of color who operate from their own worldview without awareness of the different worldviews held by other clients of color may be guilty of cultural oppression, imposing their values and standards upon culturally diverse clients. The outcome can be quite devastating and harmful to clients of color. Let us use the example of a potential misunderstanding likely to occur between a Latina counselor and an Asian American client (both holding the values described earlier). As the Latina counselor encounters the Asian American client who values restraint of strong feelings, several potential culture‐clash scenarios are likely to occur in a situation where the expression of feelings seems called for: First, the Asian American client's reluctance to express feelings in an emotional situation (loss of a job, death of a loved one, etc.) might be perceived as denial, or as emotionally inappropriate or unfeeling. Second, in a situation where the feelings are being discussed and the client does not desire to, or appears unable to, express them, the counselor may potentially interpret the client as resistant, unable to access emotions, repressed, or inhibited. These potentially negative misinterpretations have major consequences for the client, who may be misdiagnosed and treated inappropriately. It is clear that counselors of color, when working with clients of color, must be aware of their own worldviews and those of their diverse clients.

Situation 3: Experiencing Clashes in Communication and Counseling Styles

One area of a possible clash in *communication styles* is in how groups use personal space when speaking to one another. African Americans and Latinos, as a rule, have a much closer conversing distance than either White Americans or Asian Americans (Jensen, 1985; Nydell,

1996). How culture dictates conversation distances is well defined, and varies according to many sociodemographic differences, including race, ethnicity, and gender. Whereas an Asian American therapist may value distance to an African American client in therapy (e.g., sitting further away and leaning back in a chair), the latter may feel quite uncomfortable and find such conversing distances to be aloof. Worse yet, the client may interpret the counselor as rude, disrespectful, or racially insensitive. The Asian American therapist, on the other hand, may view the African American client as overly emotional. Further, major differences may be exaggerated by the manner of communication. Blacks tend to be more direct in their *communication styles* (thoughts and feelings), whereas Asian Americans tend to be more indirect and subtle in communication; an African American client may not feel comfortable with or trust an Asian American therapist who expresses him‐ or herself in such an indirect manner.

Therapy is a context in which communication is paramount, and there are many ways that these differences in *communication styles* across races and cultures manifest in the therapeutic relationship. First, because Asian Americans, Latinx Americans, and American Indians may be indirect in their *communication styles* and may avoid eye contact when listening and speaking, they are often pathologized as being resistant to therapy (Sue, 2010a). At the same time, because Black Americans are stereotyped as being quick to anger and prone to violence and crime, they are often viewed as threatening and can trigger fear in people (Sue, 2010b). The combination of these two contrary types of communication can lead to various tensions in a therapeutic relationship. Again, counselors of color must (a) understand their communication and therapeutic styles and the potential impact they have on other clients of color, (b) be aware of and knowledgeable about the *communication styles* of other groups of color, and (c) be willing to modify their intervention styles to be consistent with the cultural values and life experiences of their culturally diverse clients.

Situation 4: Receiving and Expressing Racial Animosity

A counselor of color may be the object of racial animosity from clients of color simply because he or she is associated with the mental health system. Many people of color have viewed mental health practice and therapy as a White middle‐class activity with values that are often antagonistic to the ones held by groups of color. African Americans, for example, may have a negative view of therapy, often holding a “historical hostility” response because of the history of oppression of Blacks in the United States (Ridley, 2005). Therapy is highly stigmatizing among many in the Asian American community, who often view it as a source of shame and disgrace (Kim & Park, 2013). Latinx Americans may react similarly, believing not only that therapy is stigmatizing but that “talk therapies” are less appropriate and helpful than concrete advice and suggestions (de las Fuentes, 2006). American Indians may vary in their views of therapy, depending on their level of assimilation; traditional American Indians may view Westernized institutions and practices as not trustworthy or as ineffective in comparison to spiritual healing or indigenous practices (Duran, 2006).

Given these different views of therapy and mental health practices, there are several dynamics that can occur between racial groups. Black American clients may view therapy as a symbol of political oppression and may perceive a Latinx American therapist or even a Black counselor as a sellout to the broader society. Or, because traditional forms of therapy oftentimes emphasize insight through the medium of verbal self‐exploration, many Asian and Latinx clients may view the process as inappropriate and question the qualifications of the therapist. American Indian clients who value nontraditional counseling or spiritual healing may not seek or continue therapy, especially if a counselor of any race does not recognize

alternatives to Western practices. All of these factors may influence the dynamics in a counseling relationship in which the therapist of color is responded to as a symbol of oppression and as someone who cannot relate to the client's problems. The therapist's credibility and trustworthiness are suspect, and will be frequently tested in the session. These tests may vary from overt hostility to other forms of resistance.

We have already spent considerable time discussing the racial animosity that has historically existed between racial groups and how it may continue to affect the race relations between groups of color. Like Situations 3 and 5 for therapists of color working with White clients, similar dynamics can occur between racial/ethnic minority individuals in the therapy sessions. Therapists of color may be either targets or perpetrators of racial animosity in therapy sessions. This is often exaggerated by differences in *cultural values* and *communication styles* that trigger stereotypes that affect their attitudes toward one another. Counselors of color may transfer their animosity toward minority clients; or, as with hostility from White clients, they may receive racial animosity from clients of color. Our clinical analysis and suggestions in those situations would be similar for counselors of color working with clients of color.

Situation 5: Dealing with the Racial Identity Status of Counselors and Clients

We have already stressed the importance of considering the racial and ethnic identity status of both therapists of color and clients of color. How it affects within‐group and between‐group racial and ethnic minority counseling is extremely important for cultural competence. The following quote from a qualitative study on Black therapists working with Black clients succinctly captures potential difficulties in this area.

> *I found, particularly with the first African American client I worked with … I was so pumped. And I was like, "Ooo, a Black woman!" And I had all these thoughts in mind of what working with her would be like. And she was more Pre‐Encounter [assimilationist views] in terms of her racial identity. So it was more challenging than I thought, and actually I was her positive encounter with Blackness that helped her to shift. And I didn't realize that until after the fact. So I think early on I had expectations, and because that was my first experience, it helped me to shift and see, "Okay, we might look alike but there's some very different dynamics that can take place, just identity‐wise."*
>
> *(Goode‐Cross & Grim, 2016, pp. 42–43)*

As illustrated in this example, the degree of assimilation/acculturation and *racial identity* of both the counselor and the client of color can result in dyadic combinations that create major conflicts. We explore this issue in detail in Chapter 11, "Racial, Ethnic, Cultural (REC) Identity Attitudes in People of Color: Counseling Implications."

REFLECTION AND DISCUSSION QUESTIONS

1. What are some of the therapeutic issues that face counselors of color working with members of their own group or with another minority group member?
2. Which minority group member do you anticipate would be most difficult to work with in counseling? Why?
3. If you were a client of color and had to choose the race of the counselor, whom would you choose? Why?
4. As a White person, would working with a minority group counselor bother you? What

reactions or thoughts do you have about this question?

5. For each of the challenges noted in this chapter, can you provide suggestions of how best to handle these situations? What are the pros and cons of your advice?

It is clear that cultural competence goals do not apply only to White helping professionals. All therapists and counselors, regardless of race, culture, gender, and sexual orientation, need to (a) become aware of their own worldviews and their biases, values, and assumptions about human behavior; (b) understand the worldviews of their culturally diverse clients; and (c) develop culturally appropriate intervention strategies in working with culturally diverse clients.

IMPLICATIONS FOR CLINICAL PRACTICE

1. Working toward cultural competence and cultural humility are functions of everyone, regardless of race, gender, sexual orientation, religious preference, and so on.
2. Marginalized group members are not immune from having biases and prejudices toward majority group members and one another.
3. Because all oppression is damaging and serves to separate rather than unify, playing the "who's more oppressed?" game is destructive to group unity and counterproductive to combating racism.
4. In order to improve interracial and interethnic counseling relationships, we must face the fact that there is also much misunderstanding and bias among and between groups of color.
5. Be aware that not all bad things that happen to people of color are the results of racism. Although we need to trust our intuitive or experiential reality, it is equally important that we do not externalize everything.
6. Despite sharing similar experiences of oppression, cultural differences may infect the therapeutic process and render your attempts to help the client ineffective.
7. Realize how your communication style (direct versus subtle, passionate versus controlled) and nonverbal differences may impact the client.
8. Therapists must evaluate their own and the client's racial and ethnic identity status and determine how these factors might impact work with clients of the same or different ethnicity.
9. Addressing or *broaching* racial, ethnic, or other differences between the therapist and the client can be useful in facilitating a helping relationship.
10. Counselors of color should be aware of and prepared to deal with the many therapeutic challenges they are likely to encounter when working with White clients and clients of color.

Video 3.5 Impact of Attitudes

Our conscious and unconscious beliefs influence the counseling session as well as the client/therapist relationship.

SUMMARY

Persons of color have major hesitations and concerns about publicly airing interracial/interethnic conflicts, differences, and misunderstandings because of the possible political ramifications for group unity. But it appears that cultural competency and cultural humility objectives are applicable both to therapists of color and to other clinicians from marginalized groups. In addition to historical relationships and sociopolitical factors that have created possible animosity between groups, differences in *cultural values*, *communication styles*, and racial and ethnic identity also contribute to misunderstanding and conflict. Little actual research has been conducted on the challenges and difficulties that counselors of color face when working with other culturally diverse groups. Less yet has been done on the subject of cultural competence as it relates to therapists of color.

In working with White clients, however, people of color might (a) be unable to contain their anger and rage toward their clients, as they view them as oppressors, (b) have difficulty understanding the worldview of their clients, (c) be hindered in their ability to establish rapport, (d) have difficulty empathizing with their clients, and (e) be guilty of imposing their racial realities upon their clients. The five challenges counselors of color are likely to encounter are (a) questioning their competence, (b) desiring to prove their competence, (c) controlling racial animosity toward White clients, (d) being viewed as super minorities, and (e) dealing with client expressions of racism.

Many of the challenges facing therapists of color working with White clients can also make their appearance in counseling dyads where both are from marginalized groups. Like their White counterparts, people of color are socialized into the dominant values and beliefs of the larger society. As a result, they may inherit the perceptions and beliefs of other racial/ethnic minority groups as well. In this case, the biases and stereotypes held for other groups of color may not be all that different from those of White Americans. Other interracial‐ and interethnic‐specific challenges may also make their appearance in the counseling dyad, including overidentifying with the client, encountering clashes in *cultural values*, experiencing clashes in communication and therapeutic styles, receiving and expressing racial animosity, and dealing with the stage of racial identity of counselors and clients.

GLOSSARY TERMS

- Broaching
- Communication styles
- Cultural values
- Historical stereotypes
- Interracial/interethnic bias
- Interracial/interethnic conflict
- Interracial/interethnic discrimination
- Interracial/interethnic group relations
- Model minority myth
- Multicultural counseling
- Racial/Ethnic identity
- Socially marginalized groups
- “Who's more oppressed?” game

Video 3.6 Counseling Session Analysis

Analysis of the counseling session.

REFERENCES

1. Adames, H. Y., Chavez‐Dueñas, N. Y., & Organista, K. C. (2016). Skin color matters in Latino/a communities: Identifying, understanding, and addressing Mestizaje racial ideologies in clinical practice. *Professional Psychology: Research and Practice*, *47*(1), 46–55.

2. Arredondo, P., Gallardo‐Cooper, M., Delgado‐Romero, E. A., & Zapata, A. L. (2014). *Culturally responsive counseling with Latinas/os*. Alexandria, VA: American Counseling Association.

3. Bautista, E. M. (2003). The impact of context, phenotype, and other identifiers on Latina/o adolescent ethnic identity and acculturation. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, *63*(7‐B), 3464.

4. Behnken, B. D. (2011). *Fighting their own battles: Mexican Americans, African Americans, and the struggle for civil rights in Texas*. Charlotte, NC: University of North Carolina Press.

5. Cashwell, C. S., Shcherbakova, J., & Cashwell, T. H. (2003). Effect of client and counselor ethnicity on preference for counselor disclosure. *Journal of Counseling and Development*, *81*, 196–201.

6. Chang, E. T. (2001). Bitter fruit: The politics of Black–Korean conflict in New York City (review). *Journal of Asian American Studies*, *4*(3), 295–298.

7. Chen, C. P. (2005). Morita therapy: A philosophy of Yin/Yang coexistence. In R. Moodley, & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 221–232). Thousand Oaks, CA: Sage.

8. Comas‐Diaz, L. (2012). *Multicultural care: A clinician's guide to cultural competence*. Washington, DC: American Psychological Association.

9. Comas‐Diaz, L., & Jacobsen, F. M. (1995). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry*, *61*, 392–402.

10. Davis, L. E., & Gelsomino, J. (1994). An assessment of practitioner cross‐racial treatment experiences. *Social Work*, *39*, 116–123.

11. Day‐Vines, N. L., Wood, S. M., Grothaus, T., Craigen, L., Holman, A., Dotson‐Blake, K., & Douglass, M. J. (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. *Journal of Counseling & Development*, *85*(4), 401–409.

12. De Genova, N. (2006). *Racial transformations: Latinos and Asians remaking the United States*. Durham, NC: Duke University Press.

13. de las Fuentes, C. (2006). Latina/o American populations. In M. G. Constantine (Ed.), *Clinical practice with people of color* (pp. 46–60). Hoboken, NJ: Wiley.

14. Duran, E. (2006). *Healing the soul wound*. New York, NY: Teachers College Press.

15. Evans, K. M. (2013). Culturally alert counseling with African Americans. In G. McAuliffe (Ed.), & Associates *Culturally alert counseling* (2nd ed.) (pp. 125–155).

Thousand Oaks, CA: Sage.

16. Fuertes, J. N., & Gelso, C. J. (2000). Hispanic counselors' race and accent and Euro Americans' universal‐diverse orientation: A study of initial perceptions. *Cultural Diversity and Ethnic Minority Psychology*, *6*, 211–219.

17. Garrett, M. T., & Portman, T. A. A. (2011). *Counseling native Americans*. Belmont, CA: Cengage.

18. Goode‐Cross, D. T., & Grim, K. A. (2016). “An unspoken level of comfort.” Black therapists' experiences working with Black clients. *Journal of Black Psychology*, *42*(1), 29–53.

19. Greenberg, J. P., Vinjamuri, M., Williams‐Gray, B., & Senreich, E. (2017). Shining the light on intersectionality: The complexities of similarity and difference in the therapeutic process from the perspectives of Black and Hispanic social workers. *Smith College Studies in Social Work*, *88*(1), 59–81.

20. Guzman, M. R., & Carrasco, N. (2011). *Counseling Latino/a Americans*. Belmont, CA: Cengage.

21. Hecht, M. L., Jackson, R. L., & Ribeau, S. A. (2002). *African American communication: Exploring identity and culture* (2nd ed.). Mahwah, NJ: Erlbaum.

22. Jensen, J. V. (1985). Perspective on nonverbal intercultural communication. In L. A. Samovar, & R. E. Porter (Eds.), *Intercultural communication: A reader* (pp. 256–272). Belmont, CA: Wadsworth.

23. Jones, J. M. (2013a). Americans rate racial and ethnic relations in U.S. positively. Retrieved from http://www.gallup.com/poll/163535/americans‐rate‐racial‐ethnic‐relations‐positively.aspx?

24. Jones, J. M. (2013b). Race always matters! *Diversity Us*. Retrieved from http://sites.udel.edu/csd/2013/08/02/race‐always‐matters‐2/

25. Kiang, L., Huynh, V. W., Cheah, C. S. L., Wang, Y., & Yoshikawa, H. (2017). Moving beyond the model minority. *Asian American Journal of Psychology*, *8*(1), 1–6.

26. Kim, B. S. K. (2011). *Counseling Asian Americans*. Belmont, CA: Cengage.

27. Kim, B. S. K., & Park, Y. S. (2013). Culturally alert counseling with East and Southeast Asian Americans. In G. McAuliffe (Ed.), & Associates *Culturally alert counseling* (pp. 157–183). Thousand Oaks, CA: Sage.

28. Kim, K. (1999). *Koreans in the hood: Conflict with African‐Americans*. Baltimore, MD: Johns Hopkins University Press.

29. Kochman, T. (1981). *Black and White styles in conflict*. Chicago, IL: University of Chicago Press.

30. Li‐Repac, D. (1980). Cultural influences on clinical perception: A comparison between Caucasian and Chinese‐American therapists. *Journal of Cross‐Cultural Psychology*, *11*, 327–342.

31. McClain, P. D., Carter, N., DeFrancesco, V., Lyle, M., Nunnally, S. C., & Cotton, K. D. (2006). Racial distancing in a southern city: Latino immigrants' views of Black Americans. *Journal of Politics*, *68*, 3–23.

32. McCormick, R. (2005). The healing path: What can counselors learn from aboriginal people about how to heal? In R. Moodley, & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 293–304). Thousand Oaks, CA: Sage.

33. Myers, E. R. (2001). African‐American perceptions of Asian‐American merchants: An exploratory study. In E. R. Myers (Ed.), *Challenges of a changing America: Perspectives on immigration and multiculturalism in the United States* (2nd ed.) (pp. 171–179). San Francisco, CA: Caddo Gap Press.

34. Nadal, K. L. (2011). *Filipino American psychology*. Hoboken, NJ: Wiley.

35. National Conference of Christians and Jews (1994). *Taking America's pulse*. New York, NY: National Conference of Christians and Jews.

36. Neel, J. (2017a). Poll: Native Americans see far more discrimination in areas where they are a majority. Retrieved from: https://www.npr.org/2017/11/14/563306555/poll‐native‐americans‐see‐far‐more‐discrimination‐in‐areas‐where‐they‐are‐a‐majo

37. Neel, J. (2017b). Poll: Asian‐Americans see individuals' prejudice as big discrimination problem. Retrieved from: https://www.npr.org/2017/12/06/568593799/poll‐asian‐americans‐see‐individuals‐prejudice‐as‐big‐discrimination‐problem

38. Nydell, M. K. (1996). *Understanding Arabs: A guide for Westerners*. Yarmouth, ME: Intercultural Press.

39. Parham, T. A., Ajamu, A., & White, J. L. (2011). *Psychology of Blacks: Centering our perspectives in the African consciousness*. Boston, MA: Prentice Hall.

40. Pew Research Center (2008). *Do Blacks and Hispanics get along?*. Washington, DC: Pew Research Center.

41. Pew Research Center (2012). *The rise of Asian Americans*. Washington, DC: Pew Research Center.

42. Pew Research Center. (2017). Most Americans Say Trump's Election has Led to Worse Race Relations in the U.S. Retrieved from: http://www.people‐press.org/2017/12/19/most‐americans‐say‐trumps‐election‐has‐led‐to‐worse‐race‐relations‐in‐the‐u‐s

43. Ratts, M. J., & Pedersen, P. B. (2014). *Counseling for multiculturalism and social justice*. Alexandria, VA: American Counseling Association.

44. Ratts, M. J., Singh, A. A., Nassar‐McMillan, S., Butler, K., & McCullough, R. J. (2015). Multicultural and social justice counseling competencies. The Multicultural Counseling Competencies Revision Committee of the American Counseling Association, Draft Report.

45. Ridley, C. R. (2005). *Overcoming unintentional racism in counseling and therapy* (2nd ed.). Thousand Oaks, CA: Sage.

46. Samad, L., Tate, A. R., Dezateaux, C., Peckham, C., Butler, N., & Bedford, H. (2006). Differences in risk factors for partial and no immunisation in the first year of life: Prospective cohort study. *British Medical Journal, 332*, 1312–1313.

47. Sanchez, D., del Prado, A., & Davis, C. III (2010). Broaching ethnicity competently in therapy. In J. A. E. Cornish, B. A. Schreier, L. I. Nadkarni, L. H. Metzger, & E. R. Rodolfa (Eds.), *Handbook of mulicultural counseling competencies* (pp. 93–116). Hoboken, NJ: Wiley.

48. Santiago‐Rivera, A., Arredondo, P., & Gallardo‐Cooper, M. (2002). *Counseling Latinos and la familia: A guide for practitioners*. Thousand Oaks, CA: Sage.

49. Scharlin, C., & Villanueva, L. V. (1994). *Philip Vera Cruz: A personal history of Filipino immigrants and the farmworkers movement*. Seattle, WA: University of Washington Press.

50. Steinberg, S. (2007). *Race relations: A critique*. Stanford, CA: Stanford University Press.

51. Sue, D. W. (2010a). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, NJ: Wiley.

52. Sue, D. W. (2010b). *Microaggressions and marginality: Manifestations, dynamics, and impact*. Hoboken, NJ: Wiley.

53. Sue, D. W. (2015). *Race talk and the conspiracy of silence: Understanding and facilitating difficult dialogues on race*. Hoboken, NJ: Wiley.

54. Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). Hoboken, NJ: Wiley.

55. U.S. Census Bureau. (2005). *Statistical abstract of the United States: 2004–2005. The national data book*. American Indian, Alaska Native tables. Retrieved from https://www.census.gov/library/publications/2004/compendia/statab/124ed.html

56. U.S. Census Bureau. (2012). U.S. Census Bureau projections show a slower growing, older, more diverse nation a half century from now. Retrieved from: https://www.census.gov/newsroom/releases/archives/population/cb12‐243.html

57. U.S. Census Bureau. (2015). New Census Bureau report analyzes U.S. population projections. Retrieved from: https://www.census.gov/newsroom/press‐releases/2015/cb15‐tps16.html

58. Weber, S. N. (1985). The need to be: The sociocultural significance of Black language. In L. A. Samovar, & R. E. Porter (Eds.), *Intercultural communication: A reader* (pp. 244–253). Belmont, CA: Wadsworth.

59. Wood, D. B. (2006). Rising Black–Latino clash on jobs. *Christian Science Monitor*. Retrieved from http://www.csmonitor.com/2006/0525/p01s03‐ussc.html

60. Yoon, I. (1997). *On my own: Korean business and race relations in America*. Chicago, IL: University of Chicago Press.

61. Zane, N., & Ku, H. (2014). Effects of ethnic match, gender match, acculturation, cultural identity, and face concern on self‐disclosure in counseling for Asian Americans. *Asian American Journal of Psychology*, *5*, 66–74.

PART II

The Impact and Social Justice Implications of Counseling and Psychotherapy

4
The Political and Social Justice Implications of Counseling and Psychotherapy

Chapter Objectives

1. **1. Understand how the sociopolitical climate affects the manifestation, etiology, diagnosis, and treatment of psychological disturbances in socially devalued groups in our society.**
2. **2. Learn why traditional counseling/mental health practice may represent cultural oppression for marginalized groups.**
3. **3. Become knowledgeable about how the educational and mental health field has historically portrayed persons of color.**
4. **4. Understand the racial realities (worldviews) of people of color and those of White Americans.**
5. **5. Know how these differences may pose problems in race relations and multicultural counseling and therapy (MCT).**
6. **6. Learn how systemic factors (institutional policies, practices, and regulations) affect mental health and counseling practices.**
7. **7. Define and describe *social justice counseling* and the importance it plays in the mental health professions.**

AN OPEN LETTER TO BROTHERS AND SISTERS OF COLOR

In 1997, I, Derald Wing Sue, was privileged to testify before President Clinton's Race Advisory Board on the President's Initiative on Race (1998) about the impact of racism on people of color. The televised public testimony evoked strong negative reactions from primarily White viewers, who claimed my colleagues and I were simply exaggerating, and that racism was now a thing of the past. In reaction to those criticisms, I published an open letter to brothers and sisters of color in 2003. A brief portion is reproduced here.

> *Dear Brothers and Sisters of Color:*
>
> *I write … to you and to those White folks who have marched with us against racism and shown that their hearts are in the right place. Throughout our people's histories, we have had to contend with invalidation, oppression, injustice, terrorism, and genocide. Racism is a constant reality in our lives. It is a toxic force that has sought to*

- *strip us of our identities,*
- *take away our dignity,*
- *make us second - class citizens,*
- *destroy our peoples, cultures, and communities,*
- *steal our land and property,*
- *torture, rape, and murder us,*
- *imprison us on reservations, concentration camps, inferior schools, segregated neighborhoods, and jails,*
- *use us as guinea pigs in medical experiments, and*
- *blame our victimization upon the faults of our own people.*

> *Attempts to express these thoughts have generally been met with disbelief and/or incredulity by many of our well - intentioned White brothers and sisters. We have been asked, "Aren't you distorting the truth? Where is your proof? Where is your evidence?"*
>
> *When we attempt to provide it, we are interrogated about its legitimacy, told that we are biased or paranoid, and accused of being dishonest in how we present the facts. After all, they say, "Our nation is built upon life, liberty, and the pursuit of happiness. It was founded upon the principles of freedom, democracy, and equality." Yet, these guiding principles seem intended for Whites only! In the classic book,* Animal Farm *(Orwell, 1945), when the issue of inequality arose, the character in a position of power justified the treatment by stating, "Some are more equal than others." Rather than offer enlightenment and freedom, education and healing, and rather than allowing for equal access and opportunity, historical and current practices in our nation have restricted, stereotyped, damaged, and oppressed persons of color.*
>
> *For too long people of color have not had the opportunity or power to express their*

> *points of view. For too long our voices have not been heard. For too long our worldviews have been diminished, negated, or considered invalid. For too long we have been told that our perceptions are incorrect, that most things are well with our society, and that our concerns and complaints are not supported. For too long we have had to justify our existence, and to fight for our dignity and humanity. No wonder that we are so tired, impatient, and angry. Yet, as people of color, we cannot let fatigue turn into hopelessness, nor anger into bitterness. Hopelessness is the forerunner to surrender, and bitterness leads to blind hatred. Either could spell our downfall!*
>
> (D. W. Sue, 2003, pp. 257–259)

Video 4.0: Introduction

Awareness of cultural competence as a universal necessity in counseling and not just a majority requirement.

THE MENTAL HEALTH IMPACT OF SOCIOPOLITICAL OPPRESSION

Multicultural counseling and therapy (MCT) means understanding the worldviews and life experiences of diverse groups in our nation. To be culturally competent means to understand the history of oppression experienced by marginalized groups in our society. The stories of discrimination and pain of the oppressed are often minimized and neglected. Many, for example, contend that the reality of racism, sexism, and homophobia is relatively unknown or ignored by those in power because of the discomfort that pervades such topics among people of every political persuasion. Ignoring or dismissing Whiteness, according to author and social critic Ta‐Nehisi Coates, has one primary motivation.

> *The motive is clear: escapism. To accept that the bloody heirloom remains potent even now, some five decades after Martin Luther King Jr. was gunned down on a Memphis balcony—even after a black president; indeed, strengthened by the fact of that black president—is to accept that racism remains, as it has since 1776, at the heart of this country's political life.*
>
> *(Coates, 2017, para. 14)*

Vernon E. Jordan, Jr., an African American attorney and former confidant of President Bill Clinton, spoke about racism's continuing impact in startling terms. In making an analogy between the terrorist attacks of September 11, 2001, and the racism directed at African Americans, Jordan stated that

> *None of this is new to Black people. War, hunger, disease, unemployment, deprivation, dehumanization, and terrorism define our existence. They are not new to us. Slavery was terrorism, segregation was terrorism, and the bombing of the four little girls in Sunday school in Birmingham was terrorism. The violent deaths of Medgar, Martin, Malcolm, Vernon Dahmer, Chaney, Shwerner, and Goodman were terrorism. And the difference between September 11 and the terror visited upon Black people is that on September 11, the terrorists were foreigners. When we were terrorized, it was by our neighbors. The terrorists were Americans.*
>
> *(Excerpted from a speech by Vernon E. Jordan, June 2002)*

Such experiences have been represented more recently by Black Lives Matter, a grassroots movement that was initiated in response to the killing of Trayvon Martin in 2012 and that went on to represent the perspectives of many Black Americans (and others) regarding the deaths of their community members at the hands of law enforcement (Hargons et al., 2017).

Likewise, in speaking about the history of psychological research conducted on ethnic minority communities by White social scientists, the late Charles W. Thomas, a respected African American psychologist, voiced his concerns strongly.

> *White psychologists have raped Black communities all over the country. Yes, raped. They have used Black people as the human equivalent of rats run through Ph.D. experiments and as helpless clients for programs that serve middle‐class White administrators better than they do the poor. They have used research on Black people as green stamps to trade for research grants. They have been vultures.*
>
> *(Thomas, 1970, p. 52)*

To many people of color, the “Tuskegee experiment” represents a prime example of the allegation by Thomas. The Tuskegee experiment was carried out from 1932 to 1972 by the

U.S. Public Health Service; more than 600 Alabama Black men were used as guinea pigs in the study of what damage would occur to the body if syphilis were left untreated. Approximately 399 were allowed to go untreated, even when medication was available. Records indicate that 7 died as a result of syphilis, and an additional 154 died of heart disease that may have been caused by the untreated syphilis! In a moving ceremony in 1997, President Clinton officially expressed regret for the experiment to the few survivors and apologized to Black America.

Likewise, in August 2011, a White House bioethics panel heard about American‐run venereal disease experiments conducted on Guatemalan prisoners, soldiers, and mental patients from 1946 to 1948: the United States paid for syphilis‐infected Guatemalan prostitutes to have sex with prisoners. Approximately 5,500 Guatemalans were enrolled, 1,300 were deliberately infected, and 83 died (McNeil, 2011). The aim of the study was to see whether penicillin could prevent infection after exposure. When these experiments came to light, President Obama apologized to President Alvaro Colom of Guatemala. Dr. Amy Gutman, the chairwoman of the bioethics panel and president of the University of Pennsylvania, described the incident as a dark chapter in the history of medical research. Experiments of this type are ghastly and give rise to suspicions that people of color are being used as guinea pigs in other medical and social experiments as well.

REFLECTION AND DISCUSSION QUESTIONS

1. Are these beliefs by people of color accurate?
2. Might they simply be exaggerations from overly mistrustful individuals?
3. Aren't people of color making a mountain out of a molehill?
4. As indicated in Chapter 1, what emotional roadblocks might you (or other readers) now be feeling? What meaning do you impute to them?
5. What has all this to do with counseling and psychotherapy?

Because the worldviews of culturally diverse clients are often linked to the historical and current experiences of oppression in the United States (American Psychological Association Presidential Task Force on Preventing Discrimination and Promoting Diversity 2012; Ponterotto, Utsey, & Pedersen, 2006), it is necessary to understand the worldview of culturally diverse clients from both a cultural and a political perspective (Owens, Queener, & Stewart, 2016; Ridley, 2005). Clients of color, for example, are likely to approach counseling and therapy with a great deal of healthy skepticism regarding the institutions from which therapists work and even the conscious and unconscious motives of the helping professional.

The main thesis of this book is that counseling and psychotherapy do not take place in a vacuum, isolated from the larger sociopolitical influences of our societal climate (Constantine, 2006; Katz, 1985; Liu, Hernandez, Mahmood, & Stinson, 2006; Prilleltensky, 1989). Multicultural counseling often mirrors the nature of race relations in the wider society, as well as the dominant–subordinate relationships of other marginalized groups (lesbian, gay, bisexual, transgender, and queer [LGBTQ] people, women, and the physically challenged). As explained in the American Psychological Association's Multicultural Guidelines (2017), multicultural counseling is fluid, multilayered, and complex; it requires comprehension of the interwoven, intersectional nature of these group memberships, in that both privileged and subordinated individuals always embody more than one identity simultaneously (Moradi & Grzanka, 2017). It serves as a microcosm, reflecting Black–White, Asian–White, Hispanic–

White, and American Indian–White relations. As we saw in Chapter 3, it also mirrors the wide variety of interethnic/interracial relations as well.

SOCIOPOLITICAL OPPRESSION AND THE TRAINING OF COUNSELING/MENTAL HEALTH PROFESSIONALS

While national interest in the mental health needs of people of color has increased, the human service professions have historically neglected this population. Evidence reveals that these marginalized groups, in addition to the common stresses experienced by everyone else, are more likely to encounter problems such as immigrant status, poverty, cultural racism, prejudice, and discrimination (Choudhuri, Santiago‐Rivera, & Garrett, 2012; West‐Olatunji & Conwill, 2011). Yet, studies continue to reveal that American Indians, Asian Americans, African Americans, and Latinx Americans tend to underutilize traditional mental health services in a variety of contexts (Kearney, Draper, & Baron, 2005; Owen, Imel, Adelson, & Rodolfa, 2012; Smith & Trimble, 2016; Wang & Kim, 2010).

Some researchers have hypothesized that people of color underutilize and prematurely terminate counseling/therapy because of the biased nature of the services themselves (Kearney et al., 2005). The services offered are frequently antagonistic or inappropriate to the life experiences of culturally diverse clients; they lack sensitivity and understanding, and they are oppressive and discriminating toward clients of color (Cokley, 2006). Many believe that the presence of ill‐prepared mental health professionals is the direct result of a *culture‐bound and biased training system* (Mio, 2005; Utsey, Grange, & Allyne, 2006). As will be discussed in the following section, the manifestations of these biases can be seen within professional approaches to the definition of mental health, as well as within the scholarly literature that supports them.

Video 4.1: Counseling Through a Western Lens

How transference and countertransference can negatively impact the counseling relationship.

DEFINITIONS OF MENTAL HEALTH

If we look at the criteria used by the mental health profession to judge normality and *abnormality*, their *ethnocentricity* becomes glaring. Several fundamental approaches that have particular relevance to our discussion have been identified (Sue, Sue, Sue, & Sue, 2016): (a) normality as a statistical concept, (b) normality as ideal mental health, and (c) *abnormality* as the presence of certain behaviors (research criteria).

Normality as a Statistical Concept

First, statistical criteria equate normality with those behaviors that occur most frequently in the population. *Abnormality* is defined in terms of those behaviors that occur least frequently. Despite the word *statistical*, however, these criteria need not be quantitative in nature: individuals who talk to themselves, disrobe in public, or laugh uncontrollably for no apparent reason are considered abnormal according to these criteria simply because most people do not behave in that way. Statistical criteria undergird our notion of a normal probability curve, so often used in IQ tests, achievement tests, and personality inventories. Statistical criteria may seem adequate in specific instances, but they fail to take into account differences in time, community standards, cultural values, and the power that different social groups have to define such classifications. When we resort to a statistical definition, it is generally the group in power that determines what constitutes normality and *abnormality*. For example, if African Americans were to be administered a personality test and it was found that they were more suspicious than their White counterparts, what would this mean? Some psychologists and educators have used such findings to label African Americans as paranoid, yet this interpretation has been challenged by many Black psychologists (Grier & Cobbs, 1968, 1971; Parham et al., 2011), who point out that marginalized groups have good reason to be suspicious and mistrustful of White society.

Normality as Ideal Mental Health

Second, humanistic psychologists have proposed the concept of ideal mental health as providing the criteria of normality (Cain, 2010). Such criteria stress the importance of attaining some positive goal like consciousness‐insight, self‐actualization/creativity, competence, autonomy, resistance to stress, or psychological mindedness. The biased nature of such approaches is grounded in the belief in a universal application (all populations in all situations) and reveals a failure to recognize the value base from which the criteria are derived. The particular goal or ideal used is intimately linked with the theoretical frame of reference and values held by the practitioner (psychodynamic, humanistic/existential, or cognitive/behavioral). For example, the psychoanalytic emphasis on *insight* as a determinant of mental health is a value in itself (London, 1988).

It is important for the mental health professional to be aware, however, that certain ethnic and cultural groups may not define insight in the same ways that they do. A characteristic often linked to the healthy personality is the ability to talk about the deepest and most intimate aspects of one's life: to self‐disclose. This orientation is very characteristic of our counseling and therapy process, in which clients are expected to talk about themselves in a very personal manner. The fact that many people of color are initially reluctant to self‐disclose can place them in a situation where they are judged to be mentally unhealthy and, in this case, paranoid (Parham, 2002). Similarly, definitions of mental health that focus on competence, autonomy, and resistance to stress are related to White middle‐class notions of

individualism (Ivey, D'Andrea, Ivey, & Simek‐Morgan, 2007), a perspective according to which people succeed solely because of their *own* efforts and abilities. Conversely, when people fail, the cause is assumed to be their own lack of ability, interest, or maturity, or some inherent weakness of the ego. Ryan (1971) was the first to coin the phrase "blaming the victim" to refer to this process, which does not account for factors such as the stress and discrimination related to minority status. A broader systems‐level analysis would show that the economic, social, and psychological conditions faced by marginalized groups are related to their oppressed status in the United States.

Abnormality as the Presence of Certain Behaviors

A third understanding involves the political and societal implications of psychiatric diagnosis and hospitalization, as forcefully pointed out years ago by Szasz (1970, 1971). Notably, although it appears that minorities underutilize outpatient services, they also appear to face greater levels of involuntary hospital commitments (Snowden & Cheung, 1990). Szasz states his opinion of the relationship between these statistics.

> *In my opinion, mental illness is a myth. People we label "mentally ill" are not sick, and involuntary mental hospitalization is not treatment. It is punishment … The fact that mental illness designates a deviation from an ethnical rule of conduct, and that such rules vary widely, explains why upper‐middle‐class psychiatrists can so easily find evidence of "mental illness" in lower‐class individuals and why so many prominent persons in the past fifty years or so have been diagnosed by their enemies as suffering from some types of insanity. Barry Goldwater was called a paranoid schizophrenic … Woodrow Wilson, a neurotic … Jesus Christ, according to two psychiatrists … was a born degenerate with a fixed delusion system.*
>
> *(Szasz, 1970, pp. 167–168)*

Szasz (1987, 1999) views the mental health professional as an inquisitor, an agent of society for the exertion of social control. Psychiatric hospitalization is, accordingly, seen as a form of control for persons who disturb us or who have lifestyles that differ from the accepted norms of society—a concept with frightening implications for people in marginalized social groups. In addition, the use of "objective" psychological inventories as indicators of maladjustment may also place people of color at a disadvantage. Many are aware that the test instruments used on them have been constructed and standardized according to White middle‐class norms. The lack of culturally unbiased instruments makes many feel that the results obtained are invalid. Indeed, in a landmark decision in the State of California (*Larry P.* v. *California*, 1986), a judge ruled in favor of the Association of Black Psychologists' claim that individual intelligence tests, such as versions of the WISC, WAIS, and Stanford Binet, could not be used in the public schools on Black students. The improper use of such instruments can lead to an exclusion of minorities from jobs and promotion, to discriminatory educational decisions, and to biased determination of what constitutes pathology and cure in counseling/therapy (Samuda, 1998).

Further, when a diagnosis becomes a label, it can have serious consequences. First, a label can cause people to interpret all activities of the affected individual as pathological. No matter what African Americans may do or say that breaks a stereotype, their behaviors will seem to reflect the fact that they are less intelligent than others around them. Second, the label may cause others to treat affected individuals differently, even when they are perfectly normal. Third, a label may cause those who are labeled to believe that they do indeed possess such characteristics (Rosenthal & Jacobson, 1968) or that the threats of being perceived as

less capable can seriously impair their performance (Steele, 2003).

Curriculum and Training Deficiencies

It appears that many of the universal definitions of mental health that have pervaded the profession have primarily been due to severe deficiencies in training programs. Educators (Chen, 2005; Mio & Morris, 1990; Sue, 2010) have asserted that the major reason for ineffectiveness in working with culturally diverse populations is the lack of culturally sensitive material taught in the curricula. It has been ethnocentrically assumed that the material taught in traditional mental health programs is equally applicable to all groups. Even now, when there is high recognition of the need for multicultural curricula, it has become a battle to infuse such concepts into course content (Vera, Buhin, & Shin, 2006). As a result, course offerings continue to lack a non‐White perspective, to treat cultural issues as an adjunct or add‐on, to portray cultural groups in stereotypic ways, and to create an academic environment that does not support their concerns, needs, and issues (Turner, Gonzalez, & Wood, 2008).

Further, a major criticism has been that training programs purposely leave out *antiracism*, antisexism, and antihomophobia curricula for fear of requiring students to explore their own biases and prejudices (Carter, 2005; Vera et al., 2006). Because multicultural competence cannot occur without students or trainees confronting these harmful and detrimental attitudes about race, gender, and sexual orientation, the education and training of psychologists remain in the cognitive and objective domain, preventing self‐exploration (Sue, 2015). This allows students to study the material from a position of safety. An effective curriculum must enable students to understand feelings of helplessness and powerlessness, low self‐esteem, and poor self‐concept, and how they contribute to low motivation, frustration, hate, ambivalence, and apathy. Each course should contain (a) a *consciousness‐raising* component, (b) an *affective/experiential* component, (c) a *knowledge* component, and (d) a *skills* component. Importantly, the American Psychological Association Presidential Task Force on Evidence‐Based Practice (2006) recommends that psychology training programs at all levels provide information on the political nature of the practice of psychology and that psychologists practice with an understanding of the professional relevance of their value positions.

Video 4.2: A History of Pathology

Historical biases and their impact on our beliefs, both consciously and unconsciously, within the counseling session.

COUNSELING AND MENTAL HEALTH LITERATURE

Many psychologists have noted how the social science literature, and specifically research, has failed to create a realistic understanding of various ethnic groups in the United States (Cokley, 2006; Guthrie, 1997). In fact, certain practices are felt to have done great harm to persons of color by ignoring them, maintaining false stereotypes, and/or presenting a distorted view of their lifestyles. Mental health practice may be viewed as encompassing the use of social power and functioning as a handmaiden of the status quo (Halleck, 1971; Katz, 1985). Social sciences are part of a culture‐bound social system, from which researchers are usually drawn; moreover, organized social science is often dependent on the status quo for financial support. People of color frequently see the mental health profession in a similar way—as a discipline concerned with maintaining the status quo (Ponterotto et al., 2006). As a result, the person collecting and reporting data is often perceived as possessing the social bias of his or her society (Ridley, 2005).

Social sciences, for example, have historically ignored the study of Asians in the United States (Hong & Domokos‐Cheng Ham, 2001; Nadal, 2011). This deficit has contributed to the perpetuation of false stereotypes, which has angered many younger Asians concerned with raising consciousness and group esteem. When studies have been conducted on people of color, research has been appallingly unbalanced. Many social scientists (Cokley, 2006; Jones, 2010) have pointed out how "White social science" has tended to reinforce a negative view of African Americans among the public by concentrating on unstable Black families instead of on the many stable ones. Such unfair treatment has also been the case in studies on Latinx Americans, which have focused on the psychopathological problems encountered by Mexican Americans (Falicov, 2005). Other ethnic groups, such as Native Americans (Sutton & Broken Nose, 2005) and Puerto Ricans (Garcia‐Preto, 2005), have fared no better. Even more disturbing is the assumption that the problems encountered by people of color are due to intrinsic factors (racial inferiority, incompatible value systems, etc.) rather than to the failure of society to address racism and other oppressive systems (Sue, 2003). Although there are many aspects to how persons of color are portrayed in social science literature, it seems crucial to explore the application of pathologizing diagnoses to people of color and the role of *scientific racism* in this process.

Pathology and Persons of Color

When we seriously study the "scientific" literature of the past relating to people of color, we are immediately impressed with how an implicit equation of them with pathology and inferiority is a common theme. Some examples of this literature focus upon the presumed genetic inferiority of people of color, while others locate the "problems" within their cultural heritage.

The Genetically Deficient Model

The portrayal of people of color in the literature has generally taken the form of stereotyping them as deficient in certain desirable attributes. For example, de Gobineau's (1915) *The Inequality of the Human Races* and Darwin's (1859) *On the Origin of Species by Natural Selection* were used to support the belief in the genetic intellectual superiority of Whites and the genetic inferiority of the "lower races." Galton (1869) wrote explicitly that African "Negroes" were "half‐witted men" who made "childish, stupid, and simpleton‐like mistakes," while Jews were inferior physically and mentally and only designed for a parasitical existence on other nations of people.

Educators and psychologists have also historically portrayed people of color in pathological ways. The belief that various human groups exist at different stages of biological and emotional development was promoted by G. Stanley Hall, the turn‐of‐the‐century psychologist who became the first president of the American Psychological Association in 1892. He stated explicitly in 1904 that Africans, Indians, and Chinese were members of adolescent races and in a stage of incomplete development (Hall, 1904). In most cases, the evidence used to support such conclusions was fabricated, extremely flimsy, or distorted to fit the belief in non‐White inferiority (Thomas & Sillen, 1972).

As recently as 1989, Professor Rushton of the University of Western Ontario claimed that human intelligence and behavior are largely determined by race, that Whites have bigger brains than Blacks, and that Blacks are more aggressive (Rushton, 1989; Samuda, 1998). Shockley (1972) expressed fears that the accumulation of weak or low‐intelligence genes in the Black population would seriously affect overall intelligence; he thus advocated that people with low IQs not be allowed to bear children—that they be sterilized. Allegations of *scientific racism* can also be seen in the work of Cyril Burt, the eminent British psychologist, who fabricated data to support his contention that intelligence is inherited and that Blacks have inherited inferior brains. Such an accusation is immensely important when one considers that Burt is a major influence in American and British psychology, is considered by many to be the father of educational psychology, was the first psychologist to be knighted, and was awarded the American Psychological Association's Thorndike Prize, as well as that his research findings form the foundation for the belief that intelligence is inherited.

A belief that race and gender dictate intelligence continues to be expressed in modern times and even by our most educated populace. In 2005, then‐Harvard President Larry Summers (former director of President Obama's National Economic Council) suggested that innate differences between the sexes might help explain why relatively few women become professional scientists or engineers. His comments set off a furor, with demands that he be fired. Women academicians were reported to have stormed out in disgust as Summers used “innate ability” as a possible explanation for sex differences in test scores. Ironically, Summers was lecturing to a room of the most accomplished women scholars in engineering and science in the nation.

The questions about whether there are differences in intelligence between races are both complex and emotional. The difficulty in clarifying these questions is compounded by many factors. Besides the difficulty in defining *race*, which has no significant biological basis, questionable assumptions exist regarding whether research on the intelligence of Whites can be generalized to other groups, whether middle‐ and lower‐class ethnic minorities grow up in environments similar to those of middle‐ and lower‐class Whites, and whether test instruments are valid for both minority and White subjects. Moreover, the historical use of science in the investigation of racial differences seems to be linked with White supremacist notions (Jones, 1997, 2010). The classic work of Thomas and Sillen (1972) refers to this as *scientific racism* and cites several historical examples to support this contention:

- Fabricated 1840 census figures were used to support the notion that Blacks living under unnatural conditions of freedom were prone to anxiety.
- Influential medical journals presented fantasies as facts, supporting the belief that anatomical, neurological, or endocrinological aspects of Blacks were always inferior to those of Whites.
- The following misconceptions were presented as facts:

- Mental health for Blacks is contentment with subservience.
- Psychologically normal Blacks are faithful and happy - go - lucky.
- Black persons' brains are smaller and less developed.
- Blacks are less prone to mental illness because their minds are so simple.
- The dreams of Blacks are juvenile in character and not as complex as those of Whites.

More frightening, perhaps, is a survey that found that many of these stereotypes have persisted among White Americans: 20% publicly expressed a belief that African Americans are innately inferior in thinking ability, 19% believed that Blacks have thicker craniums, 23.5% believed they have longer arms, 50% believed Blacks have achieved equality, and 30% believed the problems of Blacks reside in their own group (Babbington, 2008; Pew Research Center, 2007; Plous & Williams, 1995). One wonders how many White Americans hold similar beliefs privately but, because of social pressures, do not publicly voice them.

The Culturally Deficient Model

Well - meaning social scientists who challenged the genetic deficit model by placing heavy reliance on environmental factors nevertheless tended to perpetuate a view that saw people of color as culturally disadvantaged, deficient, or deprived. Instead of a biological condition that caused differences, the blame now shifted to the lifestyles or values of various ethnic groups. The term *cultural deprivation* was first popularized by Riessman's widely read book, *The Culturally Deprived Child* (1962). It was used to indicate that many groups perform poorly on tests or exhibit deviant characteristics because they lack many of the advantages of middle - class culture (education, books, toys, formal language, etc.). In essence, these groups are culturally impoverished!

While Riessman was well - intentioned in trying to not attribute blame to “genes” and intended to improve the condition of African Americans in the United States, some educators strenuously objected to the term. First, *culturally deprived* means to lack a cultural background (e.g., as though enslaved Blacks arrived in America culturally naked), which is incongruous, because everyone inherits a culture. Second, such terms cause conceptual and theoretical confusions that may adversely affect social planning, educational policy, and research; for example, the oft - quoted Moynihan Report asserts that “at the heart of deterioration of the Negro society is the deterioration of the Black family. It is the fundamental source of the weakness in the Negro community” (Moynihan, 1965, p. 5). Action was thus directed toward infusing White concepts of the family into those of Blacks. Third, “cultural deprivation” is used synonymously with deviation from and inferiority to White middle - class values. Fourth, these deviations in values become equated with pathology, in which a group's cultural values, families, or lifestyles transmit the pathology. Thus, the term “cultural deprivation” provides a convenient rationalization and alibi for the perpetuation of racism and the inequities of the socioeconomic system.

The Culturally Diverse Model

Many now maintain that the *culturally deficient* model serves only to perpetuate the myth of people of color's inferiority. The focus tends to be one of blaming the person, with an emphasis on pathology and a use of White middle - class definitions of desirable and undesirable behavior. The social science use of a common, standard assumption implies that to be different is to be deviant, pathological, or sick. Is it possible that intelligence and

personality scores for minority children are really measures of how Anglicized the child has become? To arrive at a more accurate understanding, people of color should no longer be viewed as deficient, but rather as *culturally diverse*. The goal of society should be to recognize the legitimacy of alternative lifestyles, the advantages of being bicultural (capable of functioning in two different cultural environments), and the value of differences.

REFLECTION AND DISCUSSION QUESTIONS

1. What reactions are you experiencing in learning that the history of the mental health movement was filled with racist formulations? As a White trainee, what thoughts and feelings are you experiencing? As a trainee of color (or a member of a marginalized group), what thoughts and feelings do you have?
2. Go back to Chapter 1 and reread the reactions to this book. Do the reactions in that chapter provide insights about your own thoughts and feelings?
3. Given the preceding discussion, in what ways may counseling and psychotherapy represent instruments of cultural oppression? How is this possibly reflected in definitions of normality and *abnormality*, the goals you have for therapy, and the way you conduct your practice with marginalized groups in our society?

CASE STUDY

THE NEED TO TREAT SOCIAL PROBLEMS—SOCIAL JUSTICE COUNSELING

DARYL

Daryl Williams (a pseudonym) is a 12 - year - old African American student attending a predominantly White grade school in Santa Barbara, California. He was referred for counseling by his homeroom teacher because of “constant fighting” on the school grounds, inability to control his anger, and “a potential to seriously injure others.” In addition, his teachers reported that Daryl was doing poorly in class and was inattentive, argumentative toward authority figures, and disrespectful. He appeared withdrawn in his classroom and seldom participated, but when he spoke, he was “loud and aggressive.” Teachers would often admonish Daryl “to calm down.”

The most recent problematic incident, an especially violent one, required the assistant principal to physically pull Daryl away to prevent him from seriously injuring a fellow student. He was suspended from school for three days and subsequently referred to the school psychologist, who conducted a psychological evaluation. Daryl was diagnosed with a conduct disorder, and the psychologist recommended immediate counseling to prevent the untreated disorder from leading to more serious antisocial behaviors. He worried that Daryl was on his way to developing an antisocial personality disorder. The recommended course of treatment consisted of medication and therapy aimed at eliminating Daryl's aggressive behaviors and “controlling his underlying hostility and anger.”

Daryl's parents, however, objected strenuously to the school psychologist's diagnosis and treatment recommendations. They described their son as a “normal child” at home and said he had not had a behavior problem before moving from Los Angeles to Santa Barbara. They described him as feeling isolated at his new school, having few friends,

being rejected by classmates, feeling invalidated by teachers, and feeling “removed” from the content of his classes. They also noted that all of the “fights” were generally instigated through “baiting” and “name‐calling” by his White classmates, that the school climate was hostile toward their son, that the curriculum was entirely Eurocentric, and that school personnel and teachers seemed naive about racial or multicultural issues. They hinted strongly that racism was at work in the school district and attempted to enlist the aid of the only Black counselor in the school, Ms. Jones. Although Ms. Jones appeared to be understanding and empathic toward Daryl's plight, she seemed reluctant to intercede on behalf of the parents. Being a recent graduate from the local college, Ms. Jones seemed to fear being ostracized by other school personnel.

The concerns of Daryl's parents were quickly dismissed by school officials as having little validity. In fact, the principal was incensed by these “accusatory statements of possible racism.” He indicated to the parents that their Los Angeles community did not have a history of academic pursuit and that discipline in the home was usually the culprit. School officials contended that Daryl needed to be more accommodating, to reach out and make friends rather than isolating himself, to take a more active interest in his schoolwork, and to become a good citizen. Further, they asserted that the school climate was not hostile and that Daryl needed to “learn to fit in.” “We treat everyone the same, regardless of race. This school doesn't discriminate,” stated the principal. He went on to say, “It may have been a mistake to move to Santa Barbara. For the sake of your son, perhaps you should consider returning to L.A. so he can better fit in with his people.” These statements greatly angered Daryl's parents.

Adapted from D. W. Sue & Constantine (2003, pp. 214–215).

Video 4.4: Systems of Oppression

Our conscious and unconscious beliefs influence the counseling session as well as the client/therapist relationship.

Video 4.5: Levels of Care

Introduction to counseling session by Dr. Joel Filmore.

If you were a counselor, how would you address this case? Where would you focus your energies? Traditional clinical approaches would direct attention to what they perceive as the locus of the problem: Daryl and his aggressive behavior with classmates, his inattentiveness in class, and his disrespect of authority figures. This approach, however, makes several assumptions: (a) that the locus of the problem resides in the person, (b) that behaviors that violate socially accepted norms are considered maladaptive or disordered, (c) that remediation or elimination of problem behaviors is the goal, (d) that the social context or status quo guides the determination of normal versus abnormal and healthy versus unhealthy behaviors, and (e) that the appropriate role for the counselor is to help the client “fit in” and become “a good citizen.”

As we have just seen, mental health assumptions and practices are strongly influenced by sociopolitical factors. An enlightened approach that acknowledges potential oppression in the manifestation, diagnosis, etiology, and treatment is best accomplished by taking a social justice approach (Flores et al., 2014; McAuliffe & Associates, 2013). In the American Counseling Association (ACA)'s Multicultural and Social Justice Counseling Competencies (MSJCC) (Ratts, Singh, Nassar‐McMillan, Butler, & McCullough, 2016), a strong case is made that multiculturalism is intimately related to social justice and that counselors must engage in actions that require both individual‐ and systems‐level work. Such an approach

might mean challenging the traditional assumptions of therapy, and even reversing them as follows.

1. The locus of the problem may reside in the social system (other students, hostile campus environment, alienating curriculum, lack of minority teachers/staff/students, etc.) rather than in the individual.
2. Behaviors that violate social norms may not be disordered or unhealthy.
3. The social norms, prevailing beliefs, and institutional policies and practices that maintain the status quo may need to be challenged and changed.
4. Although remediation is important, the more effective long‐term solution is prevention.
5. Organizational change requires a macrosystems approach involving other roles and skills beyond the traditional clinical ones.

Along with these five assumptions, implementing *social justice counseling* means recognizing that interventions can occur at four different foci, as Figure 4.1 depicts. These are: (a) *individual*, or the traditional focus on personal insight and change; (b) *professional*, or the modification and evolution of professional codes of practice; (c) *organizational*, or the need to address monocultural institutional procedures; and (d) *societal*, or social policies that undermine the emotional well‐being of marginalized racial‐cultural groups. A basic premise of *social justice counseling* is that culturally competent helping professionals must not confine their perspectives to just individual treatment but must be able to intervene effectively at the professional, organizational, and societal levels as well.

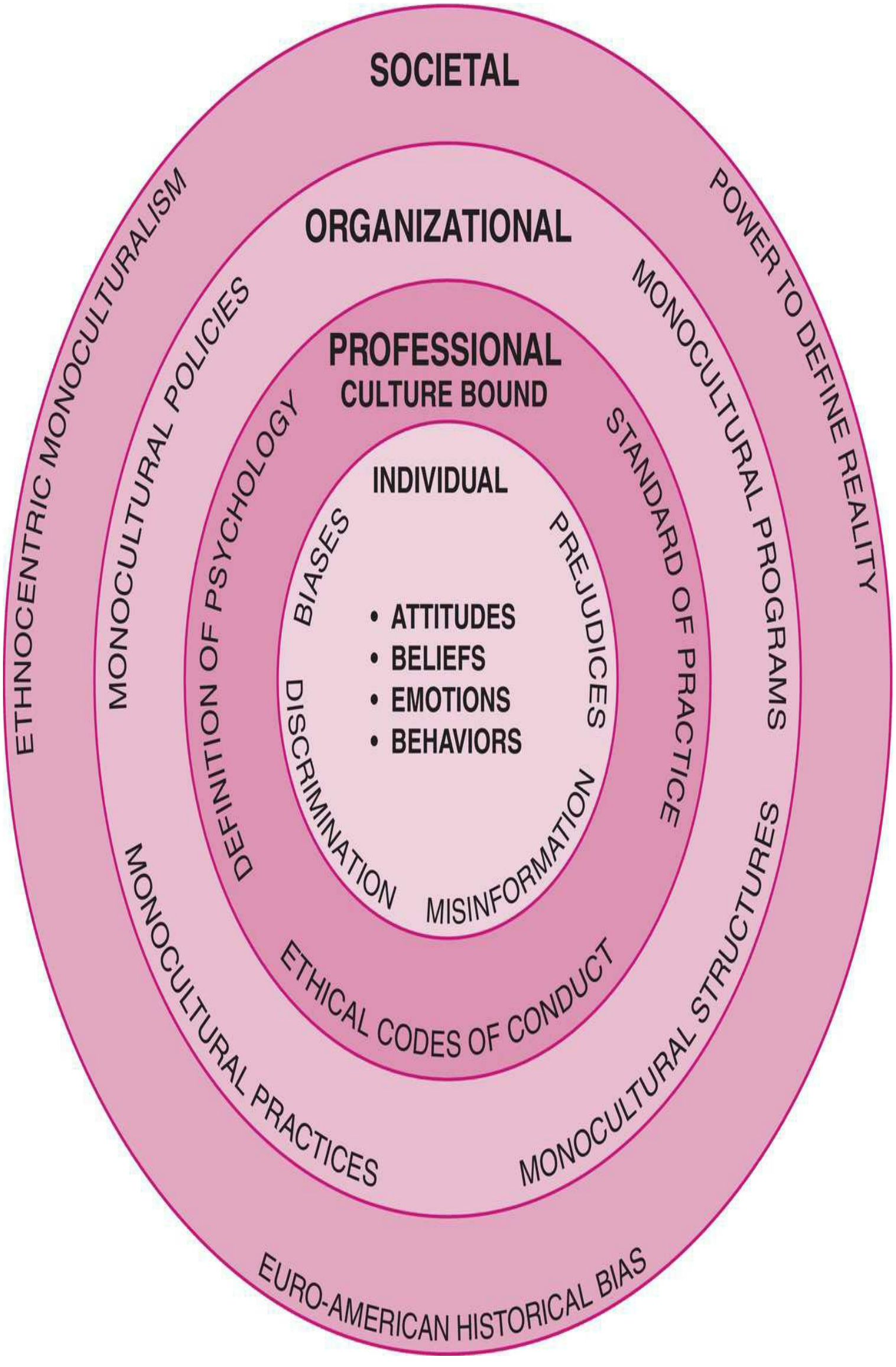
SOCIETAL
ORGANIZATIONAL
PROFESSIONAL
CULTURE BOUND
INDIVIDUAL
• ATTITUDES
• BELIEFS
• EMOTIONS
• BEHAVIORS
BIASES
PREJUDICES
DISCRIMINATION
MISINFORMATION
ETHNOCENTRIC MONOCULTURALISM
MONOCULTURAL POLICIES
DEFINITION OF PSYCHOLOGY
STANDARD OF PRACTICE
MONOCULTURAL PROGRAMS
POWER TO DEFINE REALITY
ETHICAL CODES OF CONDUCT
MONOCULTURAL PRACTICES
MONOCULTURAL STRUCTURES
EURO-AMERICAN HISTORICAL BIAS

FIGURE 4.1 Levels of Counseling Interventions

Select this link to open an interactive version of Figure 4.1.

Often, psychologists treat individuals who are the victims of failed systemic processes. Nevertheless, psychology concentrates primarily on the individual and has been deficient in developing more systemic and large - scale change strategies. Using the case of Daryl, let us illustrate some social justice principles as they apply to multicultural counseling.

Principle 1: A Failure to Develop a Balanced Perspective Between Person and System Focus Can Result in False Attribution of the Problem

It is apparent that school officials have attributed the locus of the problem—that he is impulsive, angry, inattentive, unmotivated, disrespectful, and a poor student—to reside in Daryl. He is labeled as having a conduct disorder with potential antisocial personality traits. Diagnosis of the problem is internal; that is, it resides in Daryl. When the focus of therapy is primarily on the individual, there is a strong tendency to see the locus of the problem as residing solely in the person (Cosgrove, 2006; Ratts & Pedersen, 2014) rather than in the school system, curriculum, or wider campus community. As a result, well - intentioned counselors may mistakenly blame the victim (e.g., by seeing the problem as a deficiency of the person) when, in actuality, the problem may reside in the environment (prejudice, discrimination, racial/cultural invalidation, etc.) (Metzl & Hansen, 2014).

We would submit that it is highly probable that Daryl is the victim of (a) a monocultural educational environment that alienates and denigrates him (Davidson, Waldo, & Adams, 2006); (b) a curriculum that does not deal with the contributions of African Americans or portrays them in a demeaning fashion; (c) teaching styles that may be culturally biased (Cokley, 2006); (d) a campus climate that is hostile to minority students (perceives them as less qualified) (Sue et al., 2011); (e) support services (counseling, study skills, etc.) that fail to understand the minority student experience; and (f) a lack of role models (presence of only one Black counselor in the school) (Alexander & Moore, 2008). For example, would it change your analysis and focus of intervention if Daryl got into fights because he was bullied by fellow students? In other words, suppose there is good reason that this 12 - year - old feels isolated, rejected, devalued, and misunderstood.

Principle 2 : A Failure to Develop a Balanced Perspective Between Person and System Focus Can Result in an Ineffective and Inaccurate Treatment Plan Potentially Harmful to the Client

Failure to understand how systemic factors contribute to individual behavior can result in an ineffective and inaccurate treatment plan; the treatment itself may be potentially harmful (Ali & Sichel, 2014). A basic premise of a broad ecological approach is the assumption that person–environment interactions are crucial to diagnosing and treating problems (Goodman, 2009; Goodman et al., 2004). Clients, for example, are not viewed as isolated units but as embedded in their families, social groups, communities, institutions, cultures, and major systems of our society (Vera & Speight, 2003). If Daryl's problems are interpreted as solely internal and intrapsychic, then it makes sense that therapy be directed toward changing the individual—Daryl. The fighting behavior is perceived as dysfunctional and should be eliminated through therapy or medication that may correct his internal biological dysfunction.

But what if the problem is external? Will having Daryl stop his fighting behavior result in the elimination of teasing from White classmates? Will it make him more connected to the

campus? Will it make him feel more valued and accepted? Treating the symptoms and eliminating self‐defensive behavior may actually make Daryl more vulnerable to racism.

Principle 3: When the Client Is an Organization or a Larger System and Not an Individual, a Major Paradigm Shift Is Required to Attain a True Understanding of Problem and Solution Identification

Let us assume that Daryl is getting into fights because of the hostile school climate and the invalidating nature of his educational experience. Given this assumption, we ask the question, "Who is the client?" Is it Daryl or the school? Where should we direct our therapeutic interventions? In his analysis of schizophrenia, R. D. Laing (1969), an existential psychiatrist, once asked the following question: "Is schizophrenia a sick response to a healthy situation, or is it a healthy response to a sick situation?" In other words, if it is the school system that is dysfunctional (sick) and not the individual client, do we or should we adjust the client to that sick situation? In this case, do we focus on stopping the fighting behavior? If we view the fighting behavior as a healthy response to a sick situation, then eliminating the unhealthy situation (teasing, insensitive administrators and teachers, monocultural curriculum, etc.) should receive top priority for change (Lee, 2007). In other words, rather than individual therapy, social therapy may be the most appropriate and effective means of intervention. Yet, mental health professionals are ill‐equipped and untrained as social change agents (Ali & Sichel, 2014; Lopez‐Baez & Paylo, 2009).

Principle 4: Organizations Are Microcosms of the Wider Society From Which They Originate; As a Result, They Are Likely to Be Reflections of the Monocultural Values and Practices of the Larger Culture

As we have repeatedly emphasized, we are all products of our cultural conditioning and inherit the biases of the larger society (Sue, 2015). Likewise, organizations are microcosms of the wider society from which they originate. As a result, they are likely to be reflections of the monocultural values and practices of the larger culture. In this case, it is not far‐fetched to assume that White students, helping professionals, and educators may have inherited the racial biases of their forebears. Further, multicultural education specialists have decried the biased nature of the traditional curriculum. Although education is supposed to liberate and convey truth and knowledge, we have seen how it has oftentimes been the culprit in perpetuating false stereotypes and misinformation about various groups in our society. It has done this, perhaps not intentionally, but through omission, fabrication, distortion, or selective emphasis of information, designed to enhance the contributions of certain groups over others (Cokley, 2006). The result is that institutions of learning become sites that perpetuate myths and inaccuracies about certain groups in society, with devastating consequences for students of color. Further, policies and practices that claim to "treat everyone the same" may themselves be culturally biased. If this is the institutional context from which Daryl is receiving his education, little wonder that he exhibits so‐called problem behaviors. Again, the focus of change must be directed at the institutional level.

Principle 5: Organizations Are Powerful Entities That Inevitably Resist Change and Possess Many Ways to Force Compliance Among Workers; Going against the Policies, Practices, and Procedures of the Institution, for Example, Can Bring About Major Punitive Actions

Let us look at the situation of Ms. Jones, the Black teacher. There are indications in this case

that she understands that Daryl may be the victim of racism and a monocultural education that invalidates him. If she is aware of this factor, why is she so reluctant to act on behalf of Daryl and his parents? First, it is highly probable that, even if she is aware of the true problem, she lacks the knowledge, expertise, and skill to intervene on a systemic level. Second, institutions have many avenues open to them that can be used to force compliance on the part of employees. Voicing an alternative opinion against prevailing beliefs can result in ostracism by fellow workers, a poor job performance rating, denial of a promotion, or even an eventual firing (Sue et al., 2011). This creates a very strong ethical dilemma for mental health workers or educators when the needs of their clients differ from those of the organization or employer. The fact that counselors' livelihoods depend on the employing agency (school district) creates additional pressures to conform. How do counselors handle such conflicts? Organizational knowledge and skills become a necessity if the therapist is to be truly effective (Toporek, Lewis, & Crethar, 2009). So, even the most enlightened educators and counselors may find their good intentions thwarted by their lack of systems intervention skills and their fears of punitive actions.

Principle 6: When Multicultural Organizational Development Is Required, Alternative Helping Roles That Emphasize Systems Intervention and Advocacy Skills Must Be Part of the Repertoire of the Mental Health Professional

Because the traditional counseling/therapy roles focus on one - to - one or small - group relationships, they may not be productive when dealing with larger ecological and systemic issues. Competence in changing organizational policies, practices, procedures, and structures within institutions requires a different set of knowledge and skills that are more action - oriented. Among them, consultation and advocacy become crucial in helping institutions move from a monocultural to a multicultural orientation (Davidson et al., 2006). Daryl's school and the school district need a thorough cultural audit, institutional change in the campus climate, sensitivity training for all school personnel, increased racial/ethnic personnel at all levels of the school, revamping of the curriculum to be more multicultural, and so on. This is a major task that requires multicultural awareness, knowledge, and skills on the part of the mental health professional.

Principle 7: Although Remediation Will Always Be Needed, Prevention Is Better

Conventional practice at the micro level continues to be oriented toward remediation rather than prevention. Although no one would deny the important effects of biological and internal psychological factors on personal problems, much research now acknowledges the importance of sociocultural factors (inadequate or biased education, poor socialization practices, biased values, and discriminatory institutional policies) in creating many of the difficulties encountered by individuals (Flores et al., 2014). As therapists, we are frequently placed in a position of treating clients who represent the aftermath of failed and oppressive policies and practices. We have been trapped in the role of remediation (attempting to help clients once they have been damaged by sociocultural biases). Although treating troubled clients (remediation) is a necessity, our task will be an endless and losing venture if the true sources of the problem (stereotypes, prejudice, discrimination, and oppression) are not changed. Would it not make more sense to take a proactive and preventive approach by attacking the cultural and institutional bases of the problem?

REFLECTION AND DISCUSSION QUESTIONS

1. Exactly how do organizational policies and practices oppress?
2. What do you need to know in order to effectively be a social - change agent?
3. Is organizational change difficult?
4. If individual counseling/therapy is ineffective in systems intervention, what alternative roles will you need to play?

Video 4.3: Stereotyping and Stigma

Client and therapist differences as a way to enrich the conversation instead of hindering or blocking rapport.

SOCIAL JUSTICE COUNSELING

The case of Daryl demonstrates strongly the need for a social justice orientation to counseling and therapy (Neville, 2015). Indeed, MCT competence is intimately linked to the values of social justice (Koch & Juntunen, 2014; Ratts et al., 2016). If mental health practice is concerned with bettering the life circumstances of individuals, families, groups, and communities in our society, then social justice is the overarching umbrella that guides our profession. The welfare of a democratic society very much depends on equal access and opportunity, fair distribution of power and resources, and empowering individuals and groups with a right to determine their own lives (Ratts & Hutchins, 2009). J. M. Smith (2003) defines a socially just world as having access to

> *adequate food, sleep, wages, education, safety, opportunity, institutional support, health care, child care, and loving relationships. "Adequate" means enough to allow [participation] in the world … without starving, or feeling economically trapped or uncompensated, continually exploited, terrorized, devalued, battered, chronically exhausted, or virtually enslaved (and for some reason, still, actually enslaved). (p. 167)*

Bell (1997) states that the goal of social justice is

> *full and equal participation of all groups in a society that is mutually shaped to meet their needs. Social justice includes a vision of society in which the distribution of resources is equitable and all members are physically and psychologically safe and secure. (p. 3)*

Given these broad descriptions, we propose the following working definition of social justice counseling/therapy.

> *Social justice counseling/therapy is an active philosophy and approach aimed at producing conditions that allow for equal access and opportunity; reducing or eliminating disparities in education, health care, employment, and other areas that lower the quality of life for affected populations; encouraging mental health professionals to consider micro, meso, and macro levels in the assessment, diagnosis, and treatment of clients and client systems; and broadening the role of the helping professional to include not only counselor/therapist but also advocate, consultant, psychoeducator, change agent, community worker, and so on.*

Thus, social justice counseling/therapy has the following goals:

1. to produce conditions that allow for equal access and opportunity;
2. to reduce or eliminate disparities in education, health care, employment, and other areas that lower the quality of life for affected populations;
3. to encourage mental health professionals to consider micro, meso, and macro levels in the assessment, diagnosis, and treatment of clients and client systems; and
4. to broaden the role of the helping professional to include not only counselor/therapist but also advocate, consultant, psychoeducator, change agent, community worker, and so on.

Advocacy for Organizational Change

All helping professionals need to understand two things about mental health practice: (a) they often work within organizations that may be monocultural in policies and practices; and (b)

the problems encountered by clients are often due to organizational or systemic factors. This is a key component of the ecological or person‐in‐environment perspective (Fouad, Gerstein, & Toporek, 2006). In the first case, the policies and practices of an institution may thwart the ability of counselors to provide culturally appropriate help for their diverse clientele. In the second case, the structures and operations of an organization may unfairly deny equal access and opportunity (access to health care, employment, and education) for certain groups in our society. It is possible that many problems of mental health are truly systemic problems caused by racism, sexism, and homophobia. Thus, understanding organizational dynamics and possessing multicultural institutional intervention skills are part of the social justice framework (Pieterse, Evans, Risner‐Butner, Collins, & Mason, 2009). Making organizations responsive to a diverse population ultimately means being able to help them become more multicultural in outlook, philosophy, and practice.

Social justice counseling (a) takes a social‐change perspective that focuses on ending oppression and discrimination in our society (e.g., within organizations, communities, municipalities, governmental entities); (b) believes that inequities that arise within our society are due not necessarily to misunderstandings, poor communication, lack of knowledge, and so on, but to monopolies of power; and (c) assumes that conflict is inevitable and not necessarily unhealthy. Diversity trainers, consultants, and many industrial‐organizational (I/O) psychologists increasingly endorse multicultural change, based on the premise that organizations vary in their awareness of how racial, cultural, ethnic, sexual orientation, and gender issues impact their clients or workers. Increasingly, leaders in the field of counseling psychology have indicated that the profession should promote the general welfare of society; be concerned with the development of people, their communities, and their environment; and promote social, economic, and political equity consistent with the goals of social justice (Toporek, Gerstein, Fouad, Roysircar, & Israel, 2006).

Thus, *social justice counseling* includes social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully (Goodman et al., 2004; Ibrahim & Heuer, 2016). If mental health professionals are concerned with the welfare of society, and if society's purpose is to enhance the quality of life for all persons, then these professionals must ultimately be concerned with the injustices and obstacles that oppress, denigrate, and harm those in our society (Chavez, Fernandez, Hipolito‐Delgado, & Rivera, 2016; Warren & Constantine, 2007). They must be concerned with issues of classism, racism, sexism, homophobia, and all the other “isms” that deny equal rights to everyone. As mentioned previously, counselors/therapists practice at three levels: micro—where the focus is on individuals, families, and small groups; meso—where the focus is on communities and organizations; and macro—where the focus is on the larger society (e.g., statutes and social policies).

Social Justice Advocacy and Cultural Humility

Mental health practitioners who take up social justice goals come to their counseling sessions with years of formal training, numerous advanced degrees, and a sincere commitment to social change. These qualifications provide them with valuable tools, but they also leave them at the risk of prioritizing their own knowledge and approaches over their clients' perspectives. *Cultural humility* (Hook, Davis, Owen, Worthington, & Utsey, 2013) refers to the crucial importance of maintaining an interpersonally open and genuinely respectful stance regarding clients' cultural identities, backgrounds, and experiences. In particular, professionals must remember that the clients are the experts on their own cultural journeys.

> *Culturally humble therapists rarely assume competence (i.e., letting prior experience and even expertise lead to overconfidence) for working with clients just based on their prior experience working with a particular group. Rather, therapists who are more culturally humble approach clients with respectful openness and work collaboratively with clients to understand the unique intersection of clients' various aspects of identities and how that affects the developing therapy alliance.*
>
> *(Hook et al., 2013, p. 354)*

Not only is a culturally humble approach a more accurate one (in that clients *do*, in fact, hold personal cultural expertise), it may also be a key element of culturally competent, socially just counseling practice. Research that explored the occurrence and impact of racial microaggressions during therapy found that clients who perceived their therapists as culturally humble (a) reported fewer microaggressive interactions and (b) experienced a less negative impact when microaggressions did occur (Hook et al., 2016). Conscious cultivation of a respectful, humble attitude may help therapists become more sensitive and aware regarding the commission of microaggressions, and it may also enable them to work through microaggressions in an open, nondefensive fashion that allows the therapeutic relationship to repaired afterward (Hook et al., 2016).

Social Justice Advocacy and Counseling Roles

To achieve conditions of social equity is truly an uphill battle. But, just as the history of the United States is the history of racism, so it is the history of *antiracism* as well. There have always been people and movements directed toward the eradication of racism, including abolitionists, civil rights workers, private organizations (e.g., the Southern Poverty Law Center, the National Association for the Advancement of Colored People [NAACP], B'nai Brith), political leaders, and especially people of color. Racism, like sexism, homophobia, and all intersecting forms of oppression, must be on the forefront of social justice work (Crenshaw, 1989, 1991; Moradi & Grzanka, 2017; Rosenthal, 2016). Efforts must be directed at social change in order to eradicate bigotry and prejudice. In this respect, psychologists and counselors must use their knowledge and skills to (a) impact the channels of socialization (e.g., education, media, groups, organizations) to spread a curriculum of multiculturalism, and (b) aid in the passage of legislation and social policy (e.g., affirmative action, civil rights voting protections, sexual harassment laws) (Goodman, 2009; Lopez‐Baez & Paylo, 2009; Ratts, 2010). To accomplish these goals, we will need to broaden our practice beyond individual psychotherapy to embrace the systems intervention roles identified by Atkinson, Thompson, and Grant (1993): advocate, change agent, consultant, adviser, facilitator of indigenous support systems, and facilitator of indigenous healing methods.

IMPLICATIONS FOR CLINICAL PRACTICE

1. The mental health profession must take the initiative in confronting the potential political nature of mental health practice. The practice of counseling/therapy and the knowledge base that underlies the profession are not morally, ethically, and politically neutral.
2. We must critically reexamine our concepts of what constitutes normality and *abnormality*, begin mandatory training programs that deal with these issues, critically examine and reinterpret past and continuing literature dealing with socially marginalized groups in society, and use research in such a manner as to improve the life conditions of

the researched populations.

3. The study of marginalized group cultures must receive equal treatment and fair portrayal at all levels of education.
4. The education and training of psychologists have, at times, created the impression that the theories and practices of psychology are apolitical and value‐free.
5. The psychological problems of marginalized group members may reside not within but outside of them.
6. Too much research has concentrated on the mental health problems and pathologies of groups of color, while little has been done to determine the advantages of being bicultural and the strengths and assets of these groups.
7. Psychological disturbances and problems in living are not necessarily caused by internal attributes (low intelligence, lack of motivation, character flaws, etc.) but may result from external circumstances, such as prejudice, discrimination, and disparities in education, employment, and health care.
8. *Social justice counseling* may dictate social and political actions that seek to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs.
9. Social justice advocacy dictates playing roles that involve advocating on behalf of clients who are victimized by the social system that creates disparities in health care, education, and employment.
10. Culturally humble counselors remember that their formal social justice training does not make them the experts on clients' individual cultural journeys—the clients themselves hold that expertise, and counselors should, first and foremost, seek to learn from them.

Video 4.6: Equity in Counseling

The client's truth and how to be intentional about honoring his or her personal experiences and personal truth.

SUMMARY

Mental health practice is strongly influenced by historical and current sociopolitical forces that impinge on issues of race, culture, and ethnicity. The therapeutic session is often a microcosm of race relations in our larger society; therapists often inherit the biases of their forebears; and therapy represents a primarily EuroAmerican activity. These failures can be seen in (a) the education and training of mental health professionals, (b) biased mental health literature, and (c) an equation of pathology with differences. The *genetic* and *culturally deficient* models have perpetuated these failures by graduating mental health practitioners from programs with the belief that people of color are lacking the right genes or the right White middle‐class values to succeed in U.S. society. The *culturally diverse model*, however, no longer views people of color as deficient, but recasts differences as alternative lifestyles and addresses the advantages of being bicultural and the inherent value of differences.

Social justice counseling recognizes that problems do not necessarily reside in individuals but may be externally located in organizations and the social system. As a result, mental health professionals must be prepared to direct their foci of interventions to the individual, professional, organizational, and societal levels. Specifically, when organizational interventions are required, seven principles are identified. Students are encouraged to study them thoroughly. All stress the importance of understanding how systemic factors (person–environment interactions) contribute to individual behavior, and all are necessary for accurate assessment, diagnosis, and treatment. Clients are viewed not as isolated units but as embedded in their families, social groups, communities, institutions, and cultures, as well as in major systems of our society.

If mental health practice is concerned with bettering the life circumstances of individuals, families, groups, and communities, then social justice is the overarching umbrella that guides our profession. The welfare of a democratic society very much depends on equal access and opportunity, fair distribution of power and resources, and the empowerment of individuals and groups with a right to determine their own lives. To accomplish this goal, therapists must be prepared to treat social and systemic problems and play alternative helping roles that have not traditionally been considered therapy. Advocacy roles in counseling fall into this category.

GLOSSARY TERMS

- Abnormality
- Antiracism
- Cultural encapsulation
- Cultural humility
- Culture - bound training
- Cultural paranoia
- Cultural deprivation
- Culturally deficient model
- Culturally diverse model
- Ethnocentricity
- Genetically deficient model
- Levels of intervention
- Scientific racism
- Social justice counseling

Video 4.7: Counseling Session Analysis

Pathologizing and blaming the victim as a way of explaining away cultural bias and discrimination.

REFERENCES

1. Alexander, R., & Moore, S. E. (2008). The benefits, challenges, and strategies of African American faculty teaching at predominantly White institutions. *Journal of African American Studies*, *12*, 4–18.

2. Ali, A., & Sichel, C. (2014). Structural competency as a framework for training in counseling psychology. *Counseling Psychologist*, *42*, 901–918.

3. American Psychological Association. 2017. Multicultural guidelines: An ecological approach to context, identity, and intersectionality. Retrieved from: http://www.apa.org/about/policy/multicultural‐guidelines.pdf

4. American Psychological Association Presidential Task Force on Evidence‐Based Practice (2006). Evidence‐based practice in psychology. *American Psychologist*, *61*, 271–285.

5. American Psychological Association Presidential Task Force on Preventing Discrimination and Promoting Diversity (2012). *Dual pathways to a better America: Preventing discrimination and promoting diversity*. Washington, DC: American Psychological Association.

6. Atkinson, D. R., Thompson, C. E., & Grant, S. K. (1993). A three‐dimensional model for counseling racial/ethnic minorities. *Counseling Psychologist*, *21*, 257–277.

7. Babbington, C. (2008). Poll shows gap between Blacks and Whites over racial discrimination. Retrieved from https://groups.yahoo.com/neo/groups/VaUMCTalk/conversations/topics/4286

8. Bell, L. A. (1997). Theoretical foundations for social justice education. In M. Adams, L. A. Bell, & P. Griffin (Eds.), *Teaching for diversity and social justice: A sourcebook* (pp. 3–15). New York, NY: Routledge.

9. Cain, D. J. (2010). *Person‐centered psychotherapies*. Washington, DC: APA Press.

10. Carter, R. T. (Ed.) (2005). *Handbook of racial‐cultural psychology and counseling*. Hoboken, NJ: Wiley.

11. Chavez, T. A., FernandezZ, I. T., Hipolito‐Delgado, C. P., & Rivera, E. T. (2016). Unifying liberation psychology and humanistic values to promote social justice in counseling. *Journal of Humanistic Counseling*, *55*, 166–182.

12. Chen, C. P. (2005). Morita therapy: A philosophy of Yin/Yang coexistence. In R. Moodley, & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 221–232). Thousand Oaks, CA: Sage.

13. Choudhuri, D. D., Santiago‐Rivera, A. L., & Garrett, M. T. (2012). *Counseling and diversity*. Belmont, CA: Cengage.

14. Coates, T. (2017). The first White president. Retrieved from https://www.theatlantic.com/magazine/archive/2017/10/the‐first‐white‐president‐ta‐nehisi‐coates/537909

15. Cokley, K. (2006). The impact of racialized schools and racist (mis)education on African American students' academic identity. In M. G. Constantine, & D. W. Sue

(Eds.), *Addressing racism* (pp. 127–144). Hoboken, NJ: Wiley.

16. Constantine, M. G. (2006). Institutional racism against African Americans. In M. G. Constantine, & D. W. Sue (Eds.), *Addressing racism* (pp. 33–41). Hoboken, NJ: Wiley.

17. Cosgrove, L. (2006). The unwarranted pathologizing of homeless mothers: Implications for research and social policy. In R. L. Toporek, L. H. Gerstein, N. A. Fouad, G. Roysircar, & T. Israel (Eds.), *Handbook for social justice in counseling psychology* (pp. 200–214). Thousand Oaks, CA: Sage.

18. Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1989*, 139–167.

19. Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*, 1241–1299.

20. Darwin, C. (1859). *On the origin of species by natural selection*. London, U.K.: Murray.

21. Davidson, M. M., Waldo, M., & Adams, E. M. (2006). Promoting social justice through preventive interventions in schools. In R. L. Toporek, L. H. Gerstein, N. A. Fouad, G. Roysircar, & T. Israel (Eds.), *Handbook for social justice in counseling psychology* (pp. 117–129). Thousand Oaks, CA: Sage.

22. de Gobineau, A. (1915). *The inequality of human races*. New York, NY: Putnam.

23. Falicov, C. J. (2005). Mexican families. In M. McGoldrick, J. Giordano, & N. Garcia‐Preto (Eds.), *Ethnicity and family therapy* (2nd ed.) (pp. 229–241). New York, NY: Guilford Press.

24. Flores, M. P., De La Rue, L., Neville, H. A., Santiago, S., Rakemayahu, K., Garite, R., … Ginsburg, R. (2014). Developing social justice competencies: A consultation training approach. *Counseling Psychologist, 46*, 998–1020.

25. Fouad, N. A., Gerstein, L. H., & Toporek, R. L. (2006). Social justice and counseling psychology in context. In R. L. Toporek, L. H. Gerstein, N. A. Fouad, G. Roysircar, & T. Israel (Eds.), *Handbook for social justice in counseling psychology* (pp. 1–16). Thousand Oaks, CA: Sage.

26. Galton, F. (1869). *Hereditary genius: An inquiry into its laws and consequences*. London, U.K.: Macmillan.

27. Garcia‐Preto, N. (2005). Puerto Rican families. In M. McGoldrick, J. Giordano, & N. Garcia‐Preto (Eds.), *Ethnicity and family therapy* (2nd ed.) (pp. 242–255). New York, NY: Guilford Press.

28. Goodman, J. (2009). Starfish, salmon, and whales: An introduction to the special section. *Journal of Counseling and Development, 87*, 259.

29. Goodman, L. A., Liang, B., Helms, J. E., Latta, R. E., Sparks, E., & Weintraub, S. (2004). Training counseling psychologists as social justice agents: Feminist and multicultural perspectives. *Counseling Psychologist, 32*, 793–837.

30. Grier, W., & Cobbs, P. (1968). *Black rage*. New York, NY: Basic Books.

31. Grier, W., & Cobbs, P. (1971). *The Jesus bag*. San Francisco, CA: McGraw‐Hill.

32. Guthrie, R. V. (1997). *Even the rat was White: A historical view of psychology* (2nd ed.). New York, NY: Harper & Row.

33. Hall, G. S. (1904). *Adolescence, its psychology, and its relation to physiology, anthropology, sociology, sex, crime, religion and education*. New York, NY: Appleton.

34. Halleck, S. L. (1971). Therapy is the handmaiden of the status quo. *Psychology Today*, *4*(30–34), 98–100.

35. Hargons, C., Mosley, D., Falconer, J., Faloughi, R., Singh, A., Stevens‐Watkins, D., & Cokley, K. (2017). Black Lives Matter: A call to action for counseling psychology leaders. *The Counseling Psychologist*, *45*(6), 873–901.

36. Hong, G. K., & Domokos‐Cheng Ham, M. (2001). *Psychotherapy and counseling with Asian American clients*. Thousand Oaks, CA: Sage.

37. Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L. Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353–366.

38. Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., Van Tongeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. *Journal of Counseling Psychology*, *63*(3), 269–277.

39. Ibrahim, F. A., & Heuer, J. R. (2016). Incorporating social justice and advocacy in counseling and psychotherapy. In F. A. Ibrahim, & J. R. Heuer (Eds.), *Cultural and social justice counseling* (pp. 99–122) Springer International Publishing.

40. Ivey, A. E., D'Andrea, M., Ivey, M. B., & Simek‐Morgan, L. (2007). *Theories of counseling and psychotherapy: A multicultural perspective* (2nd ed.). Boston, MA: Allyn & Bacon.

41. Jones, J. M. (1997). *Prejudice and racism* (2nd ed.). Washington, DC: McGraw‐Hill.

42. Jones, J. M. (2010). I'm White and you're not: The value of unraveling ethnocentric science. *Psychological Science*, *5*, 700–707.

43. Katz, J. (1985). The sociopolitical nature of counseling. *Counseling Psychologist*, *13*, 615–624.

44. Kearney, L. K., Draper, M., & Baron, A. (2005). Counseling utilization of ethnic minority college students. *Cultural Diversity and Ethnic Minority Psychology*, *11*, 272–285.

45. Koch, J. M., & Juntunen, C. L. (2014). Nontraditional teaching methods that promote social justice: Introduction to the special issue. *Counseling Psychologist*, *42*, 894–900.

46. Laing, R. D. (1969). *The politics of experience*. New York, NY: Pantheon.

47. Lee, C. C. (2007). *Counseling for social justice*. Alexandria, VA: American Counseling Association.

48. Liu, W. M., Hernandez, J., Mahmood, A., & Stinson, R. (2006). Linking poverty, classism, and racism in mental health: Overcoming barriers to multicultural competency. In M. G. Constantine, & D. W. Sue (Eds.), *Addressing racism* (pp. 65–86). Hoboken, NJ: Wiley.

49. London, P. (1988). *Modes and morals of psychotherapy*. New York, NY: Holt, Rinehart & Winston.

50. Lopez‐Baez, S. I., & Paylo, M. J. (2009). Social justice advocacy: Community collaboration and systems advocacy. *Journal of Counseling and Development*, *87*, 276–283.

51. McAuliffe, G. J., & Associates (2013). *Culturally alert counseling*. Thousand Oaks, CA: Sage.

52. McNeil, D. G. (2011). Panel hears grim details of venereal disease tests. *New York Times*, August 30.

53. Metzl, J., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science and Medicine, 103,* 126–133.

54. Mio, J. S. (2005). Academic mental health training settings and the multicultural guidelines. In M. G. Constantine, & D. W. Sue (Eds.), *Strategies for building multicultural competence in mental health and educational settings* (pp. 129–144). Hoboken, NJ: Wiley.

55. Mio, J. S., & Morris, D. R. (1990). Cross‐cultural issues in psychology training programs: An invitation for discussion. *Professional Psychology: Theory and Practice*, *21*, 434–441.

56. Moradi, B., & Grzanka, P. R. (2017). Using intersectionality responsibly: Toward critical epistemology, structural analysis, and social justice activism. *Journal of Counseling Psychology, 64*(5), 500–513.

57. Moynihan, D. P. (1965). Employment, income and the ordeal of the Negro family. *Daedalus, 140,* 745–770.

58. Nadal, K. L. (2011). *Filipino American psychology*. Hoboken, NJ: Wiley.

59. Neville, H. A. (2015). Social justice mentoring: Supporting the development of future leaders for struggles, resistance, and transformation. *Counseling Psychologist*, *43*, 157–169.

60. Orwell, G. (1945). *Animal farm*. London, U.K.: Secker and Warburg.

61. Owen, J., Imel, Z., Adelson, J., & Rodolfa, E. (2012). “No‐show”: Therapist racial/ethnic disparities in client unilateral termination. *Journal of Counseling Psychology*, *29*, 314–320.

62. Owens, D., Queener, J., & Stewart, T. (2016). Counseling African American males utilizing nontraditional clinical treatment approaches. In W. Ross (Ed.), *Counseling African American males: Effective therapeutic interventions and approaches*. Charlotte, NC: Information Age Publishing.

63. Parham, T. A. (2002). *Counseling persons of African descent*. Thousand Oaks, CA: Sage.

64. Parham, T. A., White, J., & Ajuma, A. (2011). *The psychology of Blacks: Centering our perspectives in the African consciousness* (4th ed.). Upper Saddle River, NJ: Prentice Hall.

65. Pew Research Center (2007). *Blacks see growing values gap between poor and middle*

class. Washington, DC: Pew Research Center.

66. Pieterse, A. I., Evans, S. A., Risner‐Butner, A., Collins, N. M., & Mason, L. B. (2009). Multicultural competence and social justice training in counseling psychology and counselor education: A review and analysis of a sample of multicultural course syllabi. *Counseling Psychologist*, *37*, 93–115.

67. Plous, S., & Williams, T. (1995). Racial stereotypes from the days of American slavery: A continuing legacy. *Journal of Applied Social Psychology*, *25*, 795–817.

68. Ponterotto, J. G., Utsey, S. O., & Pedersen, P. B. (2006). *Preventing prejudice: A guide for counselors, educators, and parents*. Thousand Oaks, CA: Sage.

69. President's Initiative on Race (1998). *One America in the twenty‐first century*. Washington, DC: U.S. Government Printing Office.

70. Prilleltensky, I. (1989). Psychology and the status quo. *American Psychologist*, *44*(5), 795.

71. Ratts, M. J. (2010). Multiculturalism and social justice: Two sides of the same coin. *Journal of Multicultural Counseling and Development*, *39*, 24–37.

72. Ratts, M. J., & Hutchins, A. M. (2009). ACA advocacy competencies: Social justice advocacy at the client/student level. *Journal of Counseling and Development*, *87*, 269–275.

73. Ratts, M. J., & Pedersen, P. B. (2014). *Counseling for multiculturalism and social justice*. Alexandria, VA: American Counseling Association.

74. Ratts, M. J., Singh, A. A., Nassar‐McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, *44*(1), 28–48.

75. Ridley, C. R. (2005). *Overcoming unintentional racism in counseling and therapy* (2nd ed.). Thousand Oaks, CA: Sage.

76. Riessman, F. (1962). *The culturally deprived child*. New York, NY: Harper & Row.

77. Rosenthal, L. (2016). Incorporating intersectionality into psychology: An opportunity to promote social justice and equity. *American Psychologist*, *71*(6), 474–485.

78. Rosenthal, R., & Jacobson, L. (1968). *Pygmalion in the classroom*. New York, NY: Holt, Rinehart & Winston.

79. Rushton, J. P. (1989). The evolution of racial differences: A response to Lynn. *Journal of Research in Personality*, *23*, 441–452.

80. Ryan, W. (1971). *Blaming the victim*. New York, NY: Pantheon.

81. Samuda, R. J. (1998). *Psychological testing of American minorities*. Thousand Oaks, CA: Sage.

82. Shockley, W. (1972). Determination of human intelligence. *Journal of Criminal Law and Criminology*, *7*, 530–543.

83. Smith, J. M. (2003). *A potent spell: Mother love and the power of fear*. Boston, MA: Houghton Mifflin.

84. Smith, T. B., & Trimble, J. E. (2016). Mental health service utilization across race: A meta‐analysis of surveys and archival studies. In T. B. Smith, & J. E. Trimble (Eds.), *Foundations of multicultural psychology: Research to inform effective practice* (pp. 67–94). Washington, DC: American Psychological Association.

85. Snowden, L. R., & Cheung, F. H. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist, 45*, 347–355.

86. Steele, C. M. (2003). Race and the schooling of Black Americans. In S. Plous (Ed.), *Understanding prejudice and discrimination* (pp. 98–107). New York: McGraw‐Hill.

87. Sue, D., Sue, D. W., Sue, D. M., & Sue, S. (2016). *Understanding abnormal behavior*. Stamford, CT: Cengage.

88. Sue, D. W. (2003). *Overcoming our racism: The journey to liberation*. San Francisco, CA: Jossey‐Bass.

89. Sue, D. W. (2010). *Microaggressions and marginality: Manifestations, dynamics, and impact*. Hoboken, NJ: Wiley.

90. Sue, D. W. (2015). Therapeutic harm and cultural oppression. *Counseling Psychologist, 43*(3). https://doi.org/10.1177/0011000014565713

91. Sue, D. W., & Constantine, M. G. (2003). Optimal human functioning in people of color in the United States. In W. B. Walsh (Ed.), *Counseling psychology and optimal human functioning* (pp. 151–169). Mahwah, NJ: Erlbaum.

92. Sue, D. W., Rivera, D. P., Watkins, N. L., Kim, R. H., Kim, S., & Williams, C. D. (2011). Racial dialogues: Challenges faculty of color face in the classroom. *Cultural Diversity and Ethnic Minority Psychology, 17*(3), 331–340.

93. Sutton, C. T., & Broken Nose, M. A. (2005). American Indian families: An overview. In M. McGoldrick, J. Giordano, & N. Garcia‐Preto (Eds.), *Ethnicity and family therapy* (2nd ed.) (pp. 43–54). New York, NY: Guilford Press.

94. Szasz, T. S. (1970). The crime of commitment. In *Readings in clinical psychology today* (pp. 167–169). Del Mar, CA: CRM Books.

95. Szasz, T. S. (1971). *The myth of mental illness*. New York, NY: Hoeber.

96. Szasz, T. S. (1987). The case against suicide prevention. *American Psychologist, 41*, 806–812.

97. Szasz, T. S. (1999). *Fatal freedom: The ethics and politics of suicide*. Westport, CT: Praeger.

98. Thomas, A., & Sillen, S. (1972). *Racism and psychiatry*. New York, NY: Brunner/Mazel.

99. Thomas, C. W. (1970). Different strokes for different folks. *Psychology Today, 4*(49–53), 80.

100. Toporek, R. L., Gerstein, L. H., Fouad, N. A., Roysircar, G., & Israel, T. (Eds.) (2006). *Handbook for social justice in counseling psychology*. Thousand Oaks, CA: Sage.

101. Toporek, R. L., Lewis, J. A., & Crethar, H. C. (2009). Promoting systemic change

through the ACA advocacy competencies. *Journal of Counseling and Development, 87*, 260–268.

Turner, C. S. V., Gonzalez, J. C., & Wood, J. L. (2008). Faculty of color in academe: What 20 years of literature tells us. *Journal of Diversity in Higher Education, 1*, 139–168.

Utsey, S. O., Grange, C., & Allyne, R. (2006). Guidelines for evaluating the racial and cultural environment of graduate training programs in professional psychology. In M. G. Constantine, & D. W. Sue (Eds.), *Addressing racism* (pp. 213–232). Hoboken, NJ: Wiley.

Vera, E. M., & Speight, S. L. (2003). Multicultural competence, social justice, and counseling psychology: Expanding our roles. *Counseling Psychologist, 31*, 253–272.

Vera, E. M., Buhin, L., & Shin, R. Q. (2006). The pursuit of social justice and the elimination of racism. In M. G. Constantine, & D. W. Sue (Eds.), *Addressing racism* (pp. 271–287). Hoboken, NJ: Wiley.

Wang, S., & Kim, B. S. K. (2010). Therapist multicultural competence, Asian American participants' cultural values, and counseling process. *Journal of Counseling Psychology, 57*, 394–401.

Warren, A. K., & Constantine, M. G. (2007). Social justice issues. In M. G. Constantine (Ed.), *Clinical practice with people of color* (pp. 231–242). New York, NY: Teachers College Press.

West‐Olatunji, C. A., & Conwill, W. (2011). *Counseling African Americans*. Belmont, CA: Cengage.

5
The Impact of Systemic Oppression Within the Counseling Process: Client Worldviews and Counselor Credibility

Chapter Objectives

1. **1. Understand how historical oppression in the lives of people of color influences reactions to counselors and the counseling process.**
2. **2. Describe how traditional counseling and therapy may be antagonistic to the lifestyles, cultural values, and sociopolitical experiences of marginalized clients.**
3. **3. Learn how counseling and psychotherapy may represent microcosms of race relations in the wider society between majority group counselors and clients of color.**
4. **4. Describe the manifestation, dynamics, and impact of *ethnocentric monoculturalism* in theories of counseling and psychotherapy and in therapeutic practice.**
5. **5. Identify the special challenges that White helping professionals may encounter regarding their *credibility* (*expertness* and *trustworthiness*) when working with clients of color.**
6. **6. Understand the concepts of *locus of control* and *locus of responsibility* and apply them to multicultural counseling.**
7. **7. Define and describe how racial *worldviews* are formed.**
8. **8. Discuss how culturally diverse clients with particular *worldviews* may respond in the therapy process.**

CASE STUDY

COUNSELING PRACTICE AS A RACIAL‐CULTURAL MICROCOSM

Can racial dynamics be detected even within a psychotherapeutic dyad—an interaction where counselors are attempting to attend to every nuance of their own and their clients' communications? The three quotes that follow are from three different posters on a weblog where participants' cross‐racial therapy dyads were being discussed (MetaFilter, 2016).

1. [My therapist] kind of steers me towards the notion that I have the power to react any way I want (which is true, I guess, except when you're a minority and the fact is you wear that skin 24/7 whether you like it or not, and people *do* treat you differently…)
2. [My therapist] said, “Yes, well, it's common for unmarried Asian women in their thirties to feel like they've failed because they're single and don't have families.” I was like, where are you getting that from??! Being single and not having a family was pretty low on my list of problems.
3. One thing I was working on was my terrible relationship with my mother, and my therapist was really hung up on this idea of “culture” being the problem … I think my therapist was genuinely trying to relate to me because she knew that our life experiences weren't similar. It's just that she had very limited tools to do so.

REFLECTION AND DISCUSSION QUESTIONS

1. For each example, describe the sources of client unease and/or tension.
2. What are the possible consequences of ruptures like these in a therapeutic relationship?
3. If these clients had revealed in session the feelings that they are sharing here, how do you imagine the therapists might have reacted? How could they have most helpfully reacted?

The preceding examples illustrate some of the ways in which the racial dynamics that characterize society at a broad level can enter into the therapeutic dyad. We question neither the sincerity of these White therapists nor their desire to work effectively with their clients of color. Rather, we present these remarks to exemplify the blind spots, missed opportunities, and distress that represent the manifestations of systemic oppression within counseling practice.

Video 5.0: Introduction

The use of stereotyping, pathology, and stigma as tools of oppression.

LOCATING CLIENTS' PROBLEMS ENTIRELY INSIDE THE CLIENTS

In the first example, the client notes that her therapist's inclination was to neglect race and culture as part of the client's narrative; rather, her default tendency was to direct the focus of the session toward individual characteristics. Mental health practice has been characterized as primarily a White male middle‐class activity that is based on values that include rugged individualism, individual responsibility, and autonomy (Ivey, Ivey, & Zalaquett, 2014). Within this framework, the traditional therapist's role is to encourage self‐exploration so that the client can act on his or her own behalf (Lum, 2011). Within this individual‐centered approach, problems are generally assumed to reside within the clients themselves, and clients should be helped to take responsibility for them in order to change them. However, many problems encountered by marginalized clients actually reside externally to them (such as bias, discrimination, and prejudice). Such clients should not be faulted for encountering these obstacles, nor for the emotions that they experience as a consequence.

Along these lines, we can surmise that the therapist in Example 1 is attempting to encourage her client to take control of her therapeutic issues by resolving to change the feelings that she is having about them. There is, of course, nothing inherently wrong with supporting clients' examination of their own reactions in many situations; however, to do so with a client of color without addressing the simultaneous and uncontrollable impact of racism represents a form of *victim blaming* (Ratts & Pedersen, 2014; Ryan, 1971).

CULTURALLY RELATED RESPONSES THAT REPRODUCE STEREOTYPES

Two of the examples do not show complete inattention to racial dynamics. Two therapists initiated interventions in which they attempted to helpfully reference race. However, in these examples (2 and 3), the therapists were *not* integrating a sociohistorical awareness of racism with their developing knowledge of who their clients were as individuals. Instead, they created interventions based on cultural biases and generalities that left their clients feeling stereotyped, unseen, and in the case of Example 2, angry. Even when therapists have learned useful information about the cultural histories of other social groups, a formulaic "cookie - cutter" application of cultural learning represents an inadequate understanding of how to use these tools, as the client in Example 3 observed.

RESPONDING WHEN THE ISSUES ARE OUR OWN: WHITE FRAGILITY

As already mentioned, the client in Example 2 seems to have felt some anger in response to her therapist's attempted intervention. Our reflection question asked you to imagine the therapist's possible response if the client had shared those feelings. Counselors are trained to prioritize the therapeutic alliance and to competently process client responses such as these, so it is worth anticipating how this unfolding might be experienced in the context of cultural competence.

Many contemporary counselors and therapists will have participated in a multicultural course or workshop; for White therapists, this may be the only time that they have reflected upon their racial identity and worldview. Although valuable, these instructional settings are limited in scope: they are orderly, protected environments; they are time‐limited; they allow for a primarily passive role for participants; they may represent race‐related attitudes as lying "out there" somewhere within other people; and they often do not tackle topics such as White supremacy in an explicit way. Participants can leave such experiences feeling comfortable that they have obtained a satisfactory level of competence, despite little exploration of depth having taken place. Inadequately prepared yet highly confident, such individuals can be derailed and even moved to anger themselves by race‐related dialogues; these reactions have been anecdotally observed in therapists by their own clients (e.g., Babu, 2017).

DiAngelo (2011) introduced this phenomenon as *White fragility*. White fragility responses are triggered by racial stress, which can result from interruptions to what is racially familiar, such as:

- Someone's suggesting that a White person's viewpoint comes from a racialized frame of reference (challenge to objectivity);
- People of color talking directly about their racial perspectives (challenge to White racial codes);
- People of color choosing not to protect the racial feelings of White people in regards to race (challenge to White racial expectations and the need/entitlement to racial comfort);
- People of color not being willing to tell their stories or answer questions about their racial experiences (challenge to colonialist relations);
- A fellow White not providing agreement with a White person's interpretations (challenge to White solidarity);
- A White person's receiving feedback that their behavior had a racist impact (challenge to white liberalism);
- The suggestion that group membership is significant (challenge to individualism);
- An acknowledgment that access is unequal between racial groups (challenge to meritocracy);
- Being presented with a person of color in a position of leadership (challenge to White authority);
- Being presented with information about other racial groups, for example movies in which people of color drive the action but are not in stereotypical roles, or multicultural education (challenge to White centrality) (DiAngelo, 2011, p. 57).

When therapists have not received training that directly addresses the historical and systemic realities of oppression or have not been prepared for personally challenging identity ‐ related dialogues via direct experience, they are at risk of acting out their fragility to the detriment of their marginalized clients. We have mentioned several times that a counselor's inability to establish rapport and a relationship of trust with culturally diverse clients is a major therapeutic barrier. If the emotional climate is realistically positive and if trust and understanding exist between the parties, the two ‐ way communication of thoughts and feelings can proceed with optimism. This latter condition is often referred to as “rapport” and sets the stage on which other essential conditions can become effective. This chapter discusses trust–mistrust and *worldviews* as they relate to marginalized groups.

EFFECTS OF HISTORICAL AND CURRENT OPPRESSION

Persons of color and members of other marginalized groups (women; lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals; those with disabilities) live under a societal umbrella of individual, institutional, and cultural forces that often demean them, disadvantage them, and deny them equal access and opportunity (Toporek & Worthington, 2014). Experiences of prejudice and discrimination are a social reality for many marginalized groups and affect the perception of the helping professional in multicultural counseling (Parham & Caldwell, 2015). Thus, mental health practitioners must become aware of the sociopolitical dynamics that form not only their clients' *worldviews*, but their own as well. As in the three examples at the start of this chapter, racial/cultural dynamics may intrude into the helping process and cause misdiagnosis, confusion, pain, and a reinforcement of the biases and *stereotypes* that both groups have of one another.

It is important for therapists to realize that the history of race relations in the United States has influenced us to the point where we are extremely cautious about revealing to strangers our feelings and attitudes about race. In an interracial or intercultural encounter with a stranger (i.e., therapy), each party will attempt to discern gross or subtle racial attitudes on the part of the other while minimizing their own vulnerability. *Ethnocentric monoculturalism* lies at the heart of oppressor–oppressed relationships, affecting trust–mistrust and self‐disclosure in the therapeutic encounter.

Ethnocentric Monoculturalism

Most mental health professionals have not been trained to work with anyone other than mainstream individuals or groups. This is understandable in light of the historical origins of education, counseling/guidance, and our mental health systems, which have their roots in EuroAmerican or Western cultures (Arredondo, Gallardo‐Cooper, Delgado‐Romero, & Zapata, 2014). As a result, U.S. psychology has been severely criticized as being ethnocentric, monocultural, and inherently biased against racial/ethnic minorities, women, LGBTQ persons, and other culturally diverse groups (Constantine & Sue, 2006; Ridley, 2005). In light of the increasing diversity of our society, mental health professionals will inevitably encounter client populations that differ from themselves in terms of race, culture, and ethnicity. Such differences are believed to pose no problems as long as psychologists adhere to the notion of an unyielding, universal psychology that is applicable across all populations.

Although few mental health professionals would voice such a belief, in reality the very policies and practices of mental health delivery systems do reflect such an ethnocentric orientation. The theories of counseling and psychotherapy, the standards used to judge normality–abnormality, and the actual process of mental health practice are culture‐bound and reflect a monocultural perspective of the helping professions (Highlen, 1994; Jones, 2010). As such, they are often culturally inappropriate and antagonistic to the lifestyles and values of diverse groups in our society. Indeed, some mental health professionals assert that counseling and psychotherapy may be “handmaidens of the status quo,” instruments of oppression, and transmitters of society's values (Halleck, 1971; Prilleltensky, 1989; Thomas & Sillen, 1972).

We believe that *ethnocentric monoculturalism* is dysfunctional in a pluralistic society such as that of the United States. It is a powerful force, however, in forming, influencing, and determining the goals and processes of mental health delivery systems. Hence, it is very

important for mental health professionals to unmask or deconstruct the values, biases, and assumptions that reside in it. *Ethnocentric monoculturalism* combines what Wrenn (1962) calls *cultural encapsulation* and what J. M. Jones (1997) refers to as *cultural racism*. Five components of *ethnocentric monoculturalism* have been identified (Sue, 2004).

Belief in the Superiority of the Dominant Group

First, there is a strong belief in the superiority of one group's cultural heritage (history, values, language, traditions, arts/crafts, etc.). The group norms and values are seen positively, and descriptors may include such phrases as “more advanced” and “more civilized.” Members of the society may possess conscious and unconscious feelings of superiority and feel that their way of doing things is the best way. In our society, White EuroAmerican cultural characteristics are seen as not only desirable but also normative. Physical characteristics such as light complexion, blond hair, and blue eyes; cultural characteristics such as a belief in Christianity (or monotheism), individualism, a Protestant work ethic, and capitalism; and behavioral characteristics such as standard English, control of emotions, and the written tradition are highly valued components of EuroAmerican culture (Anderson & Middleton, 2011; Katz, 1985). People possessing these traits are perceived more favorably and often are allowed easier access to the privileges and rewards of the larger society (Furman, 2011).

Belief in the Inferiority of Others

Second, there is a belief in the inferiority of the cultural heritage of persons of color, which extends to their customs, values, traditions, and language (Jones, 1997). Other societies or groups may be perceived as less developed, uncivilized, primitive, or even pathological. These groups' lifestyles or ways of doing things are considered to be inferior or to represent exotic curiosities. Physical characteristics such as dark complexion, black hair, and brown eyes; cultural characteristics such as belief in non‐Christian religions (Islam, Confucianism, polytheism, etc.), collectivism, present‐time orientation, and the importance of shared wealth; and linguistic characteristics such as bilingualism, nonstandard English, speaking with an accent, use of nonverbal and contextual communication, and reliance on the oral tradition are usually seen as less desirable by the society (Sue, 2010). Studies consistently reveal that individuals who are physically different, who speak with an accent, and who adhere to different cultural beliefs and practices are more likely to be evaluated more negatively in our schools and workplaces. Culturally diverse groups may be seen as less intelligent, less qualified, and less popular, and as possessing more undesirable traits.

Power to Impose Standards

Third, the dominant group possesses the power to impose its standards and beliefs on less powerful groups (Ratts & Pedersen, 2014; Ridley, 2005). This third component of *ethnocentric monoculturalism* is very important. All groups are to some extent ethnocentric; that is, they feel positive about their cultural heritage and way of life. People from marginalized groups can be biased, can hold stereotypes, and can strongly believe that their way is the best way. Yet, if they do not possess the sociocultural power to impose their values on others, then they lack the ability to enforce them via oppression. It is the power differential, or the unequal status relationship between groups, that enables oppression and that defines *ethnocentric monoculturalism*. *Ethnocentric monoculturalism* is the individual, institutional, and cultural expression of the belief in the superiority of one group's cultural heritage over that of another, combined with the possession of the power to impose one's standards broadly on less powerful groups. Since marginalized groups do not possess a share

of economic, social, and political power equal to that of Whites in our society, they are generally unable to discriminate on a large‐scale basis (Ponterotto, Utsey, & Pedersen, 2006), although as mentioned, they may certainly hold prejudiced attitudes of their own.

Manifestation in Institutions

Fourth, the ethnocentric values and beliefs of the dominant group are manifested in the programs, policies, practices, structures, and institutions of the society. For example, chain‐of‐command systems, training and educational systems, communications systems, management systems, and performance‐appraisal systems dictate and control many aspects of our lives. Ethnocentric values attain untouchable and unquestioned status within organizations. Because most systems are monocultural in nature and demand compliance, persons of color and women may be oppressed. J. M. Jones (1997) labels *institutional racism* as a set of policies, priorities, and accepted normative patterns designed to subjugate and oppress individuals and groups, and force their dependence on a larger society. It does this by sanctioning unequal goals, unequal status, and unequal access to goods and services. *Institutional racism* has fostered the enactment of discriminatory statutes, the selective enforcement of laws, the blocking of economic opportunities and outcomes, and the imposition of forced assimilation/acculturation on the culturally diverse.

The Invisible Veil

Fifth, since people are the products of cultural conditioning, their values and beliefs (*worldviews*) represent an *invisible veil* that operates outside the level of conscious awareness (Neville, Gallardo, & Sue, 2016). As a result, people assume universality: that, regardless of race, culture, ethnicity, or gender, everyone shares the nature of reality and truth. This assumption is erroneous but is seldom questioned because it is firmly ingrained in our *worldview*. It is well‐intentioned individuals who consider themselves moral, decent, and fair‐minded who may have the greatest difficulty in understanding how their belief systems and actions may be biased and prejudiced. It is clear that no one is born wanting to be racist, sexist, or homophobic. Misinformation related to culturally diverse groups is not acquired by our free choice but rather is imposed through a relentless, often subconscious, process of social conditioning; all of us were taught to hate and fear others who are different in some way (Sue, 2003). Likewise, because all of us live, play, and work within organizations, those policies, practices, and structures that may be less than fair to minority groups are invisible in controlling our lives. Perhaps the greatest obstacle to a meaningful movement toward a multicultural society is our failure to understand our unconscious and unintentional complicity in perpetuating bias and discrimination via our personal values/beliefs and our institutions. The power of racism, sexism, and homophobia is related to the invisibility of the powerful forces that control and dictate our lives.

Historical Manifestations of Ethnocentric Monoculturalism

The EuroAmerican *worldview* can be described as possessing the following values and beliefs: rugged individualism, competition, mastery and control over nature, a unitary and static conception of time, religion based on Christianity, separation of science and religion, and competition (Katz, 1985; Ratts & Pedersen, 2014). It is important to note that *worldviews* are neither right nor wrong, good nor bad. They become problematic, however, when they are expressed and enforced through the process of *ethnocentric monoculturalism*. In the United States, the historical manifestations of this process are quite clear. The European colonization efforts toward the Americas, for example, operated from the assumption that the enculturation

of indigenous peoples was justified because European culture was superior. Forcing colonized people to adopt European beliefs and customs was seen as civilizing them. This practice was clearly evident in the treatment of Native Americans, whose lifestyles, customs, and practices were seen as backward and uncivilized; these attitudes were used to justify the conversion of the “heathens” (Duran, 2006; Gone, 2010).

Monocultural ethnocentric bias has a long history in the United States, as reflected in the uneven application of the Bill of Rights, which favored White immigrants/descendants over minority populations (Barongan et al., 1997). In 1776, Britain's King George III accepted a Declaration of Independence from his former subjects who had moved to this new country. This proclamation was destined to shape and reshape the geopolitical and sociocultural landscape of the world many times over. The lofty language penned by its principal architect, Thomas Jefferson, and signed by those present, was indeed inspiring: “We hold these truths to be self evident, that all men are created equal.”

Yet, as we now view the historic actions of that time, we cannot help but be struck by the paradox inherent in them. First, all 56 of the signatories were White males of European descent—hardly a representation of the current racial and gender composition of the population. Second, the language of the declaration suggests that only men are created equal; what about women? Third, many of the founding fathers were slave owners who seem not to have recognized the hypocritical personal standards that they used because they considered Blacks to be subhuman. Fourth, the history of this land did not start with the Declaration of Independence or the formation of the United States of America; nevertheless, our textbooks continue to teach us an ethnocentric perspective (“Western Civilization”) that ignores the natives of this country. Last, it is important to note that those early Europeans who came to this country were immigrants attempting to escape persecution (oppression), but who failed to recognize their own role in the oppression of the indigenous peoples (American Indians) who had already resided in the land for centuries.

While *ethnocentric monoculturalism* is much broader than the concept of racial oppression, race and color have been primary determinants of the social order: the White race has been seen as superior and White culture as normative. Thus, a study of U.S. history must include a study of racism and racist practices directed at people of color (e.g., Zinn, 2015). The oppression of the indigenous people of this country (Native Americans), the enslavement of African Americans, the widespread segregation of Hispanic Americans, the passage of exclusionary laws against the Chinese, and the forced internment of Japanese Americans are social realities. Telling “the rest of the story” is important. Thus, it should be of no surprise that our racial/ethnic ‐ minority citizens may view EuroAmericans and our institutions with considerable mistrust and suspicion. Likewise, in counseling and psychotherapy, which demand a certain degree of trust between therapist and client, an interracial encounter may be fraught with historical and current psychological baggage related to issues of discrimination, prejudice, and oppression.

Video 5.1: Access and Accessibility

The impact of institutional and political oppression on the experiences of clients of color.

Surviving Systemic Oppression

Many multicultural specialists (Parham, Ajamu, & White, 2011; Ponterotto et al., 2006) have pointed out how African Americans, in responding to their forced enslavement, the history of discrimination against them, and majority reactions to their skin color, have adopted toward

Whites behavior patterns that are important for survival in a racist society. These behavior patterns may include indirect expressions of hostility, aggression, and fear. During slavery, to raise children who would fit into a segregated system and who could physically survive it, African American mothers were forced to teach them (a) to express aggression indirectly, (b) to read the thoughts of others while concealing their own, and (c) to engage in ritualized accommodating/subordinating behaviors designed to create as few waves as possible. This process involved a "mild dissociation," whereby African Americans separated their true selves from their role as "Negroes" (Boyd‐Franklin, 2010; Jones, 1997). In this dual identity, the true self is revealed to fellow Blacks, while the dissociated self is revealed to meet the expectations of prejudiced Whites.

For example, *playing it cool* has been identified as style of interaction by which African Americans or other minorities may conceal their true feelings (Boyd‐Franklin, 2010; Cross, Smith, & Payne, 2002; Grier & Cobbs, 1971; Jones, 1985). This behavior is intended to prevent Whites from knowing what the minority person is thinking or feeling and to instead express feelings and behaviors in such a way as to prevent offending or threatening them (Jones & Shorter‐Gooden, 2003; Ridley, 2005). Similarly, the *Uncle Tom syndrome* may be used by Blacks to appear docile, nonassertive, and happy‐go‐lucky. Especially during slavery, Blacks learned that the performance of passivity was at times a necessary survival technique.

In summary, it becomes all too clear that past and present discrimination against certain culturally diverse groups is a tangible basis for distrust of the majority society (McAuliffe & Associates, 2013). White people are often perceived as potential oppressors unless proved otherwise. Under such a sociopolitical atmosphere, marginalized groups may use several adaptive devices to prevent Whites from knowing their true feelings. Because multicultural counseling may mirror the sentiments of the larger society, these modes of behavior and their detrimental effects may be reenacted in sessions. The fact that many marginalized clients are suspicious, mistrustful, and guarded in their interactions with White or otherwise privileged therapists is certainly understandable in light of the foregoing analysis.

Despite their conscious desire to help, therapists are not immune from inheriting racist attitudes, beliefs, myths, and *stereotypes* about individuals from marginalized social groups (Sue, 2004). Such stereotypes result in their failure to understand the following considerations:

1. As a group, African Americans tend to communicate nonverbally more than their White counterparts and to assume that nonverbal communication is a more accurate barometer of one's true thoughts and feelings. E. T. Hall (1976) observed that African Americans are frequently better able to read nonverbal messages (high context) than are their White counterparts and that they rely less on verbalizations than on nonverbal communication to make a point. Whites, on the other hand, tune in more to verbal messages than to nonverbal messages (low context). Because they rely less on nonverbal cues, Whites often need greater verbal elaboration to get a point across (Sue, Ivey, & Pedersen, 1996). Being unaware of and insensitive to these differences, White therapists are prone to feel that African American clients are unable to communicate in complex ways. This judgment is based on the high value that therapy places on intellectual/verbal activity.
2. Rightfully or not, White therapists are often perceived as symbols of institutionalized privilege who have inherited the racial biases of their forebears. Thus, socially marginalized clients may impute all the negative experiences of oppression to them. This may prevent clients from responding to helping professionals as individuals. While

therapists may be possessed of the most admirable motives, clients may reject helping professionals simply because they are White. Thus, communication may be directly or indirectly shut off.

3. Some culturally diverse clients may lack confidence in the counseling and therapy process because White counselors often propose White solutions to their concerns (Atkinson, Kim, & Caldwell, 1998). Many pressures are placed on clients of color to accept a White‐identified value system and reject their own. We have already indicated how counseling and psychotherapy may be perceived as instruments of oppression whose function is to force assimilation and acculturation. As some racial/ethnic minority clients have asked, “Why do I have to become White in order to be considered healthy?”
4. The *playing it cool* and Uncle Tom responses of many people of color are also present in therapy sessions. As already pointed out, these mechanisms are attempts to conceal true feelings, to hinder self‐disclosure, and to prevent the therapist from getting to know the client. Such adaptive survival mechanisms have been acquired through generations of experience with a hostile and invalidating society. The therapeutic dilemma encountered by the helping professional in working with a client of color is how to gain trust so that the client gradually feels encouraged to bring more of their true self into the room. What therapists ultimately do in sessions will determine their *trustworthiness*.

In closing, culturally diverse clients entering counseling or therapy are likely to experience considerable anxiety about ethnic/racial/cultural differences. Suspicion, apprehension, verbal constriction, unnatural reactions, open resentment and hostility, and passive or cool behavior may all be expressed. Self‐disclosure and the possible establishment of a working relationship can be seriously delayed or prevented from occurring. In all cases, the therapist's *trustworthiness* may be put to severe test. Culturally effective therapists are ones who (a) can view these behaviors in a nonjudgmental manner (i.e., they are not necessarily indicative of pathology but are a manifestation of adaptive survival mechanisms), (b) can avoid personalizing any potential hostility expressed toward them, and (c) can adequately resolve challenges to their *credibility*. Thus, it becomes important for us to understand those dimensions that may enhance or diminish the culturally different client's receptivity to self‐disclosure.

COUNSELOR CREDIBILITY AND ATTRACTIVENESS

Counselors who are perceived by their clients as credible (expert and trustworthy) and attractive (similar) are better able to establish rapport with them than those who are not (Heesacker & Carroll, 1997). Regardless of the counseling orientation (psychodynamic, humanistic, behavioral, etc.), a therapist's effectiveness depends on client perceptions of their *expertness*, *trustworthiness*, and *attractiveness*. Most studies on social influence and counseling, however, have dealt exclusively with a White population (Heesacker, Conner, & Pritchard, 1995; Strong, 1969). Thus, counselor attributes traditionally associated with *credibility* and *attractiveness* may not be so perceived by culturally diverse clients. It is entirely possible that *credibility*, as defined by professional credentials or advanced degrees, might only indicate to a Latinx client that the White therapist has no knowledge or expertise in working with Latinx individuals. It seems important, therefore, for helping professionals to understand what factors/conditions may enhance or negate counselor *credibility* and *attractiveness* when working with diverse clients.

Counselor Credibility

Credibility may be defined as the constellation of characteristics that makes certain individuals appear worthy of belief, capable, entitled to confidence, reliable, and trustworthy. *Credibility* has two components: *expertness* and *trustworthiness*. *Expertness* is an *ability variable*, whereas *trustworthiness* is a *motivation variable*. *Expertness* depends on how well informed, capable, or intelligent others perceive the communicator (counselor/therapist) to be. *Trustworthiness* is dependent on the degree to which people perceive the communicator as motivated to make valid or invalid assertions. The weight of evidence supports our commonsense belief that the helping professional who is perceived as expert and trustworthy can influence clients more than can one who is perceived not to be so.

Expertness

Clients often go to a therapist not only because they are in distress and in need of relief but also because they believe the counselor is an expert, and has the necessary knowledge, skills, experience, training, and tools (*problem - solving set*) to help them. Perceived *expertness* is typically a function of (a) reputation, (b) evidence of specialized training, and (c) behavioral evidence of proficiency/competency. Clients seeing a therapist of a different race/culture seem to raise the issue of therapist *expertness* more often than do those who see a therapist of their own culture and race (Okun, Chang, Kanhia, Dunn, & Easley, 2017). The fact that therapists have degrees and certificates from prestigious institutions (*authority set*) may not enhance perceived *expertness*. This is especially true of socially marginalized clients who are aware that institutional bias exists in training programs. Indeed, it may have the opposite effect, by reducing *credibility*! Additionally, reputation - expertness (*authority set*) is unlikely to impress diverse clients unless the favorable testimony comes from someone of their own group.

Thus, behavior - expertness, or a demonstration of the ability to help the client, becomes the critical form of *expertness* in effective multicultural counseling (*problem - solving set*). It appears that using counseling skills and strategies appropriate to the life values of the culturally diverse client is crucial. We have already mentioned evidence that certain minority groups often prefer a much more active approach to counseling. A counselor playing a relatively inactive role may be perceived as being incompetent and unhelpful. The following example shows how the therapist's approach can lower perceived *expertness*.

Asian American Male Client:

It's hard for me to talk about these issues. My parents and friends … they wouldn't understand … if they ever found out I was coming here for help …

White Male Therapist:

I sense it's difficult to talk about personal things. How are you feeling right now?

Asian American Client:

Oh, all right.

White Therapist:

That's not a feeling. Sit back and get in touch with your feelings. [pause] Now tell me, how are you feeling right now?

Asian American Client:

Somewhat nervous.

White Therapist:

When you talked about your parents and friends not understanding, the way you said it made me think you felt ashamed and disgraced at having to come. Was that what you felt?

Although this exchange appears to indicate that the therapist could (a) see the client's discomfort and (b) interpret his feelings correctly, it also points out the therapist's lack of understanding and knowledge of Asian cultural values. Although we do not want to be guilty of *stereotyping* Asian Americans, many believe that publicly expressing feelings to a stranger is inappropriate. The therapist's persistent attempts to focus on feelings and his direct and blunt interpretation of them may indicate to the Asian American client that the therapist lacks the more subtle skills of dealing with a sensitive topic or that the therapist is shaming the client.

Furthermore, it is possible that the Asian American client in this case is much more used to discussing feelings in an indirect or subtle manner. A direct response from the therapist addressed to a feeling may not be as effective as one that deals with it indirectly. In many traditional Asian groups, subtlety is a highly prized art, and the traditional Asian client may feel much more comfortable when dealing with feelings in an indirect manner.

Many educators claim that specific therapy skills are not as important as the attitude one brings into the therapeutic situation. Behind this statement is the belief that universal attributes of genuineness, love, unconditional acceptance, and positive regard are the only things needed. Yet, the question remains: How does a therapist communicate these things to culturally diverse clients? While a therapist may have the best of intentions, it is possible that these might be misunderstood. Let us use another example with the same Asian American client.

Asian American Client:

I'm even nervous about others seeing me come in here. It's so difficult for me to talk

about this.

White Therapist:

We all find some things difficult to talk about. It's important that you do.

Asian American Client:

It's easy to say that. But do you really understand how awful I feel, talking about my parents?

White Therapist:

I've worked with many Asian Americans, and many have similar problems.

Here we find a distinction between the therapist's intentions and the effects of his comments. The therapist's intentions were to reassure the client that he understood his feelings, to imply that he had worked with similar cases, and to make the client feel less isolated (i.e., that others have the same problems). The effects, however, were to dilute and dismiss the client's feelings and concerns and to take the uniqueness out of the situation.

Trustworthiness

Perceived *trustworthiness* encompasses such factors as sincerity, openness, honesty, and perceived lack of motivation for personal gain. A therapist who is perceived as trustworthy is likely to exert more influence over a client than one who is not. In our society, many people assume that certain roles, such as minister, doctor, psychiatrist, and counselor, exist to help people. With respect to minorities, self - disclosure can be associated with this attribute of perceived *trustworthiness*. Because mental health professionals are often perceived by minorities to be agents of the Establishment, trust is something that does not come with the role. Indeed, many minorities may perceive that therapists cannot be trusted unless otherwise demonstrated. Again, the role and reputation that the therapist has as being trustworthy must be evidenced in behavioral terms. More than anything, challenges to the therapist's *trustworthiness* will be a frequent theme blocking further exploration and movement until they are resolved to the satisfaction of the client. These verbatim transcripts illustrate the trust issue.

White Male Therapist:

I sense some major hesitations … It's difficult for you to discuss your concerns with me.

Black Male Client:

You're damn right! If I really told you how I felt about my [White] coach, what's to prevent you from telling him? You Whities are all of the same mind.

White Therapist [angry]:

Look, it would be a lie for me to say I don't know your coach. He's an acquaintance but not a personal friend. Don't put me in the same bag with all Whites! Anyway, even if he were a close friend, I hold our discussion in strictest confidence. Let me ask you this question: What would I need to do that would make it easier for you to

trust me?

Black Client:

You're on your way, man!

This verbal exchange illustrates several issues related to *trustworthiness*. First, the African American client is likely to test the therapist constantly regarding issues of confidentiality. Second, the onus of responsibility for proving *trustworthiness* falls on the therapist. Third, to prove that one is trustworthy requires, at times, self‐disclosure on the part of the mental health professional. That the therapist did not hide the fact that he knew the coach (openness), became angry about being lumped with all Whites (sincerity), assured the client that he would not tell the coach or anyone else about their sessions (confidentiality), and asked the client how he could work to prove he was trustworthy (genuineness) were all elements that enhanced his *trustworthiness*.

Handling the “prove to me that you can be trusted” ploy is very difficult for many therapists. It is difficult because it demands self‐disclosure, something that graduate training programs have taught us to avoid. It places the focus on the therapist rather than on the client. In addition, it is likely to evoke defensiveness on the part of many mental health practitioners. Here is another verbatim exchange in which defensiveness is evoked, destroying the helping professional's *trustworthiness*.

Black Female Client:

Students in my drama class expect me to laugh when they do “Stepin Fechit” routines and tell Black jokes … I'm wondering whether you've ever laughed at any of those jokes.

White Male Therapist:

[long pause] Yes, I'm sure I have. Have you ever laughed at any White jokes?

Black Client:

What's a White joke?

White Therapist:

I don't know [nervous laughter]; I suppose one making fun of Whites. Look, I'm Irish. Have you ever laughed at Irish jokes?

Black Client:

People tell me many jokes, but I don't laugh at racial jokes. I feel we're all minorities and should respect each other.

Again, the client tested the therapist indirectly by asking him if he ever laughed at racial jokes. Since most of us probably have, to say “no” would be a blatant lie. The client's motivation for asking this question was to find out (a) how sincere and open the therapist was and (b) whether the therapist could recognize his racist attitudes without letting it interfere with therapy. While the therapist admitted to having laughed at such jokes, he proceeded to

destroy his *trustworthiness* by becoming defensive. Rather than simply stopping with his statement of “Yes, I'm sure I have” or making some other similar remark, he defends himself by trying to get the client to admit to similar actions. Thus, the therapist's *trustworthiness* is seriously impaired. He is perceived as motivated to defend himself rather than to help the client.

The therapist's obvious defensiveness in this case has prevented him from understanding the intent and motive of the question. Is the African American female client really asking the therapist whether he has laughed at Black jokes before? Or is the client asking the therapist if he is a racist? Both of these speculations have a certain amount of validity, but it is our belief that the Black female client is actually asking the following important question of the therapist: “How open and honest are you about your own racism, and will it interfere with our session here?” Again, the test is one of *trustworthiness*, a motivational variable that the White male therapist has obviously failed.

REFLECTION AND DISCUSSION QUESTIONS

1. Think about yourself, your characteristics, and your interaction style. Think about your daily interactions with friends, coworkers, colleagues, or fellow students. How influential are you with them? What makes you influential?
2. As a counselor or therapist, what makes you credible with your clients? Using the psychological sets outlined earlier, how do you convey *expertness* and *trustworthiness*?
3. What do you believe would stand in the way of your *trustworthiness* with clients of color? How would you overcome it?

Video 5.2: Challenges and Triumphs

The level of care, or foci, can impact how counseling is performed; knowing how to assess your client's issues is key to a more positive outcome.

FORMATION OF INDIVIDUAL AND SYSTEMIC WORLDVIEWS

The dimensions of trust–mistrust and *credibility* in the helping professions are strongly influenced by *worldviews*. *Worldviews* determine how people perceive their relationship to the world (nature, institutions, other people, etc.), and they are highly correlated with a person's cultural upbringing and life experiences (Koltko‐Rivera, 2004). Put in a much more practical way, not only are *worldviews* composed of our attitudes, values, opinions, and concepts, but they also affect how we think, define events, make decisions, and behave. For marginalized groups in the United States, a strong determinant of *worldviews* is very much related to the subordinate position assigned to them in society. Helping professionals who hold a *worldview* different from that of their clients and who are unaware of the basis for this difference are most likely to impute negative traits to clients and to engage in *cultural oppression*. To understand this assertion, we discuss two different psychological orientations considered important in the formation of *worldviews*: (a) *locus of control* and (b) *locus of responsibility*.

Locus of Control

Locus of control can be conceptualized as having two dimensions (Rotter, 1966). Internal locus of control (IC) refers to the belief that reinforcements are contingent on our own actions and that we can shape our own fate. External locus of control (EC) refers to the belief that reinforcing events occur independently of our actions and that the future is determined more by chance and luck. Research suggests that high internality is associated with multiple positive attributes such as higher achievement motivation, belief in mastery over the environment, superior intellect, superior coping skills, and so on (Lefcourt, 1966; Rotter, 1966, 1975). These attributes are highly valued by U.S. society and seem to constitute some of the core features of Western mental health.

On the other hand, it has been found that people of color, women, and people with low socioeconomic status score significantly higher on the external end of the locus‐of‐control continuum (Sue, 1978; Koltko‐Rivera, 2004). Using the IC–EC dimension as a criterion of mental health would mean that people of color and poor or female clients would be viewed as possessing less desirable attributes. Thus, a clinician who encounters a minority client with a high external orientation (e.g., “It's no use trying,” “There's nothing I can do about it,” “You shouldn't rock the boat”) might interpret the client as being inherently apathetic, prone to procrastinating, lazy, depressed, or anxious about trying. The problem with an unqualified application of the IC–EC dimension is that it fails to take into consideration different cultural and social experiences of the individual. This failure may lead to highly inappropriate and destructive applications in therapy. It seems plausible that different cultural groups, women, and people with a lower socioeconomic status have learned that control in their lives operates differently from how it operates for society at large (American Psychological Association, 2007; Ridley, 2005). For example, externality related to impersonal forces (chance and luck) is different from that ascribed to cultural forces and from that ascribed to powerful others.

Externality and Culture

Chance and luck operate equally across situations for everyone. However, the forces that determine *locus of control* from a cultural perspective may be viewed by a particular ethnic group as acceptable and benevolent. In this case, externality is viewed positively. U.S. culture, for example, values the uniqueness, independence, and self‐reliance of individuals. It places a high premium on self‐reliance, individualism, and status achieved through one's

own efforts. In contrast, the situation‐centered Chinese culture places importance on the group, on tradition, on social roles expectations, and on harmony with the universe (Kim, 2011; Ratts & Pedersen, 2014). Thus, the cultural orientation of the more traditional Chinese tends to elevate the external scores. In contrast to U.S. society, Chinese society values externality highly.

Externality and Sociopolitical Factors

Likewise, high externality may constitute a realistic sociopolitical presence. A major force in the literature dealing with *locus of control* is that of powerlessness. Powerlessness may be defined as the expectancy that a person's behavior cannot determine the outcomes or reinforcements that he or she seeks. For example, low‐socioeconomic status individuals and Blacks are not given an equal opportunity to obtain the material rewards of Western culture. Because of racism, African Americans may perceive, in a realistic fashion, a discrepancy between their ability and their attainment. For this reason, focusing on external forces may be motivationally healthy if it results from assessing one's chances for success against real systematic and external obstacles rather than unpredictable fate. The IC–EC continuum is useful for therapists only if they make clear distinctions about the meaning of the EC dimension. High externality may be due to (a) chance/luck, (b) cultural dictates that are viewed as benevolent, and (c) political forces (racism and discrimination) that represent malevolent but realistic obstacles.

Locus of Responsibility

Another important dimension in world outlooks is the concept of *locus of responsibility* (Jones, 1997). In essence, this dimension measures the degree of responsibility or blame placed on an individual or system. In the case of Latinx Americans, their lower standard of living may be primarily attributed to either their personal shortcomings or to racial discrimination and lack of opportunities. The former orientation blames the individual, while the latter blames the system.

The degree of emphasis placed on the individual as opposed to the system in affecting a person's behavior is important in the formation of life orientations. Those who hold a person‐centered orientation believe that success or failure is attributable to the individual's skills or personal inadequacies, and that there is a strong relationship between ability, effort, and success in society. In essence, these people adhere strongly to the Protestant ethic that idealizes rugged individualism.

On the other hand, situation‐centered people may view the sociocultural and sociopolitical environment as more potent than the individual. Social, economic, and political forces are powerful; success or failure is seen in the context of social forces and not attributed solely to personal characteristics. Defining the problem as residing in the person enables society to ignore the influence of external factors and to protect and preserve existing social institutions and belief systems. Thus, the individual/system‐blaming continuum may need to be viewed differentially for socially devalued groups. An internal response (acceptance of blame for one's failure) might be considered normative for the White middle class, but for minorities it may be extreme and intropunitive to disregard the impact of social forces.

Video 5.3: Internal or External Control

The importance of meeting your clients where they are and empathizing with their reality.

FORMATION OF WORLDVIEWS

The two psychological orientations, *locus of control* and *locus of responsibility*, are independent of one another. As shown in Figure 5.1, both may be placed on the continuum in such a manner that they intersect, forming four quadrants: internal locus of control–internal locus of responsibility (IC - IR), external locus of control–internal locus of responsibility (EC - IR), external locus of control–external locus of responsibility (EC - ER), and internal locus of control–external locus of responsibility (IC - ER). Each quadrant represents a different *worldview* or orientation to life.

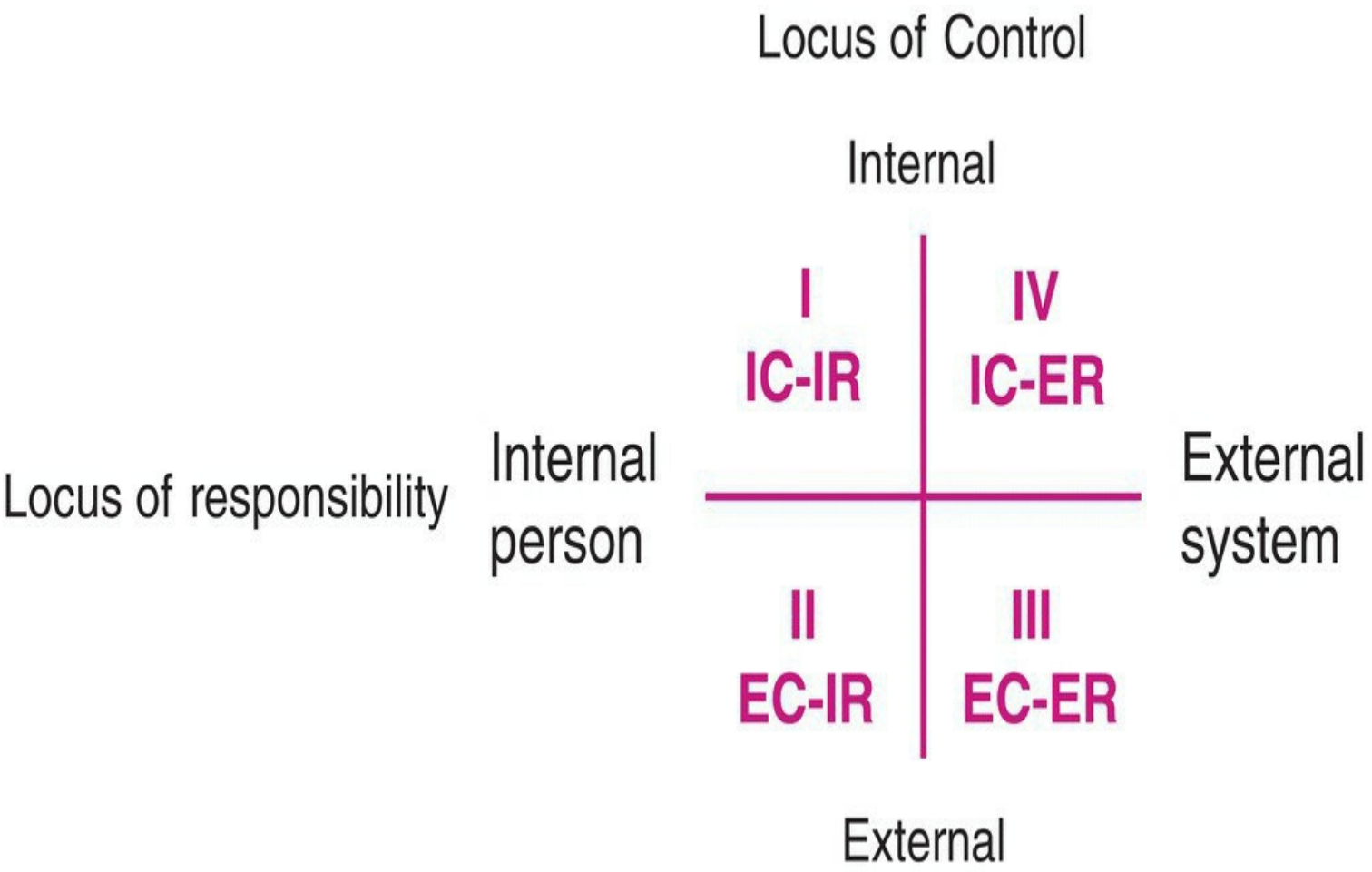

FIGURE 5.1 Graphic Representation of Worldviews

Source: D. W. Sue (1978). Eliminating Cultural Oppression in Counseling: Toward a General Theory. *Journal of Counseling Psychology*, 25, 422. Copyright © 1978 *Journal of Counseling Psychology*. Reprinted with permission.

Select this link to open an interactive version of Figure 5.1.

Internal Locus of Control (IC)–Internal Locus of Responsibility (IR)

As mentioned earlier, individuals high in IC believe that they are masters of their fate and that their actions do affect their life outcomes. Likewise, people high in IR attribute their current status and life conditions to their own unique attributes; success is due to one's own efforts, and lack of success to one's shortcomings or inadequacies. Perhaps the greatest exemplification of the IC–IR philosophy is U.S. society. American culture can be described as the epitome of the individual - centered approach that emphasizes uniqueness, independence, and self - reliance. A high value is placed on personal resources for solving all problems, on self - reliance, on pragmatism, on individualism, on status achievement through one's own effort, and on power or control over others, things, animals, and forces of nature. Democratic ideals such as “equal access to opportunity,” “liberty and justice for all,” “God helps those who help themselves,” and “fulfillment of personal destiny” all reflect this

worldview. The individual is held accountable for all that transpires. Most members of the White upper and middle classes would fall within this quadrant.

Counseling Implications

Most Western‐trained therapists are of the opinion that people must take major responsibility for their own actions, and they assume that people can always improve their lot in life by their own efforts. Clients who occupy this quadrant tend to be White middle‐class clients, and for these clients such approaches might be entirely appropriate. In working with clients from different cultures, however, such an approach might be inappropriate. *Cultural oppression* in therapy becomes an ever‐present danger.

External Locus of Control (EC)–Internal Locus of Responsibility (IR)

Individuals who fall into this quadrant are most likely to accept the dominant culture's definition of self‐responsibility but to have very little real control over how they are defined by others. The term *marginal man* (person) was first coined by Stonequist (1937) to describe a person living on the margins of two cultures and not fully accommodated to either. Marginal individuals deny the existence of racism; believe that the plight of their own people is the result of laziness, stupidity, and a clinging to outdated traditions; reject their own cultural heritage and believe that their ethnicity represents a handicap in Western society; evidence racial self‐hatred; accept White social, cultural, and institutional standards; perceive physical features of White men and women as an exemplification of beauty; and are powerless to control their sense of self‐worth because approval must come from an external source. As a result, they are high in person focus and EC.

Counseling Implications

The psychological dynamics for the EC–IR minority client are likely to reflect his or her marginal status and self‐hate or internalized racism (e.g., Choi, Israel, & Maeda, 2017; Watts‐Jones, 2002). For example, White therapists might be perceived as more competent and preferred than are therapists of the client's own race. To EC–IR individuals, focusing on feelings may be very threatening because it ultimately might reveal the presence of self‐hate. A culturally encapsulated White counselor or therapist who does not understand the sociopolitical dynamics of the client's concerns may unwittingly perpetuate the conflict. For example, the client's preference for a White therapist, coupled with the therapist's implicit belief in the values of U.S. culture, becomes a barrier to effective counseling. Culturally competent therapists need to help clients (a) understand the particular dominant–subordinate political forces that have created this dilemma and (b) distinguish between positive attempts to acculturate and a negative rejection of one's own cultural values.

External Locus of Control (EC)–External Locus of Responsibility (ER)

A person high in system blame and EC feels that there is very little one can do in the face of systemic oppression. In essence, the EC response may be a manifestation of (a) having given up or (b) attempting to placate those in power. In the former case, individuals internalize their powerlessness even though they are aware of the external basis of their plight. In its extreme form, oppression may result in a form of learned helplessness. When marginalized groups learn that their responses have minimal effect on the environment, the resulting phenomenon can best be described as an expectation of helplessness. People's susceptibility to helplessness depends on their experience with controlling the environment. In the face of continued oppression, many may give up in their attempts to achieve personal goals, and instead act to

accommodate or placate the powerful others in their environment.

The dynamics of the placater, however, are not equivalent to the response of giving up. Rather, social forces in the form of prejudice and discrimination are seen as too powerful to combat at that particular time. The best one can hope to do is to suffer the inequities in silence for fear of retaliation. The phrases that most describe this mode of adjustment include “Don't rock the boat,” “Keep a low profile,” and “Survival at all costs.” Life is viewed as relatively fixed, and there appears to be little that the individual can do. Passivity in the face of oppression is a primary reaction and survival strategy of the placater. Slavery was one of the most important historical factors in shaping the sociopsychological adaptation of the African American community. Interpersonal relations between Whites and Blacks were highly structured and placed African Americans in a subservient and inferior role. Those Blacks who broke the rules or did not show proper deferential behavior were severely punished. The spirits of most African Americans, however, were not broken. Conformity to White EuroAmerican rules and regulations was dictated by the need to survive in an oppressive environment. Direct expressions of anger and resentment were dangerous, but indirect expressions were frequent.

Counseling Implications

EC–ER individuals are very likely to see a more privileged therapist as symbolic of any other dominant–subordinate social relations. They are likely to show “proper” deferential behavior and not to take seriously admonitions by the therapist that they are the masters of their own fate. As a result, an IC–IR therapist may perceive the culturally different client as lacking in courage and ego strength and as being passive. A culturally effective therapist, however, would realize the basis of these adaptations. Unlike EC–IR clients, EC–ER individuals do understand the political forces that have subjugated their existence. The most helpful approaches on the part of the therapist would include (a) teaching the client new coping strategies, (b) having them experience successes, and (c) validating who and what they represent.

Internal Locus of Control (IC)–External Locus of Responsibility (ER)

Individuals who score high in IC and system focus believe that they are able to shape events in their own life if given a chance. They do not accept the idea that their present state is due to their own inherent weakness. However, they also realistically perceive that external barriers of discrimination, prejudice, and exploitation can operate to block their paths to the successful attainment of goals. Recall that the IC dimension was correlated with greater feelings of personal efficacy, higher aspirations, and so forth, and that ER was related to collective action in the social arena. Hence, we would expect that IC–ER people would be more likely to participate in civil rights activities and to value racial identity and activism. The low self - esteem engendered by widespread prejudice and racism is actively challenged, and there is an attempt to redefine a group's existence by stressing consciousness and pride in one's cultural heritage. For example, such phrases as “Black is beautiful” accompany the historical relabeling of identity from “Negro” and “colored” to “Black” or “African American.”

Counseling Implications

Much evidence indicates that people with marginalized group memberships are becoming increasingly conscious of their own cultural and racial identities as they relate to oppression in U.S. society. In keeping with these trends, it is also probable that more and more

individuals are likely to hold an IC–ER *worldview*. Thus, therapists who work with culturally diverse clients will increasingly be exposed to clients with an IC–ER *worldview*. In many respects, these clients may pose the most challenging problems for the White IC–IR therapist, as the helping professional is likely to be seen as a part of the establishment that has oppressed minorities. Self - disclosure on the part of the client is not likely to come quickly; more than with any other *worldview*, the IC–ER client is likely to play a much more active part in the therapy process and to seek action and accountability from a more privileged therapist.

IMPLICATIONS FOR CLINICAL PRACTICE

1. Understand and apply the concepts of *ethnocentric monoculturalism* to the wider society and to marginalized groups; understand how it may manifest and affect the dynamics in dominant–subordinate counseling relationships.
2. Distinguish between behaviors indicative of a true mental disorder and those that result from oppression and survival tactics.
3. Do not personalize the suspicions a client may have of your motives. If you become defensive, insulted, or angry with the client, your effectiveness will be seriously diminished.
4. Be willing to understand and overcome your *stereotypes*, biases, and assumptions about other cultural groups.
5. Know that *expertness* and *trustworthiness* are important components of any therapeutic relationship, but that this relationship may be affected by experiences of oppression.
6. Know that your *credibility* and *trustworthiness* will be tested when working with culturally diverse clients. Tests of *credibility* may occur frequently in the therapy session, and the onus of responsibility for proving *expertness* and *trustworthiness* lies with the therapist.
7. Understanding the worldviews of culturally diverse clients means understanding how they are formed.
8. Know that traditional counseling and therapy operate from the assumption of high IC and responsibility. Be able to apply and understand how Western therapeutic characteristics may detrimentally interact with other *worldviews*.

Video 5.4: Personal Worldview Formulation

Introduction to counseling session by Dr. Joel Filmore.

SUMMARY

The history of race relations in the United States has influenced most of us to the point where we are extremely cautious about revealing to strangers our feelings and attitudes about race. In an interracial or intercultural encounter with a stranger (i.e., therapy), each party will attempt to discern gross or subtle racial attitudes of the other while minimizing their own vulnerability. *Ethnocentric monoculturalism* lies at the heart of oppressor–oppressed relationships, affecting trust–mistrust and self‐disclosure in the therapeutic encounter. The five components of *ethnocentric monoculturalism* are belief in the superiority of one group over another, belief in the inferiority of all other groups, power to impose standards on socially devalued groups, manifestation and support of institutions, and invisibility of the imposition process.

It is clear that past and present discrimination against certain culturally marginalized groups is a tangible basis for minority distrust of the majority society. Majority group members are often perceived as potential oppressors unless proved otherwise. Under such a sociopolitical atmosphere, marginalized group members may use several adaptive behaviors to prevent Whites from knowing their true feelings. Because multicultural counseling may mirror the sentiments of the larger society, these modes of behavior and their detrimental effects may be reenacted in the sessions. The fact that many marginalized clients are suspicious, mistrustful, and guarded in their interactions with White therapists is certainly understandable in light of the foregoing analysis.

Counselors who are perceived by their clients as *credible* (expert and trustworthy) and *attractive* (similar) are better able to establish rapport with them than those who are not. Social psychologists have identified the psychological mindsets of people who work toward establishing communicator and therapist *credibility*. In multicultural counseling, client testing of *trustworthiness* and *expertness* is likely to enhance or negate the counselor's *credibility* in the client's mind. Such tests are likely to prove challenging to well‐intentioned therapists. Cultural competence means seeking to understand the *worldviews* of diverse clients. *Locus of control* (people's belief that they can shape their own fate—IC, or that chance or luck determines outcomes—EC) and *locus of responsibility* (people's belief that causation resides in the person—IR, or that it lies in the system—ER) interact to form four major *worldviews* that explain possible majority and diverse client perceptions and interactions: IC–IR, EC–IR, EC–ER, and IC–ER, each of which carries therapeutic implications.

GLOSSARY TERMS

- Attractiveness
- Credibility
- Cultural oppression
- Ethnocentric monoculturalism
- Expertness
- Institutional racism
- Invisible veil
- Locus of control
- Locus of responsibility
- Playing it cool
- Stereotyping
- Trustworthiness
- Uncle Tom syndrome
- Victim blaming
- White fragility
- White privilege
- Worldview

Video 5.5: Counseling Session Analysis

The counselor functions as a tool for change by recognizing oppressive behaviors in order to reestablish a connection to the client.

REFERENCES

1. American Psychological Association (2007). Guidelines for the psychological practice with girls and women. *American Psychologist*, *62*, 949–979.

2. Anderson, S. H., & Middleton, V. A. (2011). *Explorations in diversity*. Belmont, CA: Cengage.

3. Arredondo, P., Gallardo‐Cooper, M., Delgado‐Romero, E. A., & Zapata, A. L. (2014). *Culturally responsive counseling with Latinas/os*. Alexandria, VA: American Counseling Association.

4. Atkinson, D. R., Kim, B. S. K., & Caldwell, R. (1998). Ratings of helper roles by multicultural psychologists and Asian American students: Initial support for the three‐dimensional model of multicultural counseling. *Journal of Counseling Psychology*, *45*, 414–423.

5. Babu, C. (2017). Why I left my white therapist. Retrieved from https://tonic.vice.com/en_us/article/d7pa5j/why‐i‐left‐my‐white‐therapist

6. Barongan, C., Bernal, G., Comas‐Diaz, L., Iijima Hall, C. C., Nagayama Hall, G. C., LaDue, R. A., & Root, M. P. P. (1997). Misunderstandings of multiculturalism: Shouting fire in crowded theaters. *American Psychologist*, *52*, 654–655.

7. Boyd‐Franklin, N. (2010). Incorporating spirituality and religion into the treatment of African American clients. *The Counseling Psychologist*, *38*, 976–1000.

8. Choi, A. Y., Israel, T., & Maeda, H. (2017). Development and evaluation of the Internalized Racism in Asian Americans Scale (IRAAS). *Journal of Counseling Psychology*, *64*(1), 52–64.

9. Constantine, M. G., & Sue, D. W. (2006). *Addressing racism*. Hoboken, NJ: Wiley.

10. Cross, W. E., Smith, L., & Payne, Y. (2002). Black identity. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (pp. 93–108). Thousand Oaks, CA: Sage.

11. DiAngelo, R. (2011). White fragility. *International Journal of Critical Pedagogy*, *3*(3), 54–70.

12. Duran, E. (2006). *Healing the soul wound*. New York, NY: Teachers College Press.

13. Furman, R. (2011). White male privilege in the context of my life. In S. H. Anderson, & V. A. Middleton (Eds.), *Explorations in diversity: Examining privilege and oppression in a multicultural society* (pp. 33–37). Belmont, CA: Cengage.

14. Gone, J. P. (2010). Psychotherapy and traditional healing for American Indians: Exploring the prospects for therapeutic integration. *The Counseling Psychologist*, *38*, 166–235.

15. Grier, W., & Cobbs, P. (1971). *The Jesus bag*. San Francisco, CA: McGraw‐Hill.

16. Hall, E. T. (1976). *Beyond culture*. New York, NY: Anchor Press.

17. Halleck, S. L. (1971). Therapy is the handmaiden of the status quo. *Psychology Today*, *4*(30–34), 98–100.

18. Heesacker, M., & Carroll, T. A. (1997). Identifying and solving impediments to the social and counseling psychology interface. *The Counseling Psychologist, 25,* 171–179.

19. Heesacker, M., Conner, K., & Pritchard, S. (1995). Individual counseling and psychotherapy: Allocations from the social psychology of attitude change. *The Counseling Psychologist, 23,* 611–632.

20. Highlen, P. S. (1994). Racial/ethnic diversity in doctoral programs of psychology: Challenges for the twenty‐first century. *Applied and Preventive Psychology, 3,* 91–108.

21. Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2014). *Intentional interviewing and counseling* (8th ed.). Belmont, CA: Brooks/Cole.

22. Jones, A. C. (1985). Psychological functioning in Black Americans: A conceptual guide for use in psychotherapy. *Psychotherapy, 22,* 363–369.

23. Jones, C., & Shorter‐Gooden, K. (2003). *Shifting: The double lives of Black women in America*. New York, NY: HarperCollins.

24. Jones, J. M. (1997). *Prejudice and racism* (2nd ed.). Washington, DC: McGraw‐Hill.

25. Jones, J. M. (2010). I'm White and you're not: The value of unraveling ethnocentric science. *Psychological Science, 5,* 700–707.

26. Katz, J. (1985). The sociopolitical nature of counseling. *The Counseling Psychologist, 13,* 615–624.

27. Kim, B. S. K. (2011). *Counseling Asian Americans*. Belmont, CA: Cengage.

28. Koltko‐Rivera, M. E. (2004). The psychology of worldviews. *Review of General Psychology, 8,* 3–58.

29. Lefcourt, H. (1966). Internal versus external control of reinforcement: A review. *Psychological Bulletin, 65,* 206–220.

30. Lum, D. (2011). *Culturally competent practice*. Belmont, CA: Cengage.

31. McAuliffe, G., & Associates (2013). *Culturally alert counseling*. Thousand Oaks, CA: Sage.

32. MetaFilter (2016). My therapist is White. I'm not. Retrieved from https://ask.metafilter.com/294347/My‐therapist‐is‐white‐Im‐not

33. Neville, H. A., Gallardo, M. E., & Sue, D. W. (2016). *What does it mean to be color‐blind? Manifestation, dynamics and impact*. Washington, DC: American Psychological Association.

34. Okun, L., Chang, D. F., Kanhai, G., Dunn, J., & Easley, H. (2017). Inverting the power dynamic: The process of first sessions of psychotherapy with therapists of color and non‐Latino White patients. *Journal of Counesling Psychology, 64*(4), 443.

35. Parham, T. A., & Caldwell, L. D. (2015). Boundaries in the context of a collective community: An African‐centered perspective. In B. Herlihy, & G. Corey (Eds.), *Boundary issues in counseling* (2nd ed.) (pp. 96–100). Alexandria, VA: American Counseling Association.

36. Parham, T. A., Ajamu, A., & White, J. L. (2011). *The psychology of Blacks. Centering our perspectives in the African consciousness*. Boston, MA: Prentice Hall.

37. Ponterotto, J. G., Utsey, S. O., & Pedersen, P. B. (2006). *Preventing prejudice: A guide for counselors, educators, and parents*. Thousand Oaks, CA: Sage.

38. Prilleltensky, I. (1989). Psychology and the status quo. *American Psychologist*, *44*(5), 795–802.

39. Ratts, M. J., & Pedersen, P. B. (2014). *Counseling for multiculturalism and social justice*. Alexandria, VA: American Counseling Association.

40. Ridley, C. R. (2005). *Overcoming unintentional racism in counseling and therapy* (2nd ed.). Thousand Oaks, CA: Sage.

41. Rotter, J. (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs*, *80*, 1–28.

42. Rotter, J. (1975). Some problems and misconceptions related to the construct of internal versus external control of reinforcement. *Journal of Consulting and Clinical Psychology*, *43*, 56–67.

43. Ryan, W. (1971). *Blaming the victim*. New York, NY: Pantheon.

44. Stonequist, E. V. (1937). *The marginal man*. New York, NY: Scribner's.

45. Strong, S. R. (1969). Counseling: An interpersonal influence process. *Journal of Counseling Psychology*, *15*, 215–224.

46. Sue, D. W. (1978). Eliminating cultural oppression in counseling: Toward a general theory. *Journal of Counseling Psychology*, *25*, 419–428.

47. Sue, D. W. (2003). *Overcoming our racism: The journey to liberation*. San Francisco, CA: Jossey‐Bass.

48. Sue, D. W. (2004). Whiteness and ethnocentric monoculturalism: Making the invisible visible. *American Psychologist*, *59*, 761–769.

49. Sue, D. W. (2010). *Microaggressions and marginality: Manifestations, dynamics, and impact*. Hoboken, NJ: Wiley.

50. Sue, D. W., Ivey, A. E., & Pedersen, P. B. (1996). *A theory of multicultural counseling and therapy*. Pacific Grove, CA: Brooks/Cole.

51. Thomas, A., & Sillen, S. (1972). *Racism and psychiatry*. New York, NY: Brunner/Mazel.

52. Toporek, R. L., & Worthington, R. L. (2014). Integrating service learning and difficult dialogues pedagogy to advance social justice training. *The Counseling Psychologist*, *46*, 919–945.

53. Watts‐Jones, D. (2002). Healing internalized racism: The role of a within‐group sanctuary among people of African descent. *Family Process*, *41*(4), 591–601.

54. Wrenn, C. G. (1962). The culturally encapsulated counselor. *Harvard Educational Review*, *32*, 444–449.

55. Zinn, H. (2015). *A people's history of the United States*. New York, NY: HarperCollins.

6
Microaggressions in Counseling and Psychotherapy

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Chapter Objectives

1. **1. Define and describe microaggressions.**
2. **2. Differentiate between the intentions (by the aggressor) and the impact (on the victim) of microaggressions.**
3. **3. Understand the psychological impact of microaggressions on marginalized groups.**
4. **4. Describe the various psychological dynamics involved in microaggressions.**
5. **5. Apply knowledge of microaggressions to understanding the therapeutic process and client/counselor dynamics.**

CASE STUDY

TOO TIRED TO STUDY: THE CASE OF MARSHALL

Marshall is a 20 - year - old Black male attending an undergraduate university in a large metropolitan city. His mother and father emigrated from Trinidad and Tobago just before he was born, moving to an urban neighborhood that was predominantly Caribbean American. Marshall attended the public school system, where he excelled in his studies and graduated at the top of his class. He chose an extremely well regarded university that was not too far from home, where he is currently in his second year of study, majoring in economics. In his first year, Marshall was heavily involved in campus life: he joined several academic and social groups, played intermural soccer, and rushed a fraternity. Over the course of that first year, Marshall experienced several similar events on campus: multiple times he was (a) randomly asked by security to show a school ID, (b) referred to a door for package deliveries when he was headed in for classes, and (c) assumed to be an institutional worker rather than a student by faculty, staff, and other students. Marshall wrote the experiences off each time as being circumstantial.

Then one night in the spring, Marshall was leaving the library after studying for finals. As he entered the cold, he put his hood up over his head. Within minutes he found himself face down on the pavement being told not to move and to put his hands behind his back. He was immediately taken into a police car for questioning, where it was explained to him that earlier that evening a woman had been accosted and robbed by a “male in a hooded sweatshirt.” Marshall was searched on site and asked multiple times what he was doing there so late. His explanation that he was studying in the library was reluctantly accepted once Marshall showed his student ID and study materials. He was let go.

In his second year, Marshall was less involved in activities and felt less motivated to engage in campus life. He noticed he was having more difficulty getting out of bed in the mornings and feeling somewhat disinterested in his studies. He started to regularly skip classes, and found himself traveling home on weekends, reluctant to return. One day, in a political science class, the students were debating whether the Black Lives Matter (BLM) movement was tied to a political party. Marshall noticed his heart racing and his head pounding during the conversation. One of his fellow students asked how a crowd of angry Black people protesting police brutality and therefore perpetrating

violence against police and White people is any different from a White supremacist rally. The professor did not have an answer and instead opened it up to the class to debate. There was minimal engagement for that question, but almost immediately a classmate asked, “don't all lives matter?” Marshall wanted to respond but felt a sense of speechlessness wash over him; he wanted to share his experience from the spring with the police but was not sure anyone would understand. He did not want to be labeled an “angry Black man” by his professor or his peers. So he stayed silent.

Eventually, with dropping attendance and grades, Marshall's advisor called him in for a meeting. During their conversation, Marshall revealed how tired and disinterested he felt. He also reported feeling like he was constantly being watched and surveyed on campus. Marshall's advisor strongly recommended that he attend the college counseling center for a consultation and potential therapy.

At the college counseling center, Marshall was assigned to Marie, a White female graduate student in her early 30s. In the first session, Marshall described feeling like he did not belong at the university. Marie wondered if the coursework was too challenging for him and asked if he was having trouble keeping up. He shared his experience of being perpetually asked for ID by school security and how he often felt disregarded by his peers and professors. Marie suggested that Marshall may be “reading into his interactions too intensely” and asked if his body language and posture might suggest to people that he is “unapproachable.” Marshall felt his heart racing and decided to share his wrongful accusations by campus police in the spring. Marie looked thoughtful and after a long pause she shared, “I cannot help but wonder about the hoodie you were wearing, and I'm thinking that without it, you may not have been accused.” Marshall had also wondered about the hoodie but ultimately felt that his daily experiences on campus were those of being treated like a suspect. He felt himself getting angry but thought that if he expressed this, he would scare Marie. Instead, he shared that he was just so tired, it felt difficult to attend to his studies.

Marie explained that depression can manifest as feelings of tiredness, trouble getting out of bed, difficulty focusing, and disengaging from activities one used to enjoy. She referred to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM‐5*) (American Psychiatric Association, 2013), pointing out that Marshall met many of the criteria for a depressive episode. Marshall shared with Marie that he often felt invisible in the classroom, ignored and unimportant, but that when he stepped out of the classroom on to campus, he suddenly felt hyper‐visible: like everyone was seeing him as potentially dangerous, criminal, and certainly out of place. Marie shared that when under stress, people can feel paranoid and jumpy, and she wondered if that was happening to Marshall. She told him that around midterms and finals, many students come into the center reporting similar feelings of depression and anxiety. She wanted Marshall to know that he was not alone. In fact, Marshall had never felt more alone. He did not return to the center for a second session.

REFLECTION AND DISCUSSION QUESTIONS

1. What are some of the assumptions that Marie makes about Marshall? Why might she be making these?
2. Can you describe the psychological impact these assumptions may be having on Marshall?

3. How might race, gender, and age be affecting the therapeutic relationship between Marshall and Marie?
4. If you were Marshall's therapist, how would you approach your work with him? What sociocultural dynamics would exist between you, and how might they influence the therapeutic process?
5. What could Marie do to repair this therapeutic rupture with Marshall? What role might cultural mistrust play in this process?

There is clearly misunderstanding and miscommunication between Marshall and Marie. Marshall was attending therapy in hopes of understanding his experiences and getting re‐engaged in school; however, his initial session has served as a microcosm for university life, where he feels disregarded and misunderstood. Marie does not acknowledge Marshall's race at all in their session, instead depending entirely on diagnosis to explain his feelings. She locates the problem as an internal one, rather than one caused by the environment and a larger climate of racism. Marshall's feelings and experiences are unknowingly invalidated, negated, and dismissed by Marie. This anecdote illustrates how microaggressions can have a detrimental impact upon marginalized groups and undermine the therapeutic process. Let us briefly review Marshall's interactions with others from his perspective.

On the college campus, Marshall experiences persistent feelings of not belonging. His professors and students often mistake him for a service worker and he is frequently asked to "prove" his position at the school by showing his ID to security. He is keenly aware of the stereotype of the "angry Black man" and does not want to be typecast should he express his frustrations. He is aware that if he is experienced as hostile and angry, then people may avoid him in the future, further compounding his feelings of alienation. Therefore, Marshall feels a persistent need to monitor his authentic reactions and his tone of voice, impeding his ability to be his true self (and using a lot of psychic energy!) while at school.

Although the therapist may be attempting to help Marshall by providing him with a diagnosis, she is actually undermining and invalidating Marshall's experiential reality. Instead of exploring the school environment and considering that racism causes people to see a Black man such as Marshall as less capable, less intelligent, and potentially dangerous, Marie immediately locates the problem within Marshall ("blaming the victim"). She does not acknowledge his race as the potential common denominator in his experiences, instead relying entirely on the *DSM‐5* to explain his problems. While he may in fact meet criteria for a depressive episode, Marshall is unlikely to be helped by this information without consideration of the trigger: racism. Further, Marie questions Marshall's academic abilities, thereby enacting a stereotype of intellectual inferiority and compounding Marshall's feelings of not belonging at the university. She goes on to further alienate him by suggesting that many students have feelings like his when facing the stress of finals. She eliminates race from every aspect of their conversation, sending a message to Marshall that his race should be invisible and nonimportant.

The incidents experienced by Marshall are examples of microaggressions. The term "racial microaggression" was originally coined by Chester Pierce to describe the subtle and often automatic put‐downs that African Americans face (Pierce, Carew, Pierce‐Gonzalez, & Willis, 1978). Since then, the definition has expanded to apply to any marginalized group. Microaggressions can be defined as brief, everyday exchanges that send denigrating messages to a target group, such as people of color, religious minorities, women, people with disabilities (PWDs), and lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals

(Sue, 2010, 2017; Sue, Capodilupo, et al., 2007). These microaggressions are often subtle in nature and can be manifested in the verbal, nonverbal, visual, or behavioral realm.

When professors and peers assume that Marshall is a service worker, they are sending a message that they do not believe Marshall belongs as a student at the university, that he is not academically capable. When Marshall is consistently asked for school ID on campus, he is made to feel like a suspect and criminal for no reason other than that he is a Black male. This is similar to the concept of “driving while Black,” which refers to the racial profiling of African American drivers. The underlying thought process seems to be that Black men are less qualified, less competent, less educated, and more likely to be criminal or dangerous. As we shall see, microaggressions create hostile and toxic environments where it is difficult to advance because of unconscious biases and beliefs held by professors and colleagues. In Marshall's case, the toxicity may prevent him from being able to learn and excel in his studies.

To help in understanding the effects of microaggressions on marginalized groups, we will be (a) reviewing related literature on contemporary forms of oppression (e.g., racism, sexism, heterosexism, ableism, and religious discrimination); (b) presenting a framework for classifying and understanding the hidden and damaging messages of microaggressions; and (c) presenting findings from studies that have explored people's lived experiences of microaggressions.

Video 6.0: Introduction

The clinician as both the expert and the learner, helping clients bridge the divide between culture and cultural competence.

CONTEMPORARY FORMS OF OPPRESSION

Most people associate racism with blatant and overt acts of discrimination that are epitomized by White supremacy and hate crimes. Studies suggest, however, that more subtle and ambiguous forms of racism are just as detrimental (if not more so) than overt expressions and are frequent, sometimes daily occurrences for people of color (Sue, 2015; Sue, Capodilupo, et al., 2007) have taken its place. A similar process seems to have occurred with sexism. Subtle sexism represents "unequal and unfair treatment of women that is not recognized by many people because it is perceived to be normative, and therefore does not appear unusual" (Swim, Mallett, & Stangor, 2004, p. 117). Whereas overt and covert sexism are intentional, subtle sexism is not deliberate or conscious. An example of subtle sexism is sexist language, such as the use of the pronoun *he* to convey universal human experience.

In many ways, subtle sexism contains many of the features that define aversive racism, a form of subtle and unintentional racism (Dovidio & Gaertner, 2000; Dovidio, Gaertner, & Pearson, 2017). Aversive racism is manifested in individuals who consciously assert egalitarian values but unconsciously hold antiminority feelings; therefore, "aversive racists consciously sympathize with victims of past injustice, support the principles of racial equality, and regard themselves as nonprejudiced. At the same time, however, they possess negative feelings and beliefs about historically disadvantaged groups, which may be unconscious" (Gaertner & Dovidio, 2006, p. 618). Inheriting such negative feelings and beliefs about members of marginalized groups (e.g., people of color, women, LQBTQ populations) is unavoidable and inevitable due to the socialization process in the United States (Sue, 2004a, 2004b), where biased attitudes and stereotypes reinforce group hierarchy (Dovidio et al., 2017). Much like aversive racism, subtle sexism devalues women, dismisses their accomplishments, and limits their effectiveness in a variety of social and professional settings (Calogero & Tylka, 2014). Researchers have begun to underscore the importance of these daily experiences of subtle sexism, arguing that they are in fact harmful and need to be recognized as such (Becker & Swim, 2012; Cundiff, Zawadzki, Danube, & Shields, 2014).

Researchers have used the templates of modern forms of racism and sexism to better understand the various forms of modern heterosexism (Smith & Shin, 2014; Walls, 2008) and modern homonegativity (Morrison & Morrison, 2002). Heterosexism and antigay harassment have a long history and are currently prevalent in the United States. Studies find the following for LGBTQ persons in the workplace: (a) between 15 and 43% experience discrimination or harassment; (b) 7–41% report verbal or physical abuse or have had their workplace vandalized; and (c) 10–28% have not been promoted because they are gay or transgender (Burns & Krehely, 2011). Antigay harassment can be defined as "verbal or physical behavior that injures, interferes with, or intimidates lesbian women, gay men, and bisexual individuals" (Burn, Kadlec, & Rexler, 2005, p. 24). While antigay harassment includes comments and jokes that convey that LGBTQ individuals are pathological, abnormal, or unwelcome, it can also take more subtle forms (Burn et al., 2005). For example, blatant heterosexism would be calling a lesbian a dyke, whereas subtle heterosexism would be referring to something as gay to convey that it is stupid. For sexual minorities, hearing this remark may result in a vicarious experience of insult and invalidation (Burn et al., 2005; Marzullo & Libman, 2009). It may also encourage individuals to remain closeted, as the environment can be perceived as hostile.

The discriminatory experiences of transgendered people have been very rarely studied in psychology (Nadal, Rivera, & Corpus, 2010), yet there is evidence to suggest that the pervasive daily discrimination faced by this population is associated with an elevated risk for suicide (Marzullo & Libman, 2009). One term used to define prejudice against transgendered

individuals is transphobia, “an emotional disgust toward individuals who do not conform to society's gender expectations” (Hill & Willoughby, 2005, p. 533). There is recent evidence to suggest that the microaggressions experienced by transgender individuals are distinct from those experienced by lesbian, gay, and bisexual people (Nadal, Skolnik, &Wong, 2012; Nadal, Griffin, Wong, Davidoff, & Davis, 2017).

Although it is increasingly considered politically incorrect to hold racist, sexist, and, to some extent, heterosexist beliefs, gender roles and expectations tend to be rigid in the United States, and people may feel more justified in adhering to their transphobic views (Nadal et al., 2012, 2017). Another area that has received limited attention in the psychological literature is religious discrimination, despite a high prevalence of religious ‐ based hate crimes in the United States (Nadal, Issa, Griffin, Hamit, & Lyons, 2010). The largest percentage of religious harassment and civil rights violations in the United States are committed against Jewish and Muslim individuals (Nadal, Issa, et al., 2010). The prejudice experienced by Muslims is often referred to as Islamophobia and is well documented in Western European countries both before and since the September 11, 2001 terrorist attacks (Nadal, Issa, et al., 2010). The media tend to depict Muslims as religious fanatics and terrorists (James, 2008), and one study reveals that Americans hold both implicit and explicit negative attitudes toward this group (Rowatt, Franklin, & Cotton, 2005).

Finally, although discriminatory practices toward PWDs is longstanding in the United States and even believed to be increasing in frequency and intensity (Leadership Conference on Civil Rights Education Fund [LCCREF], 2009, as cited in Keller & Galgay, 2010), ableism is rarely included in discussions about modern forms of oppression (Keller & Galgay, 2010). The expression of ableism “favors people without disabilities and maintains that disability in and of itself is a negative concept, state, and experience” (Keller & Galgay, 2010).

What makes the phenomenon of subtle discrimination particularly complex is that ambiguity and alternative explanations obscure the true meaning of the behavior not only for the person who engages in it, but also for the person on the receiving end.

Video 6.1: Mistakes in Microaggressions

Goal setting as a way of addressing internal and external locus of control issues with clients of color

THE EVOLUTION OF THE "ISMS": MICROAGGRESSIONS

Microaggressions are "brief and commonplace daily verbal or behavioral indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults that potentially have a harmful or unpleasant psychological impact on the target person or group" (Sue, Bucceri, Lin, Nadal, & Torino, 2007). They can also be delivered environmentally through the physical surroundings of target groups, where they are made to feel unwelcome, isolated, unsafe, and alienated.

Authors have further introduced the term "macroaggression" (Huber & Solorzano, 2015) to refer to systemic and institutional forms of discrimination that impact entire cultural groups. For example, in the current political climate, the travel ban on Muslim - majority countries represents a macroaggression. As explained by Sue et al. (in press, p. 7), "In many respects, racial macroaggressions represent an overarching umbrella that validates, supports, and enforces the manifestation of individual acts of racial microaggressions."

Based on the literature on subtle forms of oppression, one might conclude the following about microaggressions: they (a) tend to be subtle, unintentional, and indirect; (b) often occur in situations where there are alternative explanations; (c) represent unconscious and ingrained biased beliefs and attitudes; and (d) are more likely to occur when people pretend not to notice differences, thereby denying that race, sex, sexual orientation, religion, or ability had anything to do with their actions (Sue, Capodilupo, et al., 2007). Three types of microaggression have been identified: microassault, microinsult, and microinvalidation.

Microassault

The term "microassault" refers to a blatant verbal, nonverbal, or environmental attack intended to convey discriminatory and biased sentiments. This notion is related to overt racism, sexism, heterosexism, ableism, and religious discrimination, in which individuals deliberately convey derogatory messages to target groups. Using epithets like "spic," "faggot," or "kyke"; requesting not to sit next to a Muslim on an airplane; and deliberately serving disabled patrons last are examples. Unless we are talking about White supremacists, most perpetrators with conscious biases will engage in overt discrimination only under three conditions: (a) when some degree of anonymity can be insured; (b) when they are in the presence of others who share or tolerate their biased beliefs and actions; or (c) when they lose control of their feelings and actions.

Two high - profile examples exemplify the first condition: (a) President Trump using vulgar terms about groping and trying to have sex with women (caught on tape); and (b) Justin Bieber's use of the N - word and racial jokes (caught on video). There are also high - profile examples of the last: (a) actor Mel Gibson making highly inflammatory anti - Semitic public statements to police officers when arrested for driving while intoxicated; and (b) comedian Michael Richards, who played Kramer on *Seinfeld*, going on an out - of - control rant at a comedy club and publicly insulting African Americans by hurling racial epithets at them. Gibson and Richards denied being anti - Semitic or racist and issued immediate apologies, but it was obvious both had lost control. Because microassaults are most similar to old - fashioned racism, no guessing game is likely to occur as to their intent: to hurt or injure the recipient. Both the perpetrator and the recipient are clear about what has transpired.

Microinsult

Microinsults are unintentional behaviors or verbal comments that convey rudeness or

insensitivity or demean a person's racial heritage/identity, gender identity, religion, ability, or sexual orientation identity. Despite being outside the level of conscious awareness, these subtle snubs are characterized by an insulting hidden message. For example, when a person frantically rushes to help a person with a disability on to public transportation, the underlying message is that disabled people are in constant need of help and dependent on others. When Marshall's therapist assumes that he is having trouble keeping up with his schoolwork, she is conveying a message of intellectual inferiority.

In fact, messages of intellectual inferiority are prevalent in educational settings for Black and Latinx Americans (Morales, 2014; Ramirez, 2014; Sue, Capodilupo, & Holder, 2008; Von Robertson & Chaney, 2017). Latinx Americans report a variety of incidences in which their academic success is questioned or they are assumed to be less qualified (Minikel‐Lacocque, 2013; Ramirez, 2014; Rivera, Forquer, & Rangel, 2010). Black students have reported a minimization and devaluation of African American culture by professors and peers, as well as facing stereotypes of being lazy, uneducated, and dangerous (Brooms, 2016; Harper, 2009; Von Robertson & Chaney, 2017).

Microinvalidation

Microinvalidations are verbal comments or behaviors that exclude, negate, or dismiss the psychological thoughts, feelings, or experiential reality of a target group. Like microinsults, they are unintentional and usually outside the perpetrator's awareness. When Marie dismissed Marshall's experiences of constantly being asked for ID on campus, she negated his racial reality. The hidden message delivered to Marshall was that he was the problem, not racism. Because Marie is in a position of power as a White therapist, she is able not only to define Marshall's experiential reality but also to direct the course of therapy.

Another common microinvalidation is when individuals claim that they do not see religion or color but instead see only the human being. When Marshall's classmate states that “all lives matter,” they are negating the sociohistorical and political lived experience of Black people. Such statements have been coined by researchers as “color‐blind” attitudes, and research shows that among White adults in a workplace setting, higher color‐blind attitudes are associated with lower likelihoods of perceiving microaggressions (Offermann et al., 2014).

To further illustrate the concepts of microinsults and microinvalidations, Table 6.1 provides some common examples, as well as their accompanying hidden messages and assumptions. Some of these categories are more applicable to certain forms of microaggression (racial, gender, religion, ability, or sexual orientation), but they all seem to share commonalities.

TABLE 6.1 Examples of Microaggressions

Themes	Microaggression	Message
Alien in Own Land When Asian Americans and Latinx Americans are assumed to be foreign‐born	“Where are you from?” “Where were you born?”	You are not American
	“You speak good English”	You are a foreigner
	A person asking an Asian American to teach them words in their native language	

Ascription of Intelligence Assigning intelligence to a person of color or a woman based on his or her race/gender	“You are a credit to your race”	People of color are generally not as intelligent as Whites
	“Wow! How did you become so good in math?”	It is unusual for a woman to be smart in math
	Asking an Asian person to help with a math or science problem	All Asians are intelligent and good in math/sciences
	“You only got into college because of affirmative action”	You are not smart enough on your own to get into college
Color Blindness Statements that indicate that a White person does not want to acknowledge race	“When I look at you, I don't see color”	Denying a person of color's racial/ethnic experiences
	“America is a melting pot”	Assimilate/acculturate to dominant culture
	“There is only one race, the human race”	Denying the individual as a racial/cultural being
Criminality/Assumption of Criminal status Assuming a person of color to be dangerous, criminal, or deviant based on their race	A White man or woman clutching their purse or checking their wallet as a Black or Latinx individual approaches or passes	You are a criminal
	A store owner following a customer of color around the store	You are going to steal/You are poor/You do not belong
	A White person waits to ride the next elevator when a person of color is on it	You are dangerous
Use of Sexist/Heterosexist Language Terms that exclude or degrade women and lesbian, gay, bisexual, transgender, and queer (LGBTQ) persons	Use of the pronoun “he” to refer to all people	Male experience is universal Female experience is meaningless
	Although a male - to - female transgendered employee has consistently referred to herself as “she,” coworkers continue to refer to her as “he”	Our language does not need to change to reflect your identity; your identity is meaningless

	Two options for Relationship Status: Married or Single	LGBTQ partnerships do not matter/are meaningless
	An assertive woman is labeled a “bitch”	Women should be passive
	A heterosexual man who often hangs out with his female friends more than his male friends is labeled a “faggot”	Men who act like women are inferior (women are inferior)/gay men are inferior
Denial of Individual Racism/Sexism/Heterosexism/Religious Discrimination A statement made when bias is denied	“I'm not racist; I have several Black friends”	I am immune to racism because I have friends of color
	“I am not prejudiced against Muslims; I am just fearful of Muslims who are religious fanatics”	I can separate Islamophobic social conditioning from my feelings about Muslim people in general
	“As an employer, I always treat men and women equally”	I am incapable of sexism
Myth of Meritocracy Statements that assert that race or gender does not play a role in life successes	“I believe the most qualified person should get the job”	People of color are given extra unfair benefits because of their race
	“Men and women have equal opportunities for achievement”	The playing field is even, so if women cannot make it, the problem is with them
Pathologizing Cultural Values/Communication Styles The notion that the values and communication styles of the dominant/White culture are ideal	Asking a Black person: “Why do you have to be so loud/animated? Just calm down”	Assimilate to the dominant culture
	To an Asian or Latinx person: “Why are you so quiet? We want to know what you think. Be more verbal. Speak up more”	
	Dismissing an individual who brings up race/culture in a work/school setting	Leave your cultural baggage outside
Second‐Class Citizen When a target group member receives	Mistaking a person of	People of color are servants to Whites;

differential treatment from the power group	color for a service worker	they couldn't possibly occupy high - status positions
	Mistaking a female doctor for a nurse	Women occupy nurturing roles
	Having a taxi cab pass a person of color and pick up a White passenger	You are likely to cause trouble and/or travel to a dangerous neighborhood
	Ignoring a person of color at a store counter and giving attention to the White customer behind them	Whites are more valued customers than people of color
	Not inviting a lesbian woman out with a group of female friends because they think she will be bored if they talk to men	You don't belong
Traditional Gender Role Prejudicing and Stereotyping When expectations of traditional roles or stereotypes are conveyed	A male professor asking a female student working on a chemistry assignment, “What do you need to work on this for anyway?”	Women are less capable in math and science
	Asking a woman her age and, upon hearing she is 31, looking quickly at her ring finger	Women should be married during child - bearing ages because that is their primary purpose
	Assuming a woman is a lesbian because she does not put a lot of effort into her appearance	Lesbians do not care about being attractive to others
Sexual Objectification When women are treated like objects at men's disposal	A male stranger putting his hands on a woman's hips or on the swell of her back as he passes her	Your body is not yours
	Whistling at and catcalling a woman as she walks down the street	Your body/appearance is for men's enjoyment and pleasure
	Using the term “gay” to describe a fellow student who is socially ostracized at school	Gay people are weird and different
		You should keep your

Assumption of Abnormality When it is implied that there is something wrong with being LGBTQ	Two men holding hands in public receiving stares from strangers	displays of affection private because they are offensive
	“Did something terrible happen to you in your childhood?” to a transgendered person	Your choices must be the result of a trauma and not your authentic identity
Helplessness [a] When people frantically try to help people with disabilities (PWDs)	Helping someone with a disability on to a bus or train, even when they need no help	You can't do anything by yourself because you have a disability
	People feeling they need to rescue someone from their disability	Having a disability is a catastrophe
Denial of Personal Identity [b] When any aspect of a person's identity other than disability is ignored or denied	“I can't believe you are married!”	Your life is not normal or like mine; the only thing I see when I look at you is your disability
Exoticization When an LGBTQ person, woman of color, or member of a religious minority is treated as a foreign object for the pleasure/entertainment of others	“I've always wanted an Asian girlfriend! They wait hand and foot on their men”	Asian American women are submissive and meant to serve the physical needs of men
	“Tell me some of your wild sex stories!” to an LGBTQ person	Your privacy is not valued; you should entertain with stories
	Asking a Muslim person incessant questions about his or her diet, dress, and relationships	Your privacy is not valued; you should educate me about your cultural practices, which are strange and different
Assumption of One's Own Religion as Normal [c]	Saying “Merry Christmas” as a universal greeting	Your religious beliefs are not important; everyone should celebrate Christmas
	Acknowledging only Christian holidays in work and school	Your religious holidays need to be celebrated on your time; they are unimportant

[a] Adapted from D. W. Sue, Bucceri et al. (2007).

[b] Themes and examples are taken from Keller and Galgay (2010).

[c] Themes and examples are taken from Nadal, Issa, et al. (2010).

Select this link to open an interactive version of Table 6.1.

REFLECTION AND DISCUSSION QUESTIONS

1. In looking at Table 6.1, can you identify how you may have committed microaggressions related to race, gender, sexual orientation, religion, or ability?
2. Compile a list of possible microaggressions you may have committed. Explore the potential hidden messages they communicated to their recipients.
3. What do your microaggressions tell you about your unconscious perception of marginalized groups?
4. If microaggressions are mostly outside the level of conscious awareness, what must you do to make them visible? What steps must you take to personally stop microaggressions?
5. What solutions can you offer that would be directed at individual change, institutional change, and societal change?

Video 6.2: Overt and Covert Microaggressions

Analysis of counseling session by Drs. Derald Wing Sue and Joel Filmore.

THE DYNAMICS AND DILEMMAS OF MICROAGGRESSIONS

The study of microaggressions presents “a complex scientific challenge because it deals with both explicit and implicit bias; explores the lived realities of marginalized groups in our society; frames microaggressive dynamics as an interaction between perpetrator, target, and the external environment; pushes powerful emotional buttons in the actors; and is difficult to separate from the sociopolitical dimensions of oppression, power, and privilege” (Sue, 2017, p. 171). Not only does the subtle and insidious nature of racial microaggressions render them outside the level of awareness of their perpetrators, but recipients also find their ambiguity difficult to handle. Victims are placed in an unenviable position of questioning not only the perpetrators, but themselves as well (e.g., “Did I misread what happened?”). Victims often replay an incident over and over again to try to understand its meaning.

Yet, despite attribution ambiguity, microaggressions significantly shape experiences and environments. Researchers have consistently identified microaggressions as creating a hostile and invalidating campus climate (Von Robertson & Chaney, 2017; Yosso, Smith, Ceja, & Solorzano, 2009), even referring to them as “toxic rain” that corrodes the educational experience of students of color (Suarez‐Orozco et al., 2015). If Marie had been familiar with the literature on Black students' experiences of primarily White institutions (PWIs), she would have quickly identified Marshall's fatigue, declining academic interest, and falling grades as being related to this “toxic rain.” The cumulative effect of microaggressions has been shown to impede learning by depleting cognitive and psychological resources (Smith, Hung, & Franklin, 2011; Watkins, Labarrie, & Appio, 2010), resulting in a phenomenon labeled “racial battle fatigue” (Smith, Allen, & Danley, 2007). In work that looks extensively at Black males' experiences at PWIs, Harper (2013, p.189) refers to this same concept as “onlyness,” defined as the “psychoemotional burden of having to strategically navigate a racially politicized space occupied by few peers, role models, and guardians from one's same racial or ethnic group.”

Understanding Marshall's lethargy, declining grades, and academic disengagement from a framework of racial battle fatigue and onlyness would allow Marshall and his therapist to consider how his context and daily experience are assailing his spirit and academic identity. It would also allow them to create strategies for dealing with daily microaggressions; joining a group such as the Black Student Union, for example, where Marshall's experiences could be validated and supported, has been shown to decrease racial battle fatigue and resultant academic disengagement (Harper, 2013). Creating the opportunity to consider microaggressions as the source of Marshall's feelings is extremely important, as their subtle, innocuous nature makes them challenging to interpret, and sometimes just the process of naming a microaggression for what it is (i.e., racism) is empowering enough to disarm its effects.

Let us use the case of Marshall to illustrate the four psychological dilemmas that take place when microaggressions occur (Sue, Capodilupo, et al., 2007).

Dilemma 1: The Clash of Sociodemographic Realities

For Marshall, one major question was: Were people assuming he did not belong because of his race? Although lived experience told him that many Whites fear and devalue Black men, chances are that his professors and peers would be offended at such a suggestion. They would likely deny they possessed any stereotypes and perhaps point to Marshall's own demeanor (i.e., not friendly enough, wearing a hoodie) as being responsible. In other words, they would

emphasize that they and their organizations do not discriminate on the basis of color, sex, sexual orientation, or creed. The question becomes: Whose reality is the true reality?

Oftentimes, the perceptions held by the dominant group differ significantly from those of marginalized groups in our society. For example, studies show that many Whites believe that racism is no longer prevalent in society and not important in the lives of people of color (Sue, 2010), that heterosexuals believe that homophobia is a "thing of the past" and that antigay harassment is on the decline (Nadal, 2013), and that men (and women) assert that women have achieved equal status and are no longer discriminated against (Cundiff et al., 2014; Swim & Cohen, 1997). Most importantly, individuals in power positions do not consider themselves capable of discrimination based on race, gender, or sexual orientation because they are free of bias.

On the other hand, people of color perceive Whites to be racially insensitive, to enjoy holding power over others, and to think that they are superior (Sue, Capodilupo, et al., 2007). LGBTQ individuals consider homonegativity and antigay harassment to be a crucial aspect of their everyday existence (Burn et al., 2005; Nadal, 2013). Women contend that sexism is alive and well in social and professional settings. Although research supports the idea that those who are most disempowered are more likely to have an accurate perception of reality, it is the groups in power that have the ability to define reality. Thus, people of color, women, and LGBTQ individuals are likely to experience their perceptions and interpretations being negated or dismissed. This becomes particularly salient in the therapeutic encounter, which represents an unequal power dynamic.

For Marshall, who has had countless experiences of being taken as a suspect or criminal, it feels clear that those around him fear him and do not see him as a student capable of academic achievement. Marie, however, has not experienced this racial reality and tries to "objectively" reason that Marshall may be reading too much into or misinterpreting the situation, or even contributing to others' perceptions of him as criminal by wearing his hoodie. Further, her racial reality blinds her against considering how a PWI might be affecting Marshall; she does not even bring race into their conversation, because in her own daily experiences, race is invisible and nonimportant.

Dilemma 2: The Invisibility of Unintentional Expressions of Bias

How could Marshall "prove" that colleagues doubted his intelligence or worth? His only evidence is his felt experience and interpretation, which are easily explained away and disregarded by coworkers, students, and professors with alternative explanations.

Further compounding the situation is the idea that Marshall is experiencing these microaggressions at his school, an environment that should be fostering and supporting his intellectual growth. Actually, Marshall's scholastic achievement is being hampered by the stress he is experiencing on campus, and his academic disengagement is a common reaction to these hostile environments (Harper, 2013; Von Robertson & Chaney, 2017). During the classroom conversation about the BLM movement, neither his classmates nor his professor take issue with the classmate who likens BLM protestors to KKK rally - goers or when the question is raised, "Don't all lives matter?" Even if they do not actually agree with these sentiments, staying silent conveys complicit agreement and/or apathy. When one hardly ever experiences their own race in their daily interactions, it is easy to dismiss the notion that race matters. Marshall, on the other hand, cannot dismiss race as it is salient part of his everyday life. He experiences a physical reaction during the classroom conversation and worries that a passionate response may enact stereotypes of angry and scary Black males. So, he stays

silent, despite having a powerful reaction. As Smith et al. (2011, p.77) explain, “these stacked conditions present a challenge and barrier for African American men … which is not acknowledged by most Whites, recognized by student support services, human resources, or health providers.” That the microaggression is essentially invisible to the perpetrator creates a psychological dilemma for the victim that can leave them feeling frustrated, powerless, and even questioning their own sanity (Bostwick & Hequembourg, 2014; Harper, 2013; Sue, Capodilupo, & Holder, 2008; Watkins et al., 2010).

Dilemma 3: The Perceived Minimal Harm of Microaggressions

Oftentimes, when perpetrators are confronted about microaggressions, they accuse the victim of overreacting or being hypersensitive or touchy. Because the microaggressions are often invisible to the perpetrators, they cannot understand how the events could cause any significant harm to the victims. Trivializing the impact of racial microaggressions can be an automatic, defensive reaction on the part of some White people, to avoid feeling blamed and guilty (Sue, Capodilupo, Nadal, & Torino, 2008). Despite a lack of acknowledgement by majority groups that everyday experiences of discrimination can be harmful to minorities, research is mounting to suggest otherwise: a large‐scale meta‐analysis reveals that perceived discrimination has cumulative and harmful effects on psychological well‐being (Schmitt, Branscombe, Postmes, & Garcia, 2014), and an American Psychological Association (2016) survey of over 3,000 respondents found that daily experiences of discrimination were significantly associated with poor physical health and high stress levels. Further, recent work links microaggressions to post‐trauma symptoms and depression (Bryant‐Davis, 2018; Torres & Taknint, 2015).

Multiple studies that look at racial microaggressions in the lived experience of African Americans find that the cumulative effect of these events is feelings of self‐doubt, frustration, isolation, powerlessness, and invisibility (Harper, 2013; Smith et al., 2011; Sue, Capodilupo, & Holder, 2008). In a two‐week daily diary study of Asian American college students' experiences of microaggressions, it was found that 78% experienced at least one microaggression, and the reporting of such events predicted higher negative affect and more somatic symptoms (Ong, Burrow, Fuller‐Rowell, Ja, & Sue, 2013). This supports earlier qualitative work that reported Asian Americans feeling belittled, angry, invalidated, invisible, and trapped by their experiences of racial microaggressions (Sue, Bucceri, et al., 2007). Multiple studies suggest that Latinx and Chicano/a students feel marginalized and frustrated by microaggressive experiences in educational settings (Huber & Cueva, 2012; Nadal, Mazzula, Rivera, & Fujii‐Doe, 2014; Ramirez, 2014).

Investigations link the experience of microaggressions on college campuses with serious behavioral and psychological consequences. For example, college students of color who experienced greater numbers of microaggressions were at increased risk for higher anxiety and binge drinking (Blume, Lovato, Thyken, & Denny, 2012). Other studies link the experience of microaggressions with low self‐esteem, depression, fatigue, pain, and lower energy levels (Nadal, Wong, Griffin, Davidoff, & Sriken, 2014; Nadal et al., 2017; Wong‐Padoongpat, Zane, Okazaki, & Saw, 2017). Specifically, microaggressions experienced in educational and workplace settings were found to be especially harmful to participants' self‐esteem (Nadal, Wong, et al., 2014). Likewise, homonegative microaggressions were associated with lower self‐esteem, negative feelings about one's sexual orientation identity, and obstacles to developing one's sexual identity (Wright & Wegner, 2012). A higher number of homonegative microaggressions experienced has also been linked to a high level of post‐traumatic stress disorder (PTSD) symptoms (Robinson & Rubin, 2016).

Dilemma 4: The Catch‐22 of Responding to Microaggressions

When a microaggression occurs, the recipient is often placed in an unenviable position of having to decide what to do. Numerous questions are likely to go through their mind: Did what I think happened really happen? If it did, how can I possibly prove it? How should I respond? Will it do any good if I bring it to the attention of the perpetrator? If I do, will it affect my relationship with my professor, other students, coworkers, or friends? Many well‐intentioned perpetrators are unaware of the exhausting nature of these internal questions, as they sap the spiritual and psychic energy of victims. Marshall was obviously caught in a conflict, asking himself: Should I voice my feelings about reactions to the BLM movement, or will I be misunderstood? Worse, will I be typecast and alienated?

The fundamental issue is that responding to a microaggression can have detrimental consequences for the victim. In work settings, hiring and firing practices hang in the balance. In school settings, academic performance can be impacted. Sometimes, the consequences of responding to microaggressions are relational. Over and over again we see Marshall suppressing his natural reactions (to campus police, in the classroom, to the therapist). Unfortunately, it has been found that this takes a psychological toll on the recipient, because it requires them to withhold and obscure their authentic thoughts and feelings in order to avoid further discrimination and stereotypic labeling (Franklin, 2004). Authors have described this process as “failure syndrome” (Kunjunfu, 1986, cited in Von Robertson & Chaney, 2017), linking it to academic achievement: “when black students, particularly males, are viewed in stereotypic ways (i.e., black males are stupid, academically incapable, and thugs) … it is possible they will internalize those negative caricatures and underperform academically.” (Von Robertson & Chaney, 2017, p. 262). A similar process has been described for girls and women, in whom it is referred to as “self‐silencing.” This has been linked to “compromising women's success by heightening feelings of alienation and reducing motivation” (London, Downey, et al. 2012, p. 219).

Confronting sexual orientation microaggressions can be complicated by LGBTQ individuals who are not out of the closet. The reality of looming antigay harassment and differential (unequal) treatment may prevent LGBTQ persons from coming out in a variety of settings, especially when there is evidence to suggest that the environment is heterosexist. Antigay slurs and pervasive use of the word “gay” to communicate that someone or something is inferior, stupid, or abnormal (Nadal et al., 2017) all contribute to hostile educational and workplace environments. The therapeutic room can be equally as unwelcoming and hostile: qualitative work reports that “fear of being seen as different had a suppressive and muting effect on some participants' disclosure of their sexual orientation to their therapists” (Shelton & Delgado‐Romero, 2013, p.66).

Video 6.3: Counseling Distress

Introduction to counseling session by Dr. Joel Filmore.

THERAPEUTIC IMPLICATIONS

Clients of color tend to prematurely terminate counseling and therapy at a 50% rate after only the first initial contact with a mental health provider (à la Marshall). We submit that racial microaggressions may lie at the core of the problem. For example, one study found that more than half of racial‐ and ethnic‐minority clients at a college counseling center reported experiencing a microaggression from their therapist (Owen, Tao, Imel, Wampold, & Rodolfa, 2014), and other studies report between 43 and 81% of clients experiencing at least one microaggression in therapy (Hook et al., 2016; Owen et al., 2012, 2015). A recent study found that the most commonly experienced microaggressions involved therapists' subtle expression of cultural stereotypes and avoidance of or minimization of cultural issues (Hook et al., 2016). A similar study of LGBTQ clients revealed that "clients were left feeling doubtful about the effectiveness of therapy, the therapists' abilities, and the therapists' investment in the therapeutic process when therapists minimized their sexual reality" (Shelton & Delgado‐Romero, 2011, p. 217).

There is growing evidence to suggest that racial, gender, and sexual orientation microaggressions have a detrimental effect on the therapeutic alliance for clients of color (Owen et al., 2014), women (Owen, Tao, & Rodolfa, 2010), and LGBTQ individuals (Shelton & Delgado‐Romero, 2011, 2013). Specifically, "microaggressions can be thought of as a special case of ruptures in therapy, wherein experiences of discrimination and oppression from the larger society are recapitulated, which places the therapeutic relationship under duress and strain" (Owen et al., 2014, p. 287). Qualitative work with LGBTQ clients supports this finding, where the therapeutic alliance has been diminished by the presence of sexual orientation microaggressions: "affective consequences of sexual orientation microaggressions included clients feeling uncomfortable, confused, powerless, invisible, rejected, and forced or manipulated to comply with treatment" (Shelton & Delgado‐Romero, 2013, p. 66).

One study found that microaggressions that went unaddressed by therapists were associated with a weaker working alliance compared to situations with (a) no microaggression or (b) a resolved microaggression (Owen et al., 2015). Although studies on microaggressions in therapy suggest that they are frequent and harmful, evidence also shows that when microaggressions are acknowledged and addressed, the therapeutic alliance can be restored with positive clinical outcomes (Owen et al., 2014). Therefore, it is paramount that helping professionals examine their own biases and beliefs and remain aware of how they may unintentionally communicate these when working with clients who are culturally diverse.

Although therapy provides an ideal opportunity for exploring microaggressions both within the therapeutic dyad and in presenting concerns, many therapists are unsure how to approach such conversations. The multicultural orientation (MCO) framework (Owen, 2013) can be used to help therapists engage in a discourse on race, culture, racism, and microaggressions. This framework includes three pillars: (a) cultural humility, (b) cultural opportunities, and (c) cultural comfort. These pillars involve therapists being (a) aware of their own cultural values and those of others, (b) curious about others' cultural identities and values, and (c) at ease and comfortable with discussions that involve race, racism, and culture. Studies suggest that these variables are associated with more positive therapeutic outcomes. Specifically, counselors who score higher on cultural humility (a) are less likely to microaggress and (b) have more positive therapy outcomes (Hook et al., 2016; Owen et al., 2014, 2017).

Video 6.4: Counselor Reconciliation

The sophistication of racism and discrimination makes it challenging to emphatically point out bias within microaggressions. But allowing yourself to be open to self-reflection can minimize these incidents.

MANIFESTATIONS OF MICROAGGRESSIONS IN COUNSELING/THERAPY

The importance of understanding how microaggressions manifest in the therapeutic relationship cannot be overstated, especially as this phenomenon may underlie the high prevalence of drop‐out rates among people of color and other marginalized groups. Let us use the case of Marshall to illustrate how microaggressions may operate in the counseling process. Marshall revealed to Marie his experiences of racial and gender microaggressions, using therapy as a space for deeper exploration of a meaningful issue. Because Marshall and Marie are not the same race or gender, they do not share similar racial realities (Dilemma 1: clash of sociodemographic realities) or worldviews. The therapist has minimal understanding of what constitutes racial or ethnic microaggressions, how they make their appearance in everyday interactions, how she herself may be guilty of microaggressive behaviors, the psychological toll microaggressions take on minorities, and the negative effects they have on the therapeutic relationship. We have already emphasized that cultural competence requires helping professionals to understand the worldviews of their culturally diverse clients.

Marie tends to minimize the importance of Marshall's feelings of not belonging and of being disregarded, to believe these feelings are trivial, and to relate them to the stress that all college students feel around finals. She cannot relate to the negative impact these feelings have on her client and thus minimizes their emotional and psychological effect (Dilemma 3: minimal harm). For Marshall, on the other hand, the experience of being regularly taken as less intelligent, less capable, and/or a thug represents one of many cumulative messages of inferiority and criminal assumptions about his race. He is placed in a constant state of vigilance in maintaining his sense of integrity in the face of constant invalidations and insults. Racial microaggressions are a constant reality for people of color, as they assail group identities and experiences. White people seldom understand how much time, energy, and effort are expended by people of color to retain some semblance of worth and self‐esteem.

Another major detrimental event in the first session is that Marie enacts a stereotype of intellectual inferiority by initially asking if Marshall is having difficulty keeping up with his studies. As a mental health professional, Marie probably considers herself unbiased and objective. However, she has cut off meaningful exploration for Marshall by removing the salience of race from the conversation (Dilemma 2: invisibility). For example, had she engaged Marshall about what was was like to be a Black male at the university, she would have learned about his frequent experiences of onlyness and of being treated like a suspect. As a client, Marshall is caught in a “damned if you do, damned if you don't” conflict (Dilemma 4: catch‐22). Both inside and outside of therapy, Marshall is probably internally wrestling with a series of questions: Did what I think happened really happen? Was this a deliberate act or an unintentional slight? How should I respond: sit and stew on it or confront the person? What are the consequences if I do confront them? These questions take a tremendous psychological toll on many marginalized groups. If Marshall chooses to do nothing, he may suffer emotionally by having to deny his own experiential reality or allow his sense of integrity to be assailed. Feelings of powerlessness, alienation, and frustration may take not only a psychological toll but also a physical one.

Table 6.2 provides several more therapy‐specific examples of microaggressions, using the same organizing themes presented in Table 6.1. We ask that you study these themes and ask if you have ever engaged in these or similar actions. If so, how can you prevent your own personal microaggressions from impairing the therapy process?

TABLE 6.2 Examples of Microaggressions in Therapeutic Practice

Adapted from D. W. Sue, Bucceri, et al. (2007).

Themes	Microaggression	Message
Alien in Own Land When Asian Americans and Latinx Americans are assumed to be foreign - born	A White client does not want to work with an Asian American therapist because she "will not understand my problem"	You are not American
	A White therapist tells an American - born Latinx client that he or she should seek a Spanish - speaking therapist	
Ascription of Intelligence Assigning a degree of intelligence to a person of color or a woman based on race or gender	A school counselor reacts with surprise when an Asian American student says they have had trouble on the math portion of a standardized test	All Asians are smart and good at math
	A career counselor asking a Black or Latinx student, "Do you think you're ready for college?"	It is unusual for people of color to succeed
	A school counselor reacting with surprise at hearing that a female student scored high on the math portion of a standardized test	It is unusual for women to be smart and good at math
Color Blindness Statements that indicate that a White person does not want to acknowledge race	A therapist says, "I think you are being too paranoid. We should emphasize similarities, not people's differences" when a client attempts to discuss her feelings about being the only person of color at her job and feeling alienated and dismissed by her coworkers	Race and culture are not important variables that affect people's lives
	A client of color expresses concern in discussing racial issues with her therapist; her therapist replies, "When I see you, I don't see color"	Your racial experiences are not valid
Criminality/Assumption of Criminal Status A person of color is presumed to be dangerous, criminal, or deviant based on their race	When a Black client shares that she was accused of stealing from work, her therapist encourages her to explore how she might have contributed to her employer's mistrust of her	You are a criminal
	A therapist takes great care to ask all substance - abuse questions in an intake with a Native American client and is suspicious of the client's nonexistent history with substances	You are deviant
Use of Sexist/Heterosexist Language Terms that exclude or degrade	During the intake session, when a female client discloses that she has	Heterosexuality is

women and lesbian, gay, bisexual, transgender, and queer (LGBTQ) groups	been in her current relationship for 1 year, the therapist asks how long the client has known her boyfriend	the norm
	When an adult female client explains she is feeling isolated at work, her male therapist asks, “Aren't there any girls you can gossip with there?”	Application of language that implies to adolescent or adult females, “your problems are trivial”
Denial of Individual Racism/Sexism/Heterosexism A statement made when a member of the power group renounces their biases	When a client of color asks his or her therapist about how race affects their working relationship, the therapist replies, “Race does not affect the way I treat you”	Your racial/ethnic experience is not important
	When a client of color expresses hesitancy in discussing racial issues with his White female therapist, she replies, “I understand. As a woman, I face discrimination also”	Your racial oppression is no different than my gender oppression.
	A therapist's nonverbal behavior conveys discomfort when a bisexual male client is describing a recent sexual experience with a man; when he asks her about it, she insists she has “no negative feelings toward gay people” and says it is important to keep the conversation on him	I am incapable of homonegativity, yet I am unwilling to explore this
Myth of Meritocracy Statements that assert that race or gender does not play a role in succeeding in career advancement or education	A school counselor tells a Black student that “if you work hard, you can succeed like everyone else”	People of color are lazy and need to work harder; if you don't succeed, you have only yourself to blame (blaming the victim)
	When a female client visits a career counselor to share her concerns that a male coworker was chosen for a managerial position over her, despite the fact that she was better qualified and has been in the job longer, the counselor responds that “he must have been better suited for some of the job requirements”	Women are incompetent and need to work harder; if you don't succeed, you have only yourself to blame (blaming the victim)
Pathologizing Cultural Values/Communication	When a Black client is loud, emotional,	

Styles The notion that the values and communication styles of the dominant/White culture are ideal	and confrontational in a counseling session, the therapist diagnoses her with borderline personality disorder	Assimilate to the dominant culture
	When a client of Asian or Native American descent has trouble maintaining eye contact with his therapist, she diagnoses him with a social anxiety disorder	
	Asking a client, “Do you really think your problem stems from racism?”	Leave your cultural baggage outside
Second - Class Citizen When a member of the power group is given preferential treatment over a target group member	When a male client calls and requests a session time that is currently taken by a female client, the therapist grants him the appointment without calling the female client to see if she can change times	Male clients are more valued than female clients
	A client of color is not welcomed or acknowledged by a receptionist	White clients are more valued than clients of color
Traditional Gender Role Prejudicing and Stereotyping When expectations of traditional roles or stereotypes are conveyed	A therapist continually asks a middle - aged female client about dating and “putting herself out there” despite the client not having expressed interest in exploring this area	Women should be married, and dating should be an important topic/part of your life
	A gay male client has been with his partner for 5 years; his therapist continually probes his desires to meet other men and be unfaithful	Gay men are promiscuous/cannot have monogamous relationships
	A therapist raises her eyebrows when a female client mentions that she has had a one - night stand	Women should not be sexually adventurous
Sexual Objectification When women are treated like objects at men's disposal	A male therapist puts his hands on a female client's back as she walks out of the session	Your body is not yours
	A male therapist looks at his female client's breasts while she is talking	Your body/appearance is for men's enjoyment and pleasure
Assumption of Abnormality Occurs when it is implied that there is something wrong with being lesbian, gay, bisexual,	When discussing his client's bisexuality, a therapist repeatedly implies that there is a “crisis of	Bisexuality represents a confusion about

transgender, and queer (LGBTQ)	identity”	sexual orientation
	When a lesbian comes in for career counseling, the therapist continually insists that she needs to discuss her sexuality	Your sexual orientation represents pathology
	The therapist of a 20 - year - old lesbian inadvertently refers to sexuality as a “phase”	Your sexuality is something that is not stable

Select this link to open an interactive version of Table 6.2.

THE PATH FORWARD

With a solid foundation of support for the pervasive existence and harmful impact of microaggressions against all marginalized groups, recent work has begun to explore how microaggressions can be combated on the interpersonal level. Researchers refer to this as “microintervention” (Sue et al., in press, p. 13), defined as “everyday words or deeds, whether intentional or unintentional, that communicate to targets of microaggressions (a) validation of their experiential reality, (b) value as a person, (c) affirmation of their racial or group identity, (d) support and encouragement and (e) reassurance that they are not alone.” Sue et al. (in press) have put forth a conceptual framework of microinterventions that serves to help targets, allies, and bystanders make the invisible visible and create a productive and potentially empowering experience when microaggressions occur.

IMPLICATIONS FOR CLINICAL PRACTICE

1. Be aware that racial, gender, and sexual orientation microaggressions are a constant reality in the lives of culturally diverse groups and take a major psychological toll.
2. Be aware that everyone has engaged in and continues to engage in unintentional microaggressions. For helping professionals, these microaggressions may serve as impediments to effective multicultural counseling and therapy (MCT).
3. Entertain the notion that culturally diverse groups may have a more accurate perception of reality than you do, especially when it comes to issues of racism, sexism, or heterosexism. Try to understand worldviews and sociocultural realities, and don't be quick to dismiss or negate racial, gender, and sexual orientation issues.
4. If your culturally different client implies that you have engaged in a microaggressive remark or behavior, engage in a nondefensive discussion and try to clarify the situation by showing you are open and receptive to conversations on race, gender, and sexual orientation. Remember, it's how the therapist “recovers,” not how he or she “covers up” that is important.

SUMMARY

Microaggressions represent daily stressors in the lives of marginalized groups in the United States. There is now ample research to support the idea that microaggressions are frustrating, psychologically taxing, and emotionally harmful to those who experience them.

Clients trust mental health professionals to take an intimate and deeply personal journey of self‐exploration with them through the process of therapy. They grant these professionals the opportunity to look into their inner world and invite them to walk with them in their everyday lives. Therapists and counselors have an obligation to their clients, especially when their clients differ from them in terms of race, gender, ability, religion, or sexual orientation, to work to understand their experiential reality. Research suggests that when therapist and client are able to successfully discuss microaggressions, the therapeutic alliance can be restored. Therefore, therapists must be open to the idea that they can commit microaggressions against their clients and be willing to examine their role in this process.

Therapists and counselors are in a position to learn from their clients about microaggressions and their relationship to their presenting concerns and developmental issues. It is imperative to encourage clients to explore their feelings about incidents that involve their race, gender, and sexual orientation so that the status quo of silence and invisibility can be destroyed.

GLOSSARY TERMS

- Ableism
- Aversive racism
- Covert sexism
- Heterosexism
- Homonegativity
- Islamaphobia
- Microaggression
- Microassault
- Microinsult
- Microinvalidation
- Overt sexism
- Racism
- Religious discrimination
- Subtle sexism
- Transphobia

Video 6.5: Counseling Session Analysis

Clinicians who are obtuse or oblivious can have a negative impact on their client's mental state. Addressing the concerns of clients of color requires that therapists suspend their opinion and focus on the client's experiential truth.

REFERENCES

1. American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.

2. American Psychological Association (2016). *Stress in America: The impact of discrimination*. Washington, DC: American Psychological Association.

3. Becker, J. C., & Swim, J. K. (2012). Reducing endorsement of benevolent and modern sexist beliefs: Differential effects of addressing harm versus pervasiveness of benevolent sexism. *Social Psychology*, *43*, 127–137.

4. Blume, A. W., Lovato, L. V., Thyken, B. N., & Denny, N. (2012). The relationship of microaggressions with alcohol use and anxiety among ethnic minority college students in a historically White institution. *Cultural Diversity and Ethnic Minority Psychology*, *18*, 45–54.

5. Bostwick, W., & Hequembourg, A. (2014). "Just a little hint": Bisexual‐specific microaggressions and their connection to epistemic injustices. *Culture, Health and Sexuality*, *16*, 488–503.

6. Brooms, D. (2016). *Being Black, being male on campus: Understanding and confronting Black male collegiate experiences*. Albany, NY: State University of New York Press.

7. Bryant‐Davis, T. (2018). Microaggressions: Considering the framework of psychological trauma. In G. C. Torino, D. P. Rivera, C. M. Capodilupo, K. L. Nadal, & D. W. Sue (Eds.), *Microaggression theory: Influence and implication*. Hoboken, NJ: Wiley.

8. Burn, S. M., Kadlec, K., & Rexer, B. S. (2005). Effects of subtle heterosexism on gays, lesbians, and bisexuals. *Journal of Homosexuality*, *49*, 23–38.

9. Burns, C., & Krehely, J. (2011). Gay and transgender people face high rates of workplace discrimination and harassment. Retrieved from https://www.americanprogress.org/issues/lgbt/news/2011/06/02/9872/gay‐and‐transgender‐people‐face‐high‐rates‐of‐workplace‐discrimination‐and‐harassment/

10. Calogero, R. M., & Tylka, T. L. (2014). Sanctioning resistance to sexual objectification: An integrative system justification perspective. *Journal of Social Issues*, *70*, 763–778.

11. Cundiff, J. L., Zawadzki, M. J., Danube, C. L., & Shields, S. A. (2014). Using experiential learning to increase the recognition of everyday sexism as harmful: The WAGES intervention. *Journal of Social Issues*, *70*, 703–721.

12. Dovidio, J. F., & Gaertner, S. L. (2000). Aversive racism and selective decisions: 1989–1999. *Psychological Science*, *11*, 315–319.

13. Dovidio, J. F., Gaertner, S. L., & Pearson, A. R. (2017). Aversive racism and contemporary bias. In F. K. Barlow, & C. G. Sibley (Eds.), *The Cambridge handbook of the psychology of prejudice* (pp. 267–294). Cambridge: Cambridge University Press.

14. Franklin, A. J. (2004). *From brotherhood to manhood: How Black men rescue their*

relationships and dreams from the invisibility syndrome. Hoboken, NJ: Wiley.

15. Gaertner, S. L., & Dovidio, J. F. (2006). Understanding and addressing contemporary racism: From aversive racism to the common ingroup. *Journal of Social Issues, 61*, 615–639.

16. Harper, S. R. (2009). Niggers no more: A critical race counternarrative on Black male student achievement at predominantly White colleges and universities. *International Journal of Qualitative Studies in Education, 22*, 697–712.

17. Harper, S. R. (2013). Am I my brother's teacher? Black undergraduates, racial socialization, and peer pedagogies in predominately white postsecondary contexts. *Review of Research in Education, 37*, 183–211.

18. Hill, D. B., & Willoughby, B. L. B. (2005). The development and validation of the genderism and transphobia scale. *Sex Roles, 53*, 531–544.

19. Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., Van Tongeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. *Journal of Counseling Psychology*, *63*(3), 269–277.

20. Huber, L. P., & Cueva, B. M. (2012). Chicana/Latina testimonios on effects and responses to microaggressions. *Equity & Excellence in Education, 45*(3), 392–410.

21. Huber, L. P., & Solorzano, D. G. (2015). Racial microaggressions as a tool for critical race research. *Race, Ethnicity, and Education, 18*(3), 297–320.

22. James, E. (2008). Arab culture and Muslim stereotypes. *World and I, 23*(5), 4.

23. Keller, R. M., & Galgay, C. E. (2010). Microaggressive experience of people with disabilities. In D. W. Sue (Ed.), *Microaggressions and marginality* (pp. 241–267). Hoboken, NJ: Wiley.

24. London, B., Downey, G., Romero‐Canyas, R., Rattan, A., & Tyson, D. (2012). Gender‐based rejection sensitivity and academic self‐silencing in women. *Journal of Personality and Social Psychology*, *102*(5), 961–979.

25. Marzullo, M. A., & Libman, A. J. (2009). Research overview: Hate crimes and violence against lesbian, gay, bisexual and transgender people. Report for the Human Rights Campaign Foundation. Retrieved from http://www.hrc.org/resources/entry/hate‐crimes‐and‐violence‐against‐lgbt‐people

26. Minikel‐Lacocque, J. (2013). Racism, college, and the power of words: Racial microaggressions reconsidered. *American Educational Research Journal*, *50*(3), 432–465.

27. Morales, E. M. (2014). Intersectional impact: Black students and race, gender and class microaggressions in higher education. *Race, Gender, & Class*, *21*(3/4), 48–66.

28. Morrison, M. A., & Morrison, T. G. (2002). Development and validation of a scale measuring prejudice toward gay men and lesbian women. *Journal of Homosexuality, 43*, 15–37.

29. Nadal, K. L. (2013). *That's so gay! Microaggressions and the lesbian, gay, bisexual, and transgender community*. Washington, DC: American Psychological Association.

30. Nadal, K. L., Griffin, K. E., Wong, Y., Davidoff, K. C., & Davis, L. S. (2017). The

injurious relationship between racial microaggressions and physical health: Implications for social work. *Journal of Ethnic & Cultural Diversity in Social Work: Innovation in Theory, Research & Practice*, *26*, 6–17.

31. Nadal, K. L., Issa, M., Griffin, K. E., Hamit, S., & Lyons, O. B. (2010). Religious microaggressions in the United States. In D. W. Sue (Ed.), *Microaggressions and marginality* (pp. 287–310). Hoboken, NJ: Wiley.

32. Nadal, K. L., Mazzula, S. L., Rivera, D. P., & Fujii‐Doe, W. (2014). Microaggressions and Latina/o Americans: An analysis of nativity, gender, and ethnicity. *Journal of Latina/o Psychology*, *2*(2), 67–78.

33. Nadal, K. L., Rivera, D. P., & Corpus, J. H. (2010). Sexual orientation and transgender microaggressions. In D. W. Sue (Ed.), *Microaggressions and marginality* (pp. 217–240). Hoboken, NJ: Wiley.

34. Nadal, K. L., Skolnik, A., & Wong, Y. (2012). Interpersonal and systemic microaggressions toward transgender people: Implications for counseling. *Journal of LGBT Issues in Counseling*, *6*(1), 55–82.

35. Nadal, K. L., Wong, Y., Griffin, K., Davidoff, K., & Sriken, J. (2014). The adverse impact of racial microaggressions on college students' self‐esteem. *Journal of College Student Development*, *55*(5), 461–474.

36. Offermann, L. R., Basford, T. E., Graebner, R., Jaffer, S., De Graaf, S. B., & Kaminsky, S. E. (2014). See no evil: Colorblindness and perceptions of subtle racial discrimination in the workplace. *Cultural Diversity and Ethnic Minority Psychology*, *20*(4), 499–507.

37. Ong, A. D., Burrow, A. L., Fuller‐Rowell, T. E., Ja, N. M., & Sue, D. W. (2013). Racial microaggressions and daily well‐being among Asian Americans. *Journal of Counseling Psychology*, *60*(2), 188–199.

38. Owen, J. (2013). Early career perspectives on psychotherapy research and practice: Psychotherapist effects, multicultural orientation, and couple interventions. *Psychotherapy*, *50*(4), 496–502.

39. Owen, J., Drinane, J., Idigo, K., & Valentine, J. (2015). Psychotherapist effects in meta‐analyses: How accurate are treatment effects? *Psychotherapy*, *52*(3), 321–328.

40. Owen, J., Drinane, J., Tao, K., Adelson, J., Hook, J., Davis, D., & Foo Kune, N. (2017). Racial/ethnic disparities in client unilateral termination: The role of therapists' cultural comfort. *Psychotherapy Research*, *27*(1), 102–111.

41. Owen, J., Imel, Z., Adelson, J., & Rodolfa, E. (2012). “No show”: Therapist racial/ethnic disparities in client unilateral termination. *Journal of Counseling Psychology*, *59*(2), 314–320.

42. Owen, J., Tao, K., & Rodolfa, E. (2010). Microaggressions and women in short‐term therapy: Initial evidence. *The Counseling Psychologist*, *38*(7), 923–946.

43. Owen, J., Tao, K. W., Imel, Z. E., Wampold, B. E., & Rodolfa, E. (2014). Addressing racial and ethnic microaggressions in therapy. *Professional Psychology: Research and Practice*, *45*(4), 283–290.

44. Pierce, C., Carew, J., Pierce‐Gonzalez, D., & Willis, D. (1978). An experiment in

racism: TV commercials. In C. Pierce (Ed.), *Television and education* (pp. 62–88). Beverly Hills, CA: Sage.

45. Ramirez, E. (2014). Que estoy haciendo aqui? (What am I doing here?): Chicanos/Latinos(as) navigating challenges and inequalities during their first year of graduate school. *Equity & Excellence in Education*, *47*(2), 167–186.

46. Rivera, D. P., Forquer, E. E., & Rangel, R. (2010). Microaggressions and the life experience of Latina/o Americans. In D. W. Sue (Ed.), *Microaggressions and marginality* (pp. 59–83). Hoboken, NJ: Wiley.

47. Robinson, J. L., & Rubin, J. L. (2016). Homonegative microaggressions and posttraumatic stress symptoms. *Journal of Gay and Lesbian Mental Health*, *20*(1), 57–69.

48. Rowatt, W. C., Franklin, L. M., & Cotton, M. (2005). Patterns and personality correlates of implicit and explicit attitudes toward Christians and Muslims. *Journal for the Scientific Study of Religion*, *44*(1), 29–43.

49. Schmitt, M. T., Branscombe, N. R., Postmes, T., & Garcia, A. (2014). The consequences of perceived discrimination for psychological well‐being: A meta‐analytic review. *Psychological Bulletin*, *140*(4), 921–948.

50. Shelton, K., & Delgado‐Romero, E. A. (2011). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Journal of Counseling Psychology*, *58*(2), 210–221.

51. Shelton, K., & Delgado‐Romero, E. A. (2013). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Psychology of Sexual Orientation and Gender Diversity*, *1*(S), 59–70.

52. Smith, L. C., & Shin, R. Q. (2014). Queer blindfolding: A case study on difference "blindness" toward persons who identify as lesbian, gay, bisexual and transgender. *Journal of Homosexuality*, *61*, 940–961.

53. Smith, W. A., Allen, W. R., & Danley, L. L. (2007). "Assume the position, you fit the description": Psychosocial experiences and racial battle fatigue among African American male college students. *American Behavioral Scientist*, *51*, 551–578.

54. Smith, W. A., Hung, M., & Franklin, J. D. (2011). Racial battle fatigue and the miseducation of Black men: Racial microaggressions, societal problems, and environmental stress. *Journal of Negro Education*, *80*(1), 63–82.

55. Suarez‐Orozco, C., Cassanova, S., Martin, M., Katsiaficas, D., Cuellar, V., Smith, N. A., & Dias, S. I. (2015). Toxic rain in class: Classroom interpersonal microaggressions. *Educational Researcher*, *44*(3), 151–160.

56. Sue, D. W. (2004a). Whiteness and ethnocentric monoculturalism: Making the invisible visible. *American Psychologist*, *59*, 761–769.

57. Sue, D. W. (2004b). *Race talk and the conspiracy of silence: Understanding and facilitating difficult dialogues on race*. Hoboken, NJ: Wiley.

58. Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, NJ: Wiley.

59 Sue, D. W. (2017). The challenges of becoming a White ally. *The Counseling Psychologist*, *45*, 706–716.

60 Sue, D. W., Alsaidi, S., Awad, M. N., Glaeser, E., Calle, C. Z., & Mendez, N. (in press). Disarming racial microaggressions: Microintervention strategies for targets, White allies, and bystanders. American Psychologist.

61 Sue, D. W., Bucceri, J., Lin, A. I., Nadal, K. L., & Torino, G. C. (2007). Racial microaggressions and the Asian American experience. *Cultural Diversity and Ethnic Minority Psychology*, *13*, 72–81.

62 Sue, D. W., Capodilupo, C. M., & Holder, A. M. B. (2008). Racial microaggressions in the life experience of Black Americans. *Professional Psychology: Research and Practice*, *39*, 329–336.

63 Sue, D. W., Capodilupo, C. M., Nadal, K. L., & Torino, G. C. (2008). Racial microaggressions and the power to define reality. *American Psychologist*, *63*, 277–279.

64 Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, *62*, 271–286.

65 Swim, J. K., & Cohen, L. L. (1997). Overt, covert, and subtle sexism. *Psychology of Women Quarterly*, *21*, 103–118.

66 Swim, J. K., Mallett, R., & Stangor, C. (2004). Understanding subtle sexism: Detection and use of sexist language. *Sex Roles*, *51*, 117–128.

67 Torres, L., & Taknint, J. T. (2015). Ethnic microaggressions, traumatic stress symptoms, and Latino depression: A moderated mediational model. *Journal of Counseling Psychology*, *62*, 393–401.

68 Von Robertson, R., & Chaney, C. (2017). “I know it [racism] still exists here”: African American males at a predominately White institution. *Humboldt Journal of Social Relations*, *39*, 260–282.

69 Walls, N. E. (2008). Toward a multidimensional understanding of heterosexism: The changing nature of prejudice. *Journal of Homosexuality*, *55*(1), 1–51.

70 Watkins, N. L., Labarrie, T. L., & Appio, L. M. (2010). Black undergraduates' experiences with perceived racial microaggressions in predominately White colleges and universities. In D. W. Sue (Ed.), *Microaggressions and marginality* (pp. 25–51). Hoboken, NJ: Wiley.

71 Wong‐Padoongpatt, G., Zane, N., Okazaki, S., & Saw, A. (2017). Decreases in implicit self‐esteem explain the racial impact of microaggressions among Asian Americans. *Journal of Counseling Psychology*, *64*(5), 574–583.

72 Wright, A. J., & Wegner, R. T. (2012). Homonegative microaggressions and their impact on LGB individuals: A measure validity study. *Journal of LGBT Issues in Counseling*, *6*, 34–54.

73 Yosso, T., Smith, W., Ceja, M., & Solorzano, D. (2009). Critical race theory, racial microaggressions, and campus racial climate for Latina/o undergraduates. *Harvard Educational Review*, *79*(4), 659–691.

PART III

The Practice Dimensions of Multicultural Counseling and Therapy

7
Multicultural Barriers and the Helping Professional: The Individual Interplay of Cultural Perspectives

Chapter Objectives

1. **1. Identify the basic values, beliefs, and assumptions that characterize U.S. society, and how these are manifested in counseling practice.**
2. **2. Determine how the generic characteristics of counseling and psychotherapy may be barriers to culturally diverse clients.**
3. **3. Describe how the cultural values of diverse populations may affect the counseling process.**
4. **4. Describe how socioeconomic class issues may impact mental health services.**
5. **5. Understand the *linguistic barriers* that are likely to arise in working with clients whose first language is not English.**
6. **6. Learn how Western definitions of the family may detrimentally impact counseling and therapy with diverse families.**

> *Dior Vargas, a 28‐year‐old Latina mental health activist, recalls a therapist in college—her second one—who she stopped going to after realizing she was "culturally incompetent."*
>
> *"She wasn't aware of how close‐knit Latino families are. That they are a part of my decision‐making process. My therapist didn't understand that, she would say: 'No, you need to stand up to your mother.' That felt very disrespectful to me. Maybe sometimes you do, but the way she said it made me very defensive."*
>
> *Vargas's two positive experiences were with therapists with whom she felt she shared a piece of identity: one with a woman with the same Ecuadorian background as her, and another with a woman who was openly gay. "I identify as queer. I felt like I could trust her," she says*.
>
> *(Hackman, 2016, para. 5)*

Video 7.0: Introduction

A breakdown in communication doesn't necessarily signal the end of the client/therapist relationship. As long as the client is present you have the opportunity to mend a breach in the counseling relationship.

MY THERAPIST DIDN'T UNDERSTAND

In the preceding excerpt, a client reflects upon an impasse that prevented her therapist from being helpful to her. Her therapist maintained a view of how family members should relate to each other—a view that excluded the cultural experiences of her client. We can assume that this therapist had every intention of being helpful, but because she could not see beyond the limits of her own values and assumptions, her client was left feeling disrespected and defensive.

The client went on to form an effective therapeutic relationship with other therapists who shared her Latina and queer identities. We can understand that shared identities can increase feelings of trust—but can therapists who do not share their clients' identities increase their awareness and effectiveness in order to help them? In this chapter, we discuss the culture ‐ related differences that can act as barriers between helping professionals and culturally diverse clients.

STANDARD CHARACTERISTICS OF MAINSTREAM COUNSELING

All theories of counseling and psychotherapy are influenced by assumptions that theorists make regarding the goals for therapy, the methodology used to invoke change, and the definition of mental health and mental illness (Corey, 2013). Counseling and psychotherapy have historically and traditionally been conceptualized in Western individualistic terms (Ivey, Ivey, Myers, & Sweeney, 2005). Whether a particular theory is psychodynamic, existential‐humanistic, or cognitive behavioral in orientation, a number of multicultural specialists (Ivey, Ivey, & Zalaquett, 2014; Ponterotto, Utsey, & Pedersen, 2006) indicate that it shares certain common components of White Western Eurocentric culture in its values and beliefs. Because this cultural worldview predominates in U.S. society, the mark that it has made on practices like psychotherapy can almost be invisible to dominant‐culture professionals, yet for individuals from other cultural backgrounds, it can be readily apparent, as in the passage that opened the chapter.

In addition to their origins in White Western culture, psychotherapeutic practices originated among middle‐class (or higher) segments of the population (Smith, 2010). For this reason, the values, assumptions, and goals associated with psychotherapy largely correspond to the lives and experiences of people with social class privilege rather than those of people living in poverty. Privileged social class memberships have often been included, therefore, among the assumed characteristics of psychotherapeutic clients. As a result, culturally diverse clients may not share all the values and characteristics seen in both the goals and the processes of therapy, and neither may clients from poor or working‐class backgrounds (APA Task Force on Socioeconomic Status, 2007; Reed & Smith, 2014). Schofield (1964) famously summarized some of these characteristics by noting that therapists seem to prefer clients who exhibit the *YAVIS syndrome*: young, attractive, verbal, intelligent, and successful. Such preferences predispose therapists against people from lower socioeconomic classes and various minority groups. This preference is more than theoretical: research indicates that therapists respond differently to service‐seeking voicemails left by clients who seem to be of different racial backgrounds. For example, a hypothetical client with a stereotypically Black name (“Lakisha”) received fewer therapist callbacks that offered services than did a client with a potentially White name (“Allison”) (Shin, Smith, Welch, & Ezeofor, 2016).

Katz (1985) has isolated some of the components of White culture that are reflected in the goals and processes of clinical work. These components are summarized in Table 7.1. The sections that follow will explore the ways in which culturally diverse clients may be excluded or inappropriately served by therapists who cannot see beyond these dominant‐culture assumptions.

TABLE 7.1 Components of White Culture: Values and Beliefs

Source: Katz, J. (1985). *The Counseling Psychologist*. Beverly Hills, CA: Sage. Copyright 1985 by Sage Publications, Inc. Reprinted by permission.

Rugged individualism Individual is primary unit Individual has primary responsibility Independence and autonomy are highly valued and rewarded Individual can control environment	***Protestant work ethic*** Working hard brings success ***Progress and future orientation*** Plan for future Delay gratification Value continual improvement and progress
Competition	***Emphasis on scientific method***

Winning is everything Win/lose dichotomy	Objective, rational, linear thinking Cause - and - effect relationships Quantitative emphasis
Action orientation Must master and control nature Must always do something about a situation Pragmatic/utilitarian view of life	***Status and power*** Measured by economic possessions Credentials, titles, and positions Believe “own” system Believe better than other systems Owning goods, space, property
Communication Standard English Written tradition Direct eye contact Limited physical contact Control of emotions	***Family structure*** Nuclear family is the ideal social unit Male is breadwinner and the head of the household Female is homemaker and subordinate to the husband Patriarchal structure
Time Adherence to rigid time Time is viewed as a commodity *Holidays* Based on Christian religion Based on White history and male leaders	***Aesthetics*** Music and art based on European cultures Women's beauty based on blonde, blue - eyed, thin, young Men's attractiveness based on athletic ability, power, economic status
History Based on European immigrants' experience in the United States Romanticize war	***Religion*** Belief in Christianity No tolerance for deviation from single god concept

Select this link to open an interactive version of Table 7.1.

CULTURE - BOUND VALUES

Culture consists of all those things that people have learned to do, believe, value, and enjoy. It is the totality of the ideals, beliefs, skills, tools, customs, and institutions into which members of society are born (Ratts & Pedersen, 2014). Although being *bicultural* is a source of strength, the process of negotiating dual group membership may cause problems for many marginalized group members. Persons of color are placed under strong pressures to adopt the ways of the dominant culture. Cultural - deficit models tend to view culturally diverse groups as possessing dysfunctional values and belief systems, which they often considered handicaps to be overcome and sources of shame. In essence, marginalized groups may be taught that to be different is to be deviant, pathological, or sick. Several culture - bound characteristics of therapy may be responsible for reinforcing these negative beliefs.

Focus on the Individual

Most forms of counseling and psychotherapy tend to be *individual - centered*. Accordingly, Ivey et al. (2014) note that U.S. culture and society are based on the concept of *individualism* and that competition between individuals for status, recognition, achievement, and so forth forms the basis of Western tradition. *Individualism*, autonomy, and the ability to become your own person are perceived as healthy and desirable goals. Pedersen and Pope (2010) observe that not all cultures view *individualism* as a positive orientation; rather, it may be perceived by some as a handicap to attaining enlightenment, one that may divert us from important spiritual goals. In many non - Western cultures, identity is not seen apart from the group orientation (*collectivism*). For example, the notion of *atman* in India defines itself as participating in unity with all things and not being limited by the temporal world.

Many societies do not define the psychosocial unit of operation as the individual. In many cultures and subgroups, the psychosocial unit of operation tends to be the family, group, or collective society. In traditional Asian American culture, one's identity is defined within the family constellation. The greatest punitive measure to be taken against an individual by the family is to be disowned. What this means, in essence, is that the person no longer has an identity. Although being disowned by a family in Western European culture is equally negative and punitive, it does not have the same connotations as in traditional Asian society. Although they may be disowned by a family, Westerners are always told that they have an individual identity as well. Likewise, many Hispanic individuals tend to see the unit of operation as residing within the family. African American psychologists (Parham, Ajamu, & White, 2011) also point out how the African view of the world encompasses the concept of “groupness.”

Collectivism is often reflected in many aspects of behavior. Traditional Asian American and Hispanic elders, for example, tend to greet one another with the question, “How is your family today?” Contrast this with how most Americans tend to greet each other: “How are you today?” One emphasizes the family (group) perspective, while the other emphasizes the individual perspective. Likewise, affective expressions in therapy can also be strongly influenced by the particular orientation one takes. When individuals engage in wrongful behaviors in the United States, they are most likely to experience feelings of guilt. In societies that emphasize *collectivism*, however, the most dominant affective element to follow a wrongful behavior is shame, not guilt. Guilt is an individual affect, whereas shame appears to be a group one (it reflects on the family or group).

Verbal/Emotional/Behavioral Expressiveness

Many counselors and therapists tend to emphasize the fact that verbal/emotional/behavioral expressiveness is important in individuals. As therapists, we like our clients to be verbal, articulate, and able to express their thoughts and feelings clearly, as this most easily and effectively allows us to use our conventional skills with them. Indeed, therapy is often referred to as "talk therapy," indicating the importance placed on Standard English as the medium of expression. *Emotional expressiveness* is also valued, as we like individuals to be in touch with their feelings and to be able to verbalize their emotional reactions. We value behavioral expressiveness as well. We like individuals to be assertive, to stand up for their own rights, and to engage in activities that indicate they are not passive beings.

All these characteristics of mainstream therapy can place culturally diverse clients at a disadvantage. For example, Native Americans and Asian Americans tend not to value verbalizations in the same way as White Americans. In traditional Chinese culture, children have been taught not to speak until spoken to. Patterns of communication tend to be vertical, flowing from those of higher prestige and status to those of lower prestige and status. In a therapy situation, many Chinese clients, to show respect for a therapist who is older and wiser and who occupies a position of higher status, may respond with silence. Unfortunately, an unenlightened counselor or therapist may perceive such clients as being inarticulate and less intelligent.

Emotional expressiveness in counseling and psychotherapy is frequently a highly desired goal. Yet, many cultural groups value restraint of strong feelings. For example, traditional Latinx and Asian cultures emphasize that maturity and wisdom are associated with one's ability to control emotions and feelings. This applies not only to public expressions of anger and frustration but also to public expressions of love and affection. Unfortunately, therapists unfamiliar with these cultural ramifications may perceive their clients in a very negative psychiatric light. Indeed, these clients are often described as inhibited, lacking in spontaneity, or repressed.

In therapy, it has become increasingly popular to emphasize expressiveness in a behavioral sense—look at the proliferation of cognitive behavioral assertiveness training programs throughout the United States (Craske, 2010) and the number of self‐help books being published in the popular mental health literature. This orientation fails to realize that there are cultural groups in which subtlety is a highly prized art. Doing things indirectly can be perceived by the mental health professional as evidence of passivity and the need to learn assertiveness skills. In their excellent review of assertiveness training, Wood and Mallinckrodt (1990) warn that therapists need to make certain that gaining such skills is a value shared by a client of color, and not one imposed by therapists.

Insight

Another generic characteristic is the use of *insight* in both counseling and psychotherapy. This approach assumes that it is mentally beneficial for individuals to obtain *insight* or understanding into their underlying dynamics and motivations (Corey, 2013; Levenson, 2010). Educated in the tradition of psychoanalytic theory, many theorists tend to believe that clients who obtain better *insight* into themselves will be better adjusted. Although many behavioral schools of thought may not subscribe to this, most therapists use *insight* in their individual practice, either as a process of therapy or as an end product or goal (Antony & Roemer, 2011).

We need to realize that *insight* is not highly valued by many culturally diverse clients. In

traditional Chinese society, psychology has little relevance. It must be noted that a client who does not seem to work well in an *insight* approach may not be lacking in *insight* or psychological‐mindedness; a person who does not value *insight* is not necessarily one who is incapable of *insight*. Simply put, many cultural groups do not value this method of self‐exploration. It is interesting to note that many Asian elders believe that thinking too much about something can cause problems. Many older Chinese believe the way to achieve to mental health is to “avoid morbid thoughts.” Advice from Asian elders to their children when they are frustrated, angry, depressed, or anxious is simply, “Don't think about it.” Indeed, it is often believed that experiencing anger or depression is related to cognitive rumination. The traditional Asian way of handling these affective elements is to “keep busy and not think about it.” There can be class‐related differences as well (APA Task Force on Socioeconomic Status, 2007). People from lower socioeconomic classes may not perceive *insight* as appropriate to their life situations and circumstances. Their immediate concerns may instead revolve around such questions as “Where do I find a job?”, “How do I feed my family?”, and “How can I afford to take my sick daughter to a doctor?”

Self‐Disclosure (Openness and Intimacy)

Most forms of counseling and psychotherapy tend to prioritize one's ability to self‐disclose and to talk about the most intimate aspects of one's life. Indeed, self‐disclosure has often been discussed as a primary characteristic of a healthy personality. Clients who do not self‐disclose readily in counseling and psychotherapy are seen as possessing negative features (i.e., being guarded, mistrustful, or paranoid). There are two difficulties in this orientation toward self‐disclosure: cultural and sociopolitical.

First, intimate revelations of personal or social problems may not be acceptable to Asian Americans, because such admissions reflect not only on the individual but also on their whole family (Chang, McDonald, & O'Hara, 2014). Thus, the family may exert strong pressures on the Asian American client not to reveal personal matters to strangers or outsiders. Similar conflicts have been reported for Latinx Americans (Torres‐Rivera & Ratts, 2014), American Indians (Thomason, 2014), and Polynesian Americans (Allen, Kim, Smith, & Hafoka, 2016). A therapist who works with a client from a different cultural background may erroneously conclude that they are repressed, inhibited, shy, or passive. All these traits are seen as undesirable by Western standards.

Related to this example is many health practitioners' belief in the desirability of self‐disclosure. Self‐disclosure refers to clients' willingness to tell therapists what they feel, believe, or think. Jourard (1964) suggests that mental health is related to one's openness in disclosing. Although this may be true, the parameters need clarification. As mentioned in Chapter 4, people of African descent may be reluctant to disclose to White counselors because of their previous experience of racism (Ratts & Pedersen, 2014). African Americans may initially perceive a White therapist as an agent of society who might use any information they provide against them, rather than as a person of good will. From the African American perspective, noncritical self‐disclosure to others is not healthy.

The actual structure of the therapy situation may also work against intimate revelations. Among many American Indians and Latinx Americans, intimate aspects of life are shared only with close friends. Relative to White middle‐class standards, deep friendships are developed only after prolonged contacts. Once friendships are formed, they tend to be lifelong in nature. In contrast, White Americans form relationships relatively quickly, but the relationships may not necessarily persist over long periods of time. Counseling and therapy also seem to reflect these values. Clients talk about the most intimate aspects of their lives

with a relative stranger once every week for a 50‐minute session. To many culturally diverse groups that stress friendship as a precondition to self‐disclosure, the counseling process seems utterly inappropriate and absurd. After all, how is it possible to develop a friendship with brief contacts once a week?

Scientific Empiricism

Counseling and psychotherapy in Western culture and society have been described as being highly linear, analytic, and verbal in their attempt to mimic the physical sciences. As indicated by Table 7.1, Western society tends to emphasize the so‐called scientific method, which involves objective, rational, linear thinking. Likewise, we often see descriptions of therapists as objective, neutral, rational, and logical (Utsey, Walker, & Kwate, 2005). Therapists rely heavily on the use of linear problem solving, as well as on quantitative evaluation that includes psychodiagnostic tests, intelligence tests, personality inventories, and so forth. This cause–effect orientation emphasizes left‐brain functioning. That is, theories of counseling and therapy are distinctly analytical, rational, and verbal, and they strongly stress the discovery of cause–effect relationships.

The emphasis on symbolic logic contrasts markedly with the philosophies of many cultures that value a more nonlinear, holistic, and harmonious approach (Sue, 2015). For example, the American Indian worldview emphasizes harmonious aspects of the world, intuitive functioning, and a holistic approach—a worldview characterized by right‐brain activities, minimizing analytical and reductionistic inquiries. Thus, when American Indians undergo therapy, the analytic approach may violate their basic philosophy of life (Garrett & Portman, 2011).

In the mental health fields, the most dominant way of asking and answering questions about the human condition tends to involve the scientific method. The epitome of this approach is the *experiment*. In graduate schools, we are often told that only through experiments can we impute cause–effect relationships. By identifying independent and dependent variables, and controlling for extraneous ones, we are able to test a cause–effect hypothesis. Although correlation studies, historical research, and other approaches may be of benefit, we are told that the experiment represents the epitome of our science. Other cultures, however, may value different ways of asking and answering questions about the human condition. We will explore this further in Chapter 10.

Distinctions Between Mental and Physical Functioning

Many American Indians, Asian Americans, African Americans, and Latinx Americans hold different concepts of what constitutes mental health, mental illness, and adjustment. Among the Chinese, the concept of mental health or psychological well‐being is not understood in the same way as it is in the Western context. Latinx Americans do not make the same Western distinction between mental and physical health as do their White counterparts (Guzman & Carrasco, 2011). Thus, nonphysical health problems are most likely to be referred to a physician, priest, or minister. Culturally diverse clients operating under this orientation may enter therapy expecting the therapist to treat them in the same manner that doctors and priests do, and to offer them immediate solutions and concrete tangible forms of treatment (advice, confession, consolation, and medication).

Patterns of Communication

The cultural upbringing of many minorities dictates different patterns of communication that

may place them at a disadvantage in therapy. Counseling, for example, initially demands that communication move from client to counselor. The client is expected to take the major responsibility for initiating conversation in the session, while the counselor plays a less active role.

However, American Indians, Asian Americans, and Latinx Americans function under different cultural imperatives, which may make this difficult. These three groups may have been reared to respect elders and authority figures and not to speak until spoken to. Clearly defined roles of dominance and deference are established in the traditional family. Evidence indicates that Asians associate mental health with exercising will power, avoiding unpleasant thoughts, and occupying one's mind with positive thoughts. They see therapy as an authoritative process in which a good therapist is direct and active, and represents a kind of father figure. A racial/ethnic minority client who is asked to initiate conversation may become uncomfortable and respond with only short phrases or statements. The therapist may be prone to interpret this behavior negatively, when in actuality it may be a sign of respect. We have much more to say about these communication style differences in the next chapter.

Video 7.3: Culturally-Specific Issues

International clients have the added struggle of communicating in a foreign language. This can be very difficult if there is no word in their own language to describe what they are experiencing. Also, their limited understanding of English can hinder the counseling relationship.

CLASS‐BOUND VALUES

Social class and *classism* have been identified as two of the most overlooked topics in psychology and mental health practice (APA Task Force on Socioeconomic Status, 2007). Although many believe that the gap in income is closing, statistics suggest the opposite— that income inequality is increasing. Those in the top 5% of income have enjoyed huge increases, whereas those in the bottom 40% are stagnant (APA Task Force on Socioeconomic Status, 2007). In the United States, 12.7% of citizens live in poverty. Segmented by race, the poverty rate for Whites was 11.0% in 2016, while for African Americans, it was twice that at 22.0%. The poverty rate for Latinx Americans was 19.4%, and for Asians, it was 10.1% (Semega, Fontenot, & Kollar, 2017). The poverty rates for American Indians are the highest in the nation at 26.2% (U.S. Census Bureau, 2017). These statistics underscore the intertwined nature of race with *social class* in the United States as the result of historic events such as the transatlantic slave trade, the seizing of lands from native people, and institutional barriers to wealth creation (Lui, Robles, Leondar‐Wright, Brewer, & Adamson, 2006).

Impact of Poverty

Research indicates that life in poverty is related to higher incidence of depression (Lorant et al., 2003), lower sense of control (Chen, Matthews, & Boyce, 2002), poorer physical health (Gallo & Matthews, 2003), and exclusion from the mainstream of society (Reed & Smith, 2014). Mental health professionals are often not aware of the additional stressors likely to confront clients who lack financial resources, nor do they fully appreciate how those stressors affect their clients' daily lives. For the therapist who comes from a middle‐ to upper‐class background, it is often difficult to relate to the circumstances and hardships affecting the client who lives in poverty.

The phenomenon of poverty and its effects on individuals and institutions can be devastating (Liu, Hernandez, Mahmood, & Stinson, 2006). The impoverished individual's life is characterized by low wages, unemployment, underemployment, little property ownership, no savings, and lack of reliable food reserves. Meeting even the most basic family needs is precarious. Pawning personal possessions and borrowing money at exorbitant interest rates only leads to greater debt. Moreover, people living in poverty are subject to daily experiences of discrimination and bias. People at higher social class positions often stereotype the poor as being lazy, inferior, drug‐abusing, or unintelligent, and frequently seek to distance themselves from the poor as a result (Lott, 2002). Feelings of helplessness, dependence, and inferiority develop easily under these circumstances. Therapists may unwittingly attribute attitudes that result from physical and environmental adversity to the cultural or individual traits of the client.

Therapeutic Class Bias

Considerable bias against people who are poor has been well documented (APA Task Force on Socioeconomic Status, 2007; Smith, 2013). For example, clinicians perceive clients who live in poverty more unfavorably than more affluent clients (as, for example, being more dysfunctional and making poorer progress in therapy). Research concerning the inferior and biased quality of treatment of lower‐class clients is historically legend (APA Task Force on Socioeconomic Status, 2007). In the area of diagnosis, it has been found that an attribution of mental illness is more likely when a person's history suggests a lower rather than a higher socioeconomic class origin (Liu et al., 2006). Many studies demonstrate that clinicians who

are given identical clinical vignettes tend to make more negative prognostic statements and judgments of greater maladjustment when the individual is said to come from a poor or working ‐ class background rather than from the middle class (Lee & Temerlin, 1970; Smith, Mao, Perkins, & Ampuero, 2011; Stein, Green, & Stone, 1972).

In addition, the class ‐ bound nature of mental health practice emphasizes the importance of assisting the client in self ‐ direction through the results of assessment instruments and through self ‐ exploration via verbal interactions between client and therapist. However, the assumptions underlying these activities are permeated by middle ‐ class values that do not always apply to life in poverty. In an extensive historic research of services delivered to minorities and low ‐ socioeconomic ‐ status clients, Lorion (1973) found that psychiatrists refer to therapy those persons who are most like themselves—White rather than non ‐ White and of upper socioeconomic status. Lorion (1974) pointed out that the expectations of poor and working ‐ class clients are often different from those of psychotherapists. For example, low ‐ income clients who are concerned with survival on a day ‐ to ‐ day basis may expect advice and suggestions from the counselor.

Appointments made weeks in advance with short, weekly, 50 ‐ minute contacts are not consistent with the need to survive chaotic circumstances and seek immediate solutions. Additionally, many people living in poverty, through multiple experiences with public agencies, may operate under what is called *minority standard time* (Schindler ‐ Rainman, 1967). Poor people have learned that endless waits are associated with medical clinics, police stations, and government agencies. One usually waits hours for a 10 ‐ to 15 ‐ minute appointment. Arriving promptly does little good and can be a waste of valuable time. Therapists, however, rarely understand this aspect of life and are prone to see late arrival as a sign of resistance, indifference, or hostility (Schnitzer, 1996).

People from poor and working ‐ class backgrounds may view *insight* and attempts to discover underlying intrapsychic problems as inappropriate, and some may expect to receive advice or some form of concrete tangible treatment. A harsh environment, where the future is uncertain and immediate needs must be met, makes long ‐ range planning of little value. Such clients may be unable to relate to the future orientation of therapy. To be able to sit and talk about things is perceived as a luxury of the middle and upper classes. A low ‐ income client's unfamiliarity with the therapy process may hinder success and cause the therapist to blame the client for the failure. Thus, the client may be perceived as hostile and resistant. The results of this interaction may be a premature termination of therapy. Considerable evidence exists that clients from more privileged socioeconomic backgrounds have significantly more exploratory interviews with their therapists and that middle ‐ class patients tend to remain in treatment longer than lower ‐ class patients (Gottesfeld, 1995; Leong, Wagner, & Kim, 1995; Neighbors, Caldwell, Thompson, & Jackson, 1994).

As people of color are overrepresented among individuals living below the poverty line, poverty undoubtedly contributes to the mental health problems among racial/ethnic minority groups, and *social class* can intersect with the type of treatment that a minority client is likely to receive. In addition, as Atkinson, Morten, and Sue (1998, p. 64) conclude,

> *Ethnic minorities are less likely to earn incomes sufficient to pay for mental health treatment, less likely to have insurance, and more likely to qualify for public assistance than European Americans. Thus ethnic minorities often have to rely on public (government ‐ sponsored) or nonprofit mental health services to obtain help with their psychological problems.*

Working effectively with clients who are poor requires several major conditions. First, the

therapist must spend time understanding his or her own biases and prejudices. Confronting one's own classism can help detect the influence of commonplace social stereotypes of poor people, which can vary in association with race. For example, poor White people can be seen through the lens of “White trash” or “redneck” stereotypes, while poor Black women can be stigmatized as “welfare queens” (Smith & Redington, 2010). These attitudes can affect the diagnosis and treatment of clients. Second, it becomes essential that counselors understand how poverty affects the lives of people who lack financial resources; behaviors associated with survival should not be pathologized. Third, counselors should consider that a more active approach in treatment that allows for information‐giving activities might be more appropriate for some clients than the passive, insight‐oriented, and long‐term models of therapy. Last, poverty and the economic disparities that are the root causes of emotional distress among the poor demand a social justice approach.

Several conclusions are suggested at this point: (a) poverty and classism present overwhelming stressors to people and may seriously undermine the mental and physical health of clients; (b) a failure to understand the life circumstance of clients who lack financial resources, along with unintentional class bias, may affect the ability of helping professionals to deliver appropriate mental health services; and (c) classism can make its appearance in the assessment, diagnosis, and treatment of lower‐socioeconomic‐class clients.

LANGUAGE BARRIERS

> *Ker Moua, a Laotian refugee, suffered from a variety of ailments but was unable to communicate with her doctor. The medical staff enlisted the aid of 12 - year - old Jue as the liaison between the doctor and the mother. Ker was diagnosed with a prolapsed uterus, the result of bearing 12 children. She took medication in the doses described by her son but became severely ill after two days. Fortunately, it was discovered that she was taking an incorrect dosage that could have caused lasting harm. The hospital staff realized that Jue had mistranslated the doctor's orders. When inquiries about the translation occurred, Jue said, "I don't know what a uterus is. The doctor tells me things I don't know how to say."*
>
> *(Burke, 2005, p. 5B)*

Asking children to translate information concerning medical or legal problems is common in many communities with high immigrant and refugee populations but may have devastating consequences: (a) it can create stress and hurt the traditional parent–child relationship; (b) children lack the vocabulary and emotional maturity to serve as effective interpreters; (c) children may be placed in a situation where they are privy to confidential medical or psychiatric information about their relatives; and (d) children may be unfairly burdened with emotional responsibilities that only adults should carry (Coleman, 2003). In 2008, California Assembly Bill 775 was introduced to ban the use of children as interpreters. Further, the federal government has acknowledged that not providing adequate interpretation for client populations is a form of discrimination.

The National Council on Interpreting in Health Care (2005) has published national standards for interpreters of health care that address issues of cultural awareness and confidentiality. These standards are based upon a number of important findings derived from focus groups of immigrants (Ngo - Metzger et al., 2003). First, nearly all immigrants interviewed expressed a preference for professional translators rather than family members. They wanted translators who were knowledgeable and respectful of their cultural customs. Second, using family members to interpret—especially children—was negatively received for fear of their inability to translate correctly. Third, discussing very personal or familial issues was often very uncomfortable (shame, guilt, and other emotional reactions) when a family member acted as the interpreter. Last, there was great concern that interpretation by a family member could be affected by the family dynamics or vice versa.

Some general guidelines in selecting and working with professional interpreters are as follows:

- Make sure that the interpreter speak the same dialect as the client. Monitor carefully whether the interpreter and client appear to have significant cultural or social differences.
- Establish a degree of familiarity with the interpreter; they should be understanding and comfortable with your therapeutic style. Use the same interpreter consistently with the same client.
- Be aware that the interpreter is not just an empty box in the therapeutic relationship; rather than a two - person interaction, this is most likely a three - person alliance. Clients may initially develop a stronger relationship with the interpreter than with the counselor.

- Provide plenty of extra time in the counseling session.
- Ensure that the interpreter realizes the code of confidentiality.
- If you believe the interpreter is not fully translating the client's words or is interjecting their own beliefs, opinions, and assumptions, it is important to have a frank and open discussion about your observations.
- Be aware that interpreters may also experience intense emotions when traumatic events are discussed. Be alert for overidentification or countertransference. You may need to work closely with the interpreter, allowing them periodic debriefing sessions.

Clearly, use of Standard English in health care delivery may unfairly discriminate against those from a bilingual or lower socioeconomic background, with potentially devastating consequences (Ratts & Pedersen, 2014; Vedantam, 2005). This inequity occurs in our educational system and in the delivery of mental health services as well. Schwartz, Rodriguez, Santiago‐Rivera, Arredondo, and Field (2010) indicate that psychologists are increasingly finding that they must interact with clients who have English as a second language or who do not speak English at all. The lack of bilingual therapists and the requirement that clients communicate in English may limit the ability to progress in counseling and therapy. If bilingual individuals do not use their native tongue in therapy, many aspects of their emotional experience may not be available for treatment; they may be unable to use the wide complexity of language to describe their particular thoughts, feelings, and unique situations. Clients who are limited in English tend to feel like they are speaking as a child and choosing simple words to explain complex thoughts and feelings. If they were able to use their native tongue, they could easily explain themselves (Arredondo, Gallardo‐Cooper, Delgado‐Romero, & Zapata, 2014).

Video 7.5: Barriers to Understanding

International clients can struggle in counseling if they do not have a cultural support system. Identifying your client's needs related to community can have a positive impact on their outcomes.

PATTERNS OF "AMERICAN" CULTURAL ASSUMPTIONS AND MULTICULTURAL FAMILY COUNSELING/THERAPY

Family systems theory may be equally as culture‐bound as any other form of therapy, and this limitation may be manifested in marital or couple counseling, parent–child counseling, or work with more than one member of a family. *Family systems* therapy possesses several important characteristics (Corey, 2013; McGoldrick, Giordano, & Garcia‐Preto, 2005):

- It highlights the importance of the family (versus the individual) as the unit of identity.
- It focuses on resolving concrete issues.
- It is concerned with family structure and dynamics.
- It assumes that these family structures and dynamics are historically passed on from one generation to another.
- It attempts to understand the communication and alliances via reframing.
- It places the therapist in an expert position.

Many of these qualities would be consistent with the worldviews of persons of color. The problem arises in how they are translated into concepts of "the family" or what constitutes a "healthy" family. Some of the characteristics of healthy families may pose problems in therapy with various culturally diverse groups. They tend to be heavily loaded with value orientations that are incongruent with the value systems of many culturally diverse clients (McGoldrick et al., 2005). According to *family systems* theory, healthy families:

- Allow and encourage the free and open expression of emotion.
- View each member as having a right to be his or her own unique self (individuate from the emotional field of the family).
- Strive for an equal division of labor among family members.
- Consider *egalitarian role* relationships between spouses desirable.
- Hold the *nuclear family* as the standard.

These orientations were first described by Kluckhohn and Strodtbeck (1961) as patterns of "American" values. Table 7.2 outlines the five major dimensions of White culture, and contrasts them with those of four major groups of color.

TABLE 7.2 Cultural Value Preferences of Middle‐Class White EuroAmericans and People of Color: A Comparative Summary

Source: Ho, M. K. (1987). *Family Therapy with Ethnic Minorities* (p. 232). Newbury Park, CA: Sage. Copyright 1987 by Sage Publications. Reprinted by permission.

Area of relationships	Middle‐class White Americans	Asian Americans	American Indians	Black Americans	Hispanic Americans
People to nature/environment	Mastery over	Harmony with	Harmony with	Harmony with	Harmony with
Time orientation	Future	Past–present	Present	Present	Past–present

People relations	Individual	Collateral	Collateral	Collateral	Collateral
Preferred mode of activity	Doing	Doing	Being - in - becoming	Doing	Being - in - becoming
Nature of man	Good and bad	Good	Good	Good and bad	Good

Select this link to open an interactive version of Table 7.2.

People–Nature Dimension

Traditional Western thinking believes in mastery and control over nature. As a result, most therapists operate from a framework that subscribes to the belief that problems are solvable and that both therapist and client must take an active part in solving problems via manipulation and control. Active intervention is stressed in controlling or changing the environment. The four other ethnic groups listed in Table 7.2 view people as harmonious with nature.

Confucian philosophy, for example, stresses a set of rules aimed at promoting loyalty, respect, and harmony among family members (Moodley & West, 2005). Harmony within the family and the environment leads to harmony within the self. Dependence on the family unit and acceptance of the environment seem to dictate differences in solving problems. Western culture advocates defining and attacking problems directly. Asian cultures tend to accommodate or deal with problems through indirection. In child rearing, many Asians believe that it is better to avoid direct confrontation and to use deflection. A White family might deal with a child who has watched too many hours of TV by saying, “Why don't you turn the TV off and study?” To be more threatening, the parent might say, “You'll be grounded unless the TV goes off!” An Asian parent might respond by saying, “That looks like a boring program; I think your friend John must be doing his homework now,” or, “I think Father wants to watch his favorite program.” Such an approach stems from the need to avoid conflict and to achieve balance and harmony among members of the family and the wider environment—values that continue to be associated with emotional well - being among Chinese people (Wang, Wong, & Yeh, 2016).

Thus, it is apparent that U.S. values that call for us to dominate nature (i.e., conquer space, tame the wilderness, or harness nuclear energy) through control and manipulation of the universe are reflected in family counseling. *Family systems* counseling theories attempt to describe, explain, predict, and control family dynamics. The therapist actively attempts to understand what is going on in the family system (structural alliances and communication patterns), identify the problems (dysfunctional aspects of the dynamics), and attack them directly or indirectly through manipulation and control (therapeutic interventions). Ethnic minorities or subgroups that view people as harmonious with nature or believe that nature may overwhelm people (“acts of God”) may find the therapist's mastery - over - nature approach inconsistent with or antagonistic to their worldview. Indeed, attempts to intervene actively in family patterns and relationships may be perceived as the problem, because they might unbalance the existing harmony.

Time Dimension

How different societies, cultures, and people view time exerts a pervasive influence on their lives. U.S. society may be characterized as preoccupied with the future (Katz, 1985;

Kluckhohn & Strodtbeck, 1961). Furthermore, our society seems very compulsive about time, in that we divide it into seconds, minutes, hours, days, weeks, months, and years. Time may be viewed as a commodity ("time is money" and "stop wasting time") in fixed and static categories, rather than as a dynamic and flowing process. It has been pointed out that the United States' future orientation may be linked to other values as well: (a) stress on youth and achievement, in which children are expected to "better their parents"; (b) controlling one's own destiny by future planning and saving for a rainy day; and (c) optimism and hope for a better future. The spirit of the nation may be embodied in an old General Electric slogan, "Progress is our most important product."

Table 7.2 reveals that both American Indians and Black Americans tend to value a present‐time orientation, whereas Asian Americans and Hispanic Americans have a combination past–present focus. Historically, Asian societies have valued the past, as reflected in ancestor worship and the equating of age with wisdom and respectability. This contrasts with U.S. culture, in which youth is valued over age and one's usefulness in life is believed to be over once one hits the retirement years. As compared to EuroAmerican middle‐class norms, Latinx Americans also exhibit a past–present time orientation. Strong hierarchical structures in the family, respect for elders and ancestors, and the value of *personalismo* all combine in this direction. American Indians also differ from their White counterparts in that they are very grounded in the here and now, rather than the future. American Indian philosophy relies heavily on the belief that time is flowing, circular, and harmonious. Artificial division of time (schedules) is disruptive to the natural pattern. African Americans also value the present, because of the spiritual quality of their existence and their history of victimization by racism. Several difficulties may occur when the counselor or therapist is unaware of the differences of time perspective (Hines & Boyd‐Franklin, 2005).

First, if time differences exist between a family of color and the White EuroAmerican therapist, it will most likely be manifested in a difference in the pace of time: both may sense things are going too slowly or too fast. An American Indian family that values being in the present and the immediate experiential reality of being may feel that the therapist lacks respect for them and is rushing them (Sutton & Broken Nose, 2005) while ignoring the quality of the personal relationship. On the other hand, the therapist may be dismayed by the "delays," "inefficiency," and lack of "commitment to change" among the family members. After all, time is precious, and the therapist has only limited time to impact upon the family. The result is frequently dissatisfaction among the parties, a failure to establish rapport, misinterpretation of behaviors or situations, and discontinuation of future sessions.

Second, Inclan (1985) pointed out how confusions and misinterpretations can arise because Hispanics, particularly Puerto Ricans, mark time differently than do their U.S. White counterparts. The language of clock time in counseling (50‐minute hour, rigid time schedule, once‐a‐week sessions) can conflict with minority perceptions of time (Garcia‐Preto, 1996). The following dialogue illustrates this point clearly:

> *"Mrs. Rivera, your next appointment is at 9:30 a.m. next Wednesday."*
>
> *"Good, it's convenient for me to come after I drop off the children at school."*
>
> *Or "Mrs. Rivera, your next appointment is for the whole family at 3:00 p.m. on Tuesday."*
>
> *"Very good. After the kids return from school we can come right in."*
>
> *(Inclan, 1985, p. 328)*

Since school starts at 8 a.m., the client is bound to show up very early, whereas in the second

example, the client will most likely be late (school ends at 3 p.m.). In both cases, the counselor is likely to be inconvenienced, but worse yet is the negative interpretation that may be made of the client's motives (anxious, demanding, or pushy in the first case, and resistant, passive - aggressive, or irresponsible in the latter). The counselor needs to be aware that many Hispanics may mark time by events rather than by the clock.

Relational Dimension

In general, the United States can be characterized as an achievement - oriented society, which is most strongly manifested in the prevailing Protestant work ethic. Basic to the ethic is the concept of *individualism*: (a) the individual is the psychosocial unit of operation; (b) the individual has primary responsibility for his or her own actions; (c) independence and autonomy are highly valued and rewarded; and (d) one should be internally directed and controlled. In many societies and groups within the United States, however, this value is not necessarily shared. Relationships in Japan and China are often described as being lineal, and identification with others is both wide and linked to the past (ancestor worship). Obeying the wishes of ancestors or deceased parents and perceiving one's existence and identity as linked to the historical past are inseparable. Almost all racial/ethnic minority groups in the United States tend to be more collateral (collectivistic) in their relationships with people. In an individualistic orientation, the definition of the family tends to be linked to a biological necessity (*nuclear family*), whereas a collateral or lineal view encompasses various concepts of the *extended family*. Not understanding this distinction and the values inherent in these orientations may lead the family therapist to erroneous conclusions and decisions. Following is a case illustration of a young American Indian.

> *A young probationer was under court supervision and had strict orders to remain with responsible adults. His counselor became concerned because the youth appeared to ignore this order. The client moved around frequently and, according to the counselor, stayed overnight with several different young women. The counselor presented this case at a formal staff meeting, and fellow professionals stated their suspicion that the client was either a pusher or a pimp. The frustrating element to the counselor was that the young women knew each other and appeared to enjoy each other's company. Moreover, they were not ashamed to be seen together in public with the client. This behavior prompted the counselor to initiate violation proceedings.*
>
> *(Red Horse, Lewis, Feit, & Decker, 1981, p. 56)*

If an American Indian professional had not accidentally come upon this case, a revocation order initiated against the youngster would surely have caused irreparable alienation between the family and the social service agency. The counselor had failed to realize that the American Indian family network is structurally open and may include several households of relatives and friends along both vertical and horizontal lines. The young women were all first cousins to the client, and each was as a sister, with all the households representing different units of the family.

Likewise, African Americans have strong kinship bonds that may encompass both blood relatives and friends. Traditional African culture values the collective orientation over *individualism* (Franklin, 1988; Hines & Boyd - Franklin, 2005). This group identity has also been reinforced by what many African Americans describe as the sense of “peoplehood” developed as a result of the common experience of racism and discrimination. In a society that has historically attempted to destroy the Black family, near and distant relatives, neighbors, friends, and acquaintances have arisen in an *extended family* support network

(Black, 1996). Thus, the Black family may appear quite different from the ideal *nuclear family*. The danger is that certain assumptions made by a White therapist may be totally without merit or may be translated in such a way as to alienate or damage the self‐esteem of African Americans. For example, the absence of a father in the Black family does not necessarily mean that the children do not have a father figure. This function may be taken over by an uncle or male family friend.

We give one example here to illustrate that the moral evaluation of a behavior may depend on the value orientation of the cultural group: because of their collective orientation, Puerto Ricans view obligations to the family as primary over all other relationships (Garcia‐Preto, 2005). When a family member attains a position of power and influence, it is expected that he or she will favor his or her relatives over objective criteria. Businesses that are heavily weighted by family members and appointments of family members to government positions are not unusual in many countries. Failure to hire a family member may result in moral condemnation and family sanctions (Inclan, 1985). This is in marked contrast to what we ideally believe in the United States. Here, appointment of family members over objective criteria of individual achievement is condemned. It would appear that differences in the relationship dimension between the mental health provider and the minority family receiving services can cause great conflict. Although family therapy may be the treatment of choice for many minorities (over individual therapy), its values may again be antagonistic and detrimental to minorities. Family approaches that place heavy emphasis on *individualism* and freedom from the emotional field of the family may cause great harm. Our approach should be to identify how we might capitalize on collaterality to the benefit of minority families.

Activity Dimension

One of the primary characteristics of White U.S. cultural values and beliefs is an action (doing) orientation: (a) we must master and control nature; (b) we must always do things about a situation; and (c) we should take a pragmatic and utilitarian view of life. In counseling, we expect clients to master and control their own lives and environment, to take action to resolve their own problems, and to fight against bias and inaction. The doing mode is evident everywhere and is reflected in how White Americans identify themselves by what they *do* (occupations), how children are asked what they want to do when they grow up, and how a higher value is given to inventors over poets and to doctors of medicine over doctors of philosophy. An essay topic commonly given to schoolchildren returning to school in the fall is, “What I Did on My Summer Vacation.”

It appears that both American Indians and Latinx Americans prefer a being or being‐in‐becoming mode of activity. The American Indian concepts of self‐determination and noninterference are examples. Value is placed on the spiritual quality of being, as manifested in self‐containment, poise, and harmony with the universe. Value is placed on the attainment of inner fulfillment and an essential serenity of one's place in the universe. Because each person is fulfilling a purpose, no one should have the power to interfere or impose values. Often, those unfamiliar with American Indian values perceive them as stoic, aloof, passive, noncompetitive, or inactive. In working with families, the counselor role of active manipulator may clash with American Indian concept of being‐in‐becoming (noninterference).

Likewise, Latinx culture may be said to have a more here‐and‐now or being‐in‐becoming orientation. Like their American Indian counterparts, Hispanics believe that people are born with *dignidad* (dignity) and must be given *respeto* (respect). They are born with innate worth and importance; the inner soul and spirit are more important than the body.

People cannot be held accountable for their lot in life (status, role, etc.) because they are born into this life state (Inclan, 1985). A certain degree of *fatalismo* (fatalism) is present, and life events may be viewed as inevitable (*Lo que Dios manda*, “what God wills”). Philosophically, it does not matter what people have in life or what position they occupy (farm laborer, public official, or attorney). Status is possessed by existing, and everyone is entitled to *respeto*.

Since this belief system deemphasizes material accomplishments as a measure of success, it is clearly at odds with EuroAmerican middle‐class society. Although a doing‐oriented family may define a member's worth via achievement, a being orientation equates worth simply to belonging. Thus, when clients complain that someone is not an effective family member, what do they mean? This needs to be clarified by the therapist. Is it a complaint that the family member is not performing and achieving (doing), or does it mean that they are not respectful and accommodating to family structures and values (being)?

Ho (1987) describes both Asian Americans and African Americans as operating from the doing orientation. However, it appears that “doing” in these two groups is manifested differently than in the White American lifestyle. The active dimension in Asians is related not to individual achievement, but to achievement via conformity to family values and demands. Controlling one's own feelings, impulses, desires, and needs in order to fulfill responsibility to the family is strongly ingrained in Asian children. The doing orientation tends to be more ritualized in the roles of and responsibilities toward members of the family. African Americans also exercise considerable control in the face of adversity (endure the pain and suffering of racism) to minimize discrimination and to maximize success.

Nature of People Dimension

Middle‐class EuroAmericans generally perceive the nature of people as neutral. Environmental influences, such as conditioning, family upbringing, and socialization, are believed to be dominant forces in determining the nature of the person. People are neither good nor bad, but are a product of their environment. Although several minority groups may share features of this belief with Whites, there is a qualitative and quantitative difference that may affect family structure and dynamics. For example, Asian Americans and American Indians tend to emphasize the inherent goodness of people. We have already discussed the Native American concept of noninterference, which is based on the belief that people have an innate capacity to advance and grow (self‐fulfillment) and that problematic behaviors are the result of environmental influences that thwart the opportunity to develop. Goodness will always triumph over evil if a person is left alone. Likewise, Asian philosophy (Buddhism and Confucianism) believes in people's innate goodness and prescribes role relationships that manifest the “good way of life.” Central to Asian belief is the idea that the best healing source lies within the family (Daya, 2005; Walsh & Shapiro, 2006) and that seeking help from the outside (e.g., counseling and therapy) is nonproductive and against the dictates of Asian philosophy.

Latinx Americans may be described as holding the view that human nature is both good and bad (mixed). Concepts of *dignidad* and *respeto* undergird the belief that people are born with positive qualities. Yet, some Hispanics, such as Puerto Ricans, spend a great deal of time appealing to supernatural forces so that children may be blessed with a good human nature (Inclan, 1985). Thus, a child's “badness” may be accepted as destiny, so parents may be less inclined to seek help from educators or mental health professionals. The preferred mode of help may be religious consultations and venting to neighbors and friends who sympathize and understand the dilemma (change means reaching the supernatural forces).

African Americans may also be characterized as having a mixed concept of people, but in general they believe, like their White counterparts, that people are basically neutral. Environmental factors have a great influence on how people develop. This orientation is consistent with African American beliefs that racism, discrimination, oppression, and other external factors create problems for the individual. Emotional disorders and antisocial acts are caused by external forces (system variables) rather than by internal, intrapsychic, psychological forces. For example, high crime rates, poverty, and the current structure of the African American family are the result of the historical and current oppression of Black people.

White Western concepts of genetic inferiority and pathology (African American people are born that way) hold little validity for the Black person.

Video 7.6: Assumptions and Identity

Analysis of counseling session by Drs. Derald Wing Sue and Joel Filmore.

OVERGENERALIZING AND STEREOTYPING

Although it is critical for therapists to have a basic understanding of the generic characteristics of counseling and psychotherapy and the culture‐specific life values of different groups, overgeneralizing and stereotyping are ever‐present dangers. For example, the listing of racial/ethnic minority group variables does not indicate that all persons coming from the same minority group will share all or even some of these traits. Generalizations are necessary for us; without them, we would become inefficient creatures. However, they are guidelines for our behaviors, to be tentatively applied in new situations, and they should be open to change and challenge. The information provided in Tables 7.1 and 7.2 should act as guidelines rather than absolutes. These generalizations should serve as the background from which the figure emerges.

IMPLICATIONS FOR CLINICAL PRACTICE

1. Become cognizant of the generic characteristics of counseling and psychotherapy: *culture‐bound values*, *class‐bound values*, and linguistic factors.
2. Know that we are increasingly becoming a multilingual nation and that the linguistic demands of clinical work may place minority populations at a disadvantage.
3. Consider the need to provide community counseling services that reach out to the minority population.
4. Realize that the problems and concerns of many groups of color are related to systemic and external forces rather than to internal psychological problems (Chavez, Fernandez, Hipolito‐Delgado, & Rivera, 2016).
5. Know that our increasing diversity presents us with different cultural conceptions of the family. One definition cannot be seen as superior to another.
6. Realize that families cannot be understood apart from the cultural, social, and political dimensions of their functioning. The traditional definition of the *nuclear family* as consisting of heterosexual parents in a long‐term marriage, raising their biological children, and having the father as sole wage earner now refers to a statistical minority.
7. Be careful not to overgeneralize or stereotype. Knowing general group characteristics and guidelines is different from rigidly holding on to preconceived notions.

Video 7.7: Limitation of Stereotypes

Introduction to counseling session by Dr. Joel Filmore.

Video Lecture: Overcoming Barriers to Effective Multicultural Counseling and Therapy

SUMMARY

Theories of counseling and psychotherapy are influenced by assumptions that theorists make regarding the goals for therapy, the method used to invoke change, and the definition of mental health and illness. Counseling and psychotherapy have traditionally been conceptualized in Western individualistic terms that may lead to premature termination of counseling and underutilization of mental health services by marginalized groups in our society. The *culture‐bound values* that may prove antagonistic to members of diverse groups include the following: focus on the individual, verbal/emotional/behavioral expressiveness, *insight* orientation, self‐disclosure, *scientific empiricism*, separation of mental and physical functioning, and pattern of communication.

In addition to this category, both *class‐bound values* and linguistic factors may prove biased against culturally diverse groups. For the therapist who comes from a middle‐ to upper‐class background, it is often difficult to relate to the circumstances and hardships affecting the client who lives in poverty. The phenomenon of poverty and its effects on individuals and institutions can be devastating. Use of Standard English in health care delivery may also unfairly discriminate against those from a bilingual or lower socioeconomic background, leading to devastating consequences. The lack of bilingual therapists and the requirement that the client communicate in English may limit progress in counseling and therapy. If bilingual individuals do not use their native tongue, many aspects of their emotional experience may not be available for treatment.

Family systems theory, while seemingly consistent with the collectivistic orientation of many diverse groups, may be equally culture‐bound, as may be manifested in marital or couple counseling, parent–child counseling, or work with more than one member of a family. For example, the following Western beliefs and assumptions about healthy families may be incongruent with diverse groups: (a) allow and encourage the free and open expression of emotion; (b) view each family member as having a right to be his or her own unique self; (c) strive for an equal division of labor among family members; (d) consider *egalitarian role* relationships between spouses desirable; and (e) hold the *nuclear family* as the standard. Especially useful for counselors to explore is the Kluckholn and Strodtbeck (1961) model of “American” cultural patterns and their manifestation in five dimensions: people–nature relationship, time orientation, relational focus, activity, and nature of people.

GLOSSARY TERMS

- Activity dimension
- Biculturalism
- Class - bound values
- Collectivism
- Culture - bound values
- Egalitarian roles
- Emotional expressiveness
- Extended families
- Family systems
- Individual - centered
- Individualism
- Insight
- Linguistic barriers
- Minority standard time
- Nature of people dimension
- Nuclear families
- Patriarchal roles
- Relational dimension
- Scientific empiricism
- Self - disclosure
- Social class
- Time dimension
- YAVIS syndrome

Video 7.8: Counseling Session Analysis

Clients from different cultures may adhere to generalized roles. But it is important to follow your clients' lead to determine the most appropriate way to interact with them during the counseling session.

REFERENCES

1. Allen, G. K., Kim, B. S., Smith, T. B., & Hafoka, O. (2016). Counseling attitudes and stigma among Polynesian Americans. *The Counseling Psychologist, 44*(1), 6–27.

2. American Psychological Association (APA) Task Force on Socioeconomic Status (2007). *Report of the APA Task Force on Socioeconomic Status*. Washington, DC: American Psychological Association.

3. Antony, M. M., & Roemer, L. (2011). *Behavior therapy*. Washington, DC: American Psychological Association.

4. Arredondo, P., Gallardo‐Cooper, M., Delgado‐Romero, E. A., & Zapata, A. L. (2014). *Culturally responsive counseling with Latinas/os*. Alexandria, VA: American Counseling Association.

5. Atkinson, D. R., Morten, G., & Sue, D. W. (1998). A minority identity development model. In D. R. Atkinson, G. Morten, & D. W. Sue (Eds.), *Counseling American minorities* (pp. 35–52). Dubuque, IA: W. C. Brown.

6. Black, L. (1996). Families of African origin: An overview. In M. McGoldrick, J. Giordano, & J. K. Pearce (Eds.), *Ethnicity and family therapy* (pp. 57–65). New York, NY: Guilford Press.

7. Burke, G. (2005). Translating isn't kid stuff. *San Jose Mercury News*, October 24.

8. Chang, C. Y., McDonald, C. P., & O'Hara, C. (2014). Counseling clients from Asian and Pacific Island heritages. In M. J. Ratts, & P. B. Pedersen (Eds.), *Counseling for multiculturalism and social justice* (pp. 127–142). Alexandria, VA: American Counseling Association.

9. Chávez, T. A., Fernandez, I. T., Hipolito‐Delgado, C. P., & Rivera, E. T. (2016). Unifying liberation psychology and humanistic values to promote social justice in counseling. *Journal of Humanistic Counseling*, *55*, 166–182.

10. Chen, E., Matthews, K. A., & Boyce, W. T. (2002). Socioeconomic differences in children's health: How and why do these relationships change with age? *Psychological Bulletin*, *128*, 295–329.

11. Coleman, J. (2003). Bill would ban using children as interpreters. *San Jose Mercury News*, April 2.

12. Corey, G. (2013). *Theory and practice of counseling and psychotherapy* (9th ed.). Belmont, CA: Brooks/Cole.

13. Craske, M. G. (2010). *Cognitive‐behavioral therapy*. Washington, DC: American Psychological Association.

14. Daya, R. (2005). Buddhist moments in psychotherapy. In R. Moodley, & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 182–193). Thousand Oaks, CA: Sage.

15. Franklin, J. H. (1988). A historical note on black families. In H. P. McAdoo (Ed.), *Black families* (pp. 3–14). Newbury Park, CA: Sage.

16. Gallo, L. C., & Matthews, K. A. (2003). Understanding the association between socioeconomic status and physical health: Do negative emotions play a role? *Psychological Bulletin*, *129*, 10–51.

17. Garcia‐Preto, N. (1996). Puerto Rican families. In M. McGoldrick, J. Giordano, & J. K. Pearce (Eds.), *Ethnicity and family therapy* (pp. 183–199). New York, NY: Guilford Press.

18. Garcia‐Preto, N. (2005). Puerto Rican families. In M. McGoldrick, J. Giordano, & N. Garcia‐Preto (Eds.), *Ethnicity and family therapy* (2nd ed.) (pp. 242–255). New York, NY: Guilford Press.

19. Garrett, M. T., & Portman, T. A. A. (2011). *Counseling native Americans*. Belmont, CA: Cengage.

20. Gottesfeld, H. (1995). Community context and the underutilization of mental health services by minority patients. *Psychological Reports*, *76*, 207–210.

21. Guzman, M. R., & Carrasco, N. (2011). *Counseling Latino/a Americans*. Belmont, CA: Cengage.

22. Hackman, R. (2016). Your therapist is white. You're not. Is that a problem? *Guardian*, May 28.

23. Hines, P. M., & Boyd‐Franklin, N. (2005). African American families. In M. McGoldrick, J. Giordano, & N. Garcia‐Preto (Eds.), *Ethnicity and family therapy* (2nd ed.) (pp. 87–100). New York, NY: Guilford Press.

24. Ho, M. K. (1987). *Family therapy with ethnic minorities*. Newbury Park, CA: Sage.

25. Inclan, J. (1985). Variations in value orientations in mental health work with Puerto Ricans. *Psychotherapy*, *22*, 324–334.

26. Ivey, A. E., Ivey, M., Myers, J., & Sweeney, T. (2005). *Developmental counseling and therapy*. Boston, MA: Lahaska.

27. Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2014). *Intentional interviewing and counseling* (8th ed.). Belmont, CA: Brooks/Cole.

28. Jourard, S. M. (1964). *The transparent self*. Princeton, NJ: Van Nostrand.

29. Katz, J. (1985). The sociopolitical nature of counseling. *The Counseling Psychologist*, *13*, 615–624.

30. Kluckhohn, F. R., & Strodtbeck, F. L. (1961). *Variations in value orientations*. Evanston, IL: Row, Patterson.

31. Lee, S. D., & Temerlin, M. K. (1970). Social class, diagnosis, and prognosis for psychotherapy. *Psychotherapy: Theory, Research, and Practice*, *7*, 181–185.

32. Leong, F. T. L., Wagner, N. S., & Kim, H. H. (1995). Group counseling expectations among Asian American students: The role of culture‐specific factors. *Journal of Counseling Psychology*, *42*, 217–222.

33. Levenson, H. (2010). *Brief dynamic therapy*. Washington, DC: American Psychological Association.

34. Liu, W. M., Hernandez, J., Mahmood, A., & Stinson, R. (2006). Linking poverty,

classism, and racism in mental health: Overcoming barriers to multicultural competency. In M. G. Con‐stantine, & D. W. Sue (Eds.), *Addressing racism* (pp. 65–86). Hoboken, NJ: Wiley.

35. Lorant, V., Deliege, D., Eaton, W., Robert, A., Philippot, P., & Ansseau, M. (2003). Socioeconomic inequalities in depression: A meta‐analysis. *American Journal of Epidemiology*, *157*, 98–112.

36. Lorion, R. P. (1973). Socioeconomic status and treatment approaches reconsidered. *Psychological Bulletin*, *79*, 263–280.

37. Lorion, R. P. (1974). Patient and therapist variables in the treatment of low‐income patients. *Psychological Bulletin*, *81*, 344–354.

38. Lott, B. (2002). Cognitive and behavioral distancing from the poor. *American Psychologist*, *57*, 100–110.

39. Lui, M., Robles, B., Leondar‐Wright, B., Brewer, R., & Adamson, R. (2006). *The color of wealth*. New York, NY: United For A Fair Economy.

40. McGoldrick, M., Giordano, J., & Garcia‐Preto, N. (2005). *Ethnicity and family therapy*. New York, NY: Guilford Press.

41. Moodley, R., & West, W. (Eds.) (2005). *Integrating traditional healing practices into counseling and psychotherapy*. Thousand Oaks, CA: Sage.

42. National Council on Interpreting in Health Care (2005). *National standards of practice for interpreters in health care*. Santa Rosa, CA: National Council on Interpreting in Health Care.

43. Neighbors, H. W., Caldwell, C. H., Thompson, E., & Jackson, J. S. (1994). Help‐seeking behavior and unmet need. In S. Friedman (Ed.), *Disorders in African Americans* (pp. 26–39). New York, NY: Springer.

44. Ngo‐Metzger, Q., Massagli, M. P., Clarridge, B. R., Manocchia, M., Davis, R. B., Iezzoni, L. I., & Phillips, R. S. (2003). Linguistic and cultural barriers to care: Perspectives of Chinese and Vietnamese immigrants. *Journal of General Internal Medicine*, *18*, 44–52.

45. Parham, T. A., Ajamu, A., & White, J. L. (2011). *The psychology of Blacks: Centering our perspectives in the African consciousness*. Boston, MA: Prentice Hall.

46. Pedersen, P. B., & Pope, M. (2010). Inclusive cultural empathy for successful global leadership. *American Psychologist*, *65*, 841–854.

47. Ponterotto, J. G., Utsey, S. O., & Pedersen, P. B. (2006). *Preventing prejudice: A guide for counselors, educators, and parents*. Thousand Oaks, CA: Sage.

48. Ratts, M. J., & Pedersen, P. B. (2014). *Counseling for multiculturalism and social justice*. Alexandria, VA: American Counseling Association.

49. Red Horse, J. G., Lewis, R., Feit, M., & Decker, J. (1981). Family structure and value orientation in American Indians. In R. H. Dana (Ed.), *Human services for cultural minorities*. Baltimore, MD: University Park Press.

50. Reed, R., & Smith, L. (2014). A social justice perspective on counseling and poverty. In M. J. Ratts, & P. B. Pedersen (Eds.), *Counseling for multiculturalism and social*

justice (pp. 259–273). Alexandria, VA: American Counseling Association.

51. Schindler‐Rainman, E. (1967). The poor and the PTA. *PTA Magazine*, *61*(8), 4–5.

52. Schnitzer, P. K. (1996). “They don't come in!”: Stories told, lessons taught about poor families in therapy. *American Journal of Orthopsychiatry*, *66*(4), 572.

53. Schofield, W. (1964). *Psychotherapy: The purchase of friendship*. Englewood Cliffs, NJ: Prentice Hall.

54. Schwartz, A., Rodriguez, M. M., Santiago‐Rivera, A. L., Arredondo, P., & Field, L. D. (2010). Cultural and linguistic competence: Welcome challenges from successful diversification. *Professional Psychology: Research and Practice*, *41*, 210–220.

55. Semega, J.L., Fontenot, K. R., & Kollar, M.A. (2017). Income and poverty in the United States: 2016. Retrieved from https://www.census.gov/library/publications/2017/demo/p60‐259.html

56. Shin, R. Q., Smith, L. C., Welch, J. C., & Ezeofor, I. (2016). Is Allison more likely than Lakisha to receive a callback from counseling professionals? A racism audit study. *The Counseling Psychologist*, *44*(8), 1187–1211.

57. Smith, L. (2010). *Psychology, poverty, and the end of social exclusion*. New York, NY: Teachers College Press.

58. Smith, L. (2013). Counseling and poverty. In D. W. Sue, & D. Sue (Eds.), *Counseling the culturally diverse: Theory and practice* (6th ed.) (pp. 517–526). Hoboken, NJ: Wiley.

59. Smith, L., & Redington, R. M. (2010). Class dismissed: Making the case for the study of classist microaggressions. In D. W. Sue (Ed.), *Microaggressions and marginality: Manifestation, dynamics, and impact* (pp. 269–285). Hoboken, NJ: Wiley.

60. Smith, L., Mao, S., Perkins, S., & Ampuero, M. (2011). The relationship of clients' social class to early therapeutic impressions. *Counselling Psychology Quarterly*, *24*(1), 15–27.

61. Stein, L. S., Green, B. L., & Stone, W. N. (1972). Therapist attitudes as influenced by A‐B therapist type, patient diagnosis, and social class. *Journal of Consulting and Clinical Psychology*, *39*, 301–307.

62. Sue, D. W. (2015). Therapeutic harm and cultural oppression. *Counseling Psychologist*, *43*(3), 359–369.

63. Sutton, C. T., & Broken Nose, M. A. (2005). American Indian families: An overview. In M. McGoldrick, J. Giordano, & N. Garcia‐Preto (Eds.), *Ethnicity and family therapy* (pp. 43–54). New York, NY: Guilford Press.

64. Thomason, T. C. (2014). Counseling native Americans and social justice. In M. J. Ratts, & P. B. Pedersen (Eds.), *Counseling for multiculturalism and social justice* (2nd ed.) (pp. 157–177). Alexandria, VA: American Counseling Association.

65. Torres‐Rivera, E., & Ratts, M. J. (2014). Counseling Latino/as from a social justice perspective. In M. J. Ratts, & P. B. Pedersen (Eds.), *Counseling for multiculturalism and social justice* (pp. 179–192). Alexandria, VA: American Counseling Association.

66. U.S. Census Bureau (2017). Facts for Features: American Indian and Alaska Native

Heritage Month. Retrieved from https://www.census.gov/newsroom/facts-for-features/2017/aian-month.html

67. Utsey, S. O., Walker, R. L., & Kwate, N. O. A. (2005). Conducting quantitative research in a cultural context. In M. G. Constantine, & D. W. Sue (Eds.), *Strategies for building multicultural competence in mental health and educational settings* (pp. 247–268). Hoboken, NJ: Wiley.

68. Vedantam, S. (2005). Patients' diversity is often discounted. *Washington Post*, June 6.

69. Walsh, R., & Shapiro, S. L. (2006). The meeting of meditative disciplines and Western psychology. *American Psychologist*, *61*, 227–239.

70. Wang, S. Y., Wong, Y. J., & Yeh, K. H. (2016). Relationship harmony, dialectical coping, and nonattachment: Chinese indigenous well-being and mental health. *The Counseling Psychologist*, *44*(1), 78–108.

71. Wood, P. S., & Mallinckrodt, B. (1990). Culturally sensitive assertiveness training for ethnic minority clients. *Professional Psychology: Research & Practice*, *21*, 5–11.

8
Communication Style and Its Impact on Counseling and Psychotherapy

Chapter Objectives

1. **1. Compare and contrast styles of communication between various racial/ethnic and other sociodemographic groups.**
2. **2. Define and recognize *nonverbal* communications and their cultural meanings.**
3. **3. Acquire knowledge and understandings of how counseling styles and roles may create barriers to effective multicultural counseling.**
4. **4. List several ways how *nonverbal communication* can (a) trigger off racial biases and fears and (b) reflect our true beliefs and feelings.**
5. **5. Describe differences in how *proxemics, kinesics, paralanguage,* and *high/low - context communication* are likely to affect communication.**
6. **6. Learn how different theories of counseling and psychotherapy can be distinguished by their communication or helping styles.**
7. **7. Explain the implications *communication styles* have for therapeutic intervention techniques.**

“Why are you so loud?”

“You need to calm down.”

“Why are you upset?”

These are all comments I have had said to me from non - Black people when I wasn't yelling, I felt pretty calm, and I wasn't upset. When I was young, these questions came as a surprise. I didn't understand how my own perception of myself could be so different from a person in the same space as me. It was alarming to think that I was unintentionally making people uncomfortable with my communication style.

(Bowen, 2017, para. 1)

It's important to note that just because communications are indirect does not mean the message is unclear … for indirect communicators, it IS clear. They pick up on the context and get the message, it's just that direct communicators are not observant enough to catch it. I was surprised to hear that my friends [who used an] accommodating communication style sometimes found direct communicators paternalistic. If someone is too direct, it's like “I understand you perfectly, you don't need to explain it like I'm five”

(Aston, 2017, para. 32)

It would be weeks of replaying that conversation (over and over again in my head) before I would pick up the phone and call [the therapist's] office … I told you about me, my struggles and how I was feeling inside. You sat there in your expensive clothing, your perfectly decorated office, and smiled at me the entire time. When I finished being open, vulnerable and raw, you said words that would haunt me to this day: “You seem like a strong Black woman, and found ways to cope. I'm proud of you. Please come back if you feel like life is too much to handle” … Why didn't you hear me? Why didn't you acknowledge the internal battle between me, my culture and my faith that I had to overcome? Why didn't you see all of me? Why did you ignore the tears that streamed down my cheeks? Why didn't you know that I had had enough of being “strong?”

(Cooper, 2017, para. 5)

“You're always moderating yourself,” [says] a Latina executive, who feels Latinas “are always tagged with the emotional thing. They're always told, ‘Calm down. You've got to be more cool. Be careful with your voice, be careful with your hands’.” Hispanic men echo her observations. One ruefully told of moving from a Hispanic‐dominated company, where he could gesture eloquently and speak passionately, to a Caucasian workplace where he had to “scale back” his expressiveness.

(Hewlett, Allwood, and Sherbin, 2016)

Asian cultures generally don't have a huge vocabulary for feelings or value them highly in the first place; we simply aren't encouraged to pay attention to them. Thus, many of us have limited awareness of our emotional experiences, let alone words to describe them. On top of that, talking about yourself is generally viewed as immodest in Asian cultures, which place a high premium on modesty. Through that lens, making regular appointments to talk about yourself seems self‐indulgent at worst and uncomfortable at best. The hurdles don't end there. Asian cultures tend to be vastly different than the Western ones from which most therapists, and the process of therapy itself, originated. In some regards, such as the emphasis on the individual vs. the group, the cultures are diametrically opposed. Thus, there's often a fear that cultural issues will be misunderstood or pathologized in therapy. (These fears are not unwarranted; the field has an embarrassing history of misinterpreting cultural nuances as personal shortcomings.)

(Lin, 2014, para. 32)

REFLECTION AND DISCUSSION QUESTIONS

1. Based on what you've learned thus far, discuss the connections between culture, historical/sociopolitical factors, and the communication impasses mentioned in these examples.
2. How can you imagine similar impasses playing out in a session between a therapist and a client?
3. What might their effect be on the client? On the therapist? On the treatment?

As we discussed in the previous chapter, cultural differences can act as barriers between therapists and clients when therapists lack multicultural awareness and skills. Culture‐related communication barriers are among the most relevant of these pitfalls for counselors, given that verbal communication is the basic vehicle by which counseling and therapy take place. In this chapter, we focus upon the essential elements of verbal and nonverbal communication, their relationships to culture, and the implications for mental health professionals.

Video 8.0: Introduction

The clinician can use testing as a way of gathering information about their client's boundaries without having to verbalize or ask direct questions. This can be effective when working with international clients.

COMMUNICATION STYLES

Effective helping depends on the counselor and the client being able to send and receive both verbal and nonverbal messages accurately and appropriately. It requires that the counselor not only *sends* messages (makes themself understood) but also *receives* messages (attends to clients). The definition of effective counseling also includes *verbal* (content of what is said) and *nonverbal* (how something is said) elements. Most counselors seem more concerned with the *accuracy* of communication (getting to the heart of the matter) than with whether their communication is *appropriate*. Moreover, the preceding examples illustrate the potential for therapists to completely miss the essence of their clients' communications when they do not appreciate the ways that their own assumptions and blind spots interact with clients' cultural backgrounds and experiences. In most cases, therapists have been trained to tune in to the content of what is said rather than to how something is said.

Communication style refers to those factors that go beyond the content of what is said. Communication specialists have historically found that only 30–40% of what is communicated conversationally is verbal (Ramsey & Birk, 1983; Singelis, 1994). What people say and do is usually qualified by other things that they say and do. A gesture, tone, inflection, posture, or degree of eye contact may enhance or negate the content of a message. *Communication styles* have a tremendous impact on our face‐to‐face encounters with others (Geva & Wiener, 2015). Whether our conversation proceeds in fits and starts, whether we interrupt one another continually or proceed smoothly, the topics we prefer to discuss or avoid, the depth of our involvement, the forms of interaction (e.g., ritual, repartee, argumentative, persuasive), and the channel we use to communicate (verbal–nonverbal versus nonverbal–verbal) are all aspects of *communication style*. Some refer to these factors as the *social rhythms* that underlie all our speech and actions. *Communication styles* are strongly correlated with race, culture, and ethnicity (Garrett & Portman, 2011; Ivey, Ivey, & Zalaquett, 2014); gender has been found to be a powerful determinant of *communication style* as well (Pearson, 1985; Robinson & Howard‐Hamilton, 2000).

Reared in a EuroAmerican middle‐class society, mental health professionals may assume that certain behaviors or rules of speaking are universal and possess the same meaning. This may create major problems for therapists and clients of varying cultural backgrounds. Since differences in *communication style* are strongly manifested in *nonverbal communication*, this chapter concentrates on those aspects of communication that transcend the written or spoken word. First, we explore how race/culture may influence several areas of nonverbal behavior: (a) *proxemics*, (b) *kinesics*, (c) *paralanguage*, and (d) *high/low‐context communication*. Second, we briefly discuss the function and importance of nonverbal behavior as it relates to the stereotypes and preconceived notions that we may have of diverse groups. Last, we propose a basic thesis that various racial minorities, such as Asian Americans, American Indians, African Americans, Arab Americans, and Latinx Americans, possess unique *communication styles* that may have major implications for mental health practice.

Nonverbal Communication

Although language, class, and cultural factors all interact to create problems in communication between culturally diverse clients and therapists, an oft neglected area is nonverbal behavior (Duran, 2006; Singelis, 1994). What people say can be either enhanced or negated by their nonverbals. When a man raises his voice, tightens his facial muscles, pounds the table violently, and proclaims, “Goddamn it, I'm not angry!”, he is clearly contradicting the content of his communication. If we all share the same cultural and social upbringing, we

may all arrive at the same conclusion. Interpreting nonverbals, however, is difficult for several reasons. First, the same nonverbal behavior on the part of an American Indian client may mean something quite different than if it were enacted by a White person (Locke & Bailey, 2014; Garrett & Portman, 2011). Second, nonverbals often occur outside our level of awareness but influence our evaluation and behavior. It is important to note that our discussion of nonverbal codes will not include all possible areas, like olfaction (taste and smell), tactile cues, and artifactual communication (clothing, hairstyle, display of material things, etc.).

Proxemics

The study of *proxemics* refers to perception and the use of personal and interpersonal space. Clear norms exist concerning the use of physical distance in social interactions. Edward Hall (1959) identified four interpersonal distance zones characteristic of U.S. culture: *intimate*, from contact to 1.5 ft.; *personal*, from 1.5 to 4 ft.; *social*, from 4 to 12 ft.; and *public* (lectures and speeches), greater than 12 ft.

In our society, individuals seem to grow uncomfortable when others stand too close rather than too far away. The range of feelings and reactions associated with a violation of personal space includes flight, withdrawal, anger, and conflict (Pearson, 1985). On the other hand, we tend to allow closer proximity to people whom we like or feel interpersonal attraction toward. Some evidence exists that personal space can be reframed in terms of dominance and status. Those with greater status, prestige, and power may occupy more space (larger homes, cars, or offices).

However, different cultures dictate different distances in personal space. For many Latinx Americans, Africans, Black Americans, Indonesians, Arabs, South Americans, and French, conversing with a person allows for a much closer stance than is normally comfortable for EuroAmericans (Jensen, 1985; Nydell, 1996). A Latinx American client's closeness may cause the therapist to back away. The client may interpret this as aloofness, coldness, or a desire not to communicate on the part of the therapist. In some cross‐cultural encounters, it may even be perceived as a sign of haughtiness and superiority. On the other hand, the therapist may misinterpret the client's behavior as an attempt to become inappropriately intimate, a sign of pushiness or aggressiveness. Both therapists and culturally diverse clients may benefit from understanding that their reactions and behaviors are attempts to create the spatial dimension to which they are culturally conditioned.

Research on *proxemics* leads to the inevitable conclusion that conversational distances are functions of the racial and cultural backgrounds of the conversants (Mindess, 1999; Susman & Rosenfeld, 1982; Wolfgang, 1985). The factor of personal space has major implications for how furniture is arranged, where seats are located, and where and how far apart therapists and clients sit. Latinx Americans, for example, may not feel comfortable speaking to a person behind a desk. Many EuroAmericans, however, like to keep a desk between themselves and others. Some Inuit may actually prefer to sit side by side rather than across from one another when talking about intimate aspects of their lives.

Kinesics

Whereas *proxemics* refers to personal space, *kinesics* is the term used to refer to bodily movements. It includes such things as facial expression, posture, characteristics of movement, gestures, and eye contact. Again, *kinesics* appears to be culturally conditioned. Many of our counseling assessments are based upon expressions on people's faces. We assume that facial cues express emotions and demonstrate the degree of responsiveness or involvement of the

individual. For example, smiling is a type of expression in our society that is believed to indicate liking or positive affect. People attribute greater positive characteristics to others who smile; they see them as intelligent, have a good personality, and are pleasant (Singelis, 1994).

On the other hand, some Asians believe that smiling may suggest other meanings or even weakness. When Japanese smile and laugh, it does not necessarily indicate happiness but may convey other meanings (e.g., embarrassment, discomfort, shyness). Among some Chinese and Japanese, restraint of strong feelings (anger, irritation, sadness, and love or happiness) is considered to be a sign of maturity and wisdom. Children learn that outward emotional displays (facial expressions, body movements, and verbal content) are discouraged except in extreme situations. Unenlightened counselors may assume that their Asian American client is lacking in feelings or is out of touch with them. Alternatively, the lack of facial expressions may be the basis of stereotypes, such as the idea that Asians are “inscrutable,” “sneaky,” “deceptive,” and “backstabbing.”

A number of gestures and bodily movements have been found to have different meanings when the cultural context is considered (LaBarre, 1985). In the Sung Dynasty in China, sticking out the tongue was a gesture of mock terror and meant as ridicule; to the Ovimbundu of Africa, it means “You're a fool” (when coupled with bending the head forward); a protruding tongue in the Mayan statues of gods signifies wisdom; and in U.S. culture, it is generally considered to be a juvenile, quasi‐obscene gesture of defiance, mockery, or contempt.

Head movements also have different meanings (Eakins & Eakins, 1985; Jensen, 1985). An educated Englishman may consider the lifting of the chin when conversing as a poised and polite gesture, but to EuroAmericans it may connote snobbery and arrogance (“turning up one's nose”). Whereas we shake our head from side to side to indicate “no,” Mayan tribe members say “no” by jerking the head to the right. In Sri Lanka, one signals agreement by moving the head from side to side like a metronome (Singelis, 1994).

Most EuroAmericans perceive squatting (often done by children) as improper and childish. In other parts of the world, people have learned to rest by taking a squatting position. On the other hand, when we put our feet up on a desk, it is believed to signify a relaxed and informal attitude. Yet, Latinx Americans and Asians may perceive it as rudeness and arrogance, especially if the bottoms of the feet are shown to them.

Shaking hands is another gesture that varies from culture to culture and may have strong cultural/historical significance. Latinx Americans tend to shake hands more vigorously, frequently, and for a longer period of time. Interestingly, most cultures use the right hand when shaking. Since most of the population of the world is right‐handed, this may not be surprising. However, some researchers believe that shaking with the right hand may be a symbolic act of peace, as in older times it was the right hand that generally held the weapons. In some Muslim and Asian countries, touching anyone with the left hand may be considered an obscenity (the left hand aids in the process of elimination and is “unclean,” whereas the right one is used for the intake of food and is “clean”). Offering something with the left hand to a Muslim may be an insult of the most serious type.

Eye contact is, perhaps, the nonverbal behavior most likely to be addressed by mental health providers. It is not unusual for us to hear someone say, “Notice that the husband avoided eye contact with the wife,” or “Notice how the client averted his eyes when…” Behind these observations is the belief that eye contact or lack of eye contact has diagnostic significance. We would agree with that premise, but in most cases, counselors attribute negative traits to

the avoidance of eye contact: shy, unassertive, sneaky, or depressed.

This lack of understanding has been played out in many different situations when Black–White interactions have occurred. In many cases, it is not necessary for Blacks to look one another in the eye at all times when communicating. An African American may be actively involved in doing other things when engaged in a conversation. Many White therapists are prone to view the African American client as being sullen, resistant, or uncooperative. Smith (1981, p. 155) provides an excellent example of such a clash in communication styles.

> *For instance, one Black female student was sent to the office by her gymnasium teacher because the student was said to display insolent behavior. When the student was asked to give her version of the incident, she replied, "Mrs. X asked all of us to come over to the side of the pool so that she could show us how to do the backstroke. I went over with the rest of the girls. Then Mrs. X started yelling at me and said I wasn't paying attention to her because I wasn't looking directly at her. I told her I was paying attention to her (throughout the conversation, the student kept her head down, avoiding the principal's eyes), and then she said that she wanted me to face her and look her squarely in the eye like the rest of the girls [who were all White]. So I did. The next thing I knew she was telling me to get out of the pool, that she didn't like the way I was looking at her. So that's why I'm here."*

As this example illustrates, African American styles of communication not only may be different from those of their White counterparts but also may lead to misinterpretations. Many Blacks do not nod their heads or say "uh - huh" to indicate that they are listening (Hall, 1976; Kochman, 1981). Statistics indicate that when White U.S. Americans listen to a speaker, they make eye contact with them about 80% of the time. When speaking to others, however, they tend to look away (avoid eye contact) about 50% of the time. This is in marked contrast to many African Americans, who make greater eye contact when speaking and make infrequent eye contact when listening!

Paralanguage

The term *paralanguage* is used to refer to other vocal cues that individuals use to communicate. For example, loudness of voice, pauses, silences, hesitations, rate of speech, inflections, and the like all fall into this category. *Paralanguage* is very likely to be manifested forcefully in conversation conventions such as how we greet and address others and how we take turns in speaking. It can communicate a variety of different features about a person, such as their age, gender, sex, race, and emotional responses.

There are complex rules regarding when to speak and when to yield to another. For example, EuroAmericans frequently feel uncomfortable with a pause or silent stretch in the conversation, feeling obligated to fill it with more talk. However, silence is not always a sign for the listener to take up the conversation. While it may be viewed negatively by many, other cultures interpret it differently. The British and Arabs use silence for privacy, while the Russians, French, and Spanish read it as agreement among the parties (Hall, 1976). In Asian culture, silence is traditionally a sign of respect for elders. Furthermore, silence by many Chinese and Japanese is not a floor - yielding signal inviting others to pick up the conversation. Rather, it may indicate a desire to continue speaking after making a particular point. Often silence is a sign of politeness and respect rather than a lack of desire to continue speaking.

The amount of verbal expressiveness in the United States, relative to other cultures, is quite high. Most EuroAmericans encourage their children to enter freely into conversations, and

teachers encourage students to ask many questions and state their thoughts and opinions. This has led many from other countries to observe that EuroAmerican youngsters are brash, immodest, rude, and disrespectful (Irvine & York, 1995; Jensen, 1985). Likewise, teachers of children of color may see reticence in speaking out as a sign of ignorance, lack of motivation, or ineffective teaching (Banks & Banks, 1993), when in reality the students may be showing proper respect (to ask questions is disrespectful because it implies that the teacher was unclear). American Indians, for example, have been taught that to speak out, ask questions, or even raise one's hand in class is immodest.

A mental health professional who is uncomfortable with silence or who misinterprets it may fill in the conversation and prevent the client from elaborating. An even greater danger is to impute incorrect motives to the minority client's silence. One can readily see how therapy, which emphasizes talking, may place many minorities at a disadvantage.

Volume and intensity of speech in conversation are also influenced by cultural values. The overall loudness of speech displayed by many EuroAmerican visitors to foreign countries has earned them the reputation of being boisterous and shameless. In Asian countries, people tend to speak more softly and would interpret the loud volume of a U.S. visitor as a sign of aggressiveness, loss of self‐control, or anger. When compared to Arabs, however, people in the United States are soft‐spoken. Many Arabs like to be bathed in sound, and the volume of their radios, DVDs, and televisions is quite loud. In some countries where such entertainment units are not plentiful, it is considered a polite and thoughtful act to allow neighbors to hear by keeping the volume high. We in the United States would view such behavior as being a thoughtless invasion of privacy.

A therapist or counselor working with clients would be well advised to be aware of possible cultural misinterpretations as a function of speech volume. Speaking loudly may not indicate anger and hostility, and speaking in a soft voice may not be a sign of weakness, shyness, or depression.

The directness of a conversation or the degree of frankness also varies considerably among various cultural groups. Observing the British in their parliamentary debates will drive this point home. The long heritage of open, direct, and frank confrontation leads to heckling of public speakers and quite blunt and sharp exchanges. Britons believe and feel that these are acceptable styles and may take no offense at being the object of such exchanges. However, U.S. citizens feel that such exchanges are impolite, abrasive, and irrational. Relative to Asians, EuroAmericans are seen as being too blunt and frank. Great care is taken by many Asians not to hurt others' feelings or embarrass them. As a result, use of euphemisms and ambiguity is the norm.

Since many groups of color may value indirectness, the U.S. emphasis on “getting to the point” and “not beating around the bush” may alienate them. Asian Americans, American Indians, and some Latinx Americans can see this behavior as immature, rude, and lacking in finesse. On the other hand, they may themselves be negatively labeled as evasive and afraid to confront the problem.

REFLECTION AND DISCUSSION QUESTIONS

1. How can *proxemics* affect conversation distances and the use of personal space in therapy with culturally diverse clients?
2. When conversing with others, how aware are you of using your hands to talk, making

eye contact, smiling or frowning, and other bodily movements?

3. Why is awareness of *kinesics* important in therapy?
4. Are you loud or soft - spoken? Do you speak quickly or slowly? When you are speaking to a person and there is a pause in the conversation, are you comfortable or uncomfortable? Does silence bother you in counseling? How do you define a silent period: one second, two seconds, three seconds, or a minute? How might differences in *paralanguage* play out in the counseling session?

High/Low - Context Communication

Edward Hall, author of such classics as *The Silent Language* (1959) and *The Hidden Dimension* (1969), is a well - known anthropologist who has proposed the concept of *high* - and *low* - *context cultures* (Hall, 1976). A *high* - *context* (HC) communication or message is one that is anchored in the physical context (situation) or internalized in the person. Less reliance is placed on the explicit code or message content. An HC communication relies heavily on nonverbals and the group identification/understanding shared by those communicating. For example, a normal - stressed "no" by a EuroAmerican might be interpreted by an Arab as a "yes." A real negation in Arab culture would be stressed much more emphatically. In Filipino culture, a mild, hesitant "yes" is interpreted by those who understand as a "no" or a polite refusal. In traditional Asian society, many interactions are understandable only in light of HC cues and situations. For example, to extend an invitation for dinner only once would be considered an affront, as it would imply that the invitation was not sincere. One must extend an invitation several times, encouraging the invitee to accept. Arabs may also refuse an offer of food several times before giving in. Most EuroAmericans believe that a host's offer can be politely refused with just a "no, thank you."

If we pay attention to only the explicit coded part of a message, we are likely to misunderstand the communication (Geva & Wiener, 2015). According to Hall (1976), *low* - *context* (LC) cultures place a greater reliance on the verbal part of the message. In addition, LC cultures have been associated with being more opportunistic, being more individual - oriented than group - oriented, and emphasizing rules of law and procedure.

It appears that the United States is an LC culture (although it is still higher than the Swiss, Germans, and Scandinavians in the amount of context required). China, perhaps, represents the other end of the continuum; its complex culture relies heavily on context. Asian Americans, African Americans, Hispanics, American Indians, and other minority groups in the United States also emphasize HC cues.

In contrast to LC communication, HC is faster, more economical, more efficient, and more satisfying. Because it is so bound to the culture, it is slow to change and tends to be cohesive and unifying. LC communication does not unify, but changes rapidly and easily.

Twins who have grown up together can and do communicate more economically (HC) than do two lawyers during a trial (LC). Bernstein's (1964) classic work in language analysis refers to restricted codes (HC) and elaborated codes (LC). Restricted codes are observed in families where words and sentences collapse and are shortened without loss of meaning. Elaborated codes, where many words are used to communicate the same content, are seen in classrooms, diplomacy, and law.

African American culture has been described as HC. For example, it is clear that many Blacks require fewer words than their White counterparts to communicate the same content (Irvine & York, 1995). An African American male who enters a room and spots an attractive

woman may stoop slightly in her direction, smile, and tap the table twice while vocalizing a long drawn out “uh huh.” What he has communicated would require many words from his White brother! The fact that African Americans may communicate more by HC cues has led many to characterize them as nonverbal, inarticulate, unintelligent, and so forth.

Video 8.2: Communicating Through Connection

Analysis of counseling session by Drs. Derald Wing Sue and Joel Filmore.

SOCIOPOLITICAL FACETS OF NONVERBAL COMMUNICATION

There is a common saying among African Americans: “If you really want to know what White folks are thinking and feeling, don't listen to what they say, but how they say it.” In most cases, such a statement refers to the biases, stereotypes, and racist attitudes that Whites are believed to possess but consciously or unconsciously conceal.

Rightly or wrongly, many minority individuals, through years of personal experience, operate from three assumptions. First, that all Whites in U.S. society are racist. Through their own cultural conditioning, they have been socialized into a culture that espouses the superiority of White culture over all others (Jones, 1997; Ridley, 2005; Sue, 2015). Second, that most Whites find such a concept disturbing and will go to great lengths to deny that they are racist or biased. Some of this is done deliberately and with awareness, but in most cases their racism is largely unconscious (Todd & Abrams, 2011). Last, that nonverbal behaviors are more accurate reflections of what a White person is thinking or feeling than what they say.

There is considerable evidence to suggest that these three assumptions are indeed accurate (McIntosh, 1989; Ridley, 2005; Sue, 2010). Counselors and mental health practitioners need to be very cognizant of nonverbal cues from a number of different perspectives. In the last section, we discussed how nonverbal behavior is culture - bound and how the counselor or therapist cannot make universal interpretations about it. Likewise, nonverbal cues are important because they often (a) unconsciously reflect our biases and (b) trigger off stereotypes we have of other people.

Nonverbals as Reflections of Bias

Some time ago, a TV program called *Candid Camera* was all the rage in the United States. It operated from a unique premise, which involved creating very unusual situations for naive subjects who were filmed as they reacted to them. One of these experiments involved interviewing housewives about their attitudes toward African American, Latinx, and White teenagers. The intent was to select a group of women who by all standards appeared sincere in their beliefs that Black and Latinx Americans were no more prone to violence than were their White counterparts. Unknown to them, they were filmed by a hidden camera as they left their homes to go shopping at the local supermarket.

The creator of the program had secretly arranged for an African American, a Latino, and a White youngster (dressed casually but nearly identically) to pass these women on the street. The experiment was counterbalanced; that is, the race of the first youngster to approach easy woman was randomly assigned. What occurred was a powerful statement on unconscious racist attitudes and beliefs.

All the youngsters had been instructed to pass the shoppers on the purse side of the street. If the woman was holding the purse in her right hand, the youngster would approach and pass on her right. If the purse was held with the left hand, the youngster would pass on her left. Studies of the film revealed consistent outcomes. Many of the women, when approached by the Black or the Latino youngster (approximately 15 ft. away), would casually switch their purse from one arm to the other! This occurred infrequently with the White subject. Why?

The answer appears quite obvious to us. The women subjects who switched their purses were operating from biases, stereotypes, and preconceived notions about what minority youngsters are like: they are prone to crime, more likely to snatch a purse or rob, more likely to be juvenile delinquents, and more likely to engage in violence (Sue, 2010). The disturbing part

of this experiment was that the selected subjects were, by all measures, sincere individuals who on a conscious level denied harboring racist attitudes or beliefs. They were not liars, nor were they deliberately deceiving the interviewer. They were normal, everyday people. They honestly believed that they did not possess these biases, yet when tested, their nonverbal behavior (purse switching) gave them away.

The power of *nonverbal communication* is that it tends not to be under conscious control. Studies support the conclusion that nonverbal cues operate primarily on an unaware level (DePaulo, 1992; Singelis, 1994), that they tend to be spontaneous and difficult to censor or falsify, and that they are more trusted than words. In our society, we have learned to use words (spoken or written) to mask or conceal our true thoughts and feelings. Note how our politicians and lawyers are able to address an issue without revealing much of what they think or believe.

Nonverbal behavior provides clues to conscious deceptions or unconscious biases (Utsey, Gernat, & Hammar, 2005). There is evidence that the accuracy of *nonverbal communication* varies with the part of the body used: facial expression is more controllable than the hands, followed by the legs and the rest of the body (Hansen, Stevic, & Warner, 1982). The implications for multicultural counseling are obvious. Therapists who have not adequately dealt with their own biases and racist attitudes may unwittingly communicate them to culturally diverse clients. Studies suggest that women and persons of color are better readers of nonverbal cues than are White males (Hall, 1976; Jenkins, 1982). Much of this may be due to their HC orientation, but another reason may be *survival*. For an African American person to survive in a predominantly White society, he or she has to rely on nonverbal cues more often than verbal ones.

One of our male African American colleagues gives the example of how he must constantly be vigilant when traveling in an unknown part of the country. Just to stop at a roadside restaurant may be dangerous to his physical well‐being. As a result, when entering a diner, he is quick to observe not only the reactions of the staff (waiter/waitress, cashier, cook, etc.) but those of the patrons as well. Do they stare at him? What type of facial expressions do they have? Do they fall silent? Does he get served immediately, or is there an inordinate delay? These nonverbal cues reveal much about the environment around him. He may choose to be himself or to play the role of a “humble” Black person who leaves quickly if the situation poses danger.

Interestingly, this very same colleague talks about tuning in to nonverbal cues as a means of *psychological survival*. He believes it is important for minorities to accurately read where people are coming from in order to prevent invalidation of the self. For example, a Black person driving through an unfamiliar part of the country may find him‐ or herself forced to stay at a motel overnight. Seeing a vacancy light flashing, he or she stops and knock on the manager's door. Upon opening the door and seeing the Black person, the White manager shows hesitation, stumbles around in his or her verbalizations, and apologizes for having forgotten to turn off the vacancy light. The Black person is faced with the dilemma of deciding whether the White manager is telling the truth or is simply not willing to rent to an African American.

Some of you might ask, “Why is it important for you to know? Why don't you simply find someplace else? After all, would you stay at a place where you were unwelcome?” But finding another place to stay may not be as important as the psychological well‐being of the minority person. Racial/ethnic minorities have encountered too many situations in which double messages are given to them (microaggressions). For the African American to accept the simple statement, “I forgot to turn off the vacancy light,” might be to deny his or her own

true feelings at being the victim of discrimination. This is especially true when the nonverbals (facial expression, anxiety in voice, and stammering) reveal other reasons.

Too often, culturally diverse individuals are placed in situations where they are asked to deny their true feelings in order to perpetuate *White deception*. Statements that minorities are oversensitive (paranoid?) may represent a form of denial (Sue, Bucceri, Lin, Nadal, & Torino, 2007). Thus, it is clear that racial/ethnic minorities are very tuned in to nonverbals. For therapists who have not adequately dealt with their own racism, clients of color will be quick to assess such biases. In many cases, clients of color may believe that the biases are too great to be overcome and will simply not continue in therapy. This is despite the good intentions of the White therapists.

Nonverbals as Triggers to Biases and Fears

Often, people assume that being an effective multicultural therapist is a straightforward process that involves the acquisition of knowledge about the various racial/ethnic groups. If we know that Asian Americans and African Americans have different patterns of eye contact and if we know that these patterns signify different things, then we should be able to eliminate the biases and stereotypes that we possess. Were it so easy, we might have eradicated racism years ago. Although increasing our knowledge base about the lifestyles and experiences of marginalized groups is important, it is not a sufficient condition in itself. Our biased attitudes, beliefs, and feelings are deeply ingrained in our total being. Through years of conditioning, they have acquired a strong irrational base, replete with emotional symbolism about each particular racial group. Simply opening a text and reading about Black and Latinx Americans will not deal with our deep‐seated fears and biases.

One of the major barriers to effective understanding is the common assumption that different cultural groups operate according to identical speech and communication conventions. In the United States, it is often assumed that distinctive racial, cultural, and linguistic features are deviant, inferior, or embarrassing (Kochman, 1981; Singelis, 1994; Stanback & Pearce, 1985). These value judgments then become tinged with beliefs that we hold about Black people: that they are racially inferior, that they are prone to violence and crime, that they are quick to anger, and that they are a threat to White folks. The *communication style* of Black people (manifested in nonverbals) can often trigger off these fears.

African American styles of communication are often high‐key, animated, heated, interpersonal, and confrontational. Many emotions, affects, and feelings are generated (Hall, 1976; Shade & New, 1993; Weber, 1985). In a debate, African Americans tend to act as advocates of a position, and to test ideas in the crucible of argument (Kochman, 1981). White middle‐class styles, however, are characterized as being detached and objective, impersonal and nonchallenging. A person acts not as an *advocate* of an idea but as a *spokesperson* for it (truth resides in the idea). A discussion of issues should be devoid of affect, because emotion and reason work against one another. One should talk things out in a logical fashion without getting personally involved. African Americans characterize their own style of communication as indicating that a person is sincere and honest, whereas EuroAmericans consider their style to be reasoned and objective (Irvine & York, 1995). Many African Americans readily admit that they operate from a point of view and, as mentioned previously, are disinclined to believe that White folks do not. Smith (1981, p. 154) aptly describes the Black orientation in the following passage.

> *When one Black person talks privately with another, he or she might say: "Look, we don't have to jive each other or be like White folks; let's be honest with one another."*

> *These statements reflect the familiar Black saying that "talk is cheap," that actions speak louder than words, and that Whites beguile each other with words … In contrast, the White mind symbolizes to many Black people deceit, verbal chicanery, and sterile intellectivity. For example, after long discourse with a White person, a Black individual might say: "I've heard what you've said, but what do you really mean?"*

Although African Americans may misinterpret White *communication styles*, it is more likely that Whites will misinterpret Black styles. The direction of the misunderstanding is generally linked to the activating of unconscious triggers or buttons about racist stereotypes and the fears they represent. As we have repeatedly emphasized, one of the dominant stereotypes of African Americans in our society is that of the hostile, angry, prone - to - violence Black male. The more animated and affective communication style, closer conversing distance, prolonged eye contact when speaking, greater bodily movements, and tendency to test ideas in a confrontational/argumentative format lead many Whites to believe that their lives are in danger. It is not unusual for White mental health practitioners to describe their African American clients as being hostile and angry. We have also observed that some White trainees who work with Black clients respond nonverbally in such a manner as to indicate anxiety, discomfort, or fear (e.g., leaning away from their African American clients, tipping their chairs back, crossing their legs or arms). These are nonverbal distancing moves that may reflect the unconscious stereotypes that they hold of Black Americans. Although we would entertain the possibility that a Black client is angry, most occasions we have observed do not justify such a descriptor.

It appears that many EuroAmericans operate from the assumption that when an argument starts, it may lead to a ventilation of anger and the outbreak of fighting. What many Whites fail to realize is that African Americans distinguish between an argument used to debate a difference of opinion and one that ventilates anger and hostility (DePaulo, 1992; Irvine & York, 1995; Kochman, 1981; Shade & New, 1993). In the former, the affect indicates sincerity and seriousness, there is a positive attitude toward the material, and the validity of ideas is challenged. In the latter, the affect is more passionate than sincere, there is a negative attitude toward the opponent, and the opponent is abused.

To understand African American styles of communication and to relate adequately to Black communication would require much study in the origins, functions, and manifestations of Black language (Jenkins, 1982). Weber (1985) believes that the historical and philosophical foundations of Black language have led to the existence of several verbal styles among Blacks. For example, *playing the dozens* is considered by many Blacks to be a high form of verbal warfare and impromptu speaking (Jenkins, 1982; Kochman, 1981; Weber, 1985). To the outsider, it may appear cruel, harsh, and provocative. Yet, to many in the Black community, it has historical and functional meanings.

The term *dozens* was used by slave owners to refer to Black people with disabilities. Because they were considered damaged goods, disabled Black people would often be sold at a discount rate with 11 other disabled or injured slaves (making one dozen) (Weber, 1985). Professor and folklorist Mona Lisa Saloy explains how this history gave rise to a contemporary form of verbal skillfulness.

> *The practice of word play hedged on verbal insult was meant to toughen these already maligned individuals from the additional hardships they were sure to face. The purpose of the dozens is "not to lose your cool, [to] control your response," Saloy says. "Because if you're sold in cheap blocks of a dozen on the slave block because you're deformed, for punishment, or for whatever reason, and you're so taunted by the outside*

society, the only way you can tolerate this is to make some play out of it, to literally turn it on its head, and so you learn how to control your reaction, because to react was to be killed or maimed further or punished … so it's the tradition … we've kept that."

(TheGrio, 2010, para. 9.)

Often played in jest, the dozens requires an audience to act as judge and jury over the originality, creativity, and humor of the combatants. Here are three examples:

Say man, your girlfriend so ugly, she had to sneak up on a glass to get a drink of water … Man, you so ugly, yo mamma had to put a sheet over your head so sleep could sneak up on you.

(Weber, 1985, p. 248)

A:

Eat shit.

B:

What should I do with your bones?

A:

Build a cage for your mother.

B:

At least I got one.

A:

She *is* the least. (Labov, 1972, p. 321)

A:

Got a match?

B:

Yeah, my ass and your face or my farts and your breath. (Kochman, 1981, p. 54)

Other minority groups also have characteristic styles that may be unfamiliar or confusing for counselors who do not share their background. One way of contrasting such *communication style* differences may be in the overt activity dimension (the pacing/intensity) of *nonverbal communication*. Table 8.1 contrasts five different groups along this continuum. How these styles affect the therapist's perception and ability to work with culturally different clients is important for each and every one of us to consider.

TABLE 8.1 Communication Style Differences (Overt Activity Dimension—Nonverbal/Verbal)

American Indians	Asian Americans and Hispanics	Whites	Blacks
1. Speak		1. Speak loud/fast	

softly/slowly 2. Indirect gaze when listening or speaking 3. Interject less; seldom offer encouraging communication 4. Delayed auditory (silence) 5. Manner of expression low - keyed, indirect	1. Speak softly 2. Avoidance of eye contact when listening or speaking to high - status persons 3. Similar rules 4. Mild delay 5. Low - keyed, indirect	to control listener 2. Greater eye contact when listening 3. Head nods, nonverbal markers 4. Quick to respond 5. Objective, task - oriented	1. Speak with affect 2. Direct eye contact (prolonged) when speaking, but less when listening 3. Interrupt (turn - taking) when able 4. Quicker to respond 5. Affective, emotional, interpersonal

Video 8.3: Utilizing Space to Create Closeness

Introduction to counseling session by Dr. Joel Filmore.

COUNSELING AND THERAPY AS COMMUNICATION STYLE

Throughout this book, we have repeatedly emphasized that *different* theories of counseling and psychotherapy represent *different communication styles* (Ivey et al., 2014). Just as race, culture, ethnicity, and gender may affect *communication styles*, so there is considerable evidence that theoretical orientations in counseling will influence helping styles. When one watches Carl Rogers (Person‐Centered Counseling) and Albert Ellis (Rational Emotive Behavior Therapy) conducting therapy, one is struck by how differently they interact with clients.

Differential Skills in MCT

There is strong support for the belief that different cultural groups may be more receptive to certain counseling/*communication styles* because of cultural and sociopolitical factors (Choudhuri, Santiago‐Rivera, & Garrett, 2012; Diller, 2011; West‐Olatunji & Conwill, 2011). Indeed, the literature on multicultural counseling and therapy (MCT) strongly suggests that American Indians, Asian Americans, Black Americans, and Hispanic Americans may tend to prefer more active‐directive forms of helping to nondirective ones (Brammer, 2012; Ratts & Pedersen, 2014). We briefly describe two of these group differences here to give the reader some idea of their implications.

Asian American clients, who may value restraint of strong feelings and believe that intimate revelations are to be shared only with close friends, can cause problems for the counselor who is oriented toward insight or feelings. It is entirely possible that such techniques as reflecting on feelings, asking questions of a deeply personal nature, and making in‐depth interpretations may be perceived as lacking in respect for the client's integrity (Locke & Bailey, 2014). Asian American clients may not initially value insight approaches. For example, some clients who come for vocational information may be perceived by counselors as needing help in finding out what motivates their actions and decisions. Requests for advice or information from the client are seen as indicative of deeper, more personal conflicts. The blind application of techniques that clash with cultural values places many Asian Americans in a seriously uncomfortable and oppressed position (Chang et al., 2014). Indeed, while research suggests that most clients of color stay in treatment longer with a therapist of their own race and ethnicity, this effect appears to be strongest with Asian American clients (Smith & Trimble, 2016).

Many years ago, Atkinson, Maruyama, and Matsui (1978) tested this hypothesis with a number of Asian American students. They prepared two tape recordings of a contrived counseling session in which the client's responses were identical but the counselor's responses differed, being directive in one case and nondirective in the other. Their findings indicated that the counselor who used the directive approach was rated more credible and approachable than the one who used the nondirective approach. Asian Americans seem to prefer a logical, rational, structured counseling approach to an affective, reflective, and ambiguous one. Other researchers have drawn similar conclusions (Atkinson & Lowe, 1995; Leong, 1986; Lin, 2001).

In a classic and groundbreaking study, Berman (1979) found similar results with a Black population. The weakness of previous studies was their failure to compare equal responses with a White population. Berman's study compared the use of counseling skills between Black and White, male and female counselors. A videotape of culturally varied client vignettes was viewed by Black and White counselor trainees. They responded to the question,

“What would you say to this person?” The data were scored and coded according to a microcounseling taxonomy that divided counseling skills into attending and influencing ones (Ivey et al., 2014). The hypothesis made by the investigator was that Black and White counselors would give significantly different patterns of responses to their clients.

Data supported the hypothesis. Black males and females tended to use the more active expressive skills (directions, expression of content, and interpretation) with greater frequency than did their White counterparts. White males and females tended to use a higher percentage of attending skills. Berman concluded that the counselor's race/culture appears to be a major factor in his or her choice of skills, and that Black and White counselors appear to adhere to two distinctive styles of counseling. Berman also concluded that the more active styles of the Black counselor tend to include practical advice and allow for the interjection of the counselor's values and opinions.

The implications for therapy are glaringly apparent. Mental health training programs tend to emphasize the more passive attending skills. Therapists so trained may be ill equipped to work with culturally different clients who might find the active approach more relevant to their own needs and values (Parham, Ajamu, & White, 2011).

Implications for MCT

Ivey's continuing contributions (Ivey, 1986; Ivey, D'Andrea, & Ivey, 2011; Ivey et al., 2014) in the field of microcounseling, multicultural counseling, and developmental counseling seem central to our understanding of counseling/*communication styles*. He believes that different theories are concerned with generating different sentences and constructs and that different cultures may also be expected to generate different sentences and constructs. Counseling and psychotherapy may be viewed as special types of temporary cultures (Ivey et al., 2011). When the counseling style of the counselor does not match the *communication style* of his or her culturally diverse clients, many difficulties may arise, including premature termination of the session, inability to establish rapport, and cultural oppression of the client. It is clear that effective multicultural counseling occurs when the counselor and the client are able to send and receive both verbal and nonverbal messages appropriately and accurately. When the counselor can engage in such activities, his or her credibility and attractiveness are increased. *Communication styles* manifested in the clinical context may either enhance or negate the effectiveness of multicultural counseling. Several major implications for counseling can be discerned.

As practicing clinicians who work with a culturally diverse population, we need to move decisively in educating ourselves about the differential meanings of nonverbal behavior and the broader implications for *communication styles*. We need to realize that *proxemics*, *kinesics*, *paralanguage*, and high/low‐context factors are important elements of communication, that they may be highly culture‐bound, and that we should guard against possible misinterpretation in our assessment of clients. Likewise, it is important that we begin to become aware of and understand our own communication/helping style.

We believe that therapists must be able to shift their *therapeutic styles* to meet the developmental needs of clients. We contend further that effective mental health professionals are those who can also shift their helping styles to meet the cultural dimensions of their clients. Therapists of differing theoretical orientations will tend to have different preferred skill patterns. These skill patterns may be antagonistic or inappropriate to the communication/helping styles of clients. In the research cited earlier, it was clear that White counselors (by virtue of their cultural conditioning and training) tended to use the more

passive attending and listening skills in counseling/therapy, whereas racial/ethnic minority populations often appeared more oriented toward an active influencing approach. There are several reasons why this may be the case.

First, we contend that the use of more directive, active, and influencing skills is more likely to provide personal information about where the therapist is coming from (self‐disclosure). Giving advice or suggestions, interpreting, and telling the client how one feels are all acts of counselor self‐disclosure. Although the use of attending or more nondirective skills may also include self‐disclosure, many counselors tend to use active or influencing skills only minimally. In multicultural counseling, the culturally diverse client is likely to approach the counselor with trepidation: “What makes you any different from all the Whites out there who have oppressed me?” “What makes you immune from inheriting the racial biases of your forebears?” “Before I open up to you [self‐disclose], I want to know where you are coming from.” “How open and honest are you about your own racism, and will it interfere with our relationship?” “Can you really understand what it's like to be Asian, Black, Hispanic, American Indian, or the like?” In other words, a culturally diverse client may not open up (or self‐disclose) until you, the helping professional, self‐disclose first. Thus, to many minority clients, therapists who express their thoughts and feelings, as well as their ideas about the direction of the work, may be better received in a counseling situation.

Second, studies support the thesis that White therapists are more likely to focus their problem diagnosis in individual rather than societal terms. In a society where individualism prevails, it is not surprising to find that EuroAmerican counselors tend to view their clients' problems as residing within the individual rather than in society. Thus, the role of the therapist will be person‐focused, and the skills they utilize will be individual‐centered (attending), aimed at changing the person. Many marginalized groups accept the importance of individual contributions to a problem, but they also give great weight to systemic or societal factors that may adversely impact their lives. People of color who have been the victims of discrimination and oppression perceive that the problem resides externally to the person (societal forces). Active systems intervention is called for, and the most appropriate way to attack the environment (stressors) is through an active approach (Ratts & Pedersen, 2014). If the counselor shares this perception, he or she may take a more active role in sessions, giving advice and suggestions and teaching strategies (becoming a partner to the client).

Finally, although it would be ideal if we could effectively engage in the full range of therapeutic responses, such a wish may prove unrealistic. We cannot be all things to all people; that is, there are personal limits to how much we can change our *communication styles* to match those of our clients. The difficulty in shifting styles may be a function of inadequate practice, the inability to understand the other person's worldview, or personal biases or racist attitudes that have not been adequately resolved. In these cases, the counselor might consider several alternatives: (a) seek additional training/education; (b) seek consultation with a more experienced counselor; (c) refer the client to another therapist; or (d) become aware of their personal *communication style* limitations and try to anticipate how they might impact the culturally diverse client. Often, a therapist who recognizes the limitations of his or her helping style and knows how they will impact a culturally diverse client can take steps to minimize possible conflicts.

IMPLICATIONS FOR CLINICAL PRACTICE

1. Recognize that no one style of counseling or therapy will be appropriate for all populations and situations. A counselor or therapist who is able to engage in a variety of

helping styles and roles is most likely to be effective in working with a diverse population.

2. Become knowledgeable about how race, culture, and gender affect *communication styles*.
3. Your clinical observation skills will be greatly enhanced if you sharpen your nonverbal powers of observation of clients.
4. Become aware of your own communication and helping styles. Know your social impact on others and anticipate how it affects your clients.
5. Try to obtain additional training and education on a variety of theoretical orientations and approaches in order to expand your helping styles.
6. Realize that we are *feeling*, *thinking*, *behaving*, *social*, *cultural*, *spiritual*, and *political* beings. Try to think holistically rather than in a reductionist manner when it comes to conceptualizing the human condition.
7. It is important for training programs to use an approach that calls for openness and flexibility both in conceptualizing the issues and in actual skill building. Develop and use helping strategies, techniques, and styles that consider not only individual characteristics, but cultural and racial factors as well.

Video 8.1: Expression and Understanding

International clients' spatial requirements are different than Western clients. It's imperative to quickly understand and gather as much information about your clients in order to facilitate rapport and improve communication.

Video Lecture: Multicultural Counseling/Therapy: Culturally Appropriate Intervention Strategies

SUMMARY

Counseling styles and approaches must be adapted to meet the sociodemographic characteristics of a diverse clientele. Helping professionals who are unaware of culture, age, and gender differences as they affect communication and helping styles may make inaccurate assessments, diagnoses, and treatments. They may assume that certain behaviors or rules of speaking are universal and always possess the same meaning. *Communication style* refers to those factors that go beyond the content of what is said. Communication specialists have historically found that only 30–40% of what is communicated conversationally is verbal. A gesture, tone, inflection, posture, or degree of eye contact may enhance or negate the content of a message.

Differences in communication style are most strongly manifested in *nonverbal communication*, or those aspects of communication that transcend the written or spoken word. Race and culture may influence several areas of nonverbal behavior, leading to misunderstandings. *Nonverbal communication* includes the following dimensions: (a) *proxemics*, the use of personal space between conversants; (b) *kinesics* or bodily movements, including facial expression, posture, characteristics of movement, gestures, and eye contact; (c) *paralanguage* or the vocal cues that individuals use to communicate, such as loudness of voice, pauses, silences, hesitations, rate of speech, and inflections; and (d) *high/low - context communication*, referring to whether a person relies more on the context or the content of a message in order to interpret its meaning. Race, culture, ethnicity, and gender all influence how people communicate in these four dimensions.

Nonverbal cues are important because they often (a) unconsciously reflect our biases and (b) trigger off stereotypes we have of other people. Several important findings have implications for work with diverse clients. First, *nonverbal communication* is less under our conscious control than is verbal communication. Second, marginalized group members are better readers of nonverbal cues than their majority counterparts. Third, in multicultural counseling, an unenlightened mental health professional may unintentionally communicate his or her biases and fears to clients. Last, in working with Asian Americans, American Indians, African Americans, and Latinx Americans, it is important to be cognizant of their unique *communication styles*, which have major implications for mental health practice.

GLOSSARY TERMS

- Communication style
- High/low - context communication
- High - context cultures
- Kinesics
- Low - context cultures
- Nonverbal communication
- Nonverbals as triggers to bias
- Paralanguage
- Playing the dozens
- Proxemics
- Therapeutic style
- Verbal communication

Video 8.5: Counseling Session Analysis

Utilizing evidence-based practices in conjunction with minority client cultural beliefs can affect the greatest change in favor of client outcomes.

REFERENCES

1. Aston, E. (2017). How do we communicate in a multicultural world? Four styles of how cultures handle conflict. Retrived from https://www.huffingtonpost.com/entry/how-do-we-communicate-in-a-multicultural-world-four_us_595108e7e4b0326c0a8d09db

2. Atkinson, D. R., & Lowe, S. M. (1995). The role of ethnicity, cultural knowledge, and conventional techniques in counseling and psychotherapy. In J. G. Ponterotto, J. M. Casas, L. M. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 3–16). Thousand Oaks, CA: Sage.

3. Atkinson, D. R., Maruyama, M., & Matsui, S. (1978). The effects of counselor race and counseling approach on Asian Americans' perceptions of counselor credibility and utility. *Journal of Counseling Psychology*, *25*, 76–83.

4. Banks, J. A., & Banks, C. A. (1993). *Multicultural education*. Boston, MA: Allyn & Bacon.

5. Berman, J. (1979). Counseling skills used by Black and White male and female counselors. *Journal of Counseling Psychology*, *26*, 81–84.

6. Bernstein, B. (1964). Elaborated and restricted codes: Their social origins and some consequences. *American Anthropologist*, *66*, 55–69.

7. Bowen, S. (2017). Lee embodies the most frustrating (& common) kind of racism on *The Bachelorette*. Retrieved from http://www.refinery29.com/2017/06/160041/bachelorette-lee-garrett-provoking-kenny-angry-black-man

8. Brammer, R. (2012). *Diversity in counseling*. Belmont, CA: Cengage.

9. Chang, C. Y., McDonald, C. P., & O'Hara, C. (2014). Counseling clients from Asian and Pacific Island heritages. In M. J. Ratts, & P. B. Pedersen (Eds.), *Counseling for multiculturalism and social justice* (pp. 127–142). Alexandria, VA: American Counseling Association.

10. Choudhuri, D. D., Santiago‐Rivera, A. L., & Garrett, M. T. (2012). *Counseling and diversity*. Belmont, CA: Cengage.

11. Cooper, C.L. (2017). An open letter to my therapist who called me “a strong black woman.” Retrieved from https://www.huffingtonpost.com/entry/an-open-letter-to-my-therapist-who-called-me-a-strong_us_59848c4ae4b0bd8232029716

12. DePaulo, B. M. (1992). Nonverbal behavior and self‐presentation. *Psychological Bulletin*, *111*, 203–243.

13. Diller, J. V. (2011). *Cultural diversity*. Belmont, CA: Cengage.

14. Duran, E. (2006). *Healing the soul wound*. New York, NY: Teachers College Press.

15. Eakins, B. W., & Eakins, R. G. (1985). Sex differences in nonverbal communication. In L. A. Samovar, & R. E. Porter (Eds.), *Intercultural communication: A reader* (pp. 290–307). Belmont, CA: Wadsworth.

16. Garrett, M. T., & Portman, T. A. A. (2011). *Counseling native Americans*. Belmont, CA: Cengage.

17. Geva, E., & Wiener, J. (2015). *Psychological assessment of culturally and linguistically diverse children and adolescents*. New York, NY: Springer.

18. Hall, E. T. (1959). *The silent language*. Greenwich, CT: Premier Books.

19. Hall, E. T. (1969). The hidden dimension: Man's use of space in public and private. Bodley Head.

20. Hall, E. T. (1976). *Beyond culture*. New York, NY: Anchor Press.

21. Hansen, J. C., Stevic, R. R., & Warner, R. W. (1982). *Counseling: Theory and process*. Toronto, Canada: Allyn & Bacon.

22. Hewlett, S.. Allwood, N., & Sherbin, L. (2016). U.S. Latinos feel they can't be themselves at work. Retrieved from https://hbr.org/2016/10/u - s - latinos - feel - they - cant - be - themselves - at - work

23. Irvine, J. J., & York, D. E. (1995). Learning styles and culturally diverse students: A literature review. In J. A. Banks, & C. A. McGee Banks (Eds.), *Handbook of research on multicultural education* (pp. 484–497). New York, NY: Macmillan.

24. Ivey, A. E. (1986). *Developmental therapy*. San Francisco, CA: Jossey - Bass.

25. Ivey, A. E., D'Andrea, M. J., & Ivey, M. B. (2011). *Theories of counseling and psychotherapy: A multicultural perspective*. Boston, MA: Allyn &Bacon.

26. Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2014). *Intentional interviewing and counseling* (8th ed.). Belmont, CA: Brooks/Cole.

27. Jenkins, A. H. (1982). *The psychology of the Afro - American*. New York, NY: Pergamon Press.

28. Jensen, J. V. (1985). Perspective on nonverbal intercultural communication. In L. A. Samovar, & R. E. Porter (Eds.), *Intercultural communication: A reader* (pp. 256–272). Belmont, CA: Wadsworth.

29. Jones, J. M. (1997). *Prejudice and racism* (2nd ed.). Washington, DC: McGraw - Hill.

30. Kochman, T. (1981). *Black and White styles in conflict*. Chicago, IL: University of Chicago Press.

31. LaBarre, W. (1985). Paralinguistics, kinesics and cultural anthropology. In L. A. Samovar, & R. E. Porter (Eds.), *Intercultural communication: A reader* (pp. 272–279). Belmont, CA: Wadsworth.

32. Labov, W. (1972). *Language in the inner city: Studies in the Black English vernacular*. Philadelphia, PA: University of Pennsylvania Press.

33. Leong, F. T. L. (1986). Counseling and psychotherapy with Asian - Americans: Review of literature. *Journal of Counseling Psychology*, *33*, 196–206.

34. Lin, E. (2014). Am Asian American, have been in therapy. Retrieved from http://thesaltcollective.org/asian - american - therapy/

35. Lin, Y. (2001). The effects of counseling styles and stages on perceived counselor

effectiveness from Taiwanese female university clients. *Asian Journal of Counselling*, *8*, 35–60.

36. Locke, D. C., & Bailey, D. F. (2014). *Increasing multicultural understanding*. Thousand Oaks, CA: Sage.

37. McIntosh, P. (1989). White privilege: Unpacking the invisible knapsack. *Peace and Freedom*, 8–10.

38. Mindess, A. (1999). Reading between the signs. In *Yarmouth*. ME: Intercultural Press.

39. Nydell, M. K. (1996). *Understanding Arabs: A guide for Westerners*. Yarmouth, ME: Intercultural Press.

40. Parham, T. A., Ajamu, A., & White, J. L. (2011). *The psychology of Blacks. Centering our perspectives in the African consciousness*. Boston, MA: Prentice Hall.

41. Pearson, J. C. (1985). *Gender and communication*. Dubuque, IA: W. C. Brown.

42. Ramsey, S., & Birk, J. (1983). Preparation of North Americans for interaction with Japanese: Considerations of language and communication style. In D. Landis, & R. W. Brislin (Eds.), *Handbook of intercultural training: Volume III* (pp. 227–259). New York, NY: Pergamon Press.

43. Ratts, M. J., & Pedersen, P. B. (Eds.) (2014). *Counseling for multiculturalism and social justice*. Alexandria, VA: American Counseling Association.

44. Ridley, C. R. (2005). *Overcoming unintentional racism in counseling and therapy* (2nd ed.). Thousand Oaks, CA: Sage.

45. Robinson, T. L., & Howard ‐ Hamilton, M. F. (2000). *The convergence of race, ethnicity, and gender*. Columbus, OH: Merrill.

46. Shade, B. J., & New, C. A. (1993). Cultural influences on learning: Teaching implications. In J. A. Banks, & C. A. McGee Banks (Eds.), *Multicultural education* (pp. 317–331). Boston, MA: Allyn & Bacon.

47. Singelis, T. (1994). Nonverbal communication in intercultural interactions. In R. W. Brislin, & T. Yoshida (Eds.), *Improving intercultural interactions* (pp. 268–294). Thousand Oaks, CA: Sage.

48. Smith, E. J. (1981). Cultural and historical perspectives in counseling Blacks. In D. W. Sue (Ed.), *Counseling the culturally different: Theory and practice* (pp. 141–185). New York, NY: Wiley.

49. Smith, T. B., & Trimble, J. E. (2016). Matching clients with therapists on the basis of race or ethnicity: A meta ‐ analysis of clients' level of participation in treatment. In T. B. Smith, & J. E. Trimble (Eds.), *Foundations of multicultural psychology: Research to inform effective practice* (pp. 115–128).

50. Stanback, M. H., & Pearce, W. B. (1985). Talking to “the man”: Some communication strategies used by members of “subordinate” social groups. In L. A. Samovar, & R. E. Porter (Eds.), *Intercultural communication: A reader* (pp. 236–253). Belmont, CA: Wadsworth.

51. Sue, D. W. (2010). *Microaggressions and marginality: Manifestations, dynamics, and impact*. Hoboken, NJ: Wiley.

52 Sue, D. W. (2015). *Race talk and the conspiracy of silence: Understanding and facilitating difficult dialogues on race*. Hoboken, NJ: Wiley.

53 Sue, D. W., Bucceri, J., Lin, A. I., Nadal, K. L., & Torino, G. C. (2007). Racial microaggressions and the Asian American experience. *Cultural Diversity and Ethnic Minority Psychology*, *13*, 72–81.

54 Susman, N. M., & Rosenfeld, H. M. (1982). Influence of culture, language and sex on conversation distance. *Journal of Personality and Social Psychology*, *42*, 66–74.

55 TheGrio (2010). Why “Yo Mama” taunts remain timeless. Retrieved from https://thegrio.com/2010/05/07/why - yo - mama - jokes - remain - timeless

56 Todd, N. R., & Abrams, E. M. (2011). White dialectics: A new framework for theory, research and practice with White students. *The Counseling Psychologist*, *39*, 353–395.

57 Utsey, S. O., Gernat, C. A., & Hammar, L. (2005). Examining White counselor trainees' reactions to racial issues in counseling and supervision dyads. *The Counseling Psychologist*, *33*, 449–478.

58 Weber, S. N. (1985). The need to be: The sociocultural significance of Black language. In L. A. Samovar, & R. E. Porter (Eds.), *Intercultural communication: A reader* (pp. 244–253). Belmont, CA: Wadsworth.

59 West - Olatunji, C. A., & Conwill, W. (2011). *Counseling African Americans*. Belmont, CA: Cengage.

60 Wolfgang, A. (1985). The function and importance of nonverbal behavior in intercultural counseling. In P. B. Pedersen (Ed.), *Handbook of cross - cultural counseling and therapy* (pp. 99–105). Westport, CT: Greenwood Press.

9
Multicultural Evidence‐Based Practice (EBP)

Chapter Objectives

1. **1. Become familiar with the role and importance of using research to determine what therapy treatment is best suited for diverse clients.**
2. **2. Define *empirically supported treatments* (ESTs).**
3. **3. Know the rationale for the development of *empirically supported relationships* (ESRs). Be able to describe the relationship variables that are considered to be research‐supported.**
4. **4. Become aware of how evidence‐based practice (EBP) and multicultural counseling are converging.**
5. **5. Describe the modifications that need to be made in the counseling alliance (*empathy* and relationship building) to work with different ethnic groups.**
6. **6. Describe how EBP differs from ESTs and ESRs. Be able to outline the advantages of focusing on client values and preferences.**
7. **7. Describe similarities and differences between EBP and cultural competence.**
8. **8. Become cognizant of the advantages and disadvantages of using "culturally adapted" forms of research‐based psychotherapies.**

How do counselors decide on the most appropriate treatment for the individuals with whom they work? Certainly, this question is relevant to the treatment of all clients, regardless of race, culture, or other identities. Most often, professionals choose an approach that is consistent with their chosen and preferred theoretical orientation. Several of these many perspectives may be applicable, yet all may be limited in how they view the totality of the human condition: the psychodynamic perspective views clients as historical‐developmental beings, the cognitive‐behavioral approach views them as behaving‐and‐thinking beings, multicultural perspectives view them as sociocultural beings (Ivey, Ivey, & Zalaquett, 2014), and so forth. As we have emphasized throughout, the fact is that we are all of these and more. In addition, given the intersecting nature of cultural identities, our lived experiences comprise multiple identities simultaneously, and each one shapes the others (Moradi & Grzanka, 2017).

Historically, therapeutic strategies chosen for treatment were often based on (a) the clinician's therapeutic orientation, (b) ideas shared by "experts" in psychotherapy, and/or (c) "clinical intuition and experience" derived from years of work with clients. These selection approaches are problematic because there are countless "experts" and some 400 schools of psychotherapy, each claiming that their techniques are valid (Corey, 2013); moreover, treatment is often implemented without questioning the relevance or appropriateness of a particular technique or approach for a specific client. Furthermore, reliance on clinical "intuition" to guide one's therapeutic approach can result in ineffective treatment. Given these points, who are we to believe, and how do we resolve this problem?

This question has propelled the field of mental health practice to assign a more central role to science and research in the treatment of mental disorders (Morales & Norcross, 2010). To prioritize the evidentiary basis for a particular treatment makes immediate sense, yet the following excerpts demonstrate that treatment selection and implementation is still not a simple, one‐size‐fits‐all matter. Each example concerns a therapeutic approach that is regarded as an evidence‐supported practice: cognitive behavioral therapy (CBT), solution‐focused brief therapy (SFBT), and dialectical behavioral therapy (DBT).

[A] common component of traditional CBT for anxiety is the use of cognitive restructuring. CBT often focuses on assumptions that individuals experiencing pathological anxiety are victims of faulty, irrational thinking and that therapy should help clients become aware of these irrational or automatic thoughts and change them through cognitive restructuring. When working with clients from traditionally marginalized backgrounds clinicians need to think deeply about the ways they are teaching clients to restructure their thoughts and the implications of these decisions. One of the challenges is that individuals from marginalized groups often have negative and automatic thoughts that are not irrational given their experiences. For instance, a client of color may express that they fear social situations with their White peers because they fear that their White peers may say something racist in their interactions.

(Graham, Sorenson, & Hayes‐Skelton, 2013, p. 104)

One possible limitation of SFBT [with Muslim American clients] is related to the discrimination and violence that Muslim Americans face as in the United States in the post 9/11 era. When these individuals enter therapy, their problem is far more complicated than simply an individual concern. They also need change and advocacy at a system or institutional level as well as strategies to cope with adverse social conditions. However, a SFBT therapist may not have the tools to expand their work beyond the one‐on‐one sessions recommended. Also, as a product of this oppression, individuals seeking therapy may have a low self‐efficacy regarding making improvements in their mental health and life satisfaction. These individuals need more than a solution‐focused approach and may require longer term care focused on improving self‐esteem and self‐confidence.

Another limitation that may arise is related to the interconnectedness and closeness of Muslim families. There is a tendency to keep important and personal information within the immediate family, extended family and religious community. If a therapist is hoping to get his client to open up either alone or in the context of a family session, it is important to be trusted by the family and community network. This may be a long process, even with a solution‐focused approach. Any information, even that which is relevant to the problem, may be too personal to share in the context of short‐term therapy. The trust and confidence needed to affect change in an individual or family system may require a longer‐term approach.

(Chaudhry & Li, 2011, p. 112)

DBT skills training groups have been effective in treating eating disorders in various clinical settings … The overarching goals of DBT are to develop a dialectical worldview, to develop an ability to accept one's current situations and at the same time make changes, and to develop skills (i.e., mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness) … DBT as a structured teaching intervention, with an emphasis on doing homework and discussion, fits the emphasis on structure and education in Chinese culture … However, some modifications were made. These include adjusting the content and application of DBT homework assignments. For instance, some of the interpersonal effectiveness skills may not be appropriate given that in Chinese culture, indirect communication and maintaining harmony in a relationship are priorities. Recognizing this, the therapist asked Cheng‐Yin [not her real name] to identify the anticipated interpersonal repercussions of using the proposed skills and to identify ways that she might use the skills to communicate her opinions while being able to preserve her own cultural expectations. In addition, the therapist was mindful not to suggest that Cheng‐Yin do things that would only make sense in the American culture.

For example, discussions about "assertiveness" were tempered by individual exploration of, and reactions to, this concept.

(Cheng & Merrick, 2017, pp. 43 and 54)

REFLECTION AND DISCUSSION QUESTIONS

1. Discuss the linkages between culture and treatment techniques in each of the preceding examples.
2. To what other client identities might these same kinds of considerations apply? Which identities, if any, might *not* be relevant in light of these treatment approaches?
3. How would you characterize your own evolving therapeutic orientation? How would you evaluate its suitability for clients of various racial - cultural identities? What modifications or adaptations might you propose for certain clients?

Video 9.0: Introduction

Introduction to counseling session by Dr. Joel Filmore.

EVIDENCE‐BASED PRACTICE (EBP) AND MULTICULTURALISM

As the preceding examples suggest, culture has consequential relevance for the appropriate application of evidence‐based practices (EBPs). At the same time, the importance of EBP is becoming increasingly accepted in the field of multicultural counseling. Discussions of EBP originally focused on research‐supported therapies for specific disorders, but the dialogue has now broadened to include clinical expertise, such as "understanding the influence of individual and cultural differences on treatment" and the importance of considering client "characteristics, culture, and preferences in assessment, treatment plans, and therapeutic outcome" (APA Presidential Task Force on Evidence‐Based Practice, 2006). In an article titled "Evidence‐Based Practices with Ethnic Minorities: Strange Bedfellows No More," Morales and Norcross (2010) describe how multiculturalism and evidence‐based treatment (EBT), two forces that were "inexorable" and "separate," are now converging, and how they can complement each other. The authors state: "Multiculturalism without strong research risks becoming an empty political value, and EBT without cultural sensitivity risks irrelevancy" (p. 823).

Although the authors are optimistic about the convergence of these forces, there is still resistance to EBP among some individuals within the field of multicultural counseling (Sue, 2015; Wendt, Gone, & Nagata, 2015). As BigFoot and Schmidt (2010) note, "Historically, government and social service organization utilization of nonadapted or poorly adapted mental health treatments with diverse populations has led to widespread distrust and reluctance in such populations to seek mental health services" (p. 849). Conflicts often exist between the values espoused in conventional psychotherapy and the cultural values and beliefs of ethnic minorities (Lau, Fung, & Yung, 2010; Nagayama‐Hall, 2001; Owens, Queener, & Stewart, 2016). As we have discussed in previous chapters, Western approaches to psychological treatment are often based on individualistic value systems instead of on the interdependent values found in many ethnic minority communities. Additionally, conventional therapies often ignore cultural influences, disregard spiritual and other healing processes, and pathologize the behavior and values of ethnic minorities and other diverse groups (Sue, Zane, Nagayama‐Hall, & Berger, 2009).

It is apparent that conventional delivery of Western‐based therapies may not be meeting the needs of many individuals from ethnic and other cultural minorities. These groups tend to underutilize mental health services (Smith & Trimble, 2016a; Thurston & Phares, 2008) and are more likely to attend fewer sessions or to drop out of therapy sooner, compared with their White counterparts (Fortuna, Alegria, & Gao, 2010; Lester, Resick, Young‐Xu, & Artz, 2010; Smith & Trimble, 2016b; Triffleman & Pole, 2010). Unfortunately, research on the effectiveness of empirically supported therapies for ethnic minorities is limited, as these groups are often not included or specifically identified in research investigations of particular treatments.

Although questions remain regarding the validity of evidence‐based approaches for ethnic minority and other diverse populations (Bernal & Sáez‐Santiago, 2006), we believe that EBPs offer an opportunity for infusing multicultural and diversity sensitivity into psychotherapy. In addition, all mental health professions (psychiatry, social work, clinical psychology, and counseling) now espouse the view that treatment should have a research base. Evidence‐based interventions are increasingly promoted in social work (Bledsoe et al., 2007; Gibbs & Gambrill, 2002), school psychology (Kratochwill, 2002), clinical psychology (Deegear & Lawson, 2003), counseling (American Counseling Association, 2014; Chwalisz, 2001), and psychiatry.

In this chapter, we will discuss the evolution of EBP, the integration of empirically supported treatment (EST) and empirically supported relationship (ESR) variables into multicultural counseling, and the relevance of enhancing cultural elements in therapy. We will also show how culturally sensitive strategies can become an important component of EBPs.

Empirically Supported Treatment (EST)

The concept of ESTs was popularized when the American Psychological Association began promoting the use of "validated" or research‐supported treatments—specific treatments confirmed as effective for specific disorders. Not only were ESTs seen as an effective response to concerns about the use of unsupported techniques and psychotherapies, but they also addressed the issue of unintended harm that can result from ineffective or hazardous treatments (Lilienfeld, 2007; Wendt et al., 2015). ESTs typically involve a very specific treatment protocol for specific disorders. Because variability among therapists might produce error variance in research studies and because it is important for ESTs to be easily replicable as originally designed, ESTs are conducted using manuals.

According to the guidelines of the task force charged with defining and identifying ESTs (Chambless & Hollon, 1998), they must demonstrate (a) superiority to a placebo in two or more methodologically rigorous, controlled studies, (b) equivalence to a well‐established treatment in several rigorous and independent controlled studies, usually randomized controlled trials, or (c) efficacy in a large series of single‐case controlled designs (i.e., within‐subjects designs that systematically compare the effects of a treatment with those of a control condition).

ESTs have been identified for anxiety, depressive, and stress‐related disorders; obesity and eating disorders; severe mental conditions such as schizophrenia and bipolar disorder; substance abuse and dependence; childhood disorders; and borderline personality disorder. Several hundred different manualized treatments are listed as empirically supported (Chambless & Ollendick, 2001; Society of Clinical Psychology, 2011; see Table 9.1 for a few examples of empirically supported therapies).

TABLE 9.1 Examples of Empirically Supported Treatments (ESTs)

Source: Chambless, D. L., & Hollon, S. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, *66*, 7–18.

"Well‐established" treatments	"Probably efficacious" treatments
Cognitive behavioral therapy for panic disorder	Cognitive therapy for obsessive‐compulsive disorder (OCD)
Exposure/guided mastery for specific phobias	Exposure treatment for post‐traumatic stress disorder (PTSD)
Cognitive therapy for depression	Brief dynamic therapy for depression
Cognitive behavioral therapy for bulimia	Interpersonal therapy for bulimia
Cognitive behavioral relapse prevention for cocaine dependence	Brief dynamic therapy for opiate dependence
Behavior therapy for headache	Reminiscence therapy for geriatrics patients
Behavioral marital therapy	Emotionally focused couples therapy

Additionally, the American Psychological Association has developed a list of ESTs and practice guidelines for ethnic minorities (American Psychological Association, 1993), women and girls (American Psychological Association, 2007), older adults (American Psychological

Association, 2014), and lesbian, gay, bisexual, transgender, and queer (LGBTQ) clients (APA Division 44, 2012). These guidelines can be consulted and modified, if necessary, in working with clients from these groups.

The rationale behind the establishment of ESTs is admirable; we believe that decisions regarding treatment approaches for particular issues or disorders should be based on research findings rather than on idiosyncratic, personal beliefs or sketchy theories. We owe it to our clients to provide them with treatment that has demonstrated efficacy. However, it is our contention that relying only on manualized treatment methods, albeit research‐supported ones, is insufficient with many clients and many mental health problems (Sue, 2015). Additionally, most ESTs have not been specifically demonstrated to be effective with ethnic minorities or other diverse populations. The shortcomings of the EST approach are summarized here:

- Owing to the focus on choosing treatment based on the specific disorder, contextual, cultural, and other environmental influences are not adequately considered (Sue, 2015).
- The validity of ESTs for minority group members is often questionable, because these groups are not included in many clinical trials (Bernal & Sáez‐Santiago, 2006; Sue et al., 2006).
- The importance of the therapist–client relationship is not adequately acknowledged. A number of studies have found that therapist effects contribute significantly to the outcome of psychotherapy. In many cases, these effects exceed those produced by specific techniques (Wampold, 2001).
- Too much emphasis is placed on randomized controlled trials versus other forms of research, such as qualitative research designs.

When treating clients with specific disorders, multicultural therapists have had the choice of ignoring ESTs or adapting them. Increasingly, there have been attempts to develop “cultural adaptations” of certain ESTs. For example, Organista (2000) made the following modifications to empirically supported cognitive behavioral strategies when working with low‐income Latinx individuals suffering from depression:

1. *Engagement strategies*. Recognizing the importance of *personalismo* (the value of personal relationships), initial sessions are devoted to relationship‐building. Time is allotted for *presentaciones* (introductions), during which personal information is exchanged between counselor and client and issues that may affect ethnic minorities, such as acculturation difficulties, culture shock, and discrimination, are discussed.
2. *Activity schedules*. In the treatment of depression, a common recommendation is for clients to take some time off for themselves. This idea may run counter to the Latinx value of connectedness and putting the needs of the family ahead of oneself. Therefore, instead of solitary activities, clients can choose social activities they find enjoyable, such as visiting neighbors, family outings, or taking children to the park. In recognizing the income status of clients, activities discussed are generally free or affordable.
3. *Assertiveness training*. Assertiveness is discussed within the context of Latinx values. Culturally acceptable ways of expressing assertiveness, such as prefacing statements with *con todo respeto* (with all due respect) and *¿me permite expresar mis sentimientos?* (is it okay if I express my feelings?) are discussed, as well as strategies for using assertion with spouses or higher‐status individuals.

4. *Cognitive restructuring*. Rather than labeling thoughts that can reduce or increase depression as rational or irrational, the terms “helpful thoughts” and “unhelpful thoughts” are used. Recognizing the religious nature of many Latinx individuals, the saying, *Ayudate, que Dios te ayudara* (God helps those who help themselves) is used to encourage follow‐through with behavioral assignments.

This adapted approach, which maintains fidelity to both empirically supported techniques and cultural influences, has resulted in a lower dropout rate and better outcome for low‐income Latinx clients compared to nonmodified therapy. *Cultural adaptations* can include factors such as: (a) matching the language and racial or ethnic backgrounds of the client and the therapist; (b) incorporating cultural values in the specific treatment strategies; (c) utilizing cultural sayings or metaphors in treatment; and (d) considering the impact of environmental variables, such as acculturation conflicts, discrimination, and income status.

Culturally adapted ESTs have been successfully used with Latinx and Haitian American adolescents (Duarte‐Velez, Guillermo, & Bonilla, 2010; Nicolas, Arntz, Hirsch, & Schmiedigen, 2011), Asian Americans experiencing phobias (Huey & Pan, 2006), Latinx adults experiencing depression (Aguilera, Garza, & Munoz, 2010), American Indians suffering from trauma (BigFoot & Schmidt, 2010), clients of urban American Indian health organizations (Pomerville & Gone, 2018), African Americans recovering from substance abuse (Cunningham, Foster, & Warner, 2010), and Chinese immigrant families (Lau et al., 2010).

Horrell (2008) reviewed 12 studies on the effectiveness of CBT for African, Asian, and Hispanic Americans experiencing a variety of psychological disorders; the majority of these studies involved some type of cultural modification. Although the results for African American clients were mixed, Asian and Hispanic American clients demonstrated significant treatment gains over those in placebo or wait‐list control conditions. Overall, evidence is increasing that ESTs can be effective with ethnic minorities, particularly when the approach includes cultural adaptation.

A meta‐analysis of studies involving the adaptation of ESTs to clients' cultural backgrounds revealed that adapted treatments for clients of color are moderately more effective than nonadapted treatments and that the most effective therapies are those that have the most *cultural adaptations* (Smith, Rodriguez, & Bernal, 2011). In a review of both published and unpublished studies of culturally adapted therapies, it was found that culturally adapted psychotherapy is more effective than nonadapted psychotherapy for ethnic minorities (Benish, Quintana, & Wampold, 2011).

Implications

The applicability of many ESTs for diverse groups has been insufficiently researched. Statistical overviews of existing research do suggest that cultural adaptations tend to result in improved results for clients of color, and that some of the most important adaptations may be those that incorporate clients' own goals, cultural contexts, and preferred languages (Smith & Trimble, 2016c). Nevertheless, guidance is limited for mental health practitioners who are faced with the challenge of selecting effective interventions for their clients' mental health issues. For clients of color, we have the option of using a standard EST for the disorder, finding an EST (or adapted EST) with research demonstrating effectiveness for members of the client's ethnic group with the client's disorder (which is highly unlikely), or taking the time to develop and research a culture‐specific EBT for the client's disorder. The latter would be inordinately difficult for most practitioners to accomplish. Additionally, culture‐

specific treatments may not be effective with people of color who are more acculturated. Thus, in choosing a treatment strategy, we believe that the best approach (given the current state of research) is for the counselor to select an intervention that is research‐based and adapt it for the individual client according to the client's individual characteristics, values, and preferences.

REFLECTION AND DISCUSSION QUESTIONS

1. What are your thoughts concerning the use of ESTs in your own practice? What reactions do you have to the idea of using research on therapeutic effectiveness to guide your work? Has your training exposed you to EBP? What challenges would you face in trying to implement such an approach?
2. What would you need to know about ESTs and the cultural background of diverse clients in order to develop a culturally adapted therapeutic approach? Although it would be a massive undertaking, discuss with your classmates what specific steps would need to be taken to culturally adapt an EST to African Americans, Asian Americans, and Latinx Americans.
3. Do you believe that simply adapting ESTs to the cultural context of the client is sufficient in working with people of color?

Empirically Supported Relationships (ESRs)

Not everyone believes that *cultural adaptations* of ESTs are sufficient to deal with cultural differences, and some express concern that such adaptations result in the imposition of EuroAmerican norms on ethnic minorities.

As Gone (2009) argues, ESTs cannot be “adorned” with “a few beads here, some feathers there” (p. 760). Those critical of reliance on ESTs alone cite the multitude of other factors impacting treatment outcome, such as the therapeutic relationship, client values and beliefs, and the working alliance between client and therapist (DeAngelis, 2005; Sue, 2015). To remedy this shortcoming, the American Psychological Association Division 29 Psychotherapy Task Force was formed to review research and identify characteristics responsible for effective therapeutic relationships and to determine means of tailoring therapy to individual clients (Ackerman et al., 2001).

This focus provided the first opportunity for the inclusion of multicultural concerns within the evidence‐based movement. It is widely agreed that the quality of the working relationship between the therapist and the client (i.e., the *therapeutic alliance*) is consistently related to treatment outcome (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Weinberger, 2002). This relationship may assume even greater significance for clients from diverse backgrounds (Davis, Ancis, & Ashby, 2015). In fact, difficulties in the *therapeutic alliance* may be a factor in the underutilization of mental health services and early termination of therapy seen with minority clients. After reviewing the research on therapist–client relationship variables as they relate to treatment outcome, the task force reached these conclusions (Ackerman et al., 2001):

1. The therapeutic relationship makes substantial and consistent contributions to psychotherapy outcome, independent of the specific type of treatment.
2. The therapy relationship acts in concert with discrete interventions, client characteristics,

and clinician qualities in determining treatment effectiveness.

3. Adapting or tailoring the therapy relationship to specific client needs and characteristics (in addition to diagnosis) enhances the effectiveness of treatment.
4. Practice and treatment guidelines should explicitly address therapist behaviors and qualities that promote a facilitative therapy relationship.

According to the task force, a number of relationship variables are considered "demonstratively effective" or "promising and probably effective" based on research findings (see Table 9.2). ESR variables include the development of a strong *therapeutic alliance*, a solid interpersonal bond (i.e., a collaborative, empathetic relationship based on *positive regard*, respect, warmth, and genuineness), and effective management of *countertransference*—all factors known to be critical for effective multicultural counseling. We elaborate on these relationship variables in the next few sections.

TABLE 9.2 Empirically Supported Relationship (ESR) Variables

Source: Ackerman, S. J., Benjamin, L. S., Beutler, L. E., Gelso, C. J., Goldfried, M. R., Hill, C., … & Rainer, J. (2001). Empirically supported therapy relationships: Conclusions and recommendations of the Division 29 Task Force. *Psychotherapy, 38,* 495–497.

Demonstrably effective	Promising and probably effective
Therapeutic alliance	Positive regard
Cohesion in group therapy	Congruence/genuineness
Empathy	Feedback
Goal consensus and collaboration	Repair of alliance ruptures
Customizing therapy	Self‐disclosure
Management of countertransference	

The Therapeutic Alliance

Research on ESRs has consistently identified the importance of a strong *therapeutic alliance*, which includes the core conditions of effective treatment described by Rogers (1957): *empathy*, respect, genuineness, and warmth. These dynamics typify a therapeutic relationship in which a client feels understood, safe, and encouraged to disclose intimate material. They transcend the therapist's therapeutic orientation or approach to treatment. The therapeutic relationship, or working alliance, is an important factor in effective treatment. Clients specifically asked about what contributed to the success of treatment often point to a sense of connection with their therapist. *Connectedness* has been described as having feelings of closeness with the therapist, working together in an enabling atmosphere, receiving support for change, and being provided an equality of status within the working relationship (Ribner & Knei‐Paz, 2002). As we noted in Chapter 2, cultural humility may be a major aspect in the *therapeutic alliance* contributing to cultural competence (Hook, Davis, Owen, Worthington, & Utsey, 2013; Owen et al., 2014).

Similarly, clients report that therapist behaviors such as "openness to ideas, experiences, and feelings" or being "nonjudgmental and noncritical," "genuine," "warm," and "validating of experiences" are helpful in therapy (Curtis, Field, Knann‐Kostman, & Mannix, 2004). A counselor's relationship skills and ability to develop a *therapeutic alliance* contribute significantly to satisfaction among clients of color (Constantine, 2002). Mulvaney‐Day, Earl, Diaz‐Linhart, and Alegria (2011) found that relationship variables with the therapist were particularly important for African American and Latinx clients, and concluded that "the

basic yearning for authentic connection with a provider transcends racial categories." (p. 36). Thus, the importance of feeling accepted by a therapist on an emotional and cognitive level seems to be a universal prerequisite for an effective *therapeutic alliance*.

Conceptualization of the *therapeutic alliance* often comprises three elements: (a) an emotional or interpersonal bond between the therapist and the client; (b) mutual agreement on appropriate goals, with an emphasis on changes valued by the client; and (c) intervention strategies or tasks that are viewed as important and relevant by both the client and the therapist (Garber, 2004). Defined in this manner, the *therapeutic alliance* exerts positive influences on outcomes across different treatment modalities, accounting for a substantial proportion of outcome variance (Hojat et al., 2011; Zuroff & Blatt, 2006). In fact, the therapist–client relationship contributes as much as 30% to the variance in therapeutic outcome (Lambert & Barley, 2001).

We believe that the *therapeutic alliance* is of critical importance in the outcome of therapy for ethnic minority clients and will describe possible modifications that may help clinicians enhance this relationship. It is important to remember that there is no set formula or response that will ensure the formation of a strong *therapeutic alliance* with a particular client. In fact, counselors often need to demonstrate behavioral flexibility to achieve a good working relationship with clients; this may be particularly true when working with individuals from diverse populations.

In a qualitative study involving Black, Asian, Latinx, and multiracial clients, most preferred an active counselor role, which was characterized by the counselor offering concrete suggestions, providing direct answers, challenging the client's thinking with thought‐provoking questions, and providing psychoeducation regarding the therapy (Chang & Berk, 2009). Mulvaney‐Day et al. (2011) found variability in the counseling relational style preferred by ethnic minority clients. A summary of the preferred relationship styles reported by the African American, Latinx, and non‐Latinx White clients in their sample is presented in Table 9.3.

TABLE 9.3 Relational‐Style Counselor Preferences of Ethnic Group Clients

Source: Mulvaney‐Day, N. E., Earl, T. R., Diaz‐Linhart, Y., & Alegria, M. (2011). Preferences for relational style with mental health clinicians: A qualitative comparison of African American, Latino and Non‐Latino White patients. *Journal of Clinical Psychology*, *67*, 31–44.

Themes	African American clients	Latinx clients	Non‐Latinx White clients
Listening	Listen to who the client really is; recognize that clients are experts on themselves	Listen in a way that communicates "paying attention"	Listen so that the client is comfortable enough to talk and express feelings
Understanding	Understand beyond immediate impressions; understand hidden aspects of the client	Understand feelings of client	Understand complexity of client choices and circumstances
Counselor qualities	Counselor should "lower" self to client's level; egalitarian relationship	Be authoritative, but connect first, then offer concrete advice and solutions	Not judge because of social distance; maintain professional distance but be human

Select this link to open an interactive version of Table 9.3.

Mental health practitioners need to be adaptable with their relationship skills in order to address the preferences and expectations of their clients. For example, many African American clients appear to value social interaction as opposed to problem‐solving approaches, especially during initial sessions, whereas Latinx clients seem to prefer a more interpersonal approach, rather than clinical distance (Gloria & Peregoy, 1996; Kennedy, 2003). We have also seen that many Asian American clients may prefer a problem‐solving approach initially. However, these are broad generalizations, and counselors must test out the effectiveness of different relational skills with a particular client, assessing the impact of their interactions with the client, asking themselves questions such as “Does the client seem to be responding positively to my relational style?” and “Have I succeeded in developing a collaborative and supportive relationship with this client?”, and modifying the approach when necessary. Although it is important not to react to clients in a stereotypic manner, counselors must be continually be aware of cultural and societal issues that may affect them. Asian, Black, Latinx, and multiracial clients who were dissatisfied in cross‐racial therapy complained about their therapist's lack of knowledge about racial identity development; the dynamics of power and privilege; the effects of racism, discrimination, and oppression due to their minority status (or multiple minority statuses); and cultural stigma associated with seeking help (Chang & Berk, 2009).

Cultural information is useful in providing general guidelines regarding an ethnic minority client's counseling‐style preference or issues that need to be addressed in therapy. However, as a counselor develops a comprehensive understanding of each client's background, values, strengths, and concerns, it is essential that they determine whether general cultural information “fits” the individual. This ongoing “search for understanding” is important with respect to each of the following components of the *therapeutic alliance*.

Emotional or Interpersonal Bond

The formation of a bond between the therapist and the client is a very important aspect of the therapeutic relationship and is defined as a collaborative partnership based on *empathy*, *positive regard*, genuineness, respect, warmth, and self‐disclosure. For an optimal outcome, the client must feel connected with, respected by, and understood by the therapist. In addition, the therapist must identify issues that may detract from the relationship, such as *countertransference* (i.e., reactions to the client based on the therapist's own personal issues). These qualities are described in detail later; their importance may vary according to the type of mental health issue being addressed and the characteristics of the client (e.g., gender, socioeconomic status, ethnicity, cultural background).

The development of an *emotional bond* is enhanced by *collaboration*, a shared process in which a client's views are respected and his or her participation is encouraged in all phases of the therapy. An egalitarian stance and encouragement of sharing and *self‐disclosure* facilitate the development of empathy (Dyche & Zayas, 2001) and reduce the power differential between therapist and client. The potential for a positive therapeutic outcome is increased when the client is “on board” regarding the definition of the problem, identification of goals, and choice of interventions. When differences exist between a client's view of a problem and the therapist's theoretical conceptualization, negative dynamics are likely to occur. Collaboration regarding definition of the problem reduces this possibility and is most effective when employed consistently throughout therapy.

Empathy

Empathy is known to significantly enhance the *therapeutic bond*. *Empathy* is defined as the

ability to place oneself in the client's world, to feel or think from the client's perspective, or to be attuned to the client. *Empathy* allows therapists to form an *emotional bond* with clients, helping the clients to feel understood. It is not enough for the therapist to simply communicate this understanding; the client must perceive the responses from the therapist as empathetic. This is why it is vital for therapists to be aware of client receptivity by evaluating both verbal and nonverbal responses from the client ("How is the client responding to what I am saying?", "What are the client's verbal and bodily cues communicating?"). *Empathy* can be demonstrated in several different ways—having an emotional understanding or emotional connection with the client (*emotional empathy*) or understanding the client's predicament cognitively, whether on an individual, family, or societal level (*cognitive empathy*). Following is an illustration of emotional *empathy*:

> *A White male therapist in his late 20s is beginning therapy with a recently immigrated 39 - year - old West Indian woman. The client expresses concern about her adolescent daughter, who she describes as behaving in an angry, hostile way toward her fiancé. The woman is well dressed and is somewhat abrupt, seeming to be impatient with the therapist. Though not a parent himself, the therapist recognizes the distress behind his client's sternness, and thinking of the struggles he had with his own father, he responds to the woman's obvious discomfort saying, "I imagine that must hurt you." This intuitive response from the therapist reduces the woman's embarrassment, and she pauses from the angry story of her daughter's ungratefulness to wipe a tear. (Dyche & Zayas, 2001, p. 249)*

Many counselors are trained to be very direct with emotional responses, using statements such as "You feel hurt" or "You sound hurt" in an effort to demonstrate *empathy*. The response "I imagine that must hurt you" would be rated a more intermediate response. Statements that are even less direct might include "Some people might feel hurt by that" or "If I was in the same situation, I would feel hurt." We have found that people differ in their reaction to the directness of *emotional empathy*, depending on such factors as the gender, ethnicity, or cultural background of the counselor or the client; the degree of comfort and *emotional bonding* with the therapist; and the specific issue involved.

For example, when working with Asian international students, we have found that although there are individual differences in preference, many prefer a less direct style of *emotional empathy*. However, some Asian international students are fine with direct *emotional empathy* (this is why the counselor must be flexible and test out different forms of *empathy* with clients, rather than prejudging them because of membership in a specific group). In general, recognition of emotional issues through either indirect or direct *empathy* increases the client's feeling of being understood. Effective therapists continually evaluate client responses and thus are able to determine if the degree and style of *emotional empathy* being used is enhancing (or detracting) from the *emotional bond* between therapist and client.

Cognitive empathy involves the therapist's ability to understand the issues facing the client. For example, in the case just described, the therapist might explore the possibility that the daughter's anger is related to her immigration experiences by saying, "Sometimes moving to a new country can be difficult." The degree of directness can be varied by making the observation tentative by prefacing statements with "I wonder if … ?" or "Is it possible that … ?" *Cognitive empathy* can also be demonstrated by communicating an understanding of the client's worldview, including the influences of family issues or discriminatory experiences, such as racism, heterosexism, ageism, or sexism. By exploring or including broader societal elements such as these, the therapist is able to incorporate diversity or cross - cultural perspectives and potentially enhance understanding of the client's concerns.

Communicating an understanding of different worldviews and acknowledging the possibility of cultural influences can increase the therapist's credibility with the client. When working with diverse clients, we believe that *empathy* must include the ability to accept and be open to multiple perspectives of personal, societal, and cultural realities. This can be achieved by exploring the impact of cultural differences or diversity issues on client problems, goals, and solutions (Chung & Bernak, 2002; Dyche & Zayas, 2001).

Empathy may be difficult in multicultural counseling if counselors are unable to identify personal cultural blinders or values they may hold. For example, among counselors working with African American clients, those with color - blind racial attitudes (i.e., a belief that race is not a significant factor in determining one's chances in society) showed lower levels of *empathy* than those who were aware of the significance of racial factors (Burkard & Knox, 2004). Some research suggests that counselors' multicultural counseling competence (awareness of issues of race and discrimination, and knowledge of their social impact on clients) accounts for a large proportion of the variance in ratings of counselor competence, expertise, and trustworthiness made by clients of color (Constantine, 2002; Fuertes & Brobst, 2002).

In a study of LGBTQ clients, a counselor's *universal–diversity orientation* (i.e., interest in diversity, contact with diverse groups, comfort with similarities and differences) was positively related to client ratings of the *therapeutic alliance*, whereas, surprisingly, similarities in sexual orientation between therapist and client were not. *Universal–diversity orientation* may facilitate therapy through affirmation and understanding of the issues that culturally diverse clients are facing (Stracuzzi, Mohr, & Fuertes, 2011).

In contrast, the *therapeutic alliance* can be adversely affected when ethnic minority clients perceive a therapist to be culturally insensitive or believe that the therapist is minimizing the importance of racial and cultural issues or pathologizing cultural values or communication styles (Constantine, 2007; Sue, Bucceri, Lin, Nadal, & Torino, 2007). This finding is likely true with other diverse groups who may endure heterosexism, ageism, religious intolerance, and/or prejudice against disability. Sensitivity to the possible impact of racial and societal issues can be made through statements such as the following:

- “How have experiences with discrimination or unfairness had an impact on the problems you are dealing with?”
- “Sometimes it's difficult to meet the societal demands of being a man/woman. How has this influenced your expression of emotions?”
- “Some people believe that family members should be involved in making decisions for individuals in the family. Is this true in your family?”
- “Being or feeling different can be related to messages we receive from our family, society, or religious institutions. Have you considered whether your feelings of isolation are related to messages you are getting from others?”
- “Families change over time. What are some of the standards or values you learned as a young child? I wonder if the conflicts in your family are related to differences in expectations between you and your parents.”

These examples are stated in a very tentative manner. If a counselor has sufficient information, more direct statements of *cognitive empathy* can be made. We believe that the perception of and response to *empathy* varies from individual to individual. There are no set responses that will convey *empathy* and understanding to all clients. In general, therapists

must learn to evaluate their use of both *cognitive* and *emotional empathy* to determine whether it is improving the *emotional bond* with the client and to make modifications, if needed, to enhance the client's perception of empathy within the relationship.

Positive Regard, Respect, Warmth, and Genuineness

The characteristics of *positive regard*, respect, warmth, and genuineness are important qualities in establishing an *emotional bond*. *Positive regard* is the demonstration by the therapist that he or she sees the strengths and positive aspects of the client, including appreciation for his or her values and differences. *Positive regard* is demonstrated when the therapist identifies and focuses on the strengths and assets of the client rather than attending only to deficits or problems. This is especially important for members of ethnic minorities and other diverse groups, whose behaviors are often pathologized. Respect is shown by the therapist's being attentive and demonstrating that he or she views the client as an important person. Behaviors such as asking clients how they would like to be addressed, showing that their comments and insights are valuable, and tailoring one's interaction according to their needs or values are all ways of communicating respect. Warmth is the emotional feeling received by the client when the therapist conveys verbal and nonverbal signs of appreciation and acceptance. Smiling, the use of humor, and showing interest in the client can all convey this feeling. Genuineness can be displayed in many different ways. It generally means the therapist is responding to the client openly and in a “real” manner, rather than in accordance with expected roles. These interpersonal attributes can strengthen the therapist–client alliance and increase the client's trust, cooperation, and motivation to participate in therapy.

Self‐Disclosure

Although self‐disclosure is considered to be a “promising and probably effective” technique (Ackerman et al., 2001), the topic of a therapist revealing personal thoughts or personal information remains controversial. In one study, brief or limited therapist self‐disclosure in response to comparable self‐disclosure by the client was associated with reductions in symptom distress and greater liking for the therapist (Barrett & Berman, 2001).

Counselor disclosure in cross‐cultural situations (e.g., sharing reactions to clients' experiences of racism or oppression) may also enhance the *therapeutic alliance* (Burkard, Knox, Groen, Perez, & Hess, 2006; Cashwell, Shcherbakova, & Cashwell, 2003). Self‐disclosures may show the therapist's human qualities and lead to the development of closer ties with the client. Research to determine the impact of therapist self‐disclosure is difficult since it depends on many variables, such as the type of disclosure, its timing and frequency, and client characteristics. Although many clients report that therapist self‐disclosure enhances the therapeutic relationship, some self‐disclosures by a therapist (e.g., that they are wealthy or politically conservative) can actually interfere with it (Chang & Berk, 2009).

Some therapists feel that self‐disclosure is not appropriate in therapy, and they either will not answer personal questions or will bounce such questions back to the client. However, some clients who ask, “Has this ever happened to you?” may be doing so in an attempt to normalize their experience. Bouncing the question back to the client by saying, “Let's find out why you want to know this” can be perceived as patronizing rather than helpful (Hays, 2001). Should you make self‐disclosures to a client? The answer is, “It depends.” Sharing experiences or reactions can strengthen the *emotional bond* between therapist and client. However, such self‐disclosure should be limited and aimed at helping the client with his or her issues. If the requests for self‐disclosure become frequent or too personal, the therapist should explore with the client the reason for their inquiries.

Management of Countertransference

Appropriate management of *countertransference* can enhance the *therapeutic alliance*, as well as minimize ruptures in the therapeutic relationship. *Countertransference* involves the therapist's emotional reaction to the client based on the therapist's own set of attitudes, beliefs, values, or experiences. These emotional reactions, whether negative or positive, can bias a therapist's judgment when working with a client. For example, a therapist might exhibit negative reactions to a client owing to factors such as heterosexism, racism, or classism. Additionally, difficulty can occur when clients demonstrate values and perspectives similar to the therapist's own; such similarity may reduce therapist objectivity. Therapists sometimes over‐identify with clients who are similar to them and subsequently underestimate the client's role in interpersonal difficulties. As we have seen in Chapter 3, this is most likely to happen in interracial/interethnic therapeutic relationships. These unconscious reactions can interfere with the formation of a healthy therapeutic *emotional bond* with the client. Because of the negative impact of *countertransference*, clinicians should examine their experiences, values, and beliefs when experiencing an emotional reaction to a client that is beyond what is expected from a therapy session.

A scientific frame of mind necessitates the examination of one's own values and beliefs in order to anticipate the impact of possible differences and similarities in worldviews on the *therapeutic alliance*. Multicultural therapists have been in the forefront of stressing the importance of acknowledging the influence of values, preferences, and worldviews on psychotherapy and the psychotherapist. It is important to be self‐aware, to recognize when personal needs or values are being activated in the therapeutic relationship, and not to project our reactions on to clients (Brems, 2000).

Goal Consensus

An agreement on goals between the therapist and the client (i.e., *goal consensus*) is another important relationship variable. Unless the client agrees on what the goals should be, little progress will be made. As therapists, we too easily envision what the appropriate outcome should be when working with a client and become dismayed or discouraged when the client does not feel the same way or seems satisfied with more limited solutions. Goals should be determined in a collaborative manner, with input from both client and therapist. Although it is very important to get the client's response in regard to the problem and goals, the therapist has the important task of clarifying client statements and providing tentative suggestions.

Clients often identify global goals, such as “wanting to improve self‐esteem.” The therapist's job is to help them define their goal more specifically and to foster alternative ways of interpreting situations (Hilsenroth & Cromer, 2007). Concrete goals enhance the ability to measure progress in therapy. To obtain more specificity regarding a global goal, therapists can ask such questions as, “What does your low self‐esteem prevent you from doing?”, “How would your life be different if you had high self‐esteem?”, “What would you be able to do if you had more self‐esteem?”, or “How would you know if you are improving in self‐esteem?”. The answer to these questions, such as “Being able to hold a job or ask for a raise,” “Feeling more comfortable in group situations,” or “Standing up for myself,” can help identify aspects of self‐esteem that are more concrete. Each of these responses can be used to define subgoals. A client might be asked, “What are small steps that you can make that will show you are moving in the direction of higher self‐esteem?”

Once goals are identified, the client and the therapist can work together to identify which strategies and techniques will be employed to help the client achieve the stated goals. In order for interventions to be useful, they need to make sense to the client. For ethnic minority

clients, interventions may require “cultural adaptation,” such as that described in the study by Huey and Pan (2006), where the treatment of phobias was modified for Asian Americans by emphasizing the strategy of emotional control and maximizing a directive role for the therapist.

Although the selection of interventions depends upon the presenting problem and diagnosis, psychological interventions are most effective when they are consistent with client characteristics, including the client's culture and values (La Roche, Batista, & D'Angelo, 2011). It is also important that the client believe that the therapeutic approach will be helpful. In a study by Coombs, Coleman, and Jones (2002), clients who reported “understanding the therapy process” and “having positive expectations of the therapy” were more likely to improve.

REFLECTION AND DISCUSSION QUESTIONS

1. What was your therapy training in regard to the formation of the *therapeutic alliance* with a client? Indicate how the relationship skills were discussed in relation to cross‐cultural competence.
2. What is your experience in working with ethnic minorities or other diverse populations? Did they appear to require different relationship skills? Did you evaluate the effectiveness of your responses?

Video 9.1: Supporting Counseling with Evidence

Utilizing evidence-based practices in conjunction with minority client cultural beliefs can affect the greatest change in favor of client outcomes.

EVIDENCE‐BASED PRACTICE (EBP) AND DIVERSITY ISSUES IN COUNSELING

The American Psychological Association's focus on ESRs provided an opening for counselors to address multicultural concerns within an evidence‐based framework. However, the broader and more recent focus on EBP has more formally introduced cultural sensitivity as an essential consideration in assessment, case conceptualization, and selection of interventions. Specifically, EBP refers to “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Presidential Task Force on Evidence‐Based Practice, 2006, p. 273; see Figure 9.1).

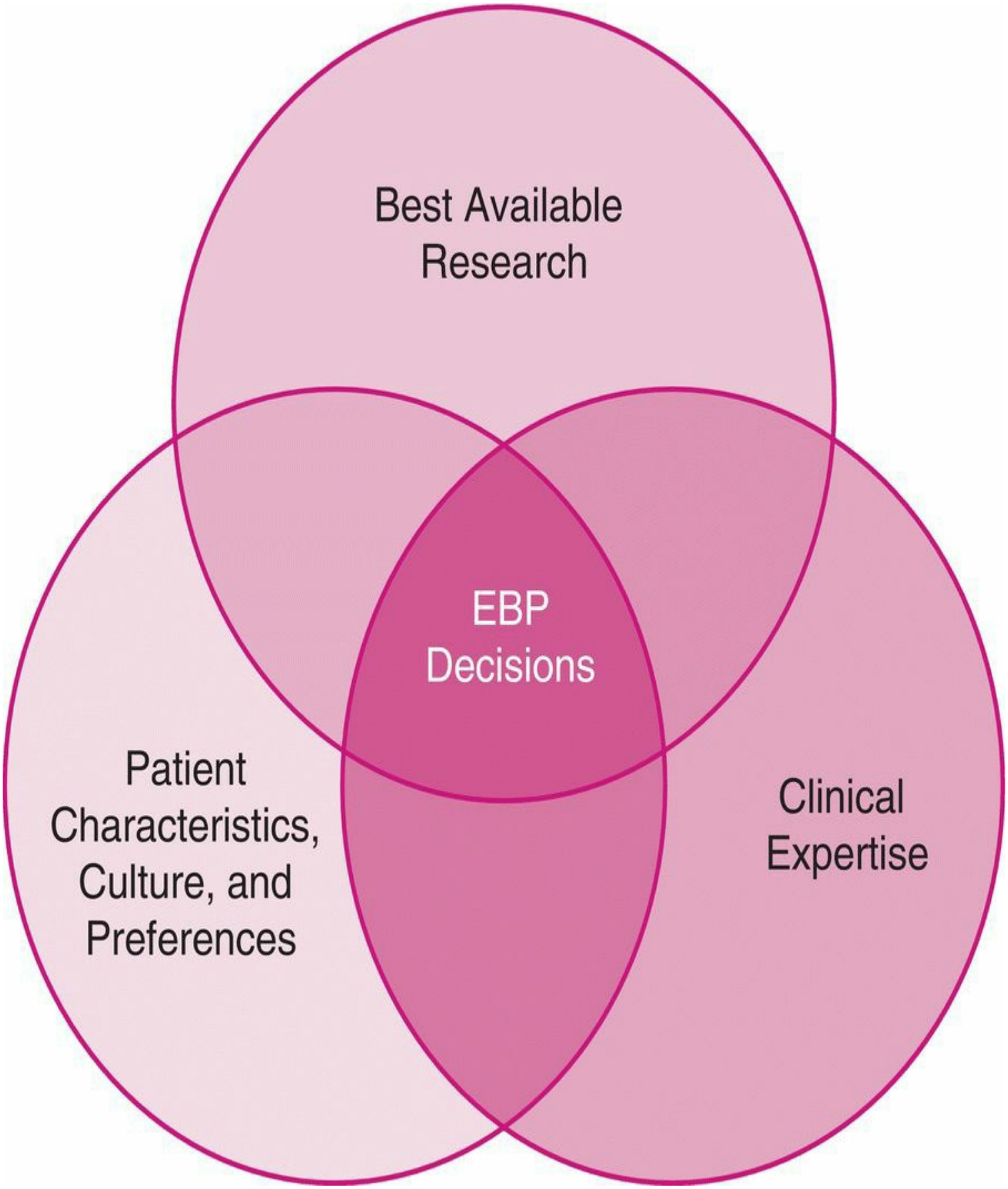

FIGURE 9.1 Three Pillars of Evidence‐Based Practice (EBP)

Source: Morales, E., & Norcross, J. (2010). Evidence based practices with ethnic minorities: Strange bedfellows no more.” *Journal of Clinical Psychology, 66*(8), 824. Reprinted with permission of John Wiley & Sons, Inc.

Select this link to open an interactive version of Figure 9.1.

Empirically based practice includes both EBTs and relationship variables but is broader and more comprehensive than a combination of the two. How does EBP differ from the EST and ESR frameworks?

First, the assumption underlying EBP is that the search for the “best research evidence” *begins* with a comprehensive understanding of the client's background and problem and goes

on to consider which therapeutic approach is most likely to provide the best outcome. In other words, the selection of intervention occurs *only after* individual characteristics, such as cultural background, values, and preferences, are assessed. This allows for the individualizing of therapy, with strong consideration given to client background and characteristics.

Second, unlike ESTs, which rely primarily on randomized controlled trials, EBP also accepts research evidence from qualitative studies, clinical observations, systematic case studies, and interventions delivered in naturalistic settings. This broadening of the definition of research allows mental health professionals greater latitude in deciding which therapy may be the best match for a particular client. For example, the National Registry of Evidence‐based Programs and Practices (NREPP) provides specific information regarding treatments for substance abuse that consider the race and ethnicity of the participants, as well as treatments designed for certain ethnic groups, such as the American Indian Life Skills Development Program (Berke, Rozell, Hogan, Norcross, & Karpiak, 2011).

Third, the definition of clinical expertise within the EBP framework focuses not only on the quality of the therapeutic relationship and *therapeutic alliance* but also on the skills essential for comprehensive assessment of the client's problem and strengths. Additionally, EBP considers clinical expertise involving factors such as knowledge about cultural differences; best practices in assessment, diagnosis, and case conceptualization; strategies for evaluating and selecting appropriate research‐based treatments; and adaptation of selected treatments in a manner that respects the client's worldview, values, and preferences.

Fourth, EBP is based on an ongoing emphasis on client characteristics, culture, and preferences and the importance of working collaboratively with the client to develop goals and treatment strategies that are mutually agreeable. Identification of client variables includes (a) age and life stage, (b) sociocultural factors (e.g., gender, sexual orientation, ethnicity, disability), (c) environmental stressors (e.g., unemployment, recent life events, racism, health disparities), and (d) personal treatment preferences (i.e., treatment expectations, goals, and beliefs).

Because the *focus* is on the client and the consideration of cultural variables, EBP sets the stage for a multiculturally sensitive counseling relationship. The following illustration of how EBP and multicultural sensitivity can be integrated is based on the case of Anna, an American Indian female who developed post‐traumatic stress disorder (PTSD) following a sexual assault.

> *Anna is a 14‐year‐old American Indian female who was sexually abused by a 22‐year‐old male in her small community. Anna disclosed the abuse to her school counselor, who then reported the incident to tribal law enforcement. After word of the incident spread through the community, several individuals accused Anna of lying and then harassed her in an attempt to recant her allegation. Anna began isolating herself at home and stopped attending school. Anna became increasingly depressed and demonstrated symptoms consistent with PTSD.*
>
> *(BigFoot & Schmidt, 2010, p. 854)*

BigFoot and Schmidt (2010) were able to meld American Indian traditional healing processes and cultural teachings within an EBP framework. Aspects of this process included assessment of Anna's personal characteristics and preferences, as well as the influence of culture on her reactions to the trauma. Following careful assessment, intervention strategies were selected based on assessment data, therapist expertise, research regarding effective treatments for post‐traumatic stress, and cultural adaptation of the therapy selected. The steps involved the following:

- Research‐supported treatments for childhood or adolescent trauma were identified. Trauma‐focused cognitive behavioral therapy (TF‐CBT) was chosen because it was seen to complement many of the traditional healing practices used in Anna's tribe, including traditional beliefs about the relationship between emotions, beliefs, and behaviors. TF‐CBT is a conjoint child and family psychotherapy that has been comprehensively evaluated and designated by the National Crime Victims Research and Treatment Center (NCVC) as having the highest level of research support as an “efficacious treatment” for childhood abuse and trauma.

    TF‐CBT has been evaluated with Caucasian and African American children and adapted for American Indian/Alaska Native populations, Latinx Americans, hearing‐impaired individuals, immigrant Cambodians, and children of countries including Zambia, Uganda, South Africa, Pakistan, the Netherlands, Norway, Sweden, Germany, and Cambodia (National Child Traumatic Stress Network, 2008). The components of TF‐CBT include a focus on reducing negative emotional and behavioral responses resulting from trauma and correcting trauma‐related beliefs through gradual exposure to memories and emotional associations with the traumatic event. Relaxation training is used to reduce negative emotions. Parents are included in the treatment process as emotional support for the child; parents are provided with strategies for helping to manage their child's emotional reaction to the trauma.

- Client characteristics and values were identified through interviews with Anna and her family and by assessing their tribal and cultural identity. In Anna's case, both she and her family agreed that she had a strong American Indian identity and valued traditional healing approaches. Thus, it was decided that a culturally adapted TF‐CBT would be the most appropriate form of treatment. (If Anna and her family had expressed minimal tribal or American Indian cultural identification, standard TF‐CBT might have been the treatment of choice.)

- *Cultural adaptations* of TF‐CBT were developed. Because of cultural beliefs that trauma can bring about disharmony and result in distorted beliefs and unhealthy behaviors, traditional healing efforts focus on returning the individual to a state of harmony through teachings, ceremonies, and tribal practices, including a ritual called Honoring Children, Mending the Circle (HC‐MC). The Circle represents the interconnectedness of spirituality and healing and the belief that all things have a spiritual nature; prayers, tribal practices, and rituals connect the physical and the spiritual worlds, bringing wellness and harmony. Additionally, adaptation of the affect management, relaxation, cognitive coping, and enhancing the parent–child relationship aspects of TF‐CBT incorporated spiritual (saying prayers), relational (support from friends and family), mental (hearing messages of love and support), and physical (helping Anna reacquire physical balance) supports, thus increasing Anna's feelings of safety and security.

    Further adaptation involved the TF‐CBT goal of extinguishing the fear response using a “trauma narrative,” during which the child “revisits” the traumatic incident and is gradually exposed to threatening cues. In the adaptation, culturally accepted methods for telling the trauma story—including use of a journey stick, tribal dances, and storytelling procedure—were used to facilitate exposure. Relaxation techniques were also adapted by having Anna breathe deeply while focused on culturally relevant images, such as the “sway

of wind‐swept grasses" or the movement of a "woman's shawl during a ceremonial dance."

As BigFoot and Schmidt (2010) concluded, "the adaption of TF‐CBT within an American Indian/Alaskan Native well‐being framework can enhance healing through the blending of science and indigenous cultures … The HC‐MC adaptation seeks to honor what makes American Indians and Alaska Natives culturally unique through respecting beliefs, practices, and traditions within their families, communities, tribes, and villages that are inherently healing" (p. 855).

REFLECTION AND DISCUSSION QUESTIONS

1. What is your reaction to EBP, especially as it applies to ethnic minorities and other diverse populations?
2. It is clear that using an EBP approach requires great time and effort on the part of clinicians to develop a treatment plan. The implication is that counselors must do out‐of‐office education or consultation regarding what is available in the research literature that might help inform their practice. Is such an approach too time‐consuming? Given that EBP research is exploding in the field, how would you keep current or informed as a practitioner?

IMPLICATIONS FOR CLINICAL PRACTICE

1. Realize that the early EST formulations inadequately addressed the needs of marginalized groups in our society, but that ESTs have begun to incorporate cultural contexts in modifying evidence‐based approaches. The standards used to determine ESTs and ESRs were often too rigid and ignored the cultural context in advocating for the role of science and research in the selection of therapeutic treatments and interventions.
2. Be aware that most mental health professionals have moved to the concept of EBP, (a) allowing for a broader array of means to determine the selection, process, and outcome of effective treatments and (b) integrating cultural factors and/or modifying approaches to fit the needs of diverse clients.
3. Know that *multicultural counseling* and EBP are "strange bedfellows no more" and that it is no longer adequate to devise a treatment plan solely on the basis of one's theoretical orientation, clinical intuition, or clinical expertise.
4. Be aware that EBP models focusing on client characteristics and evaluating the degree of fit between a therapeutic approach and an individual client have actually legitimized the outcry of those in the field of *multicultural counseling*—that it is essential to consider the cultural beliefs and values of the client and that relational counselor styles may need to vary according to an individual's cultural background.
5. Know that the integration of EBP and multiculturalism is resulting in an explosion of research. With the former emphasizing client characteristics, values, preference, and culture, EBP and multicultural therapy are becoming inextricably entwined, with each adding strengths to the other.
6. Understand that EBP can provide clinicians with information regarding which therapies

are most effective with which specific disorders and which specific population. Thus, in choosing a treatment strategy, the best approach (given the current state of research) is for the counselor to select an intervention that is research‐based (if available) and adapt it for the individual client according to his or her individual characteristics, values, and preferences.

7. Know that culturally competent counseling and therapy is more than a technique‐driven search for effective techniques and strategies. We now know that the *therapeutic alliance* or working relationship is crucial to therapeutic outcome.
8. Be prepared to modify your therapeutic style to be consistent with the cultural values, lifestyles, and needs of culturally diverse clients. Remember, respect, unconditional *positive regard*, warmth, and empathy are most effective in the *therapeutic alliance* when they are communicated in a culturally consistent manner.
9. Be aware that some research suggests that a counselor's *multicultural counseling* competence and humility (awareness of issues of race and discrimination and knowledge of their social impact on clients) accounts for a large proportion of the variance in ratings of counselor competence, expertise, and trustworthiness made by clients of color.
10. Note that most approaches to counseling and therapy attempt to adapt the research findings of EBP to fit the unique cultural characteristics and needs of diverse populations. But what if we approach the challenge to develop culturally appropriate therapeutic techniques and relationships from an indigenous perspective first? This is a question we address in Chapter 10 on Non‐Western Indigenous Methods of Healing.

Video 9.2: Client Values and Evidence-Based Practice

Reconciling EBP with cultural values can be challenging but isn't impossible. Openness in dialogue can be the fastest, clearest means to an end. Explaining the purpose of EBPs, and how they can impact change, are important when working with minority clients.

Video Lecture: Science, Ethnicity and Bias: Where Have We Gone Wrong? by Stanley Sue

SUMMARY

The importance of EBP is becoming increasingly accepted in the field of *multicultural counseling*. Discussions of EBP originally focused on research‐supported therapies for specific disorders, but the dialogue has now broadened to contain clinical expertise, including understanding the influence of individual and cultural differences on treatment and the importance of considering client characteristics and culture. Although optimism about the convergence of these forces is increasing, there is still resistance to EBP among some individuals within the field of *multicultural counseling*. The applicability of EBP for many diverse groups has been insufficiently researched, and the concept of "evidence" has historically been very narrow. Furthermore, the therapist–client relationship is not adequately acknowledged in the EBT and EST formulations.

It is now widely agreed that the quality of the working relationship between the therapist and the client is consistently related to treatment outcome and has led to the formulation of ESRs. A number of relationship variables are considered effective based on research findings. ESR variables include the development of a strong *therapeutic alliance*, a solid interpersonal bond (i.e., a collaborative, empathetic relationship based on *positive regard*, respect, warmth, and genuineness), effective management of *countertransference*, and *goal consensus*—all factors known to be critical for effective *multicultural counseling*.

The assumption underlying EBP is that the best research evidence begins with a comprehensive understanding of the client's background and problem and goes on to consider which therapeutic approach is most likely to provide the best outcome. This allows for the individualizing of therapy with strong consideration of client background and characteristics. It broadens the definition of research and allows mental health professionals greater latitude in deciding which therapy may be the best match for a particular client. EBP is based on an ongoing emphasis on client characteristics, culture, and preferences and the importance of working collaboratively with the client to develop goals and treatment strategies that are mutually agreeable. Because the focus is on the client and the consideration of cultural variables, EBP sets the stage for a multiculturally sensitive counseling relationship.

GLOSSARY TERMS

- Cognitive empathy
- Countertransference
- Cultural adaptations
- Emotional bond
- Emotional empathy
- Empathy
- Empirically supported relationships
- Empirically supported treatments
- Evidence‐based practices
- Therapeutic alliance
- Therapeutic bond
- Universal–diversity orientation

Video 9.3: Counseling Session Analysis

Analysis of counseling session by Drs. Derald Wing Sue and Joel Filmore.

REFERENCES

1. Ackerman, S. J., Benjamin, L. S., Beutler, L. E., Gelso, C. J., Goldfried, M. R., Hill, C., … Rainer, J. (2001). Empirically supported therapy relationships: Conclusions and recommendations of the Division 29 Task Force. *Psychotherapy*, *38*, 495–497.

2. Aguilera, A., Garza, M. J., & Munoz, R. F. (2010). Group cognitive ‐ behavioral therapy for depression in Spanish: Culture ‐ sensitive manualized treatment in practice. *Journal of Clinical Psychology*, *66*, 857–867.

3. American Counseling Association (2014). *Code of ethics*. Alexandria, VA: American Counseling Association.

4. American Psychological Association (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist*, *48*, 45–48.

5. American Psychological Association (2007). Guidelines for the psychological practice with girls and women. *American Psychologist*, *62*, 949–979.

6. American Psychological Association (2014). Guidelines for psychological practice with older adults. *American Psychologist*, *69*, 34–65.

7. American Psychological Association (APA) Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients (2012). Guidelines for psychotherapy with lesbian, gay, and bisexual clients. *American Psychologist*, *67*, 10–42.

8. American Psychological Association (APA) Presidential Task Force on Evidence ‐ Based Practice (2006). Evidence ‐ based practice in psychology. *American Psychologist*, *61*, 271–285.

9. Barrett, M. S., & Berman, J. S. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Consulting and Clinical Psychology*, *69*, 597–603.

10. Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct ‐ comparison meta ‐ analysis. *Journal of Counseling Psychology*, *58*, 279–289.

11. Berke, D. M., Rozell, C. A., Hogan, T. P., Norcross, J. C., & Karpiak, C. P. (2011). What clinical psychologists know about evidence ‐ based practice: Familiarity with online resources and research methods. *Journal of Clinical Psychology*, *67*, 329–339.

12. Bernal, G., & Sáez ‐ Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology*, *34*, 121–132.

13. BigFoot, D. S., & Schmidt, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma ‐ focused cognitive ‐ behavioral therapy for American Indian and Alaska Native children. *Journal of Clinical Psychology: In Session*, *66*, 847–856.

14. Bledsoe, S. E., Weissman, M. M., Mullen, E. J., Ponniah, K., Gameroff, M. J., Verdell, H., … Wichramaratne, P. (2007). Empirically supported psychotherapy in social work training programs: Does the definition of evidence matter? *Research on Social Work*

Practice, *17*, 449–455.

15. Brems, C. (2000). *Dealing with challenges in psychotherapy and counseling*. Belmont, CA: Brooks/Cole.

16. Burkard, A. W., & Knox, S. (2004). Effect of therapist color‐blindness on empathy and attributions in cross‐cultural counseling. *Journal of Counseling Psychology*, *51*, 1–29.

17. Burkard, A. W., Knox, S., Groen, N., Perez, M., & Hess, S. (2006). European American therapist self‐disclosure in cross‐cultural counseling. *Journal of Counseling Psychology*, *53*, 15–25.

18. Cashwell, C. S., Shcherbakova, J., & Cashwell, T. H. (2003). Effect of client and counselor ethnicity on preference for counselor disclosure. *Journal of Counseling and Development*, *81*, 196–201.

19. Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology*, *64*, 497–504.

20. Chambless, D. L., & Hollon, S. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, *66*, 7–18.

21. Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, *52*, 685–716.

22. Chang, D. F., & Berk, A. (2009). Making cross‐racial therapy work: A phenomenological study of clients' experiences of cross‐racial therapy. *Journal of Counseling Psychology*, *56*, 521–536.

23. Chaudhry, S., & Li, C. (2011). Is solution‐focused brief therapy culturally appropriate for Muslim American counselees? *Journal of Contemporary Psychotherapy*, *41*(2), 109–113.

24. Cheng, P. H., & Merrick, E. (2017). Cultural adaptation of dialectical behavior therapy for a Chinese international student with eating disorder and depression. *Clinical Case Studies*, *16*(1), 42–57.

25. Chung, R. C.‐Y., & Bernak, F. (2002). The relationship of culture and empathy in cross‐cultural counseling. *Journal of Counseling and Development*, *80*, 154–159.

26. Chwalisz, K. (2001). A common factors revolution: Let's not “cut off our discipline's nose to spite its face.”. *Journal of Counseling Psychology*, *48*, 262–267.

27. Constantine, M. G. (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and ratings of their counselors' general and multicultural counseling competence. *Journal of Multicultural Counseling and Development*, *30*(4), 210–215.

28. Constantine, M. G. (2007). Racial microaggressions against African American clients in a cross‐racial counseling relationship. *Journal of Counseling Psychology*, *54*, 1–16.

29. Coombs, M. M., Coleman, D., & Jones, E. E. (2002). Working with feelings: The importance of emotion in both cognitive‐behavioral and interpersonal therapy in the

NIMH Treatment of Depression Collaborative Research Program. *Psychotherapy: Theory/Research/Practice/Training*, *39*, 233–244.

30. Corey, G. (2013). *Theory and practice of counseling and psychotherapy* (9th ed.). Belmont, CA: Brooks/Cole.

31. Cunningham, P. B., Foster, S. L., & Warner, S. E. (2010). Culturally relevant family ‐ based treatment for adolescent delinquency and substance abuse: Understanding within ‐ session processes. *Journal of Clinical Psychology: In Session*, *66*, 830–846.

32. Curtis, R., Field, C., Knann ‐ Kostman, I., & Mannix, K. (2004). What 75 psychoanalysts found helpful and hurtful in their own analysis. *Psychoanalytic Psychology*, *21*, 183–202.

33. Davis, T. A., Ancis, J. R., & Ashby, J. S. (2015). Therapist effects, working alliance, and African American Women substance users. *Cultural Diversity and Ethnic Minority Psychology*, *21*, 126–135.

34. DeAngelis, T. (2005). Shaping evidence ‐ based practice. *Monitor on Psychology*, *36*, 26–31.

35. Deegear, J., & Lawson, D. M. (2003). The utility of empirically supported treatments. *Professional Psychology: Research and Practice*, *34*, 271–277.

36. Duarte ‐ Velez, Y., Guillermo, B., & Bonilla, K. (2010). Culturally adapted cognitive ‐ behavioral therapy: Integrating sexual, spiritual, and family identities in an evidence ‐ based treatment of a depressed Latino adolescent. *Journal of Clinical Psychology: In Session*, *66*, 895–906.

37. Dyche, L., & Zayas, L. H. (2001). Cross ‐ cultural empathy and training the contemporary psychotherapist. *Clinical Social Work Journal*, *29*, 245–258.

38. Fortuna, L. R., Alegria, M., & Gao, S. (2010). Retention in depression treatment among ethnic and racial minority groups in the United States. *Depression and Anxiety*, *27*, 485–494.

39. Fuertes, J. N., & Brobst, K. (2002). Clients' ratings of counselor multicultural competency. *Cultural Diversity and Ethnic Minority Psychology*, *8*, 214–223.

40. Garber, B. D. (2004). Therapist alienation: Foreseeing and forestalling third ‐ party dynamics: Undermining psychotherapy with children of conflicted caregivers. *Professional Psychology: Research and Practice*, *35*, 357–363.

41. Gibbs, L., & Gambrill, E. (2002). Evidence ‐ based practice: Counterarguments to objections. *Research on Social Work Practice*, *12*, 452–476.

42. Gloria, A. M., & Peregoy, J. J. (1996). Counseling Latino alcohol and other substance users/abusers. *Journal of Substance Abuse Treatment*, *13*, 119–126.

43. Gone, J. P. (2009). A community ‐ based treatment for Native American historical trauma: Prospects for evidence ‐ based practice. *Journal of Consulting and Clinical Psychology*, *17*, 751–762.

44. Graham, J. R., Sorenson, S., & Hayes ‐ Skelton, S. A. (2013). Enhancing the cultural sensitivity of cognitive behavioral interventions for anxiety in diverse populations. *The Behavior Therapist/AABT*, *36*(5), 101.

45. Hays, P. A. (2001). *Addressing cultural complexities in practice: A framework for clinicians and counselors*. Washington, DC: American Psychological Association.

46. Hilsenroth, M. J., & Cromer, T. D. (2007). Clinician interventions related to alliance during the initial interview and psychological assessment. *Psychotherapy: Theory, Research, Practice, Training*, *44*, 205–218.

47. Hojat, M., Louis, D. Z., Markham, F. W., Wender, R., Rabinowitz, C., & Gonnella, J. S. (2011). Physicians' empathy and clinical outcomes for diabetic patients. *Academic Medicine*, *86*, 359–364.

48. Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*, 353–366.

49. Horrell, S. C. V. (2008). Effectiveness of cognitive ‐ behavioral therapy with adult ethnic minority clients: A review. *Professional Psychology: Research and Practice*, *39*, 160–168.

50. Huey, S. J., & Pan, D. (2006). Culture ‐ responsive one ‐ session treatment for phobic Asian Americans: A pilot study. *Psychotherapy: Theory, Research, Practice, Training*, *43*, 549–554.

51. Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2014). *Intentional interviewing and counseling* (8th ed.). Belmont, CA: Brooks/Cole.

52. Kennedy, R. (2003). Highlights of the American Psychiatric Association 55th Institute on Psychiatric Services. Retrieved from http://www.medscape.com/viewarticle/471433

53. Kratochwill, T. R. (2002). Evidence ‐ based interventions in school psychology: Thoughts on thoughtful commentary. *School Psychology Quarterly*, *15*, 518–532.

54. Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy*, *38*, 357–361.

55. La Roche, M. J., Batista, C., & D'Angelo, E. (2011). A content analysis of guided imagery scripts: A strategy for the development of cultural adaptations. *Journal of Clinical Psychology*, *67*, 45–57.

56. Lau, A. S., Fung, J. J., & Yung, V. (2010). Group parent training with immigrant Chinese families: Enhancing engagement and augmenting skills development. *Journal of Clinical Psychology: In Session*, *66*, 880–894.

57. Lester, K., Resick, P. A., Young ‐ Xu, Y., & Artz, C. (2010). Impact of race on early treatment termination and outcomes in posttraumatic stress disorder treatment. *Journal of Consulting and Clinical Psychology*, *78*, 480–489.

58. Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Psychological Science*, *2*, 53–70.

59. Moradi, B., & Grzanka, P. R. (2017). Using intersectionality responsibly: Toward critical epistemology, structural analysis, and social justice activism. *Journal of Counseling Psychology*, *64*(5), 500–513.

60. Morales, E., & Norcross, J. C. (2010). Evidence ‐ based practices with ethnic minorities:

Strange bedfellows no more. *Journal of Clinical Psychology*, *66*, 821–829.

61. Mulvaney‐Day, N. E., Earl, T. R., Diaz‐Linhart, Y., & Alegria, M. (2011). Preferences for relational style with mental health clinicians: A qualitative comparison of African American, Latino and Non‐Latino White patients. *Journal of Clinical Psychology*, *67*, 31–44.

62. Nagayama‐Hall, G. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology*, *69*, 502–510.

63. National Child Traumatic Stress Network. (2008). Trauma‐focused cognitive behavioral therapy. Retrieved from https://www.nctsn.org/interventions/trauma‐focused‐cognitive‐behavioral‐therapy

64. Nicolas, G., Arntz, D. L., Hirsch, B., & Schmiedigen, A. (2011). Cultural adaptation of a group treatment for Haitian American adolescents. *Professional Psychology: Research and Practice*, *40*, 378–384.

65. Organista, K. C. (2000). Latinos. In J. R. White, & A. S. Freeman (Eds.), *Cognitive‐behavioral group therapy: For specific problems and populations* (pp. 281–303). Washington, DC: American Psychological Association.

66. Owen, J., Jordan, T. A., Turner, D., Davis, D. E., Hook, J. N., & Leach, M. M. (2014). Therapists' multicultural orientation: Client perceptions of cultural humility, spiritual/religious commitment, and therapy outcomes. *Journal of Psychology and Theology*, *42*, 91–98.

67. Owens, D., Queener, J., & Stewart, T. (2016). Counseling African American males utilizing nontraditional clinical treatment approaches. In W. Ross (Ed.), *Counseling African American Males: Effective Therapeutic Interventions and Approaches*. Charlotte, NC: Information Age Publishing.

68. Pomerville, A., & Gone, J. P. (2018). Behavioral health services in urban American Indian health organizations: A descriptive portrait. *Psychological Services*, *15*, 1–10.

69. Ribner, D. S., & Knei‐Paz, C. (2002). Client's view of a successful helping relationship. *Social Work*, *47*, 379–387.

70. Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*, 95–103.

71. Smith, T. B., & Trimble, J. E. (2016a). Mental health service utilization across race: A meta‐analysis of surveys and archival studies. In T. B. Smith, & J. E. Trimble (Eds.), *Foundations of multicultural psychology: Research to inform effective practice* (pp. 67–94). Washington, DC: American Psychological Association.

72. Smith, T. B., & Trimble, J. E. (2016b). Participation of clients of color in mental health services: A meta‐analysis of treatment attendance and treatment completion/attrition. In T. B. Smith, & J. E. Trimble (Eds.), *Foundations of multicultural psychology: Research to inform effective practice* (pp. 95–114). Washington, DC: American Psychological Association.

73. Smith, T. B., & Trimble, J. E. (2016c). Culturally adapted mental health services: An updated meta‐analysis of client outcomes. In T. B. Smith, & J. E. Trimble (Eds.),

Foundations of multicultural psychology: Research to inform effective practice (pp. 129–144). Washington, DC: American Psychological Association.

74. Smith, T. B., Rodriguez, M. D., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology*, *67*, 166–175.

75. Society of Clinical Psychology (2011). Psychological treatments. Retrieved from https://www.div12.org/psychological‐treatments/

76. Stracuzzi, T. I., Mohr, J. J., & Fuertes, J. N. (2011). Gay and bisexual male clients' perceptions of counseling: The role of perceived sexual orientation similarity and counselor universal‐diverse orientation. *Journal of Counseling Psychology*, *58*, 299–309.

77. Sue, D., & Sue, D. M. (2008). *Foundations of counseling and psychotherapy: Evidence‐based practices in a diverse society*. Hoboken, NJ: Wiley.

78. Sue, D. W. (2015). Therapeutic harm and cultural oppression. *The Counseling Psychologist*, *43*, 359–369.

79. Sue, D. W., Bucceri, J., Lin, A. I., Nadal, K. L., & Torino, G. C. (2007). Racial microaggressions and the Asian American experience. *Cultural Diversity and Ethnic Minority Psychology*, *13*, 72–81.

80. Sue, S., Zane, N., Levant, R. F., Silverstein, L. B., Brown, L. S., & Olkin, R. (2006). How well do both evidence‐based practices *and* treatment as usual satisfactorily address the various dimensions of diversity? In J. C. Norcross, L. F. Beutler, & R. F. Levant (Eds.), *Evidence‐based practice in mental health: Debate and dialogue on the fundamental questions* (pp. 329–337). Washington, DC: American Psychological Association.

81. Sue, S., Zane, N., Nagayama‐Hall, G. C., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology*, *60*, 525–548.

82. Thurston, I. B., & Phares, V. (2008). Mental health utilization among African American and Caucasian mothers and fathers. *Journal of Consulting and Clinical Psychology*, *76*, 1058–1067.

83. Triffleman, E. G., & Pole, N. (2010). Future directions in studies of trauma among ethnoracial and sexual minority samples: Commentary. *Journal of Consulting and Clinical Psychology*, *78*, 490–497.

84. Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum.

85. Weinberger, J. (2002). Short paper, large impact: Rosenzweig's influence on the common factor movement. *Journal of Psychotherapy Integration*, *12*, 67–76.

86. Wendt, D. C., Gone, J. P., & Nagata, D. K. (2015). Potentially harmful therapy and multicultural counseling: Bridging two disciplinary discourses. *The Counseling Psychologist*, *43*, 334–358.

87. Zuroff, D. C., & Blatt, S. J. (2006). The therapeutic relationship in the brief treatment of depression: Contributions to clinical improvement and enhanced adaptive capacities. *Journal of Consulting and Clinical Psychology*, *74*, 130–140.

Note

Significant portions of this chapter are adapted from D. Sue and D. M. Sue (2008).

10
Non‐Western Indigenous Methods of Healing: Implications for Multicultural Counseling and Therapy (MCT)

Chapter Objectives

1. **1. Outline basic assumptions of *indigenous healing* and shamanism.**
2. **2. Explain shamanic and indigenous explanations of illness.**
3. **3. Identify commonalities between what therapists and *shamans/traditional healers* do.**
4. **4. Describe how shamanism and traditional healing makes different assumptions from Western scientific approaches in mental health treatment.**
5. **5. Discuss the belief in altered states of consciousness or different planes of existence.**
6. **6. Explain how religion and *spirituality* affect the belief systems of indigenous groups.**
7. **7. Articulate your beliefs about your level of comfort in talking to clients about religion and *spirituality*.**
8. **8. Outline the argument for the role religion and *spirituality* play in counseling and therapy.**
9. **9. Discuss implications of non‐Western indigenous beliefs and practices for work with diverse populations.**

Yemi is a freshman majoring in computer science at an elite university in the Northeast United States; he moved there shortly after graduating from secondary school in Nigeria. Yemi shared with his professor that he was unable to complete his assignment because of the intense burning and crawling sensations in his head, which worsened when he worked on the project; he explained studying left him too exhausted to do much else during the day. The professor referred him to the student health center; there appeared to be no physiological explanation for his symptoms.

After resettling in Chicago from Laos, Vang was visited by spirits while he slept, making it difficult for him to move or breathe beneath their weight. In the middle of the night, he would wake up screaming and in complete terror. His fear of dying in his sleep was not unfounded because he had heard of other Hmong refugee men who had died in this manner. Vang most likely did not fall victim to Hmong sudden death syndrome because he sought help from a shaman. She identified the problem vexing Vang and his family, and by performing local rituals they were able to free the spirits haunting him.

Joy has been in therapy with Dr. Spencer to deal with trauma associated with a recent sexual assault and relationship difficulties for nearly half a year. Her grandmother's sister died about a month ago after a long battle with lung cancer. A series of unfortunate events prevented Joy from attending the funeral, which she regrets dearly. The past few therapy sessions have felt very different for both Joy and Dr. Spencer. Joy reports thinking about death much more than she ever had in her life; she relays the terror she feels after the nightmares she has started having. She has lost nearly 10 pounds because she hasn't felt like eating. It seems like with each passing week, she experiences increasing levels of anxiety and feeling weak. Dr. Spencer becomes particularly concerned when Joy said she now has daily dizzy spells. She encourages Joy to get a physical, which ultimately suggests there are no physical explanations for her symptoms. Dr. Spencer begins to explore with Joy her understanding of the

symptoms. She asks Joy if she has had these symptoms before and what she thinks is causing them. Joy shares her mother's interpretation of the symptoms. According to her mother, who is from the Navajo nation, Joy is experiencing ghost sickness. At the urging of her mother, Joy returns to her community. They seek guidance from spiritual leaders and the tribal members perform sacred rituals allowing her great aunt's spirit to find peace.

Clinical knowledge regarding cultural syndromes suggests that Yemi's, Vang's, and Joy's experiences are consistent with a pattern of troubling, even dangerous, symptoms that are rooted within a particular cultural context. Meditation and learning muscle relaxation techniques provided Yemi some relief from *brain fag* (a response to academic stress in some West African countries). Western treatments, however, provided no answers or relief for Vang and Joy. Remedies came in the form of traditional healing practices, drawing on centuries of knowledge about health and disease. After participating in indigenous healing ceremonies that "released the unhappy spirits," Vang has reported no more problems with nightmares or with his breathing during sleep, and Joy's appetite has returned and she is getting restful sleep. Theories about *Hmong sudden death syndrome* and *ghost sickness* may appear unbelievable and akin to mysticism to many people, especially after reading the last chapter on evidence‐based practice (EBP). After all, most of us have been trained in a Western ontology that does not embrace indigenous or alternative healing approaches. Indeed, if anything, it actively rejects such approaches as unscientific and supernatural. Mental health professionals are encouraged to rely on sensory information, defined by the physical plane of existence rather than the spiritual plane (Pedersen & Pope, 2010; Walsh & Shapiro, 2006). Such a rigid stance is unfortunate and shortsighted, because there is much that *Western healing* can learn from these age‐old forms of treatment.

Video 10.0: Introduction

Introduction to counseling session by Dr. Joel Filmore.

WORLDVIEWS AND CULTURAL SYNDROMES

Western science remains skeptical of using supernatural interpretations to explain phenomena and certainly does not consider the existence of spirits to be a scientifically sound belief. Yet, belief in spirits and its parallel relationship to religious, philosophic, and scientific worldviews has existed in every known culture, including the United States (e.g., the witch hunts of Salem, Massachusetts). Among many Southeast Asian, African, and indigenous groups, it is not uncommon to posit the existence of good and evil spirits, to assume that they are intelligent beings, and to believe that they are able to affect the life circumstances of the living (Fadiman, 1997; E. Lee, 1996; Moodley, 2005). Vang, for example, believed strongly that his problems were due to spirits who were unhappy with him and were punishing him. Such worldview differences pose problems for Western‐trained mental health professionals, who may quickly dismiss these belief systems and impose their own explanations and treatments on culturally diverse clients. Working outside of the belief system of such clients may not have the desired therapeutic effect, and the risk of unintentional harm (in this case, the potential death of Vang) is great (Wendt, Gone, & Nagata, 2015). That the sudden death and *ghost sickness* phenomena are cultural forms of disorder is being increasingly recognized by Western science (Kamarck & Jennings, 1991). Most researchers now acknowledge that attitudes, beliefs, and emotional states are intertwined and can have a powerful effect on physiological responses and physical well‐being. For example, death from bradycardia (slowing of the heartbeat) seems correlated with feelings of helplessness.

Beginning with the fourth and continuing into the fifth edition, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM‐IV‐TR* and *DSM‐5*; American Psychiatric Association, 2000, 2013) has made some strides in recognizing the importance of ethnic and cultural factors related to psychiatric diagnosis. The manual warns that mental health professionals who work with immigrant and ethnic minorities must take into account (a) the predominant means of manifesting disorders (e.g., possessing spirits, nerves, fatalism, inexplicable misfortune), (b) the perceived causes or explanatory models, and (c) the preferences for professional and indigenous sources of care. Culture‐bound syndromes and cultural idioms of distress are now recognized in the *DSM‐5* and the International Statistical Classification of Diseases and Related Health Problems (ICD‐10); some of these are listed in Table 10.1.

TABLE 10.1 Culture‐Bound Syndromes

Culture‐bound syndromes include disorders with a unique combination of psychological and somatic symptoms that are recognized within a specific cultural group as an illness. These disorders are not easily captured in Western classification systems. They have local names and a shared understanding of the etiology and course of treatment.	
Amok (“attacking furiously”)	Mainly considered a disorder in Malaysia, but is found in other Southeast Asian countries (e.g., Laos, the Philippines, Papua New Guinea), as well as Puerto Rico and among Navajo. It is a dissociative episode often preceded by social isolation or humiliation and followed by an outburst of violent, aggressive, or homicidal behavior toward people and objects. Persecutory ideas, amnesia, and exhaustion signal a return to the premorbid state.
Ataque de nervios (“attack	Occurs in many Latinx and Caribbean cultures in reaction to a stressful life event, typically related to a family member (e.g., a death). People may feel out of control and experience acute anxiety, inconsolable crying, chest

of nerves”)	tightness, and uncontrollable screaming or shouting,
Dhat, Shen‐K'uei, Shenkui	Fear over excessive semen discharge in India (Dhat), Taiwan (Shen‐K'uei), and China (Shenkui) can create tremendous anxiety in some men, resulting in a range of somatic concerns. The fear is associated with loss of semen through excessive sexual activity such as intercourse and masturbation or through nocturnal emissions. Worry over loss of semen often leads to the man's feeling weak and fatigued, and may cause sexual dysfunction. In Chinese culture, loss of semen causes an unbalance in the body and represents the loss of one's vital essence.
Ghost sickness	Observed among members of American Indian tribes, this disorder is a preoccupation with death and the deceased. It is sometimes associated with witchcraft and includes bad dreams, weakness, feelings of danger, loss of appetite, fainting, dizziness, anxiety, and a sense of suffocation.
Koro	This Malaysian term refers to an intense fear of the shrinkage or retraction of one's genitals—typically the penis for males or the breasts for females. It is sometimes referred to as the “genital retraction syndrome.” For some, the “penis panic” is believed to lead to the removal of the male organ and, in some cases, death. It can occur in epidemic proportions in local areas and has been reported in China, Thailand, and other South and East Asian countries.
Nervios (“nervousness,” “anxiety”)	This idiom of distress is mainly found among Latinx individuals in the United States and throughout the Americas. Common symptoms include nervousness, easy tearfulness, shaking, dizziness, tingling sensations, and feelings of sadness and hopelessness. Nervios symptoms appear over a period of time and are less severe in expression than ataque de nervios.
Susto (“fright”)	This disorder is associated with fright or soul loss and is a prevalent folk illness among some Latinx individuals in the United States and throughout the Americas Typically attributed to a traumatic event that causes the soul or spirit to leave the body. Common symptoms include depression, anxiety, heart palpitations, insomnia, fever, and lack of appetite.

In summary, it is very important for mental health professionals not only to become familiar with the cultural background of their clients but also to be knowledgeable about specific cultural syndromes. A primary danger from lack of cultural understanding is the tendency to overpathologize (overestimate the degree of pathology); the mental health professional would have been wrong in diagnosing Vang as a paranoid schizophrenic suffering from delusions and hallucinations or Joy as experiencing post‐traumatic stress disorder (PTSD) symptoms or signs of depression and anxiety. Most psychiatrists would have prescribed powerful psychotropic medication. The fact that both Vang and Joy were cured so quickly indicates that such a diagnosis would have been erroneous. Interestingly, it is equally dangerous to underestimate the severity or complexity of a person's emotional condition.

The Shaman and Traditional Healer as Therapist: Commonalities

It is probably safe to conclude that every society and culture has individuals or groups designated as healers—those who comfort the ailing. Their duties involve not only physical ailments but also those related to psychological distress or behavioral deviance (Harner, 1990; Ross, 2014). Although every culture has multiple healers, in non‐Western cultures the

shaman is perhaps the most powerful of all, because only he or she possesses the ultimate magico‐religious powers that go beyond the senses (Eliade, 1972). The *shaman* treating Vang was well‐known and respected in the Hmong community. Although her approach (incense, candle burning, newspaper, trance‐like chanting, spirit diagnosis, and even her home visit) might resemble mysticism on the surface, there is much in her behavior that is similar to Western psychotherapy.

First, as we saw in Chapter 5, the healer's credibility is crucial to the effectiveness of therapy. In the case of Vang, the traditional healer had the cultural credentials of a *shaman*; she was a specialist and professional with long years of training and experience dealing with similar cases. By reputation and behavior, she acted in a manner familiar to Vang and his family. More importantly, she shared their worldview as to the definition of the problem. Like the Western therapist, she offered herself as the chief instrument of cure. The healing rituals she performed helped to get in touch with the hidden world of the spirits (in Western terms, the unconscious?) and helped Vang to understand (become conscious of) the mysterious power of the spirits (unconscious) to effect a cure.

Similarly, in the case of Joy, the traditional healers her family sought help from shared a similar cultural understanding of the problem and the appropriate course of treatment. They were acknowledged within the community for their training and expertise in treating *ghost sickness*. Additionally, as with Vang, treatment incorporated family participation in the sacred rituals. For Joy, non‐Western and Western forms of healing were combined for maximum effect. Dr. Spencer practiced culturally informed therapy, welcomed cultural interpretation of the new symptoms, and encouraged Joy to also seek indigenous healers as part of the treatment plan.

Not all people of color and immigrants are so fortunate as to have access to culturally informed therapy and/or the services of a traditional healer in the United States. Witness the case of the Nguyen family.

CASE STUDY

THE NGUYEN FAMILY

Mr. and Mrs. Nguyen and their four children left Vietnam in a boat with 36 other people. Several days later, they were set upon by Thai pirates. The occupants were all robbed of their belongings; some were killed, including two of the Nguyens' children. Nearly all the women were raped repeatedly. The trauma of the event is still very much with the Nguyen family, who now reside in St. Paul, Minnesota. The event was most disturbing to Mr. Nguyen, who had watched two of his children drown and his wife being raped. The pirates had beaten him severely and tied him to the boat railing during the rampage. As a result of his experiences, he continued to suffer feelings of guilt, suppressed rage, and nightmares.

The Nguyen family came to the attention of the school and social service agencies because of suspected child abuse. Their oldest child, 12‐year‐old Phuoc, came to school one day with noticeable bruises on his back and down his spinal column. In addition, obvious scars from past injuries were observed on the child's upper and lower torso. His gym teacher saw the bruises and scars and immediately reported them to the school counselor. The school nurse was contacted about the possibility of child abuse, and a conference was held with Phuoc. He denied that he had been hit by his parents and refused to remove his garments when requested to do so. Indeed, he became quite

frightened and hysterical about taking off his shirt. Since there was still considerable doubt about whether this was a case of child abuse, the counselor decided to let the matter drop for the moment. Nevertheless, school personnel were alerted to this possibility.

Several weeks later, after 4 days of absence, Phuoc returned to school. The homeroom teacher noticed bruises on his forehead and the bridge of his nose. When the incident was reported to the school office, the counselor immediately called Child Protective Services to report a suspected case of child abuse. Because of their heavy caseload, a social worker was unable to visit the family until weeks later. The social worker, Mr. P., called the family and visited the home late on a Thursday afternoon. Mrs. Nguyen greeted Mr. P. upon his arrival. She appeared nervous, tense, and frightened. Her English was poor, and it was difficult to communicate with her. Since Mr. P. had specifically requested to see Mr. Nguyen as well, he inquired about his whereabouts. Mrs. Nguyen answered that he was not feeling well and was in the room downstairs. She said he was having "a bad day," had not been able to sleep last night, and was having flashbacks. In his present condition, he would not be helpful.

When Mr. P. asked about Phuoc's bruises, Mrs. Nguyen did not seem to understand what he was referring to. The social worker explained in detail the reason for his visit. Mrs. Nguyen explained that the scars were due to the beating given to her children by the Thai pirates. She became very emotional about the topic and broke into tears. Although this had some credibility, Mr. P. explained that there were fresh bruises on Phuoc's body as well. Mrs. Nguyen seemed confused, denied that there were new injuries, and denied that she and her husband would hurt Phuoc. The social worker pressed Mrs. Nguyen about the new injuries until she suddenly looked up and said, "*Thùôc Nam*." It was obvious that Mrs. Nguyen now understood what Mr. P. was referring to. When asked to clarify what she meant by the phrase, Mrs. Nguyen pointed at several thin bamboo sticks and a bag of coins wrapped tightly in a white cloth. It looked like a blackjack! She then pointed downstairs in the direction of the husband's room. It was obvious from Mrs. Nguyen's gestures that her husband had used these implements to beat her son.

A Case of Child Abuse?

There are many similarities between the case of the Nguyen family and that of Vang. One of the most common experiences of refugees forced to flee their country is the extreme stressors that they experience. Constantly staring into the face of death is, unfortunately, all too common an experience. Seeing loved ones killed, tortured, and raped; being helpless to change or control such situations; living in temporary refugee or resettlement camps; leaving familiar surroundings; encountering a strange and alien culture—these experiences can only be described as multiple severe traumas.

It is highly likely that many Cambodian, Hmong/Laotian, and Vietnamese refugees suffer from serious PTSD and other forms of major affective disorder. Mr. and Mrs. Nguyen's behaviors (flashbacks, desire to isolate the self, emotional fluctuations, anxiety, and tenseness) might all be symptoms of PTSD. Accurate understanding of refugees' life circumstances will prevent a tendency to overpathologize or underpathologize their symptoms. These symptoms, along with a reluctance to disclose to strangers and discomfort with social workers, should be placed in the context of the stressors that they have experienced and their cultural background. More important, as in the case of the Nguyen family, behaviors should not be interpreted to indicate guilt or a desire not to disclose the

truth about child abuse.

Mental health professionals must consider potential linguistic and cultural barriers when working with refugees, especially when they lack both experience and expertise. In the case of the Nguyens, it is clear that the teacher, the school counselor, the school nurse, and even the social worker did not have sufficient understanding or experience in working with Southeast Asian refugees. For example, the social worker's failure to understand Vietnamese phrases and Mrs. Nguyen's limited English placed serious limitations on their ability to communicate accurately (Schwartz et al., 2010). The social worker might have avoided much of the misunderstanding if an interpreter had been present. In addition, the school personnel may have misinterpreted many culturally sanctioned forms of behavior on the part of the Vietnamese. Phuoc's reluctance to disrobe in front of strangers (the nurse) may have been prompted by cultural taboos rather than by attempts to hide his injuries. Traditional Asian culture dictates strongly that family matters are handled within the family. Many Asians believe that family affairs should not be discussed publicly, and especially not with strangers (Chang, McDonald, & O'Hara, 2014). Disrobing publicly and telling others about the scars or the trauma of the Thai pirates would not be done readily. Such knowledge is required by educators and social service agencies in order to make enlightened decisions.

Both school and social service personnel were obviously also unenlightened about *indigenous healing* beliefs and practices. In the case of Vang, we saw how knowledge and understanding of cultural beliefs led to appropriate and helpful treatment. In the case of the Nguyen family, lack of understanding led to charges of child abuse. But is this really a case of child abuse? When Mrs. Nguyen said "*Thùôc Nam*," what was she referring to? What did the fresh bruises along Phuoc's spinal column, forehead, and bridge of the nose mean? And didn't Mrs. Nguyen admit that her husband used the bamboo sticks and bag of coins to "beat" Phuoc?

In Southeast Asia, traditional medicine derives from three sources: Western medicine (Thùôc Tay), Chinese or Northern medicine (Thùôc Bac), and Southern medicine (*Thùôc Nam*). Many forms of these treatments continue to exist among Asian Americans, especially Vietnamese refugees (Hong & Domokos‐Cheng Ham, 2001). *Thùôc Nam* involves using natural fruits, herbs, plants, animals, and massage to heal the body. Massage treatment is the most common cause of misdiagnosis of child abuse, because it leaves bruises on the body. Three common forms of massage treatment are *Băt Gió* ("catching the wind"), *Cao Gió* ("scratching the wind" or "coin treatment"), and *Giác Hoi* ("pressure massage" or "dry cup massage"). *Băt Gió* involves using both thumbs to rub the temples and massaging toward the bridge of the nose at least 20 times. Fingers are used to pinch the bridge of the nose. *Cao Gió* involves rubbing the patient with a mentholated ointment and then using coins or spoons to strike or scrape lightly along the ribs and both sides of the neck and shoulders. *Giác Hoi* involves steaming bamboo tubes so that the insides are low in pressure, applying them to a portion of the skin that has been cut, and sucking out "bad air" or "hot wind." All three treatments leave bruises on the parts of the body treated.

If the social worker had been able to understand Mrs. Nguyen, he would have known that Phuoc's 4‐day absence from school was due to illness and that he was treated by his parents via traditional folk medicine. Massage treatments are a widespread custom practiced not only by Vietnamese but also by Cambodians, Laotians, and Chinese. These treatments are aimed at curing a host of physical ailments, such as colds, headaches, backaches, and fevers. In the mind of the practitioner, such treatments have nothing to do with child abuse. Yet, the question still remains: Is it child abuse when traditional healing practices result in bruises? This is a very difficult question to answer because it raises a larger question: Can culture justify a practice, especially when it is harmful? Although we are unable to answer this

second question directly (we encourage you to engage in dialogue about it), we would point out that many medical practitioners in California do not consider *Thùôc Nam* child abuse because: (a) the medical literature reveals no physical complications as a result of it; (b) the intent is not to hurt the child but to help him or her; and (c) it is frequently used in conjunction with Western medicine. However, we would add that health professionals and educators have a responsibility to educate parents concerning the potential pitfalls of many folk remedies and indigenous forms of treatment.

Video 10.1: Eastern vs. Western Cultural Norms

Belief systems of non-Western clients need to be incorporated into counseling sessions much the same way Western religious beliefs are incorporated.

THE PRINCIPLES OF INDIGENOUS HEALING

Ever since the beginning of human existence, all societies and cultural groups have developed not only their own explanations of abnormal behaviors but also culture‐specific ways of dealing with human problems and distress (Gone, 2010; Solomon & Wane, 2005). Within the United States, counseling and psychotherapy are the predominant psychological healing methods. In other cultures, however, *indigenous healing* approaches continue to be widely used (Mpofu, 2011). Although there are similarities between EuroAmerican helping systems and the indigenous practices of many cultural groups, there are major dissimilarities as well. *Indigenous healing* can be defined as helping beliefs and practices that originate within a culture or society (Edwards, 2011). It is not transported from other regions, and it is designed to treat the inhabitants of the given group.

Western forms of counseling, for example, rely on sensory information defined by the physical plane of reality (Western science), whereas most indigenous methods rely on the spiritual plane of existence in seeking a cure. In keeping with the cultural encapsulation of our profession, *Western healing* has been slow to acknowledge and learn from these age‐old forms of wisdom (Constantine, Myers, Kindaichi, & Moore, 2004; Gone, 2010). In its attempt to become culturally responsive, however, the mental health field must begin to put aside the biases of Western science, to acknowledge the existence of intrinsic help‐giving networks, and to incorporate the legacy of ancient wisdom that may be contained in indigenous models of healing.

What is called the *universal shamanic tradition*, which encompasses the centuries‐old recognition of healers (*shamans*) within a community, refers to people often called witches, witch doctors, wizards, medicine men or women, sorcerers, and magic men or women (E. Lee, 1996). These individuals are believed to possess the power to enter an altered state of consciousness and journey to other planes of existence beyond the physical world during their healing rituals (Garrett et al., 2011; Moodley, 2005). Such was the case with the *shaman* working with Vang, who journeyed to the spirit world in order to find a cure for him.

Indigenous healing in non‐Western countries usually involves three approaches (Lee, Oh, & Mountcastle, 1992). First, there is heavy reliance on the use of communal, group, and family networks to shelter the disturbed individual (Saudi Arabia), to problem‐solve in a group context (Nigeria), and to reconnect the individual with family or significant others (Korea). Second, there is the use of spiritual and religious beliefs and traditions of the community in the healing process. Examples include reading verses from the Qur'an and using religious houses or churches. Third, there is the use of *shamans* (called *piris* and *fakirs* in Pakistan and Sudan), who are perceived to be the keepers of timeless wisdom. In many cases, the person conducting the healing ceremony may be a respected elder of the community or a family member.

Let us now consider three core assumptions related to the principles of indigenous healing: holistic outlook, interconnectedness, and harmony; belief in metaphysical levels of existence; and acceptance of spirituality in life and the cosmos.

Holistic Outlook, Interconnectedness, and Harmony

The concepts of separation, isolation, and individualism are hallmarks of the EuroAmerican worldview. On an individual basis, modern psychology takes a reductionist approach to describing the human condition (i.e., id, ego, and superego; belief, knowledge, and skills; cognitions, emotions, and behaviors). The search for cause and effect is linear and allows us

to identify the independent variables, the dependent variables, and the effects of extraneous variables that we attempt to control. It is analytical and reductionist in character. The attempt to maintain objectivity, autonomy, and independence in understanding human behavior is also stressed. Such tenets have resulted in the separation of the person from the group (valuing of individualism and uniqueness), science from *spirituality*, and man/woman from the universe.

Most non‐Western indigenous forms of healing take a *holistic outlook* on well‐being, in that they make minimal distinctions between physical and mental functioning and believe strongly in the unity of spirit, mind, and matter. The interrelatedness of life forms, the environment, and the cosmos is a given. As a result, the indigenous peoples of the world tend to conceptualize reality differently (Mpofu, 2011). The psychosocial unit of operation for many culturally diverse groups, for example, is not the individual but the group (collectivism). In many cultures, acting in an autonomous and independent manner is seen as the problem, because it creates disharmony within the group.

Illness, distress, and problematic behaviors are seen as an imbalance in people relationships, a disharmony between the individual and his or her group, or a lack of synchrony with internal or external forces. Harmony and balance are the healer's goal. Among American Indians, for example, harmony with nature is symbolized by the circle, or hoop of life (Garrett & Portman, 2011; McCormick, 2005; Sutton & Broken Nose, 2005). Mind, body, spirit, and nature are seen as a single unified entity, with little separation between the realities of life, medicine, and religion. All forms of nature (not just the living) are to be revered, because they reflect the creator or deity. Illness is seen as a break in the hoop of life, an imbalance, or a separation between the elements. Many indigenous beliefs come from a metaphysical tradition. They accept the interconnectedness of cosmic forces in the form of energy or subtle matter (less dense than the physical) that surrounds and penetrates the physical body and the world.

Both the ancient Chinese practice of acupuncture and chakras in Indian yoga philosophy involve the use of subtle matter to rebalance and heal the body and mind (Highlen, 1996). Chinese medical theory is concerned with the balance of yin (cold) and yang (hot) in the body, and believes that strong emotional states or an imbalance in the types of food eaten may create illness (Pedersen & Pope, 2010; So, 2005). As we saw in the case of Phuoc Nguyen, treatment might involve using massage treatment to suck out “bad” or “hot” air, as well as eating specific types or combinations of foods. Such concepts of illness and health can also be found in the Greek theory of balancing body fluids (blood, phlegm, black bile, and yellow bile; Bankart, 1997).

Many indigenous African approaches to spirituality also teach that human beings are part of a holistic fabric—that they are interconnected and should be oriented toward collective rather than individual survival (Boyd‐Franklin, 2010; Parham & Caldwell, 2015). The indigenous Japanese assumptions and practices of Naikan and Morita therapy attempt to move clients away from individualism and toward interdependence, connectedness, and harmony with others (Bankart, 1997; Chen, 2005). Naikan therapy, which derives from Buddhist practice, requires clients to reflect on three aspects of human relationships: (a) what other people have done for them; (b) what they have done for others; and (c) how they cause difficulties to others (Walsh & Shapiro, 2006). The overall goal is to expand awareness of how much we receive from others, how much gratitude is due to them, and how little we demonstrate such gratitude. This leads to a realization of the interdependence of the parts to the whole. Working for the good of the group ultimately benefits the individual.

Belief in Metaphysical Levels of Existence

Some time back, two highly popular books—*Embraced by the Light* (Eadie, 1992) and *Saved by the Light* (Brinkley, 1994)—and several television specials described fascinating cases of near‐death experiences. All had certain commonalities: the individuals who were near death felt like they were leaving their physical bodies, observed what was happening around them, saw a bright beckoning light, and journeyed to higher levels of existence. Although the popularity of such books and programs might indicate that the American public is inclined to believe in such phenomena, science has been unable to validate these personal accounts and remains skeptical of their existence. Yet, many societies and non‐Western cultures accept as given the existence of different levels or planes of consciousness, experience, or existence. They believe the means of understanding and ameliorating the causes of illness or the problems of life are often found in a plane of reality separate from the physical world of existence.

Asian psychologies posit detailed descriptions of states of consciousness and outline developmental levels of *enlightenment* that extend beyond the concepts of Western psychology. Asian perspectives concentrate less on psychopathology and more on *enlightenment* and ideal mental health (Cashwell & Bartley, 2014; Pankhania, 2005). The normal state of consciousness in many ways is not considered optimal and may be seen as a "psychopathology of the average" (Maslow, 1968). Moving to higher states of consciousness has the effect of enhancing perceptual sensitivity and clarity, concentration, and the sense of identity, as well as emotional, cognitive, and perceptual processes. Such movement, according to Asian philosophy, frees one from the negative pathogenic forces of life. Attaining *enlightenment* and liberation can be achieved through the classic practices of meditation and yoga.

Research findings indicate that meditation and yoga are the most widely used of all therapies (Goldberg et al., 2017; Walsh & Shapiro, 2006). They have been shown to reduce anxiety, specific phobias, and substance abuse (Kwee, 1990; Shapiro, 1982; West, 1987); to benefit those with medical problems by reducing blood pressure and aiding in the management of chronic pain (Kabat‐Zinn, 1990); to enhance self‐confidence, sense of control, marital satisfaction, and so on (Alexander, Rainforth, & Gelderloos, 1991); and to extend longevity (Alexander, Langer, Newman, Chandler, & Davies, 1989). Today, meditation and yoga have become accepted practices among millions in the United States, especially for relaxation and stress management. For their practitioners, altered states of consciousness are unquestioned aspects of reality.

According to some cultures, nonordinary reality states allow some healers to access an invisible world surrounding the physical one. Puerto Ricans, for example, believe in *espiritismo* (spiritism), the idea that spirits can have major impacts on the people residing in the physical world (Chavez, 2005). *Espiritistas*, or mediums, are culturally sanctioned indigenous healers who possess special faculties allowing them to intervene positively or negatively on behalf of their clients. Many cultures strongly believe that human destiny is often decided in the domain of the spirit world. Mental illness may be attributed to the activities of hostile spirits, often in reaction to transgressions of the victim or the victim's family (C. C. Lee, 1996; Mullavey‐O'Byrne, 1994). *Shamans*, mediums, and indigenous healers often enter the spirit world on behalf of their clients in order to seek answers, enlist the help of spirits, or aid in realigning the spiritual energy field that surrounds the body and extends throughout the universe.

Ancient Chinese methods of healing and the Hindu concept of chakras also acknowledge

another reality that parallels the physical world. Accessing this world allows the healer to use these special energy centers to balance and heal the body and mind. Occasionally, the *shaman* may aid the helpee or novice to access the other plane of reality so that he or she may find the solutions for him - or herself. The *vision quest*, for example, in conjunction with the sweat lodge experience, is used by some American Indians as a form of religious renewal or rite of passage (Garrett et al., 2011; Heinrich, Corbin, & Thomas, 1990; Smith, 2005). The ceremony of the vision quest is intended to prepare a young man for the proper frame of mind; it includes rituals and sacred symbols, prayers to the Great Spirit, isolation, fasting, and personal reflection. Whether in a dream state or in full consciousness, another world of reality is said to reveal itself. Mantras, chants, meditation, and the taking of certain drugs (peyote) all have as their purpose a journey into another world of existence (Duran, 2006).

Acceptance of Spirituality in Life and the Cosmos

Although people may not have a formal religion, indigenous helpers believe that *spirituality* is an intimate aspect of the human condition. Western psychology acknowledges the behavioral, cognitive, and affective realms, but it makes only passing reference to the spiritual one. Yet, indigenous helpers believe that *spirituality* transcends time and space, mind and body, and our behaviors, thoughts, and feelings (Lee & Armstrong, 1995; Smith, 2005).

One does not have to look beyond the United States to see such spiritual orientations; many racial/ethnic minority groups in this country are strongly spiritual. Traditional American Indians look on all things as having life, spiritual energy, and importance. A fundamental belief is that all things are connected. The universe consists of a balance among all of these things and a continuous flow of cycling of this energy. American Indians believe that we have a sacred relationship with the universe that is to be honored. All things are connected, all things have life, and all things are worthy of respect and reverence. *Spirituality* focuses on the harmony that comes from our connection with all parts of the universe—in which everything has a purpose and value exemplary of personhood, including plants (e.g., “tree people”), the land (“Mother Earth”), the winds (“the Four Powers”), “Father Sky,” “Grandfather Sun,” “Grandmother Moon,” and “The Red Thunder Boys.” Spiritual being essentially requires only that we seek our place in the universe; everything else will follow in good time. Because everyone and everything was created with a specific purpose to fulfill, no one should have the power to interfere or to impose on others the best path to follow (Garrett & Garrett, 1994, p. 187).

The Lakota Sioux often say “*Mitakuye Oyasin*” at the end of a prayer or as a salutation. Translated, it means, “to all my relations,” which acknowledges the spiritual bond between the speaker and all people present and extends to forebears, the tribe, the family of humanity, and Mother Nature. It speaks to the philosophy that all life forces, Mother Earth, and the cosmos are sacred beings and that the spiritual is the thread that binds all together.

African Americans, Asian Americans, and Latinx Americans all place strong emphasis on the interplay and interdependence of spiritual life and healthy functioning (Boyd - Franklin, 2010; Garrett & Portman, 2011). Puerto Ricans, for example, may sacrifice material satisfaction in favor of values pertaining to the spirit and the soul. Likewise, a strong spiritual orientation has always been a major aspect of life in Africa, and this was carried into the slavery era in the United States.

> *Highly emotional religious services conducted during slavery were of great importance in dealing with oppression. Often signals as to the time and place of an escape were*

> *given then. Spirituals contained hidden messages and a language of resistance (e.g., "Wade in the Water" and "Steal Away"). Spirituals (e.g., "Nobody Knows the Trouble I've Seen") and the ecstatic celebrations of Christ's gift of salvation provided Black slaves with outlets for expressing feelings of pain, humiliation, and anger.*
>
> *(Hines & Boyd‐Franklin, 1996, p. 74)*

The African American church has a strong influence over the lives of many Black people and is often the hub of religious, social, economic, and political life (Boyd‐Franklin, 2010). Religion is not separated from the daily functions of the church, as it acts as a complete support system for the African American community, with the minister, deacons, deaconesses, and church members operating as one big family. A strong sense of peoplehood is fostered via social activities, choirs, Sunday school, health‐promotion classes, daycare centers, tutoring programs, and counseling. For many African Americans, especially women, the road to mental health and the prevention of mental illness lies in the health potentialities of their spiritual life (Reed & Neville, 2014).

Mental health professionals are becoming increasingly open to the potential benefits of *spirituality* as a means for coping with hopelessness, identity issues, and feelings of powerlessness (Eriksen et al., 2013). As an example of this movement, the Association for Counselor Education and Supervision (ACES) adopted a set of competencies related to *spirituality*. It defines *spirituality* as:

> *the animating force in life, represented by such images as breath, wind, vigor, and courage. Spirituality is the infusion and drawing out of spirit in one's life. It is experienced as an active and passive process. Spirituality is also described as a capacity and tendency that is innate and unique to all persons. This spiritual tendency moves the individual towards knowledge, love, meaning, hope, transcendence, connectedness, and compassion. Spirituality includes one's capacity for creativity, growth, and the development of a values system. Spirituality encompasses the religious, spiritual, and transpersonal.*
>
> *(American Counseling Association, 1995, p. 30)*

Interestingly enough, it appears that many in the United States are experiencing a "spiritual hunger," or a strong need to reintegrate spiritual or religious themes into their lives (Hage, 2004; Thoresen, 1998). For example, it appears that there is a marked discrepancy between what patients want from their doctors and what doctors supply. Often, patients want to talk about the spiritual aspects of their illness and treatment, but doctors are either unprepared or disinclined to do so (Eriksen et al., 2013). Likewise, most mental health professionals feel uncomfortable, disinclined, or unprepared to speak with their clients about religious or spiritual matters.

The relationship between *spirituality* and health is highly positive (Aldwin, Park, Jeong, & Nath, 2014; Thoresen, 1998). Those with higher levels of *spirituality* have lower disease risk, fewer physical health problems, and higher levels of psychosocial functioning. It appears that people require faith as well as reason to be healthy and that psychology may profit from allowing the spirit to rejoin matters of mind and body (Strawbridge, Cohen, Shema, & Kaplan, 1997).

In general, *indigenous healing* methods have much to offer to EuroAmerican forms of mental health practice. The contributions are valuable not only because multiple belief systems now exist in our society but also because counseling and psychotherapy have historically neglected the spiritual dimension of human existence. Our heavy reliance on science and the reductionist approach to treating clients has made us view human beings and human behavior

as composed of separate noninteracting parts (cognitive, behavioral, and affective). There has been a failure to recognize our spiritual being and to take a *holistic outlook* on life (Cashwell & Bartley, 2014). Indigenous models of healing remind us of these shortcomings and challenge us to look for answers in realms of existence beyond the physical world.

Video 10.2: Incorporating Non-Western Beliefs

Research shows that incorporating religious and spiritual beliefs into the counseling session can positively impact outcomes. Allowing your client to be the expert regarding religious/spiritual non-Western beliefs can build rapport and self-esteem.

EXAMPLES OF INDIGENOUS HEALING APPROACHES

Ho'oponopono

An excellent example that incorporates various principles of *indigenous healing* is the Native Hawaiian *ho'oponopono* healing ritual (Nishihara, 1978; Rezentes, 2006). Translated literally, this means "a setting to right, to make right, to correct." In cultural context, *ho'oponopono* attempts to restore and maintain good relations among family members and between the family and the supernatural powers. It is a kind of family conference (family therapy) aimed at restoring good and healthy harmony. Many Native Hawaiians consider it to be one of the soundest methods of restoring and maintaining good relations that any society has ever developed. Such a ceremonial activity usually occurs among members of the immediate family, but it may involve the extended family and even nonrelatives if they were involved in the *pilikia* (trouble). The process of healing consists of the following:

1. The *ho'oponopono* begins with *pule weke* (opening prayer) and ends with *pule ho'opau* (closing prayer). The pule creates the atmosphere for the healing and involves asking the family gods for guidance. These gods are not asked to intervene, but to grant wisdom, understanding, and honesty.
2. The ritual elicits *'oia'i'o* (truth telling), sanctioned by the gods, and makes compliance among participants a serious matter. The leader states the problem, prays for spiritual fusion among members, reaches out to resistant family members, and attempts to unify the group.
3. Once this occurs, the actual work begins through *mahiki*, a process of getting to the problems. Transgressions, obligations, righting the wrongs, and forgiveness are all aspects of *ho'oponopono*. The forgiving/releasing/severing of the wrongs, the hurts, and the conflicts produces a deep sense of resolution.
4. Following the closing prayer, the family participates in *pani*, the termination ritual, in which food is offered to the gods and to the participants.

In general, we can see several principles of indigenous Hawaiian healing: (a) problems reside in relationships with people and spirits; (b) harmony and balance in the family and in nature are desirable; (c) healing must involve the entire group and not just an individual; (d) *spirituality*, prayer, and ritual are important aspects of healing; (e) the healing process comes from a respected elder of the family; and (f) the method of healing is indigenous to the culture (Rezentes, 2006).

Native American Sweat Lodge Ceremony

Another example of *indigenous healing* increasingly being employed by Western cultures in medicine, mental health, substance abuse, and correctional facilities is the Native American *sweat lodge ceremony* (sweat therapy) (Garrett & Portman, 2011; Garrett et al., 2011). Among Native Americans, the sweat lodge and the ensuing rituals are filled with cultural and spiritual symbolism and meaning. The sweat lodge itself is circular or oval and symbolizes the universe and/or womb from which life originates; the stone pit represents the power of the creator, and the stones (healing power of the earth) are heated by the sacred fire; the water used in the ceremony is essential for all life; the steam that rises when water is thrown on the stones represents both the prayers of the participants and ancient knowledge; and the sweat of

the participants is part of the purification process. Consistent with most indigenous mandates, the *sweat lodge ceremony* is conducted under the following conditions, as described by Garrett et al. (2011):

1. The lodge is constructed from materials garnered from Mother Earth. Permission is sought from the wood, bark, rocks, and other materials to participate in the sacred ritual. The reciprocity involved in requesting permission and giving thanks is part of the belief in the interrelationship of all things and the maintenance of balance and harmony.
2. A Fire Keeper has the responsibility of tending the sacred fire in which the stones will be heated.
3. Participants strip themselves of all clothing and jewelry and enter on their hands and knees to show respect for Mother Earth. They then sit in a sacred circle (hoop of life).
4. The ceremony begins in silence (true voice of the Creator); then invocation and thanks are given to the Great Spirit, Mother Earth, the four directions, spirits, and all relations in nature.
5. Water or an herbal mixture is poured on the heated rocks, producing a purifying steam.
    1. The ritualized cleansing of the body is meant to ensure harmony, balance, and wellness in the person. The participants purify themselves by joining with the powers of Mother Earth and the Universal Circle that connects living and nonliving beings.
    2. Unlike most Western forms of healing, the *sweat lodge ceremony* takes place in the presence of a person's support network: the family, clan, and community. Not only does the ceremony cleanse the body, mind, and spirit, but it also brings together everyone to honor the energy of life.

As mentioned previously, sweat therapy has been increasingly adopted in Western society as a form of treatment. Its use, however, is based on other Western therapeutic rationales rather than that ascribed to Native Americans.

REFLECTION AND DISCUSSION QUESTIONS

1. What thoughts do you have about the role of spirituality and religion in psychology and mental health?
2. Should therapists avoid discussing these matters with clients and leave it to religious or spiritual leaders?
3. What are the possible positive and negative outcomes of doing so?
4. Would you feel comfortable talking about religion with your clients? How about spirituality?
5. If you were in therapy, how important would it be to discuss your religious beliefs? Your spirituality?
6. Are you a religious person? A spiritual person? Is one more important to you than the other?

Video 10.3: Benefitting from Religion and Spirituality

Creating a safe space within the counseling session where your clients can discuss their beliefs can often be key to successfully transitioning. Clients may not feel comfortable simply because they don't know if the clinician is a 'safe' person to share with.

DANGERS AND BENEFITS OF SPIRITUALITY

Although we have discussed the important role that *indigenous healing* plays in many societies and cultures, there are downsides reflected in our historical past, where an uncritical acceptance of religious or spiritual belief systems may actually harm rather than heal or enlighten. Such was the case during the Middle Ages, when supernatural explanations of human behavior led to a total eclipse of science and resulted in the deaths of many innocent people, primarily those accused of being witches (women, the mentally ill, those with disfigurements, gypsies, and scientists who voiced beliefs that differed from the Church's doctrines). Early Christianity did little to promote science and in many ways actively discouraged it. The Church demanded uncompromising adherence to its tenets. Christian fervor brought with it the concepts of heresy and punishment; certain truths were deemed sacred, and those who challenged them were denounced as heretics. Scientific thought that was in conflict with Church doctrine was not tolerated.

The role of demons, witches, and possessions in explaining abnormal behavior has been part and parcel of many cultures and societies. There is good reason why Western science has viewed religion with skepticism. Until recently, the mental health profession has been largely silent about the influence or importance of *spirituality* and religion in mental health. During therapy or work with clients, therapists have generally avoided discussing such topics. It has been found, for example, that many therapists (a) do not feel comfortable or competent in discussing spiritual or religious issues with their clients, (b) are concerned they will appear proselytizing or judgmental if they touch on such topics, (c) believe they may usurp the role of the clergy or other religious leaders by doing so, and (d) may feel inauthentic addressing client concerns, especially if they are atheists or agnostics (Gonsiorek, Richards, Pargament, & McMinn, 2009; Knox, Catlin, Casper, & Schlosser, 2005).

Yet, it has been found that about 75% of Americans say that religion is important in their lives, that in both medical and mental health care patients express a strong desire for providers to discuss spiritual and faith issues with them, and that persons of color believe that spiritual issues are intimately linked to their cultural identities (Gallup Organization, 2017). More compelling are findings that reveal a positive association between *spirituality*/religion and optimal health outcomes, longevity, and lower levels of anxiety, depression, suicide, and substance abuse (Cornah, 2006). Studies on the relationship of *spirituality* and health have found that higher levels of *spirituality* are associated with lower disease risk, fewer physical health problems, and higher psychosocial functioning (Thoresen, 1998). On a therapeutic level, these findings provide a strong rationale for professionals in the field of counseling and psychology to incorporate *spirituality* into their research and practice.

Surveys support the inescapable conclusion that many in the United States are experiencing a spiritual hunger, or a strong need to reintegrate spiritual or religious themes into their lives (Hage, 2004). Many counseling/mental health professionals are becoming increasingly open to the potential benefits of *spirituality* in the treatment of clients. As part of that process, psychologists are making distinctions between *spirituality* and religion. *Spirituality* is an animating life force that is inclusive of religion and speaks to the thoughts, feelings, and behaviors related to a transcendent state. *Religion* is narrower, involving a specific doctrine and particular system of beliefs. *Spirituality* can be pursued outside a specific religion because it is transpersonal and includes one's capacity for creativity, growth, and love (Eriksen et al., 2013). Mental health professionals are increasingly recognizing that people are thinking, feeling, behaving, social, cultural, and spiritual beings and that the human condition is broad, complex, and holistic.

IMPLICATIONS FOR CLINICAL PRACTICE

1. Do not invalidate the indigenous belief systems of your clients. Entertaining alternative realities does not mean that the counselor must subscribe to a particular belief system. It does mean, however, that he or she must avoid being judgmental.
2. Become knowledgeable about indigenous beliefs and healing practices. Counselors have a professional responsibility to become knowledgeable and conversant about the assumptions and practices of *indigenous healing* so that a process of desensitization and normalization can occur.
3. Avoid overpathologizing a culturally diverse client's problems. Therapists or counselors who are culturally unaware and who believe primarily in a universal psychology may often be culturally insensitive and inclined to see differences as deviance.
4. Avoid underpathologizing a culturally diverse client's problems. While being understanding of a client's cultural context, having knowledge of culture - bound syndromes, and being aware of cultural relativism is desirable, being oversensitive to these factors may predispose the therapist to minimize problems.
5. Be willing to consult with traditional healers or to make use of their services. Mental health professionals must be willing and able to form partnerships with indigenous healers or to develop community liaisons.
6. Recognize that *spirituality* is an intimate aspect of the human condition and a legitimate aspect of mental health work.
7. A counselor or therapist who does not feel comfortable dealing with the spiritual needs of clients or who believes in an artificial separation of the spirit (soul) from the everyday life of the culturally different client may not be providing the needed help.
8. Be willing to expand your definition of the helping role to community work and involvement. More than anything else, *indigenous healing* is community - oriented and community - focused.

SUMMARY

Since the beginning of human existence, all societies and cultural groups have developed their own explanations of abnormal behaviors and forms of healing. Within the United States, counseling and psychotherapy are the predominant psychological treatment methods. In other cultures, however, *indigenous healing* approaches continue to be widely used, and many people of color continue to be influenced by such beliefs and practices. In many societies, the centuries - old recognition of healers (*shamans*) within a community refers to people often called witches, witch doctors, wizards, medicine men or women, sorcerers, and magic men or women. These individuals are believed to possess the power to enter an altered state of consciousness and journey to other planes of existence beyond the physical world during their healing rituals.

There are both similarities and differences between EuroAmerican helping systems and non - Western indigenous practices. *Shamans* share many common characteristics with Western therapists. In the eyes of clients, for example, both have high credibility, show compassion and a professional stance, share one another's worldviews, and offer themselves as the chief instruments for change. The differences, however, are great. Western forms of counseling rely on sensory information defined by the physical plane of reality (Western science), whereas most indigenous methods rely on the spiritual plane of existence in seeking a cure. *Indigenous healing* operates under three guiding principles: (a) *holistic outlook*, interconnectedness, and harmony; (b) belief in metaphysical levels of existence; and (c) *spirituality* in life and the cosmos. *Western healing* has been slow to acknowledge and learn from these age - old forms of wisdom. In its attempt to become culturally responsive, however, the mental health field must begin to put aside the biases of Western science, to acknowledge the existence of intrinsic help - giving networks, and to incorporate the legacy of ancient wisdom that may be contained in indigenous models of healing.

Such reconciliation may be found in the desire among many Americans for religious and spiritual integration. Studies show that an overwhelming number of Americans say that religion is important in their lives, that both medical and mental health care patients express a strong desire for providers to discuss spiritual and faith issues with them, and that persons of color believe that spiritual issues are intimately linked to their cultural identities.

GLOSSARY TERMS

- Băt Gió
- Brain fag
- Cao Gió
- Enlightenment
- Espiritismo
- Ghost sickness
- Giác Hoi
- Hmong sudden death syndrome
- Ho'oponopono
- Holistic outlook
- Indigenous healing
- Mahiki
- ’Oia’i’o
- Pani
- Pule ho'opau
- Pule weke
- Shaman
- Spirituality
- Sweat lodge ceremony
- Thùôc Nam
- Universal shamanic tradition
- Western healing

Video 10.4: Counseling Session Analysis

Analysis of counseling session by Drs. Derald Wing Sue and Joel Filmore.

REFERENCES

1. Aldwin, C. M., Park, C. L., Jeong, Y. - J., & Nath, R. (2014). Differing pathways between religiousness, spirituality, and health: A self - regulation perspective. *Psychology of Religion and Spirituality*, *6*(1), 9–21.

2. Alexander, C., Langer, E., Newman, R., Chandler, H., & Davies, J. (1989). Transcendental meditation, mindfulness and longevity: An experimental study with the elderly. *Journal of Personality and Social Psychology*, *57*, 950–964.

3. Alexander, C., Rainforth, M., & Gelderloos, P. (1991). Transcendental meditation, self - actualization and psychological health: A conceptual overview and statistical meta - analysis. *Journal of Social Behavior and Personality*, *6*, 189–247.

4. American Counseling Association (1995). Summit results in formation of spiritual competencies. *Counseling Today*, *38*(6), 30.

5. American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.

6. American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

7. Bankart, C. P. (1997). *Talking cures: A history of Western and Eastern psycho therapies*. Pacific Grove, CA: Brooks/Cole.

8. Boyd - Franklin, N. (2010). Incorporating spirituality and religion into the treatment of African American clients. *The Counseling Psychologist*, *38*, 976–1000.

9. Brinkley, D. (1994). *Saved by the light*. New York, NY: Villard Books.

10. Cashwell, C. S., & Bartley, J. L. (2014). Engaged spirituality: A heart for social justice. In M. J. Ratts, & P. B. Pedersen (Eds.), *Counseling for multiculturalism and social justice* (pp. 275–288). Alexandria, VA: American Counseling Association.

11. Chang, C. Y., McDonald, C. P., & O'Hara, C. (2014). Counseling clients from Asian and Pacific Island heritages. In M. J. Ratts, & P. B. Pedersen (Eds.), *Counseling for multiculturalism and social justice* (pp. 127–142). Alexandria, VA: American Counseling Association.

12. Chavez, L. G. (2005). Latin American healers and healing: Healing as a redefinition process. In R. Moodley, & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 85–99). Thousand Oaks, CA: Sage.

13. Chen, C. P. (2005). Morita therapy: A philosophy of Yin/Yang coexistence. In R. Moodley, & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 221–232). Thousand Oaks, CA: Sage.

14. Constantine, M. G., Myers, L. J., Kindaichi, M., & Moore, J. L. (2004). Exploring indigenous mental health practices: The roles of healers and helpers in promoting well - being in people of color. *Counseling and Values*, *48*, 110–125.

15. Cornah, D. (2006). *The impact of spirituality on mental health: A review of the literature*. London: Mental Health Foundation.

16. Duran, E. (2006). *Healing the soul wound*. New York, NY: Teachers College Press.

17. Eadie, B. J. (1992). *Embraced by the light*. Carson City, NV: Gold Leaf Press.

18. Edwards, S. D. (2011). A psychology of indigenous healing in southern Africa. *Journal of Psychology in Africa*, *21*, 335–348.

19. Eliade, M. (1972). *Shamanism: Archaic techniques of ecstasy*. New York, NY: Pantheon.

20. Eriksen, K., Jackson, S. A., Weld, C., & Lester, S. (2013). Religion and spirituality. In G. McAuliffe (Ed.), & Associates*Culturally alert counseling* (2nd ed.) (pp. 453–503). Thousand Oaks, CA: Sage.

21. Fadiman, A. (1997). *The spirit catches you and you fall down*. New York, NY: Farrar, Straus & Giroux.

22. Gallup Organization. (2017). Religion: Gallup historical trends. Retrieved from http://news.gallup.com/poll/1690/religion.aspx

23. Garrett, J. T., & Garrett, M. W. (1994). The path of good medicine: Understanding and counseling Native American Indians. *Journal of Multicultural Counseling and Development*, *22*, 134–144.

24. Garrett, M. T., & Portman, T. A. A. (2011). *Counseling Native Americans*. Belmont, CA: Cengage.

25. Garrett, M. T., Torres‐Rivera, E., Brubaker, M., Portman, T. A. A., Brotherson, D., West‐Olatunji, C., & Grayshield, L. (2011). Crying for a vision: The Native American sweat lodge ceremony as therapeutic intervention. *Journal of Counseling and Development*, *89*, 318–325.

26. Goldberg, S. B., Tucker, R. P., Greene, P. A., Davidson, R. J., Wampold, B. E., Kearney, D. J., & Simpson, T. L. (2017). Mindfulness‐based interventions for psychiatric disorders: A systematic review and meta‐analysis. *Clinical Psychology Review*, *59*, 52–60.

27. Gone, J. P. (2010). Psychotherapy and traditional healing for American Indians: Exploring the prospects for therapeutic integration. *Counseling Psychologist*, *38*, 166–235.

28. Gonsiorek, J. C., Richards, P. S., Pargament, K. I., & McMinn, M. R. (2009). Ethical challenges and opportunities at the edge: Incorporating spirituality and religion into psychotherapy. *Professional Psychology: Research and Practice*, *40*, 385–395.

29. Hage, S. M. (2004). A closer look at the role of spirituality in psychology training programs. *Professional Psychology: Research and Practice*, *37*, 303–310.

30. Harner, M. (1990). *The way of the shaman*. San Francisco, CA: Harper & Row.

31. Heinrich, R. K., Corbin, J. L., & Thomas, K. R. (1990). Counseling Native Americans. *Journal of Counseling & Development*, *69*, 128–133.

32. Highlen, P. S. (1996). MCT theory and implications for organizations/systems. In D. W. Sue, A. E. Ivey, & P. B. Pedersen (Eds.), *A theory of multicultural counseling and therapy* (pp. 65–85). Pacific Grove, CA: Brooks/Cole.

33. Hines, P. M., & Boyd‐Franklin, N. (1996). African American families. In M. McGoldrick, J. Giodano, & J. K. Pearce (Eds.), *Ethnicity and family therapy* (pp. 66–84). New York, NY: Guilford Press.

34. Hong, G. K., & Domokos‐Cheng Ham, M. (2001). *Psychotherapy and counseling with Asian American clients*. Thousand Oaks, CA: Sage.

35. Kabat‐Zinn, J. (1990). *Full catastrophe living*. New York, NY: Delacorte.

36. Kamarck, T., & Jennings, J. R. (1991). Biobehavioral factors in sudden cardiac death. *Psychological Bulletin, 109*, 42–75.

37. Knox, S., Catlin, L., Casper, M., & Schlosser, L. Z. (2005). Addressing religion and spirituality in psychotherapy: Clients' perspectives. *Psychotherapy Research, 15*, 287–303.

38. Kwee, M. (1990). *Psychotherapy, meditation and health*. London: East‐West.

39. Lee, C. C. (1996). MCT theory and implications for indigenous healing. In D. W. Sue, A. E. Ivey, & P. B. Pedersen (Eds.), *A theory of multicultural counseling and therapy* (pp. 86–98). Pacific Grove, CA: Brooks/Cole.

40. Lee, C. C., & Armstrong, K. L. (1995). Indigenous models of mental health intervention: Lessons from traditional healers. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 441–456). Thousand Oaks, CA: Sage.

41. Lee, C. C., Oh, M. Y., & Mountcastle, A. R. (1992). Indigenous models of helping in nonwestern countries: Implications for multicultural counseling. *Journal of Multicultural Counseling and Development, 20*, 1–10.

42. Lee, E. (1996). Chinese families. In M. McGoldrick, J. Geordano, & J. K. Pearce (Eds.), *Ethnicity and family therapy* (pp. 249–267). New York, NY: Guilford Press.

43. Maslow, A. H. (1968). *Toward a psychology of being*. Princeton, NJ: Van Nostrand.

44. McCormick, R. (2005). The healing path: What can counselors learn from aboriginal people about how to heal? In R. Moodley, & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 293–304). Thousand Oaks, CA: Sage.

45. Moodley, R. (2005). Shamanic performances: Healing through magic and the supernatural. In R. Moodley, & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 2–14). Thousand Oaks, CA: Sage.

46. Mpofu, E. (2011). *Counseling people of African ancestry*. Cambridge, MA: Cambridge University Press.

47. Mullavey‐O'Byrne, C. (1994). Intercultural communication for health care professionals. In R. W. Brislin, & T. Yoshida (Eds.), *Improving intercultural interactions* (pp. 171–196). Thousand Oaks, CA: Sage.

48. Nishihara, D. P. (1978). Culture, counseling, and ho'oponopono: An ancient model in a modern context. *Personnel and Guidance Journal, 56*, 562–566.

49. Pankhania, J. (2005). Yoga and its practice in psychological healing. In R. Moodley, & W. West (Eds.), *Integrating traditional healing practices into counseling and*

psychotherapy (pp. 246–256). Thousand Oaks, CA: Sage.

50. Parham, T. A., & Caldwell, L. D. (2015). Boundaries in the context of a collective community: An African‐centered perspective. In B. Herlihy, & G. Corey (Eds.), *Boundary issues in counseling* (pp. 96–100). Alexandria, VA: American Counseling Association.

51. Pedersen, P. B., & Pope, M. (2010). Inclusive cultural empathy for successful global leadership. *American Psychologist, 65*, 841–854.

52. Reed, T. D., & Neville, H. A. (2014). The influence of religiosity and spirituality on psychological well‐being among Black women. *Journal of Black Psychology*, *40*(4), 384–401.

53. Rezentes, W. C. III (2006). Hawaiian psychology. In L. T. Hoshmand (Ed.), *Culture, psychotherapy and counseling* (pp. 113–133). Thousand Oaks, CA: Sage.

54. Ross, R. (2014). *Indigenous healing: Exploring traditional paths*. Toronto, ON: Penguin Group Canada.

55. Schwartz, S., Hoyte, J., James, T., Conoscenti, L., Johnson, R., & Liebschutz, J. (2010). Challenges to engaging Black male victims of community violence in healthcare research: Lessons learned from two studies. *Psychological Trauma: Theory, Research, Practice, and Policy*, *2*, 54–62.

56. Shapiro, D. H. (1982). Overview: Clinical and physiological comparison of meditation with other self‐control strategies. *American Journal of Psychiatry*, *139*, 267–274.

57. Smith, D. P. (2005). The sweat lodge as psychotherapy. In R. Moodley, & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 196–209). Thousand Oaks, CA: Sage.

58. So, J. K. (2005). Traditional and cultural healing among the Chinese. In R. Moodley, & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 100–111). Thousand Oaks, CA: Sage.

59. Solomon, A., & Wane, J. N. (2005). Indigenous healers and healing in a modern world. In R. Moodley, & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 52–60). Thousand Oaks, CA: Sage.

60. Strawbridge, W. J., Cohen, R. D., Shema, S. J., & Kaplan, G. A. (1997). Frequent attendance at religious services and mortality over 28 years. *American Journal of Public Health, 87*, 957–961.

61. Sutton, C. T., & Broken Nose, M. A. (2005). American Indian families: An overview. In M. McGoldrick, J. Giordano, & N. Garcia‐Preto (Eds.), *Ethnicity and family therapy* (pp. 43–54). New York, NY: Guilford Press.

62. Thoresen, C. E. (1998). Spirituality, health and science: The coming revival? In S. R. Roemer, S. R. Kurpius, & C. Carmin (Eds.), *The emerging role of counseling psychology in health care* (pp. 409–431). New York, NY: Norton.

63. Walsh, R., & Shapiro, S. L. (2006). The meeting of meditative disciplines and Western psychology. *American Psychologist, 61*, 227–239.

64. Wendt, D. C., Gone, J. P., & Nagata, D. K. (2015). Potentially harmful therapy and

multicultural counseling: Bridging two disciplinary discourses. *The Counseling Psychologist*, *43*, 334–358.

65 West, M. (1987). *The psychology of meditation*. Oxford: Clarendon Press.

PART IV

Racial, Ethnic, Cultural (REC) Attitudes in Multicultural Counseling and Therapy

11
Racial, Ethnic, Cultural (REC) Identity Attitudes in People of Color: Counseling Implications

Chapter Objectives

1. **1. Learn the important factors that are influential in the development of racial, ethnic, cultural (REC) identity in people of color.**
2. **2. Describe how sociopolitical forces influence the REC identity attitudes of people of color.**
3. **3. Outline key REC models and describe how they incorporate attitudes, beliefs, and behaviors toward oneself, toward members of one's own group, and toward majority group members.**
4. **4. Become knowledgeable about how the REC identity attitudes of people of color impact the counseling/therapy situation.**
5. **5. Describe the various common characteristics of clients at each of the following levels of identity formation: *conformity*, *dissonance*, *resistance and immersion*, *introspection*, and *integrative awareness*.**
6. **6. Discuss the therapeutic challenges likely to confront a counselor or therapist working with clients at each of the five levels of identity development.**

CASE STUDY

"JENNY": SANSEI (THIRD‐GENERATION) JAPANESE AMERICAN WOMAN

For nearly all my life I have never seriously attempted to dissect my feelings and attitudes about being a Japanese American woman. Aborted attempts were made, but they were never brought to fruition, because it was unbearably painful. Having been born and raised in Arizona, I had no Asian friends. I suspect that given an opportunity to make some, I would have avoided them anyway. That is because I didn't want to have anything to do with being Japanese American. Most of the Japanese images I saw were negative. Japanese women were ugly; they had "cucumber legs," flat yellow faces, small slanty eyes, flat chests, and were stunted in growth. The men were short and stocky, sneaky and slimy, clumsy, inept, "wimpy looking," and sexually emasculated. I wanted to be tall, slender, large eyes, full lips, and elegant looking; I wasn't going to be typical Oriental!

At Cal [University of California, Berkeley], I've been forced to deal with my Yellow‐White identity. There are so many "yellows" here that I can't believe it. I've come to realize that many White prejudices are deeply ingrained in me; so much so that they are unconscious. To accept myself as a total person, I also have to accept my Asian identity as well. But what is it? I just don't know. Are they the images given me through the filter of White America, or are they the values and desires of my parents?

Yesterday, I had a rude awakening. For the first time in my life I went on a date with a Filipino boy. I guess I shouldn't call him a "boy," as my ethnic studies teacher says it is derogatory toward Asians and Blacks. I only agreed to go because he seemed different from the other "Orientals" on campus. (I guess I shouldn't use that word either.) He's president of his Asian fraternity, very athletic and outgoing. When he asked me, I figured, "Why not?" It'll be a good experience to see what it's like to date an Asian boy. Will he be like White guys who will try to seduce me, or will he be too afraid to make

any move when it comes to sex? We went to San Francisco's Fisherman's Wharf for lunch. We were seated and our orders were taken before two other White women. They were, however, served first. This was painfully apparent to us, but I wanted to pretend that it was just a mix - up. My friend, however, was less forgiving and made a public fuss with the waiter. Still, it took an inordinate amount of time for us to get our lunches, and the filets were overcooked (purposely?). My date made a very public scene by placing a tip on the table, and then returning to retrieve it. I was both embarrassed but proud of his actions.

This incident and others made me realize several things. For all my life I have attempted to fit into White society. I have tried to convince myself that I wasn't different, that I was like all my other White classmates, and that prejudice and discrimination didn't exist for me. I wonder how I could have been so oblivious to prejudice and racism. I now realize that I cannot escape from my ethnic heritage and from the way people see me. Yet I don't know how to go about resolving many of my feelings and conflicts. While I like my newly found Filipino “male” friend (he is sexy), I continue to have difficulty seeing myself married to anyone other than a White man. (Excerpts from “Jenny,” a Sansei student class journal)

Video 11.0: Introduction

Introduction to counseling session by Dr. Joel Filmore.

RACIAL AWAKENING

Oriental, Asian, or White?

Jenny is experiencing a *racial awakening* that has strong implications for her racial, ethnic, cultural (REC) identity. Her previous belief systems concerning White Americans and Asian Americans are being challenged by social reality and the experiences of being a "visible racial/ethnic minority." First, a major theme involving societal portrayals of Asian Americans is clearly expressed in her beliefs about REC characteristics: Jenny describes the Asian American man and woman in highly unflattering terms. She seems to have internalized these beliefs and to be using White standards to judge Asian Americans as being desirable or undesirable. For this student, the process of incorporating these standards has not only attitudinal but also behavioral consequences. In Arizona, she would not have considered making Asian American friends even if the opportunity had presented itself. In her mind, she was not a "typical Oriental"; she disowned or felt ashamed of her ethnic heritage. She even concludes that she has trouble picturing marrying anyone but a White man.

Denial Breakdown

Jenny's denial that she is an Asian American is beginning to crumble. Being immersed in the student body on a campus in which there are many fellow Asian Americans in attendance forces her to explore REC identity issues—a process she has been able to avoid while living in a predominantly White area. Part of the avoidance may have been a REC coping mechanism to fit in at all cost. In the past, when she encountered prejudice or discrimination, she was able to deny it or to rationalize it away. The differential treatment she received at the restaurant and her friend's labeling of it as "discrimination" makes such a conclusion inescapable. The shattering of illusions is manifest in her realization that (a) despite her efforts to "fit in," it is not enough to gain social acceptance among many White Americans, (b) she cannot escape her REC heritage, and (c) she has been brainwashed into believing that one group is superior to another.

The Internal Struggle for Identity

Jenny's internal struggle to cast off the cultural conditioning of her past and the attempts to define her REC identity are both painful and conflicting. We have clear evidence of the internal turmoil she is undergoing when she (a) refers to her "Yellow - White" identity, (b) writes about her negative images of Asian American men but winds up dating one, (c) uses the terms "Oriental" and "boy" (in reference to her Asian male friend) but acknowledges their derogatory racist nature, (d) describes Asian men as "sexually emasculated" but sees her Filipino date as "athletic," "outgoing," and "sexy," (e) expresses embarrassment at confronting the waiter about discrimination but feels proud of her friend for doing so, and (f) states that she finds her friend attractive but would have trouble considering marrying anyone but a White man. Understanding the process by which REC identity attitudes develop and change over time in persons of color is crucial for effective multicultural counseling and therapy (MCT).

Locus of the Problem

It is clear that Jenny is a victim of ethnocentric monoculturalism. As we mentioned previously, the problem she is experiencing does not reside in her but in our society: a society

that portrays REC characteristics as inferior, primitive, deviant, pathological, or undesirable. The resulting damage strikes at the self - esteem and self/group identity of many people of color; many, like this student, may come to believe that their REC heritage or characteristics are burdens to be changed or overcome. Understanding REC identity attitudes and their relationship to therapeutic practice are the goals of this chapter.

Video 11.1: Clients of Color and Self-Awareness

Clients of color go through a developmental process in which they become aware of their 'differentness'. It is during this process that they achieve an awakening related to their race/ethnicity.

REC IDENTITY ATTITUDE MODELS

The historic work on REC identity attitudes among people of color has led to major breakthroughs in the field of multicultural psychology (Atkinson, Morten, & Sue, 1998; Cross, 1971, 1995; Cross, Smith, & Payne, 2002; Helms, 1984, 1995; Horse, 2001; Kim, 1981; Ruiz, 1990). Most would agree that Asian Americans, African Americans, Latinx Americans, and American Indians have distinct REC heritages that make each different from the others. The rise of the REC identity models in the 1970s and the current extensions of them allow researchers and counselors opportunities to acknowledge within‐group differences among the distinct REC groups; that is, to challenge the erroneous belief that all Asians are the same, all Blacks are the same, all Latinx are the same, or all American Indians are the same. Treating REC groups as monolithic has led to numerous therapeutic problems, including early termination from counseling/therapy (Owen et al., 2017). The high failure‐to‐return rate of many clients seems to be intimately connected to the mental health professional's inability to assess their cultural identities accurately (Ivey, D'Andrea, & Ivey, 2011).

Another important contribution of REC identity models is their acknowledgment of sociopolitical influences in shaping identity (à la “Jenny”). Early models of REC identity all incorporated the effects of racism and prejudice (oppression) upon the identity transformation of their victims. Vontress (1971), for instance, theorized that African Americans moved through decreasing levels of dependence on White society to emerging identification with Black culture and society (Colored, Negro, and Black). Other similar models for African Americans have been proposed (Cross, 1971; Jackson, 1975; Thomas, 1970, 1971). The fact that other marginalized groups, such as Asian Americans (Kim, 2012; Sue & Sue, 1971), Latinx Americans (Ferdman & Gallegos, 2012), Native Americans (Horse, 2012), women (Downing & Roush, 1985; McNamara & Rickard, 1989), lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals (Cass, 1979), and individuals with disabilities (Olkin, 1999), have similar processes may indicate experiential validity for such models as they relate to various oppressed groups. More recent REC identity conceptualizations also provide insights about how to consider the ways in which multiple identity attitudes influence the counseling/therapy process; that is, the consideration of REC identity attitudes along with other social identity attitudes such as gender, sexual orientation, and religion (Robinson‐Wood, 2016).

Foundational REC Models

Early attempts to define a process of minority identity transformation came primarily through the works of Black social scientists and educators (Cross, 1971; Jackson, 1975; Thomas, 1971). Although there are several Black identity development models, the Cross model of psychological *nigrescence* (the process of becoming Black) is perhaps the most influential and well documented (Cross, 1971, 1991, 1995). The original Cross model was developed during the civil rights movement and delineates a five‐stage process in which Blacks in the United States move from a White frame of reference to a positive Black frame of reference: *preencounter*, *encounter*, *immersion‐emersion*, *internalization*, and *internalization‐commitment*.

- The *preencounter* stage is characterized by African Americans consciously or unconsciously devaluing their own Blackness and concurrently valuing White values and ways. There is a strong desire to assimilate and acculturate into White society.

Blacks at this stage evidence self‐hate, low self‐esteem, and poor mental health (Vandiver, 2001).

- In the *encounter* stage, a two‐step process begins to occur. First, the Black person encounters a profound crisis or event that challenges his or her previous mode of thinking and behaving; second, he or she begins to reinterpret the world, resulting in a shift in worldviews. Cross points out how the slaying of Martin Luther King Jr. was such a significant experience for many African Americans. More recently, the shooting of Michael Brown in Ferguson, Missouri and the choking death of Eric Garner in New York, both in 2014, are other examples. The person experiences both guilt and anger over being brainwashed by White society.
- In the third stage, *immersion‐emersion*, the person withdraws from the dominant culture and becomes immersed in African American culture. Black pride begins to develop, but *internalization* of positive attitudes toward one's own Blackness is minimal. In the emersion phase, feelings of guilt and anger begin to dissipate with an increasing sense of pride.
- The next stage, *internalization,* is characterized by inner security, as conflicts between the old and new identities are resolved. Global anti‐White feelings subside as the person becomes more flexible, more tolerant, and more bicultural/multicultural.
- The last stage, *internalization‐commitment*, speaks to the commitment that such individuals have toward social change, social justice, and civil rights. It is expressed not only in words but also in actions that reflect the essence of their lives.

Cross's original model makes a major assumption: the evolution from the *preencounter* stage to the *internalization* stage reflects a movement from psychological dysfunction to psychological health (Vandiver, 2001).

Confronted with evidence that these stages, which some psychologists now refer to as “statuses,” may mask multiple racial identities; questioning his original assumption that all Blacks at the preencounter stage possess self‐hatred and low self‐esteem; and aware of the complex issues related to *race salience*, Cross (1991) revised his theory of *nigrescence* in his book *Shades of Black*. His changes, which are based on a critical review of the literature on Black racial identity, have increased the model's explanatory powers and promise high predictive validity (Vandiver, Fhagen‐Smith, Cokley, Cross, & Worrell, 2001; Worrell, Cross, & Vandiver, 2001). In essence, the revised model contains nearly all the features from the earlier formulation, but it differs in several significant ways.

First, Cross introduces the concept of *race salience*, the degree to which race is an important and integral part of a person's approach to life. The Black person may function with “race” consciousness playing either a large or a minimal role in his or her identity. In addition, salience for Blackness can possess positive (pro‐Black) or negative (anti‐Black) valence. Instead of using the term “pro‐White” in describing the *preencounter* stage, Cross now uses the term *race salience*. Originally, Cross believed that the rejection of Blackness and the acceptance of an American perspective were indicative of only one identity, characterized by self‐hate and low self‐esteem. His current model now describes three identity subtypes: (a) *preencounter* assimilation; (b) *preencounter* miseducation; and (b) *preencounter* anti‐Black. People represented in the first subtype have low salience for race and a neutral valence toward Blackness; the second subtype reflects internalization of negative messages in society about Blacks but an ability to separate one's personal identity from one's racial group membership; the third describes individuals who hate Blacks and hate being Black (high

negative salience). In other words, it is possible for a Black person in *preencounter* to experience the salience of race as very minor and to have his or her identity oriented toward an "American" perspective, without self‐hate or low self‐esteem.

The sense of low self‐esteem, however, is linked to the *preencounter* anti‐Black orientation. According to Cross, such a psychological perspective is the result of miseducation and self‐hatred. The miseducation results from the negative portrayal of Blacks in the mass media, among neighbors, friends, and relatives, and in educational literature (Blacks are unintelligent, criminal, lazy, and prone to violence). The result is an incorporation of such negative images into the personal identity of the Black person. Interestingly, the case of Jenny, although Japanese American, would seem to possess many of the features of Cross's *preencounter* anti‐Black identity.

Second, the *immersion‐emersion* stage once described one fused identity (anti‐White/pro‐Black) but is now divided into two subtypes: anti‐White alone and anti‐Black alone. While Cross speaks about two separate identities, it appears that there are three possible combinations: anti‐White, pro‐Black, and an anti‐White/pro‐Black combination.

Third, Cross collapsed the fourth and fifth stages (*internalization* and *internalization‐commitment*) into one: *internalization*. He observed that minimal differences existed between the two stages except in the characteristic of "sustained interest and commitment." This last stage is characterized by Black self‐acceptance and can be manifested in three types of identity: (a) Black nationalist (high Black positive *race salience*); (b) biculturalist (Blackness and fused sense of Americanness); and (c) multiculturalist (multiple identity formation, including race, gender, sexual orientation, etc.).

Cross's *nigrescence* model influenced a generation of REC and other social identity models, including models of Asian American (e.g., Kim 1981), Latinx (e.g., Ruiz 1990), and people of color and White identity (e.g., Helms, 1995). In the next section, we describe one of the only general REC identity models that accounts for the attitudes and activities related to one's own REC group as well as other REC groups.

A GENERAL MODEL OF REC IDENTITY

In the past several decades, Asian Americans, Latinx Americans, and American Indians have experienced sociopolitical identity transformations so that a Third World consciousness has emerged, with the awareness of cultural oppression as the common unifying force. As a result of studying these models and integrating them with their own clinical observations, Atkinson et al. (1998) proposed a five‐stage Minority Identity Development (MID) model in an attempt to pull out common features that cut across the population‐specific proposals. Sue and Sue (1990, 1999) later elaborated on the MID, renaming it the Racial/Cultural Identity Development (R/CID) model, to (a) encompass a broader population and (b) avoid the disempowering term "minority." As discussed shortly, this model may be applied to White identity development as well.

The *R/CID model* proposed here is not a comprehensive theory of personality, but rather a conceptual framework or heuristic to aid therapists in understanding their REC diverse clients' attitudes and behaviors. Five levels of development that oppressed people experience as they struggle to understand themselves in terms of their own culture, the dominant culture, and the oppressive relationship between the two are described: *conformity*, *dissonance*, *resistance and immersion*, *introspection*, and *integrative awareness*. At each level, there are four corresponding beliefs and attitudes, the understanding of which may help therapists better understand their clients. These attitudes/beliefs are an integral part of identity, and are manifest in how a person views (a) the self, (b) others of the same minority, (c) others of another minority, and (d) majority individuals. Table 11.1 outlines the *R/CID model* and the interaction of its phases with these attitudes and beliefs.

TABLE 11.1 The R/CID Model

Source: Atkinson, D. R., Morten, G., & Sue, D. W. (1998). *Counseling American minorities: A cross‐cultural perspective* (5th ed.). Boston, MA: McGraw‐Hill.

Phases of minority development model	Attitude toward self	Attitude toward others of the same group	Attitude toward others of a different marginalized group	Attitude toward dominant group
Status 1—Conformity	Self‐depreciating or neutral due to low race salience	Group‐depreciating or neutral due to low race salience	Discriminatory or neutral	Group‐appreciating
Status 2—Dissonance	Conflict between self‐depreciating and group‐appreciating	Conflict between group‐depreciating views of minority hierarchy and feelings of shared experience	Conflict between dominant‐held and group‐depreciating	Conflict between group‐appreciating and group‐depreciating
Status 3—Resistance and immersion	Self‐appreciating	Group‐appreciating experiences and feelings of culturocentrism	Conflict between feelings of empathy for	Group‐depreciating

			other minority	
Status 4—Introspection	Concern with basis of self - appreciation	Concern with nature of unequivocal appreciation	Concern with ethnocentric basis for judging others	Concern with the basis of group depreciation
Status 5—Integrative awareness	Self - appreciating	Group - appreciating	Group - appreciating	Selective appreciation

Select this link to open an interactive version of Graphic 11.1: The R/CID Model

Conformity Status

Similar to individuals mostly in *preencounter* (Cross, 1991), persons of color are distinguished by their unequivocal preference for dominant cultural values over those of their own culture. White Americans in the United States represent their reference group, and the identification set is quite strong. Lifestyles, value systems, and cultural/physical characteristics that most resemble those of White society are highly valued, whereas those most associated with their own group of color may be viewed with disdain or may hold low salience. We agree with Cross that individuals at this stage can be oriented toward a pro - American identity without subsequent disdain or negativism toward their own group. Thus, it is possible for a Chinese American to feel positive about U.S. culture, values, and traditions without evidencing disdain for Chinese culture or feeling negatively about their self (absence of self - hate). Nevertheless, we believe that such individuals represent a small proportion of persons of color at this stage. Research on their numbers, on how they have handled the social - psychological dynamics of majority–minority relations, on how they have dealt with their marginalized status, and on how they fit into the models (progression issues) needs to be conducted.

We believe that the *conformity* phase continues to be most characterized by individuals who have bought into majority societal definitions about their marginalized status in society. Because the *conformity* phase represents, perhaps, the most damning indictment of White racism and because it has such a profound negative impact on persons of color, understanding its sociopolitical dynamics is of utmost importance for the helping professional. Those in the *conformity* phase are really victims of larger social - psychological forces operating in our society. The key issue here is the dominant–subordinate relationship between two different cultures (Atkinson et al., 1998; Freire, 1970). It is reasonable to believe that members of one cultural group tend to adjust themselves to the group possessing the greater prestige and power in order to avoid feelings of inferiority. Yet, it is exactly this act that creates ambivalence in the individual. The pressures for assimilation and acculturation (melting - pot theory) are strong, creating possible culture conflicts. These individuals are victims of *ethnocentric monoculturalism*: (a) belief in the superiority of one group's cultural heritage—its language, traditions, arts - crafts, and ways of behaving (White) over all others; (b) belief in the inferiority of all other lifestyles (non - White); and (c) the power to impose such standards on to the less powerful group.

Internalized racism has been the term used to describe the process by which persons of color absorb the racist messages that are omnipresent in our society and internalize them (Kohli, 2013; Pyke, 2010). Constantly bombarded on all sides by reminders that Whites and their way of life are superior and that all other lifestyles are inferior, many begin to wonder whether they themselves are somehow inadequate, whether members of their own group are

not to blame, and whether subordination and segregation are not justified. Clark and Clark (1947) first brought this to the attention of social scientists by stating that racism may contribute to a sense of confused self‐identity among Black children. In a study of racial awareness and preference among Black and White children, they found that (a) Black children preferred playing with a White doll over a Black one, (b) the Black doll was perceived as being "bad," and (c) approximately one‐third, when asked to pick the doll that looked like them, picked the White one.

It is unfortunate that the perceived inferior status of people of color is constantly reinforced and perpetuated by the mass media through television, movies, newspapers, radio, books, and magazines. This contributes to widespread stereotypes that tend to trap them: Blacks are superstitious, childlike, ignorant, fun loving, dangerous, and criminal; Latinx individuals are lazy, sneaky, and criminal; Asian Americans are sneaky, sly, cunning, and passive; Native Americans are drunkards, violent, and primitive savages. The incorporation of the larger society's standards may lead group members to react negatively toward their own racial and cultural heritage. They may become ashamed of who they are, reject their own group identification, and attempt to identify with the desirable "good" White minority; such individuals come to accept White standards as a means of measuring physical attractiveness, attractiveness of personality, and social relationships. *Internalized racism*—or racial self‐hatred, in which people dislike themselves for being Asian, Black, Hispanic, or Native American—has a widespread influence on the mental health of people of color (e.g., Choi, Israel, & Maeda, 2017; Mouzon & McLean, 2017).

People primarily in *conformity* have, to some degree, internalized negative messages about their own group. They seem to possess the following characteristics:

1. *Attitudes and beliefs toward the self* (self‐depreciating attitudes and beliefs). Physical and cultural characteristics identified with one's own REC group are perceived negatively, as something to be avoided, denied, or changed. Physical characteristics (black skin color, "slant‐shaped eyes" of Asians), traditional modes of dress and appearance, and behavioral characteristics associated with the minority group are a source of shame. There may be attempts to mimic what is perceived as White mannerisms, speech patterns, dress, and goals. Low internal self‐esteem is characteristic of persons in this state.
2. *Attitudes and beliefs toward members of the same group* (group‐depreciating attitudes and beliefs). Majority cultural beliefs and attitudes about the minority group are also held by the person in this stage. These individuals may have internalized the majority of White stereotypes about their group. In the case of Hispanics, for example, the person may believe that members of his or her own group have high rates of unemployment because "they are lazy, uneducated, and unintelligent." Little thought or validity is given to other viewpoints, such as unemployment's being a function of job discrimination, prejudice, racism, unequal opportunities, and inferior education. Because persons in the *conformity* stage find it psychologically painful to identify with these negative traits, they divorce themselves from their own group. The denial mechanism most commonly used is, "I'm not like them; I've made it on my own; I'm the exception."
3. *Attitudes and beliefs toward members of different marginalized groups* (discriminatory). Because the *conformity*‐stage person most likely strives for identification with White society, he or she shares similar dominant attitudes and beliefs not only toward his or her own group but toward other marginalized groups as well. Groups most similar to White cultural groups are viewed more favorably, whereas those most different are viewed less

favorably.

> For example, Asian Americans may be viewed more favorably than African Americans or Latinx Americans in some situations. Although stratification probably exists, we caution readers that such a ranking is fraught with hazards and potential political consequences. It often manifests itself in debates over which group is more oppressed and which has done the best. Such debates are counterproductive when used to (a) negate another groups' experience of oppression, (b) foster an erroneous belief that hard work alone will result in success in a democratic society, (c) shortchange a marginalized group (i.e., Asian Americans) from receiving the necessary resources in our society, and (d) pit one marginalized group against another (divide and conquer) by holding one up as an example to others.

4. *Attitudes and beliefs toward members of the dominant group* (group - appreciating attitude and beliefs). This status is characterized by a belief that White cultural, social, and institutional standards are superior. Members of the dominant group are admired, respected, and emulated. White people are believed to possess superior intelligence. Some individuals may go to great lengths to appear White. In the *Autobiography of Malcolm X* (Haley, 1966), the author relates how he tried desperately to appear as White as possible. He went to painful lengths to straighten and dye his hair so that he would appear more like White males. Reports that Asian women have undergone surgery to reshape their eyes to conform to White female standards of beauty may typify this dynamic.

Dissonance Status

No matter how much an individual attempts to deny his or her own REC heritage, he or she will encounter information or experiences that are inconsistent with culturally held beliefs, attitudes, and values. An Asian American who believes that Asians are inhibited, passive, inarticulate, and poor in people relationships may encounter an Asian person who seems to break all these stereotypes (e.g., Jenny). A Latinx person who feels ashamed of his or her cultural upbringing may encounter another Latinx person who seems proud of it. An African American who believes that race problems are due to laziness, untrustworthiness, or personal inadequacies of his or her own group may suddenly encounter racism on a personal level. Denial begins to break down, which leads to a questioning and challenging of the attitudes/beliefs of the *conformity* stage. This was clearly what happened when Jenny encountered discrimination at the restaurant.

In all probability, transition into *dissonance* is a gradual process. Its very definition indicates that the individual is in conflict between disparate pieces of information or experiences that challenge his or her current self - concept. People generally begin to experience this conflict slowly, but a traumatic event may propel some individuals to move into *dissonance* at a much more rapid pace. Cross (1971) stated that a monumental event such as the assassination of a major leader like Martin Luther King Jr. can often push people quickly into the dissonance. Coates (2015) suggested the killing of teenager Michael Brown and the acquittal of the officer who shot him in Ferguson, Missouri pushed many youth, like his son, into an existential questioning of race and its meaning in the United States.

1. *Attitudes and beliefs toward the self* (conflict between self - depreciating and self - appreciating attitudes and beliefs). There is now a growing sense of personal awareness

that racism does exist, that not all aspects of one's own culture or of the majority culture are good or bad, and that one cannot escape one's cultural heritage. For the first time, the person begins to entertain the possibility of positive attributes in his or her own group's culture and, with them, a sense of pride in self. Feelings of shame and pride are mixed in the individual, and a sense of conflict develops. This conflict is most likely to be brought to the forefront quickly when other members of the group express positive feelings toward the person: “We like you because you are Asian [or Black, American Indian, or Latinx].” At this stage, an important personal question is being asked: “Why should I feel ashamed of who and what I am?”

2. *Attitudes and beliefs toward members of the same group* (conflict between group - depreciating and group - appreciating attitudes and beliefs). Dominant - held views of the person's own group's strengths and weaknesses begin to be questioned as new, contradictory information is received. Certain aspects of his or her culture begin to have appeal. For example, a Latinx person who values individualism may marry, have children, and then suddenly realize how Latinx cultural values that hold the family as the psychosocial unit possess positive features. Or a person may find certain members of his or her group to be very attractive as friends, colleagues, lovers, and so forth.
3. *Attitudes and beliefs toward members of a different marginalized group* (conflict between dominant - held views of minority hierarchy and feelings of shared experience). The person begins to question stereotypes associated with other marginalized groups, and feels a growing sense of comradeship with other oppressed groups. It is important to keep in mind, however, that little psychic energy is associated with resolving conflicts with other marginalized groups. Almost all energies are expended toward resolving conflicts toward the self, one's own group, and the dominant group.
4. *Attitudes and beliefs toward members of the dominant group* (conflict between group - appreciating and group - depreciating attitudes). The person experiences a growing awareness that not all cultural values of the dominant group are beneficial. This is especially true when the person experiences personal discrimination. Growing suspicion and some distrust of certain members of the dominant group develop.

Resistance and Immersion Status

The primary orientation of individuals in this status is the tendency to endorse minority - held views completely and to reject values of the dominant society and culture. Desire to eliminate oppression becomes an important motivation of the individual's behavior. In the *resistance and immersion* status, the three most active types of affective feeling are guilt, shame, and anger. There are considerable feelings of guilt and shame that in the past the individual has sold out his or her own racial and cultural group. These feelings of guilt and shame extend to the perception that during this past “sellout,” he or she was a contributor to and participant in the oppression of his or her own group and other marginalized groups. This is coupled with a strong sense of anger at the oppression, and feelings of having been brainwashed by forces in White society. Anger is directed outwardly in a very strong way toward oppression and racism. Movement into this stage seems to occur for two reasons. First, a resolution of the conflicts and confusions of the previous stage allows greater understanding of social forces (racism, oppression, and discrimination) and one's own role as a victim. Second, a personal questioning of why people should feel ashamed of themselves develops. The answer to this question evokes feelings of guilt, shame, and anger.

1. *Attitudes and beliefs toward the self* (self‐appreciating attitudes and beliefs). The individual with this status is oriented toward self‐discovery of his or her own history and culture. There is an active seeking out of information and artifacts that enhance the person's sense of identity and worth. Cultural and racial characteristics that once elicited feelings of shame and disgust become symbols of pride and honor. The individual moves into this status primarily because he or she asks the question, “Why should I be ashamed of who and what I am?” The original low self‐esteem engendered by widespread prejudice and racism that was most characteristic of the *conformity* status is now actively challenged in order to raise self‐esteem. Phrases such as “Black is beautiful” and “Black lives matter” represent a symbolic relabeling of identity for many Blacks. Unapologetic racial pride is embraced.
2. *Attitudes and beliefs toward members of the same group* (group‐appreciating attitudes and beliefs). The individual experiences a strong sense of identification with and commitment to his or her group as enhancing information about the group is acquired. There is a feeling of connectedness with other members of the racial and cultural group, and a strengthening of the new identity begins to occur. Members of one's group are admired, respected, and often viewed as the new reference group or ideal. Cultural values of the group are accepted without question. As indicated, the pendulum swings drastically from original identification with White ways to unquestioning identification with the group's ways. Persons in this phase are likely to restrict their interactions as much as possible to members of their own group.
3. *Attitudes and beliefs toward members of a different marginalized group* (conflict between feelings of empathy for other marginalized group experiences and feelings of culturocentrism). Although members at this status experience a growing sense of comradeship with persons from other socially devalued groups, a strong culturocentrism develops as well. Alliances with other groups tend to be transitory and based on short‐term goals or some global shared view of oppression. There is less of an attempt to reach out and understand other racial‐cultural groups and their values and ways, and more of a superficial surface feeling of political need. Alliances generally are based on convenience factors or are formed for political reasons, such as combining together as a large group to confront an enemy perceived to be larger.
4. *Attitudes and beliefs toward members of the dominant group* (group depreciating attitudes and beliefs). The individual is likely to perceive the dominant society and culture as an oppressor and as the group most responsible for the current plight of minorities in the United States. Characterized by both withdrawal from the dominant culture and immersion in one's cultural heritage, this status also gives rise to considerable anger and hostility directed toward White society. There is a feeling of distrust and dislike for all members of the dominant group in an almost global anti‐White demonstration and feeling. White people, for example, are not to be trusted because they are the oppressors or enemies. In extreme form, members may advocate complete destruction of the institutions and structures that have been characteristic of White society.

Introspection Status

Several factors seem to work in unison to move the individual from the *resistance and immersion* phase into the *introspection* phase. First, the individual begins to discover that this level of intensity of feelings (anger directed toward White society) is psychologically draining and does not permit one to really devote crucial energies to understanding oneself or

one's own racial - cultural group. The *resistance and immersion* phase tends to be a reaction against the dominant culture and is not proactive in allowing the individual to use all energies to discover who or what he or she is. Self - definition in the previous status tends to be reactive (against White racism), and now a need for positive self - definition in a proactive sense emerges.

Second, the individual experiences feelings of discontent and discomfort with group views that may be quite rigid in the *resistance and immersion* phase. Often, in order to please the group, the person is asked to submerge individual autonomy and individual thought in favor of the group good. Many group views may now be seen as conflicting with individual ones. A Latinx individual who forms a deep relationship with a White person may experience considerable pressure from his or her culturally similar peers to break off the relationship because that White person is the "enemy." However, the personal experiences of the individual may not support this group view.

It is important to note that some clinicians often confuse certain characteristics of the introspective status with parts of the *conformity* status. A person in the introspective status who speaks against the decisions of his or her group may often appear similar to the *conformity* - status person. The dynamics are quite different, however. While the *conformity* - status person is motivated by global racial self - hatred, the introspective person has no such global negativism directed at his or her own group.

1. *Attitudes and beliefs toward the self* (concern with basis of self - appreciating attitudes and beliefs). Although the person originally, in the *conformity* phase, held predominant majority group views and notions, to the detriment of his or her own group, the person now feels that he or she has too rigidly held on to the group views and notions in order to submerge personal autonomy. The conflict becomes quite great between responsibility and allegiance to one's own group and notions of personal independence and autonomy. The person begins to spend more and more time and energy trying to sort out these aspects of self - identity and begins increasingly to demand individual autonomy.
2. *Attitudes and beliefs toward members of the same group* (concern with the unequivocal nature of group appreciation). Although attitudes of identification are continued from the preceding *resistance and immersion* status, concern begins to build up regarding the issue of group - usurped individuality. Increasingly, the individual may see his or her own group taking positions that might be considered quite extreme. In addition, there is now increasing resentment over how his or her group attempts to pressure or influence the individual into making decisions that may be inconsistent with his or her values, beliefs, and outlooks. Indeed, it is not unusual for a minority group to make it clear to individual members that if they do not agree with the group, they are against it. A common ploy used to hold members in line is exemplified in questions such as "How Asian are you?" and "How Black are you?"
3. *Attitudes and beliefs toward members of a different marginalized group* (concern with the ethnocentric basis for judging others). There is now greater uneasiness with culturocentrism, and an attempt is made to reach out to other groups to find out what types of oppression they experience and how this has been handled. Although similarities are important, there is a movement toward understanding potential differences in oppression that other groups might have experienced.
4. *Attitudes and beliefs toward members of the dominant group* (concern with the basis of

group depreciation). The individual experiences conflict between attitudes of complete distrust for the dominant society and culture and attitudes of selective trust and distrust according to a dominant individual's demonstrated behaviors and attitudes. Conflict is most likely to occur here because the person begins to recognize that there are many elements in U.S. culture that are highly functional and desirable, yet feels confusion about how to incorporate these elements into his or her own culture. Would acceptance of certain White cultural values make the person a sellout to his or her own race? There is a lowering of intense feelings of anger and distrust toward the dominant group and a continued attempt to discern elements that are acceptable.

Integrative Awareness Status

Persons with this status have developed an inner sense of security and can now own and appreciate unique aspects of their culture as well as those of U.S. culture. The person's own culture is not necessarily in conflict with White dominant cultural ways. Conflicts and discomforts experienced in the previous status become resolved, allowing greater individual control and flexibility. There is now the belief that there are acceptable and unacceptable aspects in all cultures and that it is very important for the person to be able to examine and either accept or reject those aspects of a culture that he or she does not see as desirable. With the *integrative awareness* status, the person has a strong commitment and desire to eliminate all forms of oppression.

1. *Attitudes and beliefs toward the self* (self - appreciating attitudes and beliefs). The individual develops a positive self - image and experiences a strong sense of self - worth and confidence. Not only is there an integrated self - concept that involves racial pride in identity and culture, but the person develops a high sense of autonomy. Indeed, he or she becomes bicultural or multicultural without a sense of having “sold out his or her integrity.” In other words, the person begins to perceive his or her self as an autonomous individual who is unique (individual level of identity), a member of his or her own racial - cultural group (group level of identity), a member of a larger society, and a member of the human race (universal level of identity).
2. *Attitudes and beliefs toward members of same group* (group - appreciating attitudes and beliefs). The individual experiences a strong sense of pride in the group without having to accept group values unequivocally. There is no longer conflict over disagreeing with group goals and values. Strong feelings of empathy with the group experience are coupled with awareness that each member of the group is also an individual. In addition, tolerant and empathic attitudes are likely to be expressed toward members of the individual's own group who may be functioning in a less adaptive manner to racism and oppression.
3. *Attitudes and beliefs toward members of a different marginalized group* (group - appreciating attitudes). There is now literally a reaching out toward different oppressed groups in order to understand their cultural values and ways of life. There is a strong belief that the more the various ethnic groups can understand one another's cultural values and beliefs, the greater the likelihood of respect between them. Support for all oppressed people, regardless of similarity to the individual's minority group, tends to be emphasized.
4. *Attitudes and beliefs toward members of the dominant group* (attitudes and beliefs of selective appreciation). The individual experiences selective trust and liking for and

from members of the dominant group who seek to eliminate oppressive activities of the group. The individual also experiences openness to the constructive elements of the dominant culture. The emphasis here tends to be on the fact that White racism is a sickness in society and that White people are also victims who are in need of help.

Video 11.2: Developmental Impact of Race/Ethnicity

The development of a person-of-color's identity can be positively or negatively affected based on their personal experiences around differentness as well as the support system that is in place to provide comfort through this transition.

Video 11.3: Identity Development

During the different stages of identity development clients of color may experience diverse emotional responses. Clinicians can utilize this opportunity to engage clients to process their emotional responses to the stage in which they find themselves.

COUNSELING IMPLICATIONS OF THE R/CID MODEL

Let us first point out some broad general clinical implications of the *R/CID model* before discussing specific meanings within each of the phases. First, an understanding of REC identity formation should sensitize therapists and counselors to the role that oppression plays in an individual's understanding of the world and lived experiences. In many respects, it should make us aware that our role as helping professionals should extend beyond the office and include dealing with the many manifestations of racism. Although individual therapy is needed, combating the forces of racism means a proactive approach for both the therapist and the client. For the helping professional, social justice advocacy and systems intervention are often the answers. For REC diverse clients, it means the need to understand, control, and direct those forces in society that negate the process of positive identity. Thus, a wider sociocultural approach to therapy is mandatory.

Second, the model will aid counselors in recognizing differences between members of the same REC group with respect to their identity. In many cases, an accurate delineation of the dynamics and characteristics of the phases may result in more culturally responsive case conceptualization and treatment with REC diverse clients. Counselors who are familiar with the various identity attitude expressions are better able to identify appropriate intervention strategies for REC diverse clients. For example, a client experiencing feelings of isolation and alienation in the *conformity* phase may require a different approach from the same client in the *introspection* phase.

Third, the model allows helping professionals to realize the potentially changing nature of identity among clients. If the goal of MCT is to move a client toward *integrative awareness*, then the therapist must be able to anticipate the potential feelings, beliefs, attitudes, and behaviors that are likely to arise. Acting as a guide and providing a comprehensible end point will allow the client to understand more quickly and work through issues related to his or her own identity. We now turn our attention to the *R/CID model* and its implications for the counseling process.

Conformity Status

For the vast majority of those in the *conformity* phase, several therapeutic implications can be derived. First, persons of color are most likely to prefer a White counselor or therapist over those from other groups. This flows logically from the belief that Whites are more competent and capable than are members of their own race. Such a racial preference can be manifested in the client's reaction to a counselor of color via negativism, resistance, or open hostility. In some instances, the client may even request a change in counselor (preferably to someone White). Likewise, the *conformity* individual who is seen by a White therapist may be quite pleased about it. In many cases, the client, in identifying with White culture, may be overly dependent on the White therapist. Attempts to please, appease, and seek approval from the helping professional may be quite prevalent.

Second, most *conformity* individuals will find that attempts to explore issues of race, racism, or cultural identity or to focus upon feelings are very threatening. Clients with this status generally prefer a task‐oriented, problem‐solving approach because an exploration of identity may eventually touch upon feelings of low self‐esteem, dissatisfaction with personal appearance, vague anxieties, and racial self‐hatred, and may challenge the client's self‐deception that he or she is not like the other members of his or her race.

Whether you are White or a counselor of color working with a *conformity* individual, the

general goal may be the same. There is an obligation to help the client sort out conflicts related to REC identity through some process of reeducation. Somewhere in the course of counseling or therapy, issues of cultural racism, majority–minority group relations, racial self‐hatred, and racial cultural identity need to be dealt with in an integrated fashion. We are not suggesting a lecture or a solely cognitive approach, to which clients with this status may be quite intellectually receptive, but exercising good clinical skills that take into account the client's socioemotional state and readiness to deal with feelings. Only in this manner will the client be able to distinguish the difference between positive attempts to adopt certain values of the dominant society and a negative rejection of his or her own cultural value (an ability characteristic of *integrative awareness*).

Although the goals for the White counselor and for the counselor of color are the same, the way a therapist works toward them may be different. For example, a counselor of color will likely have to deal with hostility from the racially and culturally similar client. As we saw in Chapter 3, a therapist of color working with a client of his or her own race or with any person of color may symbolize all that the client is trying to reject. Because therapy stresses the building of a coalition, establishment of rapport, and to some degree a mutual identification, the process may be especially threatening. The opposite may be true of work with a White counselor. The client of color may be overeager to identify with the White professional in order to seek approval.

Rather than being detrimental to MCT, these two processes can be used quite effectively and productively. If the therapist of color can aid the client in working through his or her feelings of antagonism and if the majority therapist can aid the client in working through his or her need to overidentify, then the client will be moved closer to awareness and away from self‐deception. In the former case, the therapist can take a nonjudgmental stance toward the client and provide a positive person of color role model. In the latter, the White therapist needs to model positive attitudes toward cultural diversity. Both need to guard against unknowingly reinforcing the client's self‐denial and rejection.

Dissonance Status

As individuals become more aware of inconsistencies between dominant‐held views and those of their own group, a sense of *dissonance* develops. Preoccupation and questions concerning self, identity, and self‐esteem are most likely to be brought in for therapy. More culturally aware than their *conformity* counterparts, *dissonance* clients may prefer a counselor or therapist who possesses good knowledge of their cultural group, although there may still be a preference for a White helper. However, the fact that minority helping professionals are generally more knowledgeable of the client's cultural group may serve to heighten the conflicting beliefs and feelings. Since the client is so receptive toward self‐exploration, the therapist can capitalize on this orientation in helping him or her come to grips with his or her identity conflicts.

Resistance and Immersion Status

Clients with high levels of resistance and immersion are likely to view their psychological problems as products of oppression and racism. They may believe that only issues of racism are legitimate areas to explore in therapy. Furthermore, they may see openness or self‐disclosure to therapists not of their own group as dangerous because White counselors or therapists are “enemies” and members of the oppressing group.

Clients in *resistance and immersion* believe that society is to blame for their present dilemma

and actively challenge the establishment. They are openly suspicious of institutions such as mental health services because they view them as agents of the establishment. Very few of the more ethnically conscious and militant minorities will use mental health services because of their identification with the status quo. When they do, they are usually suspicious and hostile toward the helping professional. A therapist working with a client with this status needs to realize several important things.

First, he or she will be viewed by the client as a symbol of the oppressive society. If the therapist becomes defensive and personalizes the attacks, he or she will lose effectiveness in working with the client. It is important not to be intimidated or afraid of the anger that is likely to be expressed; often, it is not personal and is quite legitimate. White guilt and defensiveness can serve only to hinder effective MCT. It is not unusual for clients with this status to make sweeping negative generalizations about White Americans. The White therapist who takes a nondefensive posture will be better able to help the client explore the basis of his or her racial tirades.

In general, clients with this status prefer a therapist of their own race. However, the fact that a therapist shares the same race or culture as the client will not insulate him or her from the attacks. Again, as outlined in Chapter 3, therapists of color working with a same‐race client in resistance can encounter unique challenges. For example, an African American client may perceive a Black counselor as a sellout to his or her own race, or as an Uncle Tom. Indeed, the anger and hostility directed at the therapist of color may be even more intense than that which would directed at a White one.

Second, clients in this status will constantly test the therapist. In earlier chapters, we described how minority clients will pose challenges to therapists in order to test their trustworthiness (sincerity, openness, and nondefensiveness) and expertise (competencies). Because of the active nature of client challenges, therapy sessions may become quite dynamic. Many therapists find that working with people with high levels of resistance is more challenging, because counselor self‐disclosure is often necessary in order to establish credibility.

Third, individuals at this phase are especially receptive to approaches that are more action‐oriented and aimed at external change (challenging racism). Also, group approaches with persons experiencing similar REC issues are well received. It is important that the therapist is willing to help the culturally different client explore new ways of relating to both minority and White persons.

Introspection Status

Clients in the *introspection* phase may continue to prefer a counselor of their own race, but they are also receptive to help from therapists of other cultures, as long as the therapist understands the client's worldview. Clients with this status may, on the surface, appear similar to *conformity* persons. *Introspection* clients are in conflict between their need to identify with their own group and their need to exercise greater personal freedom. Exercising personal autonomy may occasionally mean going against the wishes or desires of their own group. This is often perceived by people of color and their REC group as a rejection of their own cultural heritage. This is not unlike *conformity* persons, who also reject their REC heritage. The dynamics within the two groups, however, are quite dissimilar. It is very important for therapists to distinguish the differences. The *conformity* person moves away from his or her own group because of perceived negative qualities associated with it. The *introspection* person wants to move away on certain issues but perceives the group positively.

Again, self‐exploration approaches aimed at helping the client integrate and incorporate a new sense of identity are important. Believing in the functional values of White American society does not necessarily mean that a person is selling out or going against his or her own group.

Integrative Awareness Status

Clients in *integrative awareness* have acquired an inner sense of security around their self‐identity. They have pride in their REC heritage but can exercise a desired level of personal freedom and autonomy. Other cultures and races are appreciated, and there is a development toward becoming more multicultural in perspective. Although discrimination and oppression remain a powerful part of their existence, persons in *integrative awareness* possess greater psychological resources to deal with these problems. Being action‐ or systems‐oriented, clients respond positively to the designing and implementation of strategies aimed at community and societal change. Preferences for therapists are based not on race, but on the ability to share, understand, and accept the client's worldviews. In other words, attitudinal similarity between therapist and client is a more important dimension than membership‐group similarity.

Video 11.4: Racial Consciousness

A client's racial consciousness can provide a safe space that allows for non-defensive dialogue with a counselor around the issues of race/ethnicity and can also increase a client's self-efficacy.

VALUE OF A GENERAL REC IDENTITY FRAMEWORK

The R/CID framework is a useful heuristic tool for counselors who work with culturally diverse populations. The model reminds therapists of several important clinical imperatives: (a) Within - group differences are very important to acknowledge in clients of color because not all members of a REC group are the same. Depending on their levels of racial consciousness, the attitudes, beliefs, and orientations of different clients of color may be quite different. (b) A culturally responsive counselor needs to be cognizant of and to understand how sociopolitical factors influence and shape identity. REC identity attitudes and expression are not solely due to cultural differences but a result of how the differences are perceived in our society. (c) The model alerts clinicians working with clients of color to certain likely challenges associated with each status or level of REC consciousness. Not only may it serve as a useful diagnostic tool, but it provides suggestions of what may be the most appropriate treatment intervention. (d) Other socially marginalized or devalued groups undergo similar identity processes. For example, formulations for women, LGBTQ groups, those with disabilities, and so forth can now be found in the psychological literature. Mental health professionals hoping to work with these specific populations would be well served to become familiar with these models as well.

One important aspect relatively untouched in the clinical and research literature is the racial identity development of helping professionals. We have spent considerable time describing the identity development of people of color from the perspective of clients. In Chapter 3, we also indicated that the level of racial consciousness of the minority therapist may impact that of the client of color. In the next chapter, we address the issue of White identity development and discuss how it may impact clients of color. It is equally important for counselors of color to consider their own racial consciousness and how it may interact with a client from their own group.

REFLECTION AND DISCUSSION QUESTIONS

1. What types of conflict and/or challenge might confront a therapist of color with the *conformity* status when working with a client of color with the *resistance and immersion* status? How might they perceive one another? How might they respond to one another? What therapeutic issues are likely to arise? What needs to be done in order for the therapist to be helpful?
2. Discuss other REC identity attitude combinations and their implications for therapists and clients of color working with one another.
3. Does a counselor of color have to be in *integrative awareness* to be helpful to clients of color?

Empirical research on REC identity and its relation to counseling and therapy processes has slowed considerably since the 1990s (Ponterotto & Mallinckrodt, 2007; Yoon, 2011). Instead, newer research has expanded the understanding of how people enact and change their REC attitudes (Cross et al., 2017; Neville & Cross, 2017) and the ways that multiple and intersecting identities play out in people's lives (e.g., Lewis et al., 2017). The enduring nature of key REC models and the emerging scholarship in this area reflect the widespread acceptance of the importance of identity development and how much it has become a part of

the social‐psychological and mental health landscape (Wijeyesinghe & Jackson, 2012). However, the state of the field is not without significant limitations; there is confusion about the theory and measurement of REC identity, especially the difference between racial (the focus in this chapter) and ethnic identities. Indeed, a special issue of the *Journal of Counseling Psychology* in 2007 (Cokley, 2007; Helms, 2007) discussed in detail the conceptual and methodological challenges confronting the field. It is clear that we have encountered an impasse that can be broken only through the development of more sophisticated and better measures of racial and ethnic identity and further qualitative research about the meaning of and changes in REC identity among diverse groups of people of color.

IMPLICATIONS FOR CLINICAL PRACTICE

1. Be aware that the *R/CID model* should not be viewed as a global personality theory with specific identifiable phases that serve as fixed categories. The process of cultural identity development is dynamic, not static.
2. Do not fall victim to stereotyping in using these models. Most clients of color may evidence a dominant characteristic, but there are mixtures from other statuses as well.
3. Know that identity development models are conceptual aids and that human development is much more complex.
4. Know that a number of issues and questions still exist. Is cultural identity development primarily a linear process? Do individuals always start at the beginning of these stages? Is it possible to skip statuses? Can people regress?
5. Be careful of the implied value judgments given in almost all development models. They assume that some cultural resolutions are healthier than others. For example, the *R/CID model* obviously holds the *integrative awareness* status as a higher form of healthy functioning.
6. Be aware that REC identity attitude models seriously lack an adequate integration of gender, class, sexual orientation, and other sociodemographic group identities.
7. Begin to look more closely at the possible therapist and client stage combinations. As mentioned earlier, therapeutic processes and outcomes are often the function of the identity stage of both therapist and client. White identity development of the therapist can either enhance or retard effective therapy.

Video Lecture: Racial/Cultural Identity Development: Implications for Counseling/Therapy

SUMMARY

In the past several decades, work on REC identity attitudes among people of color has led to major breakthroughs in the field of MCT. Racial identity attitude models have proven helpful in many respects. First, they reveal major within‐group differences that occur depending on one's level of identity. Second, research suggests that reactions to counseling and the counseling process are influenced by REC identity and are not simply linked to minority group membership. Third, they clarify the impact of sociopolitical forces in shaping racial identity. Fourth, identity models that discuss the oppressor–oppressed relationship seem equally applicable to other marginalized groups, such as women, LGBTQ individuals, and individuals with disabilities.

The *R/CID model* proposed is a conceptual framework to aid therapists in understanding their culturally diverse clients' attitudes and behaviors. Five general types of attitude expression that oppressed people experience as they struggle to understand themselves in terms of their own culture, the dominant culture, and the oppressive relationship between the two are described: *conformity*, *dissonance*, *resistance and immersion*, *introspection*, and *integrative awareness*. At each level of identity, four corresponding beliefs and attitudes, the understanding of which may help therapists better understand their clients, are discussed. These attitudes/beliefs are an integral part of identity, and are manifest in how a person views (a) the self, (b) others of the same minority, (c) others of another minority, and (d) majority individuals.

Each specific level of racial identity offers unique challenges for the counselor. Clients in the *conformity* status are dealing with *internalized racism* and may not respond well to therapists of color; *dissonance* clients are dealing with racial inconsistencies in their previous belief systems; *resistance and immersion* clients are likely to reveal strong anger about racism; *introspection* clients struggle with group loyalties and self‐autonomy; and *integrative awareness* clients are self‐secure and motivated toward multicultural integration. A culturally competent counselor needs to be cognizant of and to understand how sociopolitical factors influence and shape identity. Identity development is not solely due to cultural differences but a result of how the differences are perceived in our society.

GLOSSARY TERMS

- Conformity
- Dissonance
- Encounter
- Identity synthesis
- Immersion - emersion
- Integrative awareness
- Internalization
- Internalization - commitment
- Internalized racism
- Introspection
- Nigrescence
- Preencounter
- Race salience
- Racial awakening
- R/CID model
- Resistance and immersion

Video 11.6: Counseling Session Analysis

Analysis of counseling session by Drs. Derald Wing Sue and Joel Filmore.

REFERENCES

1. Atkinson, D. R., Morten, G., & Sue, D. W. (1998). *Counseling American minorities* (5th ed.). Boston, MA: McGraw‐Hill.

2. Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality*, *4*, 219–235.

3. Choi, A. Y., Israel, T., & Maeda, H. (2017). Development and evaluation of the Internalized Racism in Asian Americans Scale (IRAAS). *Journal of Counseling Psychology*, *64*(1), 52–64.

4. Clark, K. B., & Clark, M. K. (1947). Racial identification and preference in Negro children. In T. M. Newcomb, & E. L. Hartley (Eds.), *Readings in social psychology* (pp. 169–178). New York, NY: Holt, Reinhart & Winston.

5. Coates, T. N. (2015). *Between the world and me*. New York, NY: Speigal & Grau.

6. Cokley, K. (2007). Critical issues in the measurement of ethnic and racial identity: A referendum on the state of the field. *Journal of Counseling Psychology*, *54*, 224–239.

7. Cross, W. E. (1971). The Negro‐to‐Black conversion experience: Towards a psychology of Black liberation. *Black World*, *30*, 13–27.

8. Cross, W. E. (1991). *Shades of Black: Diversity in African American identity*. Philadelphia, PA: Temple University Press.

9. Cross, W. E. (1995). The psychology of Nigrescence: Revising the Cross model. In J. G. Pon‐terotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 93–122). Thousand Oaks, CA: Sage.

10. Cross, W. E., Smith, L., & Payne, Y. (2002). Black identity. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (pp. 93–108). Thousand Oaks, CA: Sage.

11. Cross, W. E. Jr., Seaton, E., Yip, T., Lee, R. M., Rivas, D., Gee, G. C., … Ngo, B. (2017). Identity work: Enactment of racial‐ethnic identity in everyday life. *Identity*, *17*(1), 1–12.

12. Downing, N. E., & Roush, K. L. (1985). From passive acceptance to active commitment: A model of feminist identity development for women. *The Counseling Psychologist*, *13*, 695–709.

13. Ferdman, B. M., & Gallegos, P. I. (2012). Latina and Latino ethnoracial identity orientations. In C. Wijeyesinghe, & B. W. Jackson (Eds.), *New perspectives on racial identity: A theoretical and practical anthology* (pp. 51–80). New York, NY: New York University Press.

14. Freire, P. (1970). *Cultural action for freedom*. Cambridge, MA: Harvard Educational Review Press.

15. Haley, A. (1966). *The autobiography of Malcolm X*. New York, NY: Grove Press.

16. Helms, J. E. (1984). Toward a theoretical explanation of the effects of race on counseling: A Black and White model. *Counseling Psychologist*, *12*, 153–165.

17. Helms, J. E. (1995). An update of Helms's White and people of color racial identity models. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 181–191). Thousand Oaks, CA: Sage.

18. Helms, J. E. (2007). Some better practices for measuring racial and ethnic identity constructs. *Journal of Counseling Psychology*, *54*(3), 235–246.

19. Horse, P. G. (2001). Reflections on American Indian identity. In C. Wijeyesinghe, & B. W. Jackson (Eds.), *New perspectives on racial identity: A theoretical and practical anthology* (pp. 91–107). New York, NY: New York University Press.

20. Horse, P. G. (2012). Twenty‐first century Native American consciousness. In C. Wijeyesinghe, & B. W. Jackson (Eds.), *New perspectives on racial identity: Integrating emerging frameworks* (2nd ed.) (pp. 108–120). New York, NY: New York University Press.

21. Ivey, A. E., D'Andrea, M. J., & Ivey, M. B. (2011). *Theories of counseling and psychotherapy: A multicultural perspective*. Boston, MA: Allyn & Bacon.

22. Jackson, B. (1975). Black identity development. *Journal of Educational Diversity*, *2*, 19–25.

23. Kim, J. (1981). The process of Asian American identity development: A study of Japanese‐American women's perceptions of their struggle to achieve personal identities as Americans of Asian ancestry. Dissertation Abstracts International, 42, 155 1A. (University Microfilms No. 81–18080.)

24. Kim, J. (2012). Asian American identity development theory. In C. Wijeyesinghe, & B. W. Jackson (Eds.), *New perspectives on racial identity: A theoretical and practical anthology* (pp. 138–160). New York, NY: New York University Press.

25. Kohli, R. (2013). *Race, ethnicity and education*. London: Rutledge.

26. Lewis, J. A., Williams, M. G., Peppers, E. J., & Gadson, C. A. (2017). Applying intersectionality to explore the relations between gendered racism and health among Black women. *Journal of Counseling Psychology*, *64*(5), 475–486.

27. McNamara, K., & Rickard, K. M. (1989). Feminist identity development: Implications for feminist therapy with women. *Journal of Counseling and Development*, *68*, 184–193.

28. Mouzon, D. M., & McLean, J. S. (2017). Internalized racism and mental health among African‐Americans, US‐born Caribbean Blacks, and foreign‐born Caribbean Blacks. *Ethnicity & Health*, *22*(1), 36–48.

29. Neville, H. A., & Cross, W. E. Jr. (2017). Racial awakening: Epiphanies and encounters in Black racial identity. *Cultural Diversity and Ethnic Minority Psychology*, *23*(1), 102–108.

30. Olkin, R. (1999). *What psychotherapists should know about disability*. New York, NY: Guilford Press.

31. Owen, J., Drinane, J., Tao, K. W., Adelson, J. L., Hook, J. N., Davis, D., & Fookune, N. (2017). Racial/ethnic disparities in client unilateral termination: The role of therapists' cultural comfort. *Psychotherapy Research*, *27*(1), 102–111.

32. Ponterotto, J. G., & Mallinckrodt, B. (2007). Introduction to the special issue on racial and ethnic identity in counseling psychology: Conceptual and methodological challenges and proposed solutions. *Journal of Counseling Psychology*, *54*, 210–223.

33. Pyke, D. D. (2010). What is internalized racial oppression and why don't we study it? Acknowledging racism's hidden injuries. *Sociological Perspectives*, *53*, 551–572.

34. Robinson‐Wood, T. (2016). *The convergence of race, ethnicity, and gender: Multiple identities in counseling*. Thousand Oaks, CA: Sage.

35. Ruiz, A. S. (1990). Ethnic identity: Crisis and resolution. *Journal of Multicultural Counseling and Development*, *18*, 29–40.

36. Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice*. New York, NY: Wiley.

37. Sue, D. W., & Sue, D. (1999). *Counseling the culturally different: Theory and practice* (3rd ed.). New York, NY: Wiley.

38. Sue, S., & Sue, D. W. (1971). Chinese‐American personality and mental health. *Amerasian Journal*, *1*, 36–49.

39. Thomas, C. W. (1970). Different strokes for different folks. *Psychology Today*, *4*, 49, 80–53.

40. Thomas, C. W. (1971). *Boys no more*. Beverly Hills, CA: Glencoe Press.

41. Vandiver, B. J. (2001). Psychological nigrescence revisited: Introduction and overview. *Journal of Multicultural Counseling and Development*, *29*, 165–173.

42. Vandiver, B. J., Fhagen‐Smith, P. E., Cokley, K. O., Cross, W. E., & Worrell, F. C. (2001). Cross's nigrescence model: From theory to scale to theory. *Journal of Multicultural Counseling and Development*, *29*, 174–200.

43. Vontress, C. E. (1971). Racial differences: Impediments to rapport. *Journal of Counseling Psychology*, *18*, 7–13.

44. Wijeyesinghe, C., & Jackson, B. W. (Eds.) (2012). *New perspectives on racial identity development: Integrating emerging frameworks* (2nd ed.). New York, NY: New York University Press.

45. Worrell, F. C., Cross, W. E., & Vandiver, B. J. (2001). Nigrescence theory: Current status and challenges for the future. *Journal of Multicultural Counseling and Development*, *29*, 201–211.

46. Yoon, E. (2011). Measuring ethnic identity in the ethnic identity scale and the multigroup ethnic identity measure—revised. *Cultural Diversity and Ethnic Minority Psychology*, *17*, 144–155.

12
White Racial Identity Development: Counseling Implications

Chapter Objectives

1. **1. Acquire understanding of what it means to be White. Be able to discern differences between how Whites and people of color see the meaning of "*Whiteness*."**
2. **2. Analyze resistance by White Americans to identifying themselves as "White."**
3. **3. Learn the meaning of nested or embedded emotions experienced by Whites as they come to accept their *Whiteness*.**
4. **4. Define *White privilege*.**
5. **5. Understand how *Whiteness* advantages Whites and disadvantages people of color.**
6. **6. Describe and discuss the various conceptualizations of *White racial identity development*.**
7. **7. Learn how the level of White racial consciousness may affect the counseling process.**
8. **8. Understand how *White racial identity development* may influence the definition of normality–abnormality, assessment, diagnosis, and treatment of culturally diverse clients.**
9. **9. Learn what a White person needs to do in order to develop a *nonracist* and antiracist White identity.**
10. **10. Learn what White helping professionals need to do in order to prevent their *Whiteness* from negatively impacting clients of color.**

Thus far, we have examined many different facets of the impact of race and culture within mental health theory and practice. As vital as it has been to understand the significance of racism and racial - cultural identity in the lives of people of color, it is equally consequential to consider their operations among White individuals. What does it mean to be White? What do White people learn about the meaning of Whiteness in their own lives? As the following excerpts illustrate, White people's perspectives on such questions vary widely.

As a person of color, I have often wondered how White people identify themselves as racial/cultural beings. At times, I have noted that White trainees often seemed to believe race was confined to persons of color and did not apply to them. To explore this phenomenon more deeply, I asked people in downtown San Francisco "What does it mean to be White?"

***Q*:**

[D.W. Sue]: What does it mean to be White?

***A*:**

[42 - year - old White male businessperson]: Frankly, I don't know what you're talking about!

***Q*:**

Aren't you White?

***A*:**

Yes, but I come from Italian heritage. I'm Italian, not White.

Q:

Well then, what does it mean to be Italian?

A:

Pasta, good food, love of wine (obviously agitated). This is getting ridiculous! (Sue, 2003, pp. 115)

We never see signs with "Hispanic Lives Matter," or "White Lives Matter," or even "All Lives Matter" protesting police violence. Are we only concerned about police brutality toward African Americans? Shouldn't we be promoting a decrease in deadly force toward all people, independent of race? Or, do "Black Lives Matter … more?" Because that is the message I'm getting from political leaders, activists, professional athletes and this newspaper.

(Stevenson, 2017, para. 4)

When he was 4, my son brought home a library book about the slaves who built the White House. I didn't tell him that slaves once accounted for more wealth than all the industry in this country combined, or that slaves were, as Ta‐Nehisi Coates writes, "the down payment" on this country's independence, or that freed slaves became, after the Civil War, "this country's second mortgage." Nonetheless, my overview of slavery and Jim Crow left my son worried about what it meant to be white, what legacy he had inherited. "I don't want to be on this team," he said, with his head in his hands. "You might be stuck on this team," I told him, "but you don't have to play by its rules."

Even as I said this, I knew that he would be encouraged, at every juncture in his life, to believe wholeheartedly in the power of his own hard work and deservedness, to ignore inequity, to accept that his sense of security mattered more than other people's freedom and to agree, against all evidence, that a system that afforded him better housing, better education, better work, and better pay than other people was inherently fair.

(Biss, 2015, para. 13)

"We're coming to the realization that white self‐hatred is a sickness," said Timothy Murdock, a 46‐year‐old alt‐right podcaster from Dearborn, Mich. He said he considers himself "pro‐white," but feels the alt‐right movement could get better traction by going to battle against "diversity."

"There is great attention to the term 'diversity', that it means 'too white', coupled with open borders," said Murdock, whose podcasts frequently talk about "white genocide."

(Kaleem, 2016, para. 27)

REFLECTION AND DISCUSSION QUESTIONS

1. With regard to the four passages above, what emerges from each about the meaning and/or experience of Whiteness?
2. Can you discern any commonalities among any of the passages? In what ways do they differ?
3. Which (if any) of these perspectives are more familiar to you, either because you or someone you know has a similar view? Which (if any) do you find to be more unfamiliar?
4. If they were asked what it means to be White, do you think people of color would also

find difficulty answering the question? Why or why not?

Research on *Whiteness*, *White privilege*, and *White racial identity development* points to one of the greatest barriers to racial understanding for White Americans: *the invisibility of their Whiteness and/or its impact on their lives* (Bell, 2003; Hegarty, 2017; Helms, 1990; Spanierman, Poteat, Beer, & Armstrong, 2006; Tatum, 1992; Todd & Abrams, 2011). Just as ethnocentric monoculturalism and implicit bias achieve their oppressive powers through invisibility, so too does *Whiteness* (Boysen, 2010; Sue, 2004). During racial interactions or conversations, many Whites appear oblivious to the meaning of their *Whiteness*, how it intrudes and disadvantages people of color, and how it affects the way they perceive the world (Bell, 2002; Sue, 2013).

It appears that the denial and mystification of *Whiteness* for White EuroAmericans are related to two underlying factors. First, most people seldom think about the air that surrounds them and about how it provides an essential life‐giving ingredient, oxygen. We take it for granted because it appears plentiful; only when we are deprived of it does it suddenly become frighteningly apparent. *Whiteness* is transparent precisely because of its everyday occurrence—its institutionalized normative features in our culture—and because Whites are taught to think of their lives as morally neutral, average, and ideal (Sue, 2004). To people of color, however, *Whiteness* is not invisible because it may not fit their normative qualities (e.g., values, lifestyles, experiential reality). Persons of color find White culture quite visible because even though it is nurturing to White EuroAmericans, it may invalidate the lifestyles of multicultural populations.

Second, EuroAmericans often deny that they are White, seem angered by being labeled as such, and become very defensive when so labeled (e.g., saying, “I'm not White; I'm Irish,” “You're stereotyping, because we're all different,” or “There isn't anything like a White race”). In many respects, these statements have validity, in that race is a social rather than a biological construct. Nonetheless, many White Americans would be hard pressed to describe their Irish, Italian, German, or Norwegian heritage in any but the most superficial manner. One of the reasons is related to the processes of assimilation and acculturation. Although there are many ethnic groups, being White allows for assimilation. While persons of color are told to assimilate and acculturate; the assumption is that there exists a receptive society. People of color are told in no uncertain terms that they are allowed only limited access to the fruits of our society.

Third, the question of how *Whiteness* defines a race is largely irrelevant. What is more relevant is that *Whiteness* is associated with unearned privilege—advantages that are systematically conferred on White Americans but not on persons of color. It is our contention that much of the denial associated with being White is related to the denial of *White privilege*.

As will be discussed in this chapter, *White privilege* connotes a number of overarching characteristics, such as: (a) having the power to define reality; (b) possessing unconscious stereotypes that people of color are less competent and capable; (c) deceiving the self that one is not prejudiced; and (d) being oblivious to how *Whiteness* disadvantages people of color and advantages White people. Strangely enough, *Whiteness* often becomes especially visible when it is denied and evokes puzzlement or negative reactions among White individuals, or when it is equated with normalcy. Few people of color react negatively when asked what it means to be Black, Asian American, Latinx, or whatever applicable race. Most could readily inform the questioner about what it means to be a person of color.

Video 12.0: Introduction

Introduction to counseling session by Dr. Joel Filmore.

UNDERSTANDING THE DYNAMICS OF WHITENESS

Our analysis of the responses from both Whites and people of color leads us to the inevitable conclusion that part of the problem of race relations (and by inference multicultural counseling and therapy [MCT]) lies in the different worldviews of both groups. It goes without saying that the racial reality of Whites is radically different from that of people of color (Sue, 2010). Which group, however, has the more accurate assessment related to this topic? The answer seems to be contained in the following series of questions: If you want to understand oppression, should you ask the oppressor or the oppressed? If you want to learn about sexism, do you ask men or women? If you want to understand homophobia, do you ask heterosexuals or homosexuals? If you want to learn about racism, do you ask Whites or persons of color? It appears that the most accurate assessment of bias comes not from those who enjoy the privilege of power, but from those who are most disempowered (Hanna, Talley, & Guindon, 2000; Sue, 2015). Taking this position, the following conclusions are made about the dynamics of *Whiteness*.

First, it is clear that most Whites perceive themselves as unbiased individuals who do not harbor racist thoughts and feelings; they see themselves as working toward social justice and possessing a conscious desire to better the life circumstances of those less fortunate than themselves. Although these are admirable qualities, this self‐image serves as a major barrier to recognizing and taking responsibility for admitting and dealing with one's own prejudices and biases. To admit to being racist, sexist, or homophobic requires people to recognize that the self‐images they hold so dear are based on false notions of the self.

Second, being a White person in this society means chronic exposure to ethnocentric monoculturalism as manifested in *White supremacy* (Hays, 2014). It is difficult, if not impossible, for anyone to avoid inheriting the racial biases, prejudices, misinformation, deficit portrayals, and stereotypes of their forebears (Cokley, 2006). To believe that one is somehow immune from inheriting such aspects of *White supremacy* is to be naive or to engage in self‐deception. Such a statement is not intended to assail the integrity of Whites but to suggest that they also have been victimized. It is clear to us that no one was born wanting to be racist, sexist, or homophobic. Misinformation is not acquired by free choice but is imposed upon White people through a painful process of cultural conditioning (Gallardo & Ivey, 2014). In general, lacking awareness of their biases and preconceived notions, counselors may function in a therapeutically ineffective manner.

Third, if White helping professionals are ever to become effective multicultural counselors or therapists, they must free themselves from the cultural conditioning of their past and move toward the development of a *nonracist White identity*. Unfortunately, many White EuroAmericans seldom consider what it means to be White in our society. Such a question is vexing to them because they seldom think of race as belonging to them—nor of the privileges that come their way by virtue of their white skin (Toporek & Worthington, 2014). Katz (1985) points out a major barrier blocking the process of White EuroAmericans investigating their own cultural identity and worldview.

> *Because White culture is the dominant cultural norm in the United States, it acts as an invisible veil that limits many people from seeing it as a cultural system … Often, it is easier for many Whites to identify and acknowledge the different cultures of minorities than accept their own racial identity … The difficulty of accepting such a view is that White culture is omnipresent. It is so interwoven in the fabric of everyday living that Whites cannot step outside and see their beliefs, values, and behaviors as creating a*

distinct cultural group.

(pp. 616–617)

As we witnessed in Chapter 6, the invisible veil allows for racial, gender, and sexual orientation microaggressions to be delivered outside the level of awareness of their perpetrators. Ridley (1995) asserts that this invisible veil can be unintentionally manifested in therapy, with harmful consequences to clients of color.

> *Unintentional behavior is perhaps the most insidious form of racism. Unintentional racists are unaware of the harmful consequences of their behavior. They may be well‐intentioned, and on the surface, their behavior may appear to be responsible. Because individuals, groups, or institutions that engage in unintentional racism do not wish to do harm, it is difficult to get them to see themselves as racists. They are more likely to deny their racism*.
>
> *(p. 38)*

The conclusion drawn from this understanding is that White counselors and therapists may be unintentional racists: (a) they are unaware of their biases, prejudices, and discriminatory behaviors; (b) they often perceive themselves as moral, good, and decent human beings and find it difficult to see themselves as racist; (c) they do not have a sense of what their *Whiteness* means to them; and (d) their therapeutic approaches to multicultural populations are likely to be more harmful (unintentionally) than helpful.

> *I used to consider myself "color‐blind." I thought I was so admirable in that I did not see my friends as Chinese, Japanese, Black, or White. However, I now realize that by not seeing their individual races as a part of who they are, I was seeing them as White, through my own perspectives and value systems, and was doing them a disservice. Race is an important part of how people identify and by not recognizing their different races I am not seeing all aspects of the individual. This is something I definitely need to keep in mind when conducting therapy … It would be detrimental to my clients if I was "color‐blind."*
>
> *(Counseling student quoted in Fu, 2015, p. 281)*

These conclusions are often difficult for White helping professionals to accept because of the defensiveness and feelings of blame they are likely to engender. Nonetheless, we ask White therapists and students not be turned off by the message and lessons of this chapter. We ask you to reread Chapter 1, where we discussed the emotive reactions likely to impede learning. And, we ask you to continue your multicultural journey in this chapter as we explore the question, "What does it mean to be White?"

Video 12.1: White Self-Awareness and Understanding

Nested and embedded emotions can make it difficult for White clinicians to understand or empathize with clients of color. Taking regular internal checks can help clinicians develop self-awareness as a way of increasing client rapport.

MODELS OF WHITE RACIAL IDENTITY DEVELOPMENT

A number of multicultural experts in the field have emphasized the need for White therapists to deal with their concepts of *Whiteness* and to examine their own racism (Gallardo & Ivey, 2014; Ponterotto, Utsey, & Pedersen, 2006; Todd & Abrams, 2011). These specialists point out that while racial/cultural identity for minority groups proves beneficial in our work as therapists, more attention should be devoted toward the White therapist's racial identity. Since the majority of therapists and trainees are White middle - class individuals, it would appear that White identity development and its implication for MCT are important aspects to consider, both in the actual practice of clinical work and in professional training.

For example, research has found that the level of White racial identity awareness is predictive of racism and internal interpersonal characteristics (Miville, Darlington, Whitlock, & Mulligan, 2005; Perry, Dovidio, Murphy, & van Ryn, 2015; Pope - Davis & Ottavi, 1994; Spanierman, Todd, & Anderson, 2009; Vinson & Neimeyer, 2000, 2003; Wang et al., 2003): (a) the less aware subjects were of their White identity, the more likely they were to exhibit increased levels of racism; (b) the higher the level of White identity development, the greater the reported multicultural counseling competence, positive opinions toward minority groups, and good therapeutic alliances; (c) higher levels of mature interpersonal relationships and a better sense of personal well - being were associated with higher levels of White identity consciousness; and (d) as a group, women were more likely than men to exhibit higher levels of White consciousness and were less likely to be racially biased. It was suggested that this last finding was correlated with women's greater experiences with discrimination and prejudice. Evidence also exists that MCT competence is correlated with White racial identity attitudes (Neville, Awad, Brooks, Flores, & Bluemel, 2013). Other research suggests that a relationship exists between a White EuroAmerican therapist's racial identity and his or her readiness for training in multicultural awareness, knowledge, and skills (Falender, Shafranske, & Falicov, 2014; Utsey, Gernat, & Hammar, 2005). Since developing multicultural sensitivity is a long - term developmental task, the work of many researchers has gradually converged toward a conceptualization of the stages/levels/statuses of consciousness of racial/ethnic identity development for White EuroAmericans. A number of these models describe the salience of identity for establishing relationships between the White therapist and the culturally different client, and some have now linked stages of identity with stages for appropriate training.

The Hardiman White Racial Identity Development Model

One of the earliest integrative attempts at formulating a *White racial identity development* model was that of Rita Hardiman (1982). Intrigued with why certain White Americans exhibit a much more nonracist identity than do other White Americans, Hardiman studied the autobiographies of individuals who had attained a high level of racial consciousness. This led her to identify five White developmental stages: (a) naiveté—lack of social consciousness, (b) acceptance, (c) resistance, (d) redefinition, and (e) internalization.

1. The *naiveté stage* (lack of social consciousness) is characteristic of early childhood, when we are born into the world innocent, open, and unaware of racism and the importance of race. Curiosity and spontaneity in relating to race and racial differences tend to be the norm. A young White child who has almost no personal contact with African Americans, for example, may see a Black man in a supermarket and loudly comment on the darkness of his skin.

2. The *acceptance stage* is marked by a conscious belief in the democratic ideal—that everyone has an equal opportunity to succeed in a free society and that those who fail bear all the responsibility for their own failure. White EuroAmericans become the social reference group, and the socialization process consistently instills messages of White superiority and minority inferiority into the child. Victim blaming is strong, as the existence of oppression, discrimination, and racism is denied. Hardiman believes that although the naiveté stage is brief in duration, the acceptance stage can last a lifetime.
3. In the *resistance stage*, the individual begins to challenge assumptions of White superiority and the denial of racism and discrimination. The White person's denial system begins to crumble as the result of a monumental event or a series of events that not only challenge but also shatter his or her denial system. A White person might, for example, make friends with a coworker of color and then discover that the images he or she has of “these people” are untrue. The racial realities of life in the United States can no longer be denied. The person becomes conscious of being White, is aware that he or she harbors racist attitudes, and begins to see the pervasiveness of oppression in our society. Feelings of anger, pain, hurt, rage, and frustration are present.
4. In the *redefinition stage*, asking the painful question of who one is in relation to one's racial heritage, honestly confronting one's biases and prejudices, and accepting responsibility for one's *Whiteness* are the culminating characteristics. New ways of defining one's social group and one's membership in that group become important.
5. The *internalization stage* is the result of forming a new social and personal identity. With the greater comfort in understanding oneself and the development of a *nonracist White identity* comes a commitment to social action. The individual accepts responsibility for effecting personal and social change, without always relying on persons of color to lead the way.

The Helms White Racial Identity Development Model

Working independently of Hardiman, Janet Helms (1984, 1990, 1994, 1995) created perhaps the most elaborate and sophisticated White racial identity model in the field. Not only has her model led to the development of an assessment instrument to measure White racial identity, but it has been scrutinized empirically (Carter, 1990; Helms & Carter, 1990) and has generated much research and debate in the psychological literature. Like Hardiman (1982), Helms assumes that racism is an intimate and central part of being a White American. To her, developing a healthy White identity requires movement through two phases: (a) abandonment of racism and (b) defining a *nonracist White identity* (Helms, 2015).

Six specific racial identity statuses (originally called stages) are distributed equally in the two phases: contact, disintegration, and reintegration; and pseudo‐independence, immersion/emersion, and autonomy.

1. *Contact status*. People in this status are oblivious to and unaware of racism, believe that everyone has an equal chance for success, lack an understanding of prejudice and discrimination, have minimal experiences with persons of color, and may profess to be color‐blind. They may make such statements as “People are people,” “I don't notice a person's race at all,” and “You don't act Black.”
2. *Disintegration status*. Although in the previous status the individual does not recognize the polarities of democratic principles of equality and the unequal treatment of minority groups, such obliviousness may eventually break down. The White person becomes

conflicted over irresolvable racial moral dilemmas that are frequently perceived as polar opposites: believing one is nonracist, yet not wanting one's son or daughter to marry a minority group member; believing that all men are created equal, even though society treats people of color as second‐class citizens; and not acknowledging that oppression exists and then witnessing it (e.g., the killings of Michael Brown and Eric Garner in 2014).

3. *Reintegration status*. This status can best be characterized as a regression in which the pendulum swings back to the most basic beliefs of White superiority and minority inferiority. In the individual's attempts to resolve the dissonance created from the previous process, there is a retreat to the dominant ideology associated with race and their own socioracial group identity. This ego status results in idealizing the White EuroAmerican group and the positives of White culture and society; there is a consequent negation and intolerance of minority groups. In general, a firmer and more conscious belief in White racial superiority is present. Racial/ethnic minorities are blamed for their own problems.
4. *Pseudo‐independence status*. This status initiates the second phase of Helms's model, which involves defining a *nonracist White identity*. As in the Hardiman model, a person is likely to be propelled into this phase because of a painful or insightful encounter or event that jars them from the reintegration status. The awareness of visible racial/ethnic minorities, the unfairness of their treatment, and a discomfort with their racist White identity may lead the individual to identify with the plight of persons of color. However, the well‐intentioned White person with this status may suffer from several problematic dynamics: (a) although intending to be socially conscious and helpful to minority groups, they may unknowingly perpetuate racism by helping minorities adjust to the prevailing White standards; and (b) they identify with minority individuals based on how similar they are to them, and the primary mechanism they use to understand racial issues is intellectual and conceptual.
5. *Immersion/emersion status*. If the person is reinforced to continue a personal exploration of him‐ or herself as a racial being, questions become focused on what it means to be White. There is an increasing willingness to confront one's own biases, to redefine *Whiteness*, and to become more active in directly combating racism and oppression. This status is different from the previous one in two major ways: it is marked by (a) a shift in focus from trying to change people of color to changing the self and other Whites and (b) an increasing experiential and affective understanding that was lacking in the previous status. The ability to achieve this affective/experiential upheaval leads to a euphoria, or even a feeling of rebirth, and is a necessary condition to developing a new, *nonracist White identity*.
6. *Autonomy status*. Increasing awareness of one's own *Whiteness*, reduced feelings of guilt, acceptance of one's role in perpetuating racism, and renewed determination to abandon White entitlement lead to an autonomy status. The person is knowledgeable about racial, ethnic, and cultural differences; values diversity; and is no longer fearful, intimidated, or uncomfortable with the experiential reality of race. Development of a *nonracist White identity* becomes increasingly strong. Indeed, the person feels comfortable with his or her *nonracist White identity*, does not personalize attacks on *White supremacy*, and can explore the issues of racism and personal responsibility without defensiveness. A person with this status “walks the talk” and actively values and seeks out interracial experiences.

Helms's model is by far the most widely cited, researched, and applied of all the White racial identity formulations. It is not, however, without its detractors. In an article critical of the Helms model (and of most “stage” models of *White racial identity development*), Rowe, Bennett, and Atkinson (1994) raised objections over the model's basis in racial/ethnic minority identity development models that may not apply to White identity and the unsupported conceptual accuracy of putting forth the model as linear developmental via stages, among other things. Finally, Rowe (2006) attacked the Helms model because it is based upon the White Racial Identity Attitude Scale (Helms & Carter, 1990), which he labels as “pseudoscience” because he asserts that the psychometric properties are not supported by the empirical literature. In subsequent writings, Helms (1994) disclaimed the Rowe (Rowe & Atkinson, 1995; Rowe et al., 1994) characterization of her model.

Select this link to open an interactive version of Chapter 12 text.

Video 12.2: White Identity Development

White identity development can be incredibly uncomfortable to process. Clinicians need to do their own internal inventory and work through their own developmental process in order to be the most effective in working with clients of color.

THE PROCESS OF WHITE RACIAL IDENTITY DEVELOPMENT: A DESCRIPTIVE MODEL

Although there are differences in the models, it appears important for Whites to view their developmental history in order to gain a sense of their past, present, and future as they struggle with racial identity development. In our work with White trainees and clinicians, we have observed some very important changes through which they seem to move as they work toward multicultural competence (Sue, 2011). We have been impressed with how Whites seem to go through parallel racial/cultural identity transformations. This is especially true if we accept the fact that Whites are as much victims of societal forces (i.e., they are socialized into racist attitudes and beliefs) as are their counterparts (Sue, 2003). No child is born wanting to be a racist! Yet, White people do benefit from the dominant–subordinate relationship in our society. It is this factor that Whites need to confront in an open and honest manner.

Using the formulation of our past work (Sue & Sue, 1990), we propose a seven‐step process that integrates many characteristics from the other formulations. Furthermore, we make some basic assumptions with respect to those models:

1. Racism is an integral part of U.S. life, and it permeates all aspects of our culture and institutions (ethnocentric monoculturalism).
2. Whites are socialized into U.S. society, and therefore inherit all its biases, stereotypes, and racist attitudes, beliefs, and behaviors.
3. How Whites perceive themselves as racial beings follows an identifiable sequence that can occur in a linear or nonlinear fashion.
4. The status of *White racial identity development* in any multicultural encounter affects the process and outcome of interracial relationships.
5. The most desirable outcome is one in which the White person not only accepts his or her *Whiteness* but also defines it in a nonracist and antiracist manner.

Seven‐Step Process

The seven phases of *white racial identity development* and their implications for White Americans are described in this section. We encourage Whites to use this information to explore themselves as racial/cultural beings and to think about their implications for work with culturally diverse clients.

1. *Naiveté phase*. This phase is relatively neutral with respect to racial/cultural differences. Its length is brief and is marked by a naive curiosity about race. As mentioned previously, racial awareness and burgeoning social meanings are absent or minimal, and the young child is generally innocent, open, and spontaneous regarding racial differences. Between the ages of three and five, however, the young White child begins to associate positive ethnocentric meanings to his or her own group and negative ones to others. The child is bombarded by misinformation through the educational channels, mass media, and significant others in his or her life, and a sense of the superiority of *Whiteness* and the inferiority of all other groups and their heritage is instilled. The following passage describes one of the insidious processes of socialization that leads to propelling the child into the conformity stage:

> *It was a late summer afternoon. A group of White neighborhood mothers, obviously friends, had brought their four - and five - year - olds to the local McDonald's for a snack and to play on the swings and slides provided by the restaurant. They were all seated at a table watching their sons and daughters run about the play area. In one corner of the yard sat a small Black child pushing a red truck along the grass. One of the White girls from the group approached the Black boy and they started a conversation. During that instant, the mother of the girl exchanged quick glances with the other mothers, who nodded knowingly. She quickly rose from the table, walked over to the two, spoke to her daughter, and gently pulled her away to join her previous playmates. Within minutes, however, the girl again approached the Black boy and both began to play with the truck. At that point, all the mothers rose from the table and loudly exclaimed to their children, "It's time to go now!"*
>
> *(Taken from Sue, 2003, pp. 89–90)*

2. *Conformity phase*. The White person's attitudes and beliefs in this phase are very ethnocentric. There is minimal awareness of the self as a racial being and a strong belief in the universality of values and norms governing behavior. The White person possesses limited accurate knowledge of other ethnic groups, but he or she is likely to rely on social stereotypes as the main source of information. Consciously or unconsciously, the White person believes that White culture is the most highly developed and that all others are primitive or inferior. The *conformity phase* is marked by contradictory and often compartmentalized attitudes, beliefs, and behaviors. A person may believe simultaneously that he or she is not racist but that minority inferiority justifies discriminatory and inferior treatment, and that minority persons are different and deviant but that "people are people" and differences are unimportant. As with their marginalized counterparts at this phase, the primary mechanism operating here is one of denial and compartmentalization. For example, many Whites deny that they belong to a race that allows them to avoid personal responsibility for perpetuating a racist system. Like a fish in water, Whites either have difficulty seeing or are unable to see the invisible veil of cultural assumptions, biases, and prejudices that guide their perceptions and actions. They tend to believe that White EuroAmerican culture is superior and that other cultures are primitive, inferior, less developed, or lower on the scale of evolution.

   > It is important to note that many Whites in this phase of development are unaware of these beliefs and operate as if they are universally shared by others. They believe that differences are unimportant and that "people are people," "we are all the same under the skin," "we should treat everyone the same," "problems wouldn't exist if minorities would only assimilate," and discrimination and prejudice are something that others do. The helping professional with this perspective professes color - blindness, views counseling/therapy theories as universally applicable, and does not question the relevance of such theories to culturally different groups. The primary mechanism used in encapsulation is denial—denial that people are different, denial that discrimination exists, and denial of one's own prejudices. Instead, the locus of the problem is seen to reside in marginalized groups. Socially devalued groups would not encounter problems if they would only assimilate and acculturate (melting pot), value education, or work harder.

3. *Dissonance phase*. Movement into the *dissonance phase* occurs when the White person

is forced to deal with the inconsistencies that have been compartmentalized or encounters information/experiences at odds with denial. In most cases, individuals are forced to acknowledge *Whiteness* at some level, to examine their own cultural values, and to see the conflict between upholding humanistic nonracist values and their contradictory behavior. For example, a person who consciously believes that all people are created equal and that he or she treats everyone the same might suddenly experience reservations about having African Americans move next door or having his or her child involved in an interracial relationship. These more personal experiences bring the individual face to face with his or her own prejudices and biases. In this situation, thoughts that "I am not prejudiced," "I treat everyone the same regardless of race, creed, or color," and "I do not discriminate" collide with the denial system. Additionally, some major event (e.g., the assassination of Martin Luther King Jr.) may force the person to realize that racism is alive and well in the United States.

> The increasing realization that one is biased and that EuroAmerican society does play a part in oppressing minority groups is an unpleasant one. Dissonance may result in feelings of guilt, shame, anger, and depression. Rationalizations may be used to exonerate one's own inactivity in combating perceived injustice or personal feelings of prejudice; for example, "I'm only one person—what can I do?" or "Everyone is prejudiced, even minorities." As these conflicts ensue, the White person may retreat into the protective confines of White culture (encapsulation of the *conformity phase*) or move progressively toward insight and revelation (*resistance and immersion phase*).
>
> Whether a person regresses is related to the strengths of the positive forces pushing the individual forward (support for challenging racism) and the negative forces pushing them backward (fear of some loss) (Sue, 2011; Todd & Abrams, 2011). For example, challenging the prevailing beliefs of the times may mean risking ostracism from White relatives, friends, neighbors, and colleagues. Regardless of the choice, there are many uncomfortable feelings of guilt, shame, anger, and depression related to the realization of inconsistencies in one's belief systems. Guilt and shame are most likely related to the recognition of the White person's role in perpetuating racism in the past. Guilt may also result from the person's being afraid to speak out on certain issues or to take responsibility for his or her part in a current situation. For example, the person might witness an act of racism, hear a racist comment, or be given preferential treatment over a minority person but decide not to say anything for fear of violating racist White norms. Many White people rationalize their behaviors by believing that they are powerless to make changes. Additionally, there is a tendency to retreat into White culture. If others (which may include some family and friends) are more accepting, forward movement is more likely.

4. *Resistance and immersion phase*. The White person who progresses to this phase will begin to question and challenge his or her own racism. For the first time, the person begins to realize what racism is all about, and his or her eyes are suddenly open. Racism is seen everywhere (e.g., advertising, television, educational materials, interpersonal interactions). This phase of development is marked by a major questioning of one's own racism and that of others in society. In addition, increasing awareness of how racism operates and its pervasiveness in U.S. culture and institutions is the major hallmark of this level. It is as if the person awakens to the realities of oppression; sees how

educational materials, the mass media, advertising, and other elements portray and perpetuate stereotypes; and recognizes how being White grants certain advantages denied to various minority groups.

> There is likely to be considerable anger at family and friends, institutions, and larger societal values, which are seen as having sold the person a false bill of goods (democratic ideals) that were never practiced. Guilt is also felt for having been a part of the oppressive system. Strangely enough, the person is likely to undergo a form of racial self‐hatred at this phase. Negative feelings about being White are present, and the accompanying feelings of guilt, shame, and anger toward the self and other Whites may develop. The White liberal syndrome may develop and be manifested in two complementary styles: the paternalistic protector role or the overidentification with another minority group (Helms, 1984; Ponterotto, 1988). In the former, the White person may devote his or her energies in an almost paternalistic attempt to protect minorities from abuse. In the latter, he or she may actually want to identify with a particular minority group (e.g., Asian, Black) in order to escape his or her own *Whiteness*. The White person will soon discover, however, that these roles are not appreciated by minority groups and will experience rejection. Again, he or she may resolve this dilemma by moving back into the protective confines of White culture (*conformity phase*), experience conflict (dissonance), or move directly to the *introspective phase*.

5. *Introspective phase*. This phase is most likely a compromise of having swung from an extreme of unconditional acceptance of White identity to a rejection of *Whiteness*. It is a state of relative quiescence, introspection, and reformulation of what it means to be White. The person realizes and no longer denies that he or she has participated in oppression and benefited from *White privilege* and that racism is an integral part of U.S. society. However, individuals at this phase become less motivated by guilt and defensiveness, accept their *Whiteness*, and seek to redefine their own identity and that of their social group. This acceptance does not mean a less active role in combating oppression. The process may involve addressing the questions, “What does it mean to be White?”, “Who am I in relation to my *Whiteness*?”, and “Who am I as a racial/cultural being?”

   > The affective elements may be existential in nature and involve feelings of disconnectedness, isolation, confusion, and loss. In other words, the person knows that he or she will never fully understand the minority experience but feels disconnected from the EuroAmerican group as well. In some ways, the *introspective phase* is similar in dynamics to the *dissonance phase*, in that both represent a transition from one perspective to another. The process used to answer the previous questions and to deal with the ensuing feelings may involve a searching, observing, and questioning attitude. Answers to these questions involve dialoging and observing one's own social group, and actively creating and experiencing interactions with various minority group members.

6. *Integrative awareness phase*. Reaching this level of development is most characterized as (a) understanding the self as a racial/cultural being, (b) being aware of sociopolitical influences regarding racism, (c) appreciating racial/cultural diversity, and (d) becoming more committed toward eradicating oppression. A nonracist White EuroAmerican identity is formed, emerges, and becomes internalized. The person values

multiculturalism, is comfortable around members of culturally different groups, and feels a strong connectedness with members of many groups. Most important, perhaps, is the inner sense of security and strength that needs to develop in order to function in a society that is only marginally accepting of integrative, aware White persons.

7. *Commitment to antiracist action phase*. Someone once stated that the ultimate *White privilege* is the ability to acknowledge one's privilege but do nothing about it. This phase is most characterized by social action. There is likely to be a consequent change in behavior and an increased commitment toward eradicating oppression. Seeing “wrong” and actively working to “right” it requires moral fortitude and direct action. Objecting to racist jokes; trying to educate family, friends, neighbors, and coworkers about racial issues; and taking direct action to eradicate racism in school and the workplace and in social policy (often in direct conflict with other Whites) are examples of actions taken by individuals who achieve this status. Movement into this phase can be a lonely journey for Whites, because they are oftentimes isolated by family, friends, and colleagues who do not understand their changed worldview. Strong pressures in society to not rock the boat, threats by family members that they will disown the individual, avoidance by colleagues, and threats of being labeled a troublemaker or not being promoted at work may all push the White person back to an earlier phase of development. To maintain a nonracist identity requires Whites to become increasingly immunized to social pressures for conformance and to begin forming alliances with persons of color or other liberated Whites, who become a second family to them. As can be seen, the struggle against individual, institutional, and societal racism is a monumental task in this society.

Video 12.3: Utilizing Your Own Development

White individuals go through a development process just like other groups and cultures. Once you are able to understand where you are developmentally, you can be more intentional about moving along the process, but also empathize with clients as they progress through their own identity development.

DEVELOPING A NONRACIST AND ANTIRACIST WHITE IDENTITY

> *I sometimes visualize the ongoing cycle of racism as a moving walkway at the airport. Active racist behavior is equivalent to walking fast on the conveyor belt. The person engaged in active racist behavior has identified with the ideology of White supremacy and is moving with it. Passive racist behavior is equivalent to standing still on the walkway. No overt effort is being made, but the conveyor belt moves the bystanders along to the same destination as those who are actively walking. Some of the bystanders may feel the motion of the conveyor belt, see the active racists ahead of them, and choose to turn around, unwilling to go to the same destination as the White supremacists. But unless they are walking actively in the opposite direction at a speed faster than the conveyor belt—unless they are actively antiracist—they will find themselves carried along with the others.*
>
> *(Tatum, 1997, pp. 11–12)*

What does this metaphor of racism tell you about the difference between active and passive racism? What is the "destination" of the walkway? If it represents our society, can you describe what that destination looks like? What does the conveyor belt symbolize? Are you on the conveyor belt? Which direction are you traveling? Do you even feel the movement of the belt? What would it take for you to reverse directions? More importantly, how can you stop the movement of the conveyor belt? What changes would need to occur for you at the individual level to reverse directions? What changes would need to happen at the institutional and societal levels to stop or reverse the direction of the conveyor belt?

As repeatedly emphasized in earlier chapters, *White supremacy* must be seen through a larger prism of individual, institutional, and societal racism. All these elements conspire in such a manner as to avoid making the "invisible" visible, and thus directly or indirectly discourage honest racial dialogue and self‐exploration.

First, the walkway metaphor is a strong and powerful statement of the continuous and insidious nature of racism; it is ever‐present, dynamic, and oftentimes invisible as it takes us on a journey to White supremacist notions, attitudes, beliefs, and behaviors. The visible actions of White supremacists moving quickly on the belt represent the overt racism that we're aware of; these forms we consciously condemn. The conveyor belt represents the invisible forces of society or the biased institutional policies, practices, and structures that control our everyday lives. From the moment of birth, we are placed on the conveyor belt, culturally conditioned, and socialized to believe that we are headed in "the right direction." For many White people, the movement of the belt is barely noticeable, and its movement remains hidden from conscious awareness. This allows White people to remain naive and innocent about the harm their inaction has on people of color.

Second, as indicated by Tatum (1997), one need not be actively racist in order to be racist. The pace at which one walks on the conveyor belt determines the degree to which one consciously or unconsciously harbors White supremacist notions: (a) "active racists" who are aware and deliberate in beliefs and actions move quickly, (b) unintentional racists, unaware of their biases and the direction they are taking, stroll slowly, and (c) "passive racists" choose not to walk at all. Despite this, passive racists are nevertheless being moved in a direction that allows for racism to thrive. On a personal level, despite beliefs of justice, equity, and fairness, inaction on the walkway ultimately means that these individuals are also responsible for the oppression of others.

Third, most people of color are desperately trying to move or run in the opposite direction.

The voices of people of color are filled with attempts to make well‐intentioned Whites aware of the direction they are taking and of the harm they are inflicting on diverse others. But they are hindered by many obstacles: well‐intentioned White Americans who tell them they are going the wrong way and don't believe them; institutional policies and practices that put obstacles in their retreating path (institutional racism); and punishment from society for "not obeying the traffic rules"—a one‐way street of bias and bigotry.

Fourth, despite limited success in battling the constant forces of racism, people of color are also slowly but surely being swept in a dangerous direction that has multiple implications for their psychological health, physical well‐being, and standard of living. Walking at a fast pace or running in the opposite direction is a never‐ending activities that is exhausting and energy‐depleting. Worse yet, they are being trampled by the large numbers of well‐intentioned White Americans moving in the opposite direction. Giving up or ultimately being swept to the end of the walkway means a life of oppression and subordination.

Last, the questions being posed to trainees are challenging. How do we motivate White Americans to (a) notice the subtle movement of the walkway (making the invisible visible), (b) discern the ominous direction it is taking (White racial supremacy), (c) begin to move in the opposite direction (antiracism), and (d) stop the conveyor belt or reverse its direction (institutional and societal change)? As indicated in the sections on *White racial identity development*, becoming *nonracist* means engaging in soul searching, individual change, and working on the self; becoming *antiracist*, however, means taking personal action to end external racism that exists systemically and in the actions of others.

White Antiracist Identifications

Tatum (2007) articulated a vision of the roles occupied by White individuals who have made their antiracist commitments and actions central to their identities:

> *It is possible to claim both one's Whiteness as a part of who one is and of one's daily experience, and the identity of being what I like to call a "White ally": namely, a White person who understands that it is possible to use one's privilege to create more equitable systems; that there are White people throughout history who have done exactly that; and that one can align oneself with that history. That is the identity story that we have to reflect to White children, and help them see themselves in it, in order to continue racial progress in our society.*
>
> *(p. 37)*

This term, *White ally*, has increasingly gained currency as antiracist White Americans have sought to take a stand against racism and to align themselves with social movements such as Black Lives Matter (Griffin, 2016). *White alliance* has professional relevance as well as individual implications. Like members of every profession, White counselors must consider the ways that their work is influenced by the unearned privilege that has accompanied their skin color. White counselors who identify as White allies also accept accountability for "work[ing] in solidarity with their colleagues of color to conduct culturally responsive professional practice, research, training, and institutional transformation" (Spanierman & Smith, 2017, p. 607).

The notion of White alliance has also been critiqued (Mizock & Page, 2016; Owens, 2017), in that even the actions of self‐described allies can be undermined by the entitlement and blind spots that accompany White privilege. The resulting pitfalls for White allies include short‐term involvement, the expression of antiracist commitments only when convenient, and engaging in recognition‐seeking for one's antiracist activities. At times, White antiracists

can be observed to enact their privilege by taking over meetings where racism is the topic, rather than working collaboratively with or taking direction from their colleagues of color. In addition, the efforts of would‐be allies can be compromised by a paternalistic "White savior" stance.

> *The notion of an ally may promote a condescending narrative of allies as "rescuers" to the "helplessly oppressed." This narrative also reinforces problematic emotions of pity for a marginalized group … Along with pity comes sympathy in the role of a "heroic ally." While sympathy has been found to be important to collective action, this role positions the ally on the sidelines instead of participating fully in social change … Furthermore, identification with an advantaged group identity may reify inferior–superior statuses associated with it … such as hero to a victim.*
>
> *(Mizock & Page, 2016, p. 24)*

These potential pitfalls do not negate the value of the authentic soul‐searching and commitment that motivate White antiracists to identify themselves as allies. They do, however, underscore that one's development as a White ally is a lifelong endeavor (Sue, 2017).

Principles of Prejudice Reduction

Although *White racial identity development* models tell us much about the characteristics most likely to be exhibited by individuals as they progress along this journey, they are very weak in giving guidance about how to develop a *nonracist White identity* (Helms, 2015). Possible answers seem to lie in the social‐psychological literature about the basic principles or conditions needed to reduce prejudice through intergroup contact first formulated by Gordon Allport (1954) in his classic book, *The Nature of Prejudice*. His work has been refined and expanded by other researchers and scholars (Aboud, 1988; Amir, 1969; Cook, 1962; Gaertner, Rust, Dovidio, Bachman, & Anastasio, 1994; Jones, 1997). Sue (2003) has summarized these findings into the basic principles of prejudice reduction: (a) having intimate and close contact with others, (b) engaging in cooperation rather than competition on common tasks, (c) sharing mutual goals, (d) exchanging accurate information rather than stereotypes, (e) sharing an equal status relationship, (f) enjoying support for prejudice reduction by authorities and leaders, and (g) feeling a sense of connection and belonging with one another. To this, we might add the contributions of *White racial identity development* theorists, who have indicated the importance of understanding oneself as a racial/cultural being. It has been found, for example, that a person's level of White racial awareness is predictive of his or her level of racism (Pope‐Davis & Ottavi, 1994; Wang et al., 2003); the less aware participants in research projects were of their White racial identity, the more likely they were to exhibit increased levels of racism.

The seven basic principles we provided in the previous section arose primarily through studies of how to reduce intergroup conflict and hostility, but several seem consistent with reducing personal prejudice through experiential learning and the acquisition of accurate information about other groups. Translating these principles into roles and activities for personal development has been made possible by recommendations from the APA Presidential Task Force on Preventing Discrimination and Promoting Diversity (2012), the President's Initiative on Race (1998, 1999), educators and trainers (Ponterotto et al., 2006; Young & Davis‐Russell, 2002), and studies on difficult racial dialogues (Sue, Lin, Torino, Capodilupo, & Rivera, 2009; Sue, Rivera, Capodilupo, Lin, & Torino, 2010).

Sue (2003) outlines five basic learning situations and activities, or principles, most likely to

enhance change in developing a *nonracist White identity*.

Principle 1: Learn About People of Color From Sources Within the Group

- You must experience and learn from as many sources as possible (not just the media or what your neighbor may say) in order to check out the validity of your assumptions and understanding.
- If you want to understand racism, White people may not be the most insightful or accurate sources. Acquiring information from persons of color allows you to understand the thoughts, hopes, fears, and aspirations of this group. It also acts as a counterbalance to the worldview expressed by White society about minority groups.

Principle 2: Learn From Healthy and Strong People of the Culture

- A balanced picture of a particular racial/ethnic group requires that you spend time with healthy and strong people of that culture. The mass media and our educational texts (written from the perspectives of EuroAmericans) frequently portray minority groups as uncivilized or pathological, or as criminals or delinquents.
- You must make an effort to fight such negative conditioning and ask yourself what are the desirable aspects of the culture, the history, and the people. This can come about only if you have contact with healthy representatives of that group.
- If you seldom spend much intimate time with persons of color, you are likely to believe the societal projection of minorities as being law breakers and unintelligent, prone to violence, unmotivated, and uninterested in relating to the larger society.
- Frequent minority - owned businesses, and get to know the proprietors.
- Attend services at a variety of churches, synagogues, temples, and other places of worship to learn about different faiths and to meet religious leaders.
- Invite colleagues, coworkers, neighbors, or students of color to your home for dinner or a holiday.
- Live in an integrated or culturally diverse neighborhood, and attend neighborhood organizational meetings and attend/throw block parties.
- Form a community organization on valuing diversity, and invite local artists, authors, entertainers, politicians, and leaders of color to address your group.
- Attend street fairs, educational forums, and events put on by the community.

Principle 3: Learn From Experiential Reality

- Although listening to readings, attending theater, and going to museums are helpful in increasing understanding, you must supplement your factual understanding with the experiential reality of the groups you hope to understand. These experiences must be carefully planned if they are to be successful, however.
- It may be helpful to identify a cultural guide: someone from the culture who is willing to help you understand his or her group; someone willing to introduce you to new experiences; someone willing to help you process your thoughts, feelings, and behaviors. This allows you to more easily obtain valid information on issues of race and racism.

Principle 4: Learn From Constant Vigilance of Your Biases and Fears

- Your life must become a “have to” in being constantly vigilant to manifestations of bias in both yourself and the people around you.
- Learn how to ask sensitive racial questions of your minority friends, associates, and acquaintances. Persons subjected to racism seldom get a chance to talk about it with a nondefensive and nonguilty person from the majority group.
- Most minority individuals are more than willing to respond, to enlighten, and to share *if they sense that your questions and concerns are sincere and motivated by a desire to learn and serve the group*.

Principle 5: Learn From Being Committed to Personal Action Against Racism

- Dealing with racism means a personal commitment to action. It means interrupting other White Americans when they make racist remarks, tell racist jokes, or engage in racist actions, even if this is embarrassing or frightening.
- It means noticing the possibility for direct action against bias and discrimination in your everyday life: in the family, at work, and in the community.
- It means taking initiative to make sure that minority candidates are fairly considered in your place of employment, advocating to your children's teachers to include multicultural material in the curriculum, volunteering in community organizations to have them consider multicultural issues, and contributing to and working for campaigns of political candidates who will advocate for social justice.
- The journey to developing a White nonracist identity is not an easy path to travel. Remember, racial identity and cultural competence are intimately linked to one another. Becoming a culturally competent helping professional involves more than “book learning”; it requires both experiential learning and taking personal action (Atkins, Fitzpatrick, Poolokasingham, Lebeau, & Spanierman, 2017). Are you ready for the challenge?

REFLECTION AND DISCUSSION QUESTIONS

1. Do these suggestions and strategies make sense to you? Are there others that come to mind?
2. What would make it difficult for you to personally implement these suggestions? What barriers stand in the way? For example, what would make it difficult for you to interrupt a stranger or even a family member when a racist or sexist joke is made?
3. Have you ever been in a situation where you were the only White person in an activity or event full of Black, Asian, or Latinx people? What feelings did you have? How did you think? Were you uncomfortable or fearful?
4. What would you need in the way of support or personal moral courage to move toward developing a White nonracist identity?

IMPLICATIONS FOR CLINICAL PRACTICE

1. Ultimately, the effectiveness of White therapists is related to their ability to overcome sociocultural conditioning and to make their *Whiteness* visible.
2. Accept the fact that racism is a basic and integral part of U.S. life and permeates all aspects of our culture and institutions. Know that as a White person, you are not immune.
3. Understand that the level of *White racial identity development* in a cross‐cultural encounter (e.g., working with minorities, responding to multicultural training) affects the process and outcome of an interracial relationship (including counseling/therapy).
4. Work on accepting your own *Whiteness*, but define it in a nondefensive, nonracist, and antiracist manner.
5. Spend time with healthy and strong people from another culture or racial group.
6. Know that becoming culturally aware and competent comes through lived experience and reality.
7. Attend cultural events, meetings, and activities led by minority communities. This allows you to hear from church leaders, to attend community celebrations, and to participate in open forums so that you may sense the strengths of the community, observe leadership in action, personalize your understanding, and develop new social relationships.
8. When around persons of color, pay attention to feelings, thoughts, and assumptions that you have when race‐related situations present themselves.
9. Dealing with racism means a personal commitment to action.

Video 12.4: Healthy Identity Development in White Clinicians

The process of White identity development is just as important to clinicians as understanding the developmental process of clients-of-color. In doing so, clinicians free themselves to become the best version of themselves, one that is based in a holistic self-understanding.

Video Lecture: White Racial Identity Development

Video Lecture: What Does It Mean to be White? The Invisible Whiteness of Being

SUMMARY

"What does it mean to be White?" is often an uncomfortable and perplexing question for White Americans. Exploring the basis of this discomfort and its meaning is important for cultural competence in mental health practice. Being a White person in this society means chronic exposure to ethnocentric monoculturalism as manifested in *White supremacy*. Research suggests that it is nearly impossible for anyone to avoid inheriting the racial biases, prejudices, misinformation, deficit portrayals, and stereotypes of their forebears. If White helping professionals are ever able to become effective multicultural counselors or therapists, they must free themselves from the cultural conditioning of their past and move toward the development of a nonracist and *antiracist White identity*.

White racial identity development models have been found to be helpful in describing how majority group members go through a process of racial awakening that has direct meaning to multicultural counseling. Two of the most influential models are those presented by Rita Hardiman and Janet Helms. It has been found that the level of White racial identity awareness is predictive of racism and of internal and interpersonal characteristics. The less aware subjects studied were of their White identity, the more likely they were to exhibit higher levels of racism, while the greater their White identity development, the greater their levels of multicultural counseling competence, the higher their positive opinions toward diverse groups, and the better their ability to form therapeutic alliances with clients of color.

A descriptive model of *White racial identity development* identifies a seven - phase process by which Whites become increasingly aware of themselves as racial/cultural beings: (a) naiveté, (b) conformity, (c) dissonance, (d) resistance and immersion, (e) introspective, (f) integrative awareness, and (g) commitment to antiracist action. Becoming *nonracist* means engaging in soul searching, individual change, and working on the self; becoming *antiracist*, however, means taking personal action to end external racism that exists systemically and in the actions of others. Five basic principles are provided to facilitate racial/cultural awareness: learn (a) from the groups you hope to understand, (b) from healthy and strong people of the culture, (c) from experiential reality, (d) from constant vigilance of fears and biases, and (e) from being committed to anti - bias action.

GLOSSARY TERMS

- Antiracist White identity
- Commitment to antiracist action phase
- Conformity phase
- Dissonance phase
- Ego statuses
- Hardiman White racial identity development
- Helms White racial identity development
- Information processing strategies
- Integrative awareness phase
- Introspective phase
- Naiveté phase
- Nonracist White identity
- Resistance and immersion phase
- Unintentional racism
- White privilege
- White racial identity development
- White racial identity development descriptive model
- White supremacy
- Whiteness

Video 12.5: Counseling Session Analysis

Analysis of counseling session by Drs. Derald Wing Sue and Joel Filmore.

REFERENCES

1. Aboud, F. E. (1988). *Children and prejudice*. Cambridge, MA: Basil Blackwell.
2. Allport, G. W. (1954). *The nature of prejudice*. Reading, MA: Addison‐Wesley.
3. American Psychological Association (APA) Presidential Task Force on Preventing Discrimination and Promoting Diversity (2012). *Dual pathways to a better America: Preventing discrimination and promoting diversity*. Washington, DC: American Psychological Association.
4. Amir, Y. (1969). Contact hypothesis in ethnic relations. *Psychological Bulletin*, *71*, 319–342.
5. Atkins, S. L., Fitzpatrick, M. R., Poolokasingham, G., Lebeau, M., & Spanierman, L. B. (2017). Make it personal: A qualitative investigation of White counselors' multicultural awareness development. *The Counseling Psychologist*, *45*(5), 669–696.
6. Bell, L. A. (2002). Sincere fictions: The pedagogical challenges of preparing White teachers for multicultural classrooms. *Equity and Excellence in Education*, *35*, 236–244.
7. Bell, L. A. (2003). Telling tales: What stories can teach us about racism. *Race, Ethnicity and Education*, *6*, 3–28.
8. Biss, E. (2015). White debt: Reckoning with what is owed—and what can never be repaid—for racial privilege. Retrieved from https://www.nytimes.com/2015/12/06/magazine/white‐debt.html?_r=0
9. Boysen, G. A. (2010). Integrating implicit bias into counselor education. *Counselor Education and Supervision*, *49*, 210–226.
10. Carter, R. T. (1990). The relationship between racism and racial identity among White Americans: An exploratory investigation. *Journal of Counseling and Development*, *69*, 46–50.
11. Cokley, K. (2006). The impact of racialized schools and racist (mis)education on African American students' academic identity. In M. G. Constantine, & D. W. Sue (Eds.), *Addressing racism* (pp. 127–144). Hoboken, NJ: Wiley.
12. Cook, S. W. (1962). The systematic study of socially significant events: A strategy for social research. *Journal of Social Issues*, *18*, 66–84.
13. Falender, C. A., Shafranske, E. P., & Falicov, E. J. (2014). *Multiculturalism and diversity in clinical supervision*. Washington, DC: American Psychological Association.
14. Fu, M. (2015). I don't see color, all people are the same: Whiteness and color‐blindness as training and supervisory issues. *Women & Therapy*, *38*(3–4), 279–294.
15. Gaertner, S. L., Rust, M. C., Dovidio, J. F., Bachman, B. A., & Anastasio, P. A. (1994). The contact hypothesis: The role of common ingroup identity on reducing intergroup bias. *Small Group Research*, *25*, 224–249.
16. Gallardo, M. E., & Ivey, A. (2014). What I see could be me. In M. E. Gallardo (Ed.),

Developing cultural humility (pp. 223–263). Thousand Oaks, CA: Sage.

17. Griffin, R. (2016). For White people who believe Black lives matter. Retrieved from https://www.huffingtonpost.com/rebecca‐griffin/for‐white‐people‐who‐beli_b_10917900.html

18. Hanna, F. J., Talley, W. B., & Guindon, M. H. (2000). The power of perception: Toward a model of cultural oppression and liberation. *Journal of Counseling and Development*, *78*, 430–446.

19. Hardiman, R. (1982). White identity development: A process oriented model for describing the racial consciousness of White Americans (Doctoral dissertation). *Dissertation Abstracts International*, *43*, 104A. (University Microfilms No. 82–10330).

20. Hays, P. A. (2014). Finding a place in the multicultural revolution. In M. E. Gallardo (Ed.), *Developing cultural humility* (pp. 49–59). Thousand Oaks, CA: Sage.

21. Hegarty, P. (2017). On the failure to notice that White people are White: Generating and testing hypotheses in the celebrity guessing game. *Journal of Experimental Psychology: General*, *146*(1), 41.

22. Helms, J. E. (1984). Toward a theoretical explanation of the effects of race on counseling: A Black and White model. *The Counseling Psychologist*, *12*, 153–165.

23. Helms, J. E. (1990). *Black and White racial identity: Theory, research, and practice*. Westport, CT: Greenwood Press.

24. Helms, J. E. (1994). How multiculturalism obscures racial factors in the therapy process: Comment on Ridley et al. (1994), Sodowsky et al. (1994), Ottavi et al. (1994), and Thompson et al. (1994). *Journal of Counseling Psychology*, *41*, 162–165.

25. Helms, J. E. (1995). An update of Helms's White and people of color racial identity models. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 181–191). Thousand Oaks, CA: Sage.

26. Helms, J. E. (2015). Taking action against racism in a post‐racism era: The origins and almost demise of an idea. *The Counseling Psychologist*, *43*, 138–145.

27. Helms, J. E., & Carter, R. T. (1990). Development of the White racial identity attitude inventory. In J. E. Helms (Ed.), *Black and White racial identity: Theory, research, and practice* (pp. 67–80). Westport, CT: Greenwood Press.

28. Jones, J. M. (1997). *Prejudice and racism* (2nd ed.). Washington, DC: McGraw‐Hill.

29. Kaleem, J. (2016). “There's nothing wrong with being White”: Trump's win brings “White pride” out of the shadows. Retrieved from http://www.latimes.com/nation/la‐na‐trump‐white‐pride‐20161117‐story.html

30. Katz, J. (1985). The sociopolitical nature of counseling. *The Counseling Psychologist*, *13*, 615–624.

31. Miville, M. L., Darlington, P., Whitlock, B., & Mulligan, T. (2005). Integrating identities: The relationship of racial, gender, and ego identities among White college students. *Journal of College Student Development*, *46*, 157–175.

32. Mizock, L., & Page, K. (2016). Evaluating the ally role: Contributions, limitations, and the activist position in counseling and psychology. *Journal for Social Action in Counseling and Psychology*, *8*(1), 17–33.

33. Neville, H. A., Awad, G. H., Brooks, J. E., Flores, M. P., & Bluemel, J. (2013). Color‐blind racial ideology: Theory, training, and measurement implications in psychology. *American Psychologist*, *68*, 455–466.

34. Owens, E. (2017). Why I'm giving up on “allies.” Retrieved from http://www.phillymag.com/news/2017/06/23/allyship‐vs‐solidarity/

35. Perry, S. P., Dovidio, J. F., Murphy, M. C., & van Ryn, M. (2015). The joint effect of bias awareness and self‐reported prejudice on intergroup anxiety and intentions for intergroup contact. *Cultural Diversity and Ethnic Minority Psychology, 21*, 89–96.

36. Ponterotto, J. G. (1988). Racial consciousness development among White counselors' trainees: A stage model. *Journal of Multicultural Counseling and Development*, *16*, 146–156.

37. Ponterotto, J. G., Utsey, S. O., & Pedersen, P. B. (2006). *Preventing prejudice: A guide for counselors, educators, and parents*. Thousand Oaks, CA: Sage.

38. Pope‐Davis, D. B., & Ottavi, T. M. (1994). Examining the association between self‐reported multicultural counseling competencies and demographic and educational variables among counselors. *Journal of Counseling and Development*, *72*, 651–654.

39. President's Initiative on Race (1998). *One America in the twenty‐first century*. Washington, DC: U.S. Government Printing Office.

40. President's Initiative on Race (1999). *Pathways to one America in the 21st century*. Washington, DC: U.S. Government Printing Office.

41. Ridley, C. R. (1995). *Overcoming unintentional racism in counseling and therapy*. Thousand Oaks, CA: Sage.

42. Rowe, W. (2006). White racial identity: Science, faith and pseudoscience. *Journal of Multicultural Counseling and Development*, *34*, 235–243.

43. Rowe, W., & Atkinson, D. R. (1995). Misrepresentation and interpretation: Critical evaluation of White racial identity development models. *The Counseling Psychologist*, *23*, 364–367.

44. Rowe, W., Bennett, S., & Atkinson, D. R. (1994). White racial identity models: A critique and alternative proposal. *The Counseling Psychologist*, *22*, 120–146.

45. Spanierman, L. B., & Smith, L. (2017). Roles and responsibilities of White allies: Implications for research, teaching, and practice. *The Counseling Psychologist*, *45*(5), 606–617.

46. Spanierman, L. B., Poteat, V. V., Beer, A. M., & Armstrong, P. I. (2006). Psychosocial costs of racism to Whites: Exploring patterns through cluster analysis. *Journal of Counseling Psychology*, *53*, 434–441.

47. Spanierman, L. B., Todd, N. R., & Anderson, C. J. (2009). Psychosocial costs of racism to Whites: Understanding patterns among university students. *Journal of Counseling Psychology*, *56*, 239–252.

48 Stevenson, B. (2017). Letter: Don't all lives matter? Retrieved from https://www.sltrib.com/opinion/letters/2017/10/21/letter - dont - all - lives - matter

49 Sue, D. W. (2003). *Overcoming our racism: The journey to liberation*. San Francisco, CA: Jossey - Bass.

50 Sue, D. W. (2004). Whiteness and ethnocentric monoculturalism: Making the invisible visible. *American Psychologist, 59,* 761–769.

51 Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, NJ: Wiley.

52 Sue, D. W. (2011). The challenge of White dialectics: Making the “invisible” visible. *The Counseling Psychologist, 39*, 414–423.

53 Sue, D. W. (2013). Race talk: The psychology of racial dialogues. *American Psychologist, 68,* 663–672.

54 Sue, D. W. (2015). *Race talk and the conspiracy of silence: Understanding and facilitating difficult dialogues on race*. Hoboken, NJ: Wiley.

55 Sue, D. W. (2017). The challenges of becoming a White ally. *The Counseling Psychologist, 45*(5), 706–716.

56 Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice*. New York, NY: Wiley.

57 Sue, D. W., Lin, A. I., Torino, G. C., Capodilupo, C. M., & Rivera, D. P. (2009). Racial microaggressions and difficult dialogues on race in the classroom. *Cultural Diversity and Ethnic Minority Psychology, 15,* 183–190.

58 Sue, D. W., Rivera, D. P., Capodilupo, C. M., Lin, A. I., & Torino, G. C. (2010). Racial dialogues and White trainee fears: Implications for education and training. *Cultural Diversity and Ethnic Minority Psychology, 16,* 206–214.

59 Tatum, B. D. (1992). Talking about race, learning about racism: The application of racial identity development theory in the classroom. *Harvard Educational Review, 62,* 1–24.

60 Tatum, B. D. (1997). *Why are all the Black kids sitting together in the cafeteria?*. New York, NY: Basic Books.

61 Tatum, B. D. (2007). *Can we talk about race?*. Boston, MA: Beacon Press.

62 Todd, N. R., & Abrams, E. M. (2011). White dialectics: A new framework for theory, research and practice with White students. *The Counseling Psychologist, 39,* 353–395.

63 Toporek, R. L., & Worthington, R. L. (2014). Integrating service learning and difficult dialogues pedagogy to advance social justice training. *The Counseling Psychologist, 46,* 919–945.

64 Utsey, S. O., Gernat, C. A., & Hammar, L. (2005). Examining white counselor trainees' reactions to racial issues in counseling and supervision dyads. *The Counseling Psychologist, 33,* 449–478.

65 Vinson, T., & Neimeyer, G. J. (2000). The relationship between racial identity development and multicultural counseling competence. *Journal of Multicultural Counseling and Development, 28,* 177–192.

66 Vinson, T., & Neimeyer, G. J. (2003). The relationship between racial identity development and multicultural counseling competence: A second look. *Journal of Multicultural Counseling and Development*, *31*, 262–277.

67 Wang, Y., Davidson, M. M., Yakushko, O. F., Savoy, H. B., Tan, J. A., & Bleier, J. K. (2003). The scale of ethnocultural empathy: Development, validation, and reliability. *Journal of Counseling Psychology*, *50*, 221–234.

68 Young, G., & Davis‐Russell, E. (2002). The vicissitudes of cultural competence: Dealing with difficult classroom dialogue. In E. Davis‐Russell (Ed.), *The California School of Professional Psychology handbook of multicultural education, research, intervention, and training* (pp. 37–53). San Francisco, CA: Jossey‐Bass.

SECTION TWO
Multicultural Counseling and Specific Populations

While Section One addressed common principles, practices, and issues of multicultural counseling and therapy that are often applicable across groups, this section is divided into four parts that recognize the unique challenges and group differences between socially marginalized groups in our society. Section Two was created for several reasons.

- First, we recognize that while issues of culture - conflict, prejudice, and discrimination affect almost all socially devalued groups in our society, the histories and the unique challenges confronting people of color, for example, may differ substantially from those confronting women, those who live in poverty, or religious minorities.
- Second, we recognize that “multiculturalism,” “diversity,” and “multicultural counseling competence” are broad terms that include race, gender, social class, religious orientation, sexual orientation, and many other sociodemographic groups in our society. To not acknowledge this fact is to render certain groups invisible, thereby invalidating their existence as unique.
- Third, numerous instructors continue to find the coverage of specific populations helpful to their students. The extensive coverage in Section Two allows instructors freedom to use all of the chapters contained within it or to selectively choose those that fit their course requirements.
- Last, but importantly, we have attempted to provide a guideline for how to approach the use of population - specific chapters through an open and flexible assessment process that avoids stereotypical and rigid therapeutic applications (see Part V).
    - Part V: Understanding Specific Populations
    - Part VI: Counseling and Therapy with Racial/Ethnic Minority Group Populations
    - Part VII: Counseling and Special Circumstances Involving Racial/Ethnic Populations
    - Part VIII: Counseling and Therapy with Other Multicultural Populations

PART V
Understanding Specific Populations

13
Culturally Competent Assessment

Chapter Objectives

1. **1. Understand the many variables that influence assessment, diagnosis, and case conceptualization.**
2. **2. Develop awareness of the dangers of stereotyping and the importance of appreciating the individuality of each client.**
3. **3. Learn how cultural competence and responsiveness prevent diagnostic errors.**
4. **4. Understand contextual and collaborative assessment.**
5. **5. Understand *Diagnostic and Statistical Manual of Mental Disorders* (*DSM‐5*) cultural formulations.**
6. **6. Learn how to infuse cultural competence and responsiveness into standard clinical assessments.**

> *I approach people as people no matter their ethnic background.*
>
> *(Common refrain heard among therapists and trainees)*
>
> *A couple walked out after the first few minutes. I had sensed their mistrust and anger and talked more than usual, immediately addressing our racial difference. They stormed out, stating that I was talking too much and not listening.*
>
> *(Maxie, Arnold, & Stephenson, 2006, p. 92)*

Accurate assessment, diagnosis, and case conceptualization—key prerequisites to the provision of appropriate treatment—are dependent upon the characteristics, values, and worldviews of both the therapist and the client (American Psychological Association, 2006, 2017). Some clinicians choose not to consider race, ethnicity, and other social identities when working with clients, as illustrated in the first quote in the epigraph, and some clinicians' racial biases and/or discomfort get in the way of them making genuine connections with clients, as evident in the second. In general, though, most therapists today recognize that client variables, such as socioeconomic status, gender, and racial or cultural background, can significantly affect assessment, diagnosis, and conceptualization. However, we often forget that as clinicians, we are not “objective” observers of our clients. Instead, we each have our own set of beliefs, values, and theoretical assumptions (e.g., the degree we think social identities shape people's lives). To reduce error, a mental health professional must be aware of potential biases that can affect clinical judgment, including the influence of *stereotypes* (i.e., generalizations based on limited or inaccurate information). Unfortunately, our current methods of assessment and diagnosis often do not adequately consider these factors, especially with respect to therapist variables. Additionally, many of our instruments and processes for assessment and diagnosis do not address client variables in a meaningful manner.

If we are to follow best‐practice guidelines and the ethical standards of our profession, we must consider broad background factors, including the worldview of each client. How can this be accomplished? First and foremost, it is critical that we operate from the awareness that an understanding of and openness toward our clients' beliefs, expectations, and experiences is an essential aspect of the assessment and case conceptualization process. We believe that *culturally responsive assessment* occurs through a combination of evidence‐based guidelines for assessment and a cultural competency framework.

In this chapter, we will cover: (a) the impact of therapist variables on assessment and

diagnosis, emphasizing the dangers of stereotyping; (b) ways in which culturally competent practices can reduce diagnostic errors; (c) contextual and *collaborative assessment*; and (d) ideas for infusing cultural competence into standard intake and assessment procedures. Careful consideration of these factors when using evidence‐based guidelines to conduct assessment will ensure that clinicians form an accurate and complete picture of the problems and issues facing each client. We will demonstrate how *culturally responsive assessment* should be conducted—in a manner that considers the unique background, values, and beliefs of each client. We hope that as you proceed through the final chapters of this book—chapters describing general characteristics and special challenges faced by various diverse populations—you will remember that we are providing this information so you will have some knowledge of the specific research and the sociopolitical and cultural factors that *might* be pertinent to a client or family from the population being discussed. However, it is critical that when counseling diverse clientele, you actively work to avoid succumbing to *stereotypes* (i.e., basing your opinions of the client on limited information or prior assumptions). Instead, your task is to develop an in‐depth understanding of each client, taking into consideration their unique personal background and worldview. By doing this, you will be in a position to develop an individually tailored treatment plan that effectively addresses presenting problems in a culturally sensitive manner.

Video 13.0: Introduction

Introduction to counseling session by Dr. Joel Filmore.

THERAPIST VARIABLES AFFECTING DIAGNOSIS

Assessment is best conceptualized as a two‐way street, influenced by both client and therapist variables. Because humans filter observations through their own set of values and beliefs, we begin our discussion by focusing on therapist self‐assessment.

> *A treatment team observing a clinical interview erupted in laughter when the foreign‐born psychiatric resident attempted to find out what caused or precipitated the client's problem. In poor and halting English, the resident asked, "How brought you to the hospital?" The patient responded, "I came by car."*
>
> *(Chambliss, 2000, p. 186)*

Later, during the case conference, the psychiatric resident attributed the patient's response to concrete thinking, a characteristic sometimes displayed by people with schizophrenia. The rest of the treatment team, however, believed the response was due to a poorly worded question. This example illustrates what can occur when therapists focus solely on the client without considering the impact of therapist variables. Personal characteristics, attitudes, and beliefs can (and do) influence how assessment is conducted and what is assessed, as well as interpretations of clinical data. Counselors and other mental health professionals are often unaware of how strongly personal beliefs can affect clinical judgment.

In one study, 108 psychotherapists read an intake report involving a male client whose sexuality was revealed through references to his previous and present partners; all clinical data were identical with the exception of references to sexual orientation. Details suggesting heterosexual or same‐sex orientation had little impact on clinical ratings; however, therapists given data suggesting the client was bisexual were more likely to "detect" emotional disturbance. The researchers concluded that these differing diagnostic perceptions were the result of *stereotypes* of bisexual men being "confused and conflicted" (Mohr, Weiner, Chopp, & Wong, 2009).

In conducting *culturally responsive assessment*, we must not only be aware of the influence of *stereotypes* but also be alert for common diagnostic errors, such as the following:

- *Confirmatory strategy*. Searching for evidence or information that supports one's hypothesis and ignoring data that are inconsistent with this perspective. When working with clients, mental health professionals might search for information that confirms beliefs based on their worldviews or theoretical orientation (Osmo & Rosen, 2002). In a similar manner, our views or *stereotypes* of the characteristics and values of ethnic and other diverse groups can act as blinders when working with clients from these groups. Counselors can combat this type of error by working cooperatively with clients to understand and interpret the presenting problem. Diagnostic accuracy is increased when clinicians test any hypotheses they formulate with the client. When determining whether these possible interpretations resonate with the client, it is critical that the therapist be open to both confirmatory and disconfirmatory information.
- *Attribution error*. Placing an undue emphasis on internal causes regarding a client's problem. For example, a therapist might interpret a problem as stemming from a personal characteristic of the client rather than considering environmental or sociocultural explanations such as poverty, discrimination, or oppression. Attribution error can be reduced by performing a thorough assessment that includes consideration of sociocultural and environmental factors and testing hypotheses regarding extrapsychic

(i.e., residing outside the person) as well as intrapsychic (residing within the person) influences.

- *Judgmental heuristics*. Commonly used quick‐decision rules. These can be problematic because they short‐circuit our ability to engage in self‐correction. For example, if we quickly identify our client as “defensive” or “overreactive,” these characterizations will reduce our attempt to gather additional or contradictory information. In one study (Stewart, 2004), 300 clinicians received identical vignettes regarding hypothetical clients, with the only difference being the clients' stated birth order. Birth order influenced the judgment of the clinicians, including the expected prognosis for the client, even though there is little research support for personality differences associated with birth order. These kinds of beliefs or spontaneous associations occur automatically and need to be identified and addressed. Therapists can reduce this tendency by acknowledging the existence of *judgmental heuristics*, questioning the basis for quick decisions, assessing additional factors, and evaluating the accuracy of opinions about clients.
- *Diagnostic overshadowing*. Providing inadequate treatment of the client's problem because one's attention is diverted to a more prominent characteristic. For example, individuals who are gay or lesbian can have a number of psychological issues that have nothing to do with their sexual orientation. In *diagnostic overshadowing*, a therapist might perceive the presenting problem as related to conflicts over sexual orientation and fail to address other critical issues. Other such prominent characteristics are race, religious affiliation, and visible disabilities.

We must be aware of our beliefs and values as we work with clients and their specific presenting problems. We are all susceptible to making errors in clinical judgment during assessment; therefore, it is important to adopt a tentative stance and test out our observations. Those who remember that errors in judgment are possible can reduce their effect by using a self‐corrective model. In the next section, for example, we discuss why it is important to consider whether the current focus on cultural competence may, in fact, be creating new sources of errors—errors resulting from applying cultural information in a stereotypic, “one‐size‐fits‐all” manner.

Video 13.1: Assessment and Diagnosis

Assessing clients of color requires more than simply handing them a form to fill out. Because most formal assessments are normed on majority populations, it's important to utilize informal assessments also in order to gather a clearer picture of clients.

CULTURAL COMPETENCE AND PREVENTING DIAGNOSTIC ERRORS

> *I guess her being a Jewish woman and my being a Black man made it a little difficult … she didn't have first‐hand knowledge of that community. She only had second‐hand knowledge, which she read, or what I told her, or what she heard. It was difficult for her to truly understand what I was talking about and the true level of value that I thought that it deserved.*
>
> *(Chang & Berk, 2009, p. 528)*
>
> *You shouldn't expect a lot of African American clients to be in touch with their feelings and do some real intrapsychic work. Sometimes you have to be more directive and problem‐focused in dealing with Black people.*
>
> *(Constantine & Sue, 2007, p. 146)*

Given the growing multicultural nature of the U.S. population, all mental health organizations now promote cultural competence and the ability to work effectively with diverse clients. But is it possible that this focus on cultural differences is creating unintended consequences? Is the emphasis on understanding cultural factors leading to problems such as stereotyping or the blind application of cultural information? The two quotes at the start of this section illustrate the problems that can occur when general cultural information is applied to clients without assessing for individual differences. Surprisingly, in the second case, the speaker was a supervisor giving *stereotype*‐based advice to her supervisee.

Multicultural awareness can, in fact, lead to *diagnostic overshadowing* if a clinician's attention to race or other diversity characteristics results in neglect of important aspects of the client (Vontress & Jackson, 2004). This tendency is increased in workshops and classes that focus primarily on the memorization of cultural information (Kissinger, 2014). As clinicians working with diverse populations, we need to consider all aspects of each client's life and not automatically assume that presenting problems are based on racial or diversity issues. In fact, it would be irresponsible for a clinician to focus on a client's diversity or environmental stressors when there are other significant concerns (Weinrach & Thomas, 2004).

Some mental health professionals have argued that the emphasis on culture and the development of culture‐specific approaches have led to fragmentation, confusion, and controversy in the field of counseling and psychotherapy. Diversity training has been accused of producing "professionally sanctioned stereotyping," in which the therapist gives primary consideration to cultural attributes rather than focusing on understanding the uniqueness and life circumstances of the individual client (Freitag, Ottens, & Gross, 1999; Sue & Sue, 2013). Although it is important to understand group‐specific differences, it is equally critical that we avoid a "cookbook" approach, in which the characteristics of different groups are memorized and applied to all clients who belong to a specific group (Lee, 2006).

Do guidelines for increasing cultural competence (e.g., increasing knowledge about different cultural groups and developing multicultural clinical skills) contribute to assessment errors, such as confirmatory bias, *diagnostic overshadowing*, and stereotyping? These errors certainly can happen, and are most likely to occur when clinicians fail to use self‐correcting strategies or fail to consider the individuality of each client. It is our belief that effective *culturally relevant assessment* can, in fact, minimize the dangers of stereotyping or of placing inordinate weight on race or other diversity issues.

Cultural Self‐Awareness

Self‐awareness is important with respect to both cultural competency and evidence‐based practice (EBP). Therapists may be unaware that *stereotypes* are affecting their views and/or responses to clients or that differences between themselves and their clients are affecting the therapeutic process. For example, studies have found that mental health professionals may pathologize clients who display nontraditional gender role behavior (Seem & Johnson, 1998) and may rate female clients as less competent than males (Danzinger & Welfel, 2000).

Such judgments (or inferential errors) constitute deviations from cultural competence and the EBP model of self‐reflection and awareness regarding the impact of one's values and beliefs. Identifying one's biases or taking the time to self‐reflect can help reduce such errors. Questions such as, “Which of my identities allow me to experience privilege?”, “Which identities expose me to oppression?”, and “How do I feel about these experiences?” can help clinicians reflect on how their own backgrounds and experiences have shaped their worldviews (Singh & Chun, 2010, p. 36).

Further, we need to develop an awareness of our assessment processes and identify our values, theoretical orientations, and beliefs about different groups whose social, cultural, or ethnic backgrounds differ from our own. We might ask such questions as, “Do I hold assumptions about gender roles, sexual orientation, older individuals, political philosophy, or ‘healthy’ family structure that may influence my clinical judgment?” and “Do I hold certain *stereotypes* or impressions of the client or the cultural groups to which the client belongs?”. Such self‐assessment is a necessary step in working with clients who differ from us and is an important component of counselor competence (Ridley, Mollen, & Kelly, 2011).

Cultural Knowledge

The knowledge component of cultural competence involves the awareness of different worldviews (e.g., that the majority of cultures in the world have a collectivistic and interdependent orientation; that the structure of some families is hierarchical in nature). Such knowledge is crucial in working with ethnic minority populations. For example, cultural knowledge is useful in helping counselors understand potential family patterns among different ethnic minority populations; such information can be particularly helpful when patterns differ from the family and relationship structure typical of White American families. However, these descriptions are “modal” cultural characteristics and may or may not be applicable to a particular client. Knowledge also involves the awareness that significant within‐group differences can exist—individuals can vary, for example, in degree of acculturation, level of identification with cultural values, and unique personal experiences.

Cultural information should not be applied rigidly; it is necessary to determine the degree of fit between the general cultural information described in the special population chapters in this book and the individual client in front of us. Gone (2009), for example, points out that it is not enough to know that a client is American Indian; you need to ask, “What kind of Indian are you?” In other words, you need to learn what tribe the client is affiliated with (if any), the nature of their connection with the tribe, and, if the client is closely connected, the particular values and practices of the tribal culture. Among ethnic minorities, within‐ and between‐group differences are quite large—some individuals and families are quite acculturated, while others retain a more traditional cultural orientation. Cultural differences, such as the degree of assimilation, socioeconomic background, family experiences, and educational level, affect each individual in a unique manner. Additionally, one's intersecting identities influence one's lived experiences. For example, a bisexual first‐generation Mexican American woman's

experience with depression is most likely shaped through the interconnection of sexual orientation, gender, generation status, and ethnic - culture.

Knowledge of cultural values and potential identity - related experiences associated with specific groups can help us generate hypotheses about the manner in which a client (or family members) might view a disorder or presenting concern. However, the accuracy of such cultural hypotheses must be assessed for each client. Thus, it is critical that we communicate with the client in order to confirm or disconfirm any hypotheses generated from our cultural "knowledge." Cultural "knowledge" requires not only that we be open to the worldviews of others, but that we take care to remember that every client has a unique life story.

Culturally Responsive or Multicultural Skills

Cultural responsiveness requires that counselors effectively apply a variety of helping skills when forming a *therapeutic alliance*. As discussed in Chapter 9 on Multicultural Evidence - Based Practice, it is important to individualize the choice of helping skills and avoid a blind application of techniques to all situations and all populations. Our manner of developing an effective therapeutic bond will differ from individual to individual and perhaps from ethnic group to ethnic group. It is important to individualize relationship skills and to consistently evaluate the effectiveness of our verbal and nonverbal interactions with the client. As discussed later in this chapter, culturally responsive or multicultural skills incorporate the entire therapy process from case conceptualization to treatment intervention. Applying cultural awareness and knowledge in the clinical assessment process—where the clinician listens deeply to and encourages client collaboration in understanding the presenting concern—is one way to demonstrate multicultural skills.

In summary, errors in assessment can occur because of biases, mistakes in thinking, and *stereotypes* held by the clinician. In the past, assessment practices focused only on the client; potential counselor biases or inaccurate assumptions were not taken into consideration. It is now clear that effective assessment requires that therapist characteristics also be considered. Do cultural competency guidelines contribute to *stereotypes*? Some mental health practitioners believe that they do. However, we would argue precisely the opposite: if used appropriately, cultural competency and EBP guidelines that focus on awareness of one's values and biases, appropriate use of cultural knowledge, and the value of understanding the unique background and experience of each client help *prevent* stereotyping.

Video 13.2: Culturally Competent Assessment

A focus on client culture can go a long way in preventing errors in diagnosis. Clients-of-color are often misdiagnosed or over diagnosed based on similar behaviors to their White counterparts. Understanding clients through an informal lens can adjust for assessment error.

CONTEXTUAL AND COLLABORATIVE ASSESSMENT

Self‐awareness is an important first step in reducing errors in multicultural assessment. However, this is only one part of the equation. Only through close collaboration with the client can we accurately identify the specific issues involved in the presenting problem and eliminate the blind application of cultural knowledge. This is best accomplished with a *collaborative approach*, in which clients are given opportunities to share their beliefs, perspectives, and expectations, as well as their explanations of problems. If a client's belief about the presenting problem differs from that of the therapist, treatment based only on the therapist's views is likely to be ineffective. In this section, we share some approaches a therapist might use to introduce the assessment and case conceptualization process in a way that facilitates dialogue and a collaborative relationship.

> *What we are going to do today is gather information about you and the problem that brings you in for counseling. In doing so, I'll need your help. In therapy we'll work together to decide what concerns to address and what solutions you feel comfortable with. Some of the questions I ask may seem very personal, but they are necessary to get a clear picture of what may be going on in your life. As I mentioned before, everything that we discuss is confidential, with the exceptions that we already went over. I will also ask about your family and other relationships and about your values and beliefs, since they might be related to your concerns or might help us decide the best strategies to use in therapy. Sometimes our difficulties are not just due to personal issues but are also due to expectations from our parents, friends, or society. The questions I'll be asking will help us put together a more complete picture of what might be happening with you and what might be causing the symptoms you came here to address. When we get to that point, we can talk together to see if my ideas about what might be going on seem to be on the right track. If there are any important issues I don't bring up, please be sure to let me know. Do you have any questions before we begin?*

Assessment and diagnosis are critical elements in the process of devising a treatment plan. An introduction such as the one just presented helps set the stage for a collaborative and contextual intake interview. Clients are informed that family, environmental, and social‐cultural influences will be explored. With notable exceptions such as the Cultural Formulation Interview (CFI) (Lewis‐Fernández, Aggarwal, Hinton, Hinton, & Kirmayer, 2016), many clinical assessments and interviews do not consider these factors. To remedy this shortcoming, we stress the importance of both the *collaborative approach*, in which the client and the therapist work together to construct an accurate definition of the problem, and the *contextual viewpoint*, which acknowledges that both the client and the therapist are embedded in systems such as family, work, and culture. These perspectives are gaining support within various mental health professions. For example, ethical principles regarding informed consent about therapy emphasize the need to give clients the information necessary to make sound decisions and, thus, be collaborators in the therapy process (Behnke, 2004).

The importance of collaboration was also stressed in the report of the President's New Freedom Commission on Mental Health (2003), in which clients are described as “consumers” and “partners” in the planning, selection, and evaluation of services. As we have already discussed, contextualism is also important—recognizing that both therapist and client operate from their own experiences and worldviews. Just as clients may have socialization experiences or experiences with prejudice or discrimination that play a role in their presenting concerns, so might therapists hold worldviews or have had experiences that influence their

perceptions of the client or the client's issues.

Collaborative Conceptualization Model

CASE STUDY

ERICA

Erica is a biracial (North American father and Korean mother) college student who was raised in Korea. She sought counseling to relieve feelings of loneliness and anxiety at the university. Erica speaks unaccented fluent English and considers herself bicultural. When asked to describe her background and her current problem, she was reluctant to give much information. The counselor entertained the possibility that cultural constraints might be involved in Erica's difficulty to talk about mental health issues and inquired about how she would describe her problems in a Korean setting. Erica responded that in Korea people did not convey their problems to others; it would be considered selfish and self‐centered. With Erica's help, the problem was conceptualized as a conflict between Korean norms and values and those of the United States. Erica's roommates believed she was too “passive and meek” and encouraged her to be more assertive. Erica explained that in Korea people were “tuned into” her needs, so she did not need to directly verbalize them. Erica began to realize that her social anxiety and loneliness were related to differing cultural expectations and concluded that she would need to learn new ways of communicating. (Seeley, 2004)

The preceding example illustrates the importance of *collaborative assessment* and the value of obtaining clients' input regarding social and cultural elements that may be associated with their presenting problems. In what ways did Erica's counselor encourage collaboration? What were the outcomes of these efforts?

Gambrill (2005) has identified ways in which therapists can enhance the accuracy and effectiveness of assessment, conceptualization, and treatment planning. First, as we have emphasized previously, therapists need to be aware of the impact of their own values, worldviews, and beliefs on their practice. Similarly, clients' unique characteristics, values, and circumstances should always be considered. Additionally, clients should be encouraged to actively participate in the assessment and conceptualization process. In other words, case conceptualization—as well as assessment—is best done in a collaborative manner, in which therapist self‐awareness, client involvement, and the scientific method are all utilized. With this approach, the therapist and the client can choose intervention strategies that involve the integration of high‐quality research, clinical expertise, and client input.

Principles of Collaborative Conceptualization

Collaborative conceptualization (modified from Spengler, Strohmer, Dixon, & Shivy, 1995 to include client involvement) consists of the following steps:

1. *Use both clinician skill and client perspective to understand the problem*. Clinical expertise is essential in assessment, developing hypotheses, eliciting client participation, and guiding conceptualization. Therapists bring experience, knowledge, and clinical skill to this process; clients bring an understanding of their own background and their

perspective on the problem. Therapists should be aware of their own values, biases, preferences, and theoretical assumptions and how these factors might influence their work with clients.

2. *Collaborate and jointly define the problem*. Within this framework, the clinician and the client, either jointly or independently, formulate conceptualizations of the problem. A joint process generally leads to more accurate conceptualization (e.g., “Erica, can you tell me if you experienced these feelings when you were living in Korea?”, “How did your family or community make meaning of your feelings?”). In cases where definitions of the problem differ, these differences are discussed, and the agreed‐upon aspects of the problem can receive primary focus. In some cases, the therapist can reframe the client's conceptualization in a manner that results in mutual agreement.
3. *Jointly formulate a hypothesis regarding the cause of the problem*. The therapist can tentatively address possibilities concerning what is causing or maintaining the problem with questions such as, “Could the problems you are having feeling lonely and anxious be related to your relatively new life on a university campus in the United States?”, “Are your feelings related to cultural differences between you and your roommate and other students on campus?”, “Do you think your experiences are related to cultural and value differences between the United States and Korea?”, and “You mentioned before that you get really down on yourself when you feel you aren't living up to your parents' expectations. Do you think that might have anything to do with how you've been feeling lately?”. When perceptions or explanations of the problem differ, these differences can be acknowledged and an attempt can be made to identify and focus on similarities.
4. *Jointly develop ways to confirm or disconfirm the hypothesis on the problem, continuing to consider alternative hypotheses*. The therapist might say, “If your anxiety and loneliness are due, in part, to a conflict between the United States and Korean cultural values and practices, how would we determine if this is the case?”, “How can we figure out if your parents' wanting you to get all A's in college is part of what is going on?”, or “What else might be involved in your feeling anxious? What about feeling lonely? Do they always occur together?”.
5. *Test out the hypothesis using both the client and the therapist as evaluators*. The therapist might ask, “You learned new ways of communicating—did that reduce your anxious feelings or your sense of loneliness?”, “Did you make other changes sense our last session? What were they? Do you think those changes reduced your feelings of anxiety and loneliness?”, or “Did anything in your environment change sense our last session?”
6. *If the conceptualization appears to be valid, develop a treatment plan*. The therapist might say, “You mentioned you felt better when you spent some time with new friends who were also from Korea. It sounds to me like you confirmed your hypothesis that your loneliness was related to not feeling connected to people on campus. You noticed that there was little change in your mood when you practiced more direct communications with other students. Let's talk about how that important information can be used when we decide how to best treat your anxiety.”
7. *If the hypothesis is not borne out, jointly collect additional data and formulate new, testable hypotheses*. The therapist might say, “It's good we checked out the idea that there is a connection between your mood and adopting more direct communications. You mentioned that when you practiced being more direct with your peers, you felt even more anxious. Can I ask you to share some of the thoughts that were going through your

head when you were practicing these new communication skills?”

We believe it is of critical importance to go through a collaborative process such as this; therapist and client can adopt a scientific framework as they work to conceptualize the problem and then have an equal voice in evaluating the problem definition. Unless there is substantial agreement on the definition of a problem, therapeutic progress is likely to be less than optimal.

There is a movement away from relying on “practitioners' ideology” or preferences for treatment options to interventions that have received research support (Edmond, Megivern, Williams, Rochman, & Howard, 2006). As mentioned in our discussion of EBP in Chapter 9, we believe that intervention strategies should align with facilitating qualities possessed by therapists (empathy, warmth, and genuineness), client characteristics (motivation, personality, and support systems), and research ‐ based therapeutic techniques. Interventions should not be rigidly applied, but instead should be modified according to client characteristics and feedback. Consensus between therapist and client regarding the course of therapy strengthens the therapeutic relationship. In addition, using a *collaborative approach* allows clients to develop confidence that the therapist understands their issues and is using methods that are likely to achieve desired goals. Thus, collaboration improves treatment outcome by enhancing clients' hope and optimism.

Video 13.3: The Context of Assessment

Focusing on systemic issues such as environment can greatly increase and improve the validity of both formal and informal assessments. Understanding how systems within the client's sphere of existence impacts them can make assessments more reliable.

INFUSING CULTURAL RELEVANCE INTO STANDARD CLINICAL ASSESSMENTS

Increasingly, interview forms and diagnostic systems are beginning to place greater emphasis on collaboration or contextualism. Good clinical assessments incorporate the client understanding of the presenting concern or disorder, an extensive exploration of their trauma history (e.g., individual, gender, racial‐ethnic, cultural or historical, etc.) and strengths, as well as an explicit exploration of their multiple identities and the contexts in which they live (Comas‐Diaz, 2012).

Cultural Formulation Interview

> *I got to voice my opinion … what's on my mind, what's in my heart … It was beautiful … It was freeing, a weight lifted off my shoulder*
>
> *(Muralidharan et al., 2017, p. 40)*

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM‐5*) (American Psychiatric Association, 2013) acknowledges the importance of cultural influences on diagnoses such as culture‐related and gender‐related issues for each mental disorder. For effective assessment, determining the cultural context of the illness is "essential." The CFI includes an overall cultural assessment that takes into account the cultural identity of the individual; cultural conceptualizations of distress, psychosocial stressors, and cultural features of vulnerability and resilience; and cultural differences between the individual and the clinician. It consists of 16 questions "that clinicians may use to obtain information during a mental health assessment about the impact of culture on key aspects of an individual's clinical presentation and care" (American Psychiatric Association, 2013, p. 750). Similar mental health cultural assessment forms are available online (Transcultural Mental Health Centre, 2015). Muralidharan et al. (2017) conducted debriefing interviews with racial and ethnic minority veterans with psychotic disorders after they participated in a CFI. Much like the participant quoted at the beginning of this section, they all reported positive therapy engagement. Although *DSM‐5* has expanded the emphasis on the importance of cultural factors in assessment, most standard intake forms only provide cursory assessment of cultural influences.

Therapists who recognize and value the importance of a collaborative and contextual approach may decide to make modifications in standard assessment intake forms. We will suggest ways in which consideration of cultural and environmental factors can be included in or added to standard intake interviews.

Culturally Sensitive Intake Interview

Nearly everyone in the mental health field conducts diagnostic intake interviews during the first sessions. Typically, the client is informed that the assessment session is not a therapy session but rather a time to gather information in order for the therapist to get to know them and to more fully understand their concerns. The specific relationship‐building skills addressed in Chapter 9 are extremely important in the context of assessment. For example, it is important that the clinician ask questions and respond to answers in a supportive and empathetic manner.

Intake forms generally include questions concerning client demographic information, the presenting problem, the history of the problem, previous therapy, psychosocial history,

educational and occupational experiences, family and social supports, medical and medication history, and risk assessment. Many standard intake questions are focused primarily on the individual, with little consideration of situational, family, sociocultural, or environmental issues. We realize that it is difficult to modify the standard intake forms used by clinics and other mental health agencies, but consideration can be given to these contextual factors when gathering data or making a diagnosis. This section presents the common areas of inquiry found in standard diagnostic evaluations and the rationale for each (Rivas‐Vazquez, Blais, Rey, & Rivas‐Vazquez, 2001), together with suggestions for specific contextual queries that can be used to supplement them when working with ethnic minorities and other diverse populations.

- *Identifying information*. Asking about the reason for seeking counseling allows the therapist to gain an immediate sense of the client and his or her problem. Other information gathered includes age, gender, ethnicity, marital status, and referral source. It is also important to inquire about cultural groups to which the client feels connected. Clinicians should consider whether other areas of diversity, such as religion, sexual orientation, age, gender, or disability, are important in understanding the client or any of the difficulties he or she is facing. For ethnic minorities or immigrants, clinicians can inquire about the degree of acculturation or adherence to traditional values. When relevant, ask about the primary language used in the home or the degree of language proficiency of the client or family members. Determine whether an interpreter is needed. (It is important not to rely on family members to translate when assessing clinical matters.)
- *Presenting problem*. To understand the source of distress in the client's own words, obtain his or her perception of the problem and assess the degree of insight he or she has regarding the problem and its chronicity. Some questions you can consider include: What is the client's explanation for his or her symptoms? Does it involve somatic, spiritual, or culture‐specific causes? Among all groups potentially affected by disadvantage, prejudice, or oppression, does the client's own explanation involve internalized causes (e.g., internalized heterosexism among gay males or lesbians, or self‐blame in a victim of a sexual assault) rather than external, social, or cultural factors? What does the client perceive are possible solutions to the problem?
- *History of the presenting problem*. To assist with diagnostic formulation, it is helpful to have a chronological account of and perceived reasons for the problem. It is also important to determine levels of functioning prior to the problem and since it has developed, and to explore social and environmental influences. When did the problem first occur, and what was going on when this happened? Has the client had similar problems before? How was the client functioning before the problem occurred? What changes have happened since the advent of the problem? Are there any family issues, value conflicts, or societal issues involving such factors as gender, ability, class, ethnicity, or sexual orientation that may be related to the problem?
- *Psychosocial history*. Clinicians can benefit from understanding the client's perceptions of past and current functioning in different areas of living, as well as early socialization and life experiences, including expectations, values, and beliefs from the family that may play a role in the presenting problem. How does the client describe his or her level of social, academic, or family functioning during childhood and adolescence? Were there any traumas during this period? Were there any past social experiences or problems with the family or community that may be related to the current problem?

McAuliffe and Eriksen (1999) describe some questions that can be used, when appropriate, to assess social background, values, and beliefs: “How has your gender role or social class influenced your expectations and life plans?”, “Do religious or spiritual beliefs play a role in your life?”, “How would you describe your ethnic heritage; how has it affected your life?”, “Within your family, what was considered to be appropriate behavior in childhood and adolescence, and as an adult?”, “How does your family respond to differences in beliefs about gender, acculturation, and other diversity issues?”, and “What changes would you make in the way your family functions?”.

- *Abuse and trauma history*. Despite the potential importance of determining if the client is facing any harmful or dangerous situations, many mental health professionals do not routinely inquire about abuse histories, even in populations known to be at increased risk of abuse. In one study, even when the intake form included a section on abuse, less than one‐third of those conducting intake interviews inquired about this topic (Young, Read, Barker‐Collo, & Harrison, 2001). It is extremely important to address this issue, since background information such as a history of sexual or physical abuse can have important implications for diagnosis, treatment, and safety planning. The following questions involve domestic violence for women (Stevens, 2003, p. 6) but can and should be expanded for use with other groups, including men and older adults:
    - Have you ever been touched in a way that made you feel uncomfortable? Have you ever been forced or pressured to have sex?
    - Do you feel you have control over your social and sexual relationships? Have you ever been threatened by a (caretaker, relative, partner)?
    - Have you ever been hit, punched, or beaten by a (caretaker, relative, or partner)?
    - Do you feel safe where you live?
    - Have you ever been scared to go home? Are you scared now?

      If, during the intake process, a client discloses a history of having been abused and there are no current safety issues, the therapist can briefly and empathetically respond to the disclosure and return to the issue at a later time in the conceptualization or therapy process. Of course, developing a safety plan and obtaining social and law enforcement support may be necessary when a client discloses current abuse issues. Other forms of abuse and trauma should also be assessed. For example, Carter and Sant‐Barket (2015) developed a clinical assessment protocol using the Race‐Based Traumatic Stress Symptom Scale.
- *Strengths*. It is important to identify culturally relevant strengths, such as pride in one's identity or culture, religious or spiritual beliefs, cultural knowledge and living skills (e.g., hunting, fishing, folk medicine), family and community supports, and resiliency in dealing with discrimination and prejudice (Hays, 2009). The focus on strengths often helps put a problem in context and defines support systems or positive individual or cultural characteristics that can be activated in the treatment process. This is especially important for ethnic group members and individuals of diverse populations subjected to negative *stereotypes*. What are some attributes they are proud of? How have they successfully handled problems in the past? What are some strengths of the client's family or community? What are sources of pride, such as school or work performance, parenting, or connection with the community? How can these strengths be used as part of the treatment plan? Using the client's strengths has been found to lower depression

and increase happiness (Gander, Proyer, Ruch, & Wyss, 2013).

- *Medical history*. It is important to determine whether there are medical or physical conditions or limitations that may be related to the psychological problem and that should be taken into consideration when planning treatment. Is the client currently taking any medications, or using herbal substances or other forms of folk medicine? Has the client had any major illnesses or physical problems that might have affected his or her psychological state? How does the client perceive these conditions? Is the client engaging in appropriate self‐care? If there is some type of physical limitation or disability, how has this influenced daily living? How have family members, friends, or society responded to this condition?
- *Substance abuse history*. Although substance use can affect diagnosis and treatment, this potential concern is often underemphasized in clinical assessment. Because substance use issues are common, it is important to ask about drug and alcohol use. What is the client's current and past use of alcohol, prescription medications, and illegal substances, including age of use, duration, and intensity? If the client drinks alcohol, how much is consumed? Do the client or their family members have concerns about the client's substance use? Has drinking or other substance use ever affected the client's social or occupational functioning? What are the alcohol‐ and substance‐use patterns of family members and close friends?
- *Risk of harm to self or others*. Even if clients do not share information about suicidal or violent thoughts, it is important to consider the potential for self‐harm and harm to others. What is the client's current emotional state? Are there strong feelings of anger, hopelessness, or depression? Is the client expressing intent to harm him‐ or herself? Does there appear to be the potential to harm others? Have there been previous situations involving dangerous thoughts or behaviors? Asking a client a simple question such as, “How likely is it that you will hurt yourself?”, may yield accurate self‐predictions of future self‐harm (Peterson, Skeem, & Manchak, 2011).

Diversity‐Focused Assessment

Diversity considerations can easily be infused into the intake process. Such questions can help the therapist understand the client's perspective on various issues. Questions that might provide a more comprehensive account of the client's perspective include (Dowdy, 2000):

- *How can I help you?* This addresses the reason for the visit and client expectations regarding therapy. Clients can have different ideas of what they want to achieve. Unclear or divergent expectations between client and therapist can hamper therapy.
- *What do you think is causing your problem?* This helps the therapist to understand the client's perception of the factors involved. In some cases, the client will not have an answer or may present an implausible explanation. The task of the therapist is to help the client examine different areas that might relate to the problem, including interpersonal, social, and cultural influences. However, one must be careful not to impose an “explanation” on the client.
- *Why do you think this is happening to you?* This question taps into the issue of causality and possible spiritual or cultural explanations for the problem. Some clients may believe the problem is due to fate or is a punishment for “bad behavior.” If this question does not elicit a direct answer or if you want to obtain a broader perspective, you can inquire, “What does your mother (husband, family members, friends) believe is happening to

you?”

- *What have you done to treat this condition? Where else have you sought treatment?* These questions can lead to a discussion of previous interventions, the possible use of home remedies, and the client's evaluation of the usefulness of these treatments. Responses can also provide information about previous providers of treatment and the client's perceptions of prior treatment.
- *How has this condition affected your life?* This question helps identify individual, interpersonal, health, and social issues related to the problem. Again, if the response is limited, the clinician can inquire about each of these specific areas.

IMPLICATIONS FOR CLINICAL PRACTICE

Although there is increased focus on cultural relevance in assessment, difficulties in effective implementation of culturally competent practices are prevalent. Hansen et al. (2006) conducted a random‐sample survey of 149 clinicians regarding the importance of multicultural competencies and, more pertinently, whether they practiced these recommendations. Although the participants rated competencies such as “Using *DSM* Cultural Formulations,” “Preparing a Cultural Formulation,” “Using Racially/Ethnically Sensitive Data‐Gathering Techniques,” and “Evaluating One's Own Multicultural Competence” as very important, they were unlikely to actually use these competencies in their practice.

What accounts for this discrepancy between the ratings of importance of multicultural competencies and the actual use of recommended practices? We believe that a contributing factor is the continued reliance on counseling and psychotherapy practices that were developed without consideration of diversity issues or the impact of therapist qualities on assessment and conceptualization. Many intake interviews and clinical assessments continue to reflect the view that a disorder resides in the individual. Until assessment questionnaires systematically include specific questions such as those discussed in this chapter, cultural competency will receive only lip service.

Knowledge of cultural variables and sociopolitical influences affecting members of different groups can sensitize therapists to *possible* cultural, social, and environmental influences on individual clients. As you read the remaining chapters, which deal with a variety of specific populations, we hope you do not see the information as an end in itself, but rather as a means to assist you to create hypotheses when working collaboratively with clients in the assessment and conceptualization process. As we advise repeatedly throughout the chapters themselves, it is important not to stereotype clients or to overgeneralize based on the information presented. Inappropriate reliance on cultural information can lead to misdiagnosis and mistaken treatment recommendations, such as seeking treatment with a folk healer. Such problems can be minimized by combining cultural and traditional psychiatric or psychological assessments (Paniagua, 2013).

In the following chapters on diverse populations, we present their various characteristics and strengths, specific challenges of working with them, and the implications of these factors for clinical practice. It is our hope that you will refer back to this chapter for guidance as you strive to implement culturally competent practices with clients from these specific populations.

SUMMARY

Accurate assessment, diagnosis, and case conceptualization are essential for the provision of culturally appropriate treatment. Most clinicians recognize the importance of their clients' socioeconomic status, gender, and racial/cultural background. However, they often forget that their own beliefs, values, theoretical assumptions, and other biases can affect their clinical judgment. Contextual and *collaborative assessment*, which infuses cultural factors into standard intake and assessment procedures and takes into consideration the client's unique personal and cultural background, can reduce diagnostic errors.

Assessment is influenced by both client and therapist variables. Clinicians should be aware of the influence of *stereotypes*, and remain alert for common diagnostic errors. Such errors include: (a) *confirmatory strategy*—searching only for evidence or information supporting one's hypothesis; (b) *attribution errors*—holding a different perspective on the problem from that of the client; (c) *judgmental heuristics*—using quick‐decision labels or automatic associations; and (d) *diagnostic overshadowing*—minimizing the client's actual problem by attending primarily to other prominent characteristics such as age, ethnicity, or sexual orientation as causal factors. We are all susceptible to making errors, and it is important to adopt a tentative stance and test out our observations.

Culturally responsive assessment involves self‐awareness, knowledge of culturally diverse groups, specific clinical skills, and the ability to intervene at the individual, group, institutional, and societal levels. This process works best with a contextual and *collaborative approach*, acknowledging that both the client and the therapist are embedded in systems such as family, work, and culture and working with the client to develop an accurate definition of the problem, appropriate goals, and effective interventions. Steps involved in *collaborative assessment* include: (a) using both clinician skill and client perspective to understand the problem; (b) jointly defining the problem; (c) working together to formulate and evaluate a hypothesis on the cause of the problem; (d) confirming or disconfirming the hypothesis; and (e) developing a treatment plan.

Standard clinical assessment forms need to account for the cultural identity of the client, cultural conceptualizations of distress and appropriate treatment, psychosocial stressors, and any cultural differences between the client and the clinician. These diversity considerations can easily be infused into the intake process.

GLOSSARY TERMS

- Attribution error
- Collaborative approach
- Collaborative assessment
- Collaborative conceptualization
- Confirmatory strategy
- Contextual viewpoint
- Culturally responsive assessment
- Culturally sensitive intake interview
- Diagnostic overshadowing
- Judgmental heuristics
- Stereotypes
- Therapeutic alliance

REFERENCES

1. American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.

2. American Psychological Association. (2017). Multicultural guidelines: An ecological approach to context, identity, and intersectionality. Retrieved from http://www.apa.org/about/policy/multicultural‐guidelines.pdf

3. Behnke, S. (2004). Informed consent and APA's new ethics code: Enhancing client autonomy, improving client care. *Monitor on Psychology*, *35*, 80–81.

4. Carter, R. T., & Sant‐Barket, S. M. (2015). Assessment of the impact of racial discrimination and racism: How to use the Race‐Based Traumatic Stress Symptom Scale in practice. *Traumatology*, *21*(1), 32–39.

5. Chambliss, C. H. (2000). *Psychotherapy and managed care: Reconciling research and reality*. Boston, MA: Allyn & Bacon.

6. Chang, D. F., & Berk, A. (2009). Making cross‐racial therapy work: A phenomenological study of clients' experiences of cross‐racial therapy. *Journal of Counseling Psychology*, *56*, 521–536.

7. Comas‐Díaz, L. (2012). *Multicultural care: A clinician's guide to cultural competence*. Washington, DC: American Psychological Association.

8. Constantine, M. G., & Sue, D. W. (2007). Perceptions of racial microaggressions among Black supervisees in cross‐racial dyads. *Journal of Counseling Psychology*, *54*, 142–153.

9. Danzinger, P. R., & Welfel, E. R. (2000). Age, gender and health bias in counselors: An empirical analysis. *Journal of Mental Health Counseling*, *22*, 135–149.

10. Dowdy, K. G. (2000). The culturally sensitive medical interview. *Journal of the American Academy of Physicians Assistants*, *13*, 91–104.

11. Edmond, T., Megivern, D., Williams, C., Rochman, E., & Howard, M. (2006). Integrating evidence based practice and social work field education. *Journal of Social Work Education*, *42*, 377–396.

12. Freitag, R., Ottens, A., & Gross, C. (1999). Deriving multicultural themes from bibliotherapeutic literature: A neglected resource. *Counselor Education & Supervision*, *39*, 120–133.

13. Gambrill, E. (2005). *Critical thinking in clinical practice*. Hoboken, NJ: Wiley.

14. Gander, F., Proyer, R. T., Ruch, W., & Wyss, T. (2013). Strength‐based positive interventions: Further evidence for their potential in enhancing well‐being and alleviating depression. *Journal of Happiness Studies, 14*, 1241–1259.

15. Gone, J. P. (2009). A community‐based treatment for Native American historical trauma: Prospects for evidence‐based practice. *Journal of Consulting and Clinical Psychology*, *17*, 751–762.

16. Hansen, N. D., Randazzo, K. V., Schwartz, A., Marshall, M., Kalis, D., Frazier, R., …

Novig, G. (2006). Do we practice what we preach? An exploratory survey of multicultural psychotherapy competencies. *Professional Psychology: Research and Practice*, *37*, 66–74.

17. Hays, P. A. (2009). Integrating evidence‐based practice, cognitive‐behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. *Professional Psychology: Research and Practice*, *40*, 354–360.

18. Kissinger, D. (2014). Sharing the burden of intercultural stress. Retrieved from http://www.psychiatrictimes.com/cultural‐psychiatry/sharing‐burden‐intercultural‐stress

19. Lee, C. C. (2006). Ethical issues in multicultural counseling. In B. Herlihy, & G. Corey (Eds.), *ACA ethical standards casebook* (6th ed.). Alexandria, VA: American Counseling Association.

20. Lewis‐Fernández, R. E., Aggarwal, N. K. E., Hinton, L. E., Hinton, D. E., & Kirmayer, L. J. (2016). *DSM‐5® handbook on the cultural formulation interview*. Arlington, VA: American Psychiatric Association.

21. Maxie, A. C., Arnold, D. H., & Stephenson, M. (2006). Do therapists address ethnic and racial differences in cross‐cultural psychotherapy? *Psychotherapy: Theory, Research, Practice, Training*, *43*(1), 85–98.

22. McAuliffe, G. J., & Eriksen, K. P. (1999). Toward a constructivist and developmental identity for the counseling profession: The context‐phase‐stage style model. *Journal of Counseling and Development*, *77*, 267–280.

23. Mohr, J. J., Weiner, J. L., Chopp, R. M., & Wong, S. J. (2009). Effects of client bisexuality on clinical judgment: When is bias most likely to occur? *Journal of Counseling Psychology*, *56*, 164–175.

24. Muralidharan, A., Schaffner, R. M., Hack, S., Jahn, D. R., Peeples, A. D., & Lucksted, A. (2017). “I Got to Voice What's in My Heart”: Participation in the cultural formulation interview—Perspectives of consumers with psychotic disorders. *Journal of Psychosocial Rehabilitation and Mental Health*, *4*(1), 35–43.

25. Osmo, R., & Rosen, A. (2002). Social workers' strategies for treatment hypothesis testing. *Social Work Research*, *26*, 9–18.

26. Paniagua, F. A. (2013). Culture‐bound syndromes, cultural variations, and psychopathology. In F. A. Paniagua, & A.‐M. Yamada (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations* (2nd ed.) (pp. 25–48). San Diego, CA: Academic Press.

27. Peterson, J., Skeem, J., & Manchak, S. (2011). If you want to know, consider asking: How likely is it that patients will hurt themselves in the future? *Psychological Assessment*, *23*, 626–634.

28. President's New Freedom Commission on Mental Health. (2003). Achieving the promise: Transforming mental health care in America. Final report. DHHS Pub. No. SMA‐03–3832. Rockville, MD: President's New Freedom Commission on Mental Health.

29. Ridley, C. R., Mollen, D., & Kelly, S. M. (2011). Beyond microskills: Toward a model

of counseling competence. *Counseling Psychologist*, *39*, 825–864.

30. Rivas‐Vazquez, R. A., Blais, M. A., Rey, G. J., & Rivas‐Vazquez, A. A. (2001). A brief reminder about documenting the psychological consultation. *Professional Psychology: Research and Practice*, *32*, 194–199.

31. Seeley, K. M. (2004). Short‐term intercultural psychotherapy: Ethnographic. *Social Work*, *49*, 121–131.

32. Seem, S. R., & Johnson, E. (1998). Gender bias among counseling trainees: A study of case conceptualization. *Counselor Education and Supervision*, *37*, 257–268.

33. Singh, A. A., & Chun, K. S. Y. (2010). From “margins to the center”: Moving towards a resilience based model of supervision with queer people of color. *Training and Education in Professional Psychology*, *4*, 36–46.

34. Spengler, P. M., Strohmer, D. C., Dixon, D. N., & Shivy, V. A. (1995). A scientist‐practitioner model of psychological assessment: Implications for training, practice, and research. *Counseling Psychologist*, *23*, 506–534.

35. Stevens, L. (2003). Improving screening of women for violence: Basic guidelines for physicians. Retrieved from http://www.medscape.org/viewarticle/464417

36. Stewart, A. E. (2004). Can knowledge of client birth order bias clinical judgment? *Journal of Counseling and Development*, *82*, 167–176.

37. Sue, D., & Sue, D. M. (2008). *Foundations of counseling and psychotherapy: Evidence‐based practices in a diverse society*. Hoboken, NJ: Wiley.

38. Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice*. Hobboken, NJ: Wiley.

39. Transcultural Mental Health Centre. (2015). Assessment guidelines and tools. Retrieved from http://www.dhi.health.nsw.gov.au/Transcultural‐Mental‐Health‐Centre/Programs‐and‐Campaigns/GPs/Cultural‐Resource‐Kit/Assessment‐Guidelines‐and‐Tools/default.aspx

40. Vontress, C. E., & Jackson, M. L. (2004). Reactions to the multicultural counseling competencies debate. *Journal of Mental Health Counseling*, *26*, 74–80.

41. Weinrach, S. G., & Thomas, K. R. (2004). The AMCD multicultural counseling competencies: A critically‐flawed initiative. *Journal of Mental Health Counseling*, *26*, 81–93.

42. Young, M., Read, J., Barker‐Collo, S., & Harrison, R. (2001). Evaluating and overcoming barriers to taking abuse histories. *Professional Psychology: Research and Practice*, *32*, 407–414.

Note

Significant portions of this chapter are adapted from Sue & Sue (2008).

PART VI

Counseling and Therapy with Racial/Ethnic Minority Group Populations

14
Counseling African Americans

Chapter Objectives

1. **1. Learn the demographics and characteristics of African Americans.**
2. **2. Identify counseling implications of the information provided for African Americans.**
3. **3. Provide examples of strengths that are associated with African Americans.**
4. **4. Know the special challenges faced by African Americans.**
5. **5. Understand how the implications for clinical practice can guide assessment and therapy with African Americans.**

During a routine traffic stop in a suburb of St. Paul, Minnesota Philando Castile was shot seven times and killed by police officer, Jeronimo Yanez. Castile's girlfriend and her daughter were in the car at the time of the death. Neither Castile nor his girlfriend committed a crime, yet his girlfriend was handcuffed and placed in a squad car shortly after the killing. Yanez was found not guilty for the killing even though the crime was ruled a homicide and large portions of the incident were captured on video.

(Ellis & Kirkos, 2017)

The Department of Justice and the U.S. Attorney's Office investigated the Chicago Police (CPD) in the aftermath of the fatal shooting of Black teenager Laquan McDonald by Officer Jason Van Dyne. The agencies concluded that "CPD officers engage in a pattern or practice of using force, including deadly force, that is unreasonable." Officer Van Dyke was eventually found guilty of second degree murder.

(U.S. Department of Justice Civil Rights Division & U.S. Attorney's Office Northern District of Illinois, 2017, p. 5)

The African American community has consistently named police violence directed at their communities as a social problem and demanded justice and reform. The movement for Black lives reflects the most recent efforts. The current movement was initially sparked by three Black women's—Alicia Garza, Patrisse Cullors, and Opal Tometi—call to action with the use of hash #BlackLivesMatter.

(McLaughlin, 2016)

In a study of women scientists working in the fields of science, technology, engineering, and math, nearly half of African American women scientists had experienced being mistakenly identified as custodial or administrative staff as compared to one - third of white women scientists. African American women attributed the incidents as because of their race while white women believed that it was because of their gender.

(Williams, Phillips, & Hall, 2014)

African Americans have a history of advocating for justice and democracy. In the close 2017 Alabama senate race between Roy Moore (someone accused of sexual misconduct with underage girls and who espoused racist, sexist, homophobic sentiments) and Doug Jones (U.S. Attorney who prosecuted KKK members responsible for the church bombing killing 4 Black girls), African Americans were largely responsible for Moore's defeat. There was a high voter turn out, with 96% of African Americans voting for Jones (98% of women and 94% of men).

(Bowerman, 2017)

The preceding scenarios illustrate the social conditions facing many African Americans and the community's resilience and contributions to U.S. society. The African American population was 46.3 million in 2015, representing about 13% of the total population (U.S. Census Bureau, 2017). Overall, African Americans' economic health is significantly less stable than that of the general U.S. population. For example, the poverty rate for African Americans remains nearly twice as high as that of all households (25.4% versus 14.7%) (U.S. Census Bureau, 2017), and the unemployment rate is over twice that of White Americans (9.5% versus 4.6%) (U.S. Department of Labor, 2015). There is also a wealth gap, with Whites having a net worth 13 times greater than African Americans (Pew Research Center, 2016). Of African American men, 38% are experiencing downward mobility out of the middle class, compared with 21% of White men (Acs, 2011). Further, infant mortality for Blacks is over twice that of Whites (Centers for Disease Control, 2013), and the lifespan of African Americans is 5–6 years shorter than that of White Americans. Although African Americans make up only 13% of the U.S. population, 40% of those incarcerated are Black, while Whites, who make up 64% of the population, account for only 39% of those in prison (Hagler, 2015). African American women are also more likely to be arrested than Latinas or White women (Brame, Bushway, Paternoster, & Turner, 2014).

Although these statistics are grim, much of the literature is based on the economically disadvantaged rather than on other segments of the African American population (Holmes & Morin, 2006). This focus on those living in poverty masks the great diversity that exists among African Americans and the significant variance in socioeconomic status, educational level, cultural identity, family structure, and reactions to *racism*. For example, 38% of African American households are middle income and 12% are upper income, compared with 44% and 26% of White households, respectively (Parlapiano, Gebeloff, & Carter, 2015). Many middle - and upper - class African Americans embrace the values of the dominant society, believe that advances can be made through hard work, feel that race has a relative rather than a pervasive influence on their lives, and take pride in their heritage. As Hugh Price, former president of the National Urban League, observed, “This country is filled with highly successful Black men who are leading balanced, stable, productive lives working all over the labor market” (Holmes & Morin, 2006, p. 1). However, even among this group of successful African American men earning $75,000 a year or more, six in ten reported being victims of *racism* and having someone close to them murdered or incarcerated.

CHARACTERISTICS AND STRENGTHS

In the following sections, we consider the characteristics, values, and strengths of African Americans and their implications in treatment. African Americans are becoming increasingly heterogeneous in terms of ethnic and *racial identity*, social class, educational level, and political orientation, so it is important to remember that the following are generalizations; their applicability needs to be assessed for each client.

Racial and Ethnic Identity

Racial identity attitudes play a role in African Americans' mental and physical health. Cross' (1991, 1995) nigrescence model, as outlined in Chapter 11, describes movement from a raceless identity to a positive, internalized Black identity. Cross identifies the statuses of preencounter, encounter, immersion‐emersion, and internalization. These statuses are associated with differences in perspective regarding the self and relationships with others, including the acceptance of White standards and deprecation of Black culture and an appreciation of both Black culture and aspects of the White culture. An individual's level of *racial identity* affects awareness of and willingness to discuss racial issues or *racism* (Forsyth, Hall, & Carter, 2015).

Implications

African Americans who have attitudes and behaviors consistent with the preencounter level are less likely to report racial discrimination, whereas those in the immersion stage tend to be least satisfied with societal conditions. African Americans with the greatest internalization of Black‐multicultural *racial identity* report the highest psychological adjustment (Telesford, Mendoza‐Denton, & Worrell, 2013). African American preferences for counselor ethnicity are often related to their current stage of *racial identity*. Parham and Helms (1981) found that African Americans with higher preencounter attitudes preferred a White counselor, whereas those in later stages preferred an African American counselor. In a study involving 128 Black college students, over 75% had no preference regarding the race of the counselor for issues such as depression, anxiety, drug or alcohol problems, meeting new people, overcoming loneliness, and dealing with anger. However, 50% indicated preference for a Black counselor for racial issues and problems with personal relationships. Elevated *cultural mistrust* and strong internalized *Afrocentric* attitudes were associated with a stronger preference for a Black counselor (Townes, Chavez‐Korell, & Cunningham, 2009).

Often, the most important counselor characteristic for African Americans is the cultural sensitivity of the counselor. Culturally sensitive counselors (those who acknowledge the possibility that race or culture might play a role in a client's problem) are seen as more competent than culture‐ or color‐blind counselors (those who do not assess for environmental issues such as *racial prejudice*) (Gushue, Walker, & Brewster, 2017; Want, Parham, Baker, & Sherman, 2004). Among a group of working‐class African American clients, the degree of therapeutic alliance with White counselors was affected not only by the client's *racial identity* attitudes but also by similarities in gender, age, attitudes, and beliefs. Additionally, clients facing issues related to parenting, drug use, or anxiety looked for therapists with understanding of these specific issues (Ward, 2005).

Family Structure

African American family structure is complicated and consists of the nuclear and the

extended family. Blood relatives and fictive kin (close family friends) play important roles in promoting the health and well‐being of the family unit. In terms of traditional indicators of family, about 45% of African American households are headed by married couples (U.S. Census Bureau, 2017). Although there has been a significant decline in nonmarital births in the United States across racial and ethnic groups, African Americans have the highest birth rate among nonmarried women, at 69.8% (Centers for Disease Control, 2018). African American children are more likely to live in a household with a grandparent present (5.6%) compared to White American children (2.6%) (U.S. Census Bureau, 2016). Given the varied structure of African American families, it is important to take into account *kinship bonds* with *extended family* and friends, as illustrated in the following case study.

CASE STUDY

JOHNNY

A mother, Mrs. J., brought her 13‐year‐old son Johnny in for counseling due to recent behavioral problems at home and in school. After asking, “Who is living in the home?” the therapist learned that Johnny lived with his mom, a stepfather, and five brothers and sisters. Also, the mother's sister, Mary, and three children had been staying with the family while their apartment was repaired. The mother also had a daughter living with an aunt in another state. The aunt was helping the daughter raise her child. When asked, “Who helps you out?” Mrs. J. responded that her mother sometimes helps watch the children but that, more frequently, a neighbor (who has children of a similar age) watches the younger children when Mrs. J. works during school hours.

Further questioning revealed that Johnny's problem developed soon after his aunt and cousins moved in. Before this, Johnny had been his mother's primary helper and took charge of the children until the stepfather returned home from work. The changes in the family structure that occurred when the sister and her children arrived were stressful for Johnny. Family treatment included Mrs. J. and her children, the stepfather, Mary and her children, and Mrs. J.'s mother. Pressures on Johnny were discussed, and alternatives were considered. Mrs. J.'s mother agreed to invite Mary and her children to come live with her temporarily. To deal with these additional disruptions in the family, follow‐up meetings focused on clarifying roles in the family system. Johnny once again assumed the role of helping his mother and stepfather watch the younger children. Within a period of months, his behavioral problems at home and in school disappeared.

Implications

Because of the possibility of the complexity of the family arrangements, questions should be directed toward clarifying who is living in the home and who helps with childcare. Therapists should work to strengthen and increase functionality of the existing family structure rather than attempt to change it. One of the strengths of the African American family is that men, women, and children are allowed to adopt multiple roles within the family. For example, as in the case of Johnny, older children might adopt a caretaking role, and friends or grandparents might help raise children. In such cases, therapy might focus on enhancing the working alliance among caregivers (Muroff, 2007).

A counselor's reaction to a client's family structure may be affected by a Eurocentric, nuclear‐family orientation. Similarly, many assessment forms and evaluation processes are based on a middle‐class European American perspective of what constitutes a family. For

family therapy to be successful, counselors must first identify their own set of beliefs and values regarding appropriate roles and communication patterns within a family and take care not to impose these beliefs on other families. Similarly, it is helpful to move away from a deficit model to an asset or strengths perspective when evaluating families (Rockymore, 2008). For example, a supportive parenting style that includes warmth, communication, and consistent discipline appears to be protective against drug use by African American youth (Gibbons et al., 2010). However, physical discipline or critical comments, unless unduly harsh, should not necessarily be viewed negatively; each situation should be assessed individually. Culturally sensitive parent education programs designed for African Americans focus on different types of discipline, single parenting, and strategies for dealing with culture conflicts and responding to *racism*. In working with African American families living in high concentrations of poverty, the counselor may need to assume various roles, including advocate, case manager, problem solver, and facilitating mentor, and to help the family navigate community systems, including the educational or judicial system.

Spiritual and Religious Values

CASE STUDY

Dee

Dee is a 42 - year - old African American woman recently divorced after 20 years of marriage and raising two children with little support from her ex - husband. She presented with depressive - like symptoms—feelings of loneliness, lack of energy, lack of appetite, and crying spells … Although part of the treatment focused on traditional psychological interventions, such as cognitive restructuring, expression of feelings, and changing behaviors, D.'s treatment also included participation in two church - related programs, including the women's ministry, a program that provides social and emotional support. Treatment also included participation in “The Mother to Son Program,” a program targeting single mothers parenting African American boys. This program provides support for mothers and mentoring relationships for their sons. (Queener & Martin, 2001, p. 120)

Implications

Religion and spirituality are important to many African Americans, like Dee, and serve as a protective factor in response to stressors; church participation provides comfort, economic support, and opportunities for self - expression, leadership, and community involvement. Over 75% of African Americans state that religion is very important to them and rely on religious and spiritual communities to deal with mental health issues (Avent & Cashwell, 2015). Among a sample of low - income African American children, those whose parents regularly attended church had fewer problems (Christian & Barbarin, 2001). Support systems connected with the church (including friends and club involvement) were found to promote resilience in African American undergraduates exposed to racial microaggressions (Watkins, Labarrie, & Appio, 2010). The African American church often functions as a religious, social, and political hub, facilitating social events that serve to foster a sense of “peoplehood” (Boyd - Franklin, 2010).

If a client is heavily involved in church activities or has strong religious beliefs, the counselor might consider enlisting church leaders to help them (or their family) deal with social and

economic stressors or conflicts involving the family, school, or community. Church personnel are often aware of the family dynamics and living conditions of parishioners. In addition, churches often sponsor parenting programs or activities that enrich family life.

Educational Characteristics

CASE STUDY

JACKIE

Jackie, a 10‐year‐old African American girl, came in with her mother presenting with anger problems, low mood, suicidal thoughts, and family discord. She had always been a stellar student, but her grades had begun to fall from straight As to Bs and Cs. Jackie notes that “she is not smart enough to keep up with the other kids.”

(Muroff, 2007, p. 131)

Implications

African American parents, acutely aware of obstacles produced by *racism* and economic conditions, often encourage their children to develop career and educational goals at an early age. In one study of 1,225 school‐aged African American males (6th to 10th graders), 62% aspired to go to college, similar to rates for White male students. Black males with plans to attend college frequently reported positive feelings about their school and teachers (Toldson, Braithwaite, & Rentie, 2009). Although gains have been made, the gap in high school graduation between African American and White children persists. In the 2014–2015 school year, the adjusted cohort graduation rate for African Americans was 75%, compared to 88% for White Americans (NCES, 2017). Similarly, more and more Black Americans are going to college, but they have different college experiences and graduation rates compared to their White counterparts. Black students are much more likely to attend a 2‐year institution or go to college part time and less likely to graduate from a 4‐year institution in 6 years (Casselman, 2014); about 20.6% of Black students who entered college in 2009 earned their degree, compared to 44.2% of White students (NCES, 2017).

The educational environment is often negative for African American youth. They are two to five times more likely to be suspended from school, and often receive harsher consequences than their White peers (Rudd, 2014). School personnel often hold stereotypes of African American parents as being neglectful or incompetent and blame children's problems on a lack of parental support for schooling. As one teacher stated, “The parents are the problem! They [the African American children] have absolutely no social skills, such as not knowing how to walk, sit in a chair, … it's cultural” (Harry, Klingner, & Hart, 2005, p. 105); but when researchers visited the homes of parents who were criticized, they often observed parental love, effective parenting skills, and family support for education.

When working with African American school‐age youth around academic performance, it is thus important to consider the ways in which teacher low expectations and school policies and practices may inadvertently discriminate against Black youth. A lot of national attention has rightly focused on Black boys' experiences in schools. Unfortunately, the experiences of Black girls, like Jackie, have been left out of this discourse. Black girls are being marginalized in the classroom, and in some instances pushed out of school altogether (Morris, 2016). In addition to significant racial disparities in expulsion rates, Black girls experience vulnerabilities that undermine their school attendance and educational opportunities. They

receive less attention than their male counterparts, and schools often do not intervene in situations of sexual harassment; additionally, Black girls report feeling uncomfortable with security protocols at schools (Crenshaw, Oce, & Nanda, 2015). Psychological interventions should consider the contexts in which youth operate and identify individual and system‐level changes.

African American Youth

CASE STUDY

MICHAEL

> Michael is a 19‐year‐old African American man brought to counseling by his aunt, Gloria, with whom he has lived for the past 2 years. Gloria is concerned about Michael's future … Although Michael graduated from high school and is employed part‐time at a fast‐food restaurant, he is frustrated with this work and confused about his future. He believes that Black men “don't get a fair shake” in life and is discouraged about his prospects about getting ahead … Michael's aunt … is concerned that Michael's peers are involved in gangs and illegal activities. She thinks the rap music he listens to is beginning to fill his head with hate and anger … Michael's major issues center around a need to develop a positive identity as an African American man and discover his place in the world.
>
> (Frame & Williams, 1996, p. 22)

Frame and Williams (1996) suggested several strategies for working with African American youth such as Michael. The first is based on the African tradition of storytelling and involves the use of metaphors. In response to statements like, “Black men don't get a fair shake,” counselors can encourage clients to identify family phrases or Biblical stories that instill hope. Additionally, the writings of prominent African Americans can be used to generate metaphors. To assist Michael with his struggle to overcome societal barriers, he could be encouraged to envision himself as a crusader for human rights as a socially appropriate way of directing his anger. The counselor could also engage Michael in discussions about rap music; issues addressed in the lyrics could be explored, as well as healthy outlets for feelings of anger or despair. Family and community support for Michael could be generated by including *extended family*, the pastor, teachers, and other important individuals in Michael's life and encouraging them to discuss their own struggles and search for identity. Use of techniques such as these, derived from African American experiences, can lead to personal empowerment.

In counseling African American girls, issues involving *racial*, *gender*, and *racial‐gender identity* should be explored. Counselors can help African American girls and women counteract negative images associated with being Black and being female. Enhancing their internal strength by developing their pride and dignity in Black womanhood can serve as a buffer to *racism* and sexism, can prevent the incorporation of negative images into their belief systems (Owens, Stewart, & Bryant, 2011), and can improve their psychological well‐being (Lewis, Williams, Peppers, & Gadson, 2017).

Cultural Strengths

Protective factors and strengths among African Americans include positive ethnic identity or

racial pride; resourcefulness and coping skills to deal with societal issues; familial, extended kin, and community support systems; flexible family roles; achievement orientation; and spiritual beliefs and practices (Kaslow et al., 2010; LaTaillade, 2006). Family and religious protective factors have been hypothesized to account for findings that African Americans have lower levels of heavy and binge drinking than any other ethnic group, with the exception of Asian Americans (Substance Abuse and Mental Health Services Administration, 2013). Additionally, African American adolescents have low rates of substance use compared to Whites and other ethnic groups (Johnston, O'Malley, Miech, Bachman, & Schulenberg, 2014).

The African American family structure has many advantages. Among families headed by females, the rearing of children is often undertaken by a large number of relatives, older children, and close friends. For many, the *extended family* network provides emotional and economic support. African American families are characterized by flexibility in family roles, strong *kinship bonds*, a strong work and achievement ethic, and a strong religious orientation (McCollum, 1997; Rockymore, 2008). Kinship support diminishes risks of internalizing or externalizing problem behaviors in children and can ameliorate conditions such as poor parenting (Taylor, Larsen‐Rife, Conger, Widaman, & Cutrona, 2010). Among low‐income single mothers, many display substantial parenting involvement and emphasize achievement, self‐respect, and racial pride with their children.

Despite the challenges of *racism* and *prejudice*, many African American families have been able to instill positive self‐esteem in their children by means of role flexibility. African American men and women value behaviors such as assertiveness. Compared to White American families, African American men are more accepting of women's work roles and are more willing to share in the family responsibilities traditionally assigned to women. Many women demonstrate a “Strong Black Woman” image that includes pride in *racial identity*, self‐reliance, and capability in handling challenges—all while nurturing the family. Although self‐efficacy can be a strength, excessive investment in meeting the expectations of such a role can lead to emotional suppression and increased vulnerability to stress (Donovan & West, 2015; Harrington, Crowther, & Shipherd, 2010).

SPECIFIC CHALLENGES

In the following sections, we consider challenges often faced by African Americans and consider their implications in treatment.

Racism and Discrimination

Racism and discrimination are significant concerns within the African American community. As former President Obama observed during his eulogy for Rev. Clementa Pinckney and eight of his congregants who were shot to death by a White supremacist, racial bias can be evident or may occur without realization, such as "the subtle impulse to call Johnny back for a job interview—but not Jamal" (Moser, 2015). A study by Bertrand and Mullainathan (2004) found that résumés with either African American or White ‐ sounding names (Lakisha and Jamal versus Emily and Greg) sent to help ‐ wanted ads received a differential response. The "White" names received 50% more calls for interviews.

African Americans perceive both subtle and direct forms of *racism* in the United States. Whereas a little over half of Whites (53%) believe Blacks have equal societal opportunities, 88% of Blacks believe more change is necessary (Pew Research Center, 2016). Due in part to the deaths of unarmed Black people at the hands of the police, 84% of Americans believe that Blacks are treated unfairly by police (Pew Research Center, 2016). A movement for Black lives has arisen to take a stand against police brutality and the anti ‐ Black *racism* in society. In response to the tragedy involving Sandra Bland, whose stop for changing lanes without signaling resulted in a sequence of events that ended with her death, U.S. Attorney General Loretta Lynch remarked,

> *I think that it highlights the concern of many in the Black community that a routine stop for many of the members of the Black community is not handled with the same professionalism and courtesy that other people may get from the police.*
>
> *(Glum, 2015)*

The specific Black Lives Matter movement points out that Black people are singled out and "intentionally left powerless at the hands of the state … and are deprived of basic human rights and dignity" (Black Lives Matter, 2015). This movement is gaining strength nationally and challenging instances of *racism* against African Americans.

Consciously or unconsciously, many people associate African Americans with crime and favor harsher punishments for African Americans. The media perpetuates the perception of African Americans as criminals. A recent study found that Black families were significantly more likely to be portrayed by various media outlets as dependent, dysfunctional, and criminal than were White families (Dixon, 2017); for example, although African Americans constitute about 27% of those arrested and charged with a crime, they make up 37% of news stories about those who have committed crimes. It is no surprise that individuals internalize these ubiquitous messages. In research studies, Whites, when primed to think about crime, focused their attention on Black rather than White faces and were more likely to identify blurry images as weapons when exposed to Black faces. When Whites read descriptions of a juvenile offender convicted of rape, they supported harsher sentences when he was described as Black (Weir, 2014). In a study involving African American defendants who were convicted of killing White victims, Eberhardt, Davies, Purdie ‐ Vaughns, & Johnson (2006) found that defendants with darker skin and broader noses were twice as likely to receive the death penalty compared to those who looked less stereotypically Black. Similarly, Viglione, Hannon, and DeFina (2011) found that African American women with lighter skin received

shorter sentences than those with darker skin who committed similar crimes.

Youth with an incarcerated parent have increased risk of poverty, school failure, emotional distress, criminal activity, and drug use. This effect can further exacerbate the cycle of racial inequality, substance abuse, and imprisonment (Roettger, Swisher, Kuhl, & Chavez, 2011). The experience of perceived racial discrimination is associated with decreased levels of self‐esteem and life satisfaction and increased depressive symptoms in African American and Caribbean Black youth (Seaton, Caldwell, Sellers, & Jackson, 2011). Some African American adolescents report drug use as a way of coping with feelings of anger in reaction to racial discrimination (Gibbons et al., 2010).

African American parents differ in the ways in which they address *racism* with their children. Some address *racism* and *prejudice* directly and help their children to develop a strong Black identity, whereas others consider race to be of minor importance, ignore the topic of race, and focus on human values or discuss the issue only if it is brought up by their children. *Racial socialization* can help buffer the negative effects of *racism* and discrimination (Lee & Ahn, 2013). In homes where race is not discussed, children have fewer opportunities to develop coping strategies when faced with discrimination. Similarly, protective factors for African American youth include a parental focus on increasing positive feelings about self and enhancing a sense of pride in one's culture (Belgrave, Chase‐Vaughn, Gray, Addison, & Cherry, 2000). Messages of cultural pride from parents are associated with the development of positive ethnic identity, self‐esteem, and socioemotional competence in African American children (Rodriguez, McKay, & Bannon, 2008). Therapists may decide to discuss the positive benefits of *racial socialization* with African American parents. The American Psychological Association's RESilience initiative has produced several resources to help therapists and parents uplift “youth through healthy communication about race” (American Psychological Association, n.d.).

Implications

Since the mental health environment is a microcosm of the larger society, mental health professionals need to identify their own racial attitudes and be ready to address mistrust from African American clients concerned about being viewed through the lens of a stereotype (Jordan, Lovett, & Sweeton, 2012). Therapists should carefully assess both the problems confronting a client and the client's response to the problem situation, including the way he or she usually deals with *racism*, with the understanding that the expression of racism may differ depending on the person's gender, class position, sexual orientation, and religion.

Jones (1985) described four interactive factors that should be considered in working with African American clients (see Figure 14.1). The first is racial oppression. Most African Americans have faced *racism*, and the possibility that this factor plays a role in the presenting problem should be examined. Other interactive factors described by Jones include the possible influence of African American culture and traditions on the client's behavior, the degree to which the client has adopted majority culture values, and the client's personal experiences. Individual experiences with racial oppression can vary significantly among African Americans. The task of the therapist is to help the client understand the effects of such experiences and allow this understanding to guide conscious, growth‐producing choices.

IMPLICATIONS FOR CLINICAL PRACTICE

The first therapy sessions are crucial in determining whether a client will return. African

Americans have a high rate of therapy termination (Fortuna, Alegria, & Gao, 2010). Termination often reflects a counselor's inability to establish an effective therapeutic alliance. Prior experiences may render issues of trust very important. The counselor can deal with these issues by discussing them directly and by being open, authentic, and empathetic. Clients often make a decision regarding continuation of therapy based on their personal evaluation of the counselor. As one African American client stated, “I am assessing to see if that person [counselor] is willing to go that extra mile and speak my language and talk about my Blackness” (Ward, 2005, p. 475). Counselors may need to have a broader role and more flexible style, including being more direct, serving in an educative function, and helping the client deal with agencies or with issues involving health and employment. Although the order of these elements can be modified and some can be omitted, these steps may be helpful to the counselor and the client:

1. *Understand that power and privilege can affect counseling*. During the first session, it may be beneficial to bring up the reaction of the client to the session. Makes statements such as, “Sometimes clients feel uncomfortable working with a counselor of a different race. Would this be a problem for you?” Or, when the counselor is Black, “Clients have different responses to the race of their counselor, what does it mean to you to have a counselor who is also Black?” Be open if the client discusses any experiences with *racism* or discrimination, or if they indicate that race does not matter.
2. *Recognize that there is great diversity among African Americans*. Assess the clients' values and preferences by identifying their expectations and worldview and what they believe counseling entails. Explore their feelings about counseling. Determine how they view the problem and possible solutions.
3. *If clients are there involuntarily, discuss how counseling can be made useful for them*. Explain your relationship with the referring agency and the limits of confidentiality.
4. *Assess the positive assets of the client*, such as personal strengths, family (including relatives and nonrelated friends), and available community resources (including the church).
5. *Help the client define goals and appropriate means of attaining them*. Assess ways in which the client, family members, and friends have handled similar problems successfully.
6. *After the therapeutic alliance has been formed, collaboratively determine interventions*. Consider culturally adapted evidence‐based therapies that have been found to be effective with African Americans. Problem‐solving and time‐limited approaches may be most acceptable. Analysis of the client's *racial identity* and family can be helpful in deciding if alternative treatment modes and approaches might be beneficial.
7. *Determine any external factors that might be related to the presenting problem*. Determine whether and how the client has responded to discrimination and *racism*, in both unhealthy and healthy ways. Do not dismiss issues of *racism* as “just an excuse”; instead, help the client address issues of discrimination and identify productive means of dealing with such problems.
8. *Examine issues around racial identity*, taking into account that many clients at the preencounter stage will not believe that race is an important factor. For some, increased *Afrocentric* identification will be important in establishing a positive self‐identity. In these cases, elements of African/African American culture can be incorporated in counseling through readings, movies, music, and discussions of prominent African

Americans.

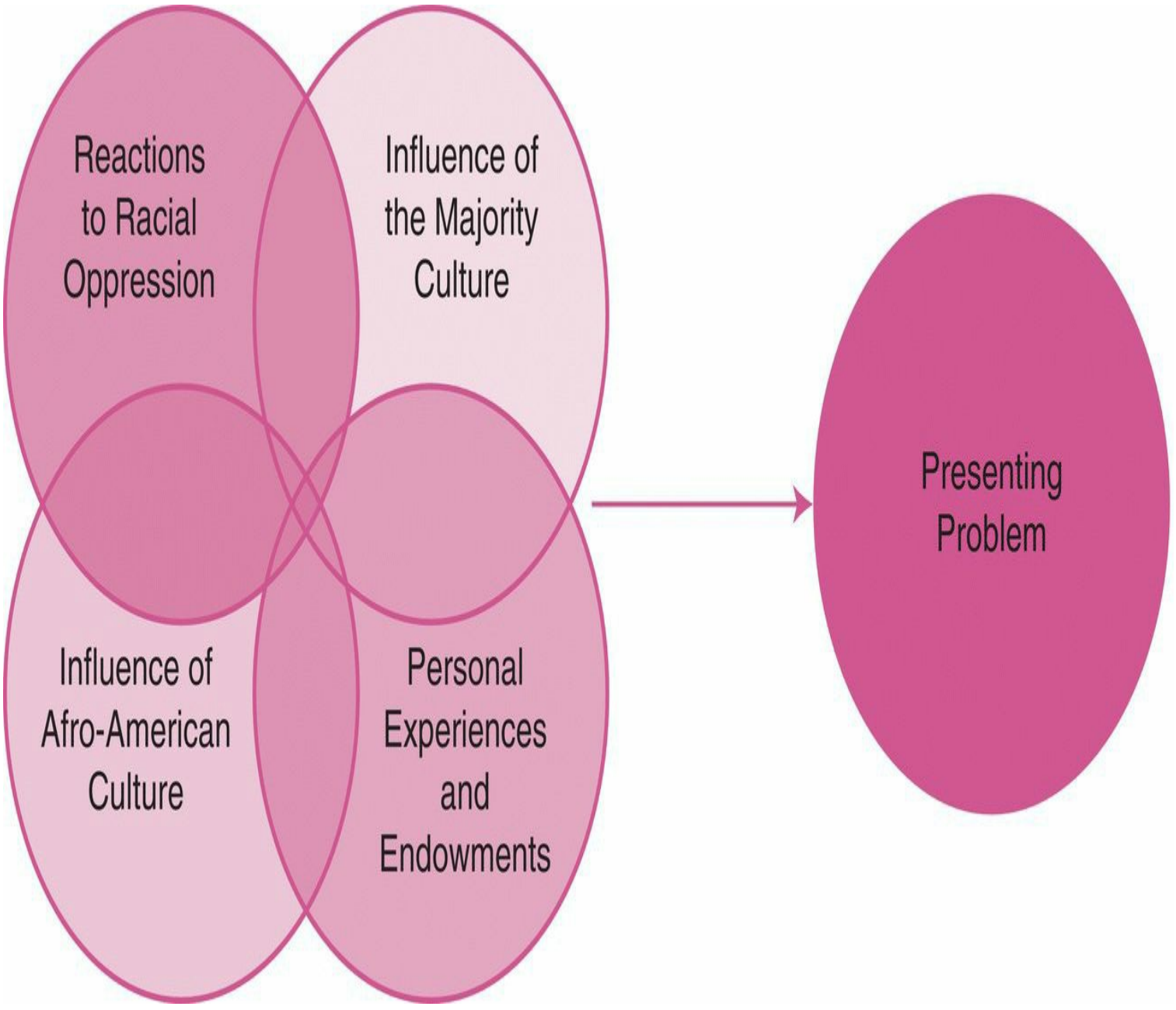

FIGURE 14.1 The Interaction of Four Sets of Factors in the Jones Model

Source: Jones, A. C. (1985). Psychological functioning in Black presenting Americans: A conceptual problem guide for use in psychotherapy. *Psychotherapy*, 22, 367. Copyright 1982 *Psychotherapy*. Reprinted with permission

Select this link to open an interactive version of Figure 14.1

Video Lecture: Culturally Competent Counseling: Innovative Approaches to Counseling African Descent People by Thomas Parham

SUMMARY

African Americans represent approximately 13% of the U.S. population. On nearly all measures of education, employment, earnings, and psychological and physical health, they experience a standard of living much below their White counterparts. Individual, institutional, and cultural *racism* accounts for many of these disparities. The life experience of African Americans affects the manifestation of mental disorders and the therapeutic process. To work effectively with African American clients, therapists must be knowledgeable of their characteristics and strengths. Ethnic and *racial identity*, family structure, spiritual and religious values, education characteristics, and the experiences of Black youths all suggest important dimensions to consider in counseling African Americans. An important aspect of cultural competency with African Americans is the recognition of protective factors and the strengths that have allowed them to survive in an intolerant society. Eight clinical implications for counselor practice are identified.

GLOSSARY TERMS

- Afrocentric
- Cultural mistrust
- Extended family
- Kinship bonds
- Prejudice
- Racial identity
- Racial socialization
- Racism
- Spirituality
- Strong Black woman

REFERENCES

1. Acs, G. (2011). Downward mobility from the middle class: Waking up from the American dream. Retrieved from https://www.urban.org/sites/default/files/publication/24856/1001603 - downward - mobility - from - the - middle - class - waking - up - from - the - american - dream.pdf

2. American Psychological Association (n.d.). RESilience booster: Parent tip tool. Retrieved from: http://www.apa.org/topics/parenting/resilience - tip - tool.aspx

3. Avent, J. R., & Cashwell, C. S. (2015). The Black church: Theology and implications for counseling African Americans. Retrieved from http://tpcjournal.nbcc.org/the - black - church - theology - and - implications - for - counseling - african - americans

4. Belgrave, F. Z., Chase - Vaughn, G., Gray, F., Addison, J. D., & Cherry, V. R. (2000). The effectiveness of a culture - and gender - specific intervention for increasing resiliency among African American preadolescent females. *Journal of Black Psychology*, *26*, 133–147.

5. Bertrand, M., & Mullainathan, S. (2004). Are Emily and Greg more employable than Lakisha and Jamal? A field experiment on labor. *The American Economic Review*, *94*, 991–1013.

6. Black Lives Matter. (2015). Black Lives Matter. This is not a moment, but a movement. Retrieved from http://blacklivesmatter.com/about

7. Bowerman, M. (2017). Twitter thanks #BlackWomen for voting for Doug Jones in Alabama State election. USA Today Network, December 13. Retrieved from https://www.usatoday.com/story/news/politics/onpolitics/2017/12/13/twitter - thanks - blackwomen - voting - democrat - doug - jones - alabama - senate - election/947403001/

8. Boyd - Franklin, N. (2010). Incorporating spirituality and religion into the treatment of African American clients. *The Counseling Psychologist*, *38*, 976–1000.

9. Brame, R., Bushway, S. D., Paternoster, R., & Turner, M. G. (2014). Demographic patterns of cumulative arrest prevalence by ages 18 and 23. *Crime & Delinquency*, *60*, 471–486.

10. Casselman, B. (2014). Race gap narrows in college enrollment, but not in graduation. *FiveThirtyEight*. Retrieved from: https://fivethirtyeight.com/features/race - gap - narrows - in - college - enrollment - but - not - in - graduation

11. Centers for Disease Control. (2018). Births: Final data for 2016. National Vital Statistics Report, 67(1). Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01_tables.pdf

12. Centers for Disease Control and Prevention (CDC). (2013). Infant mortality statistics from the 2010 period linked birth/infant death data set. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_08.pdf

13. Christian, M. D., & Barbarin, O. A. (2001). Cultural resources and psychological

adjustment of African American children: Effects of spirituality and racial attribution. *Journal of Black Psychology*, *27*, 43–63.

14. Crenshaw, K., Ocen, P., & Nanda, J. (2015). *Black girls matter: Pushed out, overpoliced, and underprotected*. New York, NY: Center for Intersectionality and Social Policy Studies, Columbia University.

15. Cross, W. E. (1991). *Shades of Black: Diversity in African American identity*. Philadelphia, PA: Temple University Press.

16. Cross, W. E. (1995). In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), The psychology of Nigrescence: Revising the Cross model, *Handbook of multicultural counseling* (pp. 93–122). Thousand Oaks, CA: Sage.

17. Dixon, T. (2017). A dangerous distortion of our families: Representations of families, by race, in news and opinion media. Retrieved from: https://colorofchange.org/dangerousdistortion

18. Donovan, R. A., & West, L. M. (2015). Stress and mental health: Moderating role of the strong Black woman stereotype. *Journal of Black Psychology*, *41*(4), 384–396.

19. Eberhardt, J., Davies, P., Purdie‐Vaughns, V., & Johnson, S. (2006). Looking deathworthy: Per‐ceived Stereotypicality of Black defendants predicts capital‐sentencing outcomes. *Psychological Science*, *17*, 383–386.

20. Ellis, R., & Kirkos, B. (2017). Officer who shot Philando Castile found not guilty on all counts. CNN, July 16. Retrieved from: https://www.cnn.com/2017/06/16/us/philando‐castile‐trial‐verdict/index.html

21. Forsyth, J. M., Hall, S., & Carter, R. T. (2015). Racial identity among African Americans and Black West Indian Americans. *Professional Psychology: Research and Practice*, *46*(2), 124–131 http://dx.doi.org/10.1037/a0038076

22. Fortuna, L. R., Alegria, M., & Gao, S. (2010). Retention in depression treatment among ethnic and racial minority groups in the United States. *Depression and Anxiety*, *27*, 485–494.

23. Frame, M. W., & Williams, C. B. (1996). Counseling African Americans: Integrating spirituality in therapy. *Counseling and Values*, *41*, 16–28.

24. Gibbons, F. X., Etcheverry, P. E., Stock, M. L., Gerrard, M., Weng, C.‐Y., & O'Hara, R. E. (2010). Exploring the link between racial discrimination and substance use: What mediates? What buffers? *Journal of Personality and Social Psychology*, *99*, 785–801.

25. Glum, J. (2015). Loretta Lynch says Sandrea Bland's death highlights Black community's concerns about police. Retrieved from http://www.ibtimes.com/loretta‐lynch‐says‐sandra‐blands‐death‐highlights‐black‐communitys‐concerns‐about‐2024943

26. Gushue, G. V., Walker, A. D., & Brewster, M. E. (2017). Motivation and color‐blind racial attitudes among White psychology trainees. *Training and Education in Professional Psychology*, *11*(2), 78–85.

27. Hagler, J. (2015). 8 facts you should know about the criminal justice system and people of color. Retrieved from

https://www.americanprogress.org/issues/race/news/2015/05/28/113436/8 - facts - you - should - know - about - the - criminal - justice - system - and - people - of - color

28. Harrington, E. F., Crowther, J. H., & Shipherd, J. C. (2010). Trauma, binge eating, and the “strong Black woman”. *Journal of Consulting and Clinical Psychology*, *78*, 469–479.

29. Harry, B., Klingner, J. K., & Hart, J. (2005). African American families under fire: Ethnographic views of family strengths. *Remedial and Special Education*, *26*, 101–112.

30. Holmes, S. A., & Morin, R. (2006). Black men torn between promise and doubt. *Washington Post*, June 4.

31. Johnston, L. D., O'Malley, P. M., Miech, R. A., Bachman, J. G., & Schulenberg, J. E. (2014). *Monitoring the future national results on drug use: 1975–2013: Overview, key findings on adolescent drug use*. Ann Arbor, MI: Institute for Social Research, University of Michigan.

32. Jones, A. C. (1985). Psychological functioning in Black Americans: A conceptual guide for use in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *22*, 363–369.

33. Jordan, A. H., Lovett, B. J., & Sweeton, J. L. (2012). The social psychology of Black - White interracial interactions: Implications for culturally competent clinical practice. *Journal of Multicultural Counseling and Development*, *40*, 132–143.

34. Kaslow, N. J., Leiner, A. S., Reviere, S., Jackson, E., Bethea, K., & Thompson, M. P. (2010). Suicidal, abused African American women's response to a culturally informed intervention. *Journal of Consulting and Clinical Psychology*, *78*, 449–458.

35. LaTaillade, J. J. (2006). Considerations for treatment of African American couple relationships. *Journal of Cognitive Psychotherapy: An International Quarterly*, *20*, 341–354.

36. Lee, D., & Ahn, S. (2013). The relation of racial identity, ethnic identity, and racial socialization to discrimination–distress: A meta - analysis of Black Americans. *Journal of Counseling Psychology*, *60*, 1–14.

37. Lewis, J. A., Williams, M. G., Peppers, E. J., & Gadson, C. A. (2017). Applying intersectionality to explore the relations between gendered racism and health among Black women. *Journal of Counseling Psychology*, *64*(5), 475–486.

38. McCollum, V. J. C. (1997). Evolution of the African American family personality: Considerations for family therapy. *Journal of Multicultural Counseling and Development*, *25*, 219–229.

39. McLaughlin, M. (2016). The dynamic history of #BlackLivesMatter explained: This is how a hashtag transformed into a movement. Huffington Post, December 16. Retrieved from https://www.huffingtonpost.com/entry/history - black - lives - matter_us_56d0a3b0e4b0871f60eb4af5

40. Morris, M. (2016). *Pushout: The criminalization of Black girls in schools*. New York, NY: The New Press.

41. Moser, W. (2015). Finding the “Jamal” in Barack Obama's immediately famous eulogy. Retrieved from http://www.chicagomag.com/city‐life/July‐2015/Finding‐the‐Jamal‐in‐Barack‐Obamas‐Immediately‐Famous‐Eulogy

42. Muroff, J. (2007). Cultural diversity and cognitive behavior therapy. In T. Ronen, & A. Freeman (Eds.), *Cognitive behavior therapy in clinical social work practice* (pp. 109–146). New York, NY: Springer.

43. National Center of Education Statistics (NCES). (2017). Public high school graduation rates. Retrieve from: https://nces.ed.gov/programs/coe/indicator_coi.asp

44. Owens, D., Stewart, T. A., & Bryant, R. M. (2011). Urban African American high school female adolescents' perceptions, attitudes, and experiences with professional school counselors: A pilot study. *Georgia School Counselors Association Journal*, *18*, 34–41.

45. Parham, T. A., & Helms, J. E. (1981). The influence of Black students' racial attitudes on preferences for counselor's race. *Journal of Counseling Psychology*, *28*, 250–257.

46. Parlapiano, A., Gebeloff, R., & Carter, S. (2015). The shrinking American middle class. Retrieved from http://www.nytimes.com/interactive/2015/01/25/upshot/shrinking‐middle‐class.html?abt=0002&abg=0

47. Pew Research Center (2016). On views of race and inequality, Blacks and Whites are worlds apart. Retrieved from: http://www.pewsocialtrends.org/2016/06/27

48. Queener, J. E., & Martin, J. K. (2001). Providing culturally relevant mental health services: Collaboration between psychology and the African American church. *Journal of Black Psychology*, *27*, 112–122.

49. Rockymore, M. (2008). *A practice guide for working with African American families in the child welfare system: The role of the caseworker in identifying, developing and supporting strengths in African American families involved in child protection services*. (DHS‐4702‐ENG 8–06). St. Paul, MN: Minnesota Department of Human Services, Child Safety and Permanency Division.

50. Rodriguez, J., McKay, M. M., & Bannon, W. M. (2008). The role of racial socialization in relation to parenting practices and youth behavior: An exploratory analysis. *Social Work in Mental Health*, *6*, 30–54.

51. Roettger, M. E., Swisher, R. R., Kuhl, D. C., & Chavez, J. (2011). Paternal incarceration and trajectories of marijuana and other illegal drug use from adolescence into young adulthood: Evidence from longitudinal panels of males and females in the United States. *Addiction*, *106*, 121–132.

52. Rudd, T. (2014). Racial disproportionality in school discipline: Implicit bias is heavily implicated. Retrieved from http://kirwaninstitute.osu.edu/racial‐disproportionality‐in‐school‐discipline‐implicit‐bias‐is‐heavily‐implicated

53. Seaton, E. K., Caldwell, C. H., Sellers, R. M., & Jackson, J. S. (2011). An intersectional approach for understanding perceived discrimination and psychological well‐being among African American and Caribbean Black youth. *Developmental Psychology*, *46*, 1372–1379.

54. Substance Abuse and Mental Health Services Administration. (2013). *Results from the*

2012 National Survey on Drug Use and Health: Summary of national findings. (NSDUH Series H‐46, HHS Publication No. SMA 13–4795.) Rockville, MD: Substance Abuse and Mental Health Services Administration.

55 Taylor, Z. E., Larsen‐Rife, D., Conger, R. D., Widaman, K. F., & Cutrona, C. E. (2010). Life stress, maternal optimism, and adolescent competence in single mother, African American families. *Journal of Family Counseling*, *24*, 468–477.

56 Telesford, J., Mendoza‐Denton, R., & Worrell, F. C. (2013). Clusters of CRIS scores and psychological adjustment. *Cultural Diversity and Ethnic Minority Psychology*, *19*(1), 86–91.

57 Toldson, I. A., Braithwaite, R. L., & Rentie, R. J. (2009). Promoting college aspirations among school‐aged Black American males. *Diversity in Higher Education*, *7*, 117–137.

58 Townes, D. L., Chavez‐Korell, S., & Cunningham, N. J. (2009). Reexamining the relationships between racial identity, cultural mistrust, help‐seeking attitudes, and preference for a Black counselor. *Journal of Counseling Psychology*, *56*, 330–336.

59 U.S. Census Bureau (2016). Grandparents and grandchildren. Retrieved from: https://www.census.gov/newsroom/blogs/random‐samplings/2016/09/grandparents‐and‐grandchildren.html

60 U.S. Census Bureau (2017). National African‐American History Month: February 2017. Retrieved from: https://www.census.gov/content/dam/Census/newsroom/facts‐for‐features/2017/cb17‐ff01.pdf

61 U.S. Department of Justice Civil Rights Division & U.S. Attorney's Office Northern District of Illinois. (2017). Investigation of the Chicago Police Department. Retrieved from: https://www.justice.gov/opa/file/925846/download

62 U.S. Department of Labor. (2015). Employment status of the civilian population by race, sex, and age. Retrieved from http://www.bls.gov/news.release/empsit.t02.htm

63 Viglione, J., Hannon, L., & DeFina, R. (2011). The impact of light skin on prison time for Black female offenders. *Social Science Journal*, *48*, 250–258.

64 Want, V., Parham, T. A., Baker, R. C., & Sherman, M. (2004). African American students' ratings of Caucasian and African American counselors varying in racial consciousness. *Cultural Diversity and Ethnic Minority Psychology*, *10*, 123–136.

65 Ward, E. C. (2005). Keeping it real: A grounded theory study of African American clients engaging in counseling at a community mental health agency. *Journal of Counseling Psychology*, *52*(4), 471–481.

66 Watkins, N. L., Labarrie, T. L., & Appio, L. M. (2010). Black undergraduates' experiences with perceived racial microaggressions in predominately White colleges and universities. In D. W. Sue (Ed.), *Microaggressions and marginality* (pp. 25–51). Hoboken, NJ: Wiley.

67 Weir, K. (2014). Injustice, in black and white. *Monitor on Psychology*, *45*, 14–15.

68 Williams, J. C., Phillips, K. W., & Hall, E. V. (2014). Double jeopardy? Gender bias against women in science. Retrieved from https://toolsforchangeinstem.org/double‐

jeopardy - report/

15
Counseling American Indians/Native Americans and Alaska Natives

Chapter Objectives

1. **1. Learn the demographics and characteristics of American Indians and Alaska Natives.**
2. **2. Identify counseling implications of the information provided for American Indians and Alaska Natives.**
3. **3. Provide examples of strengths that are associated with American Indians and Alaska Natives.**
4. **4. Know the special challenges faced by American Indians and Alaska Natives.**
5. **5. Understand how the implications for clinical practice can guide assessment and therapy with American Indians and Alaska Natives.**

> *Many American Indian children were forced to attend boarding schools far away from their homes in which they were compelled to adopt European American culture. Although attendance at such schools for the most part ended in the late 1960s, we still see remnants of intolerant attitudes among teachers. Mirranda Washinawatock was publicly ridiculed and punished for speaking her native Menominee at her Catholic school. This was particularly hurtful to many of the older tribe members who remember being beaten for speaking their language, which sadly accounts for some of the loss of the language now.*
>
> *(Black, 2012)*

> *For nearly two years, the Energy Transfer Partners worked to receive federal approval to build pipeline to carry crude oil from North Dakota to Iowa, passing through Standing Rock Sioux land. American Indians from across the country, joined their Sioux brothers and sisters to protest the construction of the pipeline because of the desecration of sacred land and the likelihood that the water and soil in the affected areas would become polluted. Among President Donald Trump's first actions in office in January 2017 was to issue a Presidential Memorandum approving the construction of the pipeline. And, as anticipated there were leaks within a few months of operation.*
>
> *(Smith & Bosman, 2017)*

> *In 2014, the city of Eureka, California, drafted an apology to the Wiyot tribe for the 1860 massacre on Indian Island, during which 200 sleeping Wiyot, including women and children, were slaughtered. The City Council removed the apology part of the letter for fear of opening itself up to liability and substituted language acknowledging that the Wiyot people had been massacred but not stating who was responsible.*
>
> *(Lee, 2015)*

The American Indian/Alaska Native (AI/AN) population is about 5.4 million people, representing nearly 2% of the U.S. population. AI/AN form a highly heterogeneous group composed of 566 distinct *tribes*, with about 170 languages (U.S. Census Bureau, 2015). In fact, over a quarter (26.8%) of AI/AN people speak another language other than English in the home. About 22% of American Indians live on *reservations*, whereas 60% reside in metropolitan areas (Office of Minority Health, 2012). The high school graduation gap has narrowed over the years: 82.4% of AI/AN have graduated high school, compared to 86.9% in the general U.S. population (U.S. Census Bureau, 2015). American Indians have the highest national poverty rate, 28.3%, with income only 69% of the mean income of all households (U.S. Census Bureau, 2015). AI/AN differ in their degree of *acculturation*. Although most do

not live on *reservations* or with their *tribes*, many are returning because of casino jobs or a more nurturing environment. One man who returned described his need for a more "friendly place, friendly face, and friendly greetings" (Shukovsky, 2001, p. A1).

What constitutes an Indian is often an area of controversy. The U.S. Census depends on self‐report of racial identity. Congress has formulated a legal definition: An individual must have an Indian blood quantum of at least 25% to be considered an Indian. This definition has caused problems both within and outside the Indian community. Some *tribes* have developed their own criteria and specify either tribal enrollment or blood quantum levels. Tribal definitions typically allow inclusion of the 60% of American Indians who have mixed heritage, including Black, White, and Latinx backgrounds (Trimble, Fleming, Beauvais, & Jumper‐Thurman, 1996).

Because AI/AN make up such a small percentage of the U.S. population, they are relatively "invisible," which makes information about them susceptible to stereotypes. This is one of the reasons many oppose the use of Indian‐themed mascots and logos. American Indians want the ability to define themselves and are aware of the harmful effects of stereotyped portrayals (Jacobs, 2014). American Indian high school and college students who viewed these types of images reported higher levels of depression, lower self‐esteem, and decreased feelings of community worth (Fryberg, Markus, Oyserman, & Stone, 2008). In examining online responses to this controversy, Steinfeldt et al. (2010) found hostile and racially offensive attitudes from mostly White respondents: "If the nickname is taken away, we should take away Indian educational programming and funding" and "We are being victimized by reverse racism and PC society."

Health statistics reveal significant disparities. The death rate by any cause is nearly 50% higher for AI/AN persons than for White individuals (Espey et al., 2014). AI/AN individuals have death rates for unintentional injuries due to motor vehicle traffic crashes, poisoning, and falls that are 1.4 to 3.0 times higher than among Whites (Murphy et al., 2014). Injuries and violence account for 75% of all deaths for AI/AN between the ages of 1 and 19. These populations also suffer disproportionately from depression, anxiety, and substance abuse (Office of Minority Health, 2012). Among Native American women at a private care facility in New Mexico, 21% reported mood disorders, 47% had an anxiety disorder, and 14% had alcohol dependence or abuse issues. These rates are 2.0 to 2.5 times higher than found in the general population (Duran et al., 2004).

CHARACTERISTICS AND STRENGTHS

In the following sections, we discuss the characteristics, values, and strengths of AI/AN populations and consider their implications in treatment. Remember that these are generalizations and that their applicability needs to be assessed for particular clients and their families.

Tribal Social Structure

For the many American Indians living both on and off *reservations*, the *tribe* is of fundamental importance. The *tribe* and the *reservation*, an interdependent system, provide Native Americans with a sense of belonging and security. Tribal connections are significant because individuals see themselves as an extension of their *tribe*. Status is achieved, and rewards gained, by adherence to tribal structure. American Indians judge themselves in terms of whether their behaviors are of benefit to the *tribe*. Personal accomplishments are honored and supported if they serve to benefit the *tribe*.

Implications

Interventions and decision‐making with AI/AN individuals should take into account the importance placed on tribal relationships. In a study of 401 AI/AN youth (half tribal‐based and half urban‐based), urban‐based youth were more likely to identify personal, familial, and environmental strengths than were tribal‐based youth, whereas the latter identified more tribal strengths (Stiffman et al., 2007). The *tribe* is very important for many Indians, even those who do not reside on a *reservation*. Many use the word *here* to describe the *reservation* and the word *there* to describe everything that is outside. The *reservation* is a place to conduct ceremonies and social events and to maintain cultural identity. American Indians who leave the *reservation* to seek greater opportunities sometimes report losing their sense of personal identity (Lone‐Knapp, 2000).

Family Structure

It is difficult to describe “the Indian family.” It varies from the matriarchal structures seen in the Navajo, where women govern the family, to patriarchal structures, in which men are the primary authority figures. Some generalizations can be made, however. A high fertility rate and strong roles for women are commonly seen. For most *tribes*, the *extended family* is the basic unit. Children are often partially raised by relatives, such as aunts, uncles, and grandparents, who live in separate households (Garrett, 2006).

Implications

The concept of the *extended family* is often misunderstood by those in the majority culture who operate under the concept of the nuclear family. Misinterpretations are possible if a counselor believes that parents should raise and be responsible for their own children. The *extended family* often includes distant relatives and even friends. It is not unusual for children to stay in multiple households. In work with children, counselors should determine the roles of various family members, so that interventions can include appropriate individuals. The emphasis on collectivism is strong. If the goals or techniques of therapy lead to discord within the family or *tribe*, they will not be effective. Interventions may need to include the input of family, relatives, friends, elders, or tribal leaders.

Cultural and Spiritual Values

Because of the great diversity and variation among American Indians, it is difficult to describe a set of values that encompasses all groups. However, certain generalizations can be made regarding common values (Garrett & Portman, 2011; Jumper‐Reeves, Dustman, Harthun, Kulis, & Brown, 2014).

1. *Sharing*. Honor and respect are gained by *sharing* and giving, in contrast with the dominant U.S. culture, where status is gained by the accumulation of material goods.
    - *Implications:* Once enough money is earned, youth and adults may stop working and spend time and energy in ceremonial activities. The accumulation of wealth is not a high priority but is a means to enjoy the present. Interventions targeting alcohol or drug use should take into consideration the emphasis on *sharing*.
2. *Cooperation*. Having a harmonious relationship is important and the *tribe* and the family take precedence over the individual. Children are often sensitive to the opinions and attitudes of their peers and may actively avoid disagreements or contradictions. Most do not like to be singled out and made to perform in school unless the whole group benefits.
    - *Implications:* Instead of going to work or school, children or adults may prioritize assisting a family member needing help. Children may be seen as unmotivated in school because of their reluctance to compete with peers.
3. *Noninterference*. It is important not to interfere with others and to observe rather than react impulsively. Rights of others are respected. This belief in noninterference extends to parenting style.
    - *Implications:* Culture significantly shapes parent–child relationships. AI/AN are more indulgent and less punitive than parents from other ethnic groups (BigFoot & Funderburk, 2010). EuroAmerican parenting styles may conflict with American Indian values. One culturally sensitive parent education program developed for this population included: (a) use of the oral tradition of storytelling to teach lessons to children; (b) an understanding of the spiritual nature of child rearing and the spiritual value of children; and (c) use of the *extended family* in child rearing. The eight‐session program included social time for parents and children before each session, including storytelling and a potluck meal. The program applied traditional teaching methods, such as nurturing, use of nature to teach lessons, and use of harmony as a guiding principle for family life (Gorman & Balter, 1997).
4. *Time orientation*. There is a greater focus on the present than on the future. Ideas of punctuality or planning for the future may be less important. Life is to be lived in the here and now.
    - *Implications:* Tasks may be approached from a logical perspective rather than according to deadlines. In contrast, the U.S. majority culture values delay of gratification and planning for future goals. In working with these issues, the counselor should acknowledge such value differences and help the individual or family develop strategies to negotiate value conflicts.
5. *Spirituality*. The spirit, mind, and body are all interconnected. Illness involves disharmony between these elements. Positive emotions can be curative; healing can take place through events such as talking to an old friend on the phone or watching children

play (Garrett & Wilbur, 1999).

- *Implications:* Traditional curative approaches attempt to restore spirit–mind–body harmony. The *sweat lodge* and *vision quest* are often used to reestablish connections between the mind, body, and spirit. To treat a problem successfully, all of these elements may need to be considered and addressed. Counselors can help clients identify factors involved in disharmony, determine curative events, behaviors, and feelings, and use client‐generated solutions to create balance.

6. *Nonverbal communication*. Learning occurs by listening rather than talking. Families tend to ask few direct questions. Direct eye contact with an elder may be seen as a sign of disrespect.

    - *Implications:* Differences in *nonverbal communication* can lead to misunderstandings. For example, counselors may view lack of eye contact or direct communication as a sign of disrespect. It is important to determine whether specific behaviors are due to cultural values or are actual problems.

Cultural Strengths

AI/AN populations had to endure genocide and assimilation efforts and were able to do so because of cultural values and strengths such as *spirituality*, respect for traditional values and ceremonies, *extended family* networks, allegiance to the family, community, and *tribe*, wisdom of the elders, respect for the environment and the land, connection to the past, adaptability, and the promotion of such themes as belonging, mastery, independence, and generosity (American Psychiatric Association, 2014; Gilgun, 2002). The values of listening and observing rather than reacting can enhance communication and decrease conflict. Spiritual and traditional practices also act as a protective factor (Garroutte, Goldberg, Beals, Herrell, & Manson, 2003). The respect shown for the environment and the interconnection between humans and the environment is something that can be emulated by all cultures. Additionally, the focus on the present is increasingly recognized as an asset, particularly among those who incorporate mindfulness activities into clinical practice (Chiesa & Serretti, 2011).

SPECIFIC CHALLENGES

In the following sections, we describe the challenges often faced by AI/AN populations and consider their implications in treatment.

Historical and Sociopolitical Background

In North America, wars and diseases that resulted from contact with Europeans decimated the AI/AN population; by the end of the eighteenth century, only about 10% of the original population remained. Additionally, the *tribes* suffered massive loss of their land. Their experience in America is not comparable to that of any other ethnic group. In contrast to immigrants, who arrived with few resources and struggled to gain equality, AI/AN originally had resources. However, their land and status were severely eroded by imperial, colonial, and then federal and state policies (Johnson et al., 1995). For years, extermination and seizure of lands seemed to be the primary governmental policy toward Indians.

In the 1830s, more than 125,000 people from different *tribes* were forced from their homes in many different states to a *reservation* in Oklahoma. The move was traumatic for their families and, in many cases, disrupted their cultural traditions. Assaults against their culture also occurred in the form of attempts to “civilize” them. Children were removed from their families and placed in English‐speaking boarding schools. They were not allowed to speak their own language and were forced to spend eight continuous years away from their families and *tribes*. Children were also removed from their homes and placed with non‐Indian families until the Indian Child Welfare Act of 1978 prohibited these practices (Johnson et al., 1995). However, during the 1998 congressional hearings regarding possible amendments to the Indian Child Welfare Act, statistics were cited indicating that over 90% of American Indian children were still being placed by state courts and child welfare workers into non‐Indian homes (Congressional Record, 1997). Although amendments to the original act dramatically reduced this type of placement, the National Indian Child Welfare Association (2014) and other advocacy organizations recently asked the Department of Justice to investigate Indian Child Welfare Act violations.

These disruptive events had a tremendous negative impact on family and tribal cohesion and prevented the transmission of cultural values from parents to children. Some professionals believe that the experiences of colonization, coercive assimilation experiences in boarding schools, and the widespread loss of indigenous languages and customs may result in “historical trauma,” in which the distress and dysfunction experienced by an individual can be passed down intergenerationally (Gone, 2014). Individuals may have unresolved grief—“soul wounds”—that lead to behavioral dysfunction and substance abuse. The following case study illustrates some of the disruptions caused by a boarding school experience.

CASE STUDY

MARY

Mary was born on the *reservation*. She was sent away to school when she was 12 and did not return to the *reservation* until she was 20. By the time she returned, her mother had died from pneumonia. She didn't remember her father, the medicine man of the *tribe*, very well. Shortly after she returned, she became pregnant by a non‐Indian man she met at a bar. Mary's father … looked forward to teaching and leaving to his grandson, John, the ways of the medicine man … John felt his grandfather was out of

> step with the twentieth century … Mary … could not validate the grandfather's way of life … [because] she remembered having difficulty fitting in when she returned to the *reservation* … In response to the growing distance between her father and her son, she became more and more depressed and began to drink heavily. (Sage, 1997, p. 48)

In the past, the *tribe*, through the *extended family*, was responsible for the education and training of children. The sense of tribal identity developed through this tradition was significantly eroded by governmental policies. In addition, even recent history is full of broken treaties, the seizure or misuse of Indian land, and battles led by local or federal officials to remove or severely limit fishing and hunting rights. Thus, AI/AN are often suspicious of the motives of the majority culture; many expect that they will not be treated fairly by non‐Indians (Cruz & Spence, 2005).

Implications

When working with children and families, it is important to consider the historical sociopolitical relationship between AI/AN and the local, state, and federal government. The counselor should understand not only the national history of oppression but also local issues and specific tribal history.

The historic disruption of families resulting in the Indian Child Welfare Act has important implications for how AI/AN might view child protective services or respond to runaway youth. Currently, decisions regarding the placement of their children are held in tribal courts. Testimony from expert witnesses familiar with the specific tribal or cultural group must be obtained before children can be removed from their homes. Additionally, if children are removed from their parents, residence with *extended family* members, other tribal members, or other AI/AN families is given primary consideration.

Educational Concerns

Educational gaps between AI/AN youth and White youth persist (National Conference of State Legislators, 2008). Native children appear to do well during the first few years of school. However, by the fourth grade, a pattern of academic decline, disengagement, and truancy develops; a significant drop in achievement motivation often occurs in middle school. Although some have argued that traditional cultural values and beliefs are incompatible with those of the educational system, there is increasing support for the view that perceived barriers to mobility are the culprit behind reduced academic performance. In other words, academic success is not perceived as leading to rewards or success. Others argue that structural issues within the school, including limited resources, a lack of teacher preparation or cultural sensitivity, and racial discrimination, are in fact pushing AI/AN youth out of traditional school settings (Johnston‐Goodstar & VeLure Roholt, 2017). In addition, some of youth from low‐income communities see that jobs are available in casinos or on the *reservation*, which can provide them with opportunities to contribute financially to their families. This makes it difficult for them to see the value in pursuing a “White man's education.”

Implications

The blame for school failure has generally been placed on the individual rather than on the school environment. However, many youths who leave school report feeling “pushed out” and express mistrust of teachers, who represent the same White community that has

historically exerted control over the economic, social, and religious lives of American Indians (Deyhle & Swisher, 1999). At a systems level, positive changes could occur if public schools and institutions of higher education were to (a) recognize the sociocultural history of AI/AN and acknowledge their perceptions of schools as a potentially hostile environment and (b) increase efforts to accommodate some of the social and cultural differences of the students, including by adapting curricula to reflect their cultural background (Reyhner, 2002). The perceived lack of reward for academic achievement also needs to be addressed. Schools must help students bridge the two worlds of AI/AN and White cultures. Some *tribes* have given up on the public school system and have developed their own learning centers and community colleges.

The AlterNative Education Program was created to interest American Indians in postsecondary education. It recruits indigenous students and alumni at Columbia University to travel to *reservations* in New Mexico and teach high school‐aged youth about their identity and past. The program covers areas such as oppression, stereotypes, and colonialism, focuses on identity building, and encourages higher education. Responses from the participants have been quite positive and have resulted in increased interest in college enrollment (Aronowitz, 2014).

Acculturation Conflicts

> *I don't know the meaning of the symbols of our culture. Instead, I know the symbols of the Catholic faith.*
>
> *(Gone, 2009, p. 757)*

> *I didn't know we had herbs and plants that grew here, that are medicine and vitamins. I didn't know we had that until they [the elders] brought it up.*
>
> *(Goodkind, Gorman, Hess, Parker, & Hough, 2015, p. 495)*

> *…some people are more spiritual‐tradition based than others. Some are more modernized, too, and have lost touch with some of that kind of stuff; it varies.*
>
> *(Flynn, Olson, & Yellig, 2014, p. 285)*

Not only do AI/AN children and adolescents face the same developmental issues as other youth, but they also may experience conflict over exposure to two very different cultures, a factor that may result in failure to develop a positive self‐image or strong ethnic identity (Garrett & Portman, 2011). Many youth are caught between the expectations of their parents that they will maintain traditional values and the necessity to adapt to the majority culture (Rieckmann, Wadsworth, & Deyhle, 2004). In one study of adolescents, the most serious problems identified involved ethnic identity, family relationships, grades, and concerns about the future. One‐third of the girls surveyed reported feeling they did not want to live (Bee‐Gates, Howard‐Pitney, LaFromboise, & Rowe, 1996).

Some AI/AN are acculturated and hold the values of the larger society. The degree to which a client identifies with the native culture or is acculturated to the dominant U.S. culture should always be considered. Garrett and Pichette (2000) have formulated five levels of cultural orientation:

1. *Traditional*. The individual may speak little English and practice traditional tribal customs and methods of worship.
2. *Marginal*. The individual may be bilingual but has lost touch with his or her cultural heritage, yet is not fully accepted in mainstream society.

3. *Bicultural*. The individual is conversant with both sets of values and can communicate in a variety of contexts.
4. *Assimilated*. The individual embraces only the mainstream culture's values, behaviors, and expectations.
5. *Pantraditional*. The individual has been exposed to and adopted mainstream values but is making a conscious effort to return to the “old ways.”

Implications

Counselors need to discuss the client's tribal affiliation (if any), languages spoken, self‐identity, and residential background, and find out whether there is a current relationship to a *tribe* or tribal culture (Garrett & Pichette, 2000). The therapeutic process and goals appropriate for someone living on a rural *reservation* may be very different from those appropriate for an urbanized American Indian who retains few traditional beliefs. Individuals with a traditional orientation may be unfamiliar with expectations of the dominant culture and may want to develop the skills and resources to deal with mainstream society. In contrast, assimilated or marginal American Indians may want to examine self‐identity conflicts and may face issues such as (a) lack of pride in or denial of their heritage, (b) pressure to adopt majority cultural values, (c) guilt over not knowing or participating in the cultural customs or events, (d) negative views regarding their group, and (e) a lack of an extended support or belief system. It may be healthiest to have a bicultural orientation that allows the individual to live in both worlds. This perspective appears to confer strength and resiliency in American Indians (Flynn et al., 2014).

The client's level of *acculturation* should also be a factor that guides the therapist's selection of therapeutic interventions. For example, acculturated and bicultural AI/AN have found success with all components of cognitive behavioral therapy (CBT), whereas those who are traditionally oriented are responsive to the short‐term focus, activity schedule, and homework assignments in CBT but have difficulty with the underlying theoretical assumptions regarding the association between thoughts and emotional symptoms (Jackson, Schmutzer, Wenzel, & Tyler, 2006). In these cases, modified explanations for CBT may be useful.

Alcohol and Substance Abuse

> *It's a good thing that I'm away from home and even though [my family] miss[es] me and I miss them … I can understand … being away from home, it just is such a big relief for them and for me … because of all the alcoholism, the drug usage … the drama and gossiping. It just seems so depressing for them and then for me as well.*
>
> *(Flynn et al., 2014, p. 286)*

Substance abuse is a significant concern among some AI/AN, particularly those living on a reservation or in a high‐poverty neighborhood. Although rates of alcohol use vary across *tribes* and regions, AI/AN have the highest weekly alcohol consumption of any ethnic group (Chartier & Caetano, 2010). As with the college student quoted by Flynn et al. (2014), some youth are exposed to the effects of alcohol use and abuse early in life. However, it must be remembered that there is variability in alcohol‐use patterns between specific subgroups; for example, Southwest Indians, especially females, have low rates of alcohol consumption (Chartier & Caetano, 2010).

A variety of explanations have been put forth for the high levels of alcohol abuse. Although drinking alcoholic beverages may initially have been incorporated into cultural practices as an

activity of *sharing*, giving, and togetherness (Swinomish Tribal Mental Health Project, 1991), heavy alcohol use is associated with other factors, such as feelings of *historical loss* in terms of language, land, and traditions (see Cromer, Gray, Vasquez, & Freyd, 2018). Further, living in extreme poverty with little access to jobs with a living wage can lead some to turn to alcohol or other substances to dull the pain.

Implications

Successful drug treatment programs have incorporated appropriate cultural elements. Because peers often support substance use, prevention and interventions should involve not only the individual but also the community and family, including siblings, cousins, and friends (Boyd‐Ball, Véronneau, Dishion, & Kavanagh, 2014). One tribal community reduced its alcoholism rate from 95% to 5% in 10 years by addressing some of the pain of *historical loss* through revitalizing traditional culture and taking a strong community stance against alcohol abuse (Thomason, 2000). Many *tribes* have developed similar programs to deal with alcohol‐ and drug‐abuse issues. Programs have the greatest chance of promoting health when they incorporate cultural strengths, evidence‐based strategies, and traditional tribal practices such as talking circles and ceremonies (Jumper‐Reeves et al., 2014).

Domestic Violence

The rate of domestic violence, along with physical and sexual assault, is quite high in many native communities. Statistics indicate that AI/AN women experience domestic violence and physical assault at much higher rates than women of other ethnicities (Peters, Straits, & Gauthier, 2015). Native women often experience sexual and physical abuse early in life; abuse is especially high among lesbian and bisexual women (D'Oro, 2010). The high incidence of domestic violence may result from changes in traditional roles for men and women, as well as substance abuse and stressors associated with social and economic marginalization. There is an intergenerational pattern of violence in many families in which individuals who witnessed family or domestic violence become aggressive with their own partners (Myhra & Wieling, 2014). Thus, the cycle of violence is perpetuated.

Implications

During counseling, it may be difficult to determine whether domestic violence is occurring within a family or couple. Native American women who are abused may remain silent because of cultural barriers, a high level of distrust of White‐dominated agencies, fear of familial alienation, and the historical failure of state and tribal agencies to protect women from domestic crimes (Wahab & Olson, 2004). Jurisdictional struggles between state and tribal authorities can also result in a lack of help for women. Many *tribes* acknowledge the problem of family violence and have developed community‐based domestic violence interventions using strategies from the Indian cultural perspective (Hamby, 2000). When working with a domestic‐violence issue with a Native American woman, tribal issues, tribal programs, and family support options should be identified.

Suicide

> *At the Montana Indian Reservation, sixteen‐year‐old Franci Jackson considered hanging herself with a rope when she felt she couldn't take any more bullying at school. But then she changed her mind. “I thought of my mom and dad and how much they love me. And if I leave, what would they do without me? But most kids don't think,” she said in tears. Six American Indian students living in her area had killed themselves in the*

previous year with another 20 attempting suicide.

(Associated Press, 2011)

Suicide rates have reached epidemic proportions among AI/AN. For individuals between the ages of 15 and 34 years, the suicide rate is about 250% higher than in the general population, and suicide is the second leading cause of death among those aged 15 to 34 years (CDC, 2013). Among a sample of 122 middle school children living on a North Plains *reservation*, 20% had made a nonfatal suicide attempt, and of this group, nearly half had attempted suicide two or more times (LaFromboise, Medoff, Harris, & Lee, 2007). Death rates from suicide are highest among AI/AN populations in Alaska and in the Northern Plain states (Herne, Bartholomew, & Weahkee, 2014). The high incidence of suicide is associated with alcohol abuse, poverty, boredom, family stress, and *historical loss* or disconnection from one's culture and community (Gray & McCullagh, 2014).

Implications

There are many societal and economic issues facing AI/AN. For those who live on a *reservation* or identify with a *tribe*, community activities sometimes focus on reducing suicidal ideation and promoting resilience in youth. Effective programs need to be culturally consistent. For example, many Indians believe that mental health issues are a result of unbalanced spiritual relationships (Limb & Hodge, 2010). In traditional belief systems, there is not only a seen world but also an unseen world. Events that disrupt the unseen world disturb the harmony in the seen world. Therefore, if intervention focuses only on the seen world, change will likely not occur (Cruz & Spence, 2005).

A promising culturally tailored suicide intervention program was implemented by LaFromboise and Howard‐Pitney (1995) at the request of the Zuni Tribal High School. Scores on a suicide probability measure indicated that 81% of the students were in the moderate‐to‐severe risk range. Of the participants, 18% reported having attempted suicide, and 40% reported knowing of a relative or friend who had committed suicide. The program included role‐playing, building self‐esteem, identifying emotions and stressors, recognizing and eliminating negative thoughts or emotions, receiving information on suicide and intervention strategies, and setting personal and community goals. The program was effective in reducing feelings of hopelessness and suicidal probability ratings. Intervention programs may need to be developed based on the needs of individual *tribes*. For example, although among the Pueblo suicidal ideation was associated with the suicidal behavior of friends, for adolescents from Northern Plain *tribes* the most significant factors were low self‐esteem and depression (LaFromboise, 2006).

IMPLICATIONS FOR CLINICAL PRACTICE

1. Explore the client's ethnic identity, tribal affiliation, and adherence to cultural values. Also, discuss family members' association with a *tribe* or *reservation* and the importance of rituals or ceremonies in healing. In addition, determine the appropriateness of a mind–body–spirit emphasis. Keep in mind that many American Indians adhere completely to mainstream values, whereas others, especially those living on or near *reservations*, may hold traditional values (Peters et al., 2015).
2. Understand the extensive history of colonization, genocide, and social injustice experienced by AI/AN and learn about local issues associated with the client's *tribe* or *reservation*. Become familiar with key books in the field, including *Native American*

Post‐Colonial Psychology and *Healing the Soul Wound*.

3. Don't fall into the trap of viewing AI/AN as a group of peoples who only existed in the past or who have been beaten down by oppression. Appreciate the rich diversity among AI/AN in the present and understand the resiliency and hope across generations.
4. Learn about the client using a client‐centered listening style, and when appropriate use self‐disclosure and provide the client with the opportunity to identify the focus of the session (Flynn et al., 2014; Thomason, 2011).
5. Assess the problem from the perspective of the individual, family, *extended family*, and, if appropriate, the tribal community; attempt to determine the role of cultural and experiential factors and whether the client has seen a traditional healer.
6. If necessary, address basic needs such as problems involving food, shelter, childcare, and employment. Identify possible resources, such as Indian Health Services or tribal programs.
7. Identify possible environmental contributors to problems, such as racism, discrimination, poverty, and *acculturation* conflicts; consider how knowledge of these factors can help reduce self‐blame.
8. Help children and adolescents determine whether cultural values or an unreceptive environment contribute to their problem. Strategize different ways of dealing with these conflicts. For some, strengthening their sense of cultural identity can be helpful.
9. Help determine concrete goals that incorporate cultural, family, *extended family*, and community perspectives.
10. Determine whether child‐rearing practices are consistent with traditional methods and how they may conflict with mainstream methods.
11. In family interventions, identify *extended family* members, determine their roles, and, when appropriate, request their assistance.
12. Generate possible solutions with the client and consider the possible consequences of change from individual, family, and community perspectives. When appropriate, include strategies that may involve cultural elements and that focus on holistic factors (mind, body, spirit).

Video Lecture: Overcoming Personal Racism: What Can I Do?

SUMMARY

American Indians/Native Americans and Alaska Natives make up such a small percentage of the U.S. population that they are relatively "invisible." Life - expectancy and mental/physical health disparities, however, are among the worst for this population. Their experience in America is not comparable to that of any other ethnic group. In contrast to immigrants, who arrived with few resources and struggled to gain equality, they originally had resources, which were severely eroded or destroyed by imperial, colonial, and federal and state policies. Alcohol and substance abuse, domestic violence, and suicide are among the most pressing behavioral health issues facing this population. In work with AI/AN, counselors need to understand how the values of *sharing*, *cooperation*, *noninterference*, time orientation, *spirituality*, and *nonverbal communication* are relevant to mental health practice. Twelve clinical implications for counselor practice are identified.

GLOSSARY TERMS

- Acculturation
- Cooperation
- Extended family
- Historical loss
- Noninterference
- Nonverbal communication
- Reservation
- Sharing
- Spirituality
- Sweat lodge
- Tribe
- Vision quest

REFERENCES

1. American Psychiatric Association. (2014). Mental health disparities: American Indians and Alaska Natives. Retrieved from https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural - Competency/Mental - Health - Disparities/Mental - Health - Facts - for - American - Indian - Alaska - Natives.pdf

2. Aronowitz, N. W. (2014). Proud heritage: Mentors teach Native students about their pasts. Retrieved from http://www.nbcnews.com/news/education/proud - heritage - mentors - teach - native - students - about - their - pasts - n184271

3. Associated Press. (2011). Senate hearing in Montana examines Indian suicides. Retrieved from https://billingsgazette.com/news/state - and - regional/montana/senate - hearing - in - montana - examines - indian - suicides/article_da784c2a - c2e6 - 11e0 - 8edd - 001cc4c03286.html

4. Bee - Gates, D., Howard - Pitney, B., LaFromboise, T., & Rowe, W. (1996). Help - seeking behavior of Native American Indian high school students. *Professional Psychology: Research and Practice*, *27*, 495–499.

5. BigFoot, D. S., & Funderburk, B. W. (2010). Honoring children, making relatives: Indigenous traditional parenting practices compatible with evidence - based treatment. Retrieved from http://www.apa.org/pi/oema/resources/communique/2010/08/indigenous - parenting.aspx

6. Black, D. (2012). Native girl punished for speaking her language. Retrieved from https://www.thestar.com/news/world/2012/02/28/native_girl_punished_for_speaking_l

7. Boyd - Ball, A. J., Véronneau, M. H., Dishion, T. J., & Kavanagh, K. (2014). Monitoring and peer influences as predictors of increases in alcohol use among American Indian youth. *Prevention Science*, *15*, 526–535.

8. Centers for Disease Control and Prevention (CDC). (2013). Web - Based Injury Statistics Query and Reporting System (WISQARS). Fatal injury reports. Retrieved from https://www.cdc.gov/injury/wisqars/index.html

9. Chartier, K., & Caetano, R. (2010). Ethnicity and health disparities in alcohol research. *Alcohol Research & Health*, *33*(1–2), 152–160.

10. Chiesa, A., & Serretti, A. (2011). Mindfulness based cognitive therapy for psychiatric disorders: A systematic review and meta - analysis. *Psychiatry Research*, *87*, 441–453.

11. Congressional Record (1997). *Indian Child Welfare Act Amendments of 1997—Hon. George Miller*. Washington, DC: Congressional Record.

12. Cromer, L. D., Gray, M. E., Vasquez, L., & Freyd, J. J. (2018). The relationship of acculturation to historical loss awareness, institutional betrayal, and the intergenerational transmission of trauma in the American Indian experience. *Journal of Cross - Cultural Psychology*, *49*(1), 99–114.

13. Cruz, C. M., & Spence, J. (2005). Oregon tribal evidence based and cultural best

practices. Retrieved from http://library.state.or.us/repository/2007/200710220927381/index.pdf

14. Deyhle, D., & Swisher, K. (1999). Research in American Indian and Alaska Native education: From assimilation to self‐determination. *Review of Research in Education, 22*, 113–194.

15. D'Oro, R. (2010). Stemming Native Americans' suicide rates. *Seattle Times*, December 12

16. Duran, B., Sanders, M., Skipper, B., Waitzkin, H., Malcoe, L. H., Paine, S., & Yager, J. (2004). Prevalence and correlates of mental disorders among Native American women in primary care. *American Journal of Public Health, 94*, 71–77.

17. Espey, D. K., Jim, M. A., Cobb, N., Bartholomew, M., Becker, T., Haverkamp, D., & Plescia, L. (2014). Leading causes of death and allcause mortality in American Indians and Alaska Natives. *American Journal of Public Health, 104*, S303–S311.

18. Flynn, S. V., Olson, S. D., & Yellig, A. D. (2014). American Indian acculturation: Tribal lands to predominately White postsecondary settings. *Journal of Counseling and Development, 92*, 280–293.

19. Fryberg, S. A., Markus, H. R., Oyserman, D., & Stone, J. M. (2008). Of warrior chiefs and Indian princesses: The psychological consequences of American Indian mascots. *Basic and Applied Social Psychology, 30*, 208–218.

20. Garrett, M. T. (2006). When Eagle speaks: Counseling Native Americans. In C. C. Lee (Ed.), *Multicultural issues in counseling: New approaches to diversity* (pp. 25–53). Alexandria, VA: American Counseling Association.

21. Garrett, M. T., & Pichette, E. F. (2000). Red as an apple: Native American acculturation and counseling with or without reservation. *Journal of Counseling and Development, 78*, 3–13.

22. Garrett, M. T., & Portman, T. A. A. (2011). *Counseling Native Americans*. Belmont, CA: Cengage.

23. Garrett, M. T., & Wilbur, M. P. (1999). Does the worm live in the ground? Reflections on Native American spirituality. *Journal of Multicultural Counseling & Development, 27*, 193–207.

24. Garroutte, E. M., Goldberg, J., Beals, J., Herrell, R., Manson, S. M., & AI‐SUPERPFP Team (2003). Spirituality and attempted suicide among American Indians. *Social Science & Medicine, 56*, 1571–1579.

25. Gilgun, J. F. (2002). Completing the circle: American Indian medicine wheels and the promotion of resilience of children and youth in care. *Journal of Human Behavior in the Social Environment, 6*, 65–84.

26. Gone, J. P. (2009). A community‐based treatment for Native American historical trauma: Prospects for evidence‐based practice. *Journal of Consulting and Clinical Psychology, 17*, 751–762.

27. Gone, J. P. (2014). Reconsidering American Indian historical trauma: Lessons from an early Gros Ventre war narrative. *Transcultural Psychiatry, 51*, 387–406.

28. Goodkind, J. R., Gorman, B., Hess, J. M., Parker, D. P., & Hough, R. L. (2015). Reconsidering culturally competent approaches to American Indian healing and well‐being. *Qualitative Health Research, 25*(4), 486–499.

29. Gorman, J. C., & Balter, L. (1997). Culturally sensitive parent education: A critical review of quantitative research. *Review of Educational Research, 67*, 339–369.

30. Gray, J. S., & McCullagh, J. A. (2014). Suicide in Indian country: The continuing epidemic in rural Native American communities. *Journal of Rural Mental Health, 38*, 79–86.

31. Hamby, S. L. (2000). The importance of community in a feminist analysis of domestic violence among American Indians. *American Journal of Community Psychology, 28*, 649–669.

32. Herne, M. A., Bartholomew, M. L., & Weahkee, R. L. (2014). Suicide mortality among American Indians and Alaska Natives, 1999–2009. *American Journal of Public Health, 104*, S336–S342.

33. Jackson, L. C., Schmutzer, P. A., Wenzel, A., & Tyler, J. D. (2006). Applicability of cognitive‐behavioral therapy with American Indian individuals. *Psychotherapy: Theory, Research, Practice, Training, 43*, 506–517.

34. Jacobs, M. R. (2014). Race, place, and biography at play: Contextualizing American Indian viewpoints on Indian mascots. *Journal of Sport & Social Issues, 38*, 322–345.

35. Johnson, K. W., Anderson, N. B., Bastida, E., Kramer, B. J., Williams, D., & Wong, M. (1995). Macrosocial and environmental influences on minority health. *Health Psychology, 14*, 601–612.

36. Johnston‐Goodstar, K., & VeLure Roholt, R. (2017). “Our kids aren't dropping out; they're being pushed out”: Native American students and racial microaggressions in schools. *Journal of Ethnic & Cultural Diversity in Social Work, 26*(1–2), 30–47.

37. Jumper‐Reeves, L., Dustman, P. A., Harthun, M. L., Kulis, S., & Brown, E. F. (2014). American Indian cultures: How CBPR illuminated intertribal cultural elements fundamental to an adaptation effort. *Prevention Science, 15*, 547–556.

38. LaFromboise, T. D. (2006). American Indian youth suicide prevention. *Prevention Researcher, 13*, 16–18.

39. LaFromboise, T. D., & Howard‐Pitney, B. (1995). The Zuni life skills development curriculum. *Journal of Counseling Psychology, 42*, 479–486.

40. LaFromboise, T. D., Medoff, L., Harris, A., & Lee, C. C. (2007). Psychological and cultural correlates of suicidal ideation among American Indian early adolescents on a Northern Plains reservation. *Research in Human Behavior, 41*, 119–143.

41. Lee, T. H. (2015). 7 apologies made to American Indians. Retrieved from https://newsmaven.io/indiancountrytoday/archive/7‐apologies‐made‐to‐american‐indians‐CzHzxFZy Vk6QdDF‐Naiyyw/

42. Limb, G. E., & Hodge, D. R. (2010). Helping child welfare workers improve cultural competence by utilizing spiritual genograms with Native American families and children. *Children and Youth Services Review, 32*, 239–245.

43. Lone‐Knapp, F. (2000). Rez talk: How reservation residents describe themselves. *American Indian Quarterly, 24*, 635–640.

44. Murphy, T., Pokhrel, P., Worthington, A., Billie, H., Sewell, M., & Bill, N. (2014). Unintentional injury mortality among American Indians and Alaska Natives in the United States, 1990–2009. *American Journal of Public Health*, *104*(S3), 470–480.

45. Myhra, L. L., & Wieling, E. (2014). Psychological trauma among American Indian families: A two‐generation study. *Journal of Loss and Trauma: International Perspectives on Stress & Coping*, *19*, 289–313.

46. National Conference of State Legislator. (2008). Striving to achieve: Helping Native American students succeed. Retrieved from http://www.ncsl.org/Portals/1/documents/statetribe/strivingtoachieve.pdf

47. National Indian Child Welfare Association. (2014). Native American Rights Fund calls for Department of Justice investigation of ICWA violations. Retrieved from http://narfnews.blogspot.com/2014/02/native‐american‐rights‐fund‐calls‐for.html

48. Office of Minority Health. (2012). Mental health and American Indians/Alaska Natives. Retrieved from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlID=39

49. Peters, W. M. K., Straits, K. J. E., & Gauthier, P. E. (2015). Psychological practice with Native women. In C. Zerbe Enns, J. Rice, & R. L. Nutt (Eds.), *Psychological practice with women: Guidelines, diversity, empowerment. Psychology of women book series* (pp. 191–224). Washington, DC: American Psychological Association.

50. Reyhner, J. (2002). American Indian/ Alaska Native education: An overview. Retrieved from http://jan.ucc.nau.edu/jar/AIE/Ind_Ed.html

51. Rieckmann, T. R., Wadsworth, M. E., & Deyhle, D. (2004). Cultural identity, explanatory style, and depression in Navajo adolescents. *Cultural Diversity and Ethnic Minority Psychology*, *10*, 365–382.

52. Sage, G. P. (1997). Counseling American Indian adults. In C. C. Lee (Ed.), *Multicultural issues in counseling* (2nd ed.) (pp. 35–52). Alexandria, VA: American Counseling Association.

53. Shukovsky, P. (2001). “Urban Indians” are going home. *Seattle Post‐Intelligencer*, March 29.

54. Smith, M., & Bosman, J. (2017). Keystone Pipeline leaks 210,000 gallons of oil in South Dakota. *New York Times*, November 16. Retrieved from https://www.nytimes.com/2017/11/16/us/keystone‐pipeline‐leaks‐south‐dakota.html

55. Steinfeldt, J. A., Foltz, B. D., Kaladow, J., Carlson, T. N., Pagano, L. A., Benton, E., & Steinfeldt, M. C. (2010). Racism in the electronic age: Role of online forums in expressing racial attitudes about American Indians. *Cultural Diversity and Ethnic Minority Psychology*, *16*, 362–371.

56. Stiffman, A. R., Brown, E., Freedenthal, S., House, L., Ostmann, E., & Yu, M. S. (2007). American Indian youth: Personal, familial, and environmental strengths. *Journal of Child and Family Studies*, *16*, 331–346.

57. Swinomish Tribal Mental Health Project (1991). *A gathering of wisdoms*. LaConner, WA: Swinomish Tribal Community.

58. Thomason, T. (2011). Best practices in counseling Native Americans. *Journal of Indigenous Research*, *1*(1), 3.

59. Thomason, T. C. (2000). Issues in the treatment of Native Americans with alcohol problems. *Journal of Multicultural Counseling and Development*, *28*, 243–252.

60. Trimble, J. E., Fleming, C. M., Beauvais, F., & Jumper‐Thurman, P. (1996). Essential cultural and social strategies for counseling Native American Indians. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (4th ed.) (pp. 177–209). Thousand Oaks, CA: Sage.

61. U.S. Census Bureau. (2015). Facts for features: American Indian and Alaska Native heritage month: November 2015. Retrieved from https://www.census.gov/newsroom/facts‐for‐features/2015/cb15‐ff22.html

62. Wahab, S., & Olson, L. (2004). Intimate partner violence and sexual assault in Native American communities. *Trauma, Violence, & Abuse*, *5*, 353–366.

Note

“American Indian” and “Native American” are used interchangeably in this chapter.

16
Counseling Asian Americans and Pacific Islanders

Chapter Objectives

1. **1. Learn the demographics and characteristics of Asian Americans and Pacific Islanders.**
2. **2. Identify counseling implications of the information provided for Asian Americans and Pacific Islanders.**
3. **3. Provide examples of strengths associated with Asian Americans and Pacific Islanders.**
4. **4. Know the special challenges faced by Asian Americans and Pacific Islanders.**
5. **5. Understand how the implications for clinical practice can guide assessment and therapy with Asian Americans and Pacific Islanders.**

> *[I]n many [Asian] societies people who suffer from major depression do not complain primarily of sadness. The symptoms that stand out for those people may be changes in appetite, headaches, backaches, stomachaches, insomnia, or fatigue. Such symptoms and complaints would take people suffering from depression to their primary care doctor, and they may be less likely to be diagnosed with a mental disorder.*
>
> *(Kalibatseva & Leong, 2011, p. 3)*

> *Calling Asian Indians the new "model minority" isn't a compliment. It's an attempt to fit them into a box for political purposes … The phase "model minority" inherently pits one minority group against others … After all, if one community is the "model," then the others are problematic and less desirable.*
>
> *(Srivastava, 2009, p. 1)*

> *"It's not enough to have Asian Americans and Pacific Islanders on just a handful of shows … Shows set in diverse cities like New York and Los Angeles should not be completely white" [Nancy Wang Yeun]—but according to TV, they are … "As much as we may want to dismiss TV as simple entertainment, it undeniably contributes to our cultural landscape and our understanding of the world … What does it mean when [Asian Americans and Pacific Islanders] are missing or tokenized in this landscape? It reinforces the idea that we don't belong" [Jenny J. Lee].*
>
> *(Ramos, 2017)*

The Asian American population is growing rapidly, and as of 2013, was close to 18 million, representing 5.3% of the total population. Native Hawaiian and other Pacific Islanders number 1.2 million and make up 0.4% of the total population (U.S. Census Bureau, 2015). The largest Asian groups in the United States include

- over 4 million Chinese,
- 3.4 million Filipinos,
- 3.2 million Asian Indians,
- 1.7 million Vietnamese,
- 1.7 million Koreans, and
- 1.3 million Japanese. (U.S. Census Bureau, 2012)

Nearly three - quarters of Asian American adults were born abroad and about two - thirds

speak a language other than English at home; approximately half do not speak English “very well.” Between‐group differences within the Asian American population are quite large, since the population comprises at least 40 distinct subgroups that differ in language, religion, and values. Counselors should not assume that Asian Americans are all the same. Individuals diverge on variables such as ethnicity, culture, migration and relocation experiences, degree of *assimilation* or *acculturation,* identification with the home country, facility in their native language and in English, family composition, educational background, religion, and sexual orientation (Nadal, Escobar, Prado, David, & Haynes, 2012).

CHARACTERISTICS AND STRENGTHS

In the following section, we present some of the cultural values, behavioral characteristics, and expectations that Asian Americans might have about therapy and consider the implications of these factors in treatment. The level of accuracy of these group generalizations for each individual client or family must be determined by the therapist.

Asian Americans: A Success Story?

The contemporary image of Asian Americans is that of a highly successful minority that has "made it" in society. Indeed, a close analysis of census data (U.S. Census Bureau, 2016) seems to support this contention. Of those over the age of 25, over half of Asian Americans and Pacific Islanders have a bachelor's degree, versus a little over 30% of their White counterparts; 21.4% have an advanced degree, compared with 12.1% of Whites (U.S. Census Bureau, 2016). Words such as *intelligent*, *hardworking*, *enterprising*, and *disciplined* are frequently applied to this population (Lim, 2014). The median income of Asian American families was $77,166 in 2013, as compared with $56,516 for the U.S. population as a whole (U.S. Census Bureau, 2013).

However, a closer analysis of the status of Asian Americans reveals a somewhat different story. First, in terms of economics, references to the higher median income of Asian Americans do not take into account (a) the higher percentage of Asian American families having more than one wage earner, (b) between ‐ group differences in education and income, and (c) a higher prevalence of poverty despite the higher median income (11.4% for Asian Americans and 17.6% for Pacific Islanders, versus 9.4% for non ‐ Hispanic Whites) (U.S. Census Bureau, 2013). Rates of poverty are particularly high among Hmong, Guamanian, Indonesian, and Cambodian immigrants (Ramakrishnan & Ahmad, 2014).

Second, in the area of education, Asian Americans show a disparate picture of extraordinarily high educational attainment among a few and a large, undereducated mass. Among Bhutanese, over 60% adults have not completed high school. Fewer than 17% of Tongan, Cambodian, Laotian, Hmong and Pacific Islander adults have a bachelor's degree (Shah & Ramakrishnan, 2017). When averaged out, this bimodal distribution indicates how misleading statistics can be.

Third, there is now widespread recognition that Chinatowns, Manilatowns, and Japantowns in San Francisco and New York represent ghetto areas with prevalent unemployment, poverty, health problems, and juvenile delinquency. People outside these communities seldom see the deplorable social conditions that exist behind the bright neon lights, restaurants, and quaint shops.

Fourth, although Asian Americans underutilize mental health services, it is unclear if this is due to low rates of socioemotional difficulties or to cultural values inhibiting self ‐ referral (Zane & Ku, 2014). It is possible that a large portion of the mental illness, adjustment problems, and juvenile delinquency among Asians is hidden. The discrepancy between official and real rates of adjustment difficulties may be due to cultural factors, such as the shame and disgrace associated with admitting to emotional problems, the handling of problems within the family rather than relying on outside resources, and the manner of symptom formation, such as a low prevalence of acting ‐ out disorders.

Fifth, Asian Americans have been exposed to discrimination and racism throughout history and continue to face anti ‐ Asian sentiments. Even fourth ‐ and fifth ‐ generation Asian

Americans are sometimes identified as “foreign” (Tsuda, 2014). In a daily diary study of Asian Americans, 78% reported experiencing at least one racial microaggression during a two‐week period, and often more, including being ignored at restaurants, being told inappropriate jokes, and being teased for not using Western utensils (Ong, Burrow, Fuller‐Rowell, Ja, & Sue, 2013). Perceived racial microaggressions and discrimination are associated with higher psychological distress, anxiety, depression, and somatic symptoms (Ong et al., 2013).

It is important for those who work with Asian Americans to look behind the success myth and to understand the historical and current experiences of Asians in America. The matter is even more pressing for counselors when we realize that Asian Americans underutilize counseling and other mental health facilities. The approach of this chapter is twofold. First, we attempt to indicate how the interplay of social and cultural forces has served to shape and define the lifestyle of recent immigrants/refugees and American‐born Asians. Second, we explore how an understanding of Asian American values and social experiences suggests a need for modifications in counseling and psychotherapeutic practices when working with some members of this population.

CASE STUDY

KATHERINE

Growing up in a traditional Asian household, there were a handful of subjects I knew never to broach: Academic failure, acting more “American,” sex and mental illness …

I … fumbled the words to tell my parents about [being depressed] and the avenues of treatment I had researched. Their response was dismissive, but not—as I later understood—in a neglectful vein. When I mentioned the possibility of medication, they became angry—the world that had shaped them was neither nurturing nor particularly nuanced. As Chinese immigrants, they lived shoulder‐to‐shoulder with poverty and near‐starvation. Their experiences were reinforced by an ironclad culture that encouraged stoic endurance and regarded mental illness as a weakness of character, a shame borne not only by the individual, but by the entire family. And here was their daughter, who lived in a manicured middle‐class suburban home and always went to bed with a full belly, complaining she felt depressed.

“It's not real. Get over it” was the gist of their advice. Then and now, to our detriment, I'm certain many Asian‐American kids have heard the same thing.

So I tried. In high school, I became the poster‐child for a “high‐functioning depressive,” as the terminology goes. I maintained a 4.0 GPA, won national writing awards and earned admission to an Ivy League university—things my parents wanted for my future. This made me a role model for the younger students in our community. I was even asked for lifestyle tips on how to succeed in school. Parents pointed at me and said to their children, “You should be more like her.” But the depression persisted, stubborn and malicious, leaching my motivation and compelling me to seek relief in terrible things. After school, I'd shut myself in my room and cut myself until I could no longer stand the pain.

(Xie, 2016)

Collectivistic Orientation

Katherine's parents' initial response to her sharing her experiences with depression reflects their cultural socialization. As Chinese immigrants, they view depression as a weakness with the potential to bring shame to the family. With this more collectivistic orientation comes the expectation that children will strive for family goals and not engage in behaviors that might bring dishonor to the family. More traditional Asian American parents tend to show little interest in children's viewpoints regarding family matters, for instance whether or not Katherine should seek treatment. Asian American adolescents are often expected to assist, support, and respect their families, even when exposed to a society that emphasizes adolescent autonomy and independence (Fuligni et al., 1999).

Whereas EuroAmerican parents rated being “self‐directed” as the most important attribute in children's social competence, Japanese American parents chose “behaves well” (O'Reilly, Tokuno, & Ebata, 1986). Chinese American parents also believed that politeness and calmness are important childhood characteristics (Jose, Huntsinger, & Liaw, 2004). Asian American families do differ, however, in the degree to which they embrace collectivistic values and in their flexibility in applying these values. For example, Katherine was hospitalized because of concerns she would hurt herself shortly before graduating high school. When she returned home, her parents began to learn more about depression and were open to her seeking help outside of the family.

Implications

Because of a possible *collectivistic orientation*, it is important to consider the family and community context during assessment and problem definition. A therapist should be open to different family orientations and should avoid automatically considering interdependence as a sign of enmeshment. After doing a client‐centered analysis of the problem, counselors can ask, “How does your family see the problem?” For traditionally oriented Asian Americans, a focus on individual client needs and wishes may run counter to the values of *collectivism*. Goals and treatment approaches may need to include a family focus, such as asking “How important is it for you to consult your family before deciding how to deal with the problem?” or “How would achieving your goals affect you, your family, friends, and social community?”. Questions such as these allow the therapist to assess the degree of *collectivism* in the family. Acculturated Asian Americans with an individualistic orientation can often benefit from traditional counseling approaches, but family issues should also be considered, since *acculturation* conflicts are common, as in Katherine's case.

Hierarchical Relationships

Traditional Asian American families tend to be hierarchical and patriarchal in structure, with males and older individuals occupying a higher status (Kim, 2011). Communication flows downward from parents to children; children are expected to defer to their elders as a matter of obligation and duty (Lau, Fung, & Yung, 2010). Sons are expected to carry on the family name and tradition. Even when they marry, their primary allegiance is to the parents. Between‐group differences do exist. Japanese Americans are the most acculturated. The majority are third‐ or fourth‐generation Americans. Filipino American families tend to be more egalitarian, whereas Korean, Southeast Asian, and Chinese American families tend to be more patriarchal and traditional in orientation (Blair & Qian, 1998). Modern Chinese societies are moving toward more egalitarian relationships between husband and wife and between parents and children (Chen, 2009), as we can see in some of this change in Katherine's family over the years.

Implications

Clients should be aware that Asian Americans may respond to the counselor as an authority figure, be reluctant to express true feelings and concerns, and say what they think the mental health professional wants to hear (Son & Ellis, 2013). In family therapy, it is important to determine the family structure and communication pattern. Does it appear to be egalitarian or hierarchical? If the structure is not clear, addressing the father first and then the mother may be most productive.

If English is a problem, use an interpreter. Having children interpret for the parents can be counterproductive because it upsets the hierarchical structure. For very traditionally oriented families, having communication between family members directed to the therapist may be more congruent with cultural values than having family members address one another. It is also important to assess possible status changes within the family. It is not uncommon among Asian immigrants for women to retain their occupational status while men are either underemployed or unemployed. Such loss of male status may result in family conflict, particularly if males attempt to maintain their status by becoming even more authoritarian. In such cases, it may be helpful to cast societal factors as the problem that needs to be addressed.

Parenting Styles

As with Katherine's parents, Asian American parenting styles tend to be more authoritarian and directive than those in EuroAmerican families (Kim, 2011), although a relaxed style is often used with children younger than six or seven (Jose et al., 2004). For example, Chinese parenting is based on the concepts of *chiao shun* (to train) and *guan* (to govern and to love) (Russell, Crockett, & Chao, 2010). Shame, the induction of guilt, and love withdrawal are often used to control and train children (Lau, Fung, Wang, & Kang, 2009). When Katherine returned home from her hospitalization, she and her parents worked through what she described as “resentful, agonized silence” that had gone on for years within the family. Problem behavior in children in some families is viewed as a lack of discipline. While praise is frequently used in the majority culture to reinforce desired behaviors, many Asian families consider instruction to be the main parenting strategy (Paiva, 2008). As one parent stated, “I don't understand why I should reward things they should already be doing. Studying hard is a normal responsibility. Listening to parents is a must. Why should they feel proud when they are merely meeting a basic obligation?” (Lau et al., 2010, p. 887). However, differences in parenting style between Asian American groups have been found. Japanese and Filipino American families tend to have the most egalitarian relationships, whereas Korean, Chinese, and Southeast Asian Americans are more authoritarian (Blair & Qian, 1998).

Implications

Egalitarian or Western ‐ style parent ‐ effectiveness training strategies may run counter to traditional child ‐ rearing patterns. Traditional Asian American families exposed to Western techniques or styles may feel that their parenting skills are being criticized. Instead of attempting to establish egalitarian relationships, the therapist can focus on identifying different aspects of parenting, such as teaching and modeling. They can then help refocus on the more positive aspects of Asian child ‐ rearing strategies, framing the change as helping the children with problems rather than as altering traditional parenting. It is also important to commiserate with parents regarding the difficulties they encounter raising children in a society with different cultural standards (Lau, 2012).

Emotionality

Strong emotional displays, especially in public, are considered signs of immaturity or a lack of self‐control; control of emotions is considered a sign of strength (Kim, 2011). Thus, some Asian Americans, especially those who are less acculturated into the United States, may be hesitant to discuss or openly display emotions. Instead, care and concern are shown by attending to the physical needs of family members. Fathers frequently maintain an authoritative and distant role and are not generally emotionally demonstrative or involved with children. Their role is to provide for the economic and physical needs of the family. Mothers in general are more responsive to the children but use less nurturance and more verbal and physical punishment than do EuroAmerican mothers (Kelly & Tseng, 1992). However, mothers are expected to meet the emotional needs of the children and often serve as the intermediary between them and the father. When children are exposed to more open displays from Western society, they may begin to question the comparative lack of emotion displayed by their parents.

Implications

Counseling techniques that focus directly on emotions may be uncomfortable and produce shame for traditional Asian Americans. Emotional behavior can be recognized in a more indirect manner. For example, if a client shows discomfort, the therapist could respond by saying either “You look uncomfortable” or “This situation would make someone uncomfortable.” In both cases, the discomfort would be recognized. We have found that many Asian Americans are more responsive to the second, more indirect acknowledgment of emotions. Feelings of shame or embarrassment may interfere with self‐disclosure and need to be addressed in counseling. The process may be facilitated by affirming that the sharing of personal information, although it may be uncomfortable, is a natural process in therapy (Zane & Ku, 2014). It is also helpful to focus on behaviors more than emotions and to identify how family members are meeting each other's needs. Among traditional Asian American couples, care and concern may be demonstrated by taking care of the physical needs of the partner rather than by verbally expressing concern. Western therapies that emphasize verbal and emotional expressiveness may not be appropriate in work with traditional Asian couples or bicultural families such as Katherine's, in which she was more acculturated than her parents.

Holistic View on Mind and Body

Katherine's “weighty periods of apathy and sadness” are similar to the way many high school girls in the United States experience depression. However, more traditional Asian Americans may not experience depression in the same way. Instead of feeling sad, someone might talk about not being able to sleep or having headaches, stomachaches, or other somatic symptoms. The somatic complaints reflect a more customary Asian American understanding of the mind–body connection. In many Asian ethnic groups, physical complaints are a common and culturally accepted means of expressing psychological and emotional stress. It is believed that physical problems cause emotional disturbances and that symptoms will disappear once the physical illness is treated. Instead of mentioning anxiety or depression, Asian clients may mention headaches, fatigue, restlessness, and disturbances in sleep and appetite (Wong, Tran, Kim, Kerne, & Calfa, 2010). Even psychotic patients typically focus on *somatic complaints* and seek treatment for these physical ailments (Nguyen, 1985).

Implications

Treat *somatic complaints* as real problems. Inquire about medications or other treatments that

are being used to treat the symptoms. To address possible psychological factors, ask questions such as, “Dealing with headaches and dizziness can be quite troublesome; how are these affecting your mood or relationships with others?” This approach both legitimizes the physical complaints and allows an indirect means of assessing psychosocial factors. It is beneficial to develop an approach that deals with both *somatic complaints* and the consequences of being “ill.”

Academic and Occupational Goal Orientation

There is great pressure for children to succeed academically and to have a successful career, since both are indicative of a successful upbringing. In Katherine's narrative, she talked about excelling in high school and in some respects surpassing her parents' high academic expectations. Katherine is not an anomaly. As a group, Asian Americans perform better academically than do their EuroAmerican counterparts. Although Asian American students have high levels of academic achievement, they also have more fear of academic failure and spend twice as much time each week studying as their non‐Asian peers (Eaton & Dembo, 1997). Their achievement often comes with a price. Similar to Katherine, Asian American adolescents report feeling isolated, depressed, and anxious, and report little praise for their accomplishments from their parents (Lorenzo, Pakiz, Reinherz, & Frost, 1995). Asian American parents often have specific career goals in mind for their children (generally in technical fields or the hard sciences). Because choice of vocation may reflect parental expectations rather than personal talent, Asian college students are sometimes uncertain about realistic career options (Lucas & Berkel, 2005). Deviations from either academic excellence or “appropriate” career choices can produce conflict with family members.

Implications

Counselors can inquire about and discuss conflicts between parental academic or career goals and the client's strengths, interests, and desires. When working with parents, counselors can encourage the recognition of all positive behaviors and contributions made by their children, rather than just academic performance. For career or occupational conflicts, counselors can acknowledge the importance parents place on their children achieving success, while indicating that there are many career options that can be considered. Differences of opinion can be presented as a culture conflict. The counselor can help the client brainstorm ways to present other possibilities to their parents. Because Asian American students often lack clarity regarding vocational interests, they may need additional career‐counseling assistance (Lucas & Berkel, 2005).

Cultural Strengths

Asian Americans' cultural values can provide resiliency and strength. The family orientation allows members to achieve honor by demonstrating respect for parents and elders and supporting siblings in their endeavors. These customs produce a collective support system that can shield the individual and family from sources of stress. Because the achievements and success of an individual are considered a source of pride for the family rather than the individual, group harmony is primary. Enculturation or identification with one's racial and ethnic background can serve as a buffer against prejudice, discrimination, and family conflicts (Hwang, Woods, & Fujimoto, 2010; Kim, 2011). For Korean American adolescents, ethnic identity pride is positively related to self‐esteem, especially when there is strong parental support (Chang, Han, Lee, & Qin, 2015).

Pacific Islanders have faced a history of colonization and oppression. Despite these

challenges and obstacles, cultural strengths such as collectivity, harmony in family relationships, and respect for elders have been an important source of resilience. Pacific Islanders can rely on the community and family during times of stress (Vakalahi, 2009). Korean American college students were found to have strong cognitive flexibility. In dealing with conflicts with parents, these individuals used creative means to prevent or resolve problems in a way that accommodated traditional cultural expectations and their own personal needs (Ahn, Kim, & Park, 2008).

SPECIFIC CHALLENGES

In the following sections, we describe the challenges often faced by Asian Americans and consider their implications in treatment.

Racial Identity Issues

> *White privilege was a concept I was unaware of, even though it was intricately woven into the fabric of my life. If someone had asked me then, I would probably have said that I have not experienced racism, and I did not feel oppressed in any way. This is not to say I had not experienced racism. I just never thought of those encounters as racism because, most of the times, they were subtle. I reacted to racial microaggressions with confusion, fear, and frustration, although I never understood my emotions.*
>
> *(Lo, 2010, p. 26)*

As Asian Americans are progressively exposed to the standards, norms, and values of the wider U.S. society, the result is increasing *assimilation* and *acculturation*. Bombarded on all sides by peers, schools, and the mass media, which uphold Western standards, Asian Americans are frequently placed in situations of extreme culture conflict and experience distress regarding their behavioral and physical differences (Kim, 2011). Asian American college women report lower self‐esteem and less satisfaction with their racially defined features than do their Caucasian counterparts (Mintz & Kashubeck, 1999). C.‐R. Lee (1995) describes his experiences as "straddling two worlds and at home in neither" and tells how he felt alienated from both American and Korean cultures. As with other adolescents, those of Asian American descent also struggle with the question of "Who am I?" In the preceding case, Lo talks about struggling with his racial identity. For Lo, three intersecting racial–ethnic–cultural identity processes are at play: (a) what it means to be racialized in the United States as an Asian American (i.e., racial identity); (b) how important or salient his Korean American identity is to him (i.e., ethnic identity); and (c) to what extent he is acculturated into the cultural values and practices of the United States and to what extent he is enculturated into the cultural values and practices of his Korean heritage.

Implications

Although identity issues can be a problem for some Asian Americans, others believe that ethnic identity is not salient or important. Assessing the ethnic self‐identity of clients is important, because it can affect how we conceptualize the presenting problems and how we choose the techniques to be used in therapy. Those who adhere to Asian values have a more negative view toward seeking counseling (Kim, 2007). Acculturated Asian American college students hold beliefs similar to those of counselors, whereas less acculturated students do not (Mallinckrodt, Shigeoka, & Suzuki, 2005). Acculturated Asian clients who have lower levels of enculturation into their home culture are generally receptive to Western styles of counseling and may not want reminders of their ethnicity. Traditionally identified Asians are more likely to be recent immigrants who retain strong cultural values and are more responsive to a culturally adapted counseling approach. Bicultural Asian Americans adhere to some traditional values, while also incorporating many Western values. Being bicultural is associated with greater physical and mental health (Jang, Park, Chiriboga, & Kim, 2017). Programs that help Asian American youth develop social awareness about ethnic identity issues and societal imbalance in power are associated with increased pride, self‐efficacy, racial and ethnic esteem, and increased interest in contributing to societal change (Suyemoto,

Day, & Schwartz, 2015).

Acculturation Conflicts

Children of Asian descent who are exposed to different cultural standards often attribute their psychological distress to their parents' backgrounds and different values. The issue of not quite fitting in with their peers yet being considered “too Americanized” by their parents is common. Parent–child conflicts are among the most common presenting problems for Asian American college students seeking counseling (Lee, Su, & Yoshida, 2005) and are often related to dating and marriage issues (Ahn et al., 2008). Chinese immigrant mothers report a larger *acculturation* gap with sons than with daughters (Buki, Ma, Strom, & Strom, 2003). The larger the *acculturation* gap between parents and children, the greater the number of family problems. Parents may complain, “My children have lost their cultural heritage” (Hwang et al., 2010). The inability to resolve differences in *acculturation* results in misunderstandings, miscommunication, and conflict (Lee, Choe, Kim, & Ngo, 2000). Parents may feel at a loss in terms of how to deal with their children. Some respond by becoming more rigid.

Implications

To prevent negative interpersonal exchanges between parents and their children, therapists can reframe problems as resulting from *acculturation* conflicts. In this way, both the parents and the children can discuss cultural standards and the expectations from larger society. Although family therapy would seem to be the ideal medium in which to deal with problems for Asian Americans, certain difficulties exist. Most therapy models are based on EuroAmerican perspectives of egalitarian relationships and require verbal and emotional expressiveness. Some models assume that a problem in a family member is reflective of dysfunction between family members. In addition, the use of direct communication between child and parents, confrontational strategies, or nonverbal techniques such as “sculpting” may be an affront to the parents.

Assess the structure of the Asian American family. Is it hierarchical or more egalitarian? What is its perception of healthy family functioning? How are decisions made? How do family members show respect for each other and contribute to the family? Focus on the positive aspects of the family and reframe conflicts to reduce confrontation. Expand systems theory to include societal factors such as prejudice, discrimination, poverty, and conflicting cultural values. Issues revolving around the pressures of being an Asian American family in U.S. society need to be investigated. Describe the session as a solution‐oriented one and explain that family problems are not uncommon. As much as possible, allow sensitive communications between family members to come through the therapist. The therapist can function as a culture broker in helping the family negotiate conflicts with the larger society.

Expectations Regarding Counseling

Because psychotherapy may be a foreign concept for some Asian Americans, it is important to carefully explain the nature of the assessment and treatment process and the necessity of obtaining personal information and insight into family dynamics. Asian American clients may expect concrete goals and strategies focused on solutions. Even acculturated Asian American college students prefer counselors to serve as direct helpers offering advice, consultation, and the facilitation of family and community support systems (Atkinson, Kim, & Caldwell, 1998). Mental health professionals must be careful not to impose techniques or strategies. Counselors often believe that they should adopt an authoritarian or highly directive stance

with Asian American clients. What many Asian American clients expect is that the counselor will take an active role in structuring the session and outlining expectations for client participation in the counseling process. It can be helpful for the therapist to accept the role of being the expert regarding therapy, while the client is given the role of expert regarding his or her life. In this way, clients can assist the therapist by facilitating understanding of key issues and possible means of approaching the problem (Chen & Davenport, 2005).

Implications

Carefully describe the client's role in the therapy process, indicating that problems can be individual, relational, or environmental, or a combination thereof, and that you will perform an assessment of each of these areas. Introduce the concept of *co‐construction*—that effective counseling involves the client and the counselor working together to identify problems and solutions. The therapist might explain, "In counseling, we try to understand the problem as it affects you, your family, friends, and community, so I will ask you questions about these different areas. With your help, we will also consider possible solutions that you can try out." *Co‐construction* reduces the chance that the therapist will impose his or her worldview on the client.

The counselor should direct therapy sessions but should ensure full participation from clients in developing goals and intervention strategies. Suggestions can be given and different options presented for consideration by the client. Clients can also be encouraged to suggest their own solutions and then select the option that they believe will be the most useful in dealing with the problem. The opportunity for Asian American clients to try interventions on their own promotes the cultural value of self‐sufficiency. The consequences for any actions taken should be considered, not only for the individual client, but also for the family. The client's perspective is also important in determining what needs to be done if cultural or family issues are involved.

Therapy should be time limited, should focus on concrete resolution of problems, and should deal with the present or immediate future. Cognitive‐behavioral and other solution‐focused strategies are useful in working with Asian Americans (Chen & Davenport, 2005). However, as with other Eurocentric approaches, these approaches may need to be altered because the focus is on the individual, whereas the unit of treatment for Asian Americans may be the family, community, or society. Cognitive‐behavioral approaches can be modified to incorporate a *collectivistic* rather than an individualistic perspective. For example, assertiveness training can be altered for Asian clients by first considering possible cultural and social factors that may affect assertiveness (e.g., minority status or personal values such as modesty) and then identifying, together with the client, situations where assertiveness might be functional, such as in class or when seeking employment, and those where a traditional cultural style might be more appropriate (e.g., with parents or other elders). Additionally, possible cultural or societal influences that affect social anxiety or assertiveness can be discussed. Finally, the client can practice role‐playing to increase assertiveness in specific situations. This concrete alteration of a cognitive‐behavioral approach considers cultural factors and allows the client to establish self‐efficacy.

Racism and Discrimination

> *At every chapter of my life, I have been made to feel like the other. So much so that I have conditioned myself to feel most comfortable when I am standing alone as the sole Asian. Despite growing up in a Chinese family, my world is saturated by so many more white perspectives that I once assumed that they were the standard.*

(Tam, 2013)

The preceding narrative comes from a blog post by journalist Ruth Tam. Tam discusses her understanding of #NotYourAsianSidekick, a term coined by writer Suey Park to characterize the intersection between patriarchy and racism that Asian women experience in the United States and abroad. Tam captures the ubiquity of Whiteness. At points in her life, she internalized how White people saw her based on their racial stereotypes. Asian Americans continue to face racial stereotyping along with racism and discrimination, the form of which may depend on their gender. These everyday experiences, whether acknowledged or not, impact Asian Americans' health and well‐being (Lee & Ahn, 2011).

Experience with discrimination in foreign‐born and U.S.‐born Asian American college students was related not only to depression but also to intergenerational conflicts, especially with the mother, probably because she is the person with whom family members primarily interact in navigating social problems (Chang, Chen, & Cha, 2015). Southeast Asian refugees who experienced racial discrimination reported high rates of depression (Noh, Beiser, Kaspar, Hou, & Rummens, 1999).

Implications

A therapist must assess the effects of possible environmental factors, such as racism, on mental health issues in Asian Americans and help ensure that they not internalize issues based on discriminatory practices. Instead, the focus should be on how to deal with racism and on possible efforts to change the environment. If a problem occurs in school, the therapist can help assess the school's social receptivity to Asian students. The same can be done with discriminatory practices at a client's place of employment. Intervention may have to occur at a systems level, with the therapist serving in the role of advocate for the client.

IMPLICATIONS FOR CLINICAL PRACTICE

> *[A] one‐size‐fits‐all approach to clinical work with Asian Americans is potentially problematic. Instead, it is important for clinicians to identify within‐group differences among their Asian American clients based on their mental illness, lay beliefs, and level of enculturation.*
>
> *(Wong et al., 2010, p. 328)*

There is a range of acceptable practices in working with Asian American clients. Qualities such as attitudinal similarity between the counselor and the client and agreement on the cause and treatment of a disorder are more important than racial match in promoting counselor credibility and a strong therapeutic alliance (Meyer, Zane, & Cho, 2011). Asian Americans view counselors who demonstrate multicultural competence by addressing their cultural beliefs as more competent (Wang & Kim, 2010). Helping Asian American clients formulate culturally acceptable strategies can improve their problem‐solving abilities and facilitate the development of skills for successful interactions within the larger society, including balancing conflicting values. Many of the counseling skills learned in current mental health programs, such as cognitive behavioral therapy (CBT), can be effective, especially if modifications are made for less acculturated clients (Lau, Chan, Li, & Au, 2010). Considerations in working with Asian American clients include the following:

1. Be aware of cultural differences between the therapist and the client in the areas of counseling, appropriate goals, and process. Use strategies appropriate to the

collectivistic, hierarchical, and patriarchal orientation of Asian Americans, when needed.

2. Build rapport by discussing confidentiality and explaining the client role, including the process of co‐constructing the problem definition and solutions.
3. Identify and incorporate the client's beliefs about the etiology and appropriate treatment regarding the disorder.
4. Assess not just from an individual perspective but including family, community, and societal influences on the problem. Discover the client's worldview, degree of *acculturation*, and ethnic identity. Explore whether the client's experiences with acculturation and ethnic identity are influenced by gender or other social identity.
5. Conduct a positive assets search. What strengths, skills, problem‐solving abilities, and social supports are available to the client or their family? How have problems been successfully solved in the past?
6. Consider or reframe the problem, when possible, as one involving issues of culture conflict or *acculturation*.
7. Determine whether *somatic complaints* are involved, and assess their influence on mood and relationships. Discuss somatic as well as psychological issues.
8. Take an active role, but allow the client to choose and evaluate suggested interventions. Asian American clients may prefer an immediate resolution to a problem to an in‐depth exploration.
9. If appropriate, use problem‐focused, time‐limited approaches that have been modified to incorporate possible cultural factors.
10. Discuss strategies you have used in the past to solve problems similar to those faced by the client.
11. With family therapy, be aware that Western‐based theories and techniques may not be appropriate for Asian families. Determine the structure and communication patterns among the family members. It may be helpful to address the father first and to initially have statements by family members directed to the therapist. Focus on positive aspects of parenting, such as modeling and teaching.
12. In couples counseling, assess for societal or *acculturation* conflicts, and determine the couple's perspective on what an improved relationship would look like. Problems often occur when there are differences in *acculturation* between the partners. Determine the ways that caring, support, and affection are shown, including in providing for economic needs.
13. With Asian children and adolescents, common problems involve *acculturation* conflicts with parents, feeling guilty or stressed over poor academic performance, negative self‐image or identity issues, and struggles between interdependence and independence.
14. Consider the need to act as an advocate or to engage in systems‐level intervention in cases of institutional racism or discrimination.

Video Lecture: Culturally Competent Counseling: Innovative Approaches to Counseling Asian Americans by Fred Leong

SUMMARY

Asian Americans and Pacific Islanders make up nearly 6% of the U.S. population, but comprise 40 distinct subgroups, each with its own language, religion, and customs. The counselor should not assume that these groups are all the same. Asian Americans are often seen as a *model minority*, which masks the historical and continuing prejudice and discrimination directed toward them. Counselors working with Asian Americans and Pacific Islanders must be cognizant of major cultural differences such as *collectivism*, *hierarchical relationships*, parenting styles, *emotionality*, holistic orientation, and academic/occupational goal orientations that contrast with EuroAmerican characteristics. A failure to acknowledge these differences may lead to inappropriate and ineffective treatments. Further, it is important to understand and work with the strengths of the group, and to be knowledgeable about racial identity development, *acculturation* conflicts, and the different expectations Asian Americans may have of counseling. Fourteen clinical implications for counselor practice are identified.

GLOSSARY TERMS

- Acculturation
- Co - construction
- Collectivistic orientation
- Emotionality
- Enculturation
- Hierarchical relationships
- Integration/Biculturalism
- Model minority
- Somatic complaints

REFERENCES

1. Ahn, A. J., Kim, B. S. K., & Park, Y. S. (2008). Asian cultural values gap, cognitive flexibility, coping strategies, and parent–child conflicts among Korean Americans. *Asian American Journal of Psychology*, *14*(4), 353–363.

2. Atkinson, D. R., Kim, B. S. K., & Caldwell, R. (1998). Ratings of helper roles by multicultural psychologists and Asian American students: Initial support for the three‐dimensional model of multicultural counseling. *Journal of Counseling Psychology*, *45*, 414–423.

3. Blair, S. L., & Qian, Z. (1998). Family and Asian students' educational performance. *Journal of Family Issues*, *19*, 355–374.

4. Buki, L. P., Ma, T.‐C., Strom, R. D., & Strom, K. (2003). Chinese immigrant mothers of adolescents: Self‐perceptions of acculturation effects on parenting. *Cultural Diversity and Ethnic Minority Psychology*, *9*, 127–140.

5. Chang, H.‐L., Chen, S.‐P., & Cha, C. H. (2015). Perceived discrimination, intergenerational family conflicts, and depressive symptoms in foreign‐born and U.S.‐born Asian American emerging adults. *Asian American Journal of Psychology*, *6*, 107–116.

6. Chang, T.‐F., Han, E.‐J., Lee, J.‐S., & Qin, D. B. (2015). Korean American adolescent ethnic‐identity pride and psychological adjustment: Moderating effects of parental support and school environment. *Asian American Journal of Psychology*, *6*, 190–199.

7. Chen, E. W.‐C. (2009). Chinese Americans. In E. W.‐C. Chen, & G. J. Yoo (Eds.), *Encyclopedia of Asian American issues today* (Vol. *1*) (pp. 222–223). Westport, CT: Greenwood.

8. Chen, S. W.‐H., & Davenport, D. S. (2005). Cognitive‐behavioral therapy with Chinese American clients: Cautions and modifications. *Psychotherapy: Theory, Research, Practice, Training*, *42*, 101–110.

9. Eaton, M. J., & Dembo, M. H. (1997). Differences in the motivational beliefs of Asian Americans. *Journal of Educational Psychology*, *89*, 433–440.

10. Fuligni, A. J., Burton, L., Marshall, S., Perez‐Febles, A., Yarrington, J., Kirsh, L. B., & Merriwether‐DeVries, C. (1999). Attitudes toward family obligations among American adolescents with Asian, Latin American, and European backgrounds. *Child Development*, *70*, 1030–1044.

11. Hwang, W.‐C., Woods, J. J., & Fujimoto, K. (2010). Acculturative family distancing (AFD) and depression in Chinese American families. *Journal of Consulting and Clinical Psychology*, *78*, 655–667.

12. Jang, Y., Park, N. S., Chiriboga, D. A., & Kim, M. T. (2017). Latent profiles of acculturation and their implications for health: A study with Asian Americans in central Texas. *Asian American Journal of Psychology*, *8*(3), 200–208.

13. Jose, P. E., Huntsinger, P. R., & Liaw, L. (2004). Parental values and practices relevant to young children's social development in Taiwan and the United States. *Journal of*

Cross‐Cultural Psychology, *31*, 677–702.

14. Kalibatseva, Z., & Leong, F. T. (2011). Depression among Asian Americans: Review and recommendations. *Depression Research and Treatment*, *2011*, 320902.

15. Kelly, M., & Tseng, H. (1992). Cultural differences in childrearing: A comparison of immigrant Chinese and Caucasian American mothers. *Journal of Cross‐Cultural Psychology*, *23*, 444–455.

16. Kim, B. S. K. (2007). Adherence to Asian and European American cultural values and attitudes toward seeking professional psychological help among Asian American students. *Journal of Counseling Psychology*, *54*, 474–480.

17. Kim, B. S. K. (2011). *Counseling Asian Americans*. Belmont, CA: Cengage.

18. Lau, A. S. (2012). Reflections on adapting parent training for Chinese immigrants: Blind alleys, thoroughfares, and test drives. In G. Bernal, & M. M. Domenech Rodriguez (Eds.), *Cultural adaptations: Tools for evidence‐based practice with diverse populations* (pp. 133–156). Washington, DC: American Psychological Association.

19. Lau, A. S., Fung, J. J., & Yung, V. (2010). Group parent training with immigrant Chinese families: Enhancing engagement and augmenting skills development. *Journal of Clinical Psychology: In Session*, *66*, 880–894.

20. Lau, J. S., Fung, J., Wang, S.‐W., & Kang, S.‐M. (2009). Explaining elevated social anxiety among Asian Americans: Emotional attunement and a cultural double bind. *Cultural Diversity and Ethnic Minority Psychology*, *15*, 77–85.

21. Lau, W.‐Y., Chan, C. K.‐Y., Li, J. C.‐H., & Au, T. K. F. (2010). Effectiveness of group cognitive‐behavioral treatment for childhood anxiety in community clinics. *Behaviour Research and Therapy*, *48*, 1067–1077.

22. Lee, C.‐R. (1995). *Native speaker*. New York, NY: Berkley.

23. Lee, D. L., & Ahn, S. (2011). Racial discrimination and Asian mental health: A meta‐analysis. *The Counseling Psychologist*, *39*(3), 463–489.

24. Lee, R. M., Choe, J., Kim, G., & Ngo, V. (2000). Construction of the Asian American Family Conflicts Scale. *Journal of Counseling Psychology*, *47*, 211–222.

25. Lee, R. M., Su, J., & Yoshida, E. (2005). Coping with intergenerational family conflict among Asian American college students. *Journal of Counseling Psychology*, *52*, 389–399.

26. Lim, B. N. (2014). I am not a model minority. Retrieved from http://www.thecrimson.com/article/2014/2/13/harvard‐model‐minority

27. Lo, H.‐W. (2010). My racial identity development and supervision: A self‐reflection. *Training and Education in Professional Psychology*, *4*, 26–28.

28. Lorenzo, M. K., Pakiz, B., Reinherz, H. Z., & Frost, A. (1995). Emotional and behavioral problems of Asian American adolescents: A comparative study. *Child and Adolescent Social Work Journal*, *12*, 197–212.

29. Lucas, M. S., & Berkel, L. A. (2005). Counseling needs of students who seek help at a university counseling center: A closer look at gender and multicultural issues. *Journal of College Student Development*, *46*, 251–266.

30. Mallinckrodt, B., Shigeoka, S., & Suzuki, L. A. (2005). Asian and Pacific Island American students' acculturation and etiology beliefs about typical counseling presenting problems. *Cultural Diversity and Ethnic Minority Psychology*, *11*, 227–238.

31. Meyer, O., Zane, N., & Cho, Y. I. (2011). Understanding the psychological processes of the racial match effect in Asian Americans. *Journal of Counseling Psychology*, *58*, 335–345.

32. Mintz, L. B., & Kashubeck, S. (1999). Body image and disordered eating among Asian American and Caucasian college students: An examination of race and gender differences. *Psychology of Women Quarterly*, *23*, 781–796.

33. Nadal, K. L., Escobar, K. M., Prado, G., David, E. J. R., & Haynes, K. (2012). Racial microaggressions and the Filipino American experience: Recommendations for counseling and development. *Journal of Multicultural Counseling and Development*, *40*, 156–173.

34. Nguyen, S. D. (1985). Mental health services for refugees and immigrants in Canada. In T. C. Owen (Ed.), *Southeast Asian mental health: Treatment, prevention, services, training, and research* (pp. 261–282). Washington, DC: National Institute of Mental Health.

35. Noh, S., Beiser, M., Kaspar, V., Hou, F., & Rummens, J. (1999). Perceived racial discrimination, depression, and coping: A study of Southeast Asian refugees in Canada. *Journal of Health and Social Behavior*, *40*, 193–207.

36. Ong, A. D., Burrow, A. L., Fuller‐Rowell, T. E., Ja, N. M., & Sue, D. W. (2013). Racial microaggressions and daily well‐being among Asian Americans. *Journal of Counseling Psychology*, *60*(2), 188.

37. O'Reilly, J. P., Tokuno, K. A., & Ebata, A. T. (1986). Cultural differences between Americans of Japanese and European ancestry in parental valuing of social competence. *Journal of Comparative Family Studies*, *17*, 87–97.

38. Paiva, N. D. (2008). South Asian parents' constructions of praising their children. *Clinical Child Psychology and Psychiatry*, *13*, 191–207.

39. Ramakrishnan, K., & Ahmad, F. Z. (2014). Income and poverty. Retrieved from https://cdn.americanprogress.org/wp‐content/uploads/2014/08/AAPI‐IncomePoverty.pdf

40. Ramos, D. (2017). Asian Americans on TV: Study finds continued underrepresentation despite new wave of AAPI‐led shows. Retrieved from: http://deadline.com/2017/09/asian‐americans‐in‐television‐study‐diversity‐representation‐inclusion‐master‐of‐none‐fresh‐off‐the‐boat‐1202165584#!

41. Russell, S. T., Crockett, L. J., & Chao, R. (Eds.) (2010). *Asian American parenting and parent–adolescent relationships*. New York, NY: Springer.

42. Shah, S., & Ramakrishnan, K. (2017). Why disaggregate data? Big differences in AAPI education. Retrieved from http://aapidata.com/blog/countmein‐aapi‐education/

43. Son, E., & Ellis, M. V. (2013). A cross‐cultural comparison of clinical supervision in

South Korea and the United States. *Psychotherapy*, *50*, 189–205.

44. Srivastava, S. (2009). Nobody's model minority. Retrieved from https://www.theroot.com/nobodys‐model‐minority‐1790869078

45. Suyemoto, K. L., Day, S. C., & Schwartz, S. (2015). Exploring effects of social justice youth programming on racial and ethnic identities and activism for Asian American youth. *Asian American Journal of Psychology*, *6*, 125–135.

46. Tam, R. (2013). What #NotYourAsianSidekick means to me. *Washington Post*, December 18.

47. Tsuda, T. (2014). “I'm American, not Japanese!”: The struggle for racial citizenship among later‐generation Japanese Americans. *Ethnic and Racial Studies*, *37*, 405–424.

48. U.S. Census Bureau. (2012). The Asian population: 2010. Report No. C2010BR‐11. Retrieved from https://www.census.gov/prod/cen2010/briefs/c2010br‐11.pdf

49. U.S. Census Bureau. (2013). Poverty rates for selected detailed race and Hispanic groups by state and place: 2007–2011. Report No. ACSBR/11‐17. Retrieved from https://www.census.gov/library/publications/2013/acs/acsbr11‐17.html

50. U.S. Census Bureau. (2015). People quickfacts. Retrieved from https://www.census.gov/quickfacts/fact/table/US/PST045217

51. U.S. Census Bureau. (2016). Educational attainment in the United States: 2015. Report No. P20‐578. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2016/demo/p20‐578.pdf

52. Vakalahi, H. F. O. (2009). Pacific Islander American students: Caught between a rock and a hard place? *Children and Youth Services Review*, *31*, 1258–1263.

53. Wang, S., & Kim, B. S. K. (2010). Therapist multicultural competence, Asian American participants' cultural values, and counseling process. *Journal of Counseling Psychology*, *57*, 394–401.

54. Wong, Y. J., Tran, K. K., Kim, S.‐H., Kerne, V. V. H., & Calfa, N. A. (2010). Asian Americans' lay beliefs about depression and professional help seeking. *Journal of Clinical Psychology*, *66*, 317–332.

55. Xie, K. (2016). What it's like to be an Asian American with depression. Retrieved from https://themighty.com/2016/07/living‐with‐depression‐as‐an‐asian‐american/

56. Zane, N., & Ku, H. (2014). Effects of ethnic match, gender match, acculturation, cultural identity, and face concern on self‐disclosure in counseling for Asian Americans. *Asian American Journal of Psychology*, *5*, 66–74.

17
Counseling Latinx Populations

Chapter Objectives

1. **1. Learn the demographics and characteristics of Latinx individuals.**
2. **2. Identify counseling implications of the information provided for Latinx individuals.**
3. **3. Provide examples of strengths that are associated with Latinx individuals.**
4. **4. Know the special challenges faced by Latinx individuals.**
5. **5. Understand how the implications for clinical practice can guide assessment and therapy with Latinx individuals.**

> *I need to hear it, see it, sound it out for a while. I do think that it is incredibly important to experiment with language as we change as a country. So [Latinx] does make sense, because our community is changing. We are talking about gender issues, we are talking about LGBT issues, and we are looking for terms that explain and help us understand our experience in this country.*
>
> *(Daisy Hernandez, quoted in Reyes, 2016)*

> *When Mexico sends its people, they're not sending their best. They're not sending you. They're sending people that have lots of problems, and they're bringing those problems with us. They're bringing drugs. They're bringing crime. They're rapists. And some, I assume, are good people.*
>
> *(Donald Trump on the presidential campaign trail in 2015)*

> *In part because of the anti‐immigrant and anti‐Latinx sentiments espoused by political leaders in the U.S., we see an increase in experiences with racism. According to a Pew Research Center poll, over half (52%) of "Hispanics" report experiencing racial or ethnic discrimination in their lifetime; this number jumps to nearly two‐thirds (65%) if we only focus on younger adults from 18 to 29.*
>
> *(Krogstad & Lopez, 2016)*

> *I grew up believing in the American dream and I worked hard to earn my place in the country that nurtured and educated me. Like the thousands of other undocumented students and graduates across America, I am looking for one thing, and one thing only: the opportunity to give back to my community, my state, and the country that is my home, the United States.*
>
> *(Maria Gomez, quoted in Durbin, 2018)*

In this chapter, we use the gender‐inclusive term "Latinx" in reference to individuals living in the United States with ancestry from Spanish‐speaking (e.g., Mexico, Puerto Rico, Cuba, Dominican Republic) and non‐Spanish‐speaking (e.g., Brazil, French Guiana, Suriname) South and Central American countries. However, people vary in preference for the terms used for pan‐ethnic self‐identification; some prefer the gendered terms "Latina" and "Latino," some prefer the term "Hispanic," and some prefer more specific ethnic terms such as "Chicana," "Puerto Rican," and "Brazilian." The U.S. Census uses the term *Hispanic* as an ethnic descriptor rather than the term *Latina/o* or *Latinx* (pronounced La‐teen‐ex).

Throughout Latin America, the immigration of European and Asian populations, the forced displacement of people from Africa, and the subsequent mixture with indigenous groups has resulted in a wide range of phenotypes. Thus, the physical traits of Latinx vary greatly, and include characteristics of indigenous groups, Africans, Asians, and light‐skinned Europeans.

About a quarter of Latinx individuals identify as Afro‐Latino and about a quarter identify as indigenous (Krogstad & Lopez, 2016). Although the growth of the Latinx population has slowed since about 2007, Latinx individuals are currently the largest minority group in the United States, making up 17.6% of the total U.S. population; among them, 63% are of Mexican origin, 9.5% are from Puerto Rico or of Puerto Rican descent, and nearly 4% have either Cuban or Salvadorian ancestry, while others have their origins in the Dominican Republic (3.3%), Guatemala (2.5%), or another Central or South American country (U.S. Census Bureau, 2017).

With the exception of American Indians, more Latinx individuals have ancestors belonging to the original lands of the Americas than in any other racial or pan‐ethnic group. Thus, it seems odd to talk about Latinx individuals, particularly those from Mexico, as immigrants in the United States. Having said that, a little over a third of Latinx individuals are immigrants (U.S. Census Bureau, 2017), and nearly half (45%) of all immigrants are of Hispanic origin (Zong, Batalova, & Hallock, 2018). It is not surprising then that nearly half of all Latinx adults express concern that they, a family member, or a close friend will be deported (Lopez, Taylor, Funk, & Gonzalez‐Barrera, 2013). Those who are undocumented occupy the lowest rung of the labor pool and are often taken advantage of because they have no legal status.

Although Latinx groups share many characteristics, there are many between‐group and within‐group differences. Many are strongly oriented toward their ethnic group, whereas others are quite acculturated to mainstream values. About three‐fourths of U.S.‐born Latinx individuals are third‐generation or higher, with many descended from the large wave of Latin Americans who began immigrating in the 1960s. In certain states and cities, they make up a substantial percentage of the population. Mexican Americans are the dominant Latinx group in metropolitan areas throughout the United States, especially in California and Texas. Most Puerto Ricans reside in the Northeast, and most Cubans live in Florida (Lopez & Dockterman, 2011). There are a number of wealth and health disparities. The median income of Latinx families ($47,675) is about 80% of the U.S. median family income ($59,039), with nearly one in five Latinx individuals living in poverty; in 2016, about 16% of Latinx individuals did not have health insurance (U.S. Census Bureau, 2017).

CHARACTERISTICS AND STRENGTHS

In the following sections we describe the characteristics, values, and strengths of Latinx individuals and consider their implications in treatment. These are generalizations and their applicability needs to be assessed for each client or family.

Cultural Values and Characteristics

The development and maintenance of interpersonal relationships are central in Latin American cultures (Kuhlberg, Pena, & Zayas, 2010). There is typically deep respect and affection among a large network of family and friends. Family unity, respect, and tradition (*familismo*) are an important aspect of life. Cooperation among family members is stressed. For many, the *extended family* includes not only relatives but also close friends and godparents (*padrinos*). Each member in the traditional family has a role: mother (caregiver), father (provider), children (obedient), grandparents (wise council), and godparents (resource) (Lopez‐Baez, 2006).

Implications

Familismo refers not only to family cohesiveness and interdependence but also to loyalty and placing the needs of close friends and family members before personal needs (Baumann, Kuhlberg, & Zayas, 2010). Counselors can inquire about clients' connectedness with extended and nuclear family members and the value placed on *familismo*. Because of these strong familial and social relationships, Latinx individuals often wait until resources from *extended family* and close friends are exhausted before seeking help. Even in cases of severe mental illness, many delay obtaining assistance (Kouyoumdjian, Zamboanga, & Hansen, 2003).

Although *familismo* is a source of resilience for many Latinx families, emotional involvement and obligations with numerous family and friends can function as a source of stress, particularly when decisions are made that affect the individual negatively (Aguilera, Garza, & Muñoz, 2010). Problem definition may need to incorporate the perspectives of both nuclear and *extended family* members, and solutions may need to bridge cultural expectations and societal demands. Additionally, family responsibilities sometimes take precedence over outside concerns, such as school attendance or work obligations. For example, older children may be kept home to care for ill siblings, attend family functions, or work (Headden, 1997). Under these circumstances, problematic behaviors (i.e., absenteeism) can be addressed by framing them as a conflict between cultural and societal expectations.

Family Structure

Traditionally oriented families are hierarchical in form, with special authority given to parents, older family members, and males. Within this type of family structure, sex roles are clearly delineated. The father is typically the primary authority figure. Children are expected to be obedient and are typically not involved in family decisions.

Parents reciprocate by providing for children through young adulthood and even after marriage. This type of reciprocal relationship is a lifelong expectation and is the cornerstone of *familism*. Older children are expected to care for and protect their younger siblings; older sisters often function as surrogate mothers. Although changing gender norms are affecting the boundaries of traditional family roles, the saliency of family as a core value and the importance of family connectedness remain central.

Implications

Assessment of family structure should consider the ways that decisions are made within the family unit. Conflicts among family members often involve differences in *acculturation* and conflicting views of roles and expectations for family members, as well as clashes between cultural values and mainstream societal expectations on the parts of parents and their children (Baumann et al., 2010). In less acculturated families, counselors may find success by helping family members reframe these issues as responses to *acculturation* stress; they can then negotiate conflicting cultural norms and values. Counselors can help clients consider ways in which they can demonstrate their allegiance to the family without significantly compromising their own *acculturation*. One such approach is demonstrated in the following case:

> *During family therapy, a Puerto Rican mother indicated to her son, "You don't care for me anymore. You used to come by every Sunday and bring the children. You used to respect me and teach your children respect. Now you go out and work, you say, always doing this or that. I don't know what spirit [que diablo] has taken over you."*
>
> *(Inclan, 1985, p. 332)*

In response, the son explained that he was sacrificing and working hard because he wanted to be a successful provider and someone of whom his children could be proud. The son has adopted future‐oriented, mainstream U.S. values, stressing hard work and individual achievement. The mother was disappointed because she believed her son should spend time with her, encourage the family to gather together, and prioritize the family over individual desires. This clash in values was at the root of the problem.

In working with this family, the therapist provided alternative ways of viewing the conflict. He explained how our views are shaped by the values that we hold. He asked the mother about her socialization and early childhood values. The son expressed how difficult it was to lose his parents' respect, but also his belief that he needed to work hard and focus on the future in order to succeed in the United States. The therapist pointed out that different adaptive styles may be necessary for different situations and that what "works best" may be dependent on the social context. Both mother and son acknowledged that they demonstrate love and affection in different ways. As a result of the sessions, mother and son better understood the nature of their conflicts and were able to improve their relationship.

Gender Role Expectations

Latinx individuals often experience conflicts over gender roles. In traditional culture, men are expected to be strong, dominant, and the provider for the family (*machismo*), whereas women are expected to maintain harmony and nurture spiritual life within the family, and to be modest, virtuous, and subordinate to others (*marianismo*) (Piña‐Watson, Castillo, Jung, Ojeda, & Castillo‐Reyes et al., 2014). Within a traditional family structure, the father expects family members to be obedient. Areas of possible gender role conflict for men (especially among immigrants) include the following (Avila & Avila, 1995; Constantine, Gloria, & Baron, 2006):

1. *Lack of confidence in areas of authority. Latino* men may lack confidence interacting with agencies and individuals outside of the family; this can result in feelings of inadequacy and concern about diminished authority, especially if the wife or children are more fluent in English.
2. *Feelings of isolation and depression because of the need to be strong*. Talking about

concerns or stressors may be seen as a sign of weakness. This difficulty discussing feelings can produce isolation and anger or depression.

3. *Conflicts over the need to be consistent in one's role*. As ambiguity and stress increase, there may be more rigid adherence to traditional roles.

For women, conflicts may involve (a) expectations associated with traditional roles, (b) anxiety or depression over not being able to live up to these standards, and (c) an inability to express feelings of anger (Lopez‐Baez, 2006). Latina immigrants are often socialized to feel inferior and to expect suffering or martyrdom. However, given the economic, political, and social climate of the United States, women may be asked to assume greater responsibility to provide financially for the family. For Latinx immigrant families, language skills and familiarity with U.S. culture may further disrupt traditional gender and other family roles. There is a shift in power dynamics within the family when children are placed in the role of language brokers, creating generational stress between parents and children. While the rupture affects all family members, it may be especially difficult for fathers, who understandably may feel as though their authority and ability to provide for their family are being called into question. With parents' increased acculturation to dominant U.S. norms, such views may shift. Certain gender roles may change more than others over time. Some women may be very modern in their views regarding education and employment but remain traditional in the area of sexual behavior and personal relationships. Others remain very traditional in all areas. Cultural differences between partners are associated with strained marital relationships, while couples with cultural similarity have a more positive marital experience (Cruz et al., 2014).

Implications

Therapists should explore the client's degree of adherence to traditional gender norms, as well as the gender role views among family members. It is important to consider the potential impact of *acculturation* on marital relationships, particularly when women function independently in the work setting or when dealing with schools and other agencies. For both men and women, role conflict is likely to occur if the man is unemployed, if the woman is employed, or both.

When dealing with gender role conflicts, counselors who believe in equal relationships must be careful not to impose their views on clients. Instead, if a Latina client desires greater independence, the counselor can help her consider the consequences of change, including potential problems within her family and community, and work to help her achieve her goal within a cultural framework. It is helpful to frame conflicts in gender roles as an external issue involving differing expectations between cultural and mainstream U.S. values and to encourage problem solving to deal with the different sets of expectations.

Spiritual and Religious Values

> *Mrs. Lopez, age 70, and her 30‐year‐old daughter sought counseling because they had a very conflictual relationship … The mother was not accustomed to a counseling format … At a pivotal point in one session, she found talking about emotional themes overwhelming and embarrassing … In order to reengage her, the counselor asked what resources she used when she and her daughter quarreled. She … prayed to Our Lady of Guadalupe.*
>
> *(Zuniga, 1997, p. 149)*

The therapist subsequently employed a culturally adapted strategy of having Mrs. Lopez use prayer and spiritual guidance to understand her daughter and to find solutions to their conflicts. This use of a cultural perspective allowed the sessions to continue. Religion (often, but not always, Catholicism) is important to many Latinx individuals, although less so among younger individuals (Pew Research Center, 2014). Prayers requesting guidance from patron saints can be a source of comfort in times of stress. It is not uncommon for Latinx youth and adults to express a certain level of *fatalism* or the belief that life experiences are determined by fate; like many cultural phenomena, *fatalism* is complex and consists of several dimensions, including luck and destiny. It seems that a sense of fate or predeterminism is related to lower health outcomes primarily for people who also adopt a higher pessimistic outlook (Piña‐Watson & Abraído‐Lanza, 2017).

Some Latinx individuals believe that good and evil spirits affect mental health problems (*espiritismo*). When they attribute their difficulties to the spirit world, they often turn to indigenous healing practices for relief. The rituals, prayers, communication with the spirits, and herbal remedies are culturally sanctioned methods of addressing the root cause of distress (Comas‐Diaz, 2012).

Implications

During assessment, it is important to consider religious or spiritual beliefs and to explore the spiritual meanings of presenting problems. If there is a strong belief that fate accounts for the current situation, instead of attempting to change this view, the therapist can acknowledge it and help the individual or family determine the most adaptive response to the situation. The therapist might say, "Given that the situation is unchangeable, how can you and your family deal with this?" with the aim of helping the client develop problem‐solving skills within certain parameters. It may be important to also tease out whether the person's understanding of the presenting concern represents a predetermined belief, such as "This is meant to happen to me," or whether it is a more pessimistic worldview of their own worthiness, such as "I am meant to suffer in life." The latter has the most negative impact on psychological health (Piña‐Watson & Abraído‐Lanza, 2017).

A strong reliance on religion can be a resource (e.g., evoking God's support through prayer to facilitate problem solving). Fatalism can be countered by stressing *"Ayu‐date, que Dios te ayudara,"* which is the equivalent of "God helps those who help themselves" (Organista, 2000). Indigenous healing practices can also be incorporated into the therapeutic process. We would not expect a Western‐trained therapist to perform traditional healing rituals; instead, it makes sense to work with a culturally sanctioned shaman or espiritista in treatment planning.

Educational Characteristics

> *The statement in my microaggression project was "Are you legal?" That's because in my freshman year [of high school], I remember some people asking me those kinds of questions. And I am a pretty calm guy. I don't get offended by almost anything. I take almost everything just as a joke. But that specific statement kind of hurt me at that time.*
>
> *(Manning, 2016)*

Many Latinx high school students experience racial discrimination and microaggressions by teachers and fellow students. Unfortunately, these experiences cause students to feel less connected to school, which in turn leads to absenteeism and lower grades (Benner & Graham, 2011). Similar to their American Indian and Black peers, some Latinx students feel pushed

out of the school system altogether. Latinx students have significantly lower public high school graduation rates compared to their White peers: 78% compared to 88% in 2014–2015 (National Center for Educational Statistics, 2017). The good news is that the gap has narrowed over the past decade.

This upward trend reflects the high value many Latinx youth place on education and their optimism about the future and performing better in school (Pew Research Center, 2009). Not surprisingly, then, college attendance is also increasing among Latinx young people: 18% were in college in 2013, versus 12% in 2009. Although there is improvement, Latinx young adults continue to lag substantially behind White youth in obtaining a bachelor's degree (9% versus 69%) (Fry, 2014).

Implications

Clinicians must assess not only intrapsychic issues but also the degree to which external conditions are involved in mental health issues. Thus, it is important to be sensitive to sociopolitical issues (e.g., anti‐immigrant sentiments) and client experiences with disenfranchisement and discrimination. For example, highly educated Latinx adults report demoralizing situations in which their academic success is questioned or they are assumed to be less qualified than they actually are (Rivera, Forquer, & Rangel, 2010).

When working with school‐aged youth, counselors should assess whether contextual factors within the school environment are contributing in some part to students' psychological or behavioral distress. Assessment areas might include broader cultural domains such as the level of acculturation and enculturation of the youth and their parent(s), the socioeconomic/financial health of the family, individual/family/community trauma, and cultural protective factors, in addition to the more specific school environment. Given that youth's experiences are shaped by who they are as individuals as well as their race, gender, and sexual orientation and their interactions, it is important to ask them directly about potential bullying or mistreatment because of their various identities. Counselors should be prepared to work with students to cope with painful racial microaggressions such as the one described at the beginning of this section, as well as to intervene more systemically within the schools to address the culture of racial intolerance.

Cultural Strengths

> *Educationally, we're there for each other. Emotionally, we're there for each other. There is also a sibling sort of rivalry. You want to do better, compete with each other, pick each other up. If one does good in math, we're all inspired to do good. The group is like a giant family. Yeah, we have our arguments, but they don't last long. We'll argue and then someone will kick you like to say, "I'm sorry," and then you move on*
>
> *(Matos, 2015, p. 445)*

The preceding quote is an excerpt from a qualitative study of the challenges and protective factors Latinx experience negotiating college environments (Matos, 2015). Findings from the study illustrate a number of the cultural strengths within Latinx communities, including a strong work ethic and valuing a sense of emotional and physical connection to others (Adames & Chavez‐Dueñas, 2016). Most Latinx children grow up in two‐parent families, often supported by a strong kinship system. *Familismo* and the related sense of connectedness and loyalty among immediate and *extended family* can be a source of significant social and emotional support for individuals and families (Kuhlberg et al., 2010). Traditional Latinx values place a great deal of emphasis on creating a harmonious atmosphere and accord within

the family system. *Personalismo* refers to a personalized communication style that is characterized by interactions that are respectful, interdependent, and cooperative. *Simpatico* refers to the relational style displayed by many Latinx individuals—a style emphasizing social harmony and a gracious, hospitable, and personable atmosphere (Holloway, Waldrip, & Ickes, 2009). Cultural identity and values can serve as a protective asset against stress by promoting a sense of belonging (Ai, Aisenberg, Weiss, & Salazar, 2014), while a strong system of spiritual and religious beliefs can be nurtured as a source of strength when dealing with personal or family issues.

SPECIFIC CHALLENGES

In the following sections, we consider challenges often faced by Latinx individuals and reflect on their implications in treatment.

Stigma Associated with Mental Illness

Depressive symptoms are common among Latinas, with 53% reporting moderate to severe symptoms versus 37% of White women (Diaz‐Martinez, Interian, & Waters, 2010). Mexican American males and Puerto Ricans of both genders have high rates of weekly alcohol consumption and binge‐drinking; additionally, alcoholism among these groups is more likely to be chronic (Chartier & Caetano, 2010). Statistics such as these confirm the need for mental health support. However, the cultural stigma associated with mental illness, including fear that psychiatric medications can cause addiction, results in reluctance to seek treatment. Latinx immigrants are also more likely than members of the majority culture to fear embarrassment or social discrimination from family, friends, and employers if they acknowledge psychological distress, and are more likely to express psychological distress via somatic symptoms.

"When *Latinos* think of mental illness, they just think one thing: *loco*," says Clara Morato, whose son, Rafaelo, was diagnosed with bipolar disorder at age 18 (Dichoso, 2010, p. 1). *Machismo* may also be a barrier to seeking treatment, owing to concerns about lost time from work (Vega, Rodriguez, & Ang, 2010). Additionally, Latinx individuals underutilize resources for their children. Although most young children are citizens, one or both parents may be undocumented and, therefore, reluctant to seek assistance (Capps, Fix, Ost, Reardon‐Anderson, & Passel, 2005). Some Latinx individuals are afraid to sign up for insurance over concern that their undocumented family members will get discovered, and deported. This results in the inability to pay for mental health treatment (Dembosky, 2014).

Implications

Clinicians can anticipate and help counteract the stigma associated with mental illness by taking the time to build rapport and provide psychoeducation about therapeutic approaches (Vega et al., 2010). Comas‐Diaz (2012), a Puerto Rican multicultural therapist, advocates exploring the client's heritage, history of cultural translocation, and views about counseling early in therapy and encourages a flexible therapeutic style that might include roles familiar to the client, such as healer, advisor, coach, teacher, guide, advocate, consultant, and mentor. Developing a culturally relevant therapeutic alliance, providing psychoeducation about how treatment is conducted and how goals are developed in a collaborative manner, and using a flexible, culture‐centered approach can help clients overcome their fear of the stigma associated with seeking help and their reluctance to participate openly in treatment.

Acculturation Conflicts

As with many ethnic minority groups, Latinx individuals are frequently faced with societal values distinctly different from their own. Additionally, the severing of ties to family and friends, the loss of supportive resources, language inadequacy, unemployment, and culture conflict all function as stressors for recent immigrants. Some maintain their traditional orientation, whereas others assimilate and exchange their native cultural practices and values for those of the host culture. Differences in *acculturation* between family members can produce stress within the family unit, as seen in the following case.

> *Juan, a 46 - year - old Latino, was born in Mexico and has lived in the United States for 10 years. He works as a cook, has been married for over 20 years, and has five children. Juan has frequent conflicts with his wife and children, believing that they want freedom from him and that they have become too "Americanized." He strongly believes in the cultural values of familismo (family connectedness), machismo (being head of the family, with responsibility for providing for the family), and respecto (respect) from his children. As husband and father, he believes that he should set the rules in the family and that his wife and children should respect his rules. Juan often feels stressed, angry, hopeless, and depressed and has had suicidal thoughts and thoughts of hurting his wife. When angry, he resorts to threats and physical violence.*
>
> *(Santiago - Rivera, Kanter, Benson, Derose, Illes, & Reyes, 2008)*

Juan's therapist recognized that traditional cognitive behavioral therapy (CBT, an evidence - based treatment for depression) might not adequately address the environmental stressors, *acculturation* conflicts, and feelings of isolation and powerlessness Juan was experiencing. Instead, he modified another evidence - based treatment (behavioral activation therapy). He encouraged Juan to participate in free or low - cost activities such as attending church services with his wife and children, thus enhancing family relationships and building social networks within the community. Differences between Juan's upbringing in Mexico and the American culture faced by his children were also discussed in therapy, increasing Juan's understanding of the issues faced by his wife and children. At the end of therapy, Juan was no longer depressed and reported improved relationships with his wife and children (Santiago - Rivera et al., 2008).

Those who completely reject or accept the values of the host culture appear to experience greater stress than those who partially accept them (Miville, Koonce, Darlington, & Whitlock, 2000). Miranda and Umhoefer (1998a, 1998b) found that both highly and minimally acculturated Mexican Americans scored high on social dysfunction, alcohol consumption, and acculturative stress. They concluded that a *bicultural orientation* (i.e., maintaining some components of the native culture while incorporating practices and beliefs of the host culture) may be the "healthiest" resolution for *acculturation*; those with *bicultural* values are able to accept and negotiate aspects of both cultures. Some of the issues involved in *acculturation* conflict are evident in the following case.

> *A Latino teenager, Mike, was having difficulty knowing "who he was" or what group he belonged with. His parents had given him an Anglo name to ensure his success in American society. They only spoke to him in English because they were fearful that he might have an accent. During his childhood, he felt estranged from his relatives because his grandparents, aunts, and uncles could speak only Spanish. At school, he did not fit in with his non - Latino peers, but also felt different from the Mexican American students who would ask him why he was unable to speak Spanish. Mike's confusion over his ethnic identity resulted in significant distress.*
>
> *(Avila & Avila, 1995)*

During their early teen years, Latinx youth may begin to have questions about their identity and question whether they should adhere to mainstream or traditional values. The representation of Latinx individuals on English - language channels often involves characters who behave criminally or are violent. The mixed heritage of many Latinx Americans raises additional identity questions. Should those of Mexican heritage call themselves "Mexican," "American," "Mexican American," "Chicano," "Latina/o," or "Hispanic"? What about those with indigenous, Asian, or African ancestry? An ethnic identity provides a sense of belonging

and group membership. Many Latinx youngsters undergo the process of searching for an identity. This struggle, in combination with acculturative stresses, may contribute to problems such as substance abuse, aggressive behavior, delinquency, low self‐esteem, and an increased risk for suicide (Smokowski, Rose, & Bacallao, 2010). Retention of one's culture may be related to positive mental health. Mexican American students who maintained their ethnic identity and heritage had higher levels of self‐esteem and life satisfaction. Cultural retention may help prevent problem behaviors (Navarro, Ojeda, Schwartz, Piña‐Watson, & Luna, 2014).

Implications

The client's degree of *acculturation* has important implications for treatment, especially during initial therapy sessions, and can influence both perceptions of and responses to counseling. For example, individuals with minimal *acculturation* may have difficulty being open and self‐disclosing or discussing their issues in depth and may believe that counseling will take only one session (Dittmann, 2005). *Acculturation* can be assessed by inquiring about the client's background, generational status, residential history, reasons for immigration (if applicable), primary language, religious orientation and strength of religious beliefs, extent of support from *extended family*, and other factors related to *acculturation*. The therapist needs to determine the client's degree of adherence both to traditional values and to those of the dominant U.S. culture. The therapeutic alliance can be enhanced by inviting the client to share their story and then listening deeply and empathically (Comas‐Diaz, 2012).

Ethnic identity issues should be recognized and incorporated during assessment and treatment of youth and adults. Conflicts between mainstream values and ethnic group values can be discussed, and clients can help brainstorm methods for bridging these differences. It should be stressed that ethnic identity is part of the normal development process. In many cases, a *bicultural* perspective may be the most functional, since such a perspective does not involve the wholesale rejection of either culture.

Counselors should also inquire about potential *acculturation* conflicts, including their impact on client symptoms or family conflicts. Although values such as *familismo* can be a source of strength for youth, distress may feel unbearable when there is parent–child discord (Hernandez, Garcia, & Flynn, 2010). Identification with core cultural values appears to serve as a protective factor against risky behavior such as substance abuse and to serve as a source of strength for children and adolescents (Dettlaff & Johnson, 2011). Counselors can help youth explore and retain their cultural values and ethnic identity to bolster self‐esteem and life satisfaction (Ai et al., 2014).

Research attempting to identify the risk factors accounting for the high incidence of suicide attempts among Latinas, particularly among girls whose mothers place high value on *familismo*, suggests that although *familismo* can be a protective factor with respect to emotional and behavioral health, conflicts that result from adolescent strivings for autonomy and subsequent parent–child discord can be a risk factor, particularly for those accustomed to close parent–child relationships and harmony in the family unit (Kuhlberg et al., 2010). Adolescents may question family obligations and parental rules and desire input into decisions. Such behavior may be viewed as disrespectful by parents and *extended family*. Larger societal factors such as immigration policies, discrimination, and concerns about family separation also serve as risk factors (Romero, Edwards, Bauman, & Ritter, 2014).

Females may feel overprotected by parents and question their rules or expectations, such as that the daughter will stay at home to care for others and be monitored on dates or forbidden to date; such *acculturation* conflict may be particularly distressing to girls, since gender

socialization for females emphasizes their role in maintaining harmonious relationships. Mother–daughter conflicts are exacerbated when the family orientation is traditional and the daughter has a high mainstream cultural involvement (Derlan, Umaña‐Taylor, Toomey, Updegraff, & Jahromi, 2015). Both *biculturalism* and *familismo* are related to higher self‐esteem and greater flexibility in negotiating both cultures among Latinx adolescents (Smokowski et al., 2010). Effective interventions for parent–child conflict include enhancing *bicultural* understanding and promoting adaptive interpersonal behaviors (e.g., improved communication, increased parental affection, and emotional connection) (Kuhlberg et al., 2010).

Linguistic Issues

Considerable evidence suggests that assessment results can be influenced by linguistic differences or misunderstandings. Assessments should always be conducted in the primary language of the client and interpreted within a sociocultural context.

Implications

It is essential that clinicians consider the validity of tests for Latinx clients and the influence of cultural or social factors, as well as language barriers, discrimination, immigration stress, and poverty. Because of the lack of bilingual counselors, problems in diagnosis can occur with clients who are not proficient in English. For example, Marcos (1973) reported that Mexican American clients were considered to have greater psychopathology when interviewed in English than when interviewed in Spanish. If an interpreter is used, this may present its own difficulties in the counseling process, such as distortions in communication.

IMPLICATIONS FOR CLINICAL PRACTICE

Several writers (Bean, Perry, & Bedell, 2001; Paniagua, 1994; Velasquez et al., 1997) have made suggestions about initial counseling sessions with Latinx clients.

1. Assess the *acculturation* level of the client and family members and modify your interactions and assessment accordingly.
2. It is important to engage in a respectful, warm, and mutual introduction with the client. Less acculturated clients may expect a more formal relationship and see the counselor as an authority figure. Paniagua (1994) recommends interviewing the father for a few minutes during the beginning of the first session, showing recognition of the father's authority and sensitivity to cultural factors in counseling.
3. Determine whether a translator is needed. Determine if a Spanish‐speaking therapist is available, if preferred.
4. Give a brief description of what counseling is and the role of each participant. Such information is particularly important for less acculturated clients, who may expect to meet for only one or two sessions or expect to have medication prescribed.
5. Explain the notion of confidentiality. Even immigrants with legal status have inquired about whether the information shared during counseling will “end up in the hands of the Border Patrol or other immigration authorities” (Velasquez et al., 1997, p. 112). Immigrant families may also be uncertain about the limits of confidentiality, especially as it applies to child abuse or neglect issues. Physical discipline is used in some families. Parents may be fearful about how their child‐rearing practices will be perceived.

6. Have clients state in their own words the problem as they see it. Determine the possible influence of religious or spiritual beliefs. Use paraphrasing to summarize and clarify the problem.
7. Consider whether there are cultural or societal aspects to the problem. What are the impacts of racism, poverty, and acculturative stress?
8. Determine the positive assets and resources available to the client and his or her family. Have they, other family members, or friends successfully dealt with similar problems?
9. Help the client prioritize the problems and decide on the goals and expectations for therapy.
10. Discuss possible negative consequences of achieving the indicated goals for the client and the family.
11. Discuss the possible participation of family members in therapy. Within the family, determine the hierarchical structure, as well as the degree of *acculturation* of the different members.
12. Assess possible problems from external sources, such as the need for food, shelter, or employment, or stressful interactions with agencies/systems based on race, gender, status, and the like. Provide necessary assistance in developing and maintaining environmental supports.
13. Explain the treatment to be used, why it was selected, and how it will help achieve the goals (culturally adapted evidence‐based therapies should be considered). Consistently evaluate the client's or family's response to the therapeutic approach chosen.
14. With the client's input, determine a mutually agreeable length of treatment. It is better to offer time‐limited, solution‐based therapies.
15. Remember that *personalismo* is a basic cultural value for many Latinx. Although initial meetings may be quite formal, once trust has developed, clients may develop a close personal bond with the counselor, treat the counselor as a close friend or family member, and give gifts or extend invitations to family functions. These behaviors are culturally based and not evidence of dependency or a lack of boundaries.
16. When there are *acculturation* conflicts, have clients identify external demands rather than merely focus on intrapsychic or relational issues.

Video Lecture: Culturally Competent Counseling: Innovative Approaches to Counseling Latina/o People

SUMMARY

The gender‐inclusive term “Latinx” refers to a diverse group of people whose countries of origin include Mexico, Puerto Rico, Cuba, and other Caribbean and Central and South American countries. As with other groups of color, their standard of living is far below that of their White counterparts and they have been subjected to continual racism and bias. Understanding the major differences in the family structures (*familismo*), gender role expectations (*machismo* and *marianismo*), spiritual and religious values, educational characteristics, and cultural strengths of this group is important in informing culturally responsive practice. Counselors must anticipate specific challenges they face, such as mental illness stigma, *acculturation* conflicts, and linguistic issues in addition to the larger social policies and practices. Sixteen clinical implications for counselor practice are identified.

GLOSSARY TERMS

- Acculturation
- Bicultural orientation
- Extended family
- *Espiritismo*
- *Familismo*
- Fatalism
- Latinx Americans
- *Machismo*
- *Marianismo*
- *Personalismo*
- *Respecto*
- *Simpatico*

REFERENCES

1. Adames, H. Y., & Chaves‐Dueñas, N. Y. (2016). *Cultural foundations and interventions in Latino/a mental health: History, theory and within group differences*. Abingdon: Routledge.

2. Aguilera, A., Garza, M. J., & Muñoz, R. F. (2010). Group cognitive‐behavioral therapy for depression in Spanish: Culture‐sensitive manualized treatment in practice. *Journal of Clinical Psychology: In Session*, *66*, 857–867.

3. Ai, A. L., Aisenberg, E., Weiss, S. I., & Salazar, D. (2014). Racial/ethnic identity and subjective physical and mental health of Latino Americans: An asset within? *American Journal of Community Psychology*, *53*, 173–184.

4. Avila, D. L., & Avila, A. L. (1995). Mexican Americans. In N. A. Vacc, S. B. DeVaney, & Wittmer (Eds.), *Experiencing and counseling multicultural and diverse populations* (3rd ed.) (pp. 119–146). Bristol, PA: Accelerated Development.

5. Baumann, A. A., Kuhlberg, J. A., & Zayas, L. H. (2010). Familism, mother‐daughter mutuality, and suicide attempts of adolescent Latinas. *Journal of Family Psychology*, *24*, 616–624.

6. Bean, R. A., Perry, B. J., & Bedell, T. M. (2001). Developing culturally competent marriage and family therapists: Guidelines for working with Hispanic families. *Journal of Marital and Family Therapy*, *27*, 43–54.

7. Benner, A. D., & Graham, S. (2011). Latino adolescents' experiences of discrimination across the first 2 years of high school: Correlates and influences on educational outcomes. *Child Development*, *82*(2), 508–519.

8. Capps, R., Fix, M., Ost, J., Reardon‐Anderson, J., & Passel, J. S. (2005). *The health and wellbeing of young children of immigrants*. Immigrant families and workers: Facts and perspectives. Washington, DC: Urban Institute.

9. Chartier, K., & Caetano, R. (2010). Ethnicity and health disparities in alcohol research. *Alcohol Research & Health*, *82*(2), 508–519.

10. Comas‐Diaz, L. (2012). *Multicultural care: A clinician's guide to cultural competence*. Washington, DC: APA.

11. Constantine, M. G., Gloria, A. M., & Baron, A. (2006). Counseling Mexican American college students. In C. C. Lee (Ed.), *Multicultural issues in counseling* (3rd ed.) (pp. 207–222). Alexandria, VA: American Counseling Association.

12. Cruz, R. A., Gonzales, N. A., Corona, M., King, M., Cauce, A. M., Robins, R. W., & Conger, R. D. (2014). Cultural dynamics and marital relationship quality in Mexican‐origin families. *Journal of Family Psychology*, *28*(4), 844–854.

13. Dembosky, A. (2014). Latinos still reluctant to sign up for Obamacare. Retrieved from http://www.marketplace.org/topics/health‐care/latinos‐still‐reluctant‐sign‐obamacare

14. Derlan, C. L., Umaña‐Taylor, A. J., Toomey, R. B., Updegraff, K. A., & Jahromi, L. B. (2015). Person–environment fit: Everyday conflict and coparenting conflict in

Mexican‐origin teen mother families. *Cultural Diversity and Ethnic Minority Psychology*, *21*, 136–145.

15. Dettlaff, A. J., & Johnson, M. A. (2011). Child maltreatment dynamics among immigrant and U.S.‐born Latino children: Findings from the National Survey of Child and Adolescent Well‐Being (NSCAW). *Children and Youth Services Review*, *33*, 936–944.

16. Diaz‐Martinez, A. M., Interian, A., & Waters, D. M. (2010). The integration of CBT, multicultural and feminist psychotherapies with Latinas. *Journal of Psychotherapy Integration*, *20*, 312–326.

17. Dichoso, S. (2010). Stigma haunts mentally ill Latinos. Retrieved from http://www.cnn.com/2010/HEALTH/11/15/latinos.health.stigma/index.html

18. Dittmann, M. (2005). Homing in on Mexican Americans' mental health access. *Monitor on Psychology*, *36*, 70–72.

19. Durbin, D. (2018). Dreamers' stories. Retrieved from https://www.durbin.senate.gov/issues/immigration‐and‐the‐dream‐act/dreamers‐stories

20. Fry, R. (2014). U.S. high school dropout rate reaches record low, driven by improvements among Hispanics, blacks. Retrieved from http://www.pewresearch.org/fact‐tank/2014/10/02/u‐s‐high‐school‐dropout‐rate‐reaches‐record‐low‐driven‐by‐improvements‐among‐hispanics‐blacks

21. Headden, S. (1997). The Hispanic dropout mystery. *U.S News & World Report*, *123*, 64–65.

22. Hernandez, B., Garcia, J. I. R., & Flynn, M. (2010). The role of familism in the relation between parent‐child discord and psychological distress among emerging adults of Mexican descent. *Journal of Family Psychology*, *24*, 105–114.

23. Holloway, R. A., Waldrip, A. M., & Ickes, W. (2009). Evidence that a simpatico self‐schema accounts for differences in the self‐concepts and social behavior of Latinos versus Whites (and Blacks). *Journal of Personality and Social Psychology*, *96*, 1012–1028.

24. Inclan, J. (1985). Variations in value orientations in mental health work with Puerto Ricans. *Psychotherapy*, *22*, 324–334.

25. Kouyoumdjian, H., Zamboanga, B. L., & Hansen, D. J. (2003). Barriers to community mental health services for Latinos: Treatment considerations. *Clinical Psychology: Science and Practice*, *10*, 394–422.

26. Krogstad, J. M. & Lopez, G. (2016). Roughly half of Hispanics have experienced discrimination. Retrieved from http://www.pewresearch.org/fact‐tank/2016/06/29/roughly‐half‐of‐hispanics‐have‐experienced‐discrimination

27. Kuhlberg, J. A., Pena, J. B., & Zayas, L. H. (2010). Familism, parent‐adolescent conflict, self‐esteem, internalizing behaviors and suicide attempts among adolescent Latinas. *Child Psychiatry and Human Development*, *41*, 425–440.

28. Lopez, M. H., & Dockterman, D. (2011). U.S. Hispanic country of origin counts for

nation, top 30 metropolitan areas. Retrieved from http://www.pewhispanic.org/2011/05/26/us‐hispanic‐country‐of‐origin‐counts‐for‐nation‐top‐30‐metropolitan‐areas/

29. Lopez, M. H., Taylor, P., Funk, C., & Gonzalez‐Barrera, A. (2013). On immigration policy, deportation relief seen as more important than citizenship. Retrieved from http://www.pewhispanic.org/2013/12/19/on‐immigration‐policy‐deportation‐relief‐seen‐as‐more‐important‐than‐citizenship

30. Lopez‐Baez, S. I. (2006). Counseling Latinas: Culturally responsive interventions. In C. C. Lee (Ed.), *Multicultural issues in counseling* (3rd ed.) (pp. 187–194). Alexandria, VA: American Counseling Association.

31. Manning, R. (2016). What are microaggressions? Let these high school students show you. PRi online blog. Retrieved from https://www.pri.org/stories/2016‐05‐06/what‐are‐microaggressions‐let‐these‐high‐school‐students‐show‐you

32. Marcos, L. R. (1973). The language barrier in evaluating Spanish‐American patients. *Archives of General Psychiatry*, *29*, 655–659.

33. Matos, J. M. (2015). La familia: The important ingredient for Latina/o college student engagement and persistence. *Equity & Excellence in Education*, *48*, 436–453.

34. Miranda, A. O., & Umhoefer, D. L. (1998a). Acculturation, language use, and demographic variables as predictors of the career self‐efficacy of Latino career counseling clients. *Journal of Multicultural Counseling and Development*, *26*, 39–51.

35. Miranda, A. O., & Umhoefer, D. L. (1998b). Depression and social interest differences between Latinos in dissimilar acculturation stages. *Journal of Mental Health Counseling*, *20*, 159–171.

36. Miville, M. L., Koonce, D., Darlington, P., & Whitlock, B. (2000). Exploring the relationship between racial/cultural identity and egoidentity among African Americans and Mexican Americans. *Journal of Multicultural Counseling and Development*, *28*, 208–224.

37. National Center for Educational Statistics. (2017). Public high school graduation rates. Retrieved from https://nces.ed.gov/programs/coe/indicator_coi.asp

38. Navarro, R. L., Ojeda, L., Schwartz, S. J., Piña‐Wat‐son, B., & Luna, L. L. (2014). Cultural self, personal self: Links with life satisfaction among Mexican American college students. *Journal of Latina/o Psychology*, *2*, 1–20.

39. Organista, K. C. (2000). Latinos. In J. R. White, & A. S. Freeman (Eds.), *Cognitive‐behavioral group therapy: For specific problems and populations* (pp. 281–303). Washington, DC: American Psychological Association.

40. Paniagua, F. A. (1994). *Assessing and treating culturally diverse clients*. Thousand Oaks, CA: Sage.

41. Pew Research Center. (2009). Between two worlds: How young Latinos come of age in America. Retrieved from http://www.pewhispanic.org/2009/12/11/between‐two‐worlds‐how‐young‐latinos‐come‐of‐age‐in‐america/

42. Pew Research Center. (2014). The shifting religious identity of Latinas/os in the United

States. Retrieved from http://www.pewforum.org/2014/05/07/the‐shifting‐religious‐identity‐of‐latinos‐in‐the‐united‐states/

43. Piña‐Watson, B., & Abraído‐Lanza, A. F. (2017). The intersection of Fatalismo and pessimism on depressive symptoms and suicidality of Mexican descent adolescents: An attribution perspective. *Cultural Diversity and Ethnic Minority Psychology*, *23*(1), 91.

44. Piña‐Watson, B., Castillo, L. G., Jung, E., Ojeda, L., & Castillo‐Reyes, R. (2014). The Marianismo beliefs scale: Validation with Mexican American adolescent girls and boys. *Journal of Latina/o Psychology*, *2*(2), 113–130.

45. Reyes, P. A. (2016). Are you Latinx? As usage grows, word draws approval, criticism. Retrieved from https://www.nbcnews.com/news/latino/are‐you‐latinx‐usage‐grows‐word‐draws‐approval‐criticism‐n651396

46. Rivera, D. P., Forquer, E. E., & Rangel, R. (2010). Microaggressions and the life experience of Latina/o Americans. In D. W. Sue (Ed.), *Microaggressions and marginality* (pp. 59–83). Hoboken, NJ: Wiley.

47. Romero, A. J., Edwards, L. M., Bauman, S., & Ritter, M. K. (2014). Risk factors for Latina adolescents' mental health and well‐being. In A. J. Romero, L. M. Edwards, S. Bauman, & M. K. Ritter (Eds.), *Preventing adolescent depression and suicide among Latinas* (pp. 35–46). Cham: Springer.

48. Santiago‐Rivera, A., Kanter, J., Benson, G., Derose, T., Illes, R., & Reyes, W. (2008). Behavioral activation as an alternative treatment approach for Latinas/os with depression. *Psychotherapy: Theory, Research, Practice, Training*, *45*, 173–185.

49. Smokowski, P. R., Rose, R. A., & Bacallao, M. (2010). Influence of risk factors and cultural assets on Latina/o adolescents' trajectories of self‐esteem and internalizing symptoms. *Child Psychiatry and Human Development*, *41*, 133–155.

50. U.S. Census Bureau. (2017). Income and poverty in the United States: 2016. Report No. P60–259. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2017/demo/P60‐259.pdf

51. Vega, W. A., Rodriguez, M. A., & Ang, A. (2010). Addressing stigma of depression in Latina/o primary care patients. *General Hospital Psychiatry*, *32*, 182–191.

52. Velasquez, R. J., Gonzales, M., Butcher, J. N., Castillo‐Canez, I., Apodaca, J. X., & Chavira, D. (1997). Use of the MMPI‐2 with Chicanos: Strategies for counselors. *Journal of Multicultural Counseling and Development*, *25*, 107–120.

53. Zong, J., Batalova, J., & Hallock, J. (2018). Frequently requested statistics on immigrants and immigration in the United States. Immigration Policy Institute. Retrieved from https://www.migrationpolicy.org/article/frequently‐requested‐statistics‐immigrants‐and‐immigration‐united‐states#Mexican

54. Zuniga, M. E. (1997). Counseling Mexican American seniors: An overview. *Journal of Multicultural Counseling and Development*, *25*, 142–155.

18
Counseling Multiracial Populations

Chapter Objectives

1. **1. Learn the demographics and characteristics of individuals of *multiracial* descent.**
2. **2. Identify counseling implications of the information provided for *multiracial* individuals.**
3. **3. Provide examples of strengths that are associated with *multiracial* individuals.**
4. **4. Know the special challenges faced by *multiracial* individuals.**
5. **5. Understand how the implications for clinical practice can guide assessment and therapy with *multiracial* individuals.**

> *When people try to get to know you, it's as if you're being demeaned to some sub‐human creature. You always feel pressured to explain your ethnicity … you just feel like some wax model in a museum exhibit. People gaze upon you either in wonder or confusion. Their reactions are predictably insensitive and inconsiderate. "Um, what are you?" they ask, overwhelmed with curiosity.*
>
> *(Harvard, 2013)*

> *Her maternal grandparents raised Lisa as White in a small Midwestern farming community. Growing up, she sometimes felt different than her peers, but she didn't know why. She noticed her skin would tan easily in the summer and her hair was curlier than most of her friends'. Lisa began questioning her assumed White identity when she moved to the South as a teenager. People teased her and called her the N‐word. Confused, she turned to her grandparents. That is when she learned her biological father was Black. In college, Lisa began to identify as Black‐biracial. She took Black Studies courses, and dated and eventually married a Black man.*
>
> *(Author's own case vignette)*

People of mixed‐race heritage are often ignored, neglected, and considered nonexistent in educational materials, media portrayals, and psychological literature (Bailey, 2013). *Multiracial* individuals are also faced with the "What are you?" question. For years, *multiracial* individuals have fought for the right to identify themselves as belonging to more than one racial group on official documents; these efforts were largely spearheaded by White mothers of multiracial children (Makalani, 2009). Our society, however, is one that tends to force people to choose one racial identity over another. Lisa received counseling to unlearn her early racial socialization as she explored the personal meaning of her African Americanness. She admitted holding some of the same negative beliefs about Black people as her peers; she made fun of Black people and thought herself somewhat superior in subtle and unquestioned ways. By raising her White, Lisa's grandparents forced her to choose one identity while actively denying her knowledge of another. There are countless everyday examples of the ways in which others ignore or deny the complexity of one's racial identity. One *multiracial* psychology intern (Japanese mother and Irish father) working in a Black community was asked by his supervisor how his clients felt about working with a "White" psychologist. When the supervisor noticed the confusion on the intern's face, he stated, "I know you are Asian but you look White" (Murphy‐Shigematsu, 2010). The intern considered the supervisor's reaction to him to be a microaggression and felt it interfered with their working relationship.

Identity formation among multiracial people is complicated and is shaped by one's phenotype, racial socialization in the home, and the neighborhood/environment in which one is raised. As

with other types of social identities, multiracial people negotiate between their self‐identity and the identities imposed by others. Unfortunately, mental health professionals often receive little training in working with *multiracial* clients. In fact, counselors may have conscious and unconscious attitudes, biases, and stereotypes similar to those of the layperson regarding race mixing (*miscegenation*) and "racial contamination." Acceptance of interracial marriages and multiracial children has increased over the years. In a recent Pew Research Center report, nearly 4 out of 10 believed that interracial marriage was positive and only about 1 in 10 opposed the idea of a relative marrying someone of another race (Bialik, 2017). Race matters, however: the figure jumped to 14% when non‐Blacks were asked about a relative marrying someone who was Black.

In more ways than one, the 2000 U.S. Census set in motion a complex psychological and political debate when, for the first time, it allowed people to check more than one box for their racial identities and to be counted as *multiracial* (Nittle, 2011). Proponents of the change have argued that it is unfair to force *multiracial* people to choose only one identity because such practices (a) deny racial realities, (b) undermine pride in being *multiracial*, and (c) ignore important personal information (e.g., the medical advantages of knowing one's racial heritage). Custom, history, and prejudices continue to affect perceptions of those who are *multiracial*, however. Additionally, many civil rights organizations, including the National Association for the Advancement of Colored People (NAACP), believe that *multiracial* categorization will dilute the strength of their constituencies. Because census numbers on race and ethnicity figure into sociopolitical calculations involving antidiscrimination laws, dispersal of funds for minority programs may also be adversely affected. Persons of mixed racial heritage negotiate this space when constructing personal and political identities. For example, someone like Lisa might identify as Black‐biracial both to acknowledge the sociopolitical aspect of their Black identity and to honor their personal biracial identity.

CHARACTERISTICS AND STRENGTHS

In the following sections, we consider the history and characteristics of *multiracialism* in the United States, the strengths of *multiracial* individuals, and their implications for treatment. These are generalizations, and their applicability needs to be assessed for each client or family.

Multiracialism in the United States

Mental health professionals can increase their understanding of *multiracialism* and related issues by increasing awareness of facts such as the following (Frey, 2014; U.S. Census Bureau, 2010):

- The *biracial* baby boom in the United States started in 1967, when the last laws against race mixing (antimiscegenation) were repealed. As a result, there was a rapid increase in interracial marriage and a subsequent rise in the number of *multiracial* children in the United States. In 2013, 12% of heterosexual newlyweds were interracial couples, with nearly 6 out of 10 American Indians marrying someone of another race (Wang, 2015). In 2015, nearly 3 out of 10 Latinx (29%) and Asian (27%) new marriages were interracial —considerably greater than for Black (18%) and White (11%) new marriages (Bialik, 2017). The most common interracial pairings during this time period were Latinx–White (42%), Asian–White (15%), multiracial–White (12%), Black–White (11%), American Indian–White (3%), and various other minority/minority couplings.
- It is estimated that *multiracial* people make up 2.4% of the national population, or more than 7.5 million people. The percentage of *multiracial* people is as high as 6.9% if one takes into account the racial background of people's parents and grandparents (Pew Research Center, 2015). The numbers of multiracial people in the United States is growing rapidly by any calculation. About 14% of infants in 2015 were multiracial, with 42% having one Latinx parent and one White parent, 22% having one multiracial and one White parent, 14% having one Asian and one White parent, and 10% having one Black and one White parent.

Implications

These statistics hide how multiracial people live their daily lives; they do not capture how identity is performed and understood and they do not shed light on how some multiracial people feel coerced into adopting a *monoracial* identity. The reality is that the offspring of a Black–White union is often considered Black by our society. Why not White? Why is it easy for us to accept the notion that children of certain interracial unions (e.g., Asian–White, American Indian–White) are *multiracial* when we cannot do the same for combinations that involve Black Americans? Why do some people of mixed - race heritage choose to identify themselves with only one race? Are certain interracial relationships more acceptable than others? Why? What accounts for the fact that Asian American women and Latinas are more likely than their male counterparts to marry outside of their ethnic group?

Mental health professionals who work with *multiracial* clients need to understand the implications of these questions if they are to be effective in their work with racially mixed clients. They need to examine their own attitudes toward interracial couples and *multiracial* children. In our journey to understand the implications of the issues confronting *multiracial* individuals, we concentrate on several themes that have been identified as important in

working with this population.

The “One Drop of Blood” Rule

Alvin Poussaint, an African American Harvard psychiatrist, stood before a packed audience and posed a pointed question: “Do you know how powerful Black blood is?” After an awkward silence, he answered: “It is so powerful that one tiny drop will contaminate the entire bloodstream of a White person!” What Poussaint was referring to is called *hypodescent*, or the *One Drop Rule*, a class‐based social system that maintains the myth of *monoracialism* by assigning a person of mixed racial heritage to the least desirable racial status. This system was institutionalized by an 1894 Supreme Court decision (*Plessy* v. *Ferguson*) that determined that a person who was seven‐eighths White and one‐eighth Black and “maintained that he did not look Negro” was nonetheless to be classified as Negro (Davis, 1991).

In essence, the *hypodescent* concept stemmed from a variety of self‐serving motives. Initially, it was an attempt by White European immigrants to maintain racial purity and superiority by passing laws against interracial marriages (antimiscegenation laws), primarily directed at Blacks and American Indians. As early as the 1660s, laws were passed making it a crime for “Negro slaves” to marry “free‐born English women” (Wehrly, Kenney, & Kenney, 1999). *Hypodescent* thinking and laws not only maintained racial “purity” but also generated additional property for slave owners and accommodated the sexual abuse of African women. Africans were purchased as slave laborers; the more slaves an owner possessed, the greater his wealth and access to free labor. Thus, economically, it was beneficial to classify the offspring of a Black–White union—often the result of a rape—as “Negro” because it increased the owner's wealth. Also, the prevalent beliefs of the time were that “Negroes and Indians” were subhuman, uncivilized, lower in intellect, and impulsively childlike. One drop of Black blood in a person would make him or her contaminated and Black.

The rule of *hypodescent* applies to other racial and ethnic minority groups as well, but it appears to predominate with African Americans. Although groups of color are often averse to discussing social desirability differences between them, conventional wisdom and some data suggest that African Americans are often considered less desirable than their Asian American counterparts (Jackson et al., 1996), although Asian Americans are still considered significantly less desirable than Whites. It also appears that the intersection of one's race and gender affects how one is perceived by society. For example, images of Asian American women are much more favorable (e.g., petite, exotic, and sexually pleasing) than those of their male counterparts (e.g., passive, inhibited, and unattractive; Sue, 2005). Because of racial‐gender prejudice, Black women are perceived as masculine and thus as undesirable dating partners (Schug, Alt, Lu, Gosin, & Fay, 2017).

These biases help explain why interracial marriages between Asian American women and European American men occur more frequently than marriages between Black women and White men, and why mixed‐race children of the former union are more likely to be considered *multiracial*, whereas those of the latter are more likely to be considered Black (Jackman, Wagner, & Johnson, 2001). These double standards not only lead to hard feelings and resentments between African Americans and Asian Americans but also create friction among men and women within specific racial or ethnic minority groups. It is important to understand that such antagonism between racial and ethnic minority groups and between men and women originates from larger biased sociopolitical processes.

Implications

Many *multiracial* individuals find that society imposes a racial identity upon them. Such identities are often influenced not only by their phenotype and racial heritage, but also by the societal status associated with their particular background (Moss & Davis, 2008). In fact, individuals of mixed‐racial heritage are generally considered to have "lower status" compared to European Americans. *Multiracial* children, when asked their heritage, have been found to answer one way internally and another way externally (Cross, 1991). The external answer may be an attempt to fit in, to not violate the expectations of the questioner, or to take the path of least resistance.

For example, answering that one is *biracial* is often not satisfactory to a questioner and is likely to result in further probing. Unable to identify their conflicts and feelings about being *multiracial* and about the frequent questions about their identity, children often settle for the answer most likely to end the questions, responding by giving the "most acceptable" *monoracial* identity, which may be at odds with their self‐definition. A number of contextual factors influence how multiracial people self‐identify when they become adults. Research with over 37,000 multiracial adults suggests that income, educational level, and where one lives consistently influence how one chooses to label oneself (Davenport, 2016). People who have incomes of over $100,000 have a greater chance of self‐labeling as White compared to identifying as Asian, Black, or Latinx; the opposite is the case for people who live in the Midwest, where there is a preference for identifying with one's racial minority identity. Interestingly, Asian–White and Black–White individuals with a college degree also prefer minority self‐identification. The main point here is for counselors to resist the urge to label a client's race and instead to explore not only how the client identifies, but what their identification means to them and their life story.

Strengths

Although a multicultural identity can result in challenges, many cite advantages, such as having access to and support from several cultural communities (Sanchez, Shih, & Garcia, 2009). *Multiracial* individuals who have multiple‐racial‐identity integration appear to have higher levels of psychological adjustment (Jackson, Yoo, Guevarra, & Harrington, 2012). Other advantages include the ability to see issues from a variety of perspectives (Cheng & Lee, 2009). Those who have an integrated multiple racial identity have lower stress levels and feelings of alienation compared to those who are in conflict about their racial identity (Binning, Unzueta, Huo, & Molina, 2009). When adolescents were asked what they perceived were advantages to being *multiracial*, they mentioned three things in particular: having greater opportunities for international travel, being comfortable with people from different racial backgrounds, and being intriguing to others (Bosquet & Sarinana, 2014).

In the present day, there is much greater acceptance of interracial marriage, especially among young adults (Pew Research Center, 2015). *Multiracial* individuals are quite visible on television, in movies, and in advertising. Support groups have arisen. For example, Michelle Lopez‐Mullin (now Watson), past president of her university's Multiracial and Biracial Student Association, has one parent who is Chinese and Peruvian and one who is White and American Indian, and finds pride in her identity (Saulny, 2011). Instead of feeling marginalized, many *multiracial* individuals possess enhanced cultural competence and feel comfortable in more than one cultural setting. They may be able to "borrow from their various racial backgrounds, culling out strengths specific to these cultures, and using them to support their well‐being" (Pedrotti, Edwards, & Lopez, 2008, p. 199). And, as in the case of Lopez‐Mullin, pride may develop through membership in different cultural groups. In a

recent survey, about 60% of *multiracial* individuals are proud of their mixed‐race heritage and believe their background has made them more open to other cultures (Pew Research Center, 2015).

SPECIFIC CHALLENGES

In the following sections, we consider challenges often faced by *multiracial* populations and consider their implications for treatment. Remember that these are generalizations and that their applicability needs to be assessed for each client.

Racial/Ethnic Ambiguity: "What Are You?"

> *My sister and I are half black, a quarter white, and a quarter Indian with British accents, and everyone we meet seems eager to immediately "place" us into neat boxes. It's human nature to be curious about people's backgrounds, and trying to solve the "puzzle" of a multiracial person is understandably interesting. But being the puzzle that people want to solve isn't always great.*
>
> *(Bahadur, 2015)*

Racial/ethnic ambiguity occurs when people are not easily able to distinguish the *monoracial* category of a *multiracial* individual from phenotypic characteristics. Phenotypic traits play a major role in how people perceive others. If African American traits are apparent, the *One Drop Rule* will automatically classify a person as Black, regardless of how they self‐identify; the observer might think, "She says she's mixed, but she is really Black" (Bean & Lee, 2009). For *multiracial* individuals with ambiguous features, the "What are you?" question becomes a constant dilemma.

The "What are you?" question requires an individual to justify his or her existence in a world rigidly built on the concepts of racial purity and *monoracialism*. This is reinforced by a *multiracial* person's attempts to answer such a question by discerning the motives of the interrogator: "Why is the person asking?" "Does it really matter?" "Are they really interested in the answer, or am I going to violate their expectations?" "Do they see me as an oddity?" If the person answers "American," this will only lead to further inquiry. If the answer is "mixed," the interrogator will query further: "What ethnicity are you?" If the answer is "part White and Black," other questions follow: "Who are your parents?" "Which is Black?" "Why did they marry?" The *multiracial* person begins to feel picked apart and fragmented by such questioning about his or her racial background (Root, 1990). The problem with giving an answer is that it is often "not good enough."

The communication from our society is quite clear: "There is something different about you." We cannot stress enough the frequency with which *multiracial* persons face a barrage of questions about their racial identities, from childhood to adulthood (Houston, 1997). The inquisition can result in invalidation, conflicting loyalties to the racial/ethnic identities of parents, internal trauma, and confused identity development.

Implications

Multiracial children often feel quite isolated and may find little support, even from their parents. This is especially true for *monoracial* parents, who themselves are not *multiracial*. How, for example, does a White woman married to a Black man raise her child? White? Black? Mixed? Parents of interracial marriages may fail to understand the challenges encountered by their children, gloss over differences, or raise the children as if they were *monoracial*. The children may, therefore, lack role models and experience loneliness. Even being a *multiracial* parent may not result in greater empathy for or understanding of the unique challenges faced by *multiracial* children, especially if the parent (themself the victim of a *monoracial* system) has not adequately resolved their own identity conflicts. Therapists

can help interracial couples prepare their children for questions about their racial heritage. Children are more likely to develop positive *multiracial* identities if their parents have modeled strong ethnic identities (Stepney, Sanchez, & Handy, 2015).

Racial Identity Invalidation

> *Being forced into a side is an all too familiar situation for me and other biracial people I have spoken to. I have found myself many times being classified as Asian because I have predominantly Asian features and therefore do not seem "white enough." Similarly, I am often classified as white because I do not have enough Asian characteristics. [My friend said it best] "You're constantly trying to find a home, somewhere you 'belong.'"*
>
> *(Sim, 2017)*

A number of multiracial individuals experience *racial identity invalidation*; people try to fit them into a *monoracial* box based on the way they look or how they behave (Franco & O'Brien, 2017). It is hurtful when people deny an aspect of one's identity, especially when the rejection comes from someone of the "minority" (Franco & Franco, 2016). A person who is Asian, White European, American Indian, and African may not be completely accepted by any of these groups. It is not uncommon for people to be told they are "not enough," as in "you are not Asian enough" or "Black enough." *Multiracial* people may thus encounter prejudice and discrimination from all sides (Sanchez et al., 2009). Experiencing *racial identity invalidation* is related to greater racial identity challenges such as not feeling like one belongs to any racial group; these challenges are in turn related to having more depressive symptoms (Franco & O'Brien, 2017).

In Chapter 11, we spent considerable time discussing racial–ethnic–cultural identity attitudes among minority group members. Criticisms leveled at these theories include the following: (a) they were developed from a *monoracial* perspective rather than a *multiracial* one; (b) they falsely assume that *multiracial* individuals will be accepted by their parent culture or cultures; and (c) their linear nature is inadequate to describe the complexity of the many possible *multiracial* resolutions (Kerwin & Ponterotto, 1995; Root, 1996). The experiences and attitudes of *multiracial* individuals differ significantly depending on the races that make up their background and how the world sees them.

Compounding the difficulty with the application of *monoracial* identity theory to *multiracial* individuals is that 61% of those with a mixed racial background do not consider themselves to be *multiracial* (Pew Research Center, 2015). Reasons why individuals do not identify as *multiracial* include (respondents could have more than one reason):

- They look like one race (47%).
- They were raised as one race (47%).
- They closely identify with a single race (39%).
- They never knew the family member or ancestor who was a different race (34%).

Another problem for racial–ethnic–cultural identity theories is that the identity for many *multiracial* individuals is fluid. About 30% of *multiracial* adults indicate that the way they view their race has changed over time. Natasha Sim (2017) comments on her "ever‐changing" racial identity in her blog post, quoted at the start of this section. Some who originally thought of themselves as only one race now consider themselves *multiracial*, and others who thought of themselves as *multiracial* now view themselves as one race (Pew

Research Center, 2015). These factors raise questions about the applicability of *monoracial* identity theories to *multiracial* Americans.

Many *multiracial* individuals confront the process of resolving *racial identity invalidation* and developing a healthy identity throughout their lives. Root (1998) describes four possible identity resolutions.

1. The *multiracial* individual accepts the identity assigned by society. For example, the child of a Black–Japanese union is likely to be considered Black by friends, peers, and family. Root believes that this can be a positive choice if the person is satisfied with the identity, receives family support, and is active rather than passive in evidencing the identity. The individual in this situation, however, may have a very fluid identity that changes radically in different situations. If they travel or move to another community or region, for example, their assigned racial identity might become Japanese or even mixed.
2. The *multiracial* individual chooses to *identify with both groups*. "I think a lot of us are chameleons. We can sit in a group of White people and feel different, but still fit in … But we can turn around and sit in a group of Black people, even though we are not Black in the same way" (Miville, Constantine, Baysden, & So‐Lloyd, 2005, p. 512). In this case, the person is able to shift from one identity (White American) when with one group to another identity (African American) when with a different group. This method of adaptation is healthy as long as the individual views the ability to move in two worlds as positive, does not lose their sense of self‐integrity, and can relate well to positive aspects of both identities and cultures.
3. The *multiracial* individual decides to *choose a single racial identity* in an active manner. Although this may appear similar to the first option, it differs in two ways: (a) it is the individual, not society, who makes the choice of racial group identity; and (b) the identity is less prone to shifting when the situational context changes. Actively choosing a single racial identity can be a positive option when the individual does not deny his or her other racial heritage and when the group with whom the individual chooses to identify does not marginalize him or her.
4. The *multiracial* individual chooses to identify with a *mixed‐race heritage* or *multiracial identity*. "I think it [being multiracial] has made me expertly cued to cultural cues. Kind of as an observer, I'm always trying to learn, 'ok, what's going on here, how does one act here, and what are the cultural norms'" (Suyemoto, 2004, p. 216). In fact, bicultural/*biracial* or multicultural/*multiracial* identification rather than identification with only one race is increasing in frequency (Brunsma, 2005; Suzuki‐Crumly & Hyers, 2004). A multicultural identity allows equal valuing of all aspects of one's racial–ethnic–cultural heritage, the ability to relate to all groups, and feelings of being well integrated.

Implications

In therapy with *multiracial* individuals, the stress associated with feeling their racial identity is not validated can sometimes come to the surface. The type of conflict and resolution may differ depending on the client's gender, the composition of their *multiracial* combination, and other group identity factors, such as socioeconomic status, age, and sexual orientation. Also, identities may shift, with the degree of fluidity displayed depending on the situational context. It is possible, as suggested by Root, that there may be more than one identity resolution that can lead to healthy adjustment.

However, it should not be assumed that a client's racial identity is the source of their problem. If experiences with *racial identity invalidation* are producing distress, positive resolution can occur with any of the choices discussed. Therapists should be aware that a growing number of *multiracial* individuals are choosing "*multiracial*" as their ethnic identity. This choice should not be considered pathological and interpreted as confusion or an inability to commit to an integrated identity (Suyemoto, 2004). Therapists should also recognize that the issue at hand may be less about identity resolution and more about acknowledging the hurt, pain, and isolation the individual feels because of the daily invalidations they are experiencing.

Intermarriage, Stereotypes, and Myths

Although national surveys indicate that people are much more accepting of interracial marriages then they were a decade ago, the reactions of some people to seeing images of couples from different races tell a different story. A minority of Americans still vigorously oppose such unions. The reaction to a Cheerios ad involving a mixed racial girl with a White mother and an African American father exemplifies this point. So many racist reactions were posted on YouTube in response to the ad that the comments section was disabled (Stump, 2013). There is considerable evidence that myths and stereotypes associated with *multiracial* individuals and interracial couples have involved attempts to prevent the mixing of races through the stigmatization of such mixture (Wehrly et al., 1999). African American males are often stereotyped as lazy, violent, and poor fathers, and African American women as aggressive, hostile, and undesirable. History is replete with incidents reflecting society's hostility and antagonism toward African Americans.

Unfortunately, sociopsychological research on this topic has often perpetuated and reinforced inaccurate beliefs about race mixing and mixed‐race people. Even now, some individuals still view interracial relationships as an oddity. When an interracial couple is asked, "So, how did the two of you meet?" the inquiry may not be due to pure curiosity but instead reflect the question: "How did you two end up together?" (Goff, 2014). Members of a minority group in mixed‐race relationships are too often seen as trying to elevate themselves socially, economically, and psychologically.

Implications

In general, early myths about mixed marriages implied that these unions were the result of unhealthy motives by the partners and that *multiracial* offspring were doomed to suffer deficiencies and pathologies. These assumptions, and the early studies of mixed‐race individuals, were problematic. First, if partners in mixed marriages or partnerships and their *multiracial* offspring experienced identity issues, conflicts, and psychological problems, it is likely that these difficulties were the result of an intolerant and hostile society. In other words, they would have resulted from bias, discrimination, and racism, rather than from anything inherent in the marriage or the "unhealthy" qualities of those involved. Second, we already know that research is influenced by and reflects societal views. It seems likely, therefore, that early researchers most likely asked questions and designed studies with a focus on identifying pathology rather than looking at the healthy and functional traits of the group. Third, in the case of interracial marriages, current research suggests that they are based on the same ingredients as other unions: love, companionship, and compatible interests and values (Rosenblatt, Karis, & Powell, 1995).

Discrimination and Racism

Multiracial individuals have also been subjected to instances of racism and discrimination.

About 55% have been exposed to racial slurs or jokes. The degree of reported exposure varies according to the specific races that are part of an individual's racial background. Although 40% of mixed‐race adults with an African American background said they were unfairly stopped by police, only 15% of White and American Indian adults, and 6% of *biracial* White and Asian individuals, reported the same experience. A similar pattern was found for other forms of racial discrimination. In fact, the exposure to racism and discrimination of mixed‐race adults was similar to that reported by single‐race individuals of a specific race. *Biracial* individuals with an African American background reported the same level of discrimination as single‐race African Americans, while mixed‐race adults with an Asian background reported discrimination at the same level as single‐race Asians (Pew Research Center, 2015). Although being *multiracial* does not itself lead to emotional problems, societal reaction to race mixture can introduce stressors. Issues of racial identity and racial discrimination among *multiracial* adolescents have been associated with substance abuse and other problem behaviors (Choi, Harachi, Gillmore, & Catalano, 2006).

Implications

It is important to understand that research has identified beneficial sociopsychological traits associated with a *multiracial* heritage, including an increased sense of uniqueness, greater variety in one's life, greater tolerance and understanding of people, a greater ability to deal with racism, and a greater ability to interact and build alliances with diverse people and groups (Sanchez et al., 2009; Saulny, 2011).

A Multiracial Bill of Rights

> *Countless numbers of times I have fragmented and fractionalized myself in order to make the other more comfortable in deciphering my behavior, my words, my loyalties, my choice of friends, my appearance, my parents, and so on. And given my multiethnic history, it was hard to keep track of all the fractions, to make them add up to one whole. It took me over 30 years to realize that fragmenting myself seldom served a purpose other than to preserve the delusions this country has created around race. Reciting the fractions to the other was the ultimate act of buying into the mechanics of racism in this country*.
>
> *(Root, 1996, pp. 4–5)*

These words were written by Maria Root, a leading psychologist in the field of *multiracial* identity and development, who expressed concerns about the way in which society has historically relegated *multiracial* persons to deviant status or ignored their existence because they do not fit into a *monoracial* classification. In her personal and professional journey, Root (1996) developed a Bill of Rights for Racially Mixed People that asserts their right not to justify their existence or ethnic legitimacy, their right to self‐identity rather than assume the identity expected by others, and their right to identify with more than one group of people.

Implications

Root's assertions have major implications for mental health providers, because they challenge our notions of a *monoracial* classification system, reorient our thoughts about the many myths of *multiracial* persons, make us aware of the systemic construction and rationalizations of race, warn us about the dangers of fractionating identities, and advocate freedom of choice for the *multiracial* individual.

IMPLICATIONS FOR CLINICAL PRACTICE

Although *monoracial* minority group members experience many of the issues faced by *multiracial* individuals, the latter, in addition to dealing with racism, are likely to experience unique stressors related to their multiple racial/ethnic identities. For example, most *monoracial* minorities find their own groups receptive and supportive of them. *Multiracial* individuals may be placed in the awkward situation of not being fully accepted by any group. Likewise, *monoracial* minority group children can expect psychological and emotional support from their parents—the parents share common experiences with their children, can act as mentors, and relate to the experiences their children encounter with respect to minority status. However, *multiracial* children are likely to have *monoracial* parents who do not understand the challenges facing them (Townsend, Markus, & Bergsieker, 2009). Common problems for *multiracial* youth and adults include communication difficulties with their parents about racial identity issues, reactions of peers and society to their identity, and pressure to assume a *monoracial* identity (Jolivette & Gutierrez‐Mock, 2008). The following are guidelines for working with *multiracial* clients.

1. Become aware of your own stereotypes and preconceptions regarding interracial relationships and marriages. When you see a racially mixed couple, do you pay extra attention to them? What thoughts and images do you have? Awareness of your own biases will help you avoid imposing them upon your clients.
2. When working with any client, do not assume their racial background or personal racial identity. Allowing *multiracial* people to self‐define and share their racial story or stories can combat a history of *racial identity invalidation*. This means being cautious about the "What are you?" question. It is important to emphasize the positive qualities of the total person rather than seeing them as a collection of parts.
3. Remember that being a *multiracial* person can mean coping with isolation resulting from external factors related to prejudice. Hence, mixed‐race persons can experience forced‐choice situations and strong feelings of loneliness, rejection, anger, and guilt/shame as a result of not fully integrating all aspects of their racial heritage.
4. Identify the strengths associated with a multicultural identity and the resources available to the client, rather than focusing only on challenges.
5. With mixed‐race clients, emphasize the freedom to choose one's identity. There is no one identity suitable for everyone. It is important to note that identities are often changing and fluid rather than fixed.
6. Remain open to exploring the forces of oppression and racism related to the client's experience as a multiracial person. The counselor can empower clients to take an active part in formulating their identities.
7. Recognize that family counseling may be especially valuable in working with mixed‐race clients, especially if they are children. Frequently, parents (especially those who are *monoracial*) are unaware of the unique challenges related to their child's *multiracial* journey. Interracial couples should also be assessed to see if differing cultural values and expectations may be impacting their children in a negative manner. Parents can be taught to empower their children to explore the meaning of their racial identity, without labeling it for them.
8. When working with *multiracial* clients, ensure that you possess basic knowledge of the history and issues related to *hypodescent* thinking (the *One Drop Rule*), ambiguity (the "What are you?" question), and marginality. The knowledge cannot be superficial, but

must entail a historical, political, social, and psychological understanding of the treatment of race, racism, and *monoracialism* in U.S. society. In essence, these four dynamics form the context within which the *multiracial* individual operates on a continuing basis.

9. Remember that many multicultural individuals are proud of their identity or have resolved their identity in a healthy manner and that their *multiracial* identity is not a factor in their presenting problem.
10. Educational institutions should provide support services for *multiracial* students and opportunities to increase awareness and understanding of *multiracial* issues in the curriculum (Ingram, Chaudhary, & Jones, 2014).

SUMMARY

Multiracial people are often ignored, neglected, and considered nonexistent in educational materials, media portrayals, and psychological literature. *Multiracial* individuals are faced with “What are you?” questions because society and even groups of color see race as *monoracial*. Others may invalidate their racial identity, which can lead to a discrepancy between their own self‐identity and that imposed by others. Mental health professionals often receive little training in working with *multiracial* clients who are distressed or confused by having *monoracial* categories imposed upon them. To work effectively with *multiracial* individuals, the therapist must understand *multiracial* identity and its unique strengths and challenges, including the stereotypes and myths associated with being *multiracial* and concepts such as *hypodescent*. Many mixed‐race individuals do not identify as being *multiracial*, and for others, identity may shift over time. There are different routes to a healthy *multiracial* identity. Ten clinical implications for counselor practice are identified.

GLOSSARY TERMS

- Biracial
- Hypodescent
- Miscegenation
- Monoracial
- Multiracial
- One Drop Rule
- Racial/ethnic ambiguity
- Racial identity invalidation

REFERENCES

1. Bahadur, N. (2015). 19 things multiracial women want you to know. Retrieved from http://www.huffingtonpost.com/2015/06/09/multiracial-women_n_7520140.html

2. Bailey, E. J. (2013). *The new face of America: How the emerging multiracial, multiethnic majority is changing the United States*. Santa Barbara, CA: ABC-CLIO.

3. Bean, F. D., & Lee, J. (2009). Multiraciality and the dynamics of race relations in the United States. *Journal of Social Issues*, *65*, 205–219.

4. Bialik, K. (2017). Key facts about race and marriage, 50 years after *Loving* v. *Virginia*. Retrieved from http://www.pewresearch.org/fact-tank/2017/06/12/key-facts-about-race-and-marriage-50-years-after-loving-v-virginia

5. Binning, K. R., Unzueta, M. M., Huo, Y. J., & Molina, L. E. (2009). The interpretation of multiracial status and its relation to social engagement and psychological well-being. *Journal of Social Issues*, *65*, 35–49.

6. Bosquet, S., & Sarinana, S. A. L. (2014). *Perceived advantages of multiraciality among multiracial adolescents*. Washington, DC: American Psychological Association.

7. Brunsma, D. L. (2005). Interracial families and racial identity of mixed-race children: Evidence from the early childhood longitudinal study. *Social Forces*, *84*, 1131–1157.

8. Cheng, C., & Lee, F. (2009). Multiracial identity integration: Perceptions of conflict and distance among multiracial individuals. *Journal of Social Issues*, *65*, 51–68.

9. Choi, Y. H., Harachi, T. W., Gillmore, M. R., & Catalano, R. F. (2006). Are multiracial adolescents at greater risk? Comparisons of rates, patterns, and correlates of substance use and violence between monoracial and multiracial adolescents. *American Journal of Orthopsychiatry*, *76*, 86–97.

10. Cross, W. E. (1991). *Shades of black: Diversity in African American identity*. Philadelphia, PA: Temple University Press.

11. Davenport, L. D. (2016). The role of gender, class, and religion in biracial Americans' racial labeling decisions. *American Sociological Review*, *81*(1), 57–84.

12. Davis, J. F. (1991). *Who is black?: One nation's definition*. University Park, PA: Pennsylvania State University Press.

13. Franco, M. G., & Franco, S. A. (2016). Impact of identity invalidation for black multiracial people: The importance of race of perpetrator. *Journal of Black Psychology*, *42*(6), 530–548.

14. Franco, M. G., & O'Brien, K. M. (2017). Racial identity invalidation with multiracial individuals: An instrument development study. *Cultural Diversity and Ethnic Minority Psychology*, *24*(1), 112–125.

15. Frey, S. (2014). Programs target crucial summer before college. Retrieved from http://edsource.org/2014/programs-target-crucialsummer-before-college/66896#.VN4rvy4sDoa

16. Goff, R. (2014). The ongoing stigma of interracialdating. Retrieved from

http://thedailybeast.com/articles/2014/09/15/the‐ongoing‐stigma‐of‐interracial‐dating.html

17. Harvard, S. (2013). The invisible child: What it's like being multiracial in America. Retrieved from http://thoughtsonliberty.com/the‐invisible‐child‐what‐its‐like‐being‐multiracial‐in‐america

18. Houston, H. R. (1997). “Between two cultures”: A testimony. *Amerasia Journal*, *23*, 149–154.

19. Ingram, P., Chaudhary, A. K., & Jones, W. T. (2014). How do biracial students interact with others on the college campus? *College Student Journal*, *48*, 297–311.

20. Jackman, C. F., Wagner, W. G., & Johnson, J. T. (2001). The attitudes toward multiracial children scale. *Journal of Black Studies*, *27*, 86–99.

21. Jackson, L. A., Hodge, C. N., Gerard, D. A., Ingram, J. M., Ervin, K. S., & Sheppard, L. A. (1996). Cognition, affect and behavior in the prediction of group attitudes. *Personality and Social Psychology Bulletin*, *22*, 306–316.

22. Jackson, K. F., Yoo, H. C., Guevarra, R. Jr., & Harrington, B. A. (2012). Role of identity integration on the relationship between perceived racial discrimination and psychological adjustment of multiracial people. *Journal of Counseling Psychology*, *59*, 240–250.

23. Jolivette, A., & Gutierrez‐Mock, J. (2008). A report on the health and wellness of multiracial youth in the Bay Area. Funded by the K. & F. Baxter Foundation, RIMI Program, and the National Center on Minority Health and Health Disparities. Retrieved from http://www.mixedheritagecenter.org/images/stories/PDF/multiracialstudy.pdf

24. Kerwin, C., & Ponterotto, J. G. (1995). Biracial identity development: Theory and research. In J. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 199–217). Newbury Park, CA: Sage.

25. Makalani, M. (2009). Race, theory, and scholarship in the biracial project. In T. Koditschek, S. K. Cha‐Jua, & H. A. Neville (Eds.), *Race struggles* (pp. 138–157). Champaign, IL: University of Illinois Press.

26. Miville, M. L., Constantine, M. G., Baysden, M. F., & So‐Lloyd, G. (2005). Chameleon changes: An exploration of racial identity themes of multiracial people. *Journal of Counseling Psychology*, *52*, 507–516.

27. Moss, R. C., & Davis, D. (2008). Counseling biracial students: A review of issues and interventions. *Journal of Multicultural Counseling and Development*, *36*, 219–230.

28. Murphy‐Shigematsu, S. (2010). Microaggressions by supervisors of color. *Training and Education in Professional Psychology*, *4*, 16–18.

29. Nittle, N. K. (2011). Five myths about multiracial people in the U.S. Retrieved from http://racerelations.about.com/od/understandingrac1/a/Five‐Myths‐About‐Multiracial‐People‐In‐The‐U‐S.htm

30. Pedrotti, J. T., Edwards, L. M., & Lopez, S. J. (2008). Working with multicultural clients in therapy: Bridging theory, research, and practice. *Professional Psychology: Research and Practice*, *39*, 192–201.

31. Pew Research Center (2015). *Multiracial in America: Proud, diverse and growing in numbers*. Washington, DC: Pew Research Center.

32. Root, M. P. P. (1990). Resolving “other” status: Identity development of biracial individuals. In L. S. Brown, & M. P. P. Root (Eds.), *Diversity and complexity in feminist therapy* (pp. 185–205). New York, NY: Haworth Press.

33. Root, M. P. P. (Ed.) (1996). *The multiracial experience*. Thousand Oaks, CA: Sage.

34. Root, M. P. P. (1998). Facilitating psychotherapy with Asian American clients. In D. R. Atkinson, G. Morten, & D. W. Sue (Eds.), *Counseling American minorities: A cross‐cultural perspective* (pp. 214–234). Boston, MA: McGraw‐Hill.

35. Rosenblatt, P. C., Karis, T. A., & Powell, R. D. (1995). *Multiracial couples*. Thousand Oaks, CA: Sage.

36. Sanchez, D. T., Shih, M., & Garcia, J. A. (2009). Juggling multiple racial identities: Malleable racial identification and psychological wellbeing. *Cultural Diversity and Ethnic Minority Psychology*, *15*, 243–254.

37. Saulny, S. (2011). Black? White? Asian? More young Americans choose all of the above. Retrieved from https://www.amren.com/news/2011/01/black_white_asi/

38. Schug, J., Alt, N. P., Lu, P. S., Gosin, M., & Fay, J. L. (2017). Gendered race in mass media: Invisibility of Asian men and Black women in popular magazines. *Psychology of Popular Media Culture*, *6*(3), 222–236.

39. Sim, N. (2017). Biracial identity: My choice, not society's. Retrieved from https://www.huffingtonpost.com/natasha‐sim/biracial‐identity‐my‐choice‐not‐societys_b_8361872.html

40. Stepney, C. T., Sanchez, D. T., & Handy, P. E. (2015). Perceptions of parents' ethnic identities and the personal ethnic‐identity and racial attitudes of biracial adults. *Cultural Diversity and Ethnic Minority Psychology*, *21*, 65–75.

41. Stump, S. (2013). “Angry over what?” Kids react to mixed‐race Cheerios ad in new video. Retrieved from http://www.today.com/news/angry‐over‐what‐kids‐react‐mixed‐race‐cheerios‐ad‐new‐6C10658002

42. Sue, D. (2005). Asian American masculinity and therapy: The concept of masculinity in Asian American males. In G. R. Brooks, & G. E. Good (Eds.), *The new handbook of psychotherapy and counseling with men: A comprehensive guide to settings, problems, and treatment approaches* (pp. 357–368). Hoboken, NJ: Wiley.

43. Suyemoto, K. L. (2004). Racial/ethnic identities and related attributed experiences of multiracial Japanese European Americans. *Journal of Multicultural Counseling and Development*, *32*, 206–221.

44. Suzuki‐Crumly, J., & Hyers, L. L. (2004). The relationship among ethnic identity, psychological well‐being, and intergroup competence: An investigation of two biracial groups. *Cultural Diversity and Ethnic Minority Psychology*, *10*, 137–150.

45. Townsend, S. S. M., Markus, H. R., & Bergsieker, H. B. (2009). My choice, your categories: The denial of multiracial identities. *Journal of Social Issues*, *65*, 185–204.

46. U.S. Census Bureau. (2010). United States profile. Retrieved from www.census.gov.

47 Wang, W. (2015). Interracial marriage: Who is “marrying out”? Pew Research Center. Retrieved from http://www.pewresearch.org/fact - tank/2015/06/12/interracial - marriage - who - is - marrying - out

48 Wehrly, B., Kenney, K. R., & Kenney, M. E. (1999). *Counseling multiracial families*. Thousand Oaks, CA: Sage.

PART VII

Counseling and Special Circumstances Involving Racial/Ethnic Populations

19
Counseling Arab Americans and Muslim Americans

Chapter Objectives

1. **1. Learn the demographics and characteristics of Arab Americans and *Muslim* Americans.**
2. **2. Understand the differences between these two populations**
3. **3. Identify counseling implications of the information provided for Arab Americans and *Muslim* Americans.**
4. **4. Provide examples of strengths that are associated with Arab Americans and *Muslim* Americans.**
5. **5. Know the special challenges faced by Arab Americans and *Muslim* Americans.**
6. **6. Understand how the implications for clinical practice can guide assessment and therapy with Arab Americans and *Muslim* Americans.**

> *Most people are really scared … there's this feeling of the walls closing in. I'll say me personally, I was really overwhelmed this weekend when everything happened at JFK [airport], when the Iraqi interpreters who worked with the U.S. military were being detained. It is this feeling of, what is happening right now? Where is this Muslim ban going?*
>
> *(H. Hoghul, as interviewed on CNN; Media Matters, 2017)*

> *Democrats were forced to defend their appointment of Rep. Andre Carson of Indiana, a Muslim, to the House Intelligence Committee after anti‐Muslim protests erupted on Twitter and other social media with complaints that exposing American secrets to Carson could be dangerous.*
>
> *(Associated Press, 2015)*

> *Nineteen year old Yusor Mohammed, a Muslim, felt like a "proud and blessed" American who fit in. "That's the beautiful thing here, is it doesn't matter where you come from … But here we're all one." She, her 23‐year‐old husband Deah Shaddy Barakat, and her 19‐year‐old sister Razan Mohammad Abu‐Salha were later shot to death by an angry neighbor.*
>
> *(Botelho & Davis, 2015)*

In this chapter, we discuss some of the characteristics, values, and challenges of the Arab and *Muslim* American community and consider their implications for treatment. Remember that this overview provides generalizations about a diverse community of people, and that the applicability of this general commentary always needs to be assessed with regard to the individual client.

CHARACTERISTICS AND STRENGTHS

Arab Americans

Arabs are individuals who originate from countries located in the Middle East and North Africa and whose primary language is Arabic. *Arabs* began immigrating to the United States in the late 1800s. Arab Americans, descending from about 20 different countries, are heterogeneous in terms of race, religion, and political ideology. The majority of Arab Americans are native‐born U.S. citizens.

Arab Americans can have African, Asian, or European ancestry. Approximately 56% of Arab Americans trace their ancestry to Lebanon, while 14% are from Syria, 11% from Egypt, 9% from Palestine, 4% from Jordan, 2% from Iraq, and 4% from other countries (El‐Badry, 2006). Although the populations of Arabic‐speaking countries include large numbers of *Muslims*, only about one‐quarter of Arab Americans are *Muslims* (Jackson & Nassar‐McMillan, 2006).

Because of categorization systems used in the U.S. Census, it is difficult to determine the precise size of the Arab American population. The U.S. Census estimates that there are 1.8 million Arab Americans. However, the Arab American Institute believes the U.S. Census severely underestimates the number in the group and that there are actually 3,665,789 Arab Americans, with 94% living in metropolitan areas such as Los Angeles, Detroit, New York, Chicago, and Washington, DC (Arab American Institute, 2012). The count of Americans of Middle Eastern and North African (MENA) descent—a group that includes Arab Americans—could soon become much clearer: in 2017, the United States Census Bureau recommended adding that category to the 2020 U.S. Census (U.S. Census Bureau, 2017).

The majority of Arab American immigrants arrived in the United States in two major waves (Nassar‐McMillan & Hakim‐Larson, 2003; Suleiman, 1999). The first lasted from 1875 until World War II and primarily involved Arab Christians from Lebanon and Syria who immigrated for economic reasons. The second wave began after World War II and included Palestinians, Iraqis, and Syrians, who left in order to escape the Arab–Israeli conflicts and civil war. This latter group included larger numbers of *Muslims*. The aftermath of the September 11 attacks initially reduced Arab immigration, yet by 2005, the number of immigrants from *Muslim* countries such as Egypt, Pakistan, and Morocco had increased again (Elliott, 2006). Recent years have seen another fluctuation, however, as the number of *Muslim* refugees and immigrants from majority *Muslim* countries to the United States appeared to fall again in 2018 (Connor & Krogstad, 2018).

In comparison with the U.S. population as a whole, Arab Americans are more likely to be married (61% versus 54%), male (57% versus 49%), young, and highly educated (46% have a bachelor's degree, versus 28% of the total adult population) (Arab American Institute, 2012). Sixty‐nine percent indicate they speak a language other than English at home, but 65% speak English “very well.” The majority work as executives, professionals, and office and sales staff. Forty‐two percent work in management positions. Arab American income is higher than the national median income ($59,012 versus $52,029) (Arab American Institute, 2012). However, the poverty rate is also higher (17% versus 12%; U.S. Census Bureau, 2005). Arab Americans participate in a variety of religions. More than 33% are Roman Catholic, 25% are *Muslim*, 18% are Eastern Orthodox, 10% are Protestant, and 13% report other religion or no affiliation (Arab American Institute, 2003).

Muslim Americans

It is estimated that over 3 million *Muslims*—followers of *Islam*—are currently living in the United States. *Islam* is one of the fastest‐growing religions in the country, with approximately one‐fourth of U.S. *Muslims* being converts to the faith (U.S. Department of State, 2002). Within *Islam*, there are two major sects: *Sunni* and *Shiite*. The *Sunnis* are the larger group, accounting for approximately 90% of *Muslims* worldwide. The remaining 10% are *Shiites*. Although many conflate *Muslims* with *Arabs*, most *Muslims* do not descend from Arabic‐speaking countries (DeSilver & Masci, 2017). The percentage of *Muslims* currently found in different regions of the world is estimated as follows: Asia‐Pasific, 61.7%; Middle East–North Africa, 19.8%; Sub‐Saharan Africa, 15.5%; Europe, 2.7%; and Americas, 0.3% (DeSilver & Masci, 2017). The majority of U.S. *Muslim* adults (58%) are first‐generation Americans who were born in another country, while approximately 18% were born in the United States and have at least one parent who emigrated from abroad. About a quarter (24%) of American Muslims are U.S. natives whose parents were born in the United States (Pew Research Center, 2017).

First‐generation *Muslim* Americans come from a wide range of countries around the world. About 25% are immigrants from the Middle East or North Africa, while about 35% come from South Asian nations. Others came to the United States from sub‐Saharan Africa (9%), European countries (4%), and Iran (11%). In the United States, 41% of *Muslim* Americans report their race as White, 20% as Black, 28% as Asian, 8% as Hispanic, and 3% as other or mixed race (Pew Research Center, 2017). The *Muslim* American population is much younger than the non‐*Muslim* population—35% of adult *Muslims* are between the ages of 18 and 29, versus 21% of other adults in the United States (Pew Research Center, 2017). The largest proportions of *Muslim* Americans describe themselves as being politically moderate, highly religious, and committed to “American dream” beliefs – that people who work hard can get ahead (Pew Research Center, 2017).

Cultural and Religious Values

The lives of many observant *Muslims* are governed by *Islamic* laws derived from the *Qur'an*, which deals with social issues, family life, economics and business, sexuality, and other aspects of life. *Muslims* consider the *Qur'an* to be the literal word of God; the name of their religion means “submission to God.” Adherence to *Islam* is demonstrated by individual accountability and a declaration of faith (“There is no god but God and *Muhammad* is his messenger”). *Muslims* engage in the ritual of prayer five times a day and annually fast during daylight hours throughout the holy month of *Ramadan*—a time for inner reflection, devotion to God, and spiritual renewal. Almsgiving and a pilgrimage to Mecca are additional signs of devotion (Nobles & Sciarra, 2000). Some *Muslim* women, particularly those of Arab descent, wear traditional clothing because of the *Islamic* teachings of modesty.

Family Structure and Values

Family structure and values of Arab Americans and *Muslim* Americans differ widely, depending on the specific country of origin and acculturation level. An Arab American engineer living in San Francisco made the following observation: “American values are, by and large, very consistent with *Islamic* values, with a focus on family, faith, hard work, and an obligation to better self and society” (U.S. Department of State, 2002, p. 1).

Some generalizations can be made about the values of many Arab Americans. Hospitality is considered an important aspect of interpersonal interactions (Nobles & Sciarra, 2000). Family

obligations and interdependence among members are very important. This group orientation can result in pressure for conformity and high expectations for children. Parents expect to remain part of their children's lives for as long as possible. In traditional Arab American families, there is a strong sense of a community and an identity that revolves around culture and God. The family structure tends to be patriarchal, with the men being the authority and head of the family. Women are responsible for raising the children and instilling cultural values in the offspring. In general, boys are advised by older males, and girls are advised by older females. The maintenance of traditional gender roles has resulted in lower employment levels for even highly educated Arab women (Al Harahsheh, 2011).

Arab culture tends to be collectivistic, so that the success or failure of an individual reflects on the entire family. This personal responsibility for social behavior sometimes leads to stress and anxiety. Arab college students appear to have higher than expected rates of social anxiety, which may result from internalized norms of social responsibility for their conduct (Iancu et al., 2011). Personal problems are often disclosed only to close family or friends. Opposite‐sex discussions with other than a family member may be problematic (Jackson & Nassar‐McMillan, 2006). Seeking treatment for emotional problems may be considered shameful, so outside help is likely to be sought only as a last resort (e.g., Heath, Vogel, & Al‐Darmaki, 2016).

In traditionally oriented *Muslim* families, the oldest son is prepared to become the head of the extended family. Family roles are complementary, with men serving as provider and head of the family and women maintaining the home and rearing children. Mothers are likely to behave affectionately toward their children, whereas fathers may be aloof, generating both fear and respect (Dwairy, 2008). Many *Muslim* women avoid physical contact with nonrelated males, such as shaking hands or hugging (Tummala‐Narra & Claudius, 2013). However, wide variation exists. Some *Muslim* American women shake hands with men, support gay marriage, and consider themselves devout even though they do not wear a hijab or head covering (Lawrence, 2014). Contrary to public opinion, U.S. women who have converted to *Islam* do not consider themselves to be “brainwashed” or as having forfeited their “free will” (Aleccia, 2013).

Implications

Counselors should be aware that traditional Arab American and *Muslim* American families tend to be hierarchical, with men considered to be the head of the family. Although Western media often portrays women as powerless victims of emotional and physical abuse, in most Arab and *Muslim* families, women are treated with honor and respect (Ibrahim & Dykeman, 2011). Problems can occur with acculturation conflicts involving the struggle between adhering to traditional familial patterns (culturally collective support) and seeking individual fulfillment.

Cultural Strengths

Arab Americans and *Muslim* Americans tend to be collectivistic rather than individualistic in orientation. Family and community supports can be protective factors in dealing with prejudice and discrimination from the larger society. Family resources can be brought to bear on personal issues and problems. Newer immigrants often receive support and acceptance within Arab communities. Arab Americans have high levels of educational and economic success, partially due to their ability to acculturate and assimilate quickly (Nassar‐McMillan, 2011). Similarly, being part of a religious community can provide guidance in dealing with problems and issues. Being a *Muslim* can provide not only religious beliefs but

also a code of behavior that encompasses cultural, racial, gender, and familial considerations.

SPECIFIC CHALLENGES

In the following sections, we discuss the challenges often faced by Arab Americans and *Muslim* Americans and consider their implications in treatment.

Stereotypes, Racism, and Discrimination

> *When an Indian American, Nina Davuluri, won the Miss America crown, social media responses included: "Congratulations Al‐Qaeda. Our Miss America is one of you," "So miss america is a terrorist," and "How the f—k does a foreigner win miss America? She is a Arab! #idiots."*
>
> *(Golgowski, 2013)*
>
> *Rita Zaweidah, the co‐founder of the Arab American Community Coalition of Washington State explains, "When somebody is picked up or arrested or they've done something, they don't just mention that it is a male that was picked up. It's a Muslim male. You never see them saying a Christian male or an Irish male or an English male or female or whatever else. But for some reason when it's anything regarding the Middle East, the religion is the first word somewhere in that sentence."*
>
> *(Zaki, 2011)*

In recent decades, *Muslims* and "Arab‐appearing" individuals have been subjected to increased discrimination and attacks. Although Arab Americans and *Muslim* Americans have always encountered prejudice and discrimination, negative behavior directed toward these groups accelerated following the September 11, 2001, attacks, the Boston marathon bombings in 2013, and the murders of staff members at the offices of the Charlie Hebdo magazine in France in 2015. Hate crimes against *Muslims* are now second only to those perpetrated against Jewish Americans (Federal Bureau of Investigation, 2010).

Arabs, Arab Americans, and *Muslims* are often stereotyped in movies as sheiks, barbarians, or terrorists (Nassar‐McMillan, Lambert, & Hakim‐Larson, 2011). *Arabs* are so commonly stereotyped as being violent or terrorists that, in one study, individuals who played a terrorist‐themed video game showed an increase in negative attitudes toward *Arabs*—even though the game involved Russian characters. This finding clearly demonstrates a "strong associative link" between *Arabs* and terrorism (Saleem & Craig, 2013).

Further, *Islam's* portrayal as a violent religion is widespread in American popular culture, fueling anti‐*Muslim* bigotry and microaggressions (Husain & Howard, 2017). In fact, in 2006, Pope Benedict XVI created a storm of protests from the *Muslim* world when he read a quote from a fourteenth‐century emperor: "Show me just what Muhammad brought that was new, and there you will find only evil and inhuman, such as his command to spread by the sword the faith he preached." The pope later professed "total and profound respect for all *Muslims*" and said he was trying to make the point that religion and violence do not go together. Nonetheless, followers of *Islam* were deeply hurt by his statement.

The September 11 attacks and the Boston Marathon bombings both had a profound impact on how Arab Americans and *Muslim* Americans were viewed in the United States. The vast majority of Arab Americans and *Muslim* Americans were angered, upset, and dismayed by the terrorist attacks, as were all Americans, and many supported retaliation against the countries supporting the terrorists (Zogby, 2001). At the same time, they were aware of the increased negative response by the public to *Muslims* and those of Arab descent as hate crimes increased and thousands of Arab American and *Muslim* American males were

subjected to deportation hearings, airline passenger profiling, vandalism, physical violence, and increased discrimination (Haq, 2013; Moradi & Hasan, 2004).

Unfortunately, many of their fears regarding discrimination were realized. In a report covering incidents involving Arab Americans occurring between September 11, 2001 and October 11, 2002, the following facts were reported:

- More than 700 violent incidents were directed at Arab Americans or those perceived to be Arab Americans or *Muslims* during the first 9 weeks after the September 11 attacks.
- More than 800 cases of employment discrimination against Arab Americans occurred.
- More than 80 cases of illegal or discriminatory removal from aircrafts after boarding occurred (removal based on perceived ethnicity).
- Thousands of Arab men were required to submit to a "voluntary interview" by government officials.
- Numerous instances of denial of services and housing occurred (American‐Arab Anti‐Discrimination Committee, 2003).

Behavioral changes resulted from the scrutiny given to Arab Americans and *Muslims*. Among *Muslim* Americans who worship at a *mosque*, nearly 100% reported being called a profane name in public, being profiled at airports, or having been visited by authorities. Because of the harassment and resulting fear, some stopped attending prayer services (Sahagun, 2006). *Muslim* American women face added stressors, since their traditional garments are clearly identifiable (Winerman, 2006). Although more than 15 years has passed since the September 11 attacks, Arab Americans and *Muslim* Americans remain wary. Their concerns may be warranted. Results from a recent poll indicate that 46% of Americans believe that Islam is more likely than other religions to encourage violence among believers (Pew Research Center, 2015).

In keeping with these trends, Executive Order 13769—more commonly known as the *Muslim* ban—was issued by President Donald Trump on January 27, 2017 (Leung, Langmaid, & Hackney, 2017). This order banned U.S. entry by residents of Iran, Iraq, Libya, Somalia, Sudan, Syria, and Yemen, all nations with *Muslim* majority populations. As border officials initiated enforcement of the order at American airports that evening, hundreds of travelers were detained or sent back to their countries, even as U.S. citizens and attorneys assembled in protest. By February 4, the resulting legal challenges to the constitutionality of the order resulted in a cessation of its enforcement, although some provisions were later reinstated (de Vogue, 2017).

The vast majority of *Muslim* Americans reject extremism and express concern over its rise both in the United States and in other countries. Half believe that it has become more difficult to be *Muslim* in the United States in recent years due to challenges such as discrimination, stereotyping, and negative media portrayals (Pew Research Center, 2017). At 66%, *Muslim* Americans are even more likely than other Americans (at 49%) to say that they are very concerned about global extremism in the name of *Islam*, and three‐quarters say that there is little or no support for extremism within the U.S. *Muslim* community (Pew Research Center, 2017). *Muslim* groups started a "Respond with Love" campaign to raise funds to help rebuild six predominantly Black churches that were damaged by fire during a 2‐week period in 2015, in what may have been cases of arson, and to "stand against hate." Regardless of the cause of the fires, the group wanted to demonstrate with "our African American brothers and sisters" against "institutionalized racism and racist violence" (Bever, 2015).

Americans' attitudes toward *Muslims* and Arabs are negative in many ways, with Republicans and White evangelicals reporting the greatest reservations. A quarter of Americans believe that half or more of Muslims are anti‐American, and 50% of Americans do not see Islam as part of mainstream society. At the same time, the percentage of Americans who associate Islam with violence declined from 50% in 2014 to 41% in 2016 (Pew Research Center, 2017). Similarly, the favorable opinion of Arabs dropped from 43% in 2010 to 32% in 2014. Further, 42% of Americans indicated support for law‐enforcement profiling of Arab Americans and *Muslim* Americans (Wisniewski, 2014).

Implications

Because many Americans have negative views of Arab Americans and Muslim Americans, mental health professionals should examine their own attitudes toward these groups.

- Have you been influenced by the negative stereotypes of individuals from these groups? Would you feel less safe during air travel with Arab‐looking passengers or if you noticed a fellow passenger carrying a *Qur'an*? What would your reaction be if a client came in wearing traditional clothing?
- It is important to realize that Arab Americans, especially those who appear to be from an Arab country or who are *Muslim*, are bombarded by negative stereotypes, prejudice, and discrimination.
- Mental health professionals should ask about discriminatory actions directed toward clients and be willing to explore these experiences and help seek solutions.
- Therapists should be informed regarding antidiscrimination policies, should be able to provide clients with information about recourses for discriminatory actions, and should support client efforts to challenge discrimination. If clients are encountering job or housing discrimination, the therapist can discuss their legal rights and assist them in taking appropriate actions, such as reporting hate crimes to the police.
- The website for the American‐Arab Anti‐Discrimination Committee (ADC) offers legal resources and information on addressing discrimination in these and other areas.

Acculturation Conflicts

> *A 14‐year‐old Middle Eastern Muslim boy was suspended from school for the use of alcohol and skipping school. He had been receiving good grades and had no previous behavioral problems. His problems stemmed from acculturation conflicts and the stigma associated with the 9/11 terrorist attacks.*
>
> *(Measham, Guzder, Rousseau, & Nadeau, 2010)*

> *Elkugia, who was born in Libya, was voted homecoming queen for her high school. While playing basketball for her high school team, she wears a headscarf, a long jersey, and athletic pants instead of shorts. Her clothing reflects her Muslim faith and is a "form of modesty."*
>
> *(Iwasaki, 2006)*

As with many groups that face discrimination and prejudice, some Arab Americans and *Muslim* Americans do not spontaneously announce their religion or ethnic background, and some have changed their names to be more "American‐sounding." Although some Arab Americans are bicultural and accept both their Arab and their American identities (Nobles & Sciarra, 2000), others try to disguise their religious and ethnic identities by wearing

American‐style clothing. Many have completely assimilated, especially those from the first wave of Arab American immigration, who were primarily Christian. Immigrant *Muslims*, on the other hand, may be struggling with the challenges of maintaining their traditional practices within an American context (Podikunju‐Hussain, 2006). *Muslim* women may wear the hijab as a sign of modesty, and the resulting ethnic visibility can increase the stereotyping and stigmatization that these women experience (Everett et al., 2015). Traditionally oriented Arab and *Muslim* Americans may avoid certain aspects of American society, preferring to maintain contact with individuals from their own religious group or country of origin. The September 11 attacks appear to have strengthened the ethnic identity of many Arab Americans, with 88% of those polled after the attacks responding that they were proud of their heritage and 84% indicating that their ethnic heritage was important in defining their identity. More than 80% said that securing Palestinian rights was personally important to them (Zogby, 2001).

Implications

Because culture, values, and religion can differ significantly within the Arab American and *Muslim* American communities, therapists need to determine the background and beliefs of each client or family, rather than responding in a stereotypical manner. Some individuals may be highly acculturated or assimilated, whereas others may adhere strongly to traditional cultural and religious standards; this is especially true for Arab Americans who are *Muslims*. Generational acculturation conflicts are common, with children acculturating more quickly than parents. This may be especially problematic for traditionally oriented Arab Americans who adhere to a hierarchical family structure in which children are expected to “behave appropriately.”

IMPLICATIONS FOR CLINICAL PRACTICE

Arab Americans are a very diverse group in terms of religion, culture, country of origin, and degree of acculturation. There is similar diversity within the *Muslim* community. Recent *Muslim* immigrants are likely to adhere more strictly to Islamic principles, whereas those who have lived in the United States for much of their lives are more likely to have a moderate perspective (Ibrahim & Dykeman, 2011). In general, non‐Arab and non‐*Muslim* Americans possess little knowledge about these groups and have often been exposed to misinformation. Because of this, many view the actions of extremist *Islamic* groups as representing the views of all Arab Americans and *Muslim* Americans. As mental health workers, we need to understand Arab culture and *Muslim* beliefs.

The following are recommendations for working with Arab American and *Muslim* American clients (Podikunju‐Hussain, 2006; Ibrahim & Dykeman, 2011):

1. Identify your attitudes about Arab Americans and *Muslim* Americans.
2. Recognize that many face discrimination and violence because of their Arab background or their religious beliefs.
3. Be ready to help those who have been discriminated against in seeking legal recourse.
4. Cross‐gender counselor pairing may be problematic with Arab or *Muslim* clients. Inquire if the gender of the therapist is a factor to be considered.
5. Recognize that Arab Americans and *Muslim* Americans are diverse groups. Recent immigrants are more likely to hold stronger traditional values and beliefs. Collaborate

with each client or family to gain an understanding of their lifestyle and beliefs, including their religion and the importance of religion in their lives. Religion may not be a factor in the presenting problem.

6. Determine the structure of the family through questions and observation. With traditional families, try addressing the husband or male first. Traditional families may appear highly interdependent, a common cultural characteristic. Determine if acculturation conflicts are producing stress within the family.
7. Be careful of self‐disclosures that may be interpreted as weakness. Positive self‐disclosures may enhance the therapeutic alliance.
8. In traditionally oriented Arab Americans families, there may be reluctance to share family issues or to express negative feelings with a therapist, especially by men (Heath, Vogel, & Al‐Darmaki, 2016).
9. There may be greater acceptance to holistic approaches that incorporate family members and the religious or social community, especially with clients who hold traditional values.
10. Be open to exploring spiritual beliefs and the use of prayer or fasting to reduce distress. Alternative explanations and expressions of psychological distress should be accepted without the imposition of a Western worldview. Counselors should be open to talking about religion and drawing on religious coping strategies. *Islam* encourages self‐responsibility in actions and alternatives to negative thoughts. Identifying the client's views regarding *Islam* may be useful in adapting therapy (Ebrahimi, Neshatdoost, Mousavi, Asadollahi, & Nasiri, 2013; Meer & Mir, 2014).
11. Cognitive behavioral strategies may be productive for *Muslims* if distressing thoughts are modified in accordance with *Islamic* beliefs (Khodayarifard & McClenon, 2011).

Video Lecture: The Psychology of Racism: Where Have We Gone Wrong?

SUMMARY

Arab Americans are descendants from countries located in the Middle East and North Africa and are heterogeneous in terms of race, religion, and political ideology. The majority of Arab Americans are native‐born U.S. citizens. *Muslims* are followers of *Islam*, one of the fastest‐growing religions in the United States. Most *Muslims* do not descend from Arabic‐speaking countries. Effective work with these populations requires knowledge of cultural and religious dictates, especially *Islamic* laws derived from the *Qur'an*, which deals with social issues, family life, economics and business, sexuality, and other aspects of life. Collectivism, hierarchical family structure, and patriarchy are important cultural values in Arab American and Muslim American populations. The increase of prejudice and discrimination toward these groups accelerated following the September 11, 2001 terrorist attacks. Hate crimes against *Muslims* are now second only to those perpetrated against Jewish Americans. Eleven clinical implications for counselor practice are identified.

GLOSSARY TERMS

- Arab
- Islam
- Muslim
- *Qur'an*
- Ramadan
- Mosque
- Muhammad
- Shiite
- Sunni

REFERENCES

1. Al Harahsheh, S. (2011). Sons, daughters, and Arab‐American family dynamics: Does a child's gender matter? Retrieved from http://digitalcommons.wayne.edu/oa_dissertations/366

2. Aleccia, J. (2013). Not “brainwashed”: American women who converted to Islam speak out. Retrieved from http://usnews.nbcnews.com/_news/2013/04/26/17897741‐not‐brainwashed‐american‐women‐who‐converted‐to‐islam‐speak‐out

3. American‐Arab Anti‐Discrimination Committee. (2003). 2003–2007 report on hate crimes and discrimination against Arab Americans. Retrieved from https://www.issuelab.org/resource/2003‐2007‐report‐on‐hate‐crimes‐and‐discrimination‐against‐arab‐americans.html

4. Arab American Institute. (2003). Religious affiliations of Arab Americans. Retrieved from www.aaiusa.org

5. Arab American Institute. (2012). Demographics. Retrieved from http://www.aaiusa.org/demographics

6. Associated Press. (2015). Democrats defend naming Muslim to House Intelligence panel. Retrieved from http://www.sandiegouniontribune.com/sdut‐democrats‐defend‐naming‐muslim‐to‐house‐2015jan16‐story.html

7. Bever, L. (2015). Muslim charities raise nearly $45K to rebuild burned‐down black churches. Retrieved from http://www.chicagotribune.com/news/nationworld/ct‐muslim‐charities‐help‐black‐churches‐arson‐20150711‐story.html

8. Botelho, G., & Davis, R. (2015). Chapel Hill Muslim shooting victim said she felt blessed to be an American. Retrieved from http://www.cnn.com/2015/02/13/us/chapel‐hill‐shooting

9. Connor, P., & Krogstad, J. (2018). The number of refugees admitted to the U.S. has fallen, especially among Muslims. Retrieved from http://www.pewresearch.org/fact‐tank/2018/05/03/the‐number‐of‐refugees‐admitted‐to‐the‐u‐s‐has‐fallen‐especially‐among‐muslims/

10. DeSilver, D., & Masci, D. (2017). The world's Muslim population is more widespread than you might think. Retrieved from http://www.pewresearch.org/fact‐tank/2017/01/31/worlds‐muslim‐population‐more‐widespread‐than‐you‐might‐think/

11. De Vogue, A. (2017) Supreme Court allows parts of travel ban to take effect. Retrieved from http://www.cnn.com/2017/06/26/politics/travel‐ban‐supreme‐court/index.html

12. Dwairy, M. (2008). Counseling Arab and Muslim clients. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (6th ed.) (pp. 147–160). Thousand Oaks, CA: Sage.

13. Ebrahimi, A., Neshatdoost, H. T., Mousavi, S. G., Asadollahi, G. A., & Nasiri, H. (2013). Controlled randomized clinical trial of spiritually integrated psychotherapy, cognitive‐behavioral therapy and medication intervention on depressive symptoms

and dysfunctional attitudes in patients with dysthymic disorder. *Advanced Biomedical Research*, *2*, 1–7.

14. El‐Badry, S. (2006). Arab American demographics. Retrieved from http://www.allied‐media.com/muslim_americans/muslim_american_demographics.html

15. Elliott, A. (2006). Muslim immigration has bounced back. *Seattle Times*, September 29.

16. Everett, J. A. C., Schellhaas, F. M. H., Earp, B. D., Ando, V., Memarzia, J., Parise, C. V., … Hewstone, M. (2015). Covered in stigma? The impact of differing levels of Islamic head‐covering on explicit and implicit biases toward Muslim women. *Journal of Applied Social Psychology*, *45*, 90–104.

17. Federal Bureau of Investigation. (2010). Hate crime statistics, 2009. Retrieved from http://www2.fbi.gov/ucr/hc2009/index.html

18. Golgowski, N.(2013). New Miss America's Indian heritage sparks racist comments. Retrieved from http://www.today.com/style/new‐miss‐americas‐heritage‐evokes‐racist‐comments‐twitter‐8C11167234

19. Haq, H. (2013). Boston bombing: US Muslims react with fear, frustration, and new resolve. Retrieved from http://www.csmonitor.com/USA/Society/2013/0425/Boston‐bombing‐US‐Muslims‐react‐with‐fear‐frustration‐and‐new‐resolve

20. Heath, P. J., Vogel, D. L., & Al‐Darmaki, F. R. (2016). Help‐seeking attitudes of United Arab Emirates students: Examining loss of face, stigma, and self‐disclosure. *The Counseling Psychologist*, *44*(3), 331–352.

21. Husain, A., & Howard, S. (2017). Religious microaggressions: A case study of Muslim Americans. *Journal of Ethnic & Cultural Diversity in Social Work*, *26*(1–2), 139–152.

22. Iancu, I., Sarel, A., Avital, A., Abdo, B., Joubran, S., & Ram, E. (2011). Shyness and social phobia in Israeli Jewish vs Arab students. *Comprehensive Psychiatry*, *52*, 708–714.

23. Ibrahim, F. A., & Dykeman, C. (2011). Counseling Muslim Americans: Cultural and spiritual assessments. *Journal of Counseling and Development*, *89*, 387–396.

24. Iwasaki, J. (2006). The best of both worlds. *Seattle Post‐Intelligencer*.

25. Jackson, M. L., & Nassar‐McMillan, S. (2006). Counseling Arab Americans. In C. C. Lee (Ed.), *Multicultural issues in counseling: New approaches to diversity* (3rd ed.) (pp. 235–247). Alexandria, VA: American Counseling Association.

26. Khodayarifard, M., & McClenon, J. (2011). Family therapy in Iran: A case study of obsessive‐compulsive disorder. *Journal of Multicultural Counseling and Development*, *39*, 78–89.

27. Lawrence, L. (2014). Islam, the American way. Retrieved from http://www.csmonitor.com/USA/Society/2014/0216/Islam‐the‐American‐way

28. Leung, N., Langmaid, T., & Hackney, D. (2017). A travel ban that descended into chaos, protests. Retrieved from http://www.cnn.com/2017/01/29/politics/immigration‐crisis‐what‐we‐know/index.html

29. Measham, T., Guzder, J., Rousseau, C. M., & Nadeau, L. (2010). Cultural considerations in child and adolescent psychiatry. *Cross‐Cultural Psychiatry*, *27*, 1–5.

30. Media Matters. (2017). On CNN, Muslim leaders explain how Trump's Muslim ban hurts their communities. Retrieved from https://www.mediamatters.org/video/2017/01/30/cnn‐muslim‐leaders‐explain‐how‐trumps‐muslim‐ban‐hurts‐their‐communities/215172

31. Meer, S., & Mir, G. (2014). Muslims and depression: The role of religious beliefs in therapy. *Journal of Integrative Psychology and Therapeutics*, *2*, 2.

32. Moradi, B., & Hasan, N. T. (2004). Arab American persons' reported experiences of discrimination and mental health: The mediating role of personal control. *Journal of Counseling Psychology, 51*, 418–428.

33. Nassar‐McMillan, S. C. (2011). *Counseling & diversity: Counseling Arab Americans*. Belmont, CA: Brooks/Cole.

34. Nassar‐McMillan, S. C., & Hakim‐Larson, J. (2003). Counseling considerations among Arab Americans. *Journal of Counseling and Development, 81*, 150–158.

35. Nassar‐McMillan, S. C., Lambert, R. G., & Hakim‐Larson, J. (2011). Discrimination history, backlash fear, and ethnic identity among Arab Americans: Post‐9/11 snapshots. *Journal of Multicultural Counseling and Development, 39*, 38–47.

36. Nobles, A. Y., & Sciarra, D. T. (2000). Cultural determinants in the treatment of Arab Americans: A primer for mainstream therapists. *American Journal of Orthopsychiatry*, *70*, 182–191.

37. Pew Research Center. (2015). Views of government handling of terrorism fall to post‐9/11 low. Retrieved from http://www.people‐press.org/2015/12/15/views‐of‐governments‐handling‐of‐terrorism‐fall‐to‐post‐911‐low/

38. Pew Research Center. (2017). U.S. Muslims concerned about their place in society but continue to believe in the American Dream. Retrieved from http://assets.pewresearch.org/wp‐content/uploads/sites/11/2017/07/09105631/U.S.‐MUSLIMS‐FULL‐REPORT‐with‐population‐update‐v2.pdf

39. Podikunju‐Hussain, S. (2006). Working with Muslims: Perspectives and suggestions for counseling. Retrieved from https://www.counseling.org/docs/default‐source/vistas/working‐with‐muslims‐perspectives‐and‐suggestions‐for‐counseling.pdf?sfvrsn=48dd7e2c_10

40. Sahagun, L. (2006). A post‐9/11 identity shift. *Seattle Post‐Intelligencer*.

41. Saleem, M., & Craig, A. (2013). Arabs as terrorists: Effects of stereotypes within violent contexts on attitudes, perceptions, and affect. *Psychology of Violence*, *3*, 84–99.

42. Suleiman, M. W. (1999). *The Arab immigrant experience*. Philadelphia, PA: Temple University Press.

43. Tummala‐Narra, P., & Claudius, M. (2013). A qualitative examination of Muslim graduate international students' experiences in the United States. *International Perspectives in Psychology: Research, Practice, Consultation*, *2*, 132–147.

44. U.S. Census Bureau. (2005). We the people of Arab Ancestry in the United States.

Retrieved from https://www.census.gov/prod/2005pubs/censr - 21.pdf

45. U.S. Census Bureau. (2017). Research to improve data on race and ethnicity. Retrieved from https://www.census.gov/about/our - research/race - ethnicity.html

46. U.S. Department of State. (2002). Muslim life in America. Retrieved from https://www.hsdl.org/?view&did=465996

47. Winerman, L. (2006). Reaching out to Muslim and Arab Americans. *APA Monitor*, *37*, 54.

48. Wisniewski, M. (2014). American opinion of Arabs, Muslims is getting worse—poll. Retrieved from http://af.reuters.com/article/worldNews/idAFKBN0FY1ZK20140729?pageNum ber=2&virtualBrandChannel=0&sp=true

49. Zaki, M. (2011). Life for Arab and Muslim Americans a decade after 9/11. Retrieved from https://www.arabamerica.com/life - for - arab - and - muslim - americans - a - decade - after - 911/

50. Zogby, J. J. (2001). Arab American attitudes and the September 11 attacks. Retrieved from http://www.aaiusa.org/arab - american - attitudes - the - september - 11 - attacks

20
Counseling Immigrants and Refugees

Chapter Objectives

1. **1. Learn the demographics and characteristics of *immigrants* and *refugees*.**
2. **2. Identify counseling implications of the information provided for *immigrants* and *refugees*.**
3. **3. Provide examples of strengths that are associated with *immigrants* and *refugees*.**
4. **4. Know the special challenges faced by *immigrants* and *refugees*.**
5. **5. Understand how the implications for clinical practice can guide assessment and therapy with *immigrants* and *refugees*.**

In responding to President Donald Trump's controversial statements about immigrants from Haiti and African countries, United Nations human rights spokesman Rupert Colville said in a briefing in Geneva "There is no other word one can use but 'racist.' You cannot dismiss entire countries and continents as 'shitholes,' whose entire populations, who are not white, are therefore not welcome."

(O'Keefe & Gearan, 2018)

Jean Yannick Diouf's story is among the nearly 70 narratives Illinois Senator Dick Durbin collected from dreamers (individuals brought to the U.S. at an early age without documentation). "When Yannick was 8, his father, a diplomat from the African country of Senegal, brought his family to the United States. Unfortunately, Yannick's parents separated, and Yannick's father returned to Senegal, leaving Yannick and the rest of the family behind. Yannick didn't realize it at the time, but when his father left the United States, Yannick lost his legal status to live in this country. Yannick—an honors student and community leader who is currently studying business management at the University of Maryland, College Park—told me that, to him, 'DACA means dignity. More than making money, having a job gives us dignity and self‐respect. I want to work for what I have. I don't look to anyone for pity. People should judge me based on what I do and what I stand for, not based on status. I want to be given a chance to prove that not only am I a functioning member of society, I am here to serve and share my talents with those in my community'."

(Durbin, 2018)

Abrahim Mosavi, a national of Iran and resident of the United States for more than three decades, applied to naturalize in 2000. Although he is eligible to become a citizen, he has waited thirteen years for a final decision on his application. "No one can tell me why I should have to wait so long," said Mr. Mosavi.

(ACLU, 2013)

The international‐born population in the United States (including *undocumented immigrants*) was 41.3 million in July 2013; nearly one out of every six adults living in the United States was born abroad (Zeigler & Camarota, 2014). Approximately 12 million are from Mexico, 10.5 million from East and South Asia, 4 million from the Caribbean, 3.2 million from Central America, 3 million from South America, 1.6 million from the Middle East, and about 7.5 million from other countries. Mexican *immigrants* made up about 28% of all U.S. *immigrants*, and Asians are currently the fastest‐growing group of *immigrants* in the United States (Pew Research Center, 2014). Immigration from Mexico slowed considerably after the economic downturn in the U.S. economy in 2009; in fact, over 1 million Mexican *immigrants* have returned to their country of origin since that time.

About 11.4 million *immigrants* are unauthorized, having entered the United States without inspection or overstayed their temporary stay; approximately 60% of *undocumented immigrants* have been here for more than a decade (Baker & Rytina, 2013). Of the unauthorized *immigrants* in the United States, an estimated 5,850,000 are from Mexico, 1,700,000 from Central America, 1,400,000 from Asia, 600,000 from Europe and Canada, 550,000 from the Caribbean, 400,000 from the Middle East or Africa, and 190,000 from South America (Pew Research Center, 2014).

The reasons for *migration* include escape from poverty, seeking a higher quality of life, and political unrest (Negy, Schwartz, & Reig‐Ferrer, 2009). Many *immigrants*, particularly those from undeveloped countries and those who are undocumented, earn extremely low wages. Approximately 23% of *immigrants* and their U.S.‐born children live in poverty (Camarota, 2012). About 60% of farm workers, who help pick billions of dollars of agricultural products, are undocumented *immigrants*. Nearly 25% of workers who butcher meat, poultry, and fish are undocumented, including many women. Most *undocumented immigrants* subsist on poverty‐level wages and are exposed to exploitation and abuse in the workplace. A high percentage of women working in these food industries are subject to sexual abuse (Southern Poverty Law Center, 2010).

Since 2012, there has been a surge of unaccompanied *immigrant* children, primarily from Central American countries such as Guatemala, Honduras, and El Salvador; many of these children have come to the United States to escape the escalating gang violence in their home countries (young children and teens are forced to join gangs; if they refuse, they and their families are subjected to violent retribution). While border patrol agents can quickly deport children from Mexico, those from Central American countries are given full court proceedings (Lind, 2014). This is creating a backlog of immigration cases. Other countries, such as Mexico, Panama, Nicaragua, and Belize, are also inundated with Central Americans seeking *asylum* (Restrepo & Garcia, 2014).

There is a wide range of educational levels among adult *immigrants*, with nearly one‐third having a college degree (U.S. Census Bureau, 2012). New *immigrants* are better educated than the U.S. population as a whole: about four out of ten *immigrants* coming to the United States between 2007 and 2013 had earned at least a bachelor's degree (Fry, 2015). *Immigrants* make up nearly 28% of physicians, 31% of computer programmers, and 47% of medical scientists. East Asians and Nigerians are the most highly educated *immigrants* in U.S. history, with more than 60% having at least a bachelor's degree (Pew Research Center, 2014; TADIAS, 2014). In contrast, about one‐third of U.S. adult *immigrants* as a whole have not completed high school (compared with 12.5% of the total adult population) (U.S. Census Bureau, 2012). Among the *immigrant* secondary school population, the high school dropout rate was 21% in 2009—significantly higher than the national average. Although *immigrants* make up 10% of high school students, they account for 27% of high school dropouts (Child Trends, 2014). In general, children of *immigrant* families have high rates of poverty (35%) (Wight, Chau, & Aratani, 2011).

According to the Department of Homeland Security, only about 39% of *undocumented immigrants* currently in the United States arrived after the year 2000. Most *undocumented immigrants* are well integrated into society, and many have children born in the United States—children whose dominant language is English and who have never visited their parents' homeland. Having established their lives in the United States and having children who only know life in the United States are powerful reasons for these *immigrants* to want to remain in the country. The work of these *undocumented immigrants* is indispensable in areas such as agriculture, construction, childcare, and the restaurant and hotel industry (Marrero, 2011).

Despite the belief that *immigrants* are a drain on society, they are no more likely to use social services than are native‐born Americans. In fact, the belief that unauthorized *immigrants* are a financial burden on society ignores the fact that they pay billions of dollars in taxes each year, and nearly half of the adults who have been in the United States for more than 10 years are homeowners (CAP Immigration Team, 2014). Meanwhile, although incidents such as the shooting of a young woman in San Francisco in 2015 by an undocumented Mexican raise fears about crime regarding this population, studies have found that *immigrants* have a much lower rate of crime and are less likely to be behind bars than are native‐born individuals. These findings apply "for both legal *immigrants* and the unauthorized regardless of their country of origin or level of education" (Ewing, Martínez, & Rumbaut, 2015). Fear regarding *immigrants*, especially those who are undocumented, may be a product of negative stereotyping or inordinate attention to the criminal acts of a few.

CHARACTERISTICS AND STRENGTHS

In the following sections we describe the historical, sociopolitical, cultural, and gender characteristics of *immigrants*, implications for treatment, and the strengths often seen among those who emigrate. Remember that these are generalizations and their applicability needs to be assessed for each client.

Historical and Sociopolitical Factors

> *The twin 12‐year‐old Duarte sisters watched in horror as their parents were accosted and taken away by U.S. Immigration Customs Enforcement (ICE) agents outside of their California home. They were born in the U.S. years after their parents immigrated to the country from Mexico. The sisters and their two older brothers are now trying to piece back together their family and their lives.*
>
> *(Keierleber, 2017)*

The election of Donald Trump as president of the United States shifted recent immigration policies and public discourse. During the 2016 election season, the Southern Poverty Law Center administered a national survey to approximately 2,000 K–12 teachers. Key findings from the survey include:

- More than two‐thirds of teachers reported that students—mainly *immigrants*, children of *immigrants*, and Muslims—had expressed concerns or fears about what might happen to them or their families after the election.
- More than half had seen an increase in uncivil political discourse.
- More than one‐third had observed an increase in anti‐Muslim or anti‐*immigrant* sentiment. (Costello, 2016, p. 4)

It seems the children's concerns and fears have to a large degree been realized.

The Trump administration's approach to immigration is part of a larger history of unfair and exclusionary laws restricting the immigration of non‐White people to the United States. Until 1952, only White persons were allowed to become *naturalized citizens*. With the Immigration Act of 1965, people from any nation were finally allowed to apply for citizenship. In part, the U.S. civil rights movement facilitated this change. Even now, however, under a little‐known federal program, the Controlled Application Review and Resolution Program (CARRP), the government excludes many applicants for citizenship or work visas from Arab, Middle Eastern, Muslim, and South Asian communities by delaying and denying their applications. According to the American Civil Liberties Union (ACLU) (2013), it does so by “relying on extraordinarily overbroad criteria that treat religious practices, national origin, and innocuous associations and activities as national security concerns.” Thus, individuals from these countries and religious backgrounds do not appear to have the same opportunities as other *immigrant* groups to work or gain citizenship in the United States.

During his first year as president, Donald Trump signed seven executive orders to change immigration policies, most designed to restrict immigration from non‐White countries or to arrest *immigrants* and/or remove them to their country of origin (Pierce & Selee, 2017). Among the executive orders include:

1. *Canceling Deferred Action for Childhood Arrivals (DACA)*. In 2012, President Obama took executive action authorizing DACA, which provided temporary deportation protection for more than 500,000 unauthorized young *immigrants* and allowed them to apply for work permits; these young adults, called "*dreamers*," were brought to the United States as children without proper documentation. In November 2014, Obama extended DACA to provide deportation relief and work permit eligibility for another 4.7 million *undocumented immigrants* who had lived in the United States for at least 5 years and whose children were citizens or legal permanent residents. These actions provided deportation protection for about 5.5 million *undocumented immigrants*, while about 6 million others did not qualify for temporary deportation relief under these programs (Lind, 2015).
2. *Ending Temporary Protected Status (TPS)*. TPS provided people fleeing war and natural disasters special privileges to live and work in the United States. Approximately, 200,000 Salvadorans, 45,000 Haitians, and 2,500 Nicaraguans must return to their country of origin by early 2019. Many of these people have been living in the United States and contributing to U.S. society since 2001, and the earthquake in El Salvador.
3. *Reducing refugee admissions to an all‐time low*. Trump capped the *refugee* settlements in the United States at 50,000 in 2017 and 45,000 in 2018, which is considerably lower than the cap under the Obama administration (110,000).

Additionally, some states have passed laws that target *immigrants*. In some cases, election officials at polling places are allowed to make inquiries of registered voters who appear to be *immigrants*, such as, "Are you a native or a *naturalized citizen*?", "Where were you born?", and "What official documentation do you possess to prove your citizenship?". The voters are then required to provide documentation and to declare, under oath, that they are the person named therein.

These anti‐immigration policies continue to provoke fear and unease within *immigrant* communities, as well as decrease the likelihood of *immigrants* reporting crimes or abuse. In response to recently implemented state laws requiring schools to inquire about the immigration status of students, federal officials have stated that school districts must "ensure that any required documents would not unlawfully bar or discourage a student who is undocumented or whose parents are undocumented from enrolling in or attending school." In other words, immigration status should not play a role in establishing residency within a school district (Khadaroo, 2014).

Despite the rise in anti‐immigration policies and rhetoric, most Americans support providing a pathway to citizenship for the *dreamers* and other *immigrants*. In a recent poll, about 70% of Americans believed *dreamers* should be allowed to stay in the country legally (Samuels, 2018) and a little over half believed immigration strengthens the United States. There is a sizable number, however, who believe the United States should tighten its boarders and restrict immigration. The argument is often made that *undocumented immigrants* violated the law by not following immigration policy and that they are a drain on the social system. Those on the other side of the debate counter that businesses have benefited from and continue to rely on the work provided by undocumented workers, many of whom have lived in the United States for decades, paying taxes and contributing to their communities.

Cultural and Acculturation Issues

Immigrants face the overwhelming task of learning about the workings of U.S. society.

Immigrants need to negotiate the educational system, acquire language proficiency, and seek employment. They must adjust and adapt to new cultural customs within a completely different society and navigate the mixed reception they receive from U.S. citizens. Placed in unfamiliar settings, adjusting to climactic differences, and lacking community and social support, many experience severe culture shock (Bemak & Chung, 2014). Feelings of isolation, loneliness, disorientation, helplessness, anxiety, and depression often characterize the immigration experience. The only sources of comfort and support may be a small circle of relatives or friends, who also may be adjusting to a different way of life.

In families in which the degree of acculturation varies, the exposure to different values, attitudes, and behavioral expectations can result in acculturation‐based problems. In *immigrant* families, children and adolescents attend school and thus more quickly acculturate and adapt to U.S. culture, whereas the parents and older family members tend to adhere to traditional cultural values. Children may believe that their parents are unable to offer advice or help with social problems. Parents may begin to feel that their children are abandoning them and their cultural background. Parent–child acculturation discrepancies can lead to a sense of alienation between family members. *Immigrant* families may seek therapy when parent–child communication difficulties lead to intergenerational conflicts or produce psychological symptoms in the child (APA Presidential Task Force on Immigration, 2013).

Implications

Counselors often need to take on multiple roles with clients who are recent *immigrants*, including educator (providing information on services and education about their rights and responsibilities) and advocate (helping negotiate the institutional structures of the health care, education, and employment systems). In addition to traditional mental health services, psychoeducational approaches are often required to assist *immigrants* to acquire (a) education and training for themselves and their children; (b) knowledge of employment opportunities, job search skills, and the ability to manage financial demands; (c) language proficiency to ensure success in U.S. society; and (d) strategies to manage family relationship conflicts.

To effectively assist *immigrants*, it is important to understand the life circumstances of *immigrant* groups, to have liaisons within the *immigrant* community, and to be familiar with community resources aimed at helping *immigrants* adjust to a new world. When addressing family problems around acculturation issues, it is often helpful to cast the exposure to different values and expectations as the source of acculturation conflicts and help family members problem‐solve methods of dealing with differing cultural expectations.

Gender Issues and Domestic Violence

Many *immigrants* come from countries in which there are gender inequities and spousal abuse; women may be reluctant to seek help because of self‐blame, concern for their children, or lack of knowledge about abuse protection laws (Ting & Panchanadeswaran, 2009). Reluctance to report partner abuse may also be influenced by economic dependence or fear of retaliation (Quiroga & Flores‐Ortiz, 2000). Further, many *immigrant* women have been socialized to sacrifice their own personal needs for the good of their husbands and children. Such training leads to their ignoring or denying their own distress and prioritizing family needs (Ro, 2002).

Male *immigrants* may face a loss of status and develop a sense of powerlessness. They may have lost their assigned roles within the family and society as a whole and may be unemployed or underemployed. Because women often find it easier to gain employment, the

resulting changes in the balance of power may increase the risk of domestic violence as men attempt to reestablish their authority (Bemak & Chung, 2014).

Implications

As with other cases involving family violence, the following steps are recommended:

- Assess the lethality of the situation. If there is a high degree of danger, develop a safety plan. The client should know where she and her children can stay if she needs to leave home. The therapist should help identify shelters or other resources available for the particular *immigrant* group to which she belongs.
- If the degree of violence is nonlethal and the client does not want to leave the home, provide psychoeducational information on abusive relationships, the cycle of violence, and legal recourse. Also provide crisis numbers or other contact information to use if the violence escalates.
- Convey an understanding of both the cultural and the situational obstacles the client faces. Recognize that some women may define their role as the one who protects and cares for everyone's welfare. Forming a strong therapeutic relationship is especially important if no support is available from other family members or friends.
- Attempt to expand support systems for the client, especially within her community. Support groups and services are now available for a number of different *immigrant* groups.

Strengths

The attributes from the various ethnic and cultural groups to which *immigrants* belong strengthen the diversity of our nation. *Immigrants* have made positive social, political, and cultural contributions to U.S. society for many generations. *Immigrants* often demonstrate significant loyalty to the United States as their chosen homeland and have brought with them both ingenuity and a strong work ethic. They have a “high level of engagement” in the labor market and generally have good psychological and physical health (APA Presidential Task Force on Immigration, 2013).

Many *immigrants* are from countries with a collectivistic orientation in which religion or spiritual practices are important; they often serve as role models of interdependence and cooperation with multiple extended family and community supports. The role of the family and the strength of spiritual beliefs serve as core resources to make meaning of and help cope with the stress associated with adapting to a completely new environment (Kira & Tummala‐Narra, 2015). *Immigrants* are often supportive of each other and promote group identification and acceptance of differences. These kinds of support can help ameliorate the stressors involved in living in a new culture, especially a society that emphasizes the individual.

SPECIFIC CHALLENGES

In the following sections, we consider challenges faced by *immigrant* individuals and consider their implications for treatment. Remember that these are generalizations and that their applicability needs to be assessed for each client.

Prejudice and Discrimination

> *Refugees who are forced to leave their countries because of persecution or war, are often described in negative terms such as "waves" of refugees that threaten to flood the country, "sponges off the welfare system," "criminals," "lacking in morals," "cockroaches" or "parasites."*
>
> *(Hamilton, Medianu, & Esses, 2013, p. 94)*

The September 11, 2001, terrorist attacks had a dramatic impact on U.S. attitudes toward *immigrants* and *refugees*. The new emphasis on preventing the entry of terrorists into the United States resulted in not only Arab or Muslim Americans being viewed with suspicion, but anyone who "appears foreign." *Immigrants* became regarded as possible terrorists. Following the trauma of September 11, the movement toward the legalization of *undocumented immigrants* slowed, and there was a dramatic decline in the admission of *refugees* (Frej, 2016). The anti‐immigration nativism movement, promoting the position that only U.S. "natives" (understood to be people of European descent) belong in the United States, is receiving greater support (Nassir, 2014). Similarly, the English‐only movement, viewed by many *immigrants* and others as being exclusionary, is strengthening.

Although *immigrants* already use less than 50% of available health care resources as compared with the average U.S. citizen (National Immigration Law Center, 2006), the climate of fear has led to even further decreases in the utilization of medical or government services by *immigrants*. While *immigrants'* children born in the United States are citizens, many undocumented parents harbor great fear and anxiety about their own immigration status or that of close family members. Parents or guardians who are undocumented are fearful of registering their children for school or seeking medical attention..Other *immigrants*, even those who are permanent legal residents, are afraid that seeking assistance might suggest an inability to live here independently and increase their chances of being deported or of not being granted citizenship.

Implications

Mental health professionals should be aware that *immigrant* clients or their families may see the therapist as an arm of government. The therapist should also be aware of the rights and exclusions associated with *immigrant* status (Bernstein, 2006):

- Hospitals are required to provide emergency care to anyone in need, including *undocumented immigrants*. Other treatments depend on local laws. Information regarding other *immigrant* issues can be obtained from the National Immigration Law Center.
- Free community clinics exist that will treat individuals regardless of immigration status.
- *Immigrants* can ask health care providers for interpreter services.
- Most documented *immigrants* are not eligible to receive Medicaid, food stamps, or social security benefits during their first 5 years in the United States or longer, regardless

of how much they have paid in taxes.

- *Undocumented immigrants* face tremendous difficulties when seeking a higher education. The imposition of out - of - state tuition fees effectively keeps them out of college in most of the country. In support of higher education for these students, 18 states currently have provisions allowing for in - state tuition rates for undocumented students, and five (California, Minnesota, New Mexico, Texas, and Washington) allow undocumented students to receive state financial aid. Three states (Arizona, Georgia, and Indiana) prohibit in - state tuition rates for undocumented students, and two (Alabama and South Carolina) prohibit them from enrolling at any public postsecondary institution (National Conference of State Legislatures, 2015).
- Many advocacy agencies now encourage *immigrant* parents to have a detailed plan in place in case they are deported, including granting power of attorney to someone who can take custody of their children (O'Neill, 2012).

Barriers to Seeking Treatment

Multiple barriers exist for *immigrants* in their utilization of social and mental health services. As mentioned earlier, *immigrants* utilize health care services much less than U.S. citizens. Mental health providers need to understand how cultural, linguistic, and informational barriers can affect *immigrants*.

In a survey of health care providers, several barriers to accessing services were identified:

- *Communication difficulties due to language differences*. More than half of the providers identified language barriers as the major source of difficulty in providing service. These barriers affect critical areas, such as obtaining accurate information during assessment. The providers also mentioned that it is difficult to obtain interpreter services, especially given the diversity of dialects within some ethnic groups (Weisman et al., 2005).
- *Lack of knowledge of mainstream service delivery*. Many *immigrants* lack knowledge about how the health care system operates in the United States. Extra time is required when providers try to explain clinic practices and paperwork. Often, apparent noncompliance in following through with recommendations is due to poor understanding of services.
- *Cultural factors*. Many *immigrant* groups are hesitant to speak about “family issues” or issues of personal concern because of the cultural importance of privacy (Chung & Bemak, 2007). Women who have been abused by their husbands or sexually assaulted may not talk about these issues because of cultural norms and shame, as well as over fear of deportation. A stigma exists for many *immigrants* around seeking help for mental health problems, and there may be fear that mental health issues will be blamed on the family.
- *Lack of resources*. Many *immigrant* families are living in poverty and may lack transportation to go to the service location. In addition, they may not have time to attend sessions, due to inflexible work schedules or the economic necessity of working as many hours as possible.

Linguistic and Communication Issues

If *immigrants* are not fluent in English, the use of *interpreters* may be necessary. Many therapists and *interpreters* are not aware of the dynamics involved when another individual

enters the therapy relationship. Most *interpreters* receive little or no training in working with distressed or traumatized individuals, and they may experience uncontrollable feelings of emotional distress when hearing traumatic stories, especially when their backgrounds are similar to those of the clients (Miller, Zoe, Pazdirek, Caruth, & Lopez, 2005). For example, one interpreter discovered that in order to protect herself from distressing feelings as she was interpreting for traumatized clients, she became dismissive and casual when describing the violent events. In another case, a therapist observed, "I had one interpreter start shaking. It was too much for her … She just became incredibly upset and angry" (Miller et al., 2005, p. 34).

Therapists also report developing reactions to *interpreters*. Some think of *interpreters* as "translation machines," whose interpersonal qualities are unimportant. Eventually, however, most realize that *interpreters* form part of a three‐person alliance. Initially, clients may develop a stronger attachment to the interpreter than to the therapist. Because of this, therapists need to deal with feelings of "being left out" and to accept that their relationships with these clients might develop in a slower fashion. Therapists may also choose to use *interpreters* as important cultural resources by obtaining their thoughts about issues discussed in sessions. In general, therapists are appreciative of *interpreters* and do not perceive any long‐term negative effects on the therapeutic progress. Sometimes, however, *interpreters* interject their own opinions, intervene directly with clients, or question interventions because they do not understand the therapeutic approach (Miller et al., 2005).

Implications

Both therapists and *interpreters* benefit from knowledge of best practices such as the following (Searight & Searight, 2009; Yakushko, 2010):

- *Interpreters* should receive brief training in specific mental disorders and the interventions employed in therapy, particularly treatment of trauma, grief, and loss.
- Because traumatic experiences discussed in therapy can affect *interpreters*, therapists should discuss self‐care strategies for the interpreter, as well as ways of dealing with exposure to traumatic reports.
- Clients do not regard *interpreters* as translation machines. Therefore, *interpreters* should be trained in the relationship skills that are needed in therapy. In the triadic relationship, interpersonal skills such as empathy and congruence are necessary.
- Therapists should also receive training on how to work effectively with *interpreters* and become conversant with different models of interpreting. Some prefer simultaneous translation, whereas others prefer delayed translation.

Therapists should be aware that, in many cases, the therapeutic alliance may form with the interpreter first. Many therapists who have worked with *interpreters* understand that for non‐English‐speaking clients, *interpreters* are the bridge between themselves and the therapist, and are critical in assessment and the provision of therapy.

Counseling Refugees

Deng fled the civil war in Sudan and has been in the United States for the past 2 years. He is 28 years old and spent 4 years in a refugee camp before coming to the United States. He describes fleeing burning villages outside of Darfur and seeing many people from his own family and community slaughtered, raped, and beaten. He remembers

> *running and hiding, being near starvation, drinking muddy water, avoiding crocodiles and once a lion, and being alarmed when bombs dropped nearby … He wonders what happened to his family and friends and feels guilty for having escaped.*
>
> *(Chung & Bemak, 2007, p. 133)*

Deng's escape from Sudan and the trauma he experienced are not uncommon for *refugees*. The United States provides *refugee* status to persons who have been persecuted or have a well‐founded fear of persecution. In contrast to other *immigrants*, who voluntarily left their country of origin, *refugees* are individuals who fled their country in order to escape persecution due to race, religion, nationality, political opinion, or membership in a particular social group. Asylees, individuals who meet the criteria for *refugee* status, are either physically present in the United States or at a point of entry when granted permission to reside in the country. Any alien present in the United States or arriving at a port of entry may seek *asylum*. Individuals granted *asylum* are authorized to work in the United States. In addition, an asylee is eligible for certain public benefits, including employment assistance, a social security card, and social services. Similar to *refugees*, *asylum* seekers have been uprooted from their countries of origin, often after suffering years of persecution or torture directed toward themselves, their family and friends, or even their entire community. Predetermined allotments for specific geographical locations limit the number of *refugees* and asylees accepted by the U.S. government; these limits change from year to year. In 2013, the 69,909 persons admitted to the United States as *refugees* were primarily from four countries: Iraq (27.9%), Burma (23.3%), Bhutan (13.1%), and Somalia (10%). Additionally, 25,199 individuals from China (34%), Egypt (14%), Ethiopia (3.5%), Nepal (3.4%), and Syria (3.2%) were granted *asylum* (Martin & Yankay, 2014). These numbers of both *refugees* and those granted asylum in the United States have significantly decreased since the election of President Donald Trump.

What characterizes the life experience of many *refugees* is their pre‐*migration* trauma, which is often life‐threatening in nature. The impact of trauma is likely to be exacerbated by the challenges of adjustment to a new world. Being displaced from their country of origin, *refugees* often express concern about adapting to a new culture and country. Losing their cultural identity is also a worry. Lacking a support or community group, *refugees* often feel estranged and isolated. Many report feelings of homesickness and concerns over the breakup of their family and the loss of community ties. There are often worries about the future, difficulties communicating in English, and unemployment.

Refugees want their children to learn their native language and to maintain family and cultural traditions. Many *refugee* parents are also especially concerned about the Americanization of their children, given the U.S. societal emphasis on openness and individuality. Parents may worry about the academic and social adjustment of their children and what they perceive to be a lack of discipline in American society. Because of the limitations on available employment, many have inflexible, low‐wage jobs that prevent them from adequately supervising their children (Weine et al., 2006).

Effects of Past Persecution, Torture, or Trauma

Post‐traumatic stress disorder (PTSD) and elevated rates of mood and anxiety disorders are frequent in the *refugee* population (Nickerson, Bryant, Silove, & Steel, 2011), including nightmares and symptoms involving dissociation, intrusive thoughts, and hypervigilance (Chung & Bemak, 2007). It is important to note, however, that the vast majority of *refugees* are able to make a healthy transition to life in the United States. Although many of the

challenges faced by *refugees* are similar to those encountered by *immigrants*, differences do exist. In general, *refugees* are under more stress compared to *immigrants*. Most *immigrants* had time to prepare for their move to the United States, whereas for most *refugees*, the escape was sudden and traumatic. Family members have often been left behind. With the exception of some *undocumented immigrants*, who often have experienced robbery, beatings, and sexual assault, *refugees* have typically been exposed to more trauma than other *immigrants* (Bemak & Chung, 2014).

The pre‐*migration* experiences of many *refugees* include the atrocities of war, torture and killing, sexual assault, incarceration, and a continuing threat of death. For example, Central American *refugees* from El Salvador, Guatemala, Nicaragua, and Honduras report violent experiences, such as witnessing beatings and killings, fearing for their own lives or those of family members, being injured, or being victims of sexual assault. These Central American *refugees* report feelings of isolation and exhibit high levels of mistrust with service providers (Asner‐Self & Marotta, 2005). *Refugees* often experience emotional reactions related to the destruction of their family and social networks, sometimes as a result of genocide. Many report that memories of war intrude into their daily lives.

Implications

To see loved ones raped, beaten, and killed can have lasting, long‐term consequences. It may be difficult to share such traumatic experiences with a therapist. In order to have a strong therapeutic relationship with traumatized *refugees*, it is especially important to establish trust and to recognize that the disclosure of traumatic experiences takes time. Questions not related to violence, exposure to weapons, or other stressful incidents might allow for greater comfort in revealing traumatic experiences and reduce feelings of fear, shame, and humiliation later (Asner‐Self & Marotta, 2005).

It is important to consider the cultural perspective of *refugees* concerning mental and physical disorders in order to determine how their views might be different from those of the dominant culture. For example, in some countries, women victimized by sexual assault are shunned and considered unfit for marriage. In addition, many *immigrants* take a somatic view of psychological disorders and see mental disorders as resulting from physical problems. If a client brings up somatic symptoms, the therapist can work first with these complaints. Also, because there may be a lack of understanding of *PTSD* symptoms, therapists can help clients understand why they occur. Symptoms can be framed as normal reactions to trauma that anyone in their situation might develop. Therapists can reassure clients that the symptoms can be treated and are not signs that they are “going crazy.”

Safety Issues and Coping with Loss

Refugees often come from politically unstable situations. In such cases, issues of safety are salient and must be addressed. In the process of requesting *refugee* status, some clients may have faced the adversarial experience of having to prove that they were persecuted. Because of this, they may be reluctant to relate their experiences or seem fearful that they will not be believed.

The loss of friends, family, and status is very troubling to *refugees*. They often feel guilty about leaving other family members behind and may go through a bereavement process. Many will not be able to resume their previous level of occupational and social functioning. It is important to identify their perceptions about what is lost.

Implications

Therapists should discuss confidentiality and the reason for assessment early in the intake process. Based on negative experiences with governmental powers in their homeland, *refugees* may be concerned about providing information or may be worried that any information they share will be used against them. Also, since problem behaviors or mental difficulties may be seen as a source of shame for the individual or the family, knowing that the information they provide will be confidential may offer some relief. It is helpful to acknowledge the difficulty involved in sharing private information, providing reassurance that it is necessary in order to develop the best solutions. To explore the possibility that cultural constraints exist, the counselor might also say something like the following: "Sometimes people in counseling believe that family issues should stay in the family. How do you feel about this belief?"

To understand the loss experienced by *refugees*, it may be helpful to ask them to share their *migration* stories as part of the assessment. This provides an understanding of their social and occupational life prior to leaving their country of origin. Information regarding family life, friends, and activities can be gathered by asking questions such as, "What was your life like before coming to the United States?", "What was family life like?", "What kind of job or family roles did you have?", and "What was your community like?". Therapists can also inquire about experiences with transition from the client's homeland and any traumas associated with this process: "What happened before, during, and after you left your country?", "What differences do you see between living in your country and living in America?", "What do you see as the advantages and disadvantages of living in either country?" It is important to understand experiences with resettlement camps and find out whether family members were separated. In addition, therapists should inquire about clients' experiences with prejudice and discrimination in their homeland and since arriving in the United States. This process gives a clearer picture of the perceived losses and experiences of *refugees* (Weisman et al., 2005).

IMPLICATIONS FOR CLINICAL PRACTICE

Many *immigrants* hold cultural belief systems that are collectivistic. In contrast to the individualistic Western worldview, they may consider interpersonal relationships and social networks to be of paramount importance. Mental health systems that value independence over interdependence, separate mental functioning from physical functioning, attribute causation as internally located, and seek to explain events from a Western empiricist approach can be at odds with the cultural belief systems of *immigrants* and *refugees*. Counselors may inadvertently impose their belief systems on these clients and communicate a disrespect for their worldview. Counselors should perform a self‐assessment with respect to their own attitudes by asking themselves questions such as, "How do I feel about *immigrants* and *refugees* coming to our country?" and "What are my feelings about *undocumented immigrants*?" (Villalba, 2009). It is important for therapists to consider the following (Bemak & Chung, 2014; Burnett & Thompson, 2005):

1. Remember that *immigrants* and *refugees* face multiple stressors, including the stress of moving to and living in another country, learning another language, and negotiating new social, economic, political, educational, and social systems. It is often a confusing and frightening experience. Mental health providers who understand the complexities of this situation can do much to reassure clients by demystifying the process.

2. Be aware that the client may have day‐to‐day stressors, such as limited resources, a need for permanent shelter, lack of employment, or frustrating interactions with agencies. Allow time to understand and to provide support related to these immediate needs, or to help the client locate resources related to specific needs.
3. Do not assume that the client has an understanding of mental health services or counseling. Give a description of what counseling is and the roles of therapist and client.
4. Inquire about the client's beliefs regarding the cause of their difficulties, listening for sociopolitical, cultural, religious, or spiritual interpretations. Understanding and validating clients' conceptualizations of presenting problems within their cultural matrix is an important aspect of providing culturally relevant services.
5. Allow time for clients to share their backgrounds, their pre‐*migration* stories, and their life experiences since immigrating.
6. Clearly describe the symptoms of mental disorders, outline various psychotherapeutic approaches, and explain how chosen strategies will help the client make desired changes. Modify evidence‐based therapies to include cultural beliefs.
7. Cultural adaptations include condensation of treatment sessions, review of concepts covered, and modification of materials such as the inclusion of visual aids and of culturally relevant metaphors, values, and proverbs (Ramos & Alegría, 2014).
8. Keep current regarding what is happening at the local, state, and federal level relative to immigration and *refugee* issues, particularly the tone of the debate. As our review indicates, sociopolitical conditions and public policy can have either positive or negative effects on *refugees'* life experiences.
9. Families may be impacted by poverty, fear of immigration raids, parents working multiple jobs, and a lack of an extended family network. In addition, acculturation conflicts can occur. In some families, children have learned to threaten parents with dialing 911 when physically disciplined (Leidy, Guerra, & Toro, 2010).
10. Mental health providers should consider offering services within the *immigrant* community rather than outside of it. These services should be made culturally relevant and partially staffed by members from the *immigrant* community.
11. Help *undocumented immigrants* have a plan in place for dealing with possible deportation of family members and to secure advocacy resources that are available to them.
12. In the course of assessment and diagnosis of mental disorders, take into account environmental factors, language barriers, and potential exposure to discrimination and hostility. When necessary, use skilled and knowledgeable *interpreters*.
13. Be knowledgeable about *refugee* experiences and the psychological strategies commonly used to cope with stress. Understand that symptom manifestations may include post‐traumatic stress and other mental disorders that arise from experiences of war, imprisonment, persecution, rape, and torture. Symptoms might involve nightmares, avoidance, hopelessness, or negative beliefs about the self and others.
14. Develop your own system of self‐care to decrease the effects of intense work with clients with traumatic histories.

SUMMARY

Immigrants come to this country to escape poverty or political unrest, and to seek a better life. Despite the belief that *immigrants* are dangerous or a drain on society, they are no more likely to use social services and to commit crimes than native‐born Americans. Nevertheless, many citizens are opposed to the number of *immigrants* entering the United States and are against providing a path to citizenship for those who are undocumented. *Refugees* are those forced to leave their countries in order to escape persecution due to race, religion, nationality, political opinion, or membership in a particular social group. In addition to facing major cultural differences and coping with a new environment, both groups have been subjected to individual, institutional, and societal prejudice and discrimination. Clinicians need to be attuned to linguistic and communication issues, pre‐*migration* trauma, and post‐traumatic stress for *refugees*. Fourteen clinical implications for counselor practice are identified.

GLOSSARY TERMS

- Asylum
- Bilingualism
- Dreamers
- Immigrants
- Interpreters
- Migration
- Naturalized citizens
- Post‐traumatic stress disorder (PTSD)
- Refugees
- Survivor's guilt
- Undocumented immigrants

REFERENCES

1. American Civil Liberties Union (ACLU). (2013). Muslims need not apply: CARRP. Retrieved from https://www.aclusocal.org/en/CARRP

2. American Psychological Association (APA) Presidential Task Force on Immigration (2013). *Crossroads: The psychology of immigration in the new century*. Washington, DC: American Psychological Association.

3. Asner‐Self, K. K., & Marotta, S. A. (2005). Developmental indices among Central American immigrants exposed to war‐related trauma: Clinical implications for counselors. *Journal of Counseling and Development*, *83*, 163–172.

4. Baker, B., & Rytina, N. (2013). *Estimates of the unauthorized immigrant population residing in the United States*. Washington, DC: U.S. Department of Homeland Security, Office of Immigration Statistics.

5. Bemak, F., & Chung, R. C.‐Y. (2014). Immigrants and refugees. In F. T. L. Leong, L. Comas‐Diaz, G. C. Nagayama Hall, V. C. McLoyd, & J. E. Trimble (Eds.), *APA handbook of multicultural psychology* (Vol. *1*) (pp. 503–517). Washington, DC: American Psychological Association.

6. Bernstein, N. (2006). Recourse grows slim for immigrants who fall ill. *New York Times*, March 3.

7. Burnett, A., & Thompson, K. (2005). Enhancing the psychosocial well‐being of asylum seekers and refugees. In K. H. Barrett, & W. H. George (Eds.), *Race, culture, psychology, and law* (pp. 205–224). Thousand Oaks, CA: Sage.

8. Camarota, S. A. (2012). Immigrants in the United States, 2010: A profile of America's foreign‐born population. Retrieved from http://cis.org/2012‐profile‐of‐americas‐foreign‐born‐population

9. Center for American Progress (CAP) Immigration Team. (2014). The facts on immigration today. Retrieved from https://www.americanprogress.org/issues/immigration/report/2014/10/23/59040/the‐facts‐on‐immigration‐today‐3

10. Child Trends. (2014). High school dropout rates. Retrieved from http://www.childtrends.org/?indicators=high‐school‐dropout‐rates

11. Chung, R. C. Y., & Bemak, F. (2007). Immigrant and refugee populations. In M. G. Constantine (Ed.), *Clinical practice with people of color* (pp. 125–142). New York, NY: Teachers College Press.

12. Costello, M. B. (2016). *The Trump effect: The impact of the presidential campaign on our nation's schools*. Montgomery, AL: Southern Poverty Law Center.

13. Durbin, D. (2018). Dreamers' stories. Retrieved from https://www.durbin.senate.gov/issues/immigration‐and‐the‐dream‐act/dreamers‐stories

14. Ewing, W. A., Martinez, D. E., & Rumbaut, R. G. (2015). The criminalization of immigration in the United States. Retrieved from

http://immigrationpolicy.org/special-reports/criminalization-immigration-united-states

15. Frej, W. (2016). How U.S. immigration policy has changed since 9/11. Retrieved from https://www.huffingtonpost.com/entry/us-immigration-since-911_us_57d05479e4b0a48094a71bc0

16. Fry, R. (2015). Today's newly arrived immigrants are the best-educated ever. Retrieved from: http://www.pewresearch.org/fact-tank/2015/10/05/todays-newly-arrived-immigrants-are-the-best-educated-ever

17. Hamilton, L. K., Medianu, S., & Esses, V. M. (2013). Towards an immigration as a defining feature of the twenty-first century. In A. G. deZavala, & A. Cichocka (Eds.), *Social psychology of social problems* (pp. 82–113). New York, NY: Palgrave Macmillan.

18. Keierleber, M. (2017). Trump's immigration crackdown is traumatizing a generation of children. *Guardian*, August 23.

19. Khadaroo, S. T. (2014). Illegal immigration: Feds tell schools what they can and can't do. Retrieved from http://www.csmonitor.com/USA/Politics/2014/0508/Illegal-immigration-Feds-tell-schools-what-they-can-and-can-t-do

20. Kira, I. A., & Tummala-Narra, P. (2015). Psychotherapy with refugees: Emerging paradigm. *Journal of Loss and Trauma*, *20*(5), 449–467.

21. Leidy, M. S., Guerra, N. G., & Toro, R. I. (2010). Positive parenting, family cohesion, and child social competence among immigrant Latino families. *Journal of Family Psychology*, *24*, 252–260.

22. Lind, D. (2014). 14 facts that help explain America's child-migrant crisis. Retrieved from http://www.vox.com/2014/6/16/5813406/explain-child-migrant-crisis-central-america-unaccompanied-children-immigrants-daca

23. Lind, D. (2015). Mitch McConnell might havefigured out how to prevent a DHS shut-down. Retrieved from https://www.vox.com/2015/2/23/8094849/dhs-shutdown-mcconnell

24. Marrero, P. (2011). Migración mexicana permanece estable. *La Opinion*, August 8.

25. Martin, D. C., & Yankay, J. E. (2014). Refugees and asylees: 2013. Retrieved from http://www.dhs.gov/publication/refugees-and-asylees-2013

26. Miller, K. E., Zoe, L. M., Pazdirek, L., Caruth, M., & Lopez, D. (2005). The role of interpreters in psychotherapy with refugees: An exploratory study. *American Journal of Orthopsychiatry*, *75*, 27–39.

27. Nassir, A. (2014). Nativism in America today. Retrieved from http://hubpages.com/hub/Nativism-in-America-Today

28. National Conference of State Legislatures. (2015). Undocumented student tuition overview. Retrieved from http://www.ncsl.org/research/education/undocumented-student-tuition-overview.aspx

29. National Immigration Law Center. (2006). Fact about immigrants' low use of health services and public benefits. Retrieved from

http://www.ailadownloads.org/advo/NILC - FactsAboutImmigantsLowUseofHealthServices.pdf

30. Negy, C., Schwartz, S., & Reig - Ferrer, A. (2009). Violated expectations and acculturative stress among U.S. Hispanic immigrants. *Cultural Diversity and Ethnic Minority Psychology, 15*, 255–264.

31. Nickerson, A., Bryant, R. A., Silove, D., & Steel, Z. (2011). A critical review of psychological treatments of posttraumatic stress disorder in refugees. *Clinical Psychology Review, 31*, 399–417.

32. O'Keefe, D., & Gearan, A. (2018). Trump, condemned for "shithole" countries remark, denies comment but acknowledges "tough" language. *Washington Post*, January 13

33. O'Neill, A. (2012). Parents deported, what happens to U.S. - born kids? Retrieved from https://www.mprnews.org/story/2012/08/26/news/parents - deported

34. Pew Research Center. (2014). Unauthorized immigrant population trends for states, birth countries and regions. Retrieved from http://www.pewhispanic.org/interactives/unauthorized - trends/

35. Pierce, S., & Selee, A. (2017). Immigration under Trump: A review of policy shifts in the year since the election. Migration Policy Institute, Policy Brief. Retrieved from https://www.migrationpolicy.org/sites/default/files/publications/TrumpatOne - final.pdf

36. Quiroga, S. S., & Flores - Ortiz, Y. G. (2000). Barriers to health care for abused Latina and Asian immigrant women. *Journal of Health Care for the Poor and Underserved, 11*, 33–44.

37. Ramos, Z., & Alegría, M. (2014). Cultural adaptation and health literacy refinement of a brief depression intervention for Latinos in a low - resource setting. *Cultural Diversity & Ethnic Minority Psychology, 20*, 293–301.

38. Restrepo, D., & Garcia, A. (2014). The surge of unaccompanied children from Central America. Retrieved from http://www.bespacific.com/surge - unaccompanied - children - central - america

39. Ro, M. (2002). Moving forward: Addressing the health of Asian American and Pacific Islander women. *American Journal of Public Health, 92*, 516–519.

40. Samuels, B. (2018). Poll: Most Americans support DACA. *The Hill*, January 14.

41. Searight, H. R., & Searight, B. K. (2009). Working with foreign language interpreters: Recommendations for psychological practice. *Professional Psychology: Research and Practice, 40*, 444–451.

42. Southern Poverty Law Center. (2010). Injustice on our plates. Retrieved from https://www.splcenter.org/20101107/injustice - our - plates

43. TADIAS. (2014). Census: Foreign - born Africans most educated immigrants in U.S. Retrieved from http://www.tadias.com/10/15/2014/census - foreign - born - africans - most - educated - immigrants - in - u - s

44. Ting, L., & Panchanadeswaran, S. (2009). Barriers to help - seeking among immigrant African American women survivors of partner abuse: Listening to women's own

voices. *Journal of Aggression, Maltreatment & Trauma*, *18*, 817–838.

45. U.S. Census Bureau. (2012). The foreign‐born population in the United States: 2010. Report No. ACS‐19. Retrieved from https://www.census.gov/library/publications/2012/acs/acs‐19.html

46. Villalba, J. A. (2009). Addressing immigrant and refugee issues in multicultural counselor education. *Journal of Professional Counseling: Practice, Theory, and Research*, *37*, 1–10.

47. Weine, S., Feetham, S., Kulauzovic, Y., Knafl, K., Besic, S., Klebic, A., & Pavkovic, I. (2006). A family beliefs framework for socially and culturally specific preventive interventions with refugee youth and families. *American Journal of Orthopsychiatry*, *76*, 1–9.

48. Weisman, A., Feldman, G., Gruman, C., Rosenberg, R., Chamorro, R., & Belozersky, I. (2005). Improving mental health services for Latino and Asian immigrant elders. *Professional Psychology: Research and Practice*, *36*, 642–648.

49. Wight, V. R., Chau, M., & Aratani, Y. (2011). Who are America's poor children? Retrieved from: http://www.nccp.org/publications/pub_1001.html

50. Yakushko, O. (2010). Clinical work with limited English proficiency clients: A phenomenological exploration. *Professional Psychology: Research and Practice*, *41*, 449–455.

51. Zeigler, K., & Camarota, S. A. (2014). *U.S. immigrant population record 41.3 million in 2013*. Washington, DC: Center for Immigration Studies.

21
Counseling Jewish Americans

Chapter Objectives

1. **1. Learn the demographics and characteristics of Jewish Americans.**
2. **2. Identify counseling implications of the information provided for Jewish Americans.**
3. **3. Provide examples of strengths that are associated with Jewish Americans.**
4. **4. Know the special challenges faced by Jewish Americans.**
5. **5. Understand how the implications for clinical practice can guide assessment and therapy with Jewish Americans.**

> *It hurts to watch the videos and hear the chants that were coming out of Charlottesville on Saturday, August 12th [2017]. "Blood and soil! Jew will not replace US!" "Heil Hitler!" "Blood and Soil" was a Nazi slogan that meant ethnicity was based solely on blood descent and the territory a person maintained. "Blood and Soil" actually became a Nazi policy in 1933, and farmers needed to produce an Aryan race certificate in order to receive benefits under the law. "Why do people hate Jews, Mama?" my youngest child asked, as we walked to school last spring.*
>
> *(Goldman, 2017)*

> *"Congress, the White House and Hollywood, Wall Street, are owned by the Zionists … Everybody is in the pocket of the Israeli lobbies, which are funded by wealthy supporters, including those from Hollywood. Same thing with the financial markets." Quote from Helen Thomas, former member of the White House press corps.*
>
> *(Weiss, 2013)*

> *Thirty percent believe that American Jews are more loyal to Israel than to America, and 26 percent believe that Jews are responsible for the death of Christ. Nineteen percent of Americans believe Jews have too much power in the business world. One out of five African Americans and more than a third of foreign‐born Hispanics hold anti‐Semitic beliefs.*
>
> *(Anti‐Defamation League, 2013)*

> *Anti‐Semitism appears to be rearing its head across Europe yet again. The perpetrators of the recent terror attacks in Paris and Copenhagen both targeted Jews … Reports of anti‐Semitic incidents have risen in the U.K. as well as in France, where the most European Jews live.*
>
> *(Looft, 2015)*

Jewish Americans constitute a diverse community with multifaceted ethnic backgrounds, cultural identifications, and religious practices (Friedman, Friedlander, & Blustein, 2005). In the following sections, we discuss some of the characteristics, values, and strengths of the Jewish American community and consider their implications for treatment. Remember that this overview provides generalizations about a diverse community of people, and that the applicability of the generalizations always needs to be assessed with regard to individual clients.

Jewish Americans include (a) people who practice *Judaism* and have a Jewish ethnic background, (b) people who have converted to *Judaism* but do not have Jewish parents, and (c) individuals with a Jewish ethnic background who do not practice *Judaism* but still maintain their cultural identity and connection to their Jewish descent (Schlosser, 2006).

Although most Jewish Americans do not follow all Jewish religious traditions (approximately 40% indicate that religion plays a major role in their lives), many retain strong Jewish connections by celebrating the major holy days of *Yom Kippur*, Hanukkah, and Passover. Also, some regularly attend *synagogue* services and follow the tradition of keeping kosher homes (food and preparation rules that adhere to religious dietary guidelines) (Younis, 2009). Although Jewish individuals have experienced centuries of discrimination both within the United States and throughout the world, they have received little attention in the multicultural literature.

In the United States, approximately 4.2 million individuals are Jewish by religion, while another 1.1 million are secular or cultural Jews, who report that they have no religion but consider themselves to be Jewish (Pew Research Center, 2013). These individuals form the largest Jewish community in the world outside of Israel (where there is a Jewish population of 7.8 million); there are also large Jewish populations in Canada and Argentina. Most American Jews (94%) identify their race as White (Pew Research Center, 2013).

The earliest Jews to arrive in the United States immigrated from Spain and Portugal. The second group immigrated from Germany and Eastern Europe because of persecution or for economic reasons. By World War I, 250,000 German‐speaking Jews had arrived in America. Eastern European Jews came to America as a result of overpopulation, poverty, and persecution. Between 1880 and 1942, more than 2 million Jews from Russia, Austria, Hungary, and Romania entered the United States, forming the largest group of Jews in the country (Zollman, 2006). Because of their historical and political background, Jewish Americans are among the most liberal political groups in America, with about 70% supporting the Democratic Party. In general, Jews describe themselves politically as “liberal” or “very liberal.” However, one subgroup, the Orthodox Jews, are not as liberal, with half describing themselves as politically conservative and supporting the Republican Party (Pew Research Center, 2013).

Since 1990, the Jewish population in the United States has decreased from 5.5 to 4.2 million. According to the Pew Research Center (2013), this population decline is due to aging (many are older than 65, and younger individuals are more likely to identify themselves as having no religion), falling birth rate, intermarriage (over one‐third of Jewish individuals who intermarry do not raise their children to be Jewish), and assimilation. Approximately 52% of Jewish women between the ages of 30 and 34 have not had any children, compared with 27% of all American women; the fertility rate of Jewish women is below that needed to maintain the population (Berkofsky, 2006). Adherence to Jewish traditions has also declined over time. In terms of religiosity, two‐thirds of Jews do not belong to a *synagogue*, about a quarter do not believe in God, and one‐third celebrate Christmas (Goldstein, 2013).

Approximately 85% of Jewish Americans were born in the United States, and almost all are native English speakers. Some speak Hebrew, Yiddish, or the language of their country of origin. Most of those born outside the United States are from the former Soviet Union. Jews are a highly educated group, with 62% of those 18 and older possessing at least a bachelor's degree, versus 22.4% of non‐Jews. Their income level and household wealth is much higher than that of the total population (Chua & Rubenfeld, 2014). Most Jewish individuals consider themselves to be a minority group and indicate that their heritage is “very” or “somewhat” important to them. About half report “strong emotional ties” to Israel. Jewish Americans were in the forefront of the civil rights movement in the 1960s. In fact, half of the White Freedom Riders and civil rights attorneys involved in the movement were Jewish Americans. Jewish Americans are well represented in all aspects of American society in terms of business, education, politics, entertainment, and the arts.

CHARACTERISTICS AND STRENGTHS

In the next sections, we present some of the attributes, values, and strengths that are generally characteristic of the Jewish community. This section will be followed by consideration of some of the challenges faced by this group.

Spiritual and Religious Values

Judaism, with its belief in an omnipotent God who created humankind, was one of the earliest monotheistic religions. According to *Judaism*, God established a covenant with the Jewish people and revealed his commandments to them in the Torah, the holy book. The most important commandments are the Ten Commandments. Individuals who wish to convert to *Judaism* go through the process of (a) studying *Judaism* and the observance of the commandments, (b) immersion in a ritual bath, and, for males, (c) circumcision (although symbolic circumcision may be allowed by some sects).

One of the most important Jewish holidays is *Yom Kippur*, the Day of Atonement. It is a time set aside to atone for sins during the past year. Rosh Hashanah, the start of the Jewish New Year, is another High Holiday in *Judaism*. This holiday, celebrated 10 days before *Yom Kippur*, represents the creation of the world or universe. Even those who are not religious often attend *synagogue* services and spend time with family during these celebrations.

Within *Judaism*, the degree of adherence to religious tradition varies. Those who are traditional (*Orthodox Judaism*) follow all Jewish traditions. *Conservative Judaism* also seeks to preserve Jewish traditions and ceremonies but is more flexible in interpreting religious law. Many others are adherents of the progressive movement (*Reform Judaism*), which advocates the freedom of individuals to make choices about which traditions to follow (Altman, Inman, Fine, Ritter, & Howard, 2010; Rich, 2011). About one ‐ third of U.S. Jews (35%) identify with the Reform movement, 18% with the Conservative movement, and 10% with Orthodox Judaism, including 6% who belong to Ultra ‐ Orthodox groups (which reject modern secular society and believe they are the most religiously authentic Jews) and 3% who are Modern Orthodox (follow traditional practices but engages with the secular world to expand their spirituality). The remaining 37% do not identify with any particular Jewish denomination. With the exception of Orthodox Jews (who are very religious), Jews are less religiously committed than the U.S. public in general (Pew Research Center, 2013).

As previously noted, individuals need not actively practice *Judaism* in order to consider themselves Jewish. Many who are nonreligious but of Jewish parentage or upbringing identify as Jewish. About half who identify as Jewish adhere to *Judaism*, while many others celebrate only some Jewish holidays, deeming such celebration a cultural rather than a religious activity. These individuals consider themselves Jewish because of the commonality of history, culture, and experiences.

Friedman et al. (2005) conducted interviews with 10 Jewish adults to understand their perspective on their own identity. All participants indicated a fluidity of identity over the years. One stated, “When I was a kid, it made me feel a little bit different in certain situations, but now I would be very proud to be associated with Jewish people and to be Jewish. I would say it has gotten stronger.” Another commented, “[I]t's the dips and valleys in my life … it is pretty much a constant, but it does go up and down” (p. 79). Among the participants, childhood experiences, such as participating in Jewish holiday traditions with family members, eating in a kosher dining room, or engaging in discussions with parents about *Judaism*, influenced their cultural identity. As adults, some expressed feelings of guilt

because they did not consistently practice religious customs. Some had a deep *Jewish identity* but did not engage in Jewish rituals. However, most expressed pride about being Jewish. From this phenomenological study, it appears that those who practice *Judaism* define *Jewish identity* differently from those who are secular and do not engage in religious practices. For many, *Jewish identity* revolves around common experiences and history, rather than religion.

Ethnic Identity

For many Jewish individuals, their identity is tied to historical events, such as the *Holocaust* and the oppression historically faced by the Jewish people. Again, it can also involve cultural traditions and ancestry, not just religious beliefs. There is no single *Jewish identity*. Instead, there is a range of identities: from individuals who are proud of their Jewish heritage, to those who have internalized *anti - Semitism* and hide their Jewish background from others, to those who feel confused and alienated from mainstream Jewish culture. While some do not publicly self - identify as Jewish, others are bicultural and take pride in both American and Jewish identities.

Schlosser (2009b) believes that Jews go through the following stages of ethnic identity development:

- Lack of awareness of one's *Jewish identity*.
- Gradual awareness of *Jewish identity*.
- Comparison of *Judaism* with other religions, such as Christianity.
- Development of a sense of Jewishness.

Counselors should recognize that American Jews may have identity concerns related to *anti - Semitism*, living under Christian privilege, the *Holocaust*, and the invisibility of *Judaism*. Jews are highly diverse in regard to cultural and ethnic identity and adherence to religious orthodoxy. The counselor should not assume that all Jewish clients see *Jewish identity* or practice *Judaism* in the same manner (Schlosser, 2006).

Gender - Related Considerations

Orthodox Jews adhere strictly to the tenets of *Judaism*, which offer a comprehensive guide to living that includes rules and practices affecting one's entire life, such as what to do upon first waking up, what foods are allowed or forbidden, what attire and grooming are appropriate, what business practices should be followed, who to marry, and the proper way of observing holidays and the Shabbat (Rich, 2011). Some of these characteristics may make Orthodox Jews suspicious of therapy. Because of their strong faith in *Judaism*, they may be reluctant to seek treatment, since that might imply that their religion has failed them or that they are defective in some way. Orthodox Jewish communities tend to be very close - knit, and the stigma associated with seeking therapy may reduce a person's opportunities to establish social relationships or find marriage (Schnall, 2006).

Although Jewish denominations arise from a traditionally patriarchal system, most Jewish Americans have moved toward an egalitarian relationship between spouses. However, those who are Orthodox are more likely to adhere to specific role divisions between males and females. Within the Orthodox tradition, women have the responsibility of taking care of the home, maintaining the health and happiness of the family, and nurturing the children. Because it is men who interpret the laws of *Judaism*, women are subject to their husband's or

father's interpretations of what constitutes appropriate behavior. The roles in marital relationships are seen to be complementary, with love and romance being less important than the task of raising a family (Schnall, 2006). Orthodox Jews are typically more restrictive about birth control and abortion than other Jewish Americans (Miller, Barton, Mazur, & Lovinger, 2014), as well as less accepting of lesbian, gay, bisexual, transgender, and queer (LGBTQ) identifications and relationships (Balkin, Watts, & Ali, 2014). Marital and family conflicts may occur as women move toward less rigid role divisions (Blackman, 2010).

Cultural Strengths

> *Judaism is a guidebook on how to live your life and be a good person … I keep Kosher because that's what I grew up with and it's something that is a comfort to me … My grandma and all my relatives … died for their religion*
>
> *(Altman et al., 2010, p. 167)*

Judaism is more than just a religion. It is a culture with a set of traditions and historical experiences that provides members with a sense of connection and commonality and with feelings of acceptance (Schlosser, 2006). For some, the sociocultural connection is more central to individual and family life than the religious aspects. Religious behavior and traditions, such as lighting Shabbat candles, can be calming, since they remind individuals of their history and their community (Altman et al., 2010). These aspects of *Judaism* serve as protective factors against the discrimination and prejudice that Jews face. Among Orthodox Jews, higher levels of religious beliefs are associated with positive mental health. This may be due to emotional and spiritual support from having a personal relationship with God (Rosmarin, Pirutinsky, Pargament, & Krumrei, 2009).

The majority of Americans hold American Jews in high regard, stressing their strong religious faith, contributions to the cultural life of the country, and emphasis on the importance of the family. Indeed, American Jews themselves are overwhelmingly proud to be Jewish and have a strong sense of being part of the Jewish community. Other aspects that are important to Jewish Americans' identity are leading an ethical life, working for justice and equality, and having a good sense of humor. However, only 19% indicated that following Jewish law was an essential part of being Jewish (Pew Research Center, 2013).

SPECIFIC CHALLENGES

In the following sections, we consider challenges often faced by those who are Jewish; subsequently, we will consider their implications in the context of treatment.

Historical Background and Sociopolitical Challenges

> *David Duke spoke to a group of Holocaust deniers at a conference on the Holocaust convened by Iran's president in 2006. During his speech, the former Imperial Wizard of the Ku Klux Klan and Louisiana State Representative claimed that the Holocaust was a hoax perpetrated by European Jews to justify the occupation of Palestine and the creation of Israel.*
>
> *(Fathi, 2006)*

Since the Middle Ages, the Jewish people have experienced persecution, oppression, and second‐class status, as well as being targeted for massacre or expulsion from their homes (e.g., during the Christian Crusades, the Spanish Inquisition, the *Holocaust* [the Shoah], and so on). For centuries, they have been stereotyped as hungry for wealth, power, and control, and they have been scapegoated during periods of financial distress.

One older Jewish woman asked her therapist, “Have you heard of the *Holocaust*?” (Hinrichsen, 2006, p. 30). The *Holocaust* represents an incredibly traumatic period in Jewish history. During this period, Nazi Germans murdered approximately 6 million Jewish men, women, and children. There were many more who survived inhumane treatment after being imprisoned in forced‐labor and concentration camps. Their lives have been affected forever.

What constitutes *Jewish identity* is complex and highly personal. An important aspect is a sense of shared cultural and historical experiences. *Holocaust deniers*—individuals who do not acknowledge or who question the existence of the genocide that occurred during the *Holocaust*—seek to invalidate the loss and suffering of *Holocaust* victims and their families, and in so doing, strike at an important part of contemporary *Jewish identity*. It is distressing when this tragic history is ignored or invalidated. It is also hurtful when our society recognizes Christian holidays and religious expectations but ignores those of the Jewish faith.

A well‐known mental health practitioner and educator, Stephen Weinrach, was proud of his *Jewish identity* and became an outspoken critic of the mental health organization to which he belonged for being blind to the plight of Jewish Americans.

> *Issues that have concerned Jews have failed to resonate with the counseling profession, including, for the most part, many of the most outspoken advocates for multicultural counseling … The near universal failure of those committed to multicultural counseling to rail against anti‐Semitism and embrace the notion of Jews as a culturally distinct group represents the most painful wound of all.*
>
> *(Weinrach, 2002, p. 310)*

Weinrach (2002) made the following observations regarding the mental health profession:

- Counseling associations ignore requests from Jewish members to reschedule meetings when they conflict with Jewish holidays (e.g., the National Board for Certified Counselors scheduled the National Counseling Exam on *Yom Kippur*, a day when work is not permitted).
- Texts on multicultural counseling often do not address Jewish Americans as a diverse

group. Only 8% of multicultural courses in American Psychological Association (APA) doctoral programs in counseling covered Jews as a distinct cultural group (Priester et al., 2008).

- Few articles in counseling journals have involved Jewish Americans, and in some texts, Jewish Americans have been portrayed in a stereotypic manner.

In our opinion, Weinrach has made some valid points. In writing this chapter, we found very few articles on clinical issues involving Jewish Americans or their history of oppression, although numerous articles were easily located for the other diverse groups covered in this text. We must recognize the degree of prejudice and discrimination faced by Jewish Americans and reexamine policies that may be insensitive to their concerns.

Prejudice and Discrimination

> *The two 17‐year‐old girls told of repeated acts of anti‐Semitic bullying—one girl had money shoved into her mouth, another kept seeing swastikas pervasively in school hallways and lockers … the Jewish students accused 35 students of anti‐Semitic behaviors. They told of finding swastikas drawn on walls and lockers, sometime accompanied by messages like "Die Jew," of slurs like "Christ killer" and "disgusting Jew" … and of being shoved, punched, taunted and humiliated and of experiencing bus rides where classmates chanted "white power" and saluted Nazi‐style.*
>
> *(Berger, 2015)*
>
> *Because of the targeting and killing of Jewish people in Paris and Copenhagen and the vandalism of hundreds of headstones at a cemetery in eastern France, Israeli Prime Minister Binyamin Netanyahu has asked Jewish individuals in European countries to migrate to Israel, saying "This wave of terror attacks can be expected to continue, including anti‐Semitic and murderous attacks. We say to the Jews, to our brothers and sisters, Israel is your home and that of every Jew. Israel is waiting for you with open arms."*
>
> *(Politi, 2015)*

Prejudice and discrimination against Jews are found all over the world. A survey of over 100 countries revealed that anti‐Semitic views and attitudes were held by 74% of the population in the Middle East and North Africa, 34% in Eastern Europe, 24% in Western Europe, 23% in Sub‐Saharan Africa, 22% in Asia, 19% in the Americas, and 14% in Oceania. The survey also showed that 35% of the world's population had never heard of the *Holocaust* and that among those who had, 32% believed it was either a myth or had been greatly exaggerated. The most widely accepted anti‐Semitic stereotypes worldwide are "Jews are more loyal to Israel than to this country/the countries they live in," "Jews have too much power in the business world," and "Jews don't care about what happens to anyone but their own kind" (ADL Global 100, 2013).

Jewish Americans have long been targets of discrimination and prejudice. That such prejudice continues to this day is revealed in the astonishing statistic that of the 1,163 hate crimes motivated by religious bias committed in the United States in 2013, the vast majority (59.2%) were anti‐Semitic (followed by anti‐Islamic, at 14.2%) (Federal Bureau of Investigation, 2013). Prejudicial reactions against Jews involve not only overt actions such as vandalism, assaults, and direct displays of *anti‐Semitism*, but also negative attitudes and beliefs. Such prejudice is revealed in personal statements such as that made by actor and director Mel Gibson in 2006 that "Jews are responsible for all the wars in the world" (Gibson

has since apologized for his statement) and a complaint purportedly made by Judith Regan, an editor at HarperCollins Publishers, that a “Jewish cabal” was against her—referring to members of the publishing firm and their decision not to publish a controversial book by O. J. Simpson that Ms. Regan had produced (Hall, 2006).

In a survey of Americans (Anti‐Defamation League, 2013), it was found that 14% of adults held “hard‐core” anti‐Semitic beliefs. Many believed that Jewish Americans wield too much power in business, the news media, and the movie and television industries. In a national poll of American voters (Council for the National Interest, 2006), 39% believed that the “Israeli lobby” was a key factor responsible for the United States confronting Iran and going to war in Iraq. Among Jewish Americans, 77% disagreed with this view. Not surprisingly, anti‐Semitic views toward American Jews often arise in conjunction with negative reactions to Israeli actions in the Middle East (Cohen, Jussim, Harber, & Bhasin, 2009).

Although Jewish individuals have achieved great success, it is evident that they remain targets of prejudice, discrimination, and even violence throughout the world. In the United States, about 43% of Jewish Americans report facing “a lot of discrimination” and 15% indicate that they have been called offensive names or have been snubbed socially because of being Jewish (Pew Research Center, 2013). Jewish Americans have reported being discriminated against at a rate similar to that reported by African Americans (Berkofsky, 2006; Goldberg, 2000).

Jewish undergraduates report experiencing microaggressions that involve suspicion from others and accusations or expectations that they are greedy or overaffiliated with their group. They also report that there is a lack of institutional cultural sensitivity for Jewish students (Na, Kleiman, Poolokasingham, & Spanierman, 2014). Additional examples of microaggressions against Jewish Americans include automatically assigning intelligence to Jews, giving preference to Christians, showing a lack of recognition of Jews during multicultural discussions, and assuming that Jews are wealthy and have control over U.S. policy and decisions in Hollywood (Schlosser, 2009a).

IMPLICATIONS FOR CLINICAL PRACTICE

It is evident that Jewish Americans continue to face a great deal of prejudice, even with the successes they have had in American society. For this reason, it is critical for therapists to be aware of the prejudice and discrimination that Jewish American clients may have experienced. A 78‐year‐old woman seeking treatment for depression asked the counseling intern, “Are you Jewish?” (Hinrichsen, 2006, p. 30). When the intern inquired about the question, the client stated that she had experienced discrimination from non‐Jews and was uncertain whether the intern would understand her difficulties.

Anti‐Semitic attitudes within ethnic minority populations may be especially troubling to those who are Jewish; that is, it can be especially hurtful when others who have experienced oppression, prejudice, and discrimination behave in a discriminatory manner toward Jews. There are several reasons for the anti‐Semitic attitudes of some foreign‐born Hispanic immigrants and African Americans toward Jewish Americans. First, many do not perceive Jews as a disadvantaged minority. Second, some may resent the fact that the Jewish community has historically opposed affirmative action policies and that its members are more likely to favor advancement based on merit (Shapiro, 2006).

Some Jewish groups may be hesitant about seeking counseling services. Among

Russian‐speaking Jewish immigrants to the United States, willingness to pursue psychotherapy has been observed to be low, especially for men (Drob, Tasso, & Griffo, 2016). Orthodox Jews may be reluctant to engage in therapy because of issues such as confidentiality and the concern that they will be asked to do things that are against their religious beliefs. Moreover, the seeking of mental health services is frequently stigmatized within the Orthodox community (Schnall et al., 2014).

Consulting with a *rabbi* on how to deal with issues such as confidentiality or how *Judaism* might affect counseling could be useful. Therapists can also work jointly with the client and the *rabbi* in defining the problem and developing interventions, so that these components of therapy do not conflict with religious beliefs. The *rabbi* may be helpful in developing culturally sensitive intervention strategies that incorporate religious principles (Schnall, 2006).

In *Jewish Issues in Multiculturalism: A Handbook for Educators and Clinicians*, Langman (1999) indicates it is difficult to use culturally appropriate interventions because of the diversity of the Jewish culture. However, he does offer some guiding principles of importance for mental health providers. First, it is very important to be respectful of and knowledgeable about Jewish culture. Because most clinicians are from a Christian background, the traditions, values, and religious rituals that are important to Jewish Americans are often overlooked or dismissed. As we discussed in Chapter 6, therapists might inadvertently commit microaggressions due to their lack of understanding. For example, Langman describes a Jewish client who requested that an appointment not be scheduled during *Yom Kippur*, to which the therapist responded, “What? Do you need to pray or something?” The client felt humiliated, devalued, ashamed, and unsupported.

Second, therapists should strive to understand the full spectrum of Jewish identities within the Jewish population, including those of both religious and nonreligious Jews. As already indicated, the therapist should have some knowledge of the history of *anti‐Semitism* and its effects on identity, as well as the possible repercussions of internalized *anti‐Semitism*. Langman (1999) discusses the latter as an insidious social conditioning process that makes some Jewish Americans ashamed of their ethnic and religious heritage. He views the sociopolitical process that defines Jewish differences as deviance to be the culprit and encourages counselors not to “blame the victim.”

Third, as Langman makes clear, therapists need to be aware of any values, assumptions, and biases of their own that may be detrimental to their Jewish clients. He cites research that indicates that Jews are viewed as being “cold,” “hostile,” and “obstructive,” whereas non‐Jews (White) are seen as being more “warm,” “friendly,” and “helpful.” He encourages counselors to explore any feelings of negativism toward Jewish Americans, Jewish culture, *Judaism*, and/or Israel.

Finally, although about two‐thirds of Jewish Americans are not associated with a *synagogue* or have only slight connections to a Jewish congregation, it may be desirable to consult with a *rabbi* when working with clients who are strongly religious, particularly those who maintain Orthodox beliefs. In some cases, religious doubts or issues about religiously prohibited behaviors or behaviors associated with guilt or shame might be best addressed with guidance from religious leaders as part of the therapeutic process. Such consultation is easier when the counselor has spent time cultivating relationships with the Jewish community.

Counselors should also consider the following (Altman et al., 2010; Schlosser, Safran,

Suson, Dettle, & Dewey, 2013):

1. As members of mental health professions, we must be aware of policies or expectations that do not take Jewish American concerns into consideration, such as scheduling meetings or appointments on Jewish holidays.
2. We need to examine our attitudes and beliefs in regard to Jewish Americans. Are their problems invisible to us? Is our failure to acknowledge the discrimination experienced by Jewish people due to a Christian‐centered worldview, a lack of knowledge, or an unconscious *anti‐Semitism*?
3. It is important to remember that Jewish Americans are the most targeted religious group for hate crimes and discrimination. Because many Jewish Americans are well educated and economically secure, we often do not understand that they may have experienced discrimination or hate.
4. Jewish American mental health professionals should also feel free to bring up their concerns when they are subjected to insensitivity or discrimination.
5. Jewish counselors should take care not to make assumptions about a client's *Jewish identity* and issues based on the counselor's own sense of identity or beliefs regarding *Judaism* (Schlosser, Safran, Suson, Dettle, & Dewey, 2013).
6. During assessment, it is helpful to ask clients about their sense of *Jewish identity* and any life‐affirming values, beliefs, and cultural norms (Miller et al., 2014).
7. The degree of receptivity to counseling and therapy may vary according to the degree of adherence to religious traditions. Orthodox versus non‐Orthodox Jews are more likely to display treatment‐seeking stigma and prefer individual to group therapy (Baruch, Kanter, Pirutinsky, Murphy, & Rosmain, 2014).
8. Among Orthodox Jews, women are expected to maintain the Jewish culture and raise Jewish children. For those who deviate from these expectations (e.g., by being lesbian, remaining single, or preferring a career to having children), conflicts may arise (Ginsberg & Sinacore, 2013).
9. When working with Orthodox Jewish clients, determine how mental health issues are defined within their religious and cultural framework and develop appropriate, culturally adapted interventions based on this knowledge (Rosen, Rebeta, & Zalman Rothschild, 2014).
10. Although most Jewish Americans value psychotherapy and are receptive to traditional forms of therapy, any concerns or issues regarding therapy should be addressed during initial counseling sessions (Miller et al., 2014).

SUMMARY

Most Jewish individuals consider themselves to be members of a minority group and feel their heritage is important to them. Within *Judaism*, the degree of adherence to religious tradition varies from orthodoxy to *progressive* beliefs, practices, and decisions. *Judaism* is more than just a religion. It is a culture with a set of traditions and historical experiences that provide Jewish individuals with a sense of connection, commonality, and acceptance. As a result, mental health providers need to understand the importance of *Jewish identity*. Jews have suffered from *anti - Semitism* in all parts of the world, and Jewish Americans have long been targets of discrimination and prejudice. The *Holocaust* represents a deeply traumatic period in Jewish history. The majority of hate crimes motivated by religious bias committed in the United States have been anti - Semitic. Cultural, gender, and identity differences also have major implications for issues likely to arise in work with Jewish clients. Ten clinical implications for counselor practice are identified.

GLOSSARY TERMS

- Anti - Semitism
- Conservative Judaism
- Holocaust
- Holocaust denier
- Jewish identity
- Judaism
- Orthodox Judaism
- Progressive Judaism
- Rabbi
- Reform Judaism
- Synagogue
- Yom Kippur

REFERENCES

1. ADL Global 100. (2013). An index of anti‐Semitism. Retrieved from http://global100.adl.org/

2. Altman, A. N., Inman, A. G., Fine, S. G., Ritter, H. A., & Howard, E. R. (2010). Exploration of Jewish ethnic identity. *Journal of Counseling and Development*, *88*, 163–173.

3. Anti‐Defamation League (2013). *A survey about attitudes towards Jews in America*. Washington, DC: Martila Communications.

4. Balkin, R. S., Watts, R. E., & Ali, S. R. (2014). A conversation about the intersection of faith, sexual orientation, and gender: Jewish, Christian, and Muslim perspectives. *Journal of Counseling & Development*, *92*(2), 187–193.

5. Baruch, D. E., Kanter, J. W., Pirutinsky, S., Murphy, J., & Rosmain, D. H. (2014). Depression stigma and treatment preferences among orthodox and non‐orthodox Jews. *Journal of Nervous and Mental Disease*, *202*, 556–561.

6. Berger, J. (2015). Settlement over anti‐Semitic bullying at Pine Bush Central Schools is approved. *New York Times*, July 9.

7. Berkofsky, J. (2006). National Jewish Population Survey: 2000. A snapshot of American Jewry. Retrieved from http://www.myjewishlearning.com/article/national‐jewish‐population‐survey‐2000

8. Blackman, M. (2010). American Orthodox Jewish women and domestic violence: An intervention design. Retrieved from https://ssa.uchicago.edu/american‐orthodox‐jewish‐women‐and‐domestic‐violence‐intervention‐design

9. Chua, A., & Rubenfeld, J. (2014). *The triple package: How three unlikely traits explain the rise and fall of cultural groups in America*. Toronto, Ontario: Penguin.

10. Cohen, F., Jussim, L., Harber, K. D., & Bhasin, G. (2009). Modern anti‐Semitism and anti‐Israeli attitudes. *Journal of Personality and Social Psychology*, *97*, 290–306.

11. Council for the National Interest. (2006). Poll: Forty percent of American voters believe the Israel lobby has been a key factor in going to war in Iraq and now confronting Iran. McLean, VA: Council for the National Interest.

12. Drob, V., Tasso, A. F., & Griffo, R. (2016). Attitudes toward psychotherapy among immigrant Russian‐speaking Jews from the former Soviet Union. *The Counseling Psychologist*, *44*(6), 921–941.

13. Fathi, N. (2006). Iran opens conference on Holocaust. *New York Times*, December 12.

14. Federal Bureau of Investigation. (2013). Hate crime statistics, 2013. Retrieved from http://www.fbi.gov/about‐us/cjis/ucr/hate‐crime/2013/topic‐pages/incidents‐and‐offenses/incidentsandoffenses_final

15. Friedman, M. L., Friedlander, M. L., & Blustein, D. L. (2005). Toward an understanding of Jewish identity: A phenomenological study. *Journal of Counseling Psychology*, *52*, 77–83.

16. Ginsberg, F., & Sinacore, A. L. (2013). Counseling Jewish women: A phenomenological study. *Journal of Counseling and Development*, *91*, 131–139.

17. Goldberg, J. J. (2000). A portrait of American Jews. *Jewish Journal*, 1–2.

18. Goldman, C. (2017). Jewish in America: Explaining to my daughters that people hate them who have never met them. Retrieved from http://www.chicagonow.com/portrait‐of‐an‐adoption/2017/08/jewish‐in‐america‐explaining‐to‐my‐daughters‐that‐people‐hate‐them‐who‐have‐never‐met‐them

19. Goldstein, L. (2013). Poll shows major shift in identity of U.S. Jews. *New York Times*, October 1.

20. Hall, S. (2006). Judith Regan goes down fighting. Retrieved from https://www.eonline.com/news/54003/judith‐regan‐goes‐down‐fighting

21. Hinrichsen, G. A. (2006). Why multicultural issues matter for practitioners working with older adults. *Professional Psychology: Research and Practice*, *37*, 29–35.

22. Langman, P. F. (1999). *Jewish issues in multiculturalism: A handbook for educators and clinicians*. Northvale, NJ: Jason Aronson.

23. Looft, C. (2015). 5 European Jews on the wave of anti‐Semitic attacks, and what it means for their future. Retrieved from http://nymag.com/daily/intelligencer/2015/02/5‐european‐jews‐on‐the‐anti‐semitic‐attacks.html

24. Miller, L., Barton, Y. A., Mazur, M., & Lovinger, R. J. (2014). Psychotherapy with Conservative and Reform Jews. In P. S. Richards, & A. E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (2nd ed.) (pp. 257–283). Washington, DC: American Psychological Association.

25. Na, S., Kleiman, S., Poolokasingham, G., & Spanierman, L. (2014). Examining the experiences of microaggressions among Jewish undergraduates. Poster session presented at the annual convention of the American Psychological Association, Washington, DC.

26. Pew Research Center. (2013). A portrait of Jewish Americans. Retrieved from http://www.pewforum.org/2013/10/01/chapter‐1‐population‐estimates

27. Politi, D. (2015). Israel's Netanyahu urges “mass immigration” of Jews after Denmark shooting. Retrieved from http://www.slate.com/blogs/the_slatest/2015/02/15/benjamin_netanyahu_urges_mass_

28. Priester, P. E., Jones, J. E., Jackson‐Bailey, C. M., Jordan, E. X., Jana‐Masri, A., & Metz, A. J. (2008). An analysis of content and instructional strategies in multicultural counseling courses. *Journal of Multicultural Counseling and Development*, *36*, 29–39.

29. Rich, T. R. (2011). Judaism 101. Retrieved from http://www.jewfaq.org

30. Rosen, D. D., Rebeta, J. L., & Zalman Rothschild, S. Z. (2014). Culturally competent adaptation of cognitive‐behavioural therapy for psychosis: Cases of Orthodox Jewish patients with messianic delusions. *Mental Health, Religion & Culture*, *17*, 703–713.

31. Rosmarin, D. H., Pirutinsky, S., Pargament, K. I., & Krumrei, E. J. (2009). Are religious beliefs relevant to mental health among Jews? *Psychology of Religion and Spirituality*, *1*, 180–190.

32. Schlosser, L. Z. (2006). Affirmative psychotherapy for American Jews. *Psychotherapy: Theory, Research, Practice, Training*, *43*, 424–435.

33. Schlosser, L. Z. (2009a). Microaggressions in everyday life: The American Jewish experience. Retrieved from https://www.bjpa.org/content/upload/bjpa/micr/microaggressions.pdf

34. Schlosser, L. Z. (2009b). A multidimensional model of American Jewish identity. Retrieved from https://www.bjpa.org/content/upload/bjpa/jewi/jewishidentityBC.pdf

35. Schlosser, L. Z., Safran, R. S., Suson, R. A., Dettle, K., & Dewey, J. J. H. (2013). The assessment, diagnosis, and treatment of mental disorders among American Jews. In F. A. Paniagua, & A. ‐ M. Yamada (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations* (2nd ed.) (pp. 347–366). San Diego, CA: Elsevier Academic Press.

36. Schnall, E. (2006). Multicultural counseling and the Orthodox Jew. *Journal of Counseling and Development*, *84*, 276–282.

37. Schnall, E., Kalkstein, S., Gottesman, A., Feinberg, K., Schaeffer, C. B., & Feinberg, S. S. (2014). Barriers to mental health care: A 25 ‐ year follow ‐ up study of the Orthodox Jewish community. *Journal of Multicultural Counseling and Development*, *42*(3), 161–173.

38. Shapiro, E. (2006). Civil rights and wrongs. My Jewish Learning.

39. Weinrach, S. G. (2002). The counseling profession's relationship to Jews and the issues that concern them: More than a case of selective awareness. *Journal of Counseling and Development*, *80*, 300–314.

40. Weiss, P. (2013). “I'm anti ‐ Zionist,” Helen Thomas declared, in twilight of long career. Retrieved from http://mondoweiss.net/2013/07/helen ‐ thomass ‐ anti ‐ zionist ‐ statements#sthash.7x6gx0ei.dpuf

41. Younis, M. (2009). Muslim Americans exemplify diversity, potential: Key findings from a new report by the Gallup Center for Muslim Studies. Retrieved from http://www.gallup.com/poll/116260/MuslimAmericans ‐ Exemplify ‐ Diversity ‐ Potential.aspx

42. Zollman, J. W. (2006). Jewish Immigration to America: Three Waves. Sephardic, German, and Eastern European immigrants each contributed to the formation of American Jewry. Retrieved from https://www.myjewishlearning.com/article/jewish ‐ immigration ‐ to ‐ america ‐ three ‐ waves/

PART VIII

Counseling and Therapy with Other Multicultural Populations

22
Counseling Individuals with Disabilities

Chapter Objectives

1. **1. Learn the demographics and characteristics of persons with *disabilities*.**
2. **2. Know the different types of *disabilities* and the models and myths regarding individuals with *disabilities*.**
3. **3. Identify counseling implications of the information provided for persons with *disabilities*.**
4. **4. Recognize strengths that are associated with persons with *disabilities*.**
5. **5. Know the special challenges faced by persons with *disabilities*.**
6. **6. Understand best practices for assessment and therapy with persons with *disabilities*.**

> *I have experienced forced intimacy my entire life as a disabled child, youth and adult. I am always expected to do the work of opening myself up for others' benefit, education, curiosity or benevolent oppression.*
>
> *(Mingus, 2017a)*

> *Members of the deaf community view deafness not as a disability but as a difference in human experience. Many have a positive attitude towards deafness and generally do not consider it a condition that needs to be "fixed" and, therefore, may oppose technological innovations such as cochlear implants.*
>
> *(Konig, 2013)*

> *A 77 - year - old woman has been on kidney dialysis for 10 years; she also has seizures, arthritis, and significant hearing loss. Communication with the social worker is not going well due to the woman's impaired hearing. The daughter explains that her mother has hearing aids but does not wear them because they hurt her ears. The social worker directs all her questions to the daughter, leaving the mother wondering what is being discussed.*
>
> *(Desselle & Proctor, 2000)*

People often lack understanding and do not know how to respond to people with *disabilities*. Attitudes toward individuals with *disabilities* may be disdainful and dismissive, or overly protective or sympathetic. In the third vignette, the social worker was talking to the daughter as if the mother were not present. The daughter felt frustrated and responded,

> *You are not even trying to communicate with my mother … She can understand you if you look at her and speak slowly and clearly … Imagine how you would feel if you and your spouse went to the doctor to consult about a major surgery you were scheduled for and the doctor directed the conversation only to your spouse as if you were not intelligent enough to know what was being discussed.*
>
> *(Desselle & Proctor, 2000, p. 277)*

There are an estimated 56.7 million Americans with some level of *disability* (physical or mental), of whom over half have a *disability* that severely affects daily functioning (Brault, 2012). Of the 72.3 million families in the United States, about 21 million have at least one member with a *disability*. Rates of *disability* are higher among African Americans (22.2%) and American Indian/Alaska Native groups (27%) compared with non - Hispanic Whites (16.2%) (Cornish, Gorgens, Olkin, Palomibi, & Abels, 2008). Because of traumatic brain injuries incurred in the wars in Iraq and Afghanistan, the incidence of individuals with

physical disabilities is increasing (Terrio, Nelson, Betthauser, Harwood, & Brenner, 2011).

Women are more likely to experience a physical *disability* than men; further, women with a physical *disability* are much more likely to experience depression than women in the general population (Brown, 2014) and are at risk for abuse (Robinson‐Whelen et al., 2010). In children, *disability* is more common in boys and in children from low‐income families (Sullivan, 2009). Children with disabilities are more likely to be subjected to maltreatment, including neglect; physical, sexual, or emotional abuse; and bullying (Jones et al., 2012; Zablotsky, Bradshaw, Anderson, & Law, 2014).

Individuals with severe *disability* have high unemployment and poverty rates (U.S. Census Bureau, 2010). As estimated by the Census Bureau's American Community Survey, only 32% of those with *disabilities* are employed, versus 73% of those without (Office of Disability Employment Policy, n.d.). Individuals with *disabilities* have significantly lower rates of college completion compared to those without (Barber, 2012). Up to 90% of individuals with psychiatric *disabilities* are unemployed—the highest unemployment of all *disability* groups (Larson et al., 2011).

In the following sections, we offer background information about individuals with *disabilities*, discuss the challenges often faced by these individuals, and consider their implications in treatment. Remember that *disabilities* vary greatly in terms of severity as well as the specific condition involved, and that people with *disabilities* constitute a diverse community with multifaceted racial‐ethnic backgrounds, cultural identifications, and religious practices. This overview, therefore, provides generalizations about a diverse group of people, the applicability of which always needs to be assessed with regard to individual clients.

CHARACTERISTICS AND STRENGTHS

In this section, we will consider the *Americans with Disabilities Act* (ADA), myths regarding individuals with *disabilities*, models of *disabilities*, and characteristics and strengths associated with this population.

The Americans with Disabilities Act (ADA)

The ADA, signed into law in 1990, prohibits discrimination against people with *disabilities* in employment, transportation, public accommodation, communications, and governmental activities and ensures that buildings, facilities, and transit vehicles are accessible and usable by people with *disabilities*. Its passage was speeded up when hundreds of individuals with *disabilities* demonstrated in front of the Capitol Building in Washington, D.C. To demonstrate the barriers they faced, dozens left their wheelchairs and crawled up the 83 steps to the building (Michaels, 2015).

The ADA defines *disability* as “a physical or mental impairment that substantially limits one or more of the major life activities of such individual.” It protects individuals with intellectual impairment, hearing or vision impairment, orthopedic conditions, learning *disabilities*, speech impairment, HIV/AIDS, and other health or physical conditions. Psychiatric disorders covered include major depression, bipolar disorder, panic and obsessive‐compulsive disorders, some personality disorders, schizophrenia, and rehabilitation from drug addiction.

Under the ADA, employers are allowed to inquire about candidates' ability to perform the job but not about their *disability*. Employers are not allowed to discriminate against an individual with a *disability* during the person's employment or in regard to promotion if the individual is otherwise qualified; similarly, employers cannot use tests that will cause individuals to be screened out because of a *disability*. Additionally, employers are required to make reasonable accommodations for people with *disabilities*.

Although the ADA has improved opportunities for employment by individuals with *disabilities*, the law has been whittled away by court decisions that have supported businesses rather than people with *disabilities*. For these reasons, the National Council on *Disability* has indicated a need to “restore the original intent” of the ADA (American Association of People with Disabilities, 2006).

Implications

Mental health professionals should keep abreast of federal and state *disability* laws, including statutes affecting the rights of individuals with *disabilities* in school and work settings. It is important for therapists to make sure that they do not provide unequal service or deny treatment to clients with *disabilities*; if an individual requires treatment outside your area of specialization, you can help facilitate a referral to a more qualified provider. Also, be alert for criteria that may screen out or disadvantage clients with *disabilities*, such as requiring a driver's license for payment by check. Policies, practices, and procedures in your office can be modified to take into consideration those with *disabilities*, such as ensuring that service animals are permitted in your building.

You may need to provide auxiliary aids and services, such as readers, sign‐language interpreters, braille materials, large‐print materials, and videotapes or audiotapes to facilitate communication with some clients. Evaluate your office for structural and architectural barriers that prevent individuals from getting the services they need. Evaluate the accessibility of your office, including the availability of ramps, parking spaces, reachable

elevator control buttons, and wide doorways.

Myths Regarding Individuals with Disabilities

There are many myths associated with people with *disabilities* (e.g., Center for Workplace Preparation, n.d.; LSU Office of Disability Services, 2011; National Service Inclusion Project, n.d.):

1. *Most people with disabilities are in wheelchairs*. Among the millions of people with *disabilities*, a small proportion use wheelchairs, crutches, or walkers. Most have more invisible *disabilities*, such as cardiovascular problems, arthritis and rheumatism, back and spine problems, hearing impairment, asthma, epilepsy, neurodevelopmental disorders (e.g., academic or intellectual impairment), and mental illness.
2. *People with disabilities are a drain on the economy*. It is true that many individuals of working age with *disabilities* are not working. However, the majority of those who are unemployed want to work. Discrimination often hampers their efforts to join the workforce.
3. *Employees with disabilities have a higher absentee rate than employees without disabilities*. Studies have found that employees with *disabilities* are not absent from work more than nondisabled employees.
4. *The greatest barriers to people with disabilities are physical ones*. In actuality, negative attitudes and stereotypes are the greatest impediments and the most difficult to change.
5. *People with disabilities are brave and courageous*. Individuals with disabilities react to situations like anyone else does. They demonstrate a variety of emotional reactions in adapting to their condition. Some adapt relatively quickly, whereas others have more difficulty coping.

As mentioned previously, not all *disabilities* are apparent. Individuals with “invisible” *disabilities* (e.g., many mental disorders or physical conditions such as traumatic brain injury) may be responded to with frustration and resentment from friends, family members, and employers. When an individual looks healthy, others may not believe they have a *disability* and may blame them for the difficulties that they display. With a visible *disability*, prejudice and discrimination can occur, but accommodations are more likely to be made.

With a less visible disabling condition, such as a traumatic brain injury, misattributions are common (e.g., blaming difficulties in recovery on the individual's personality or unwillingness to cooperate). There may also be unrealistic hopes for full recovery. Invisible *disabilities* can be assessed by consulting with family and friends about the client's preinjury behaviors, abilities, personality, and attitudes to determine whether there have been any changes in these characteristics due to the injury. If this is the case, the counselor can educate family members about the nature of the condition and explain how unrealistic expectations sometimes develop with unobservable injuries (McClure, 2011).

Models of Disability

There are three models of *disability*, each influencing societal perceptions of disabling conditions and possible treatment strategies (Artman & Daniels, 2010; Olkin, 1999). First, the *moral model* focuses on the “defect” as representing some form of sin or moral lapse. The *disability* may be perceived as a punishment or a test of faith. The individual or family

members may respond with feelings of shame and responsibility. In some cultures, *disabilities* are believed to result from such factors as evil spirits, curses, or retribution from unhappy ancestors. Second, the *medical model* regards *disability* as a defect or loss of function that resides in the individual. Action is taken to cure or rehabilitate the condition. In some cultural groups, intervention targets rebalancing mind–body disharmony. The *medical model* has been responsible for many technological advances and treatments targeting a variety of conditions. Additionally, this approach dismisses the notion that moral issues have caused the *disability*. Third, the *minority model* views *disability* as an external problem involving an environment that is filled with negative societal attitudes and that fails to accommodate the needs of individuals with special needs. This perspective emphasizes the oppression, prejudice, and discrimination encountered by individuals who are disabled—experiences very similar to those of other minority groups.

Implications

Much research indicates that empowering individuals and caregivers increases life satisfaction. Unfortunately, the stress and prejudice associated with *disabilities* increase the risk for psychiatric or substance abuse problems (Turner, Lloyd, & Taylor, 2006). If mental health issues appear to be related to the *disability*, it is important to identify the way the *disability* is viewed by the client and by family members; such information may influence problem definition and intervention strategies. If the *disability* is seen as a moral issue (e.g., a test of faith), religious support may be an important component of the treatment process. Goals might include reducing guilt, giving meaning to the experience, generating support from the religious community, and developing problem‐solving approaches.

From the *medical model* perspective, the client or family members may want to focus on improving the client's condition, using technology or other interventions to help “normalize” functioning. Mental health professionals can not only help clients and family members obtain technological resources but also enhance clients' independent living skills and advocate for appropriate accommodations in school or work environments.

Incorporating perspectives from the *minority model* can be useful; counselors can emphasize how societal attitudes play a large role in the problems faced by individuals with *disabilities* and focus on environmental supports directed at maximizing the potential of the client. An emphasis on self‐empowerment and self‐advocacy can help inoculate clients against societal prejudices and discrimination and protect their self‐esteem.

Life Satisfaction

> *I should have picked up the pieces and made the adjustment, and not dwell on it … The problem is the rest of the world is dwelling on it … this place won't hire you and this company won't insure you and that potential lover won't look at you … So that reopens the wound maybe twenty times a day and yet you're supposed to have made the adjustment.*
>
> *(Noonan et al., 2004, p. 72)*

> *Because of an auto accident, Gary Talbot went from being an “able‐bodied man to able‐bodied wheelchair user.” He evaluates his life this way: “I don't like the fact that I can't walk down the street or go jogging or climb a hill or ride a bike. [But] there's so much I can do and that I've been able to do that I just wouldn't change anything about my life.”*
>
> *(Rosenbaum, 2010)*

Ratings of life satisfaction among individuals with *disabilities* tend to be lower than among those without *disabilities*. However, this depends on the type of *disability* and the timing of the rating. Some individuals adjust well, whereas others remain chronically distressed. In one study of the life satisfaction of people with traumatic spinal cord injuries, 37% indicated they were “very satisfied” and 31% “somewhat satisfied” with their lives. This compares to 50% “very satisfied” and 40% “somewhat satisfied” among the general population. An interesting aspect of the study was that those who perceived themselves as “in control” reported the greatest satisfaction (Chase, Cornille, & English, 2000). Similarly, in a longitudinal study of 307 individuals who were “severely” handicapped, with a reduced capacity to work, life satisfaction was reduced in the first year but rose to preinjury levels by the fourth year. Those who were most likely to improve had the personality characteristic of “agreeableness,” an attribute associated with the ability to access and cultivate social support. Thus, helping clients develop or maximize social skills may enhance recovery (Boyce & Wood, 2011).

Having close social relationships and paid employment are also associated with increased life satisfaction (Crompton, 2010). Individuals with *disabilities* often rate activities such as communication, thinking, and relating socially as more important than being able to walk or to dress oneself. Unfortunately, many health professionals display a negative attitude toward *disability*. Only 18% of physicians and nurses imagined that they would be glad to be alive if they had a high‐level spinal cord injury; in sharp contrast, 92% of those with this condition reported satisfaction with their lives (Gerhart, Koziol‐McLain, Lowenstein, & Whiteneck, 1994).

Implications

Mental health and health care providers often underestimate the potential quality of life for individuals with *disabilities*. They may accept signs of depression or suicidal thoughts as normal because of their low expectations regarding life opportunities for this population. The research seems to show that many individuals with *disabilities* feel satisfied with their lives and that increasing their sense of control is important. Self‐efficacy can be enhanced by encouraging as much personal control and decision making as possible. If depressive or suicidal thoughts or wishes surface, they should be addressed. Some support the right of individuals with *disabilities* to engage in assisted suicide. However, other organizations argue that individuals with *disabilities* are an oppressed group and express concern that they may be coerced to end their lives (Coleman, 2015).

Sexuality and Reproduction

> *In response to intrusive questions regarding her intimate experiences, poet Kelsey Warren, who uses a wheelchair, replied “Cripple copulation may be slightly more complicated, but it is always climactic.”*
>
> *(Zeilinger, 2015)*

Men and women with *disabilities* often express concerns over sexual functioning and reproduction. They worry about their sexual attractiveness and how to relate to or find a partner. Some may not know whether it is possible to have children or may have questions about the genetic implications of procreating. Mental health professionals who are uncomfortable with these topics may minimize or overlook these areas of concern.

Implications

Clearly, both clients and therapists need to be educated on these subjects as they relate to

specific *disabilities*. Many individuals who have a *disability* receive the societal message that they should not be sexual or that they are sexually unattractive. This concern should be addressed and assessed both individually and, where applicable, for couples. Therapists can emphasize that sexual relationships are based on communication and emotional responsiveness and can help individuals or couples develop new ways of achieving sexual satisfaction. Prior perspectives regarding sexuality may have to be replaced with new ones.

Sexual pleasure is possible even with the loss of sensation in the genitals that occurs with spinal cord injuries. Among men with spinal cord injuries, some are able to attain an erection and ejaculate, although they may have to learn new forms of stimulation (Craig Hospital, 2015). Many women with spinal cord injuries are still capable of orgasms and sexual pleasure from stimulation of the genitals or other parts of the body (Perrouin‐Verbe, Courtois, Charvier, & Giuliano, 2013). Such injury also does not preclude the ability to become pregnant or deliver a child.

Spirituality and Religiosity

Spirituality and religious beliefs can be a source of inner strength and support. One woman with a *disability* wrote, “It sort of helps me to identify myself, thinking I am a woman created by God and I am so precious and I am so loved and I have so much beauty inside of me” (Nosek & Hughes, 2001, p. 23). Religion and spirituality (connection to a higher power) are associated with increased life satisfaction and functional ability for individuals with traumatic brain injuries (Waldron‐Perrine et al., 2011).

Implications

The mental health professional should determine the role, if any, that religious beliefs or spirituality play in the life of a client with a *disability*. The spirituality of the woman in the quoted example enhanced her sense of self. Such beliefs can be a source of support for clients and their caregivers. Therapists can ask clients about their religious or spiritual beliefs and how their beliefs help them confront challenges; they can then incorporate these beliefs into treatment (Waldron‐Perrine et al., 2011). In some cases, individuals may believe that their *disability* is a punishment from God or may blame God for not preventing the injury. These issues should also be addressed and resolved. Therapists can consult with or refer to religious leaders when working with clients who are attempting to come to terms with a *disability*.

Strengths

> *Many individuals with disabilities who have lived through natural disasters show resiliency and adaptation. Instead of responding, “Where were they when we needed them?” they were more likely to think, “What are my possibilities? What options do I have?”*
>
> *(Fox, White, Rooney, & Cahill, 2010, p. 237)*

Because of the variety of *disabilities* and because individuals with disabilities can come from any population, we will focus on personal characteristics that enhance daily living and satisfaction with life. Individuals with traumatic brain injuries who feel a connection to a higher power show greater life satisfaction and functional ability. Among those with spinal cord injuries, coping strategies, hope, and optimism are associated with a higher quality of life (Kortte, Gilbert, Gorman, & Wegener, 2010). Qualities such as creativity, resilience, self‐control, self‐advocacy and the ability to make positive connections with others and find meaning in life are strengths that can be tapped in the therapy process (Wehmeyer,

2014). Many individuals already possess these strengths; however, they can also be developed or enhanced in counseling by focusing on changing the client's and the client's significant others' perceptions of the *disability*. Outcome is enhanced by improving self‐confidence and finding and developing ways to empower the client (Shallcross, 2011) and encourage active decision making (Artman & Daniels, 2010).

For some, the development of a "*disability* identity" or a positive affirmation about the *disability* may enhance self‐image. This might include association with the *disability* community, confronting discrimination and prejudice, and advocacy to reduce constraints—for example, by eliminating physical barriers that hamper access. Those with a *disability* identity often adapt to and view their *disability* as a valuable experience rather than a decrement. This perspective has been associated with lower distress levels among individuals with multiple sclerosis (Bogart, 2015). Others can have a positive self‐identity even in the absence of an emotional and social connection to the *disability* community. Counselors must listen to what their clients need rather than force them into a specific direction in relation to their *disability* (Dunn & Burcaw, 2013).

In general, finding meaning in one's experience is associated with better adjustment and cognitive adaptation. Individuals facing a life‐changing *disability* benefit when they embrace the opportunity to develop a new perspective on life, or view their changed life circumstances as a signal to slow down or change their life for the better. In contrast, some individuals do not search for meaning in their experiences, yet still make a good adjustment to life. If a client is engaged in the search for meaning, the counselor can help with the process. However, attempting to encourage such inquiry in a client who is not searching for meaning may be counterproductive (Davis & Novoa, 2013).

SPECIFIC CHALLENGES

In the following sections, we consider challenges faced by individuals with disabilities and their implications in treatment. Remember that these are generalizations and that their applicability needs to be assessed for each client.

Prejudice and Discrimination

Ableism is an all‐too‐common discriminatory practice in which individuals without *disabilities* are favored or given preferential treatment, with the implication that those with a *disability* are somehow inferior (Keller & Galgay, 2010). Of course, people with *disabilities* always have additional racial, ethnic, and gender‐related identities, and as a result, they may experience ableist attitudes in concert with other forms of bias. In fact, the operations of intersectionality in the lives of people with *disabilities* have not received extensive attention from counseling researchers; a recent study found *disability* to be one of the two least studied social identities within intersectional research (with the other being social class) (Shin et al., 2017).

Additionally, individuals who have *disabilities* may be evaluated based on an insidious deficit perspective (i.e., a belief that something is wrong with them). For example, employers believe that individuals with physical *disabilities* are less competent than individuals without a *disability* (Wang, Barron, & Hebl, 2010). Rohmer and Louvet (2009) make the point that "visible *disability* can be considered a superordinate social category" (p. 76); that is, *disability* appears to be a highly salient characteristic. For example, individuals with observable physical *disabilities* are often referred to using language such as "confined to a wheelchair" or "wheelchair bound" (Artman & Daniels, 2010).

Prejudicial terms such as *retarded*, *lame*, and *crazy* are also used without conscious awareness of their impact on individuals with *disabilities*. Other reactions may be a result of not understanding the nature of specific *disabilities*. For example, most people without hearing loss do not understand that hearing aids can amplify all sounds, resulting in jumbled hearing, which is why individuals with hearing impairment may choose not to wear them. The public often has low expectations for individuals with *disabilities* and assumes that *disability* in one area affects skills in other areas. Additionally, able‐bodied individuals often do not consider the structural and psychological barriers that individuals with *disabilities* have to face.

Implications

It is important for counselors to understand that individuals with *disabilities* are people first; like members of any group, they may demonstrate a wide range of functional difficulties, as well as varying accomplishments. Mental health professionals need to actively assist individuals with *disabilities* to maximize their educational and employment opportunities. Approximately 9% of students enrolled in postsecondary educational institutions have some form of *disability* (Haller, 2006). Mental health professionals can prepare these students for success at the college level by teaching them to be self‐advocates—encouraging them to alert their professors to their *disability* status and request course accommodations, if needed.

The greatest prejudice may occur with hidden *disabilities*, such as psychiatric conditions. As a person with schizophrenia stated, "I don't want to tell anybody, because people who aren't ill, they do have a tendency sometimes to treat you different … We've got to disguise ourselves a lot" (Goldberg, Killeen, & O'Day, 2005, p. 463). Educating employers and

workplace colleagues about specific conditions can sometimes allay fears (Law, 2011), as well as address false stereotypes associated with *disabilities* (Mizrahi, 2014). Independence for individuals with intellectual *disabilities* or severe mental health issues can be encouraged by teaching them skills such as interviewing for jobs, managing money, doing laundry, and performing other daily living tasks (Ericksen‐Radtke & Beale, 2001).

Mental health professionals need to recognize that they are also subject to *disability* prejudice and address any discomfort they may have with *disabilities*. Several suggestions are helpful (American Psychological Association, 2001; Landsberger & Diaz, 2010):

1. Instead of thinking about a "disabled person," change the focus and use the phrase "person living with a *disability*." This emphasizes the individual rather than the limitation.
2. Do not sensationalize *disability* by referring to the achievements of well‐known individuals with *disabilities* as "superhuman" or "extraordinary." Such references create unfair expectations. Most individuals with *disabilities* have the same range of skills as those without.
3. Avoid the use of phrases that evoke pity and conjure up a nonfunctional status, such as "afflicted with," "suffering from," and "a victim of."
4. Respond to individuals with a *disability* according to their skills, personality, and other personal attributes, rather than their *disability*. Increase your understanding of an individual's specific condition and related resources, but take care not to assume that the *disability* is a primary concern.

See Table 22.1 for additional suggestions about working with clients with various *disabilities*.

TABLE 22.1 Things to Remember When Interacting with Individuals with Disabilities

Source: Adapted from United Cerebral Palsy (2001) and New York State Department of Health (**2009**).

1. People with physical disabilities:
    - Ask if assistance is required before providing it; if your offer is accepted, ask for instructions on how to help and then follow them.
    - Do not use or move items such as wheelchairs, crutches, and canes without permission. They are considered part of the individual's personal space. Address the individual directly; it is important to attend to the client rather than to someone who might have accompanied him or her.
    - Sit at eye level to facilitate comfort in communication.
    - Make certain there is easy access to your office.
2. People with vision loss:
    - Identify yourself and anyone else who is present when greeting the client. If the individual does not extend a hand, offer a verbal welcome.
    - Offer the use of your arm to guide—rather than steer or push—the individual.
    - Give verbal instructions to facilitate navigation.
    - If a service dog is present, do not pet or play with it.
    - Ask about the individual's preference regarding presentation of information (e.g.,

large print, braille, audiotapes).
    - Let the individual know if you are moving about or if the conversation is to end.
    - Give verbal cues when offering a seat. Place the individual's hand on the back of the chair and he or she will not need further help.
3. People who are deaf or hard of hearing:
    - Ask about the individual's preferred communication (some use American Sign Language and identify culturally with the deaf community, whereas others may prefer to communicate orally, read lips, or rely on residual hearing).
    - Address the individual directly, rather than a person accompanying them.
    - Realize that talking very loud may not enhance communication.
    - To get attention, call the person by name. If there is no response, lightly touch them on the arm or shoulder.
    - Do not pretend to understand if you do not.
    - Use certified interpreters to facilitate communication; their role is to relay information.
    - Try to avoid using family members as interpreters.
    - Make direct eye contact, and keep your face and mouth visible.
4. People with speech impediments:
    - Allow the individual to finish speaking before you speak.
    - Realize that communication may take longer, and plan accordingly. Do not rush.
    - Face the individual, and give full eye contact.
    - Address the individual directly.
    - Do not pretend to understand if you do not.
    - When appropriate, use yes - or - no questions.
    - Check with the individual, if needed, to ensure understanding.
        - Remember that a speech impediment does not mean the individual has limited intelligence.

Select this link to open an interactive version of Table 22.1

Supports for Individuals with Disabilities

In the past, programs for persons with neurodevelopmental *disabilities* (e.g., autism, intellectual impairment, learning *disabilities*) were limited to efforts at “rehabilitation” rather than assistance in maximizing potential and developing independent living skills. There has been gradual recognition that deficiencies in experiences and opportunities can significantly limit an individual's development and that services are most effective when they enable independence, self - determination, and productive participation in society. To accomplish this task, it is important to support students with *disabilities* in completing school and learning job skills.

Many school - to - work transition programs, including those that provide students with

disabilities the opportunity to learn work‐related skills through local employment opportunities, have shown promising results (e.g., see DC Partners in Transition at www.dctransition.org). Some programs for individuals with moderate to severe intellectual or physical *disabilities* provide prevocational orientations for both the family and the student. Information on job preparation and job expectations is provided, followed by skills training and then an internship in a local business, where employers give feedback on the individual's performance. Such programs have been successful both in helping youth with *disabilities* make the transition to employment or further education and in opening doors in the business community. Mentors can also play an important role in helping college students with *disabilities* achieve academic success. Many graduates attribute their academic success to significant relationships with a faculty member or special services staff member (Barber, 2012).

With regard to educational settings themselves, college students with *disabilities* have been found to report more distress related to academic performance than other students, as well as higher rates of anxiety and suicidal ideation. Support personnel throughout campus communities—including counselors, faculty, residence hall staff, and offices of *disability* services—should coordinate their efforts to reach out to these students as early as possible in their college careers (Coduti, Hayes, Locke, & Youn, 2016).

Implications

There has been a shift in the orientation of programs for people with disabilities from remediation or “making them as normal as possible” to identifying and strengthening interests and skills. Mental health professionals working with individuals with *disabilities* should be aware of programs offering educational and employment assistance. For example, the ParentCenterHub.org website is a repository of different resources for individuals with *disabilities*, such as Organizations and Agencies in Your State, Employment, Postsecondary Education, Recreation, Independent Living, Assistive Technology, and Disability Living Online. Media such as *Ability Magazine*, *Disability Scoop*, *e‐Bility*, and *New Mobility* (a magazine for active wheelchair users) also provide useful information and support for individuals with *disabilities*. It is important for mental health professionals to be aware of the ways current technology is enhancing quality of life and employment opportunities for many individuals with *disabilities*. Vocational and support group information is easily accessible via the Internet.

Counseling Issues with Individuals with Disabilities

> *I want to say unequivocally that disabled people are everywhere. We are one of the largest oppressed groups on the planet. We are part of political movements, even if you don't know or don't acknowledge that we are. No matter what community you're working with, you are working with disabled people.*
>
> *(Mingus, 2017b)*

Helping professionals often display the same attitude as the general public toward individuals with *disabilities* and may feel uncomfortable or experience guilt or pity when working with this population. As when working with other oppressed groups, counselors must examine their own views in regard to clients with disabilities and identify and question any prejudicial assumptions. A client's *disability* should not be the sole focus of counseling. However, environmental contributions to the problems a client is experiencing (e.g., frustrations with architectural barriers or with negative stereotypes or prejudices) should be identified and addressed in counseling.

Implications

As with all clients, comprehensive, nonbiased assessment is essential for those who have *disabilities*. Kemp and Mallinckrodt (1996) point out some of the errors that can occur in assessment and counseling relationships with individuals with *disabilities*. First, errors of omission may be made. The counselor may fail to ask questions about critical aspects of the client's life because they assume that the issue is unimportant due to the presence of the *disability*. For example, sexuality and relationship issues may be ignored because of the belief that the individual lacks the ability to pursue—or interest in pursuing—these intimacies. Affective issues may also be avoided, because the counselor is uncomfortable addressing the impact of the *disability* on the client. The counselor may display lowered expectations of the client's capabilities.

Second, errors of commission may occur. In such cases, counselors make the unjustified assumption that certain issues should be important because of the *disability*, when, in fact, they are not important for the client. Further, a therapist might inaccurately assume that personal problems faced by the client result from the *disability*. Career and academic counseling may become a focus even when it is not what the client wants to discuss. Therapists also make errors by not addressing the *disability* at all, encouraging dependency and the "sick" role, or failing to confront countertransference issues (e.g., wanting to "rescue" the client).

It is generally appropriate to ask a client about the *disability*, including any related concerns. The therapist can also ask if there are ways that the *disability* is part of the presenting problem. Such an approach allows the therapist to address the *disability* directly. In doing so, it is important not to succumb to the "spread" phenomenon that often exists with *disabilities*: believing that the *disability* encompasses unrelated aspects of the individual. If the *disability* is of recent origin, factors such as coping strategies, recent challenges, the possibility of self‐blame for the injury, and the amount of social support available can be assessed.

Family Counseling

Family caregivers now operate as integral parts of the health care system and provide services that were once performed by professional health care providers. It is, therefore, important to help reduce the impact of stressors on caregivers and other family members. Additionally, emotional issues, such as distress, guilt, self‐punishment, and anger, may need to be considered. Family members may feel angry about their caretaking responsibilities or somehow feel responsible for the disabling condition (Resch et al., 2010).

Implications

Clients with a *disability* and their family members can work together to create positive changes that enhance both client well‐being and family functioning. Among family caregivers, attributes such as positive problem‐solving skills, positive problem orientation, and coping strategies are associated with greater satisfaction for themselves and the individual with the *disability* (Elliot, Shewchuk, & Richards, 1999). One effective approach employed by caregivers is using problem‐solving strategies when encountering difficulties; such caretakers learn to define the problem, generate and evaluate alternatives, implement solutions, and assess outcomes. This approach helps increase self‐efficacy among family members and improves their ability to cope with stress.

IMPLICATIONS FOR CLINICAL PRACTICE

1. Identify your beliefs, assumptions, and attitudes about individuals with *disabilities*.
2. Understand the prejudice, discrimination, inconveniences, and barriers faced by individuals with physical *disabilities* and the problems faced by individuals with "invisible" *disabilities*.
3. Assess the impact of multiple sources of discrimination on ethnic minorities and other diverse populations with *disabilities* (Dispenza, Varney, & Golubovic, 2017).
4. Redirect internalized self‐blame for the *disability* to societal attitudes.
5. Employ necessary modifications to enhance communication, and address the client directly rather than through conversation with an accompanying individual.
6. Determine whether the *disability* is related to the presenting problem and, if so, identify whether the client adheres to the *moral model* (*disability* results from a moral lapse), *medical model* (*disability* is a physical limitation), or *minority model* (*disability* results from societal failure to accommodate individual differences).
7. Determine whether the *disability* will influence assessment or treatment strategies. If this is not an issue, continue with your usual methods of assessment and case conceptualization.
8. If formal tests are employed, provide appropriate accommodations. Interpret the results with care, since standardization does not take into account various physical *disabilities*.
9. Recognize that family members and other social supports are important.

   When possible, include them in your assessment, case conceptualization, goal formation, and selection of techniques, but try not to use family members as interpreters for those with communication difficulties. Be aware that family members may not fully understand psychiatric issues or may be part of the problem (Ali, 2012).
10. Identify environmental changes or accommodations that may be needed, and assist the client or family with the planning necessary to implement them.
11. Help family members reframe the problem so that family and client strengths can be identified. Focus on and reinforce the positive attributes of the client and family members.
12. Help both the client and family members develop self‐advocacy skills.
13. Realize that mental health professionals may need to serve as advocates or consultants to initiate changes in academic and work settings.
14. Be aware of Web resources and provide links to *disability*‐related products such as computer accessibility, clothing, augmentative communication devices, legal and advocacy resources, job training, and educational resources.

Video Lecture: Can You Hold the Door for Me? Including Disability in Diversity by Rhoda Olkin

SUMMARY

There are approximately 56.7 million Americans with some level of *disability* (physical or mental); among this group, over half have a *disability* that severely affects daily functioning. People often lack understanding and do not know how to respond to people with *disabilities*. Attitudes vary from being disdainful and dismissive to being overly protective or sympathetic. *Ableism* is an all too common discriminatory practice in which individuals without *disabilities* are favored or given preferential treatment, thereby implying that those with a *disability* are somehow inferior. The 1990 ADA extended the federal mandate of nondiscrimination to individuals with *disabilities* and to state and local governments and the private sector. Because of the number of myths and beliefs about those with *disabilities*, counselors need to be informed in areas such as sexuality and reproduction, worker capabilities, resource availability, and especially their own feelings of discomfort or bias around those with *disabilities*. Fourteen clinical implications for counselor practice are identified.

GLOSSARY TERMS

- Ableism
- Americans with Disabilities Act
- Disability
- Medical model
- Minority model
- Moral model
- Rehabilitation approach

REFERENCES

1. Ali, S. (2012). Providing interpreters for patients with hearing disabilities: ADA requirements. *Innovations in Clinical Neuroscience*, *9*, 30–33.

2. American Association of People with Disabilities. (2006). Bipartisan legislation introduced to restore ADA protections. *AAPD News*, pp. 1, 3.

3. American Psychological Association (2001). *Aging and human sexuality resource guide*. Washington, DC: American Psychological Association.

4. Artman, L. K., & Daniels, J. A. (2010). Disability and psychotherapy practice: Cultural competence and practical tips. *Professional Psychology: Research and Practice, 41*, 442–448.

5. Barber, P. (2012). College students with disabilities:what factors influence successful degree completion? A case study. Retrieved from http://www.heldrich.rutgers.edu/sites/default/files/products/uploads/College_Students_

6. Bogart, K. R. (2015). Disability identity predicts lower anxiety and depression in multiple sclerosis. *Rehabilitation Psychology*, *60*, 105–109.

7. Boyce, C. J., & Wood, A. M. (2011). Personality prior to disability determines adaptation: Agreeable individuals recover lost life satisfaction faster and more completely. *Psychological Science*, *22*, 1397–1402.

8. Brault, M. W. (2012). *Americans with Disabilities: 2010*. Washington, DC: U.S. Census Bureau.

9. Brown, R. L. (2014). Psychological distress and the intersection of gender and physical disability: Considering gender and disability ‐ related risk factors. *Sex Roles*, *71*, 171–181.

10. Center for Workplace Preparation. (n.d.). Disability: Dispelling the myths. Retrieved from https://ohioemploymentfirst.org/up_doc/Disability_Business_Case.pdf

11. Chase, B. W., Cornille, T. A., & English, R. W. (2000). Life satisfaction among persons with spinal cord injuries. *Journal of Rehabilitation, 66*, 14–20.

12. Coduti, W. A., Hayes, J. A., Locke, B. D., & Youn, S. J. (2016). Mental health and professional help ‐ seeking among college students with disabilities. *Rehabilitation Psychology, 61*(3), 288–296.

13. Coleman, D. (2015). Why do disability rights organizations oppose assisted suicide laws? Retrieved from http://notdeadyet.org/why ‐ do ‐ disability ‐ rights ‐ organizations ‐ oppose ‐ assisted ‐ suicide ‐ laws

14. Cornish, J. A. E., Gorgens, K. A., Olkin, R., Palomibi, B. J., & Abels, A. V. (2008). Perspectives on ethical practice with people who have disabilities. *Professional Psychology: Research and Practice*, *39*, 488–497.

15. Craig Hospital. (2015). Sexual function for men after a spinal cord injury. Retrieved from https://craighospital.org/resources/sexual ‐ function ‐ for ‐ men ‐ after ‐ a ‐ spinal ‐ cord ‐ injury

16. Crompton, S. (2010). Living with disability series: Life satisfaction of working‐age women with disabilities. Retrieved from https://www150.statcan.gc.ca/n1/pub/11‐008‐x/2010001/article/11124‐eng.htm

17. Davis, C. G., & Novoa, D. C. (2013). Meaning‐making following spinal cord injury: Individual differences and within‐person change. *Rehabilitation Psychology, 58*, 166–177.

18. Desselle, D. C., & Proctor, T. K. (2000). Advocating for the elderly hard‐of‐hearing population: The deaf people we ignore. *Social Work, 45*, 277–281.

19. Dispenza, F., Varney, M., & Golubovic, N. (2017). Counseling and psychological practices with sexual and gender minority persons living with chronic illnesses/disabilities (CID). *Psychology of Sexual Orientation and Gender Diversity, 4*(1), 137.

20. Dunn, D. S., & Burcaw, S. (2013). Disability identity: Exploring narrative accounts of disability. *Rehabilitation Psychology, 58*, 148–157.

21. Elliott, T. R., Shewchuk, R. M., & Richards, J. S. (1999). Caregiver social problem‐solving abilities and family member adjustment to recent onset physical disability. *Rehabilitation Psychology, 44*, 104–123.

22. Ericksen‐Radtke, M. M., & Beale, A. V. (2001). Preparing students with learning disabilities for college: Pointers for parents—Part 2. *Exceptional Parent, 31*, 56–57.

23. Fox, M. H., White, G. W., Rooney, C., & Cahill, A. (2010). The psychosocial impact of Hurricane Katrina on persons with disabilities and independent living staff living on the American Gulf Coast. *Rehabilitation Psychology, 55*, 231–240.

24. Gerhart, K. A., Koziol‐McLain, J., Lowenstein, S. R., & Whiteneck, G. G. (1994). Quality of life following spinal cord injury: Knowledge and attitudes of emergency care providers. *Annals of Emergency Medicine, 23*, 807–812.

25. Goldberg, S. G., Killeen, M. B., & O'Day, B. (2005). The disclosure conundrum: How people with psychiatric disabilities navigate employment. *Psychology, Public Policy, and Law, 11*, 463–500.

26. Haller, B. A. (2006). Promoting disability‐friendly campuses to prospective students: An analysis of university recruitment materials. *Disability Studies Quarterly, 26*, 1–10.

27. Jones, L., Bellis, M. A., Wood, S., Hughes, K., McCoy, E., Eckley, L., … Officer, A. (2012). Prevalence and risk of violence against children with disabilities: A systematic review and meta‐analysis of observational studies. *Lancet, 380*, 899–907.

28. Keller, R. M., & Galgay, C. E. (2010). Microaggressive experience of people with disabilities. In D. W. Sue (Ed.), *Microaggressions and marginality* (pp. 241–267). Hoboken, NJ: Wiley.

29. Kemp, N. T., & Mallinckrodt, B. (1996). Impact of professional training on case conceptualization of clients with a disability. *Professional Psychology: Research and Practice, 27*, 378–385.

30. Konig, J. (2013). Cognitive processing therapy with a prelingually deaf patient suffering from posttraumatic stress disorder. *Clinical Case Studies, 12*, 73–90.

31. Kortte, K. B., Gilbert, M., Gorman, P., & Wegener, S. T. (2010). Positive psychological variables in the prediction of life satisfaction after spinal cord injury. *Rehabilitation Psychology, 55*, 40–47.

32. Landsberger, S. A., & Diaz, D. R. (2010). Communicating with deaf patients: 10 tips to deliver appropriate care. *Current Psychiatry*, *9*, 36–37.

33. Larson, J. E., Ryan, C. B., Wassel, A. K., Kaszynski, K. L., Ibara, L., & Boyle, M. G. (2011). Analysis of employment incentives and barriers for individuals with psychiatric disabilities. *Rehabilitation Psychology, 56*, 145–149.

34. Law, N. (2011). Disability discrimination in the workplace on the rise. Retrieved from http://www.disabled‐world.com/disability/discrimination/workplace‐law.php

35. LSU Office of Disability Services. (2011). Dispelling myths about people with disabilities. Retrieved from https://www.lsu.edu/disability/faculty‐staff/myths.php

36. National Service Inclusion Project. (n.d.). Myths and facts about people with disabilities. Retrieved from http://www.serviceandinclusion.org/index.php?page=myths

37. McClure, J. (2011). The role of causal attributions in public misconceptions about brain injury. *Rehabilitation Psychology*, *56*, 85–93.

38. Michaels, S. (2015). The Americans with Disabilities Act is turning 25. Watch the dramatic protest that made it happen. Retrieved from https://www.motherjones.com/politics/2015/07/americans‐disabilities‐act‐capitol‐crawl‐anniversary/

39. Mingus, M. (2017a). Forced intimacy: An ableist norm. Retrieved from https://leavingevidence.wordpress.com/2017/08/06/forced‐intimacy‐an‐ableist‐norm

40. Mingus, M. (2017b). Access intimacy, interdependence, and disability justice. Retrieved from https://leavingevidence.wordpress.com/2017/04/12/access‐intimacy‐interdependence‐and‐disability‐justice

41. Mizrahi, J. L. (2014). False stereotypes of people with disabilities hold employers back. Retrieved from http://www.huffingtonpost.com/jennifer‐laszlo‐mizrahi/false‐stereotypes‐of‐peop_b_5353818.html

42. New York State Department of Health. (2009). People first: Communicating with and about people with disabilities. Retrieved from https://www.health.ny.gov/publications/0951

43. Noonan, B. M., Gallor, S. M., Hensler‐McGinnis, N. F., Fassinger, R. E., Wang, S., & Goodman, J. (2004). Challenge and success: A qualitative study of the career development of highly achieving women with physical and sensory disabilities. *Journal of Counseling Psychology*, *51*, 68–80.

44. Nosek, M. A., & Hughes, R. B. (2001). Psychospiritual aspects of sense of self in women with physical disabilities. *Journal of Rehabilitation*, *67*, 20–25.

45. Office of Disability Employment Policy. (n.d.). Economic picture of the disability community project. Retrieved from https://www.dol.gov/odep/pdf/20141022‐KeyPoints.pdf

46. Olkin, R. (1999). *What psychotherapists should know about disability*. New York, NY: Guilford Press.

47. Perrouin‐Verbe, B., Courtois, F., Charvier, K., & Giuliano, F. (2013). Sexuality of women with neurologic disorders. *Progressive Urology*, *23*, 594–600.

48. Resch, J. A., Mireles, G., Benz, M. R., Grenwelge, C., Peterson, R., & Zhang, D. (2010). Giving parents a voice: A qualitative study of the challenges experienced by parents of children with disabilities. *Rehabilitation Psychology*, *55*, 139–150.

49. Robinson‐Whelen, S., Hughes, R. B., Powers, L. E., Oschwald, M., Renker, P., & Curry, M. A. (2010). Efficacy of a computerized abuse and safety assessment intervention for women with disabilities: A randomized controlled study. *Rehabilitation Psychology*, *55*, 97–107.

50. Rohmer, O., & Louvet, E. (2009). Describing persons with disability: Salience of disability, gender, and ethnicity. *Rehabilitation Psychology*, *54*, 76–82.

51. Rosenbaum, P. (2010). Amazing success fueled by act of discrimination. Retrieved from http://www.cnn.com/2010/LIVING/07/26/ada.talbot/?hpt=Sbin

52. Shallcross, L. (2011). Seeing potential, not disability. *Counseling Today*, *54*, 28–35.

53. Shin, R. Q., Welch, J. C., Kaya, A. E., Yeung, J. G., Obana, C., Sharma, R., Vernay, C, & Yee, S. (2017). The intersectionality framework and identity intersections in the *Journal of Counseling Psychology* and *The Counseling Psychologist*: A content analysis. *Journal of Counseling Psychology*, *64*(5), 458.

54. Sullivan, P. M. (2009). Violence exposure among children with disabilities. *Clinical Child and Family Psychological Review*, *12*, 196–216.

55. Terrio, H. P., Nelson, L. A., Betthauser, L. M., Harwood, J. E., & Brenner, L. A. (2011). Postdeployment traumatic brain injury screening questions: Sensitivity, specificity, and predictive values in returning soldiers. *Rehabilitation Psychology*, *56*, 26–31.

56. Turner, R. J., Lloyd, D. A., & Taylor, J. (2006). Physical disability and mental health: An epidemiology of psychiatric and substance disorders. *Rehabilitation Psychology*, *51*, 214–223.

57. United Cerebral Palsy (2001). *Etiquette tips for people with physical disabilities*. Portland, OR: United Cerebral Palsy.

58. Waldron‐Perrine, B., Rapport, L. J., Hanks, R. A., Lumley, M., Meachen, S.‐J., & Hubbarth, P. (2011). Religion and spirituality in rehabilitation outcomes among individuals with traumatic brain injury. *Rehabilitation Psychology*, *56*, 107–116.

59. Wang, K., Barron, L. G., & Hebl, M. R. (2010). Making those who cannot see look best: Effects of visual resume formatting on ratings of job applicants with blindness. *Rehabilitation Psychology*, *55*, 68–73.

60. Wehmeyer, M. L. (2014). *The Oxford handbook of positive psychology and disability*. New York, NY: Oxford University Press.

61. Zablotsky, B., Bradshaw, C. P., Anderson, C. M., & Law, P. (2014). Risk factors for bullying among children with autism spectrum disorders. *Autism*, *18*, 419–427.

62. Zeilinger, J. (2015). This poem reveals what it's like to have sex when you have a

disability. Retrieved from http://mic.com/articles/122159/poet - destroys - stereotypes - about - having - sex - with - a - disability

23
Counseling LGBTQ Populations

Chapter Objectives

1. **1. Learn the demographics and issues faced by lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals.**
2. **2. Identify counseling implications of the information provided for LGBTQ individuals.**
3. **3. Recognize strengths that are associated with LGBTQ individuals.**
4. **4. Know the special challenges faced by LGBTQ individuals.**
5. **5. Understand how the implications for clinical practice can guide assessment and therapy with LGBTQ individuals.**

On June 26, 2015, The Supreme Court ruled 5–4 that same‐sex couples have the right to marry. With the ruling, gay marriage became legal in all 50 states, affecting not only the right to marry but also the right to be recognized as a spouse or parent on birth and death certificates and other legal documents.

(Hurley, 2015)

A lone gunman opened fire at the Pulse nightclub in Orlando, Florida on June 22, 2016. Almost 50 people were killed and another 58 injured in the predawn massacre. The majority of the victims were Latinx gay individuals.

LGBT youth need support from their families—not derision. If you tell a child or teenager they're not good enough, that they're worthless, that who they are is broken or wrong, that's abuse.

(Valenti, 2015)

Zoey Tur, who was told that she would never work again in news if she transitioned to a female, has been hired as a reporter for the "Inside Edition" television program. Interestingly, she says the most difficult part of becoming a woman was the loss of "male privilege."

(Soopermexican, 2015)

In this chapter, we will discuss *lesbian*, *gay*, *bisexual*, *transgender*, and queer (LGBTQ) Americans—individuals who have an affectional and/or sexual attraction to a person of the same sex (*gay* men and *lesbian women*); individuals who have an affectional and/or sexual attraction to members of both sexes (*bisexual individuals*); people whose gender identification is inconsistent with the gender they were assigned at birth (*transgender*); and people who identify as *queer*. The Q is sometimes also used to refer to individuals who are questioning their sexuality.

About 3.5% of U.S. adults, or 9 million Americans, identify as *lesbian*, *gay*, or *bisexual* and 0.3% as *transgender*. In addition, about 19 million Americans have engaged in same‐sex behaviors and around one‐fourth of the adult population acknowledges some same‐sex attraction (Gates, 2011). Higher percentages for LGBTQ are reported among millennials between the ages of 18 and 35. Of this group, 4% identified themselves as *bisexual*, 3% as *gay* or *lesbian*, and 1% as *transgender* (Public Relations Research Institute, 2014).

The mood of the country reveals contradictory attitudes and actions toward sexual minorities. Overall, there appears to be increased acceptance of LGBTQ individuals and their lifestyles. In 1985, 89% of the public indicated that they would be upset if their child told them that he or she was *gay* or *lesbian*; 9% would not be. To the same question in 2015, 39% responded

that they would be upset but 57% would not be. Also, in the same poll, 63% indicated that "homosexuality should be accepted by society." However, strong negative attitudes and feelings toward *gay* people continue among older adults and White Evangelicals (Pew Research Center, 2015).

Changes are also occurring in societal views regarding *transgender* individuals. Their issues are also being discussed more openly, as represented by television shows with *transgender* characters—such as "Transparent" and "Orange Is the New Black" (Leitsinger, 2015). When receiving the Arthur Ashe Courage Award, Caitlin Jenner made a plea that people should be respected and accepted, especially the "thousands of kids coming to terms with who they are" (Melas, 2015). New York City is making it easier for *transgender* individuals to change the sex listed on their birth certificates, even without undergoing sex‐change operations. This is also true in Oregon, Washington, California, Iowa, Vermont, and Washington, D.C. (Wong, 2014). When he was in office, President Obama signed a memorandum indicating that hospitals participating in Medicare or Medicaid programs "may not deny visitation privileges on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability," and California Governor Jerry Brown signed a bill requiring schools to modify the social studies curriculum to include the contributions of LGBTQ individuals (Lin, 2011).

As with many other areas of progress, these steps forward have been met with resistance and retraction. The Trump administration issued several setbacks to LGBTQ rights in its first year in office, including limiting protections for LGBTQ workers, rescinding past guidance on transgender bathroom protection in public schools, and recommending a significant number of judicial nominees with anti‐LGBTQ records (Lopez, 2018). In this chapter, we contextualize the identity development and strengths of LGBTQ individuals within the current social climate in the United States, as well as some of the major issues and challenges facing sexual minorities, including the *coming out* process, societal misconceptions, and the stress associated with ongoing prejudice and discrimination.

CHARACTERISTICS AND STRENGTHS

Schools and our society more generally vigorously reinforce gender norms and behaviors, and those who do not adhere to these customs are often ridiculed and bullied. LGBTQ individuals live in a *heterosexual* and *cisgender* society (i.e., a culture expecting "normative" gender behavior) where they face the challenge of developing a healthy self‐identity in the midst of societal norms that view their *sexual orientation* or gender identification as "abnormal." This disharmony can significantly affect the transition from childhood to adolescence to adulthood, as well as family relationships and personal identity development. In the following sections, we will consider the issues faced by LGBTQ individuals in these areas, as well as the strengths found in this population.

Sexual and Gender Identity Awareness

Once LGBTQ individuals recognize *heterosexual* and *transgender* societal realities, the discovery of being "different" can be agonizing. As one individual observed: "No matter how open‐minded I believed my companion to be, the coming‐out conversation was always excruciating. I was a sweaty, self‐conscious mess, having no idea what reaction I would get" (Diehl, 2013). Awareness of *sexual orientation* for *gay* males and *lesbians* usually takes place in the early teens, with sexual experiences and self‐identification typically occurring during the mid‐teens and same‐sex relationships beginning during the late teens or early 20s (Pew Research Center, 2013). In a longitudinal study of 156 *gay*, *lesbian*, and *bisexual* youth, 57% consistently self‐identified as *gay*/*lesbian* and 15% consistently identified as *bisexual*, while 18% of *bisexuals* transitioned to *gay*/*lesbian* (Rosario, Schrimshaw, Hunter, & Braun, 2006). *Bisexual* individuals are much less likely to say that *sexual orientation* is a big part of who they are or to have come out to important people. They also report few instances of discrimination (Parker, 2015).

Gender identity is an even more important aspect of one's total being. *Transgender* people feel a marked incongruence between the gender with which they self‐identify and the gender assigned to them based on their physical characteristics at birth. They often report feeling "different" at an early age. *Gender dysphoria*, a mental health condition defined in the *Diagnostic and Statistical Manual of Mental Disorder*s (*DSM‐5*), occurs when there is significant distress and impairment resulting from an incongruence between a person's gender identity and assigned gender. One activist described *gender dysphoria* as "one of the greatest agonies … when your anatomy doesn't match who you are inside" (Wright, 2001). Although *gender dysphoria* is still considered a mental disorder (American Psychiatric Association, 2013), many *transgender* individuals are hoping that they can follow the successful path taken by the *gay* and *lesbian* movement and eventually eliminate such classification.

Because *transgender* individuals have a longstanding conviction that nature somehow placed them in the wrong body, they often wish to replace their physical sexual characteristics with those of the appropriate gender. Therefore, sex reassignment surgery is frequently considered. Such surgery has produced variable results; many females who undergo sexual reassignment express satisfaction with the outcome, whereas males who change to female are less likely to feel satisfied. This may be because adjusting to life as a man is easier than adjusting to life as a woman, or perhaps because man‐to‐woman changes are more likely to produce negative reactions (Lawrence, 2008).

Many LGBTQ individuals struggle with accepting their self‐identity, which they may perceive to contrast with society's definition of what is healthy. The struggle for identity

involves one's internal perceptions, which likely contrast with external perceptions and the assumptions made by others about one's *sexual orientation*. This process is particularly complex for *transgender* individuals because their *sexual orientation* may be *heterosexual*, same‐sex, or *bisexual* (Wester, McDonough, White, Vogel, & Taylor, 2010). Interrogating and challenging the ways in which one has internalized heterosexism, homophobia, biphobia, and/or transphobia is essential in the process of self‐acceptance and pride (Chaney, Filmore, & Goodrich, 2011). A reduction of stress often occurs when an individual ceases struggling to be "straight" and begins to establish a new identity, self‐concept, and understanding of what constitutes an authentic and meaningful life. During this period, individuals (and members of their families) often deal with issues of grief over letting go of the old, sometimes idealized, identity (Adelson, 2012).

Implications

Adolescence and early adulthood is a time of exploration and experimentation. *Heterosexual* activity does not mean one is a *heterosexual*, nor does same‐sex activity indicate homosexuality. Many LGBTQ individuals describe feeling "different" from early childhood. When they begin to acknowledge their sexual or *transgender* identity, they soon confront the stigma associated with being *gay*, *lesbian*, *bisexual*, or *transgender*. Because of the discrimination and prejudice they have faced or anticipate, it is important for mental health professionals to take an affirming position that validates and helps normalize the individual's identity. Often the stress and depression experienced by LGBTQ individuals is promulgated by the *cisgender* and *heterosexual* nature of our society (Chaney et al., 2011).

Because of fear of the consequences of disclosure during their struggle with identity issues, some LGBTQ youth (and adults) face this process alone, without the potential support and nurturance of peers, parents, and other family members, or of others who have gone through the same struggle. Many pretend to be straight or avoid discussing sexuality. Mental health professionals can help LGBTQ individuals develop coping/survival skills, and expand their environmental supports. Therapists should also work with others to address anti‐LGBTQ bias and discrimination in schools, work places and other public spaces.

LGBTQ Youth

> *In many schools, discriminatory policies and practices exacerbate the sense of exclusion students face … [T]eachers are made to fear adverse employment consequences for identifying as LGBT or supporting LGBT students. Students in same‐sex relationships are barred or discouraged from attending events as a couple, and transgender students are denied access to facilities, classes, and extracurricular activities because of their gender identity.*
>
> *(Human Rights Watch, 2016a)*

LGBTQ youth who are questioning their *sexual orientation* face a variety of stressors. Discrimination and harassment in the school environment is common. In a large survey of middle and high school students, over 80% of LGBTQ students reported experiencing harassment at school in the past year, and about two‐thirds reported feeling unsafe because of their sexual or gender orientation. Nearly 40% of LGBTQ students reported being physically harassed, and over 18% had been physically assaulted in school because of their *sexual orientation*. Further, 55% were exposed to cyberbullying through text messages, emails, and postings on social networking sites. Safety concerns led one‐third of the LGBTQ students surveyed to skip school (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012).

LGBTQ youth are more likely than their *heterosexual* peers to attempt suicide, especially when they live in an unsupportive environment (Hatzenbuehler, 2011). Even higher rates of suicide attempts are found among Black and Latinx LGBTQ youth (Meyer, Dietrich, & Schwartz, 2008). LGBTQ youth also have increased risk for substance use and abuse (McCabe, Hughes, Bostwick, West, & Boyd, 2009), especially when there is also a history of childhood abuse or victimization (McCabe, Wilsnack, West, & Boyd, 2010).

Implications

As when working with adults, mental health professionals need to address the problems of LGBTQ youth at both the systems and the individual levels. To improve the school environment, professionals can advocate for inclusion of *gay* and *transgender* people in the curriculum. They can also promote opportunities for social skill development relevant to LGBTQ youth, provision of adequate social services, and a nondiscriminatory school environment. About 20 states have antibullying laws prohibiting bullying on the bases of sexual orientation or gender identity; a number of other states, however, have laws restricting teachers and students from talking about LGBTQ issues within schools, including Alabama, Arizona, Louisiana, Mississippi, Oklahoma, Texas, and Utah (Human Rights Watch, 2016b).

It is essential to encourage school personnel to consistently enforce policies that protect LGBTQ youth from harassment and violence and to push for legislation protecting the rights of LGBTQ youth. Programs promoting gay–straight alliances and antibullying policies reduce not only harassment but also the risk of suicide (Hatzenbuehler, 2011; Poteat, 2017).

Support groups that allow LGBTQ students to discuss their concerns in a safe and confidential environment are also important. LGBTQ youth need safe places to meet others and to socialize. Community‐based supports such as hotlines, youth clubs, and such groups as Parents, Families, and Friends of Gays and Lesbians (PFLAG), the Trevor Project, and gay–straight alliances can be helpful. The Gender Spectrum provides resources in working with children and youth with gender issues. Such organizations defuse possible harassment and violence in schools and allow LGBTQ students to gain support and openly express their sexual identities (Valenti, 2015).

On the individual level, bullying can lead to an internalization of negative attitudes by LGBTQ youth and the development of dysfunctional shame‐focused coping strategies such as social withdrawal, self‐criticism, and self‐harm. The counselor can help their clients to realize that they are not responsible for the bullying and replace negative strategies and cognitions with self‐affirmations and positive coping strategies (Greene, Britton, & Fitts, 2014).

LGBTQ Couples and Families

As opposition to gay marriage has eased over the past decade, the number of openly *gay* and *lesbian* couples in the United States has nearly doubled, to about 650 000. Approximately one out of five same‐sex couples is raising children (Yen, 2011). Upwards of 6 million children and adults have an LGBTQ parent (Gates, 2013). Many LGBTQ couples and individuals have a keen interest in becoming parents, and their legal right to adopt a child is now supported by 63% of Americans, according to a Gallup Poll (Swift, 2014).

However, the right of *gays* and *lesbians* to adopt children has been challenged in many states. Some religious agencies have gone so far as to discontinue adoption services to protest state laws allowing *gay* men and *lesbian* women to adopt children (Stern, 2014). Many adoption agencies still have discriminatory practices.

As one adoption worker observed, “I have seen a gay couple inquire about 30 children and not get one answer back of interest in their home. That just would not happen and it does not happen with the heterosexual couples we work with.” Even when *gay* and *lesbian* applicants pass the required background checks, they still face the risk of being turned down if they do not meet agency “standards” (Graham, 2013).

Are children raised by LGBTQ couples or individuals harmed in any way? Despite myths to the contrary, children raised by same‐sex parents have no increased likelihood of gender or sexual confusion or of developing a same‐sex *sexual orientation* (Patterson, 2013). Research findings indicate that children raised by *gay* or *lesbian* parents are as mentally healthy as children with *heterosexual* parents and that there is no reason to believe that a *heterosexual* family structure is necessary for healthy child development. The relationships within *gay* and *lesbian* households appear to be similar to those among *heterosexual* individuals, although *lesbian* couples share a more egalitarian relationship than many *heterosexual* couples (Riggle, Whitman, Olson, Rostosky, & Strong, 2008). In fact, children raised by *lesbian* mothers perform better academically and have fewer behavioral problems than their peers (Gartrell & Bos, 2010).

Implications

In addition to the typical relationship difficulties faced by *heterosexual* couples and families, LGBTQ couples also face prejudice and discrimination from society. Conflicts sometimes occur when individuals in LGBTQ relationships differ in terms of internalized homophobia/biphobia/transphobia or the extent to which they are “out” to others in their social, work, or family networks. For example, one member of the relationship may be uncomfortable showing public displays of affection or may feel the need to hide the couple's *sexual orientation* or their relationship.

In work with LGBTQ parents or in determining their suitability as adoptive parents, mental health professionals should examine their own attitudes and beliefs about LGBTQ individuals. The empirical data indicate that LGBTQ parenting styles and child‐rearing practices do not differ significantly from those of their *heterosexual* counterparts. In addition to normal developmental issues, children of LGBTQ parents may benefit from support when explaining their nontraditional family to peers. Many hope that changes in school curricula encouraging respect for diversity and diverse lifestyles will help with this challenge.

Strengths

> *Queer people of color not only survive experiences of oppression, they develop resilience and coping skills in the process.*
>
> *(Singh & Chun, 2010, p. 38)*

Although LGBTQ people face discrimination, prejudice, and disadvantaged status in society, many show considerable resilience in the face of adversity and effectively use such strategies as maintaining hope and seeking social support (Singh, Hays, & Watson, 2011). Many cite positive aspects of being a *lesbian* or a *gay* man, such as belonging to a supportive community, being able to create families of choice, serving as positive role models, living authentically, being involved in social justice and activism, and enjoying freedom from gender‐specific roles (Orel & Fruhauf, 2014). The egalitarianism frequently seen in *lesbian* couples not only promotes resilience in their children but also provides a positive model for respectful interpersonal relationships (Bos & Gartrell, 2010).

SPECIFIC CHALLENGES

In the following sections, we discuss challenges faced by LGBTQ individuals and consider their implications in treatment. Societal pressures and related struggles are reflected in the higher incidence of substance abuse and of anxiety and depressive disorders within this population. *Gay* youth are especially vulnerable because of pressures within the school and peer environment and struggles with *coming out* to family members. Adults face issues related to letting others know "who they really are," as well as settling down with a partner, getting married, and having children—things that *heterosexual* individuals take for granted.

Coming Out

> *Transgender teen Leelah Alcorn stepped in front of a semitrailer. In her suicide note, she said her family did not accept her when she came out to them. Her mother responded by stating that Leelah would never be a girl and that God doesn't make mistakes; she continued to refer to Leelah by her male name, Josh.*
>
> *(Helling, 2015)*

> *I'm 14 and I wanted to share this story with you. So last night I came out to my dad. I wasn't nervous as I knew he would be understanding. Since I was at dance I couldn't speak to him face to face. So I sent him a text saying "I'm bisexual" and he replied with "as long as you're doing the best in life as you can, who you're with doesn't matter. I love you forever and always." I was in tears when I saw this and I'm happy he knows because I wouldn't have wanted to keep a secret from him.*
>
> *(whenicameout.tumblr.com)*

The process of maintaining secrets about *sexual orientation* or gender identity issues can seriously affect relationships with friends and family. The decision to *come out* is extremely difficult for many individuals, and is often influenced by the overwhelming sense of isolation that they feel. *Coming out* to parents and friends can lead to rejection, anger, and grief. Rejection is especially difficult for adolescents who are emotionally and financially dependent on their family. For some, however, coming can lead to relief and acceptance. There are data suggesting that when people decide to come out to their mother, it either strengthens or does not change the relationship (Pew Research Center, 2013).

Coming out is an ongoing process for LGBTQ individuals—each time, they need to determine with whom and when to disclose. During the initial stages of this process, self‐esteem, life satisfaction, and happiness may decrease as the individual faces negative reactions from others (Chaney et al., 2011). *Bisexual* individuals may encounter more difficulty, since it is often assumed that they are "just going through a phase" or that they are *gay* or *lesbian* but are unwilling to accept their *sexual orientation* (Schulman, 2014).

Coming out is often more difficult for ethnic minorities, who face the stigma of being "multiple minorities." Asian, Black, and Latinx *gay* and *lesbian* youth are more reluctant to disclose their *sexual orientation* than are their White counterparts and are less likely to be involved in gay‐related social activities (Adelson, 2012). *Gay* Mexican American men have a greater degree of internalized homophobia, partly because of the cultural value of *machismo*. In Latinx communities, there is strong negative reaction to *gay* men and frequent use of slurs such as *maricon* (sissy) and *joto* (fag) (Estrada, Rigali‐Oiler, Arciniega, & Tracey, 2011). Further, Latino men who are *gay* report racism, discomfort, and rejection from the *gay* community, especially those with darker skin or more Indian features (Ibanez, VanOss Marin, Flores, Millett, & Diaz, 2009).

Lindsey (2005), who is an African American, was asked to write a chapter on sexual diversity for the 2005 edition of *Our Bodies, Ourselves*. She notes,

> *In the mainstream media, both gay and straight, coming out is portrayed in an extremely idealized and simplistic way. The gay person, always white and middle class, decides he or she is gay, tells families and friends, who might experience a little homophobia … and ends up marching proudly down the main thoroughfare of a progressive major metropolitan area.*
>
> *(p. 186)*

The experience of *coming out* is often different for people of color—they frequently face both rejection from their communities and racism from the majority European American culture. Among the working poor, it also means the possibility of losing their jobs. *Transgender* individuals face additional challenges as friends, family, children, and coworkers adjust to their change in gender and physical appearance (Budge, Tebbe, & Howard, 2010).

Implications

The decision of "when" and "with whom" to come out should be carefully considered. Factors such as age, ethnicity, relationship status, and spiritual beliefs should be taken into account (Chaney et al., 2011). To whom does the individual want to reveal the information? What are the possible effects and consequences (both long‐ and short‐term) of self‐disclosure, both for the individual and for the recipient of the information? What new sources of support are available if negative reactions are encountered? If the individual is already in a relationship, how will the disclosure affect his or her partner? In some cases, the client may conclude that it is not yet a good time to disclose. If they do decide to *come out*, the counselor can offer specific help and preparation in determining how this is best accomplished. Role‐plays and the discussion of possible reactions can be practiced.

Clients needing support during the disclosure process may choose to disclose or pursue follow‐up discussion during a counseling session. Disclosure to parents may provoke feelings of both grief (e.g., loss of their visions of their child's future, including weddings and grandchildren) and guilt (i.e., believing their parenting was responsible). Parents may need support in dealing with the societal stigma of having an LGBTQ family member and may benefit from receiving information and education about myths and stereotypes. If parents or other family members are rejecting, the client must strengthen other sources of social support. This may be particularly important for ethnic minorities, who can face additional culturally based reactions. Prior to and during the *coming out* process, the counselor can help the client deal with both external and internalized heterosexism and other societal beliefs that are at the core of homophobia (Scott, 2011). Thus, rather than allowing clients to internalize self‐blame, counselors can help them understand that it is societal prejudice that is the problem.

Prejudice, Discrimination, and Misconceptions

> *About one‐quarter of LGBT staff, faculty, and students reported experiencing harassment … with transgender individuals receiving even higher levels of harassment … About one‐third have considered leaving their institutions … 43% of transgender students, faculty, and staff … feared for their physical safety.*
>
> *(Rankin, Weber, Blumenfeld, & Frazer, 2010, p. 4)*

We have alluded to the overwhelming prejudice and discrimination facing LGBTQ youth and adults. Sexual assaults in adulthood have been reported by 12% of *gay* men and 13% of *bisexual* men, compared to 2% of *heterosexual* men. Among women, the rates of sexual

assault were 16% for *lesbians*, 17% for *bisexual* women, and 8% for *heterosexual* women (Balsam, Rothblum, & Beauchaine, 2005). A recent Pew Research Center (2013) study found among LGBTQ adults:

- 58% have been subjected to slurs or jokes.
- 4 out of 10 were rejected by a family member or close friend after *coming out*.
- 3 out of 10 have been physically assaulted or threatened.
- 3 out of 10 felt unwelcome at a place of worship.
- Nearly one‐quarter received poor service in a restaurant or other business.

Further, *bisexual* individuals sometimes experience hostility both from *heterosexuals* and from the *gay* community (Brewster & Moradi, 2010). Mental distress is particularly pronounced among *bisexual* women (Ward, Dahlhamer, Galinsky, & Joestl, 2014). *Transgender* individuals face being viewed as mentally ill, delusional, or self‐destructive not only by the public, but also by mental health workers (Mizock & Fleming, 2011).

In addition to openly antigay harassment, LGBTQ individuals often experience subtle heterosexism, such as the common practice of equating the word *gay* with *stupid* or automatically making the assumption that most people are *heterosexual*; practices such as these create distress and feelings of denigration (Burn, Kadlec, & Rexer, 2005). LGBTQ individuals face microaggressions that invalidate their *sexual orientation*, including the use of language and terms that demonstrate heteronormality and *heterosexual* privilege (Smith, Shin, & Officer, 2011). Perceived discrimination based on *sexual orientation*, especially among those who keep silent about their experiences, increases the risk of depression (McLaughlin, Hatzenbuehler, & Keyes, 2010).

It is likely that societal stressors such as prejudice and discrimination account for the finding that LGBTQ youth report elevated rates of major depression, generalized anxiety disorder, and substance abuse (Rienzo, Button, Sheu, & Li, 2006) and that LGBTQ adults are at higher risk for substance‐ and alcohol‐related problems (Ward, Dahlhamer, Galinsky, & Joestl, 2014). Although *gay* men report high rates of major depression, *lesbians* appear to fare better and report mental health equal to that of their *heterosexual* counterparts (DeAngelis, 2002).

A number of research studies reveal that bias continues to exist among mental health professionals (Shelton & Delgado‐Romero, 2013). In one study, 97 counselors read a fictitious intake report about a *bisexual* woman seeking counseling, with no indication that the problem involved her *sexual orientation*. Instead, the problems given concerned her career choice, troubles with her parents over independence, ending a two‐year relationship with another woman, and troubles with her boyfriend. Hence, the issues involved were boundaries with parents, career choice, and romantic relationships. Counselors with the most negative attitude toward *bisexuality* believed her problems stemmed from her *sexual orientation* and rated her lower in psychosocial functioning (Mohr, Israel, & Sedlacek, 2001).

It is not uncommon for therapists to engage in biased and inappropriate practices or to hold beliefs that affect the therapeutic alliance with LGBTQ clients (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1998; Shelton & Delgado‐Romero, 2013), including the following:

1. Assuming that a client is *heterosexual*, thereby making it harder to bring up issues around *sexual orientation*.
2. Believing that same‐sex orientation is sinful or a form of mental illness.

3. Failing to understand that a client's emotional problems may result from experiences with discrimination or internalization of society's view of homosexuality.
4. Focusing on *sexual orientation* when it is not relevant.
5. Attempting to have a client renounce or change their *sexual orientation*.
6. Lacking an understanding of identity development in *lesbian* women and *gay* men, or viewing homosexuality solely as sexual activity.
7. Not understanding the impact of possible internalized negative societal pressures or homophobia/biphobia/transphobia on identity development.
8. Underestimating the consequences of *coming out* for the client, and suggesting they *come out* without careful discussion of the pros and cons of this disclosure.
9. Misunderstanding or underestimating the importance of intimate relationships for *gay* men and *lesbians*. One therapist reportedly advised a *lesbian* couple who were having problems in their relationship to not think of it as a permanent relationship and to consider going to a *gay* bar to meet others.
10. Presuming that clients with a different *sexual orientation* cannot be good parents, and automatically assuming that their children's problems are a result of their *sexual orientation*.
11. Overidentifying with LGBTQ clients; offering excessive displays of acceptance or "understanding."

Implications

Although mental health organizations have acknowledged that homosexuality is not a mental disorder, it is recognized that a "need for better education and training of mental health practitioners" exists (Shelton & Delgado‐Romero, 2013). *Heterosexist bias* in therapy needs to be acknowledged and changed. Fortunately, many mental health training programs have made curricular changes to increase their emphasis both on the concerns and challenges of LGBTQ individuals and on the positive characteristics and supportive relationships found in these groups.

It is important for therapists to continue to examine possible stereotypes or negative attitudes they may hold regarding LGBTQ clients and to monitor their behavior and interactions for possible microaggressions. LGBTQ clients report perceiving counselors more positively and feeling a greater willingness to disclose personal information, including *sexual orientation*, when a counselor refrains from heterosexist language (e.g., using the term "partner" instead of "boyfriend"/"girlfriend" or "husband"/"wife"). Workshops and training in the use of nondiscriminatory intake forms and the identification of psychological and health issues faced by many LGBTQ clients are helpful means of increasing health care providers' effectiveness (Pachankis & Goldfried, 2013).

Aging

> *Kelly Glossip was accepted in a senior citizens home but turned it down, "I'm used to being out, so the idea of going into senior housing in a straight environment is horrifying … I know that I would have to go completely back in the closet."*
>
> *(Watkins, 2010, p. 1)*

Because of anticipated or previous discrimination by health care providers, older LGBTQ individuals underutilize health care. Their concerns appear to be justified.

In a recent study, *heterosexual* male and female nurses showed a strong preference for *heterosexual* over *lesbian* and *gay* patients (Sabin, Riskind, & Nosek, 2015). Aging LGBTQ individuals are fearful of having to go to retirement or assisted‐living communities, where prejudice may exist. In interviews, residents of these communities assumed that people living there were *heterosexual* and many expressed the view that it is "OK" to have LGBTQ residents as long as they do not talk about their orientation (Clay, 2014). Unless attitudes change, these types of problems will only increase, because nearly 1.5 million LGBTQ individuals in the United States are older than age 65, and this number is expected to double in 15 years (Movement Advancement Project, 2010). In addition, as with other segments of U.S. society, ageism exists within *gay* and *lesbian* communities. All of these issues can produce a great deal of concern among older LGBTQ adults as they confront declining health and a diminishing social support system.

Implications

With older LGBTQ individuals, issues of *coming out* (or *coming out* again) may need to be addressed as their needs for health care or social services increase. Counselors can assist these clients to develop coping skills, expand their social support systems, and locate services for older LGBTQ adults. Advocacy groups for this population are increasing in number. One organization, Senior Action in a Gay Environment (SAGE), provides counseling, educational and recreational activities, and discussion groups for older LGBTQ individuals. The Gay and Lesbian Association of Retiring Persons (GLARP) operates retirement communities for LGBTQ individuals and provides them with support and education on aging (Donahue & McDonald, 2005). To promote a welcoming environment, some retirement communities use marketing materials that show same‐sex couples and other indications of diversity.

In addition to these services, LGBTQ‐friendly teleconferences exist for homebound seniors. Project Visibility, a training program for staff and administrators of nursing homes and assisted‐living facilities, incorporates culturally competent practices that counter stereotypes and foster compassionate care for older LGBTQ adults living in these facilities (Mellskog, 2011). Many organizations have added the *transgender* community to their mission statements. The mental health professional needs to be aware of these resources and advocate for laws that support LGBTQ partnership rights.

IMPLICATIONS FOR CLINICAL PRACTICE

1. Examine your own views regarding *heterosexuality*, and determine their impact on work with LGBTQ clients. Understand *heterosexual* and *cisgender* privilege. A way to personalize this perspective is to assume that some of your family, friends, or coworkers may be LGBTQ.
2. Study appropriate practice guidelines and reports on therapy with LGBTQ individuals, including the American Counseling Association's LGBTQ (ALGBTIC et al., 2013) and transgender (2010) counseling competencies; the American Psychological Association's LGB (American Psychological Association, 2011) and transgender and gender nonconforming (American Psychological Association, 2015) guidelines for psychotherapy; the Appropriate Therapeutic Responses to Sexual Orientation in the American Psychological Association's Multicultural Competency in Geropsychology (American Psychological Association, 2009a); the Report of the American Psychological Association Task Force on Gender Identity and Gender Variance (American Psychological Association, 2009b); and Adelson's (2012) Practice Parameter

on Gay, Lesbian, or Bisexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents.

3. Develop partnerships, consultation, or collaborative efforts with local and national LGBTQ organizations.
4. Ensure that your intake forms, interview procedures, and language are free of *heterosexist bias* and include a question on sexual behavior, attraction, or orientation; include questions about gender identity and pronoun preference. Be aware that LGBTQ clients may have specific concerns regarding confidentiality.
5. Do not assume that presenting problems are necessarily the result of *sexual orientation* and *gender identity*. Typical presenting problems may include relationship difficulties, self‐esteem issues, depression, and anxiety (Lyons, Bieschke, Dendy, Worthington, & Georgemiller, 2010). Keep in mind that societal factors may play a role in these problems.
6. Remember that mental health issues may result from stress due to prejudice and discrimination; internalized homophobia/biphobia/transphobia; the *coming out* process; a lack of family, peer, school, or community support; experiences of sexual victimization or physical assault; suicidal ideation or attempts; and substance abuse. Ethnic minority LGBTQ individuals may be dealing with rejection from their ethnic communities as well as marginalization within the LGBTQ community.
7. Realize that LGBTQ couples may have problems similar to those of their *heterosexual* counterparts but may also display unique concerns, such as differences in their degree of comfort with public demonstrations of their relationship or reactions from their families of origin.
8. Assess spiritual and religious needs. Many LGBTQ individuals have a strong religious faith but they may encounter exclusion. Religious support is available. For example, for individuals of the Christian faith, the Fellowship United Methodist Church accepts all types of diversity and is open to *gay* congregation members. LGBTQ individuals who have strong religious beliefs but who belong to a nonaffirming church can explore different options, such as joining an affirming religious group, exploring more liberal sects of their own religion, or developing their own definitions of what it means to be *gay* or religious (Sherry, Adelman, Whilde, & Quick, 2010). It is much easier to adapt to a different religious group than to change one's *sexual orientation* (Haldeman, 2010).
9. Because many LGBTQ clients have internalized the societal belief that they cannot have long‐lasting relationships, access to materials that portray healthy and satisfying long‐term LGBTQ relationships can help counteract these stereotypes.
10. Recognize that a large number of LGBTQ clients have been subjected to hate crimes as well as microaggression. Depression, anger, post‐traumatic stress, and self‐blame may result. These conditions need to be assessed and treated. It can be helpful to ask questions such as, “Have you had incidences where you thought you were treated differently because you are a sexual minority person?” (Kashubeck‐West, Szymanski, & Meyer, 2008, p. 617).
11. For clients still dealing with internalized homophobia/biphobia/transphobia, it may help to focus on assisting them to identify and replace heterosexist and *cisgender* messages with positive affirming messages about their identity. Many LGBTQ individuals avoid discrimination by assuming a *heterosexual* identity and avoiding the issue of sexuality with others, whereas others are able to reveal their true identity. The consequences of

each of these reactions need to be considered from both individual and societal perspectives.

12. A number of therapeutic strategies can be useful with internalized homophobia, prejudice, and discrimination. Effective interventions may involve assisting clients to identify and correct cognitive distortions, practice coping skills, or expand social supports.
13. To increase awareness of internalized heterosexism, encourage LGBTQ clients who have expressed concerns related to *sexual orientation* to talk about their *coming out* experiences; thoughts and feelings about their sexuality; feelings of homophobia; experiences with heterosexism in school, family, work, and religion; degree of interactions with other LGBTQ individuals; and the availability of support (Kashubeck‐West et al., 2008).
14. Systems‐level intervention is often needed in schools, employment situations, and religious organizations. Diversity workshops can help organizations acquire accurate information about sexual and gender diversity. Even with the Supreme Court decision legalizing same‐sex marriage, counselors may need to be advocates for change and to assist clients who are facing discriminatory action in regards to legal matters such as adoptions.
15. *Transgender* individuals may need specific assistance making name changes, connecting with local support groups, or locating medical professionals who provide hormones or surgical options associated with a gender transition (Bess & Stabb, 2009).
16. Do not assume that *coming out* is the goal in all situations. Both counselor and client should carefully consider consequences, especially for younger individuals, and develop strategies to deal with possible negative reactions from family or friends.

SUMMARY

The acronym LGBTQ refers to individuals who have an affectional and/or sexual attraction to persons of the same sex (*gay* men and *lesbians*) or to members of both sexes (*bisexuals*), individuals whose gender identity is inconsistent with their assigned gender (*transgender*), and individuals who self‐identify as *queer*. Overall, there appears to be increased societal acceptance of LGBTQ individuals and their lifestyles, especially among the young. Despite this change, prejudice, discrimination, and violence against sexual minorities continues. Because of this fact, sexual identity issues and *coming out* are especially intense for adolescents. Suicide attempts are high among LGBTQ adolescents and young adults. *Heterosexist bias* in therapy needs to be acknowledged and changed. It is important for therapists to continue to examine possible stereotypes or negative attitudes regarding LGBTQ clients and to monitor their behavior and interactions for possible microaggressions. Sixteen clinical implications for counselor practice are identified.

GLOSSARY TERMS

- Bisexual
- Cisgender
- Coming out
- Gay
- Gender dysphoria
- Heterosexist bias
- Heterosexual
- Lesbian
- LGBTQ
- Queer
- Sexual orientation
- Transgender

REFERENCES

1. Adelson, S. L. (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *51*, 957–974.

2. ALGBTIC LGBQQIA Competencies Taskforce, Harper, A., Finnerty, P., Martinez, M., Brace, A., Crethar, H. C., … Hammer, T. R. (2013). Association for lesbian, gay, bisexual, and transgender issues in counseling competencies for counseling with lesbian, gay, bisexual, queer, questioning, intersex, and ally individuals. *Journal of LGBT Issues in Counseling*, *7*(1), 2–43.

3. American Counseling Association (2010). American Counseling Association competencies for counseling with transgender clients. *Journal of LGBT Issues in Counseling*, *4*, 135–159.

4. American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

5. American Psychological Association (2009a). *Multicultural competency in geropsychology*. Washington, DC: American Psychological Association.

6. American Psychological Association (2009b). *Report of the APA task force on gender identity and gender variance*. Washington, DC: American Psychological Association.

7. American Psychological Association. (2011). Practice guidelines for LGB clients. Retrieved from http://www.apa.org/pi/lgbt/resources/guidelines.aspx

8. American Psychological Association (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist*, *70*, 832–864.

9. Balsam, K. F., Rothblum, E. D., & Beauchaine, T. P. (2005). Victimization over the life span: A comparison of lesbian, gay, bisexual, and heterosexual siblings. *Journal of Consulting and Clinical Psychology*, *73*, 477–487.

10. Bess, J. A., & Stabb, S. D. (2009). The experiences of transgendered persons in psychotherapy: Voices and recommendations. *Journal of Mental Health Counseling*, *31*, 264–282.

11. Bos, H., & Gartrell, N. (2010). Adolescents of the USA National Longitudinal Lesbian Family Study: Can family characteristics counteract the negative effects of stigmatization. *Family Process*, *49*, 559–572.

12. Brewster, M. E., & Moradi, B. (2010). Perceived experiences of anti‐bisexual prejudice: Instrument development and evaluation. *Journal of Counseling Psychology*, *57*, 451–468.

13. Budge, S. L., Tebbe, E. N., & Howard, K. A. S. (2010). The work experience of transgender individuals: Negotiating the transition and career decision‐making process. *Journal of Counseling Psychology*, *57*, 377–393.

14. Burn, S. M., Kadlec, K., & Rexer, B. S. (2005). Effects of subtle heterosexism on gays, lesbians, and bisexuals. *Journal of Homosexuality*, *49*, 23–38.

15. Chaney, M. P., Filmore, J. M., & Goodrich, K. M. (2011). No more sitting on the

sidelines. *Counseling Today*, *34*, 37.

16. Clay, R. J. (2014). Double‐whammy discrimination. *Monitor on Psychology*, *45*, 46–49.

17. DeAngelis, T. (2002). New data on lesbian, gay, and bisexual mental health. *APA Monitor*, *33*, 46–47.

18. Diehl, W. (2013). Yes, I really am bisexual. Deal with it. *New York Times*, April 25.

19. Donahue, P., & McDonald, L. (2005). Gay and lesbian aging: Current perspectives and future directions for social work practice and research. *Families in Society*, *86*, 359–366.

20. Estrada, F., Rigali‐Oiler, M., Arciniega, M., & Tracey, T. J. G. (2011). Machismo and Mexican American men: An empirical understanding using a gay sample. *Journal of Counseling Psychology*, *58*, 358–367.

21. Garnets, L., Hancock, K. A., Cochran, S. D., Goodchilds, J., & Peplau, L. A. (1998). Issues in psychotherapy with lesbians and gay men: A survey of psychologists. In D. R. Atkinson, & G. Hackett (Eds.), *Counseling diverse populations* (2nd ed.) (pp. 297–316). Boston, MA: McGraw‐Hill.

22. Gartrell, N., & Bos, H. (2010). US National Longitudinal Lesbian Family Study: Psychological adjustment of 17‐year‐old adolescents. *Pediatrics*, *126*, 28–36.

23. Gates, G. J. (2011). How many people are lesbian, gay, bisexual, and transgender? Retrieved from https://williamsinstitute.law.ucla.edu/wp‐content/uploads/Gates‐How‐Many‐People‐LGBT‐Apr‐2011.pdf

24. Gates, G. J. (2013). LGBT parenting in the United States. The William Institute. Retrieved from http://williamsinstitute.law.ucla.edu/wp‐content/uploads/LGBT‐Parenting.pdf

25. Graham, L. (2013). How adoption agencies discriminate against hopeful LGBT parents. Retrieved from http://michiganradio.org/post/how‐adoption‐agencies‐discriminate‐against‐hopeful‐lgbt‐parents

26. Greene, D. C., Britton, B. J., & Fitts, B. (2014). Long‐term outcomes of lesbian, gay, bisexual, and transgender recalled school victimization. *Journal of Counseling & Development*, *92*, 406–417.

27. Haldeman, D. C. (2010). Reflections of a gay male psychotherapist. *Psychotherapy Theory: Research and Practice*, *47*, 177–185.

28. Hatzenbuehler, M. L. (2011). The social environment and suicide attempts in lesbian, gay, and bisexual youth. *Pediatrics*, *127*, 896–903.

29. Helling, S. (2015). Suicide of transgender teen Leelah Alcorn sparks emotional debate. Retrieved from https://people.com/celebrity/suicide‐of‐transgender‐teen‐leelah‐alcorn‐sparks‐emotional‐debate/

30. Human Rights Watch. (2016a). United States: LGBT students face discrimination. Retrieved from https://www.hrw.org/news/2016/12/07/united‐states‐lgbt‐students‐face‐discrimination

31. Human Rights Watch. (2016b). “Like walking through a hailstorm”: Discrimination

against LGBT youth in the U.S. schools. Retrieved from https://www.hrw.org/sites/default/files/report_pdf/uslgbt1216web_2.pdf

32. Hurley, L. (2015). Supreme Court's landmark ruling legalizes gay marriage nationwide. Retrieved from http://www.reuters.com/article/2015/06/26/us - usa - court - gaymarriage - idUSKBN0P 61SW20150626

33. Ibanez, G. E., VanOss Marin, B., Flores, S. A., Millett, G., & Diaz, R. M. (2009). General and gay - related racism experienced by Latino gay men. *Cultural Diversity and Ethnic Minority Psychology*, *15*, 215–222.

34. Kashubeck - West, S., Szymanski, D., & Meyer, J. (2008). Internalized heterosexism: Clinical implications and training considerations. *Counseling Psychologist*, *36*, 615–630.

35. Kosciw, J. G., Greytak, E. A., Bartkiewicz, M. J., Boesen, M. J., & Palmer, N. A. (2012). *The 2011 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools*. New York, NY: GLSEN.

36. Lawrence, A. A. (2008). Gender identity disorders in adults: Diagnosis and treatment. In D. Row - land, & L. Incrocci (Eds.), *Handbook of sexual and gender identity disorders* (pp. 423–456). Hoboken, NJ: Wiley.

37. Leitsinger, M. (2015). Sex reassignment surgery at 74: Medicare win opens door for transgender seniors. Retrieved from http://www.nbcnews.com/news/us - news/sex - reassignment - surgery - 74 - medicare - win - opens - door - transgender - se niors - n276986

38. Lin, J. (2011). Calif. gov signs landmark law to teach gay history. Retrieved from https://www.deseretnews.com/article/700151685/Calif - gov - signs - landmark - law - to - teach - gay - history.html

39. Lindsey, E. S. (2005). Reexamining gender and sexual orientation: Revisioning the representation of queer and trans people in the 2005 edition of *Our Bodies, Ourselves*. *NWSA Journal*, *17*, 184–189.

40. Lopez G. (2018). Trump promised to be LGBTQ - friendly. His first year in office proved it was a giant con. Retrieved from https://www.vox.com/identities/2018/1/22/16905658/trump - lgbtq - anniversary

41. Lyons, H. Z., Bieschke, K. J., Dendy, A. K., Worthington, R. L., & Georgemiller, R. (2010). Psychologists' competence to treat lesbian, gay and bisexual clients: State of the field and strategies for improvement. *Professional Psychology: Research and Practice*, *41*, 424–434.

42. McCabe, H. T., Wilsnack, S. E., West, B. T., & Boyd, C. J. (2010). Victimization and substance use disorders in a national sample of heterosexual and sexual minority women and men. *Addiction*, *105*, 2130–2140.

43. McCabe, S. E., Hughes, T. L., Bostwick, W. B., West, B. T., & Boyd, C. J. (2009). Sexual orientation, substance use behaviors and substance dependence in the United States. *Addiction*, *104*, 1333–1345.

44. McLaughlin, K. A., Hatzenbuehler, M. L., & Keyes, K. M. (2010). Responses to discrimination and psychiatric disorders among Black, Hispanic, female, and lesbian,

gay, and bisexual individuals. *American Journal of Public Health*, *100*, 1477–1484.

45. Melas, C. (2015). Caitlyn Jenner brought to tears at ESPYS after awarded Arthur Ashe award. Retrieved from http://hollywoodlife.com/2015/07/15/caitlyn-jenner-speech-espys-video-espy-awards-2015

46. Mellskog, P. (2011). LGBT program for Longmont seniors gets $100,000 grant. *Times-Call*, May 30.

47. Meyer, I. H., Dietrich, J., & Schwartz, S. (2008). Lifetime prevalence of mental disorders and suicide attempts in diverse lesbian, gay and bisexual populations. *American Journal of Public Health*, *98*, 1004–1006.

48. Mizock, L., & Fleming, M. Z. (2011). Transgender and gender variant populations with mental illness: Implications for clinical care. *Professional Psychology: Research and Practice*, *42*, 208–213.

49. Mohr, J. J., Israel, T., & Sedlacek, W. E. (2001). Counselors' attitudes regarding bisexuality as predictors of counselors' clinical responses: An analogue study of a female bisexual client. *Journal of Counseling Psychology*, *48*, 212–222.

50. Movement Advancement Project. (2010). LGBT older adults: Facts at a glance. Retrieved from https://www.lgbtagingcenter.org/resources/pdfs/LGBTOlderAdultsFactsataGlance.pdf

51. Orel, N. A., & Fruhauf, C. A. (2014). *The lives of LGBT older adults: Understanding challenges and resilience*. Washington, DC: American Psychological Association.

52. Pachankis, J. E., & Goldfried, M. R. (2013). Clinical issues in working with lesbian, gay, and bisexual clients. *Psychology of Sexual Orientation and Gender Diversity*, *1*, 45–58.

53. Parker, K. (2015). Among LGBT Americans, bisexuals stand out when it comes to identity, acceptance. Retrieved from http://www.pewresearch.org/fact-tank/2015/02/20/among-lgbt-americans-bisexuals-stand-out-when-it-comes-to-identity-acceptance/

54. Patterson, C. J. (2013). Children of lesbian and gay parents: Psychology, law, and policy. *Psychology of Sexual Orientation and Gender Diversity*, *1*, 27–34.

55. Pew Research Center. (2013). A Survey of LGBT Americans: Attitudes, experiences and values in changing times. Retrieved from http://www.pewsocialtrends.org/2013/06/13/a-survey-of-lgbt-americans

56. Pew Research Center. (2015). Support for same-sex marriage at record high, but key segments remain opposed. Retrieved from http://www.people-press.org/2015/06/08/support-for-same-sex-marriage-at-record-high-but-key-segments-remain-opposed/

57. Poteat, V. P. (2017). Gay-straight alliances: Promoting student resilience and safer school climates. *American Educator*, *40*(4), 10–43.

58. Public Relations Research Institute, (2014). A shifting landscape: A decade of change in American attitudes about same-sex marriage and LGBT issues. Retrieved from https://www.prri.org/research/2014-lgbt-survey/

59. Rankin, S., Weber, G., Blumenfeld, W., & Frazer, S. (2010). 2010 state of higher education for lesbian, gay, bisexual & transgender people. Retrieved from https://www.campuspride.org/wp-content/uploads/campuspride2010lgbtreportssummary.pdf

60. Rienzo, B. A., Button, J. W., Sheu, J.-J., & Li, Y. (2006). The politics of sexual orientation issues in American schools. *Journal of School Health*, *76*, 93–97.

61. Riggle, E. D. B., Whitman, J. S., Olson, A., Rostosky, S. S., & Strong, S. (2008). The positive aspects of being a lesbian or gay man. *Professional Psychology: Research and Practice*, *39*, 210–217.

62. Rosario, M., Schrimshaw, E. W., Hunter, J., & Braun, L. (2006). Sexual identity development among lesbian, gay, and bisexual youths: Consistency and change over time. *Journal of Sex Research*, *43*, 46–58.

63. Sabin, J. A., Riskind, R. G., & Nosek, B. A. (2015). Health care providers' implicit and explicit attitudes toward lesbian women and gay men. *American Journal of Public Health*, *105*(9), 1831–1841.

64. Schulman, M. (2014). Bisexual: A label with layers. *New York Times*, January 3.

65. Scott, D. (2011). Coming out: Intrapersonal loss in the acquisition of a stigmatized identity. Retrieved from http://www.derekscott.co/wp-content/uploads/coming_out.pdf

66. Shelton, K., & Delgado-Romero, E. A. (2013). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Psychology of Sexual Orientation and Gender Diversity*, *1*, 59–70.

67. Sherry, A., Adelman, A., Whilde, M. R., & Quick, D. (2010). Competing selves: Negotiating the intersection of spiritual and sexual identities. *Professional Psychology: Research and Practice*, *41*, 112–119.

68. Singh, A. A., & Chun, K. S. Y. (2010). From “margins to the center”: Moving towards a resilience-based model of supervision with queer people of color. *Training and Education in Professional Psychology*, *4*, 36–46.

69. Singh, A. A., Hays, D. G., & Watson, L. S. (2011). Strength in the face of adversity: Resilience strategies of transgender individuals. *Journal of Counseling & Development*, *89*, 20–27.

70. Smith, L. C., Shin, R. Q., & Officer, L. M. (2011). Moving counseling forward on LGB and transgender issues: Speaking queerly on discourses and microaggressions. *Counseling Psychologist*, *40*, 385–408.

71. Soopermexican. (2015). Transgender news reporter says hardest part of transition is “loss of male privilege”. Retrieved from http://therightscoop.com/transgender-news-reporter-says-hardest-part-of-transition-is-loss-of-male-privilege

72. Stern, M. J. (2014). Some conservatives would rather keep kids in foster care than let gays adopt them. Retrieved from http://www.slate.com/blogs/outward/2014/08/01/conservatives_want_to_keep_gay_co

73. Swift, A. (2014). Most Americans say same-sex couples entitled to adopt. Retrieved

from http://www.gallup.com/poll/170801/ameri cans - say - sex - couples - entitled - adopt.aspx

74. Valenti, J. (2015). Telling an LGBT child they're worthless or broken is abuse. *New York Times*, January 8.

75. Ward, B. W., Dahlhamer, J. M., Galinsky, A. M., & Joestl, S. S. (2014). *Sexual orientation and health among U.S. adults: National Health Interview Survey, 2013*. Hyattsville, MD: National Center for Health Statistics.

76. Watkins, T. (2010). Aging issues can be tougher on gays. Retrieved from http://www.cnn.com/2010/LIVING/wayoflife/03/17/gays.aging.problems/index.html

77. Wester, S. R., McDonough, T. A., White, M., Vogel, D. L., & Taylor, L. (2010). Using gender role conflict theory in counseling male - to - female transgender individuals. *Journal of Counseling and Development*, *88*, 214–219.

78. Wong, C. M. (2014). New York's transgender residents will now be able to change birth certificate sex designation without surgery. Retrieved from http://www.huffingtonpost.com/2014/12/08/new - york - transgender - birt_n_6290590.html

79. Wright, K. (2001). To be poor and transgender. *Progressive*, *65*, 21–24.

80. Yen, H. (2011). Census: Many gay couples say they're married—even if they technically aren't. Retrieved from http://www.nbcnews.com/id/44690992/ns/us_news - life/t/census - many - gay - couples - say - theyre - married - even - if - they - technically - arent/#.W4caDc5KgdU

24
Counseling Older Adults

Chapter Objectives

1. **1. Learn the demographics and characteristics of older adult clients.**
2. **2. Identify counseling implications of the information provided for older adult clients.**
3. **3. Recognize strengths associated with older adult clients.**
4. **4. Know the special challenges faced by older adult clients.**
5. **5. Understand best practices in assessment and therapy with older adult clients.**

I have lived by contributing to others, but when you retire, you can lose that feeling of contributing value. Give us a chance to work with younger people as equals, and not be directed by other people all the time!

(Participant in Smith, Shenk, Tran, Poon, Wahba, &Voegtli, 2017)

An examination of Facebook comments revealed that older adults are often "vilified" and subjected to comments advocating that they be banned from public activities such as driving and shopping; some Facebook users even proposed the execution of older individuals.

(Levy, Chung, Bedford, & Navrazhina, 2014)

"[G]erontophobia" is harmful because we internalize it. Ageism has been described as prejudice against one's future self. It tells us that age is our defining characteristic and that, as midnight strikes on a milestone birthday, we will become nothing but old—emptied of our passions, abilities and experience, infused instead with frailty and decline.

(Karpf, 2015)

Individuals aged 65 and older currently constitute 16.2% of the U.S. population. This group is growing, and is expected to constitute more than 20% of the population by 2030. During the past decade, the age - 85 - and - older group, the fastest - growing segment of the adult population, has increased by 38%. Because females live longer than males, at age 85 there are only 39 men for every 100 women (Ortman, Velkoff, & Hogan, 2014). Because of the "graying" of adults, definitions of "old" are changing. Most Baby Boomers define old as being age 70 or older, although 25% believe that a person is not old until they reach the age of 80 (Carroll, 2011).

We are an aging society, yet we are poorly prepared to handle our current aged population and are certainly not equipped for the aging Baby Boomer generation. Information is lacking on therapies and medications for older individuals. As a group, older adults are less likely to receive new treatments for heart attacks or other illnesses, and older women are less likely to receive radiation and chemotherapy after breast cancer surgery. This is surprising, since a healthy person who is 65 years of age has an average life expectance of 19.3 more years (20.5 years for women and 17.9 years for men) (DHHS, 2014).

CHARACTERISTICS AND STRENGTHS

In the following sections, we consider the characteristics and strengths of older adults and the associated treatment implications. Keep in mind that older adults constitute a diverse community with multifaceted ethnic backgrounds, cultural identifications, and religious practices. This overview, therefore, provides generalizations about a diverse group of people, and its applicability always needs to be assessed with regard to individual clients.

Physical and Economic Health

> *She calls it "being sidelined." Greta Hale, an 82 - year - old grandmother of five, looks forward to visiting her large family but often feels like an outsider when she does. On holidays, she often sits alone while younger generations buzz about, preparing meals, telling jokes, and engaging in lively debates. "My hearing is not so good anymore," she explains. Otherwise spry and healthy, Ms. Hale wants to participate but avoids doing so because, she admits, "I don't always understand what people are saying. I think maybe it's just easier for them to pretend I'm not there." She considers this one of the more difficult aspects of aging.*
>
> *(Wallhagen, Pettengill, & Whiteside, 2006, p. 40)*

Older adults often have physical impairments, such as hearing or vision loss or cardiovascular disease (McDonnall, 2011). About 30% of adults between the ages of 65 and 74 have some hearing impairment, and this increases to about half of those older than 75 (Wallhagen et al., 2006). Up to 25% of older adults have insomnia or difficulty falling asleep (Silvertsen et al., 2006). Ethnic minority older Americans tend to have more chronic, debilitating diseases, such as diabetes and heart disease (Costantino, Malgady, & Primavera, 2009).

The majority of older individuals, however, are quite healthy and are able to live independent lives requiring only minimal assistance. Only 3.3% of adults 65–74 years need help with personal care from other persons; this percentage increases to 10.5% for those 75 and older (CDC, 2015). In all age categories, women are more likely to need assistance than are men (U.S. Census Bureau, 2005). The percentage of adults requiring nursing home care is only 1% for those 65–74, 3% for those age 75–84, and 10% for those age 85 and older (DHHS, 2014).

Implications

When providing mental health services for older adults, counselors should consider the possibility that some will have physical limitations. To ensure that the counseling environment is appropriate for older clients, rooms should have adequate light and be free from extraneous noise, as well as any limiting environmental barriers. If the client uses eyeglasses or hearing aids, make sure these are present during the session. Because of the frequency of physical illness (e.g., cardiovascular disease, hypertension), it is critical to work with medical providers to rule out the possibility that physical conditions, medications, or medication interactions are causing or contributing to emotional symptoms. Also, poverty, unemployment, poor living conditions, discrimination, and lack of receptivity among health care providers can significantly contribute to mental health concerns among older adults and may need to be addressed.

Sexuality in Later Years

> *The topic of sexuality and the aging process is often given little consideration. Underlying this neglect is the belief that sexuality should not be considered in the aged.*

> *Stereotypes of older adults as being asexual are incorrect. Romantic relationships are common in later life. In Internet personal ads, older men seek physical attractiveness and younger women, while older women are more selective, seeking status and security.*
>
> *(Alterovitz & Mendelsohn, 2009)*

In our youth‐oriented society, older adults are not expected to be interested in sex. One psychology intern remarked, “You never think the same about your older clients [or your grandparents] after you have an 80‐year‐old woman telling you how much she enjoys oral sex” (Zeiss, 2001, p. 1). Some consider sexual activity among older persons to be rare or even inappropriate. However, sexual interest and activity continue well into the 80s and 90s for many individuals. Among people 70 and older, 80% of men and 39% of women indicated that a satisfying sexual relationship is an important part of the quality of life (Fisher, 2010). In a study of over 3,000 older people, 53% between the ages of 65 and 74 were sexually active, as were 26% between the ages of 75 and 85. In fact, a study found that while sexual frequency among married couples decreased over time, it began to increase again in those married for 50 years or more (Stroope, McFarland, & Uecker, 2015). Women reported significantly less sexual activity than men; in part, this was due to a reduced likelihood of having a spousal or intimate relationship, as well as sexual problems such as low desire, difficulty with vaginal lubrication, and inability to reach orgasm. The most prevalent sexual problem in older men was erectile dysfunction (Lindau et al., 2007).

Changes do occur in sexual functioning in both older men and older women. In men, erections occur more slowly and require continuous stimulation, although they can be maintained for longer periods without the need for ejaculation. The refractory period increases, so that it may take a day or two for the man to become sexually responsive again. Antihypertensive drugs, vascular diseases, and diabetes are common causes of impotence in men. For women, aging is associated with a decline in estrogen, resulting in decreases in vaginal lubrication. However, sexual responsiveness of the clitoris is similar to that of younger women. Sexual activities remain important for older men and women. Medical and psychological methods have been successful in treating sexual dysfunctions in older adults.

Age does not appear to be related to sexual satisfaction. In one survey involving 600 older women, most respondents voiced positive reactions to their sexual experiences, such as “Physical satisfaction is not the only aim of sex … It is the nearness of someone throughout the lonely nights” and “I believe sex is a wonderful outlet for love and physical health and worth trying to keep alive in advancing age … It makes one feel youthful and close to one's mate and pleased to ‘still work’” (Johnson, 1995, p. A23).

Implications

Emotional stressors (retirement, caregiving, and lifestyle changes) and physical changes can produce problems in sexual functioning. As with younger adults, therapists should remain aware of possible sexual concerns. The mental health professional should determine the reason for any difficulties, encouraging the client to consult with medical professionals when appropriate. Many treatments and medications are now available to improve sexual functioning in older adults. Knowledge of these advances is important for those counseling this population.

Strengths

> *“There's an intimacy that comes later that is staggeringly wonderful,” she said. “You can hold hands with this person you love and adore, and somehow it's just as passionate*

as having sex at an earlier age. There is such a sense of connection and intimacy that grows out of a long relationship, that touch carries with it the weight of so many memories."

(Hoffman, 2015)

The majority of older adults have good emotional stability and high levels of affective well‐being. Although they may have less control over their environment, many show flexibility in their ability to adjust to different situations. They also show greater facility in understanding and managing emotions than younger individuals (Scheibe & Carstensen, 2010). Most older adults are socially engaged and mentally alert. They also possess years of life and work experience. Interestingly, more than half of the individuals selected to serve as chief executive officers (CEOs) in Fortune 500 companies are over the age of 55 (Begley, 2010).

Many older adults, especially ethnic and minority group members, place a high value on religious beliefs, a factor contributing to a sense of hope and optimism, meaning and purpose in life, and better mental health (American Psychological Association, 2009). In recent studies, older adults who believed they were resilient—had the ability to deal with stressors—tended to display successful aging regardless of physical or cognitive impairments. The same was true with those who rated themselves low on depression. Despite physical health status, self‐ratings of successful aging were highly dependent on attitudinal qualities such as belief in one's ability to cope with challenges (Jeste et al., 2013). Similarly, in a 16‐year longitudinal study involving adults aged 70–100, most were satisfied with aging, felt younger than their chronological age, and downgraded the importance of age‐related changes. Only when they approached death did they become less satisfied with aging (Kotter‐Gruhn, Kleinspehn‐Ammerlahn, Gerstorf, & Smith, 2009).

SPECIFIC CHALLENGES

In the following sections, we discuss challenges often faced by older populations and consider their implications in treatment.

Prejudice and Discrimination

> *Old people are a pain in the [expletive deleted] as far as I'm concerned and they are a burden on society. I hate everything about them, from their hair nets in the rain to their white Velcro sneakers … they are senile, they complain about everything, they couldn't hear a dumptruck.*
>
> *(Levy et al., 2014, p. 173)*
>
> *[Those who meet the] "stereotype of being depressed, cranky, irritable and obsessed with their alimentary canal" constitute "no more than 10% of the older population … The other 90% of the population isn't like that at all," according to Paul Costa who has studied aging for over 30 years.*
>
> *(Tergesen, 2014)*

Older individuals are subject to negative stereotypes and discrimination (Alterovitz & Mendelsohn, 2009). *Ageism*, defined as negative attitudes toward the process of aging or toward older individuals, is common in our society and around the world (North & Fiske, 2015). Older people always experience ageism at the intersections of other identities, such as those associated with race, ethnicity, and gender, and the resulting manifestations of ageism often differ. Older women, for example, are likely to be viewed negatively by society as a whole, and many internalize ageist norms involving qualities such as beauty (Clarke, 2011). In a review of negative attitudes toward older individuals, Palmore (2005) found that older adults were thought to be inflexible in their thought processes; lacking in health, intelligence, and alertness; and either lacking in sexual interest or, if they were sexually active, engaging in activity inappropriate for their age. Older adults are also viewed as "all alike," possessing such characteristics as being rigid, sickly, dependent, and depressed (American Psychological Association, 2009). Jokes about old age abound and are primarily negative in nature. The entertainment industry, news broadcasts, and advertising media are dominated by younger individuals. Information about older people is often presented by youthful reporters who may not understand the experiences of older generations.

Implications

Ageism influences how both the general public and mental health professionals perceive older persons. Negative stereotypes often result in older adults feeling invisible or less valued. Many older individuals come to accept ageist views and suffer a loss of self‐esteem. In fact, many internalize negative societal beliefs. Unfortunately, mental health professionals also display age bias (Weiss, 2005), expressing reluctance to work with older adults, perceiving this population as having a poorer prognosis, and viewing older people as less interesting, more set in their ways, and less likely to benefit from therapy. Additionally, mental health problems in older adults may be inaccurately attributed to aging. Such beliefs can limit referrals for necessary services.

As always, therapists should be sensitive to intersectional considerations when working with older adults, and should comprehensively assess for potential problems with discrimination when working with those who have a disability, who come from a different ethnic or cultural group to the therapist's own, or who are members of a sexual minority. Counselors can help

clients grapple with factors associated with *ageism* and find different sources of social support. They can also actively work to change negative societal attitudes.

Mental Deterioration

> *Everyone knows that as we age, our minds and bodies decline—and life inevitably becomes less satisfying and enjoyable. Everyone knows that cognitive decline is inevitable. Everyone knows that as we get older, we become less productive at work.*
>
> *(Tergesen, 2014)*

A common view of older persons is that they are mentally incompetent. Although there is some cognitive slowing associated with normal aging (e.g., periodic minor memory difficulties, such as forgetting names or phone numbers or misplacing objects), the majority of older adults do not demonstrate significant mental decline. In fact, most are still mentally sharp and benefit from the store of knowledge they have acquired over a lifetime. Although they may show decrements on cognitive tests, their performance is much better in real‐life situations that incorporate their skills and prior experiences (Salthouse, 2012). Even when cognitive slowing occurs, older adults often use various strategies to compensate for deficits (Krendl, Heatherton, & Kensinger, 2009). Multitasking involving activities that compete for attention (e.g., talking on a cell phone while crossing the street) becomes more difficult for many older adults, although passive tasks are not affected (Neider et al., 2011). Similarly, memory for perceptual information, highly practiced responses, and general knowledge holds up well even when working memory is compromised (Craik, 2008).

Approximately one in seven adults aged 71 or older has *dementia* (i.e., memory impairment and declining cognitive functioning), including the 5.2 million in this age group diagnosed with *Alzheimer's disease*. *Alzheimer's disease* is now the fifth leading cause of death among American adults aged 65 and older; the risk of *Alzheimer's disease* and other *dementias* increases with age (Alzheimer's Association, 2014). Women usually live longer than men, so they are more likely to develop *dementia*; among 65‐year‐olds, the lifetime risk of developing *dementia* is approximately 11% for men and 19% for women (Gatz, 2007).

Implications

Older adults who report a cognitive decline should undergo assessment to determine if their difficulties are associated with normal aging or due to pathological factors. For those with a “normal” decline, reassurance and strategies to improve cognitive functioning can be useful (American Psychological Association, 2014). Research has found that cognitive decline in older adults can be delayed or reduced through lifestyle changes such as the use of cognitive activities to stimulate the mind (e.g., chess, crossword puzzles, computer games, reading), engaging in physical activity, and better nutrition. These lifestyle interventions appear to improve neuroplasticity, increase neuronal connections in the brain, and increase cognitive reserve (Williams & Kemper, 2010). Normal cognitive declines may be reversed with specific training. In one study, older adults with declines in inductive reasoning or spatial orientation were given a five‐hour training to improve these skills. Over two‐thirds improved with the training, and 40% reached the same performance level in these areas as they demonstrated 14 years previously. Such training may be useful for reversing specific types of cognitive declines (Schaie, Willis, & Caskie, 2004).

For older adults demonstrating significant cognitive decline and for those suspected of having a neurodegenerative condition such as *Alzheimer's disease*, the traditional mental status exam can provide some indication of problem areas. However, a more frequently used assessment

is the Mini‐Mental State Examination (MMSE). This test takes about 5–10 minutes to administer and has normative and validity data. It comprises 11 items that assess orientation, attention and calculation, recall, language, and visual motor integrity.

Early detection of cognitive decline allows for treatment and advanced planning involving legal matters or potential problems such as driving.

Other steps to take in evaluating cognitive changes include the following:

- Obtain a self‐report from the client about possible changes in memory or other areas of cognitive function.
- Obtain reports from family members and friends regarding the client's cognitive performance. Be especially alert to discrepancies.
- Take a careful history of the onset and progression of the cognitive changes.
- Coordinate with medical professionals who can assess for possible side effects of medication or other physical conditions that may cause cognitive decline.
- Assess for depression, since it can also result in dementia‐like performance or the overreporting of cognitive problems. Remember that depression and *dementia* often occur together.

Although *dementia* has a gradual progression, the effects of this condition can quickly affect both the client and family members. In the early stages, memory problems are often the primary concern. Delusions and hallucinations may develop as the *dementia* progresses. Family members may not understand that individuals with *dementia* do not always recall what they are told. They may become frustrated when the affected individual is forgetful or needs extra assistance following through with tasks. Some may believe the behavior is willful or may try to assume responsibility over all aspects of the older person's life, even when he or she can perform effectively in some areas.

Self‐identity and autonomy are important to older adults, including those with *dementia*. Adult children may infantilize or dominate a parent with a cognitive decline, assuming that their actions are in the best interest of the parent but failing to take the parent's own preferences or values into consideration. *Elderspeak*, such as “Are we ready for our bath?” or “You want to take your medicine now, don't you?” (Williams, Kemper, & Hummert, 2005, p. 15), is often used with exaggerated intonation and elevated pitch, along with terms such as “honey” or “good girl.” *Elderspeak* was found to be commonly used by one group of certified nursing assistants when working with older adults with cognitive dysfunctions, especially when other individuals were not around (Lombardi et al., 2014). Many older adults consider *elderspeak* to be demeaning, and even those with severe *dementia* may react negatively to its use by showing behavioral resistance (Williams, Herman, Gajewski, & Wilson, 2009).

Caregiving may be stressful and may increase conflict among family members. When working with families that care for a relative with *dementia*, mental health professionals should address the following:

1. The need for patience and understanding when working with individuals with *dementia*.
2. Potential stresses on family members and the need to enhance coping strategies, including self‐care.
3. Education about specific neurological difficulties and their effects on cognition and

behavior; available treatments; and strategies for dealing with agitation, wandering, and other safety issues.

4. The family dynamics as they relate to the caregiving situation, including the allocation of caregiving responsibilities.
5. Strategies for effective communication among family members, possibly including encouraging family members to avoid the use of *elderspeak*, oversimplification, and unnecessary repetition of requests.
6. Financial and legal matters, such as power - of - attorney provisions.

Elder Abuse and Neglect

> *She raises her hands to her snow - white hair in a gesture of frustrated bewilderment, then slowly lowers them to cover eyes filling with tears. The woman, in her 70s, is trying to explain how she wound up in a shelter that could well be where she spends the rest of her life … She says she was usually ordered to "go to bed," where she lay in a dark room, upset, unable to sleep. A family member "just yelled at me all the time. Screamed at me, cussed me out," the woman says. "I don't know what happened. She just got tired of me, I guess."*
>
> *(Sewell, 2013)*

Maltreatment of older adults, including neglect and emotional, financial, physical, and sexual abuse, is a significant public health concern. Many cases of abuse or neglect go undetected, especially among those who are most vulnerable (e.g., individuals with *dementia*, depression, or significant health concerns). Family circumstances most commonly associated with abuse and neglect include (a) previous traumatic experiences and a pattern of violence in the family, (b) stress (including marital stress) resulting from accommodating an older parent or relative in the family home, (c) financial burdens, (d) overcrowded quarters, and (e) low levels of social support (Acierno et al., 2010). It is also important to be alert for client self - neglect (e.g., unsafe driving, failure to eat or to take medications), another common concern that can have serious consequences (Mosqueda & Dong, 2011).

Implications

It is essential that counselors be familiar with best practice guidelines for treating older adults (American Psychological Association, 2014; Molinari, 2011) and the complex ethical and legal issues pertaining to defining and reporting *elder abuse and neglect*, including self - neglect (Zeranski & Halgin, 2011). Counselors may see signs of bruising or malnutrition in older clients or indications that they are suffering from emotional abuse. Assessment may be difficult, since the client may have feelings of shame or dependency on the caregiver (Horning, Wilkins, Dhanani, & Henriques, 2013). Several steps can be taken to reduce the prevalence of *elder abuse and neglect* (American Psychological Association, 2001). First, continued public education can bring the problem out in the open and increase awareness of the risk factors for abuse. Second, respite care (e.g., family members, friends, or hired workers helping with caregiving) can help reduce caregiver burnout. Third, increasing social contact and support for caregivers can help keep stress more manageable. It may also be possible to get assistance from religious or community organizations, as well as organizations focused on particular medical conditions.

Substance Abuse

> *“I wouldn't get up in the morning,” she said. “I realized I was using alcohol to raise my spirits. It raises your spirits for a little while, and then you become depressed … With people dying around you, you feel more lonely and isolated.”*
>
> *(Wren, 1998, p. 12)*

Alcohol abuse can begin after a loss. Genevieve May, a psychiatrist, started abusing alcohol after the death of her husband. Finding that this was not a solution, Dr. May entered the Betty Ford Center and was successfully treated at age 83. There has been a dramatic increase in substance abuse and the nonmedical use of prescription medications among older adults. It is estimated that 11% of older adults abuse alcohol or prescription drugs; some of the misuse of prescription drugs may involve misunderstanding of dosing instructions. Drugs that have abuse potential include the benzodiazepines, opiates, and muscle relaxants. What is especially problematic is that aging produces physiological changes that may increase the potency of drugs and of their interactions. Because of this, the National Institute of Alcohol Abuse and Alcoholism recommends that men 65 or older not have more than one drink daily, and a maximum of two drinks on any occasion. Lower limits are recommended for women (Bogunovic, 2012). The misuse of drugs can produce conditions resembling organic or mental health conditions.

Between 1992 and 2008, the proportion of substance abuse treatment admissions involving older Americans increased from 7.2 to 16.0% for heroin, from 2.9 to 11.4% for cocaine, from 0.7 to 3.5% for prescription medications, and from 0.6 to 2.9% for marijuana (Substance Abuse and Mental Health Services Administration, 2010). About 20% of seniors take pain medications several times per week; about 18% of these individuals abuse or become addicted to these drugs (Lowry, 2013).

Implications

Older adults rarely seek treatment for substance abuse problems because of shame and perhaps because they feel uncomfortable in programs that deal with “street” drugs, such as heroin and cocaine. Late‐onset alcohol and drug abuse problems seem to be related to stressors such as the death of a spouse, family member, or friend; retirement issues; family conflicts; physical health problems; or financial concerns. Many of these stressors are typical issues faced in later life. Early intervention to identify and provide support for these situations can reduce substance abuse risk. As compared to younger substance abusers, older patients respond better to more structured programs, more flexible rules concerning discharge, more comprehensive assessment, and greater outpatient mental health aftercare (Moos, Mertens, & Brennan, 1995). The U.S. Department of Health and Human Services (DHHS, 2005) has published a comprehensive treatment manual for use by counselors that contains an evidence‐based cognitive behavioral group treatment for substance abuse in older adults. It includes modifications to therapy that incorporates physiological, cognitive, and social changes that are characteristic of this population. The manual is helpful in providing specific interventions in either a group or an individual format.

Social Isolation, Depression, and Suicide

Depression and social isolation are common complaints among older adults. Although physical changes associated with aging (e.g., hearing or vision loss or cardiovascular disease) can sometimes lead to depression (McDonnall, 2011), depression is not a normal consequence of aging. Depression is more strongly associated with feelings of “being old” than with actual age or health status (Rosenfeld, 2004). The rate of depression increases with age for males, whereas in women it decreases after the age of 60. Stressful life changes, such

as the deaths of friends and relatives, increasing social isolation, or financial distress, can increase the risk of depression. Social isolation is related not only to depression but also to other mental health conditions and physical complaints; between 10 and 43% of older adults living in the community report experiencing social isolation (Nicholson, 2012).

Among older men, the highest rates of depression are for those who never married (20.6%) or who are separated or divorced (19.2%). The prevalence of depression among older women is highest among those who are separated or divorced (23.1%) or widowed (15.4%). For males and females with partners, depression is most common among those in stressful relationships (St. John & Montgomery, 2009). Depression needs to be identified and treated, since it is also seen as an independent risk factor for cardiovascular and cerebrovascular disease. Not only does late‐life depression significantly affect older adults' physical health, but it can also affect social connections and overall functioning, and increase the risk of suicide (Beyer, 2007).

Baby Boomers—those born in the 1950s and '60s—have shown a dramatic spike in suicides, especially among Whites, Native Americans, and Alaskan men. This increase may be the result of coming from a youth‐oriented and optimistic generation, and an associated inability to deal with signs of aging or perceived lack of achievement (Bahrampour, 2013). Suicide rates are exceptionally high among older men, with the risk increasing with advancing age; White males aged 85 or older have the second highest suicide rate of any group. It is unclear whether this group has less resilience and fewer coping strategies or whether the high suicide rate is because life changes associated with advanced age (e.g., loss of employment, physical changes, loss of control) are a greater stressor for men. Factors associated with suicide include being separated, divorced, or alone; suffering depression; having an anxiety disorder; having physical or medical problems; and dealing with family conflict or loss of a relationship (American Foundation for Suicide Prevention, 2015).

Implications

It is important to avoid assuming that depression is a normal consequence of aging (American Psychological Association, 2009). Interestingly, in a sample of 139 people over 100 years of age, most were in good spirits even though they scored higher for depression than individuals in their 60s (Scheetz, Martin, & Poon, 2012). However, in many cases, major depression tends to be unrecognized in older adults and is a significant predictor of suicide. It is therefore essential to assess for depression and suicidality when working with older adults. A popular instrument for screening for depression is the Geriatric Depression Scale, which was developed for older adults. It has age‐related norms and omits somatic symptoms that may be associated with physical problems rather than depression.

Because depression often co‐occurs with physical illnesses, such as cardiovascular disease, stroke, diabetes, and cancer, health providers often believe that the mood disturbance is a normal consequence of these problems, so they are less likely to refer for mental health treatment. Many older individuals who commit suicide have visited a primary care physician very close to the event (45% within 1 week, 73% within 1 month) (Juurlink, Herrmann, Szalai, Kopp, & Redelmeier, 2004). There is an urgent need to detect and adequately treat depression in order to reduce suicide among older individuals.

Because of the deleterious effects of social isolation on older adults, early assessment and intervention to prevent further isolation is important. Encouraging older adults to participate in senior centers or other social activities in their community may decrease social isolation (Nicholson, 2012). There is some evidence that the impact of loneliness and depression can be counteracted by helping older adults focus on positive emotions such as happiness,

optimism, and resilience; in other words, happiness has been found to “undo” or negate the negative effects of loneliness and depression in older adults (Newall, Chipperfield, Bailis, & Stewart, 2013).

A number of biological and psychological treatments are effective in treating depression in older adults. Approximately 80% of older adults with depression show improvement when they are given appropriate treatment. Antidepressants such as certain selective serotonin reuptake inhibitors (SSRIs) have comparatively few side effects and are more likely to be continued—an important consideration, since rates of noncompliance with medication are high among older adults (Cooper et al., 2005). Meta‐analyses of evidence‐based therapies, such as cognitive behavioral therapy (CBT), dialectical behavior therapy, and interpersonal therapy, indicate that these therapies are effective in reducing depression and dealing with issues such as loss, transition, and cognitive decline in older individuals (Chand & Grossberg, 2013). Interpersonal therapy has been demonstrated to reduce suicidal ideation (Heisel, Duberstein, Talbot, King, & Tu, 2009).

IMPLICATIONS FOR CLINICAL PRACTICE

Many older adults develop meaningful support systems in the community and have positive contact with family members. Social contacts are important, and engaging in either paid or volunteer work can enhance the self‐esteem and life satisfaction of older individuals (Acquino, Russell, Cutrona, & Altmaier, 1996). Issues that older adults face may include retirement and other changing roles; loss and illness of loved ones; more limited financial resources; caretaking responsibilities; social isolation; health and physical problems, including sensory impairment; and cultural devaluation of their group by society (Corna, Wade, Streiner, & Cairney, 2009).

A number of therapy approaches, such as helping clients improve coping skills and teaching them strategies to resolve interpersonal difficulties, can reduce depression in older adults (Reynolds et al., 2014). CBT and interpersonal therapy are evidence‐based therapies that can help older adults deal with issues of grief, role transition, interpersonal conflict, and social skills deficit (Van Orden, Talbot, & King, 2012; Wyman‐Chick, 2013). Reducing loneliness or social isolation by increasing social opportunities and developing positive emotions can be effective in improving the mental and physical life of older adults. Finally, interventions that affirm older adults' ethnic and cultural connections may enhance resilience and well‐being (e.g., Chavez‐Korell, Benson‐Flórez, Delgado‐Rendón, & Farías, 2014).

Counseling can also significantly improve the quality of life for adults nearing their time of death, or help them resolve late‐life issues. The American Counseling Association includes end‐of‐life care provisions (quality of care, counselor competence, and confidentiality) in its ethics code, and should be consulted when working with terminally ill clients and their loved ones (Werth & Crow, 2009).

Following are some suggestions for offering mental health services to older adults (American Psychological Association, 2014; Blando, 2014; Knight & McCallum, 1998; Pennington, 2004):

1. Acquire specific knowledge and skills in counseling older adults, and critically evaluate your own attitudes and beliefs regarding aging and older adults.
2. Remain knowledgeable about legal and ethical issues that arise when working with older

adults (e.g., competency issues).

3. Determine the reason for evaluation and the social factors affecting the problem, such as recent losses, financial stressors, and family issues.
4. Show older adults respect, and give them as much autonomy as possible, regardless of mental status or the issues involved. When communicating with older adults:
    - Give full attention to the individual.
    - Talk to, rather than about, the person.
    - Use respectful language (not *elderspeak*).
    - Treat the person as an adult.
    - Take the individual's concerns seriously.
5. Determine the older adult's view of the problem, belief system, stage - of - life issues, educational background, and social and ethnic influences.
6. Assist in interpreting the impact of cultural issues, such as ethnic group membership, gender, and sexual orientation, on the client's life and presenting problems.
7. Presume competence in older adult clients unless the contrary is obvious.
8. If necessary, reduce the pace of therapy to accommodate cognitive slowing.
9. Involve older adults in decisions as much as possible. If there are cognitive limitations, it may be necessary to use legally recognized individuals to assist with decision - making.
10. Use multiple assessments, and include relevant sources (client, family members, significant others, and health care providers).
11. Determine the roles of family caregivers, educate them about emotional or neurocognitive disorders, and help them develop strategies to reduce burnout.
12. When working with an older couple, help negotiate issues around time spent alone and together (especially after retirement). Arguments over recreation are common. There is often too much “couple time” and no “legitimate” reason for separateness.
13. Recognize that it is important to help individuals who are alone establish support systems in the community.
14. Help older adults develop a sense of fulfillment in life by discussing the positive aspects of their experiences. Success can be defined as having done one's best or having met and survived challenges. A life review is often helpful.
15. Infections and medication side effects can be particularly troublesome for older adults. A physical evaluation may be needed to determine whether mental symptoms have physical causes.
16. Help adults very close to the end of their lives deal with their attachment to cherished objects by having them decide how heirlooms, keepsakes, and photo albums will be distributed and cared for.

SUMMARY

We are an aging society, and the older population has increased dramatically as the Baby Boomers have retired and the average life span has increased. Yet, we are poorly prepared to handle our current aged population, and information is lacking on therapies and medications for older individuals. Physical changes and economic concerns become increasingly important stressors in the life of this population. Counselors must become knowledgeable about how aging affects cognitive functioning, sexuality, and social isolation as friends and relatives pass away. Among older adults, special challenges present themselves: *elder abuse and neglect*, substance abuse, depression, and suicide. One of the greatest challenges facing this population is prejudice and discrimination directed at the elderly. Older individuals are subjected to *ageism*, defined as negative attitudes toward the process of aging or toward older individuals. Not only is less value placed on their lives, but they are often seen as a burden to society. Sixteen clinical implications for counselor practice are identified.

GLOSSARY TERMS

- Ageism
- Alzheimer's disease
- Dementia
- Elder abuse and neglect
- Elderspeak
- Multiple discrimination

REFERENCES

1. Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. R., Steve, K., Muzzy, W., & Kilpatrick, D. G. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment study. *American Journal of Public Health*, *100*, 292–297.

2. Acquino, J. A., Russell, D. W., Cutrona, C. E., & Altmaier, E. M. (1996). Employment status, social support, and life satisfaction among the elderly. *Journal of Counseling Psychology*, *43*, 480–489.

3. Alterovitz, S. S. ‐ R., & Mendelsohn, G. A. (2009). Partner preferences across the life span: Online dating by older adults. *Psychology and Aging*, *24*, 513–517.

4. Alzheimer's Association (2014). 2014 Alzheimer's disease facts and figures. *Alzheimer's & Dementia*, *10*, 1–75.

5. American Foundation for Suicide Prevention. (2015). Suicide statistics. Retrieved from https://www.afsp.org/understanding ‐ suicide/facts ‐ and ‐ figures

6. American Psychological Association (2001). *Elder abuse and neglect: In search of solutions*. Washington, DC: American Psychological Association.

7. American Psychological Association (2009). *Multicultural competency in geropsychology*. Washington, DC: American Psychological Association.

8. American Psychological Association (2014). Guidelines for psychological practice with older adults. *American Psychologist*, *9*, 34–65.

9. Bahrampour, T. (2013). Baby boomers are killing themselves at an alarming rate, raising question: Why? *Washington Post*, June 3.

10. Begley, S. (2010). The science of aging brains. Retrieved from https://www.newsweek.com/science ‐ aging ‐ brains ‐ 73219

11. Beyer, J. L. (2007). Managing depression in geriatric populations. *Annals of Clinical Psychiatry*, *19*, 221–238.

12. Blando, J. (2014). *Counseling older adults*. London: Routledge.

13. Bogunovic, O. (2012). Substance abuse in aging and elderly adults. Retrieved from http://www.psychiatrictimes.com/geriatric ‐ psychiatry/substance ‐ abuse ‐ aging ‐ and ‐ elderly ‐ adults

14. Carroll, L. (2011). Elderly ignore heat warnings—because they are not old. Retrieved from http://www.nbcnews.com/id/43761917/ns/health ‐ aging/t/elderly ‐ ignore ‐ heat ‐ warnings ‐ because ‐ theyre ‐ not ‐ old/

15. Centers for Disease Control and Prevention (CDC). (2015). Disability and dysfunction (noninstitutionalized adults aged 18 and over). Retrieved from http://www.cdc.gov/nchs/fastats/disability.htm

16. Chand, S. P., & Grossberg, G. T. (2013). How to adapt cognitive ‐ behavioral therapy for older adults. Retrieved from http://www.currentpsychiatry.com/home/article/how ‐ to ‐ adapt ‐ cognitive ‐

behavioral - therapy - for - older - adults/99ca3dc03cddedc62b20b672dcc4e56c.html

17. Chavez - Korell, S., Benson - Flórez, G., Delgado - Rendón, A., & Farías, R. (2014). Examining the relationships between physical functioning, ethnic identity, acculturation, familismo, and depressive symptoms for Latino older adults. *The Counseling Psychologist*, *42*, 255–277.

18. Clarke, L. H. (2011). *Facing age: Women growing older in anti - aging culture*. Toronto, ON: Rowman & Littlefield.

19. Cooper, C., Carpenter, I., Katona, C., Scholl, M., Wagner, C., Fialova, D., & Livingston, G. (2005). The Ad - HOC study of older adults' adherence to medication in 11 countries. *American Journal of Geriatric Psychiatry*, *13*, 1067–1076.

20. Corna, L. M., Wade, T. J., Streiner, D. L., & Cairney, J. (2009). Transitions in hearing impairment and psychological distress in older adults. *Canadian Journal of Psychiatry*, *54*, 518–525.

21. Costantino, G., Malgady, R. G., & Primavera, L. H. (2009). Congruence between culturally competent treatment and cultural needs of older Latinos. *Journal of Consulting and Clinical Psychology*, *77*, 941–949.

22. Craik, F. I. M. (2008). Memory changes in normal and pathological aging. *Canadian Journal of Psychiatry*, *53*, 343–345.

23. Fisher, L. L. (2010). *Sex, romance, and relationships: 2009 AARP survey of midlife and older adults*. Washington, DC: AARP.

24. Gatz, M. (2007). Genetics, dementia, and the elderly. *Current Directions in Psychological Science*, *16*, 123–127.

25. Heisel, M. J., Duberstein, P. R., Talbot, N. L., King, D. A., & Tu, X. M. (2009). Adapting interpersonal psychotherapy for older adults at risk for suicide: Preliminary findings. *Professional Psychology: Research and Practice*, *40*, 156–164.

26. Hoffman, J. (2015). Married sex gets better in the golden years. Retrieved from http://well.blogs.nytimes.com/2015/02/23/married - sex - gets - better - in - the - golden - years

27. Horning, S. M., Wilkins, S. S., Dhanani, S., & Henriques, D. (2013). A case of elder abuse and undue influence: Assessment and treatment from a geriatric interdisciplinary team. *Clinical Case Studies*, *12*, 373–387.

28. Jeste, D. V., Savla, G. N., Thompson, W. K., Vahia, I. V., Glorioso, D. K., Martin, A. S., … Depp, C. A. (2013). Association between older age and more successful aging: critical role of resilience and depression. *American Journal of Psychiatry*, *170*, 188–196.

29. Johnson, B. (1995). Elderly women need not abandon sexuality. *Seattle Post - Intelligencer*.

30. Juurlink, D. N., Herrmann, N., Szalai, J. P., Kopp, A., & Redelmeier, D. A. (2004). Medical illness and the risk of suicide in the elderly. *Archives of Internal Medicine*, *164*, 1179–1184.

31. Karpf, A. (2015). The liberation of growing old. *New York Times*, January 3.

32. Knight, B. G., & McCallum, T. J. (1998). Adapting psychotherapeutic practice for older clients: Implications of the contextual, cohort‐based, maturity, specific challenge model. *Professional Psychology: Research and Practice*, *29*, 15–22.

33. Kotter‐Gruhn, D., Kleinspehn‐Ammerlahn, A., Gerstorf, D., & Smith, J. (2009). Self‐perceptions of aging predict mortality and change with approaching death: Results from the Berlin aging study. *Psychology and Aging*, *24*, 654–667.

34. Krendl, A. C., Heatherton, T. F., & Kensinger, E. A. (2009). Aging minds and twisting attitudes: An fMRI investigation of age differences in inhibiting prejudice. *Psychology and Aging*, *24*, 530–541.

35. Levy, B. R., Chung, P. H., Bedford, T., & Navrazhina, K. (2014). Facebook as a site for negative age stereotypes. *Gerontologist*, *54*, 172–176.

36. Lindau, S. T., Schumm, L. P., Laumann, E. O., Levinson, W., O'Muircheartaigh, C. A., & Waite, L. J. (2007). A study of sexuality and health among older adults in the United States. *New England Journal of Medicine*, *357*, 762–774.

37. Lombardi, N. J., Buchanan, J. A., Afierbach, S., Campana, K., Sattler, A., & Lai, D. (2014). Is elderspeak appropriate? A survey of certified nursing assistants. *Journal of Gerontological Nursing*, *40*, 44–52.

38. Lowry, F. (2013). Opioid abuse in the elderly an urgent concern. Retrieved from http://www.medscape.com/viewarticle/776128

39. McDonnall, M. C. (2011). Physical status as a moderator of depressive symptoms among older adults with dual sensory loss. *Rehabilitation Psychology*, *56*, 67–76.

40. Molinari, V. (Ed.) (2011). *Specialty competencies in geropsychology*. New York, NY: Oxford University Press.

41. Moos, R. H., Mertens, J. R., & Brennan, P. L. (1995). Program characteristics and readmission among older substance abuse patients: Comparisons with middle‐aged and younger patients. *Journal of Mental Health Administration*, *22*, 332–346.

42. Mosqueda, L., & Dong, X. (2011). Elder abuse and self‐neglect: “I don't care anything about going to the doctor, to be honest…”. *Journal of the American Medical Association*, *306*, 532–540.

43. Neider, M. B., Gaspar, J. G., McCarley, J. S., Crowell, J. A., Kaczmarski, H., & Kramer, A. F. (2011). Walking and talking: Dual‐task effects on street crossing behavior in older adults. *Psychology and Aging*, *26*, 260–268.

44. Newall, N. E., Chipperfield, J. G., Bailis, D. S., & Stewart, T. L. (2013). Consequences of loneliness on physical activity and mortality in older adults and the power of positive emotions. *Health Psychology*, *32*, 921–924.

45. Nicholson, N. R. (2012). A review of social isolation: An important but underassessed condition in older adults. *Journal of Primary Prevention*, *33*, 137–152.

46. North, M. S., & Fiske, S. T. (2015). Modern attitudes toward older adults in the aging world: A cross‐cultural meta‐analysis. *Psychological bulletin*, *141*(5), 993.

47. Ortman, J. M., Velkoff, V. A., & Hogan, H. (2014). *An aging nation: The older population in the United States*, *current population reports*, *P25–1140*. Washington,

DC: U.S. Census Bureau.

48. Palmore, E. (2005). Three decades of research on ageism. *Generations, 29*, 87–90.

49. Pennington, D. (2004). Until the “sunset”: Helping persons who are older and their caregivers to cope with Alzheimer's, other forms of dementia. *Counseling Today, July*, 22–23.

50. Reynolds, C. F. III, Thomas, S. B., Morse, J. Q., Anderson, S. J., Albert, S., Dew, M. A., … Quinn, S. C. (2014). Early intervention to preempt major depression among older Black and White adults. *Psychiatric Services*, *65*, 765–773.

51. Rosenfeld, B. (2004). *Assisted suicide and the right to die*. New York, NY: Guilford Press.

52. Salthouse, T. (2012). Consequences of age‐related cognitive declines. *Annual Review of Psychology*, *63*, 201–226.

53. Schaie, K., Willis, S., & Caskie, G. (2004). The Seattle longitudinal study: Relationship between personality and cognition. *Neuropsychology of Cognition*, *11*, 304–324.

54. Scheetz, L. T., Martin, P., & Poon, L. W. (2012). Do centenarians have higher levels of depression? Findings from the Georgia Centenarian Study. *Journal of the American Geriatrics Society*, *60*, 238–242.

55. Scheibe, S., & Carstensen, L. L. (2010). Emotional aging: Recent findings and future trends. *Journal of Gerontology: Psychological Sciences*, *65*, 135–144.

56. Sewell, D. (2013). Aging America: Elder abuse on the rise. Retrieved from http://vitals.nbcnews.com/_news/2013/01/27/16725913‐aging‐america‐elder‐abuse‐on‐the‐rise?lite

57. Silvertsen, B., Omvik, S., Pallesen, S., Bjorvatn, B., Havik, O. E., & Nordhus, I. H. (2006). Cognitive behavioral therapy vs Zopiclone for treatment of chronic primary insomnia in older adults. *JAMA*, *295*, 2851–2858.

58. Smith, L., Shenk, M., Tran, C., Poon, D., Wahba, R., & Voegtli, K. (2017). “There's not a rug big enough to hide us under”: Participatory action research as anti‐ageist psychological practice. *Professional Psychology: Research and Practice*, *48*(6), 412–420.

59. St. John, P. D., & Montgomery, P. R. (2009). Marital status, partner satisfaction, and depressive symptoms in older men and women. *Canadian Journal of Psychiatry*, *54*, 487–492.

60. Stroope, S., McFarland, M. J., & Uecker, J. E. (2015). Marital characteristics and the sexual relationships of U.S. older adults: An analysis of national social life, health, and aging project data. *Archives of Sexual Behavior*, *44*, 233–247.

61. Substance Abuse and Mental Health Services Administration. (2010). New admissions data show sharp increase in the proportion of older Americans being treated for illicit substances such as cocaine, heroin and marijuana. Retrieved from http://www.samhsa.gov/newsroom/press‐announcements/201006161100

62. Tergesen, A. (2014). Why everything you think about aging may be wrong. *Wall Street Journal*, November 30.

63. U.S. Census Bureau (2005). *65+ in the United States: 2005*. Washington, DC: U.S. Government Printing Office.

64. U.S. Department of Health and Human Services (DHHS) (2005). *Substance abuse relapse prevention for older adults: A group treatment approach*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

65. U.S. Department of Health and Human Services (DHHS). (2014). A profile of older Americans: 2014. Retrieved from https://www.acl.gov/aging - and - disability - in - america/data - and - research/profile - older - americans

66. Van Orden, K. A., Talbot, N., & King, D. (2012). Using the interpersonal theory of suicide to inform interpersonal psychotherapy with a suicidal older adult. *Clinical Case Studies*, *11*, 333–347.

67. Wallhagen, M. I., Pettengill, E., & Whiteside, M. (2006). Sensory impairment in older adults, Part 1: Hearing loss. *American Journal of Nursing*, *106*, 40–48.

68. Weiss, I. (2005). Interest in working with the elderly: A cross - national study of graduating social work students. *Journal of Social Work Education*, *41*, 379–391.

69. Werth, J. L. Jr., & Crow, L. (2009). End - of - life care: An overview for professional counselors. *Journal of Counseling and Development*, *87*, 194–201.

70. Williams, K. N., & Kemper, S. (2010). Interventions to reduce cognitive decline in aging. *Journal of Psychosocial Nursing and Mental Health Services*, *48*, 42–51.

71. Williams, K., Kemper, S., & Hummert, M. L. (2005). Enhancing communication with older adults: Overcoming elderspeak. *Journal of Psychosocial Nursing and Mental Health Services*, *43*, 12–16.

72. Williams, K. N., Herman, R., Gajewski, B., & Wilson, K. (2009). Elderspeak communication: Impact on dementia care. *American Journal of Alzheimer's Disease and Other Dementias*, *24*, 11–20.

73. Wren, C. S. (1998). Many women 60 and older abuse alcohol and prescribed drugs, study says. *New York Times*, June 5

74. Wyman - Chick, K. A. (2013). Combining cognitive - behavioral therapy and interpersonal therapy for geriatric depression with complicated grief. *Clinical Case Studies*, *11*, 361–375.

75. Zeiss, A. M. (2001). *Aging and human sexuality resource guide*. Washington, DC: American Psychological Association.

76. Zeranski, L., & Halgin, R. P. (2011). Ethical issues in elder abuse reporting: A professional psychologist's guide. *Professional Psychology: Research and Practice*, *42*, 294–300.

25
Counseling Individuals Living in Poverty

Chapter Objectives

1. **1. Learn the demographics associated with *poverty*.**
2. **2. Identify counseling implications of the information provided regarding impoverished clients.**
3. **3. Recognize strengths associated with experiences involving *poverty*.**
4. **4. Know the special challenges faced by impoverished clients.**
5. **5. Understand best practices for working with impoverished clients.**

> *We're people with lives and things in our lives that are affecting our health … Talking about our mental health is not the same as someone who feels down sometimes. If you don't have a roof over your head, if you don't have your electric bill paid, then how are you going to take care of your mental health? There is not a traditional mental health strategy that gets at that.*
>
> *(Participant in the Reaching Out About Depression [ROAD] project, Goodman et al., 2007, p. 286)*

> *At least 12 states have passed legislation requiring drug testing for certain people receiving public assistance such as food stamps, public health care, and unemployment benefits. This reinforces the view that the poor do not want jobs and as one legislator argued "It reinforces the stigma that people who are in need, who are poor, are drug users."*
>
> *(Laine, 2015)*

> *[W]hen the therapist and client come from different class backgrounds, they do not always view situations, family relationships, nor solutions from the same viewpoint … I did not find that these therapists were particularly unsympathetic or knowingly unkind. What I did find was that the therapists … were unaware of their own class values.*
>
> *(Chalifoux, 1996, p. 32)*

Poverty does not constitute a cultural designation in the true sense of the word, yet the challenges and landmarks of life in *poverty* diverge enough from mainstream life to warrant consideration by counseling professionals. The following sections offer an overview of the circumstances facing individuals living in *poverty* and consider their implications in treatment. Keep in mind that people living in *poverty* constitute a diverse community with multifaceted racial‐ethnic backgrounds, cultural identifications, and religious practices. This overview, therefore, provides generalizations about a diverse group of people, and its applicability always needs to be assessed with regard to individual clients.

For counselors who come from middle‐class (and more affluent) backgrounds, it will be important to learn about the everyday realities experienced by those living in *poverty*. Even more crucial, however, is learning about the class‐related biases, attitudes, assumptions, and procedures that are often embedded in the worldviews of people who hold *social class privilege*, and the ways that these assumptions are manifested within psychological theory, research, and practice. Without an awareness of the social, cultural, and interpersonal discrimination that accompanies *poverty*, counselors may be unable to work effectively with low‐income clients—and may even unintentionally contribute to their oppression.

These factors will be presented within the context of *social class stratification theory* (e.g., Beeghley, 2008). Many of us are not well acquainted with *social class* theory; we are much more familiar with numerical calculations like socioeconomic status, and often think of

poverty only in terms of inadequate financial resources. Financial resources are indeed critical to understanding life in *poverty*. A *social class* framework, however, positions *poverty* as more than a lack of purchasing power. Rather, *poverty* involves being on the bottom - most rung in a hierarchical system of sociocultural power relations that goes beyond differences in income. Within this hierarchy, *social class* oppression is called *classism* (Lott & Bullock, 2007), and it operates to limit access to many kinds of socially valued assets. As will be described later, these assets include the availability of essential services and resources (e.g., education and health care), entrée to mainstream opportunities and experiences, cultural inclusion/exclusion, and representation within our nation's system of participatory democracy (Smith, 2010).

CHARACTERISTICS AND STRENGTHS

The U.S. Census Bureau estimated that the U.S. *poverty* rate was 12.7% in 2016, down from 13.5% in 2015 (Semega, Fontenot, & Kollar, 2017). The following trends and data illustrate provide a demographic snapshot of U.S. *poverty* today:

- In 2016, adults with no children were considered to be living in *poverty* if they had $12,486 or less in annual income. An adult with a child fell below the *poverty* threshold if he or she had less than $16,543 in income per year (Semega et al., 2017).
- An overall decrease in *poverty* characterized most demographic groups. The only group to experience an increase in its *poverty* rate was adults aged 65 and older (Semega et al., 2017).
- The *poverty* rate for Whites in 2016 was 11.0%, for African Americans it was twice that at 22.0%, for Latinx people it was 19.4%, and for Asians it was 10.1% (Semega et al., 2017). The highest U.S. *poverty* rates are found among American Indians, at 26.2% (U.S. Census Bureau, 2017).
- Children (at a *poverty* rate of 18.0%) continue to be the age group most likely to live in *poverty* (Semega et al., 2017), and the U.S. child *poverty* rate is one of the highest in the developed world (UNICEF, 2012).
- Women are more likely to live in *poverty* than men. In 2016, 11.3% of males and 14.0% of females were impoverished (Semega et al., 2017).
- Globally, one of the distinguishing features of American *poverty* is that it takes place in the wealthiest nation in the world. The United States continues to have one of the world's most unequal income distributions. As measured by the Gini coefficient—a statistic that reflects the disparity between the lowest and highest income levels in a nation—and after adjusting for taxes, the United States has the highest level of disposable ‐ income inequality among wealthy developed countries (Fisher & Smeedling, 2016). This inequality has grown steadily over recent decades: in the 1970s, the share of total income earned by the top 1% of families was less than 10%, but by the end of 2012, it exceeded 20% (Saez & Zucman, 2014).
- Similarly, the continuing escalation of wealth inequity in the United States is dramatic. The top 0.1% of American families—a group comprising 160,000 families—by itself owned 22% of all U.S. wealth in 2012, up from 7% in the late 1970s (Saez & Zucman, 2014).

These statements use the word *poverty* with reference to specific numerical criteria such as the federal *poverty* threshold. Different branches of the U.S. government compute such designations slightly differently, yet such calculations always underestimate the number of families who are struggling economically. For example, according to the *poverty* threshold given here, an adult with a child who is attempting to live on $16,544 per year would *not* be counted among the poor. These statements also illustrate a significant characteristic of the American *social class* structure: positions of lower socioeconomic power and access—that is, life in *poverty*—intersect meaningfully with marginalization along other dimensions of identity, such as race and gender.

Strengths

Presenting the strengths of people living in *poverty* is a somewhat self‐contradictory undertaking. On the one hand, the question may seem to suggest that poor people are somehow inherently different from the rest of us. However, research evidence supports the opposite contention. Certainly, an individual *can* suffer a financial downturn for a variety of personal reasons. Nevertheless, the fact that particular cultural groups are consistently overrepresented among the poor supports the notion that *poverty* generally derives from people's historical and sociopolitical contexts rather than from individual deficits (e.g., Belle, 1990; Carmon, 1985; Costello, Compton, Keeler, & Angold, 2003). Similarly, the elevated levels of stress, deprivation, and physical wear‐and‐tear that are characteristically detected among poor people would theoretically be expected to affect almost anyone who found themselves constrained to survive life in *poverty*.

On the other hand, when people *do* survive *poverty*, they demonstrate strengths that are not part of the stereotypical image that many people have of the poor. For example, Banyard (2008) wrote of the patience, persistence, and determination of homeless women as they struggled to make decent lives for their children—women who have often been stereotyped with the classist, racist label *welfare queen*. The words of these homeless mothers illustrate Banyard's characterization of them as not only surviving, but tenaciously creating survival strategies, solving problems, and maintaining hope as they prioritize their children and their roles as mothers.

> *[Y]ou have an allotted time to get out of the [shelter]. That's stressful, knowing that the clock's ticking … You've worked all your life, and then you're stuck on welfare, and then your children ask for things.*
>
> *(p. 1)*
>
> *We just, we think of it again, and think of another route. You know, like taking another street. You know, it's not like you'll hit a highway … but it won't be a dead end street.*
>
> *(p. 2)*
>
> *You know, it's like I run this race, I fall down. I'm not just going to lay there. Even if I lose, I'm going to get up and still try to make it to the finish line.*
>
> *(p. 2)*

Obviously, most of us would wish for a world in which mothers, fathers, and children did not have to demonstrate their ability to survive homelessness. However, it is important to take stock of the strengths that people in *poverty* demonstrate, as Banyard (2008) explained.

> *If we assume that women in poverty are lazy and unmotivated (common stereotypes), we are likely to design policies that focus exclusively on giving them, as individuals, penalties for not finding a job. If we, on the other hand, assume that many women possess the desire to make a better life for themselves and their families, and listen to their stories of how hard it is to feed and house a family on minimum wage or to find affordable childcare, then we design policies which encourage work by supporting a living wage and educational opportunities for low‐income workers and increasing accessible, affordable childcare for their children.*
>
> *(p. 2)*

Most of us can readily recognize how a scarcity of the essential resources and services that support life—healthy food, safe communities, good schools, adequate health care, a roof over one's head—may lead in obvious ways to discomfort, distress, and crisis for poor families. What may not be as obvious is the additional stress that results from institutional and cultural *classism*. As is the case with other forms of oppression, classist attitudes often exist at an

unconscious level within the worldviews of well‐intentioned individuals, and may be unintentionally perpetuated by counselors who are unaware of the implications of their actions. Moreover, classism is always experienced at intersections with racial, ethnic, and gender‐related identities, which means that poor people often experience classism in concert with other forms of bias. It is worth mentioning that the operations of intersectionality in the lives of people in *poverty* has not received extensive attention from counseling researchers; a recent study found *poverty* to be the least studied social identity within intersectional research (Shin et al., 2017). Understanding *classism*, therefore, is an essential component of multiculturally competent practice. The following sections profile some examples of classist discrimination.

SPECIFIC CHALLENGES

In this section, we consider the challenges faced by those living in *poverty*, such as their invisibility, educational inequity, disparities in the judicial system, and health care inequities.

The Cultural Invisibility and Social Exclusion of the Poor

The American author and poet Dorothy Allison (1994), who was raised in *poverty*, observed, “My family's life was not on television, not in books, not even in comic books” (p. 17), a perception that has subsequently been borne out by the social psychological literature. Bullock, Wyche, and Williams (2001) found that poor people rarely appear within televised media representations, and when they do, they are often portrayed as lazy, promiscuous, dysfunctional, and/or drug‐addicted. Similarly, the experiences of working‐class people are largely without representation in popular culture, and there are few poor or working‐class voices in the national discourse on public policy issues. When they are included, usually with regard to specific topics such as organized labor, they are often presented in a negative light.

Increasingly, the poor are being physically as well as metaphorically excluded from mainstream cultural life. A report entitled “Homes Not Handcuffs” documented the rise in civic ordinances that restrict the sharing of food, make it illegal to sit or sleep in public spaces, and drive homeless people away from public areas, often resulting in the loss of their personal documents, medications, and other property (National Law Center on Homelessness and Poverty and National Coalition for the Homeless, 2009). Ehrenreich (2009) called this trend “the criminalization of poverty” (p. 2).

Educational Inequities

> *In 2013, 51% of public school students were considered low income (qualifying for free or reduced fee meals) as compared to 38% in 2000. As one educator warned “Without improving the educational support that the nation provides its low income students—students with the largest needs and usually with the least support—the trends of the last decade will be prologue for a nation not at risk, but a nation in decline.”*
>
> *(Southern Education Foundation, 2015, p. 4)*

Although education is often promoted as a pathway out of *poverty*, American educational disparities are such that the families with the greatest need are often relegated to the least adequate educational resources. Further, children in *poverty* often do not have proper nutrition, health insurance coverage, or necessary educational supplies.

The test score gap between affluent students and those from lower income families has increased by 40% since the 1960s; 22% of those from lower income families do not graduate from high school, as compared to 6% of those from higher income families (Annie E. Casey Foundation, 2012). Jonathan Kozol (2006) has chronicled the interface of class, race, and schooling in the United States in books like *The Shame of the Nation*, finding that children who attend public schools in poor communities are more likely to be taught by poorly paid, uncertified teachers, and to have fewer computers, fewer library books, fewer classes, fewer extracurricular opportunities, and fewer teachers as compared with wealthier students.

According to “Losing Ground,” a report by the National Center for Public Policy and Higher Education (2002), the relatively small number of students from low‐income families who make it to college campuses will find that the costs of a college education have escalated at a

rate higher than both inflation and family income. As a result, the graduation rates of low‐income students are reduced, while students from middle‐class and wealthy families continue to attend college in record numbers.

Up to 40% of low‐income students who indicate that they will attend college fail to show up in the fall. This phenomenon is called “summer melt.” Because they often lack role models among family members and friends, these students are unfamiliar with the process of completing paperwork for admission, financial assistance, housing, and class registration. This is especially problematic when counselors are not available in the summer. Even after financial packages receive preliminary approval, there is a need for documentation regarding income and other resources. Unless assistance is available to help applicants respond to these requests, prospective students may become confused and give up.

Implications

Low‐income students need assistance in navigating the application process for college admittance and follow‐up support to ensure that enrollment proceeds successfully. Bridge programs that facilitate the move from high school to college have been effective in reducing summer melt attritions (Castleman & Page, 2014; Frey, 2014). Counselors play an important role in assuring successful entry into college. In one case, the manager of a college housing complex contacted a female student to inform her that she needed to immediately send in $1,700 to cover her deposit and rent. Her mother contacted a transition counselor, who was able to intervene until state financial assistance became available. Practical assistance such as this is often necessary to help low‐income students navigate the complexities of the educational system (Frey, 2014).

Poverty and Mental Illness

> *Living in poverty for any significant length of time increases all sorts of risk factors for health and mental health problems. You are more stressed, worrying about money constantly, and how you're going to pay the bills or have enough money to eat … If you can still afford to live on your own, you will likely do so in a neighborhood more prone to violence, exposing you to more trauma and risk for personal violence.*
>
> *(Grohol, 2011)*

Poverty is related to and often precedes the development of emotional problems such as anxiety and depression (Hudson, 2005); it produces conditions conducive to the development of mental health issues. Individuals who live in *poverty* face a number of stressors, such as economic worries, discrimination, family conflict, inadequate housing, and frequent moves—all of which may result in psychiatric symptoms, including heightened physiological reactions to even minor anxiety‐inducing events (Wadsworth & Achenbach, 2005; Wadsworth & Rienks, 2012). In addition, the living environment associated with *poverty* can increase the risk of exposure to violence and trauma, resulting in high rates of stress disorders such as post‐traumatic stress disorder (PTSD), and other problems such as aggression, delinquency, substance abuse, and academic difficulties (Kearney, Wechsler, Kaur, & Lemos‐Miller, 2010).

Implications

Many individuals living in *poverty* do not seek treatment because of practical problems such as limited transportation, inflexible work schedules, lack of health insurance, or other factors that affect their access to mental health services. Counselors working with low‐income

clients should seek to develop a flexible schedule and style to meet the needs of individuals who may not be able to attend weekly or 50 - minute sessions, address barriers that may affect attendance, and increase the outreach component in providing therapy (Santiago, Kaltman, & Miranda, 2013).

Environmental Injustice

Waste dumps, “dirty industries,” and other pollution - producing operations are frequently located in the urban and rural areas where poor people and people of color live. U.S. Environmental Protection Agency (EPA) administrator Lisa Jackson called these neighborhoods “hot spots of emissions, hot spots of contamination” as she discussed efforts to address the resulting elevated risk of asthma and other pollution - related conditions (Eilperin, 2010, para. 17).

Disparities in the Judicial System

Mentioned regularly in media descriptions of legal proceedings, bail represents one of the more overt forms of classist discrimination: the poor remain in prison cells while wealthier people accused of the same crimes go home. Moreover, funding for legal aid services is sufficient only to provide counsel to a small proportion of the Americans who need it, with the result that millions of poor people are priced out of the U.S. civil legal process for the vast majority of their legal concerns (Rhode, 2004). Reiman (2007) has argued that the criminal justice system itself is deeply classist, in that it portrays crime as the misdeeds of the poor. In other words, street crimes like burglary, theft, and selling drugs are the contents of the typical police blotter and are detailed in national crime rate statistics. This practice serves to deflect attention from the crimes that actually cause the most death, destruction, and suffering in our country—crimes that derive from the actions of people with *social class privilege*: corporate fraud, the creation of toxic pollutants, profiteering from unhealthy or unsafe products, and risky high - level financial ventures, for which the American public ends up bearing the consequences.

Classism and the Minimum Wage

Without people working in minimum - wage jobs, the lives of middle - class and wealthy Americans would come to a standstill. Our society relies upon the people who ring up our purchases, work in childcare, change hospital beds, clean offices, and serve food; yet, the citizens who perform these necessary jobs cannot earn enough money to lift their families above the *poverty* line. The federal minimum wage of $7.25 per hour does not allow a full - time worker to lift his or her family of four out of *poverty*, a conclusion that emerges from examining the cost of living around the country via Penn State's Living Wage Calculator. This tool calculates the minimum cost of essential food, medical, housing, and transportation requirements in almost every U.S. city and county, and is available online at www.livingwage.geog.psu.edu. This observation goes hand - in - hand with a finding by the National Coalition for the Homeless (2005): as many as 25% of people in U.S. homeless shelters have jobs. The unlivable level of the federal minimum wage gives rise to inherent ethical contradictions, suggesting that classist attitudes toward the poor may influence public debate (or lack thereof) over this issue.

Health Care Inequities

The health disparities research is resoundingly clear: poor people face elevated rates of nearly

every sort of threat to survival, including heart disease, diabetes, exposure to toxins, cognitive and physical functional decline, and homicide, among many other threats (e.g., Belle, Doucet, Harris, Miller, & Tan, 2000; Scott, 2005). In the first quarter of 2014, the number of Americans without health insurance dropped to 41 million, from 50 million in 2009 (Kaiser Foundation, 2010; Tavernise, 2014). This decrease was primarily because of enrollment via provisions of the Affordable Care Act. This trajectory appears to have reversed, however: the number of Americans without health insurance rose by 3.2 million between 2016 and 2017, which corresponded to an increase of 1.3 percentage points to 12.2% of the population (Abulateb, 2018). The majority of the uninsured come from low‐income families, yet *61% come from families where one or more members work full‐time*. Not surprisingly, people without access to medical care often have no choice but to allow preventable conditions to escalate into serious ones, and to leave serious problems untreated. Correspondingly, a 2009 Harvard study found that nearly 45,000 U.S. deaths annually are associated with a lack of health insurance (Wilper et al., 2009).

Negative Attitudes and Beliefs

> *Many states have passed laws restricting what food stamp recipients and people on other food nutritional programs can buy including items such as crab or other shellfish, energy drinks, soda, cookies, chips and steak (Kackley, 2015). Kansas politicians also proposed a $25 withdrawal limit from ATMs by welfare recipients to "help" these individuals manage their money better.*
>
> *(Paulson, 2015)*
>
> *My kids brought home a letter asking us to bring cookies or bars to a school potluck … buying ingredients for making cookies is expensive, so we used our food stamps to buy Oreos, self‐consciously explaining our dilemma to the store clerk … Make no mistake: Forcing families to spend two‐thirds of their benefits on approved foods is not about stemming growth in programs, teaching responsibility or curbing the extremely rare instances of abuse. It is about shaming.*
>
> *(Beyer, 2015)*

The current laws restricting the "misuse" of government assistance to low‐income individuals are based on negative characterizations that have little basis in truth. The small amount of money that these families receive is spent on the necessities of life, not on buying expensive foods. The proposed $25 cap on ATM withdrawals would cause welfare recipients to spend more on fees and to travel more frequently to withdraw funds. Drug testing of welfare applicants has incurred a cost of nearly 1 million dollars, and very few drug users have been found. Although the national drug use rate is 9.4%, the rate of positive drug tests for welfare applicants ranges from 0.002% to 8.3%. In fact, the positive drug rate for applicants from all states but one is under 1% (Covert & Israel, 2015). These restrictive laws only serve to strengthen negative stereotypes of lower‐income individuals, resulting in shame and stigmatization.

By contrast, wealthy people can become national celebrities on the basis of their wealth alone, with the media chronicling their everyday activities. Moreover, within popular culture, intellectualism and critical thinking are largely presented as the exclusive province of more affluent Americans. Although tax breaks for the wealthy contribute to the growing economic gap between the top 1% and the rest of the population, such inequities receive only minor criticism. Corporate welfare (grants, tax breaks, subsidies, and other special treatment for corporations) cost taxpayers hundreds of billions of dollar a year (Bennett, 2015). As Brunari

(2014) writes, “The largest, wealthiest, most powerful organizations in the world are on the public dole … Boeing receives $13 billion in government handouts and everyone yawns … Where is the outrage?” By contrast, support for social programs for low‐income individuals is carefully scrutinized, criticized, and considered a drain on society, and individuals using these programs are described as *irresponsible*, *drug addicts*, *spendthrifts*, and *lazy* (Johnson, 2014; Lott & Saxon, 2002).

IMPLICATIONS FOR CLINICAL PRACTICE

Collectively, the manifestations of *classism* discussed in this chapter operate to create a physically challenging, socially excluded life experience for men, women, and children living in *poverty*. Like other forms of oppression, therefore, *classism* can undermine the physical and emotional well‐being of people withstanding its impact. The social exclusion of the poor was captured by psychologist Bernice Lott (2002), who described the primary characteristic of *classism* as *cognitive and behavioral distancing* from the poor. In particular, Lott linked this phenomenon to psychologists' lack of attention to *poverty*, which is often apparent even in the context of their consideration of other cultural issues. As a consequence, psychological theory, research, and practice tend to be largely inaccessible by poor people and are not particularly relevant to their experiences (Smith, 2010). In addition, counselors who offer services in poor communities may find that their work is compromised by previously unexamined classist assumptions. Aponte (1994), a family therapist who devoted his career to working with poor clients, suggested that “therapy with the poor must have all the sophistication of the best psychological therapies. It must also have the insight of the social scientist and the drive of the community activist” (p. 9). The following suggestions can help guide counselors in improving their skills in the context of *poverty* (Smith, 2005, 2009):

1. *Supplement your knowledge of social class, poverty, and related issues*. Although most counselors do not receive training experiences focused on *poverty*, helpful resources exist by which counselors, supervisors, and trainees can deepen their understanding of *social class*, the circumstances faced by poor Americans, and the implications of both for clinical work. Some useful starting points include the following:
    - *Psychology and Economic Injustice* (Lott & Bullock, 2007)
    - *The Color of Wealth* (Lui, Leondar‐Wright, Brewer, & Adamson, 2006)
    - *Where We Stand*: *Class Matters* (Hooks, 2000)
    - *Report of the Task Force on Resources for the Inclusion of Social Class in Psychology Curricula* (American Psychological Association, 2008).
2. *Increase your understanding and awareness of social class privilege*. Many counselors‐in‐training receive multicultural training experiences that facilitate their awareness of ethnic‐ and race‐related identities; enhancing class awareness is an analogous process, although it is seldom addressed as such. To aid counselors in this effort, Liu, Pickett, and Ivey (2007) developed a list of self‐statements corresponding to White middle‐class privilege, including “I can be assured that I have adequate housing for myself and my family” and “My family can survive an illness of one or more members” (p. 205). The authors also presented a case example to which counselors can refer in applying class‐related considerations within counseling practice.
3. *Learn about the everyday realities of life in poverty*. Students in some professions (such

as social work) receive training that educates them about welfare procedures, housing offices, food stamps, and other aspects of government bureaucracy; this training helps prepare them to work with clients who have nowhere to turn for health services, shelter, or childcare. Mental health counselors, who often lack this preparation, can find themselves disoriented by the unfamiliar deprivations of life in a poor community. Because such information is often locally specific and subject to change, city and state government websites and Internet searches are a good way to learn about available resources.

4. *Learn to see the everyday signs of social class stratification and bias*. Although *social class* is not often discussed openly in the United States, the signs of its existence are all around us if we begin to open our eyes to it. Sometimes these signs can be seen readily, as in the aforementioned public fascination with the lives of wealthy people, or in people's interest in wearing clothing that features corporate or designer logos. Others are more subtle, such as those that are manifested through *classist microaggressions* (Smith & Redington, 2010). These expressions of class‐based derogation are directly analogous to microaggressions based on other marginalized identities (Sue et al., 2007). Classist microaggressions include the use of class‐referenced words to indicate favorable or unfavorable evaluations, such as describing an object or a person as *classy* or *high‐class* in a complimentary fashion or describing it as *low‐class* or *low‐rent* to discredit it. Other classist microaggressions illustrate specific intersections with other identities. Hartigan (2005) discusses the meanings inherent in the name‐calling directed toward poor White Americans, such as *White trash*, *trailer trash*, *rednecks*, and *hillbillies*, whereas Rose (2008) analyzes a microaggression that derives from oppression according to race, class, and gender: *welfare queen*.
5. *Integrate a social justice framework within counseling practice*. Many counselors who go to work in poor communities will encounter bleak urban landscapes, crowded schools, and crumbling housing developments. How are counselors to incorporate the impact of such environmental and contextual dimensions within psychotherapeutic practice, which often seems concerned primarily with an individual's emotional interior? The application of a social justice model to counseling practice makes room within case conceptualization and treatment design for counselors' analyses of the systemic aspects and origins of client distress. Feminist and multicultural examinations of social justice practice can be found within other chapters of this book, as well as in works by Aldarondo (2007), Goodman et al. (2004), Miller and Stiver (1997), and Nelson and Prilleltensky (2005).
6. *Adopt a flexible approach to treatment*. As multicultural psychologists have long contended, the conventional roles and behaviors of psychological practice are at best culture‐bound and at worst oppressive to clients from marginalized groups (Sue et al., 1998). As mentioned, life in *poverty* can be vastly different from the middle‐class existence portrayed in many counseling skills textbooks, and counselors must therefore be willing to use their skills flexibly. Dumont (1992) wrote about his experience with clients living in *poverty*, having come to practice in a community mental health center as a psychoanalytically trained psychiatrist. Contending with the pathological social and environmental forces—racism, pollution, involuntary unemployment, and malnutrition—that predominated in his clients' lives, he concluded that “the 50‐minute hour of passive attention, of pushing toward the past, of highlighting the shards of unconscious material in free association, just does not work” (p. 6).

Along these lines, when counselors are willing to learn from community

members about the interventions that might be most useful, different kinds of supplementary (or alternative) modalities can emerge. These interventions might involve the development of new practices and modalities in accordance with local needs, such as group discussions offered as part of community gatherings, psychoeducational groups in local classrooms, and collaborative events with homeless shelters (Smith, 2005; Smith, Chambers, & Bratini, 2009). Other modalities might involve the formation of community partnerships that combine counseling practice with peer counseling and local social justice advocacy (Goodman et al., 2007). Participatory action research projects are also a means of enhancing the well‐being of poor communities, in concert with social justice activism (Smith & Romero, 2010).

7. *Be willing to incorporate problem‐solving and resource identification within sessions—but don't assume that this will be the focus of the work.* People living in *poverty* are often only a paycheck or an accident away from a health or housing crisis. Even in the absence of crisis, they may be constrained to devote time and energy to such exigencies as securing childcare and making food stamps last until the end of the month. Counselors have indicated that they often feel that discussion of such issues is not sufficiently "deep" and does not therefore qualify as the "real" work that they are there to do (Schnitzer, 1996). Such a response bears traces of class bias in that it discounts as superficial some of the most pressing realities of poor clients' lives. This bias can also work in the other direction—middle‐class counselors can be so unsettled by their clients' lack of resources that they assume that their psychological realities are oriented entirely around securing them. The latter assumption undermines the therapeutic encounter as well, in that it can hinder counselors from engaging poor clients in exploring the same kinds of feelings, fears, hopes, and other emotional issues that clients in any setting are likely to find important (Smith, 2005). It should go without saying that many poor clients come to speak with counselors about precisely these issues. The suggestion that emerges from this balancing act has much in common with good multicultural counseling more generally: be accountable for understanding the unique aspects of clients' sociocultural context and be open to addressing them, but do not assume that this knowledge constitutes a "recipe" for working with them.
8. *Incorporate an advocacy role into your work.* Chen (2013) identified *advocate* as one of the systems intervention roles in which counselors should be competent, and at no time is that role more relevant than when working in the context of oppression. Moreover, given that research has conclusively demonstrated the damage that *poverty* exacts upon people's physical and emotional well‐being, advocating for the eradication of *poverty* and the greater cultural inclusion of the poor *is* advocating for psychological well‐being. Such advocacy can be expected to benefit a large portion of society, given that over half of Americans are likely to spend at least a year below the *poverty* line at some point during their lives (Hacker, 2006). Opportunities for advocacy include support for broadened access to mental and physical health care for poor families, and participation in the living wage movement, which seeks to raise the minimum wage to a level that would allow workers to lift their families out of *poverty*.

SUMMARY

Poverty does not constitute a cultural designation in the true sense of the word, but the challenges of a life in *poverty* are so different from mainstream life that it warrants consideration by clinicians. Counselors are likely to come from middle‐class (or more affluent) backgrounds and lack understanding about how the assumptions of mental health and the process of counseling may be antagonistic and detrimental to their clients. Being familiar with the demographics and the strengths of the poor is important for informed work. The poor face many challenges in their lives: invisibility and social exclusion, educational inequities, *poverty*‐related mental illness, disparities in the judicial system, wage and health care inequities, and negative attitudes and beliefs about them. Eight clinical implications for counselor practice are identified.

GLOSSARY TERMS

- Classism
- Cognitive and behavioral distancing
- Poverty
- Social class
- Social class privilege
- Social stratification theory

REFERENCES

1. Abulateb, Y. (2018). Number of Americans without health insurance rose by 3 million in 2017. Retrieved from https://www.insurancejournal.com/news/national/2018/01/17/477331.htm

2. Aldarondo, E. (2007). *Advancing social justice through clinical practice*. Mahwah, NJ: Erlbaum.

3. Allison, D. (1994). *Skin*. Ithaca, NY: Firebrand.

4. American Psychological Association. (2008). Report of the Task Force on Resources for the Inclusion of Social Class in Psychology Curricula. Retrieved from http://www.apa.org/pi/ses/resources/publications/social - class - curricula.aspx

5. Annie E. Casey Foundation. (2012). The 2012 KIDS COUNT data book. Retrieved from http://www.aecf.org/resources/the - 2012 - kids - count - data - book

6. Aponte, H. J. (1994). *Bread and spirit: Therapy with the new poor*. New York, NY: Norton.

7. Banyard, V. (2008). Welfare queens or courageous survivors? Strengths of women in poverty. *The University Dialogue, 34*.

8. Beeghley, L. (2008). *The structure of social stratification in the United States*. Boston, MA: Allyn & Bacon.

9. Belle, D. (1990). Poverty and women's mental health. *The American Psychologist, 45*(3), 385–389.

10. Belle, D., Doucet, J., Harris, J., Miller, J., & Tan, E. (2000). Who is rich? Who is happy? *The American Psychologist, 55*, 1160–1161.

11. Bennett, J. T. (2015). *Corporate welfare and the crony capitalism that enriches the rich*. Piscataway, NJ: Transaction Publishers.

12. Beyer, M. G. (2015). Don't shame food stamp recipients. Retrieved from http://host.madison.com/news/opinion/column/guest/maria - gaie - beyer - don - t - shame - food - stamp - recipients/article_13e12dee - a5f3 - 52c5 - a1b6 - b5779a7f35f0.html

13. Brunari, D. (2014). Where is the outrage over corporate welfare? Retrieved from http://www.forbes.com/sites/taxanalysts/2014/03/14/where - is - the - outrage - over - corporate - welfare

14. Bullock, H. E., Wyche, K. F., & Williams, W. R. (2001). Media images of the poor. *Journal of Social Issues, 57*, 229–246.

15. Carmon, N. (1985). Poverty and culture: Empirical evidence and implications for public policy. *Sociological Perspectives, 28*, 403–417.

16. Castleman, B. L., & Page, L. C. (2014). *Summer melt: Supporting low - income students through the transition to college*. Cambridge, MA: Harvard Education Press.

17. Chalifoux, B. (1996). Speaking up: White working class women in therapy. In M. Hill, & E. D. Rothblum (Eds.), *Classism and feminist therapy* (pp. 25–34). New York, NY:

Harrington Park.

18. Chen, E. C. (2013). Multicultural competence and social justice advocacy in group psychology and group psychotherapy. Retrieved from http://www.apadivisions.org/division - 49/publications/newsletter/group - psychologist/2013/04/multicultural - competence.aspx

19. Costello, E. J., Compton, S. N., Keeler, G., & Angold, A. (2003). Relationships between poverty and psychopathology: A natural experiment. *JAMA*, *290*(15), 2023–2029.

20. Covert, B., & Israel, J. (2015).What 7 states discovered after spending more than $1 million drug testing welfare recipients. Retrieved from https://thinkprogress.org/what - 7 - states - discovered - after - spending - more - than - 1 - million - drug - testing - welfare - recipients - c346e0b4305d/

21. Dumont, M. P. (1992). *Treating the poor: A personal sojourn through the rise and fall of community mental health*. Belmont, MA: Dymphna Press.

22. Ehrenreich, B. (2009). Is it now a crime to be poor? *New York Times*, August 8.

23. Eilperin, J. (2010). Environmental justice issues take center stage. *Washington Post*, November 21.

24. Fisher, J., & Smeedling, T. M. (2016). Income inequality. In D. Grusky, M. Mattingly, & C. Varner (Eds.), *Pathways: The poverty and inequality report* (pp. 32–38). Stanford, CA: The Stanford Center on Poverty and Inequality.

25. Frey, S. (2014). Programs target crucial summer before college. Retrieved from http://edsource.org/2014/programs - target - crucial - summer - be fore - college/66896#.VN4rvy4sDoa

26. Goodman, L. A., Liang, B., Helms, J. E., Latta, R. E., Sparks, E., & Weintraub, S. (2004). Training counseling psychologists as social justice agents: Feminist and multicultural perspectives. *The Counseling Psychologist*, *32*, 793–837.

27. Goodman, L. A., Litwin, A., Bohlig, A., Wein - traub, S. R., Green, A., Walker, J., … Ryan, N. (2007). Applying feminist theory to community practice: A multilevel empowerment intervention for low - income women with depression. In E. Aldarondo (Ed.), *Advancing social justice through clinical practice* (pp. 265–290). Mahwah, NJ: Erlbaum.

28. Grohol, J. M. (2011). The vicious cycle of poverty and mental health. Retrieved from http://psychcentral.com/blog/archives/2011/11/02/the - vicious - cycle - of - poverty - and - mental - health

29. Hacker, J. S. (2006). *The great risk shift: The new insecurity and the decline of the American dream*. New York, NY: Oxford University Press.

30. Hartigan, J. (2005). *Odd tribes: Toward a cultural analysis of White people*. Durham, NC: Duke University Press.

31. Hooks, B. (2000). *Where we stand: Class matters*. New York, NY: Routledge.

32. Hudson, C. G. (2005). Socioeconomic status and mental illness: Tests of the social causation and selection hypotheses. *American Journal of Orthopsychiatry*, *75*, 3–18.

33. Johnson, D. (2014). 7 common myths about people on welfare. Retrieved from

http://everydayfeminism.com/2014/11/common-myths-people-welfare

34. Kackley, R. (2015). Chew on this: Should food stamp recipients have their shopping lists limited? Retrieved from http://pjmedia.com/blog/chew-on-this-should-food-stamp-recipients-have-their-shopping-lists-limited

35. Kaiser Foundation. (2010). The uninsured: A primer. Retrieved from https://www.kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-under-the-affordable-care-act/

36. Kearney, C. A., Wechsler, A., Kaur, H., & Lemos-Miller, A. (2010). Posttraumatic stress disorder in maltreated youth: A review of contemporary research and thought. *Clinical Child and Family Psychology Review*, *13*, 46–76.

37. Kozol, J. (2006). *The shame of the nation*. New York, NY: Broadway Books.

38. Laine, S. (2015). Drug testing for welfare recipients: Wisconsin poised to join other states. Retrieved from http://www.csmonitor.com/USA/USA-Update/2015/0123/Drug-testing-for-welfare-recipients-Wisconsin-poised-to-join-other-states

39. Liu, W. M., Pickett, T., & Ivey, A. E. (2007). White middle-class privilege: Social class bias and implications for training and practice. *Journal of Multicultural Counseling and Development*, *35*, 194–206.

40. Lott, B. (2002). Cognitive and behavioral distancing from the poor. *The American Psychologist*, *57*, 100–110.

41. Lott, B., & Bullock, H. E. (2007). *Psychology and economic injustice*. Washington, DC: American Psychological Association.

42. Lott, B., & Saxon, S. (2002). The influence of ethnicity, social class and context on judgments about U.S. women. *Journal of Social Psychology*, *142*, 481–499.

43. Lui, M., Leondar-Wright, B., Brewer, R., & Adamson, R. (2006). *The color of wealth*. Boston, MA: New Press.

44. Miller, J. B., & Stiver, I. P. (1997). *The healing connection*. Boston, MA: Beacon Press.

45. National Center for Public Policy and Higher Education. (2002). Losing ground: A national status report on the affordability of American higher education. Retrieved from http://www.highereducation.org/reports/losing_ground/ar.shtml

46. National Coalition for the Homeless. (2005). Who is homeless? NCH Fact Sheet #3. Retrieved from https://www.nationalhomeless.org/publications/facts/Whois.pdf

47. National Law Center on Homelessness and Poverty and the National Coalition for the Homeless. (2009). Housing not handcuffs. Retrieved from https://www.nlchp.org/documents/Housing-Not-Handcuffs

48. Nelson, G., & Prilleltensky, I. (Eds.) (2005). *Community psychology: In pursuit of liberation and well-being*. New York, NY: Palgrave Macmillan.

49. Paulson, A. (2015). Why is Kansas pursuing tougher welfare rules? Retrieved from http://www.csmonitor.com/USA/Society/2015/0407/Why-is-Kansas-pursuing-tougher-welfare-rules-video

50 Reiman, J. (2007). *The rich get richer and the poor get prison*. New York, NY: Pearson.

51 Rhode, D. (2004). Access to justice. *Georgetown Journal of Legal Ethics, 17*(3), 369–422.

52 Rose, T. (2008). *The hip‐hop wars*. New York, NY: Basic Books.

53 Saez, E., & Zucman, G. (2014). The explosion in U.S. wealth inequality has been fuelled by stagnant wages, increasing debt, and a collapse in asset values for the middle classes. Retrieved from http://blogs.lse.ac.uk/usappblog/2014/10/29/the‐explosion‐in‐u‐s‐wealth‐inequality‐has‐been‐fuelled‐by‐stagnant‐wages‐increasing‐debt‐and‐a‐collapse‐in‐asset‐values‐for‐the‐middle‐classes

54 Santiago, C. D., Kaltman, S., & Miranda, J. (2013). Poverty and mental health: How do low‐income adults and children fare in psychotherapy? *Journal of Clinical Psychology*, *69*, 115–126.

55 Schnitzer, P. K. (1996). “They don't come in!” Stories told, lessons taught about poor families in therapy. *American Journal of Orthopsychiatry*, *66*, 572–582.

56 Scott, J. (2005). Life at the top in America isn't just better, it's longer. In Correspondents of the New York Times (Ed.), *Class matters* (pp. 27–50). New York, NY: Times Books.

57 Semega, J.L., Fontenot, K. R., & Kollar, M.A. (2017). Income and poverty in the United States: 2016. Retrieved from https://www.census.gov/library/publications/2017/demo/p60‐259.html

58 Shin, R. Q., Welch, J. C., Kaya, A. E., Yeung, J. G., Obana, C., Sharma, R., … Yee, S. (2017). The intersectionality framework and identity intersections in the Journal of Counseling Psychology and The Counseling Psychologist: A content analysis. *Journal of Counseling Psychology*, *64*(5), 458.

59 Smith, L. (2005). Classism, psychotherapy, and the poor: Conspicuous by their absence. *The American Psychologist*, *60*, 687–696.

60 Smith, L. (2009). Enhancing training and practice in the context of poverty. *Training and Education in Professional Psychology*, *3*, 84–93.

61 Smith, L. (2010). *Psychology, poverty, and the end of social exclusion*. New York, NY: Teachers College Press.

62 Smith, L., & Redington, R. (2010). Class dismissed: Making the case for the study of classist microaggressions. In D. W. Sue (Ed.), *Microaggressions and marginalized groups in society: Race, gender, sexual orientation, class and religious manifestations* (pp. 269–286). Hoboken, NJ: Wiley.

63 Smith, L., & Romero, L. (2010). Psychological interventions in the context of poverty: Participatory action research as practice. *American Journal of Orthopsychiatry*, *80*, 12–25.

64 Smith, L., Chambers, D. A., & Bratini, L. (2009). When oppression is the pathogen: The participatory development of socially‐just mental health practice. *American Journal of Orthopsychiatry*, *79*, 159–168.

65. Southern Education Foundation. (2015). A new majority research bulletin: Low income students now a majority in the nation's public schools. Retrieved from http://www.southerneducation.org/Our‐Strategies/Research‐and‐Publications/New‐Majority‐Diverse‐Majority‐Report‐Series/A‐New‐Majority‐2015‐Update‐Low‐Income‐Students‐Now

66. Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., … Vazquez‐Nutall, E. (1998). *Multicultural counseling competencies*. Thousand Oaks, CA: Sage.

67. Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *The American Psychologist*, *62*, 271–286.

68. Tavernise, S. (2014). Number of Americans without health insurance falls, survey shows. *New York Times*, September 16.

69. UNICEF. (2012). Tens of millions of children living in poverty in the world's richest countries. Retrieved from http://www.unicef.org/media/media_62521.html

70. U.S. Census Bureau. (2017). Facts for features: American Indian and Alaska native heritage month. Retrieved from https://www.census.gov/newsroom/facts‐for‐features/2017/aian‐month.html

71. Wadsworth, M. E., & Achenbach, T. M. (2005). Explaining the link between low socioeconomic status and psychopathology: Testing two mechanisms of the social causation hypothesis. *Journal of Consulting and Clinical Psychology*, *73*, 1146–1153.

72. Wadsworth, M. E., & Rienks, S. L. (2012). Stress as a mechanism of poverty's ill effects on children: Making a case for family strengthening interventions that counteract poverty‐related stress. Retrieved from http://www.apa.org/pi/families/resources/newsletter/2012/07/stress‐mechanism.aspx

73. Wilper, A. P., Woolhandler, S., Lasser, K. E., McCormick, D., Bor, D. H., & Himmelstein, D. U. (2009). Health insurance and mortality in US adults. *American Journal of Public Health*, *9*, 1–7.

26
Counseling Women

Chapter Objectives

1. **1. Review gender demographics and societal expectations affecting women.**
2. **2. Identify counseling implications of the information provided.**
3. **3. Recognize strengths that are associated with women.**
4. **4. Know the special challenges faced by women.**
5. **5. Understand how best practices can guide assessment and therapy with women.**

> *For a long time, most women defined their own sexual harassment and assault in this way: as something unspoken, something private, something to be ashamed of acknowledging. Silence, although understandable, has its cost. A decade ago, I couldn't have conceived of the fact that so many women had experienced sexual coercion or intimidation; now, I'd be surprised if I could find a single one who hadn't. On Sunday afternoon, the actress Alyssa Milano used her Twitter account to encourage women who'd been sexually harassed or assaulted to tweet the words #MeToo. In the last 24 hours, a spokesperson from Twitter confirmed, the hashtag had been tweeted nearly half a million times.*
>
> *(Gilbert, 2017)*

> *Microsoft CEO Satya Nadella stated during a conference on women and technology that female employees should not ask for raises because it would be "good karma" not to do so, that "the system" will compensate them over time, and that being patient for raises was one of women's "superpowers." He later admitted that he was "completely wrong."*
>
> *(Smith, 2014)*

> *Nearly 40 million Americans provide unpaid care to an adult friend or relative, and of those caregivers 60% are women, including 38% who report feeling highly stressed. The typical caregiver in the United States is a 49 - year - old female who balances a full - time job with at least 20 hours each week of helping an older or sick family member who lives nearby.*
>
> *(Gurnon, 2015)*

There were 163,433,400 females in the United States in 2016, compared to 156,938,600 males (Kaiser Foundation, 2017). The ratio of women to men increases with age; among those aged 85 or older, there are about twice as many women as men (U.S. Census Bureau, 2014). Although women constitute more than half of the population, we include them in the special populations section because within the patriarchal nature of U.S. society, women have been historically subjected to prejudice and *discrimination* as well as a disadvantaged status. For centuries, governmental leadership and legal decision makers (e.g., the Supreme Court), as well as religious leaders, have been primarily male—such power imbalances are deeply ingrained in the social context of our society. Contemporarily, women continue to face oppressive conditions and experience high levels of economic and psychological stress.

In this chapter, we focus on many feminist issues. *Feminism*, a frequently misunderstood term, refers to efforts directed toward gender equality—equal economic, social, and political rights and opportunities for women. Early feminists focused on voting and property rights, whereas contemporary feminists advocate for reproductive rights; parental leave and quality childcare; psychosocial safety for women (e.g., targeting domestic violence and sexual assault); and ending wage disparity, sexist power structures, and other forms of *discrimination*. Many feminists focus on the social forces that contribute to gender

oppression, as well as related socialization practices.

Feminist therapists believe that the patriarchal nature of U.S. society contributes to many of the problems faced by women and that psychological symptoms are often the result of women's subordinate status in society; feminist case conceptualizations incorporate the intersection between multicultural influences and other forms of oppression. Interventions based on a feminist perspective focus on goals such as empowerment, identifying personal strengths, and discovering areas for self‐growth outside of traditional roles (Diaz‐Martinez, Interian, & Waters, 2010).

CHARACTERISTICS AND STRENGTHS

In the following sections, we discuss issues faced by women—such as their prescribed roles and socialization experiences—and their implications in treatment. We conclude with a discussion of women's strengths. Keep in mind that women themselves are diverse, and have multifaceted racial‐ethnic backgrounds, cultural identifications, and religious practices. This overview, therefore, provides generalizations about a diverse group of people, and its applicability always needs to be assessed with regard to individual clients.

Societal Roles and Expectations

Ongoing socialization experiences affect women's self‐perceptions. For example, the more women are treated as sexual objects (e.g., subjected to sexualized evaluation such as erotic gazes or overt visual inspection and related sexual comments), the more they feel devalued and trivialized (Hill & Fischer, 2008). Such objectification is pervasive. Melissa Farley, a clinical psychologist who conducted a study on the buying of sex (broadly defined as purchases such as prostitution, pornography, phone sex, lap dances, etc.) found that it was exceedingly difficult to locate men who do not participate in at least some of these activities. She voices concern about the burgeoning demand for (and proliferation of) such products and services, with the resultant dehumanization and commoditization of women (Bennetts, 2011). Some are concerned that films that associate physical violence and pain with sex (such as *Fifty Shades of Grey*) will result in the “erotic normalization of violence against women” (Thistlethwaite, 2015).

There are ongoing concerns about the film industry's sexualization and marginalization of females, even in family‐oriented films (Smith & Choueiti, 2011). The stereotyped standards of beauty expressed through advertisements and the mass media also have a strong impact on the health and self‐esteem of girls and women. The sexualization of young girls, sometimes as early as the preschool years, is particularly troublesome (Machia & Lamb, 2009). When females are exposed to stereotyped societal messages via toys (e.g., dolls), television, music videos, song lyrics, magazines, and advertising, they begin to (a) believe that their primary value comes from being attractive, (b) define themselves according to media‐influenced body standards, and (c) see themselves as sexualized objects (American Psychological Association, 2010; Moffitt & Szymanski, 2011).

Additionally, societal pressure for females to be thin leads to the internalization of an unrealistic “thin ideal,” with resultant body dissatisfaction, disordered eating patterns, and frequent dieting (Fallon, Harris, & Johnson, 2014; Hill & Fischer, 2008). In one sample of 4,745 middle and high school students, many more females than males were unhappy with their bodies (42% of females versus 25% of males) and reported self‐esteem issues due to body shape or weight (36% of females versus 24% of males) (Ackard, Fulkerson, & Neumark‐Sztainer, 2007). The need to meet societal standards for thinness or beauty becomes more intense when girls experience the physical changes associated with puberty. Underweight models and digitally “enhanced” photos further convey unrealistic messages about ideal body size and shape. Exposure to such photos is strongly associated with increased depression, body dissatisfaction, and disordered eating in young women (Grabe, Ward, & Hyde, 2008; Moffitt & Szymanski, 2011).

In addition to the focus on physical attributes, females are socialized to prioritize the needs of others, taking on the role of nurturer and caregiver. They are influenced by beliefs that “good mothers” should stay home with their children or be available if needed by their children

during work hours. Women often experience “role overload” and exhaustion due to disproportionate responsibility for childcare, household chores, and care of elders. For example, women are 2.5 times more likely than men to do housework, and among couples with children, women spend nearly three times as much time on childcare as men (Bureau of Labor Statistics, 2015). Such family responsibilities can affect women's employment status and career commitment (Bertrand, Goldin, & Katz, 2010). Further, women are also more likely to take on primary caretaking responsibilities for older or disabled family members (National Alliance for Caregiving, 2009).

Implications

Interventions directed at challenging and changing the unrealistically thin female image promoted by advertisers, magazines, and other mass media can help reduce body dissatisfaction in females. Programs aimed at preventing or altering disturbed eating patterns generally involve: (a) learning to develop a more positive attitude toward one's body; (b) becoming aware of unhealthy societal messages of “what it means to be female” (e.g., girls must be thin, pretty, and sexy); (c) understanding the consequences of internalized gender‐related societal messages (e.g., distorted expectations and negative self‐statements); (d) developing healthier eating and exercise habits; (e) increasing comfort in expressing feelings to peers, family members, and significant others; (f) choosing appropriate self‐care messages (e.g., “Being healthy is important, so I will eat and exercise appropriately”); (g) developing plans to implement health‐based changes; and (h) identifying healthy strategies to deal with stress and pressure (Richardson & Paxton, 2010).

Strengths

Women are acculturated to display affiliative qualities, such as sensitivity, nurturance, kindness, and concern with relationships (dePillis & dePillis, 2008)—characteristics that are often undervalued in our society. Such relationship strengths result in effective teamwork and better rapport within family systems and within society. Women have a strong capacity for developing and maintaining robust social support networks. Many women also demonstrate skill at understanding how others are feeling, and responding accordingly; thus, they are skilled at anticipating the emotional consequences of decisions. Women often show talent in terms of creativity, problem solving, and mental flexibility, and are frequently guided by strong values. A recent poll (Pew Research Center, 2015) revealed that Americans believe women are just as creative and intelligent as men and that women are more honest, ethical, compassionate, and organized, and better able to work out compromises compared to men.

Gender‐based characteristics such as emotional self‐regulation and an orientation to relationships are assets in work settings (Raffaelli, Crocket, & Shen, 2005). Women employees and leaders are more likely to display an open, consensus‐building, and collegial approach to work; to encourage participation, teamwork, and cooperative efforts among colleagues; and to share power (Caliper, 2005). These qualities are increasingly recognized as important attributes in a work environment (Rosette & Tost, 2010). Women are also more likely than men to display a transformational leadership style—an energetic, passionate approach to projects and the ability to energize others to work toward clearly articulated goals (Vinkenburg, vanEngen, Eagly, & Johannesen‐Schmidt, 2011).

SPECIFIC CHALLENGES

In the following sections, we consider the challenges often faced by women and consider implications for treatment.

Discrimination, Harassment, and Victimization

Women continue to experience both *sexism* and gender‐based *discrimination* in social and professional settings, with the vast majority of women reporting experiences with *sexual harassment*, being disrespected due to their gender, or being subjected to sexist behavior by strangers (Lord, 2010). Nearly two‐thirds of women believe that their gender faces *discrimination* in today's society (Pew Research Center, 2015). As mentioned in our discussion of microaggressions in Chapter 6, *sexism* can be overt (i.e., blatantly unequal and unfair treatment), covert (i.e., unequal, harmful treatment conducted in a hidden manner, such as gender‐biased hiring practices), or subtle (i.e., unequal treatment that is so normative that it is unquestionably accepted). Women at the intersections of multiple marginalized identities, such as lesbian, gay, bisexual, transgender, and queer (LGBTQ) women and women of color, can face a particularly high degree of discrimination (Balsam, Molina, Beadnell, Simoni, & Walters, 2011).

Sexual harassment (broadly defined as verbal or physical conduct of a sexual nature, sometimes with explicit or implicit expectations that a woman submit to sexual requests) continues to be quite prevalent in school and work environments. Intimidating, hostile, or sexually offensive work environments (e.g., where sexually suggestive pictures are displayed or sexual jokes are told) are also examples of *sexual harassment*. A national survey indicates that *sexual harassment* in schools remains a significant concern—one that affects not only girls' psychological well‐being, but also their learning (AAUW, 2011). Women feel threatened and devalued by these unwanted sexual experiences (Smith, 2012). In a study involving women working as servers in U.S. restaurants, it was found that sexual objectification experiences can lead to depression and negative job satisfaction (Szymanski & Feltman, 2015). The more women are treated as sexual objects (e.g., subjected to sexualized evaluation such as erotic gazes or overt visual inspection and related sexual comments), the more they feel devalued and trivialized. Although harassment can be extremely distressing and can influence academic and work performance, many women are hesitant to report such behavior.

Sexual and physical assault is also a significant concern for women. During their lifetime, an estimated 31.5% of U.S. women are subjected to intimate‐partner violence, 19.3% are raped, 43.9% suffer some other form of sexual violence, and 15.2% are the victims of violence outside of the home. These statistics are higher among certain groups. It is estimated that 32.3% of multiracial women, 27.5% of American Indian/Alaskan women, and 21.2% of Black women have been raped at some point during their lifetime. Additionally, 65% of multiracial women and 55% of American Indian/Alaska Native women have experienced sexual violence other than rape (Breiding et al., 2014). Up to half of one sample of college women reported experiencing some form of sexual aggression (Yeater, Treat, Viken, & McFall, 2010). Finally, rates of violence against transgender women are disproportionately high; it is estimated that the risk of becoming a homicide victim is 4.3 times greater in this population than among women overall (Human Rights Campaign and Trans People of Color Coalition, 2017).

Sexual *victimization* and intimate‐partner violence disproportionately affect women,

accounting for 27% of all violence experienced by females (U.S. Department of Commerce, 2011). Many women affected by intimate‐partner violence report significant ongoing psychological distress (Zahnd, Aydin, Grant, & Holtby, 2011). Such abuse or harassment can have long‐term effects, including chronic headaches, pelvic pain, gastrointestinal distress, and other physical symptoms, as well as emotional symptoms such as anxiety, depression, disordered eating, and post‐traumatic stress disorder (PTSD) (Chen et al., 2010; Steiger et al., 2010).

Implications

Violence and *sexual harassment* against females can lead to a number of mental health problems. It is important for counselors to ask about experiences with *discrimination*, harassment, or gender‐based violence and to consider the effect of such events in case conceptualization. Even among adolescents, screening should be performed for intimate‐partner abuse, especially in cases where suicidal thoughts, use of drugs, or disordered eating patterns exist.

The American Psychological Association (2007) recommends support for policy initiatives, including legal and legislative reform addressing the issue of violence against women; improved training for mental health workers so that they can recognize and treat those affected by such violence; dissemination of information regarding violence against women to churches, community groups, educational institutions, and the general public; and exploration of psychoeducational and sociocultural interventions to change male objectification of women. California and New York have passed a “yes means yes” law—legislation that clearly conveys that consent to sexual activity requires an “an affirmative, conscious, and voluntary agreement.” State‐supported colleges must adhere to this definition when investigating sexual assaults (Garrido, 2014; McDermid, 2015).

Students and employees can benefit from knowing how to identify harassment and exactly what steps to take if harassment occurs (e.g., request that the behavior stop; seek help from parents, counselors, or administrative staff; record details of the event). Prevention strategies targeting dating violence are sometimes implemented in high school and college settings (Yeater et al., 2010). Similarly, strategies for assertively reacting to overt or covert *sexism* can empower women who are confronted with offensive or discriminatory behaviors. Additionally, therapists can help women who have been subjected to violence decrease self‐blame (Szymanski & Feltman, 2014).

Educational Barriers

> *You never see someone that looks like me as a scientist. No matter how long I stay here. When I walk through the campus, no one's ever gonna look at me and just think that I'm a physicist … I guess the things that made other people find it hard to see me as a scientist are making it hard for me to see myself as a scientist, too.*
>
> *(Soffa Caldo, Chicana college senior, quoted in Ong, 2005, p. 593)*

Although women make up 51% of the U.S. population, they are affected by implicit bias, gender stereotyping, and *discrimination* and are thus underrepresented in positions of power. Further, the National Coalition for Women and Girls in Education (2008) reports that girls and women continue to be underrepresented in such areas as math and science, and female students continue to receive less attention, encouragement, and praise than males. Teachers are often unaware that they may be promoting *sexism* by providing differential responses to male and female students (Frawley, 2005). In one study of third‐grade teachers who

believed they had a gender‐free style, it was found that boys were allowed to speak out of turn, whereas girls were not; boys were less likely to be confronted when involved in disagreements; and when girls spoke out of turn, they were reminded to raise their hands (Garrahy, 2001).

Some progress has been made in promoting gender equality, but inequities continue. In many cases, the culture of masculinity (including images of dominance and forcefulness) is deeply entrenched in "masculine" fields of study within institutions of higher education (dePillis & dePillis, 2008). Women face particular barriers in the fields of science, math, technology, and engineering (Moss‐Racusin et al., 2015).

Implications

In the educational arena, mental health professionals can advocate for changes at the system levels. Coursework for teachers can include demonstrations and discussion of responses that may inadvertently convey gender‐restrictive messages. Attitudes and negative gender stereotypes do affect performance (Johns, Schmader, & Martens, 2005). One study investigating the influence of *stereotype threat* found that female engineering students who interacted with men behaving in a sexist manner prior to taking an engineering test performed more poorly than women exposed to a nonsexist male prior to the test. This effect was found for engineering tests but not for English tests (i.e., an area not expected to be affected by *stereotype threat*) (Logel et al., 2009).

Attitudes and expectations regarding stereotyped personality characteristics and appropriate career choices need to be addressed in educational programs and with individual clients. Small changes in the culture of mathematics, science, and engineering departments (e.g., hiring female faculty, providing mentoring systems for female staff and students, combating negative stereotypes) can help attract women to these fields and maintain their interest, enthusiasm, and sense of belonging (Hill, Corbett, & St. Rose, 2010).

Economic and Employment Barriers

Although women make up 55% of college students and account for a greater percentage of associate, bachelor's, and master's degrees, women earn less than their male counterparts across all racial groups. Hispanic women show the largest gap, making only 54% of the earnings of White men (AAUW, 2014). This affects not only the women themselves, but also the families they are supporting. The poverty rate for single mothers with children is 37%—the highest of any demographic group in the United States. Women with a low income are especially at risk for depression and domestic violence (Levy & O'Hara, 2010).

Many organizations continue to operate under a value system that emphasizes power and control rather than relationship skills. Nontraditional career fields are often not hospitable to women; thus, many women remain in "feminine" careers. Women are underrepresented not only in fields such as science and engineering, but also in managerial and executive‐level jobs—occupations associated with "masculine" qualities, such as being assertive and independent and influencing others, rather than "feminine" qualities, such as sensitivity, nurturance, kindness, and being concerned with relationships (dePillis & dePillis, 2008).

College women are also aware that when a woman behaves in a manner that is not considered feminine, negative consequences may result. For example, if a woman displays a task‐oriented style of leadership that violates the gender norm of modesty, she may be rated as competent but at the expense of lower social attraction and likability ratings; men displaying the same leadership style are rated high in both competence and likability (Rudman, 1998).

Women leaders often confront divergent expectations—they are expected to be assertive and in control, but are simultaneously criticized for these same traits. Even successful businesswomen report barriers to advancement on the corporate ladder, including the following (Lyness & Thompson, 2000):

1. Women were made to feel that they somehow needed to change, that they were hired or promoted due to "token‐hiring practices," and that they were not a "good fit" for senior management.
2. Male coworkers heightened cultural boundaries by emphasizing male camaraderie and their differences from women, relying on a "good old boys network," and withholding from women information necessary for job performance.
3. Women executives received less frequent and less effective mentoring than their male counterparts, including limited access to potential mentors, mentors unwilling to work with them, and the misinterpretation of a mentorship request as a sexual invitation.

A study involving 610 women of different races working in the fields of science, technology, engineering, and math (Williams, Phillips, & Hall, 2014) found the following forms of gender bias that may contribute to the underrepresentation of women in nontraditional fields:

- *Prove it again*. Two‐thirds of women indicated that they had to repeatedly demonstrate a higher level of competence than their male colleagues. African American women were most likely to experience this type of bias.
- *The tightrope*. Over three‐quarters of women reported having to walk a fine line between being seen as "too feminine" to be competent and as "too masculine" to be likeable. Asian American women were much more likely to report a backlash from being assertive, whereas African American women were given more "leeway" in behaving in a "dominant" manner.
- *The maternal wall*. Nearly two‐thirds of women with children faced the assumption that motherhood would reduce their competence and commitment to work.
- *Tug of war*. Women may also be biased against other women in these fields. Although most reported that female colleagues supported one another, about half believed that some women demonstrate considerable gender bias toward other women.
- *Sexual harassment*. Over one‐third of women reported *sexual harassment*, with White women being much more likely to be victims of this behavior.

Implications

Counselors can encourage continued education and job training for women working in minimum‐wage jobs. Where needed, they can provide information on quality childcare and assistance with locating food, clothing, and affordable housing. Counselors should consider the worldview of women living in poverty and the web of stress with which low‐income women contend. Therapists can use multicultural therapy models such as *feminist relational advocacy*, a therapeutic approach focused on listening to women's narratives, recognizing the role of oppression in creating emotional distress, recognizing strengths, and providing advocacy as well as emotional and practical support (Goodman, Glenn, Bohlig, Banyard, & Borges, 2009). When possible, mental health services should be provided in convenient locations serviced by public transportation. Childcare and other on‐site programs for family members can increase participation in the mental health system.

Mental health professionals should also help expand the career choices available to women. In doing so, a comprehensive, skills‐based approach is most effective. One program for college women (Sullivan & Mahalik, 2000) focused on increasing career self‐efficacy by enhancing understanding of the impact of gender socialization on career choice and development; learning about the career paths of successful women (e.g., reading about and discussing women's unique career development and observing successful women and interviewing them about their career decision‐making processes and insights); promoting skills to manage anxiety through relaxation and adaptive self‐talk; and counteracting internalized stereotypes by identifying and challenging self‐defeating thoughts.

Ageism and Women

The number of women aged 65 and older is expected to double by 2030, reaching 40 million (U.S. Census Bureau, 2011). Given the emphasis on youth and beauty that exists in our society, women face additional barriers as they age, including age *discrimination* at work (Neumark, Burn, & Button, 2017); preferential treatment of younger females in stores, restaurants, and other public establishments; reduced dating opportunities (e.g., men often prefer to date younger women); and a sense of being “invisible” (Committee on Women in Psychology, 1999). In addition, older women often confront changing roles (e.g., an “empty nest,” loss of career, increased caretaking of aging family members, accommodation of a partner's retirement). Responses to midlife changes such as menopause can be influenced by both *ageism* and *sexism*, as well as by the cultural meanings ascribed to menopause (e.g., beliefs that sexual attractiveness and youthful qualities such as enthusiasm and energy are lost at menopause).

Many women report that midlife transitions were not as stressful as they anticipated. Among women between the ages of 40 and 59, nearly three‐fourths reported feeling “very happy” or “happy.” Most were enjoying midlife because of increased independence, freedom from worrying about what others think, freedom from parenting, and the ability to define their own identity based on their own interests (McQuaide, 1998). Instead of being concerned about a midlife crisis, aging, the empty nest syndrome, or menopause, many middle‐aged women report going through a midlife review process, as well as having confidence, a strong sense of identity, and a sense of power over their lives (Gibbs, 2005). These findings indicate that transitions through midlife may be easier than was previously assumed. Different transition experiences may occur for women experiencing the stress of poverty or caretaking responsibilities.

Implications

It is important not to assume that all women experience a “midlife crisis” and to be aware that women may differ significantly in how they experience life transitions. The life path of women is quite variable. For example, some women are grandmothers in their late 30s or early 40s; others delay childbearing until their 40s or never have children. Thus, women may experience various midlife transitions at significantly different ages. The personal meanings of and reactions to these events are different for each individual. Counselors can help women negotiate the loss of prior roles by affirming new commitments in life and by assisting women to develop the personal meaning of their life experiences through self‐exploration. It is helpful to normalize feelings of anxiety or doubt associated with life transitions and to reframe such experiences as opportunities for greater personal and spiritual development.

Depression

Depression is one of the most prevalent psychiatric disorders and a leading cause of worldwide disability (Andrade et al., 2010). Women have a 70% greater lifetime risk of experiencing a major depressive episode compared with men (Kessler, Chiu, Demler, & Walters, 2005); various stressors, such as sexual abuse and unequal *gender roles* (Chen et al., 2010; Vigod & Stewart, 2009), as well as perceived *discrimination* based on gender, especially among those who do not talk to others about their experiences (McLaughlin, Hatzenbuehler, & Keyes, 2010), contribute to the higher prevalence in this population. The following three additional factors encountered by females are also linked with the development of depression:

- The presence of stress, especially acute stress and stress involving interpersonal problems and the need to depend on others (Muscatell, Slavich, Monroe, & Gotlib, 2009).
- Work environments that involve chronic stress and few decision‐making opportunities—conditions experienced by many women in the workplace (Verboom et al., 2011).
- Exposure to targeted rejection involving active, intentional social exclusion or rebuff (Slavich, Way, Eisenberger, & Taylor, 2010).

Gender‐specific socialization practices can influence females' feelings of self‐worth. Although males are socialized to value autonomy, self‐interest, and achievement‐oriented goals, females are taught to value interdependent functioning and social goals such as behaving in a caring or nurturing manner. The opinions of others, therefore, often influence women's self‐perceptions. Women frequently try to maintain relationships at the cost of their own needs and wishes. Failures in relationships are often viewed as personal failures, compounding stress and affecting mood. Additionally, gender‐role expectations can decrease women's sense of control over life situations and diminish their sense of personal worth. Women are often affected by interpersonal stress, particularly stressors involving close friends or family. Ruminating (i.e., repeatedly thinking about concerns or events) further increases depressive symptoms among females (Hankin, 2009). Additionally, adolescent girls experiencing depression are more likely to generate interpersonal stress, which can lead to further ongoing depressive symptoms (Rudolph, Flynn, Abaied, Groot, & Thompson, 2009).

Women who are subject to stressors such as racism, *ageism*, and exposure to poverty have increased vulnerability to depression. For example, among African American women, everyday encounters with *discrimination* are linked with increases in depressive symptoms (Wagner & Abbott, 2007). Community‐based focus‐group discussions involving African American women with histories of violent *victimization* underscore the role of interpersonal violence in the development of depression among these women (Nicolaidis et al., 2010).

Implications

In therapy, it is important to address the stressors faced by clients, identifying societal and cultural factors as well as individual influences. Counselors should assess for environmental factors, such as poverty, racism, economic conditions, and abusive relationships, as well as specific experiences with overt, covert, or subtle *sexism*. Women often benefit from psychoeducation regarding the power differential in society, unrealistic gender expectations, and the impact of these expectations on mood. Identifying internalized stereotypes and related self‐defeating thoughts and substituting more positive self‐statements can reduce depression. Establishing strong social support networks and locating sources of assistance with specific needs (e.g., financial, health, childcare) can help women who are experiencing

stressful life circumstances.

Evidence‐based therapies involving exposure to positive activities; facilitation of social interactions; improved social, communication, and assertiveness skills; and identification of role conflicts can help women decrease depressive symptoms and find relationships more satisfying (Lejuez, Hopko, Acierno, Daughters, & Pagoto, 2011; Levenson et al., 2010). Similarly, learning strategies to alter negative, self‐critical thoughts and negative self‐biases can reduce depressive symptoms (DeRubeis, Siegle, & Hollon, 2008). Using mindfulness strategies involving calm awareness of present experiences, thoughts, and feelings and developing an attitude of acceptance rather than being judgmental, evaluative, or ruminative can disrupt the cycle of negative thinking (Gilbert & Christopher, 2010). Therapy focused on improving interpersonal relationships and enhancing social support has been helpful in decreasing depression in women affected by intimate‐partner violence (Zlotnick, Capezza, & Parker, 2011).

Gender Bias in Therapy

It is important for counselors to recognize the sexist nature of our society and to be aware of possible biases when working with female clients (Diaz‐Martinez et al., 2010). For example, does the counselor believe there are certain attributes associated with a healthy feminine identity? In past research, qualities such as being more submissive, emotional, and relationship‐oriented were identified as positive qualities in women (Atkinson & Hackett, 1998). If counselors consciously or unconsciously adhere to these stereotypic societal standards, they may convey blaming attitudes to clients during counseling (Notestine, Murray, Borders, & Ackerman, 2017). For example, one study of family therapy sessions revealed that counselors interrupted women more often than they interrupted men (Werner‐Wilson, Price, Zimmerman, & Murphy, 1997). The therapists, unaware of their behavior, were engaged in subtle *sexism*. *Gender‐based microaggressions* such as this are not only destructive to the therapeutic alliance, but can also significantly affect a female client's sense of empowerment (Owen, Tao, & Rodolfa, 2010).

Biases can also occur during diagnosis, especially for ethnic minority women (American Psychological Association, 2007). Some researchers and clinicians contend that certain personality disorders are based on exaggerated gender characteristics. Self‐dramatization and exaggerated emotional expressions; intense fluctuations in mood, self‐image, and interpersonal relationships; and reliance on others and the inability to assume responsibilities are characteristics of histrionic, borderline, and dependent personality disorders, respectively. Not surprisingly, women are much more likely to be diagnosed with these disorders.

Many psychological theories are gender‐biased. For example, the concepts of “codependency” and “enmeshment,” descriptors more frequently applied to women, involve behaviors such as devotion to home and relationships, connectedness, nurturance, and placing the needs of the family over personal needs—behaviors that are strongly influenced by cultural expectations and gender‐based socialization practices. Gender bias is also inherent in family‐systems therapeutic models: these approaches generally fail to recognize the effects of gender‐based power imbalance, including unequal distribution of power within families. Also, disturbances are often interpreted as problems in the system rather than as troubles due to stressors experienced by individual family members. Under this theoretical conceptualization, women who are abused are seen as contributors to the system dysfunction.

IMPLICATIONS FOR CLINICAL PRACTICE

Both male and female counselors should self‐assess for possible sexist beliefs, assumptions, or behaviors and take care not to limit client growth by fostering traditional *gender roles*. Each female client should be provided the opportunity to choose the life path that is best for her, despite societal gender expectations and political correctness. Problems identified by female clients should be viewed within a societal context in which devaluation of women is a common occurrence; gender‐based considerations should be understood as integral aspects of problem conceptualization and treatment planning. Guidelines for counselors working with female clients include the following (American Psychological Association, 2007; Szymanski, Carr, & Moffitt, 2011):

1. Remain aware of potential biases in the diagnosis and treatment of women.
2. Recognize that many counseling theories and practices are male‐centered and may require modifications when working with women. For example, cognitive‐behavioral therapeutic approaches can be modified to include a focus on internalized societal messages or unrealistic standards of beauty.
3. Possess up‐to‐date information regarding the biological, psychological, and sociological issues that affect women, including a strong understanding of the physiological and social implications of reproductive processes such as menstruation, pregnancy (including unplanned pregnancy), birth, infertility and miscarriage, and menopause.
4. Assess sociocultural factors to determine their role in the presenting problem. Consider the influence of gender‐role socialization; overt, covert, and subtle *sexism*; *discrimination* and harassment; and economic, educational, and employment barriers.
5. Help clients realize the impact of power imbalances, gender expectations, and societal definitions of attractiveness on mental health.
6. Emphasize the unique strengths and talents that women bring to work and interpersonal relationships, including the effectiveness of democratic, people‐oriented leadership styles.
7. Help clients correct cultural misperceptions that men are superior in math, science, and technology. Discuss women's achievements in leadership positions and in nontraditional fields for women (e.g., science, math, technology, and engineering), as well as strategies women have used to overcome barriers in these fields. Exposure to successful female role models is important for both girls and women.
8. Encourage females to take challenging coursework in math and science and to recognize that academic achievement is an ongoing, cumulative process.
9. Assess for the possible impact of abuse or trauma‐related experiences. If necessary, help the client mobilize resources, such as support from friends and family, and develop plans to leave (see Hays, 2013).
10. Clients may need assistance in developing financial independence and other supports necessary to leave unhappy marriages or abusive relationships.
11. Do not allow traditional definitions of “good leadership” to mask the talents and strengths women bring to the workplace. Systems‐level intervention may be needed to create work environments that optimize the contributions of female leaders and employees.
12. Counselors can educate women about how negative gender‐based stereotypes and

stereotype threat undermine women's confidence and lead to lower performance—such knowledge can reduce the influence of negative stereotypes (Johns et al., 2005).

13. Be alert for signs of depression. Keep in mind that women tend to internalize problems and that maternal depression can have a significant effect on children's behavior and well‐being (Tully, Iacono, & McGue, 2008).
14. Encourage women to identify and address their own needs and to practice assertively setting boundaries when confronted with unrealistic demands.
15. Be ready to take an advocacy role in initiating systems‐level changes as they relate to *sexism* and *sexual harassment*.
16. Tailor the focus of treatment to encompass the additional concerns that are faced by women with multiple marginalized identities, such as women of color (Bryant‐Davis & Comas‐Díaz, 2016) and LGBTQ women (Singh, 2016).

SUMMARY

Women constitute over half the population of the United States, but because of the patriarchal nature of society, they occupy a disadvantaged status. For centuries, governmental leadership and legal decision makers, as well as religious leaders, have been primarily male—such power imbalances are deeply ingrained in the social context of our society. Contemporarily, women continue to face oppressive conditions and experience high levels of economic and psychological stress. Effective work with female clients requires understanding gender‐based societal pressures, sexual objectification, stereotyping, harassment, *victimization*, *discrimination*, educational/employment barriers, depression, and *ageism*. Gender bias in therapy is a reality. *Feminism*, a frequently misunderstood term, refers to efforts directed toward gender equality—equal economic, social, and political rights and opportunities for women. Feminist therapy represents a school of thought and action directed at addressing these inequalities. Sixteen clinical implications for counselor practice are identified.

GLOSSARY TERMS

- Ageism
- Discrimination
- Feminism
- Gender microaggressions
- Gender roles
- Sexism
- Sexual harassment
- Stereotype threat
- Victimization

REFERENCES

1. Ackard, D. M., Fulkerson, J. A., & Neumark‐Sztainer, D. (2007). Prevalence and utility of *DSM‐IV* eating disorder diagnostic criteria among youth. *International Journal of Eating Disorders*, *40*, 409–417.

2. American Association of University Women (AAUW). (2011). Crossing the line: Sexual harassment at school. Retrieved from https://www.aauw.org/research/crossing‐the‐line/

3. American Association of University Women (AAUW). (2014). The simple truth about the gender pay gap. Retrieved from http://www.aauw.org/research/the‐simple‐truth‐about‐the‐gender‐pay‐gap/

4. American Psychological Association (2007). Guidelines for the psychological practice with girls and women. *American Psychologist*, *62*, 949–979.

5. American Psychological Association. (2010). Report of the APA Task Force on the sexualization of girls. Retrieved from http://www.apa.org/pi/women/programs/girls/report‐full.pdf

6. Andrade, P., Noblesse, L. H., Temel, Y., Ackermans, L., Lim, L. W., Steinbusch, H. W., & Visser‐Vandewalle, V. (2010). Neurostimulatory and ablative treatment options in major depressive disorder: A systematic review. *Acta Neurochirugia*, *152*, 565–577.

7. Atkinson, D. R., & Hackett, G. (1998). *Counseling diverse populations* (2nd ed.). Boston, MA: McGraw‐Hill.

8. Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring multiple minority stress: the LGBT People of Color Microaggressions Scale. *Cultural Diversity and Ethnic Minority Psychology*, *17*(2), 163.

9. Bennetts, L. (2011). The John next door. *Newsweek*, July 25.

10. Bertrand, M., Goldin, C., & Katz, L. F. (2010). Dynamics of the gender gap for young professionals in the financial and corporate sectors. *American Economic Journal: Applied Economics*, *2*, 228–255.

11. Breiding, M., Smith, S. G., Basile, K. C., Walters, M. L., Chen, J., & Merrick, M. T. (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization—National Intimate Partner and Sexual Violence Survey, United States, 2011. *Morbidity and Mortality Weekly Report*, *63*, 1–18.

12. Bryant‐Davis, T. E., & omas‐Díaz, L. E. (2016). *Womanist and mujerista psychologies: Voices of fire, acts of courage*. Washington, DC: American Psychological Association.

13. Bureau of Labor Statistics. (2015). American time use survey summary. Retrieved from http://www.bls.gov/news.release/atus.nr0.htm

14. Caliper. (2005). The qualities that distinguish women leaders. Retrieved from https://www.calipercanada.com/portfolio/the‐qualities‐that‐distinguish‐women‐leaders/

15. Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., & Zirakzadeh,

A. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta‐analysis. *Mayo Clinic Proceedings*, *85*, 618–629.

16. Committee on Women in Psychology (1999). *Older psychologists survey*. Washington, DC: American Psychological Association.

17. dePillis, E. G., & dePillis, L. G. (2008). Are engineering schools masculine and authoriarian? The mission statements say yes. *Journal of Diversity in Higher Education*, *1*, 33–44.

18. DeRubeis, R. J., Siegle, G. J., & Hollon, S. D. (2008). Cognitive therapy vs. medications for depression: Treatment outcomes and neural mechanisms. *National Review of Neuroscience*, *9*, 788–796.

19. Diaz‐Martinez, A. M., Interian, A., & Waters, D. M. (2010). The integration of CBT, multicultural and feminist psychotherapies with Latinas. *Journal of Psychotherapy Integration*, *20*, 312–326.

20. Fallon, E. A., Harris, B. S., & Johnson, P. (2014). Prevalence of body dissatisfaction among a United States adult sample. *Eating Disorders*, *15*, 151–158.

21. Frawley, T. (2005). Gender bias in the classroom: Current controversies and implications for teachers. *Childhood Education*, *81*, 221–227.

22. Garrahy, D. A. (2001). Three third‐grade teachers' gender‐related beliefs and behavior. *Elementary School Journal*, *102*, 81–94.

23. Garrido, E. (2014). California adopts “yes means yes” sex‐assault rule. Retrieved from http://206.41.125.21/showthread.php?t=210147

24. Gibbs, N. (2005). Midlife crisis? Bring it on! Retrieved from http://www.time.com/time/magazine/article/0,9171,1059032,00.html

25. Gilbert, B. D., & Christopher, M. S. (2010). Mindfulness‐based attention as a moderator of the relationship between depressive affect and negative cognitions. *Cognitive Therapy and Research*, *34*, 514–521.

26. Gilbert, S. (2017). The movement of #MeToo. Retrieved from https://www.theatlantic.com/entertainment/archive/2017/10/the‐movement‐of‐metoo/542979/

27. Goodman, L., Glenn, C., Bohlig, A., Banyard, V., & Borges, A. (2009). Feminist relational advocacy processes and outcomes from the perspective of low‐income women with depression. *The Counseling Psychologist*, *37*, 848–876.

28. Grabe, S., Ward, L. M., & Hyde, J. S. (2008). The role of the media in body image concerns among women: A meta‐analysis of experimental and correlational studies. *Psychological Bulletin*, *134*, 460–476.

29. Gurnon, E. (2015). Who America's caregivers are and why it matters. Retrieved from http://www.nextavenue.org/who‐americas‐caregivers‐are‐and‐why‐it‐matters/

30. Hankin, B. L. (2009). Development of sex differences in depressive and co‐occurring anxious symptoms during adolescence: Descriptive trajectories and potential explanations in a multi‐wave prospective study. *Journal of Clinical Child and*

Adolescent Psychology, *38*, 460–472.

31. Hays, B. E. (2013). Women's resistance strategies in abusive relationships: An alternative framework. Retrieved from: http://sgo.sagepub.com/content/3/3/2158244013501154

32. Hill, C., Corbett, C., & St. Rose, A. (2010). Why so few? Women in science, technology, engineering, and mathematics. Retrieved from https://www.aauw.org/aauw_check/pdf_download/show_pdf.php?file=why - so - few - research

33. Hill, M. S., & Fischer, M. S. (2008). Examining objectification theory. *The Counseling Psychologist*, *36*, 745–776.

34. Human Rights Campaign and Trans People of Color Coalition. (2017). A matter of life and death: Fatal violence against transgender people in America 2016. Retrieved from https://assets2.hrc.org/files/assets/resources/A - Matter - of - Life - and - Death - 2016.pdf?_ga=2.223049432.2117460299.1537064810 - 1975210620.1537064810

35. Johns, M., Schmader, T., & Martens, A. (2005). Knowing is half the battle: Teaching stereotype threat as a means of improving women's math performance. *Psychological Science*, *16*, 175–179.

36. Kaiser Foundation. (2017). Population distribution by gender. Retrieved from https://www.kff.org/other/state - indicator/distribution - by - gender/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22

37. Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12 - month *DSM* - *IV* disorders in the National Comorbidity Survey replication. *Archives of General Psychiatry*, *62*, 617–627.

38. Lejuez, C. W., Hopko, D. R., Acierno, R., Daughters, S. B., & Pagoto, S. L. (2011). Ten - year revision of the brief behavioral activation treatment for depression: Revised treatment manual. *Behavior Modification*, *35*, 111–161.

39. Levenson, J. C., Frank, E., Cheng, Y., Rucci, P., Janney, C. A., & Fagiolini, A. (2010). Comparative outcomes among the problem areas of interpersonal psychotherapy. *Depression and Anxiety*, *27*, 434–440.

40. Levy, L. B., & O'Hara, M. W. (2010). Psychotherapeutic interventions for depressed, low - income women: A review of the literature. *Clinical Psychology Review*, *30*, 934–950.

41. Logel, C., Walton, G. M., Spencer, S. J., Iserman, E. C., vonHippel, W., & Bell, A. E. (2009). Interacting with sexist men triggers social identity threat among female engineers. *Journal of Personality and Social Psychology*, *96*, 1089–1103.

42. Lord, T. Y. (2010). The relationship of gender - based public harassment to body image, self - esteem, and avoidance behavior. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, *70*(8 - B), 5171.

43. Lyness, K. S., & Thompson, D. E. (2000). Climbing the corporate ladder: Do female and male executives follow the same route? *Journal of Applied Psychology*, *85*, 86–101.

44. Machia, M., & Lamb, S. (2009). Sexualized innocence: Effects of magazine ads portraying adult women as sexy little girls. *Journal of Media Psychology*, *21*, 15–24.

45. McDermid, B. (2015). All NY colleges to adopt “yes means yes” sex assault policy. Retrieved from https://www.reuters.com/article/us‐usa‐new‐york‐sexcrimes‐college/all‐ny‐colleges‐to‐adopt‐yes‐means‐yes‐sex‐assault‐policy‐idUSKCN0PH23Y20150708

46. McLaughlin, K. A., Hatzenbuehler, M. L., & Keyes, K. M. (2010). Responses to discrimination and psychiatric disorders among Black, Hispanic, female, and lesbian, gay, and bisexual individuals. *American Journal of Public Health*, *100*, 1477–1484.

47. McQuaide, S. (1998). Women at midlife. *Social Work*, *43*, 21–31.

48. Moffitt, L. B., & Szymanski, D. M. (2011). Experiencing sexually objectifying environments: A qualitative study. *The Counseling Psychologist*, *39*, 67–106.

49. Moss‐Racusin, C. A., Molenda, A. K., & Cramer, C. R. (2015). Can evidence impact attitudes? Public reactions to evidence of gender bias in STEM fields. *Psychology of Women Quarterly*, *39*, 1–16.

50. Muscatell, K. A., Slavich, G. M., Monroe, S. M., & Gotlib, I. H. (2009). Stressful life events, chronic difficulties, and the symptoms of clinical depression. *Journal of Nervous and Mental Disease*, *197*, 154–160.

51. National Alliance for Caregiving. (2009). Caregiving in the U.S. 2009. Retrieved from http://www.caregiving.org/data/Caregiving_in_the_US_2009_full_report.pdf

52. National Coalition for Women and Girls in Education. (2008). Report from the National Coalition for Women and Girls in Education: “Title IX at 35: Beyond the headlines.” Retrieved from http://www.ncwge.org/pubs‐reports.html

53. Neumark, D., Burn, I., & Button, P. (2017). Age discrimination and hiring of older workers. *Age*, *2017*, 6.

54. Nicolaidis, C., Timmons, V., Thomas, M. J., Waters, A. S., Wahab, S., & Mitchell, R. (2010). “You don't go tell White people nothing”: African American women's perspectives on the influence of violence and race on depression and depression care. *American Journal of Public Health*, *100*, 1470–1476.

55. Notestine, L. E., Murray, C. E., Borders, L. D., & Ackerman, T. A. (2017). Counselors' attributions of blame toward female survivors of battering. *Journal of Mental Health Counseling*, *39*(1), 56–70.

56. Ong, M. (2005). Body projects of young women of color in physics: Intersections of gender, race, and science. *Social Problems*, *52*, 593–617.

57. Owen, J., Tao, K., & Rodolfa, E. (2010). Microaggressions and women in short term therapy: Initial evidence. *The Counseling Psychologist*, *38*(7), 923–946.

58. Pew Research Center. (2015).Women and leadership: Public says women are equally qualified, but barriers persist. Retrieved from http://www.pewsocialtrends.org/2015/01/14/women‐and‐leadership/

59. Raffaelli, M., Crocket, L. J., & Shen, Y. (2005). Developmental stability and change in self‐regulation from childhood to adolescence. *Journal of Genetic Psychology*, *166*, 54–75.

60. Richardson, S. M., & Paxton, S. J. (2010). An evaluation of a body image intervention

based on risk factors for body dissatisfaction: A controlled study with adolescent girls. *International Journal of Eating Disorders*, *43*, 112–122.

61 Rosette, A. S., & Tost, L. P. (2010). Agentic women and communal leadership: How role prescriptions confer advantage to top women leaders. *Journal of Applied Psychology*, *95*, 221–235.

62 Rudman, L. A. (1998). Self‐promotion as a risk factor for women: The costs and benefits of counter‐stereotypical impression management. *Journal of Personality and Social Psychology*, *74*, 629–645.

63 Rudolph, K. D., Flynn, M., Abaied, J. L., Groot, A. G., & Thompson, R. D. (2009). Why is past depression the best predictor of future depression? Stress generation as a mechanism of depression continuity in girls. *Journal of Clinical Child and Adolescent Psychology*, *38*, 473–485.

64 Singh, A. A. (2016). Moving from affirmation to liberation in psychological practice with transgender and gender nonconforming clients. *American Psychologist*, *71*(8), 755.

65 Slavich, G. M., Way, B. M., Eisenberger, N. I., & Taylor, S. E. (2010). Neural sensitivity to social rejection is associated with inflammatory responses to social stress. *Proceedings of the National Academy of Sciences of the United States of America*, *107*, 14,817–14,822.

66 Smith, E. (2012). Hey baby! Women speak out against street harassment. Retrieved from http://www.cnn.com/2012/10/06/living/street‐harassment/index.html

67 Smith, R. (2014). The career advice Microsoft's CEO should have given to women. Retrieved from https://www.forbes.com/sites/ricksmith/2014/10/27/the‐3‐things‐microsofts‐ceo‐should‐have‐said‐to‐women/#3798fbfb3514

68 Smith, S. L., & Choueiti, M. (2011). Gender inequality in cinematic content? A look at females on screen & behind the camera in top‐grossing 2008 films. Retrieved from https://annenberg.usc.edu/sites/default/files/MDSCI_Gender_Inequality_in_TopGrossi

69 Steiger, H., Richardson, J., Schmitz, N., Israel, M., Bruce, M. I., & Gauvin, L. (2010). Trait‐defined eating‐disorder subtypes and history of childhood abuse. *International Journal of Eating Disorders*, *43*, 428–432.

70 Sullivan, K. R., & Mahalik, J. R. (2000). Increasing career self‐efficacy for women: Evaluating a group intervention. *Journal of Counseling and Development*, *78*, 54–62.

71 Szymanski, D. M., & Feltman, C. E. (2014). Experiencing and coping with sexually objectifying treatment: Internalization and resilience. *Sex Roles*, *71*, 159–170.

72 Szymanski, D. M., & Feltman, C. E. (2015). Linking sexually objectifying work environments among waitresses to psychological and job‐related outcomes. *Psychology of Women Quarterly*, *39*, 390–404.

73 Szymanski, D. M., Carr, E. R., & Moffitt, L. B. (2011). Sexual objectification of women: Clinical implications and training considerations. *The Counseling Psychologist*, *39*, 107–126.

74 Thistlethwaite, S. B. (2015). #50ShadesIsAbuse: The erotic normalization of violence against women. Retrieved from http://www.huffingtonpost.com/rev‐dr‐susan‐

brooks‐thistlethwaite/50shadesis abuse‐the‐eroti_b_6640884.html

75. Tully, E. C., Iacono, W. G., & McGue, M. (2008). An adoption study of parental depression as an environmental liability for adolescent depression and childhood disruptive disorders. *American Journal of Psychiatry*, *165*, 1148–1154.

76. U.S. Census Bureau. (2011). Age and sex composition: 2010. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br‐03.pdf

77. U.S. Census Bureau. (2014). U.S. people quick facts. Retrieved from https://www.census.gov/quickfacts/fact/table/US/PST045217

78. U.S. Department of Commerce (2011). *Women in America*. Washington, DC: U.S. Government Printing Office.

79. Verboom, C. E., Sentse, M., Sijtsema, J. J., Nolen, W. A., Ormel, J., & Penninx, B. W. (2011). Explaining heterogeneity in disability with major depressive disorder: Effects of personal and environmental characteristics. *Journal of Affective Disorders, 132*, 71–81.

80. Vigod, S. N., & Stewart, D. (2009). Emergent research in the cause of mental illness in women across the lifespan. *Current Opinion in Psychiatry*, *22*, 396–400.

81. Vinkenburg, C. J., vanEngen, M. L., Eagly, A. H., & Johannesen‐Schmidt, M. C. (2011). An exploration of stereotypical beliefs about leadership styles: Is transformational leadership a route to women's promotion? *Leadership Quarterly, 22*, 10–21.

82. Wagner, J., & Abbott, G. (2007). Depression and depression care in diabetes: Relationship to perceived discrimination in African Americans. *Diabetes Care*, *30*, 364–366.

83. Werner‐Wilson, R. J., Price, S. J., Zimmerman, T. S., & Murphy, M. J. (1997). Client gender as a process variable in marriage and family therapy: Are women clients interrupted more than men clients? *Journal of Family Psychology*, *11*, 373–377.

84. Williams, J. C., Phillips, K. W., & Hall, E. V. (2014). Double jeopardy: Gender bias against women of color in science. Retrieved from https://toolsforchangeinstem.org/double‐jeopardy‐report/

85. Yeater, E. A., Treat, T. A., Viken, R. J., & McFall, R. M. (2010). Cognitive processes underlying women's risk judgments: Associations with sexual victimization history and rape myth acceptance. *Journal of Counseling and Clinical Psychology*, *78*, 375–386.

86. Zahnd, E., Aydin, M., Grant, D., & Holtby, S. (2011). The link between intimate partner violence, substance abuse and mental health in California, Policy Brief (UCLA Center for Health Policy Research)(PB2011–10), 1–8.

87. Zlotnick, C., Capezza, N. M., & Parker, D. (2011). An interpersonally based intervention for low income pregnant women with intimate partner violence: A pilot study. *Archives of Women's Mental Health*, *14*, 55–65.

Glossary

Ableism:

An all‐too‐common discriminatory practice in which individuals without disabilities are favored or given preferential treatment, thereby implying that those with a disability are somehow inferior

Abnormality:

A term used to describe a deviation from some standard or norm considered to be desirable

Acculturation:

The process of internalizing the values, beliefs and traditions of the larger society

Activity dimension:

A reference to how different cultural groups lie in their action orientation from one of “doing” and influencing the world, to one of “being” or living in harmony with nature

Afrocentric:

An ideology that focuses on the Black experience, history, culture and traditions

Ageism:

Negative attitudes and behaviors toward the process of aging or toward older individuals

Alzheimer's disease:

A form of dementia that generally strikes older adults and is currently incurable

Americans with Disabilities Act:

The Americans with Disabilities Act (ADA) was signed into law in 1990, extending the federal mandate of nondiscrimination to individuals with disabilities and to state and local governments and the private sector

Antiracism:

When people, organizations, or social movements work toward the eradication of racism

Antiracist:

A person with a nonracist identity who advocates and actively intervenes when injustice makes its presence felt at the individual, institutional, and societal levels

Antiracist white identity:

The complementary identity to a nonracist one in that the person is likely to take direct action to eradicate its manifestation in individuals, institutions and society

Anti‐Semitism:

Anti‐Semitism is prejudice, discrimination, and hatred of people of Jewish descent

Arab:

Individuals who originate from countries located in the Middle East and North Africa and whose primary language is Arabic

Asylum:

Asylum can be granted to certain classes of refugees due to political persecution

Attractiveness:

Attractiveness based upon how similar the client is to the counselor

Attribution error:

Attribution errors occur when the therapist holds a different perspective of the problem than that of the client and uses it to define problems and to propose solutions

Aversive racism:

A form of subtle and unintentional racism

Awareness:

Being conscious and mindful of one's own worldview, and the possible differences between culturally diverse clients, and other group identities

Băt Gió:

Southeast Asian massage treatment called Băt Gió means “catching the wind” and involves using both thumbs to rub the temples and massaging toward the bridge of the nose at least 20 times

Behavioral resistance (to multicultural training):

Resistance that entails paralysis or inaction in the presence of discrimination from majority group individuals

Bicultural orientation:

When an individual ascribes to and values two different cultures

Biculturalism:

When an individual ascribes to and values two different cultures

Bilingualism:

This term describes individuals who speak two languages

Biracial:

Individuals who are come from two racial heritages

Biracial/multiracial identity development:

A model of identity development used to describe the stages of biracial identity development in contrast to the monoracial development models

Bisexual:

This is a term that describes individuals who have an affectional and/or sexual attraction to members of both sexes

Brain fag:

This culture ‐ bound disorder is usually manifested by students in West Africa in response to academic stress

Broaching:

The skill to address sociocultural issues such as race, gender, class, and sexual orientation within a therapy context

Cao Gió:

Southeast Asian massage treatment, Cao Gió means “scratching the wind,” or “coin treatment” and involves rubbing the patient with a mentholated ointment and then using coins or spoons to strike or scrape lightly along the ribs and both sides of the neck and shoulders

Cisgender:

One’s gender identity and expression matches the sex they were assigned to at birth

Class ‐ bound values:

Socioeconomic values that permeate counseling and psychotherapy (middle and

upper class) and may prove disadvantageous to clients from poverty or less affluent situations

Classism:

Social class oppression is called classism and it operates to limit access to many kinds of socially - valued assets

Co - construction:

Co - construction involves the client and the counselor working together to identify problems and solutions

Cognitive and behavioral distancing:

The social exclusion of the poor is captured by society's cognitive and behavioral distancing from them

Cognitive empathy:

Cognitively understanding the client's predicament associated with others or his or her life circumstance

Cognitive resistance (to multicultural training):

A form of intellectual denial in which individuals from the majority group provide alternative reasons or excuses to explain incidences of racism, oppression, or discrimination

Collaborative approach:

When the therapist and client work together to construct an accurate definition of the problem and the contextual background

Collaborative assessment:

The clinical approach that values and obtains clients' input regarding social and cultural elements that may be associated with presenting problems

Collaborative conceptualization:

Developing a joint definition of the problem and treatment through formulating and testing hypotheses from both the clinician's clinical experiences and perspectives of the client

Collectivism:

The psychosocial unit of operation resides in the family, group, or collective society rather than the individual

Collectivistic orientation:

A philosophy that the psychosocial unit of identity resides in the family, group, or collective society

Coming out:

The process of when a gay, lesbian, bisexual, or transgender person reveals his or her gender or sexual orientation to others

Commitment to antiracist action phase:

In the Sue and Sue White identity development model, this phase is most characterized by social action and increased commitment toward eradicating oppression

Communication styles:

Characteristics of communication associated with race, gender and other group identities often manifested in verbal and nonverbal communication language

Confirmatory strategy:

Confirmatory strategy involves the search for evidence or information supporting

one's hypothesis and ignoring data that is inconsistent with this perspective

Conformity:

A characteristic of the Racial/Cultural Identity Development model (RCID), distinguished by an unequivocal preference for dominant cultural values over their own

Conformity phase:

In the Sue and Sue White racial identity development model, it refers to beliefs that White culture is the most highly developed and that all others are primitive or inferior

Conservative Judaism:

Politically conservative Jews who generally support the Republican party

Contextual viewpoint:

An approach or viewpoint that acknowledges the client and therapist are both embedded in systems such as family, work, and culture

Cooperation:

A cultural value of Native Americans where harmony and betterment of the tribe holds precedence over individual needs

Countertransference:

Involves the therapist's emotional reaction to the client based on the therapist's own attitudes, beliefs, values, or life experiences

Covert sexism:

Unequal and harmful treatment of women that is conducted in a hidden manner

Credibility:

People who perceived as possessing expertness and trustworthiness

Cultural adaptations:

The counseling process of attempting to incorporate culture specific variables and factors into specific treatment strategies, thereby making them more culturally relevant

Cultural competence:

Cultural competence is the awareness, knowledge and skills needed to function effectively with culturally diverse populations

Cultural deprivation:

The belief that groups of color are “culturally deprived” because they lack White middleclass values

Cultural encapsulation:

Counselors who are culturally unaware and who operate in isolation from a broader cultural context

Cultural Humility:

A complementary component to cultural competence associated with an open attitudinal stance or a multiculturally open orientation to work with diverse clients

Cultural mistrust:

When a person of one culture develops a mistrust of someone from another culture due to personal or historical experiences between the two groups

Cultural oppression:

When members of the dominant culture impose their standards upon culturally diverse populations without regard for differences

Cultural paranoia:

A term used to describe the guardedness, suspiciousness and mistrust of marginalized group members toward majority group members

Cultural relativism:

The belief that the manifestation and treatment of mental disorders must take into consideration cultural differences

Cultural values:

Values held in common by a cultural group which often help shape worldview and the perceptions of individuals of that culture

Culturally deficient model:

Belief that people of color are inferior because they were culturally disadvantaged, deficient, or deprived of a White middle - class upbringing

Culturally diverse model:

Belief that all cultures are valued and that diversity should not indicate whether one group's cultural heritage is better than another's

Culturally responsive:

An approach that takes into consideration and responds to the cultural values, life styles, strengths and assets of the client as they interact with the wider society

Culturally responsive assessment:

The process of understanding and evaluating clients through a collaborative framework that takes into account cultural and sociopolitical factors

Culturally sensitive intake interviews:

Intake interviews that take into consideration situational, family, sociocultural, or environmental issues that impact the client and includes other areas of diversity and identity

Culture bound syndromes:

Mental disorders unique to various cultures

Culture - bound training:

Multicultural training that reflects only one cultural perspective, usually the White, EuroAmerican, middle - class perspective

Culture - bound values:

Traditional western counseling and therapy are seen to possess the values of the dominant culture

Dementia:

Memory impairment and declining cognitive functioning as a result of brain disease

Diagnostic overshadowing:

Misdiagnosing a problem by focusing on a salient characteristic that has nothing to do with the problematic issue

Disability:

The ADA defines disability as “a physical or mental impairment that substantially limits one or more of the major life activities of such individual

Discrimination:

Negative or prejudicial treatment toward a person or group of people usually based on biased beliefs and stereotypes

Dissonance:

Under the Racial/Cultural Identity Development model (R/CID), people of color

become more aware of inconsistencies between dominant‐held views and those of their own group resulting in a sense of dissonance

Dissonance phase:

In the Sue and Sue White identity development model, it refers to how Whites are forced to deal with inconsistencies in their racial attitudes and behaviors as they encounter information/experiences at odds with their racial denial and naiveté

Dreamers:

Individuals brought to the U.S. at an early age without documentation

Egalitarian roles:

When roles are based on equality between genders

Ego statuses:

Reference to the different levels of ethnic identity development and the traits and defenses associated with them

Elder abuse and neglect:

The abuse and/or neglect of an elderly person

Elderspeak:

A derogatory way of speaking to someone of the geriatric generation

Emic (culturally specific):

The belief that cultural differences must be considered in the diagnosis and treatment of culturally diverse groups

Emotional affirmation:

Occurs when individuals from marginalized groups feel their lived experiences of oppression and discrimination has been heard, acknowledged, understood, and validated

Emotional bond:

The strength of the therapeutic relationship is often due to the emotional understanding or emotional connection with the client

Emotional empathy:

An emotional understanding or emotional connection with the client

Emotional expressiveness:

The value placed upon clients who are encouraged to express their feelings and to verbalize their emotional reactions

Emotional invalidation:

When individuals negate or dismiss the lived experiences of oppression and discrimination of marginalized groups

Emotional resistance (to multicultural education):

A defensive maneuver that entails emotions such as guilt, anger, defensiveness, or helplessness that block self‐exploration

Emotional self‐revelation:

An uncovering of strong personal feelings in response to race‐ and diversity‐related stimuli

Emotionality:

A term used to describe the degree to which an individual or group is taught to express or restrain emotional displays

Empathy:

The ability to place oneself in the client's world, to feel or think from the client's

perspective, or to be attuned to the client

Empirically supported relationships:

Therapeutic interventions that possess empirical support for the efficacy of the therapeutic relationship, client values and beliefs, and the working alliance between client and therapist

Empirically supported treatments:

Treatments that have empirical evidence regarding their effectiveness

Encounter:

The second stage of the Cross black identity development model where African Americans encounter situations which challenge their previous acceptance of White ways

Enculturation:

The process of learning and internalizing the values, beliefs and traditions of one's home culture

Enlightenment:

Asian psychologies states of consciousness in which attaining the highest level enhances perceptual sensitivity and clarity, concentration, and sense of identity, as well as emotional, cognitive, and perceptual processes

Espiritismo:

The belief that good and evil spirits affect mental health

Ethnocentric monoculturalism:

Refers to a belief in the superiority of one's group's cultural heritage over another, and the imposition of those standards upon the less powerful group

Ethnocentricity:

The belief that one's culture is superior to other cultures

Etic (culturally universal):

The belief that human beings share overwhelming commonalities and that the manifestation and treatment of disorders are similar across all cultures and societies

Evidence - based practices:

Counseling interventions based on research evidence from qualitative studies, clinical observations, systematic case studies, and interventions delivered in naturalistic settings

Expertness:

Typically a function of reputation, evidence of specialized training, and behavioral evidence of proficiency/competency

Extended family:

Families that include others outside of the nuclear unit such as godparents, aunts, uncles, cousins, or fictive kin

Familismo:

Reference to the importance of the extended family kinship system and its importance to a sense of connectedness, support, and identity of members

Family systems:

This comprises the system that makes up the family and includes structural alliances and communication patterns

Fatalism:

Latinos often believe that life's misfortunes are inevitable and feel resigned to their

fate (fatalismo)

Feminism:

A philosophical stance that refers to beliefs and practices directed toward gender equality—equal economic, social, and political rights and opportunities for women

Gay:

This is a term that describes a man who has an affectional and/or sexual attraction to another man

Gender Dysphoria:

A mental health condition defined in *DSM‐5* as significant distress and impairment resulting from an incongruence between a person's gender identity and assigned gender

Gender microaggressions:

The everyday slights, put‐downs, invalidations, and insults directed toward a specific gender, typically women

Gender roles:

Societal and cultural expectations and rules governing gender role definitions of acceptable behaviors, values and beliefs for males and females

Genetically deficient model:

Belief that people of color are inferior by virtue of their biological makeup

Ghost sickness:

A culture‐bound syndrome in which victims become preoccupied with the deceased and suffer from nightmares, terror, and loss of appetite

Giác Hoi:

Southeast Asian massage treatment, Giác Hoi means “pressure massage,” or “dry cup massage” and involves steaming bamboo tubes so that the insides are low in pressure, applying them to a portion of the skin that has been cut, and sucking out “bad air” or “hot wind”

Group level of identity:

Identity associated with group membership such as race, gender, sexual orientation, religious affiliation and so on

Hardiman White racial identity development:

The White racial identity development model formulated by Rita Hardiman

Helms White racial identity development:

The White racial identity development model formulated by Janet Helms

Heterosexism:

Cultural ideology that assumes heterosexuality to be the societal norm and distinctively superior to homosexuality

Heterosexist bias:

The assumption that everyone is a heterosexual and its manifestation in societal practices

Heterosexual:

This is a term that describes a person who has an affectional and/or sexual attraction to a person of the opposite sex

Hierarchical relationships:

A family structure whereby males and older individuals are given higher status in decision making and females and children are expected to defer to the authority of

males and their elders

High context cultures (HC):

Communications that rely more on the context to interpret the meaning of messages

High - /low - context communication:

Reference to whether a person relies more on the context to interpret the meaning or the content of the message

Historical loss:

Cross - generational losses of land, language, and cultural practices

Historical stereotypes:

Stereotypes which are fueled by the historical relationship between cultural groups

Hmong Sudden Death Syndrome:

A culture - bound mental disorder or phenomenon observed among the Hmong of Southeast Asian whereby individuals die suddenly in their sleep from unknown causes

Holistic outlook:

Most non - Western indigenous forms of healing make minimal distinctions between physical and mental functioning and believe strongly in the unity of spirit, mind, and matter

Holocaust:

An incredibly traumatic period in Jewish history in which Nazi Germans murdered approximately 6 million Jewish men, women, and children

Holocaust denier:

Individuals who do not acknowledge or who question the genocide that occurred during the Holocaust

Homonegativity:

Includes homophobia, or phobia of homosexual individuals, and cultural attitudes that devalue sexual minorities

Ho'oponopono:

A healing ritual of Native Hawaiians that attempts to restore and maintain good relations among family members and between the family and the supernatural powers

Hypodescent:

Also known as the “one drop rule,” which is a class - based social system that maintains the myth of monoracialism by assigning the person of mixed racial heritage to the least desirable racial status

Identity synthesis:

The process of successfully integrating multiple identities such as ethnicity, sexual orientation, gender and so forth

Immersion - emersion:

The third stage of the Cross black identity development model is characterized by a withdrawal from the dominant culture and immersion in African American culture

Immigrants:

People who have moved from their country of origin to the United States in which they now reside

Indigenous healing:

Helping beliefs and practices that originate within the culture or society

Individual level of identity:

Identity which acknowledges that no two individuals are alike, because people are unique and do not share the same experiences in life, not even identical twins

Individual - centered:

A culture - bound value in mental health practice in which the individual is the psychosocial unit of operation and independence and autonomy are the primary goals to treatment

Individualism:

One of the primary values of U.S. culture and society and refers to valuing individualism

Information - processing strategies:

These are strategies that White people use to avoid or assuage anxiety and discomfort around the issue of race

Insight:

A generic characteristic of counseling that values the attainment of insight in mental health and treatment

Institutional racism:

A set of institutional policies, practices, and priorities, designed to subjugate, oppress, and force dependence of individuals and groups on the larger society

Integration/biculturalism:

Entails an individual retaining many Asian values while simultaneously learning the necessary skills and values for adaptation to the dominant culture

Integrative awareness:

Under the Racial/Cultural Identity Development model (R/CID), people of color develop an inner sense of racial security and can own and appreciate unique aspects of their culture as well as those in US culture

Integrative awareness phase:

In the Sue and Sue White identity development model, this phase is marked by an understanding of self as a racial/cultural being, being aware of sociopolitical influences regarding racism, appreciating racial/cultural diversity, and becoming more committed toward eradicating oppression

Internalization:

The fourth stage of the Cross black identity development model characterized by resolution of conflicts between the old and new identities and a movement toward becoming more bicultural/multicultural

Internalization - commitment:

The last stage of the Cross black identity development model characterized by commitment to social change, social justice, and civil rights

Internalized racism:

The term used to describe the process by which persons of color absorb and internalize the society's racist messages about their own group, and other groups of color

Interpreters:

Bilingual individual who acts as a language translator between two individuals who do not speak each other's language

Interracial/interethnic bias:

This is the bias that a person of one racial/ethnic group harbors for members of another racial/ethnic group which can be fueled by erroneous stereotypes or negative experiences with a member of the other racial/ethnic group and can cause cognitive dissonance or denial by the holder of the bias

Interracial/interethnic conflict:

These are differences and conflicts between interracial/interethnic groups that are infrequently publicly aired because of possible political ramifications for group unity

Interracial/interethnic discrimination:

This is discrimination that is extended to a racial/ethnic group or member by another racial/ethnic group or member

Interracial/interethnic group relations:

This pertains to the historical and current relationships between racial/ethnic groups

Introspection:

Under the Racial/Cultural Identity Development model (R/CID), the introspection stage includes self‐reflection and rethinking of rigidly held racial beliefs and its relationship to whiteness

Introspective phase:

In the Sue and Sue White identity development model, the introspective phase is characterized by a state of relative quiescence, self‐reflection, introspection, and reformulation of what it means to be White

Invisible veil:

The invisibility of people's values and beliefs (worldviews) which are outside the level of conscious awareness

Islam:

Islam is the religion of Muslims and it means “submission to God”

Islamaphobia:

Prejudice directed toward Muslim individuals or followers of Islam

Jewish identity:

Refers to a highly complex and personal sense of shared cultural and historical experiences among Jews

Judaism:

Judaism is a religion with a belief in an omnipotent God who created humankind; it is one of the earliest monotheistic religions

Judgmental heuristics:

Judgmental processes commonly used to make quick‐decisions by short‐circuiting the ability to engage in self‐correction

Kinesics:

The study of how bodily movements that include facial expression, posture, characteristics of movement, gestures, and eye contact orientation affect interpersonal transactions

Kinship bonds:

Bonds between relatives

Knowledge:

The presence of accurate information about diverse groups

Latinx Americans:

Describes individuals of Mexican or Latin descent

Lesbian:

This is a term that describes a woman who has an affectional and/or sexual attraction to another woman

Levels of intervention:

The intended target(s) toward which mental health professionals aim the intended beneficial impact of their work; may range from a single individual to an entire organization to a society - wide institution or policy

LGBT Q:

This is an acronym that stands for Lesbian, Gay, Bisexual, Transgender, and Queer (or Questioning)

Linguistic barriers:

Language barriers often place culturally diverse clients at a disadvantage because counseling is usually provided in standard English

Locus of control:

Locus of control refers to people's beliefs about the degree of control they have over their life circumstance

Locus of responsibility:

Locus of responsibility refers to the degree of responsibility or blame placed on the individual or system

Low - context cultures (LC):

Communications that rely more on the content of what is said to interpret the meaning of the message

Machismo:

In traditional Latino/a culture, men are expected to be strong, dominant, and the provider for the family (machismo)

Mahiki:

The actual work that occurs during the Native Hawaiian healing ritual of Ho'oponopono begins through mahiki, a process of getting to the problems

Marianismo:

In traditional Latino/a culture, women are expected to be nurturing, modest, virtuous, submissive to the male, and self - sacrificing (marianismo)

Medical model:

Regards disability as a defect or loss of function that resides in the individual

Microaggression:

Brief, everyday exchanges that send denigrating messages to a target group

Microaggressions:

Microaggressions are the everyday slights, put - downs, invalidations, and insults directed to socially devalued group members by well - intentioned people who may be unaware that they have engaged in such biased and harmful behaviors

Microassault:

Blatant verbal, nonverbal, or environmental attacks intended to convey discriminatory and biased sentiments

Microinsult:

Behaviors or verbal comments that convey rudeness or insensitivity or demean a person's group identity heritage

Microinvalidation:

Verbal comments or behaviors that exclude, negate, or dismiss the psychological thoughts, feelings, or experiential reality of the target group

Migration:

The movement of groups of people from one geopolitical area to another

Minority model:

Views disabilities as an external problem involving an environment that is filled with negative societal attitudes and that fails to accommodate the needs of individuals with special needs

Minority standard time:

A reference to how people from situations of poverty often perceive time, and the resultant effects it has on behavior

Miscegenation:

This term describes the "mixing" of two or more different races

Model minority:

A term used to describe the myth of Asian American success in U.S. society

Model minority myth:

The "model minority" myth is the overgeneralization of the Asian American success story in the United States and depicting the group as the ideal racial/ethnic minority group

Monoracial:

Individuals who are, or who are perceived to be, of just one racial heritage

Moral model:

Regards the "defect" as representing some form of sin or moral lapse

Mosque:

A mosque is a place of worship for followers of Islam

Muhammad:

Muhammad is the messenger of God according to the Muslim religion and its holy book the *Quran*

Multicultural counseling/therapy:

A helping role and a process that uses modalities and defines goals consistent with the life experiences and cultural values of diverse clients

Multiculturalism:

Multiculturalism is the integration, acceptance, and embracing of cultural differences that include race, gender, sexual orientation, and other sociodemographic identities

Multiple discrimination:

Discrimination based on more than one aspect of diversity

Multiracial:

Individuals who are of mixed racial heritage

Muslim:

Muslims are followers of Islam or the Quran, the Islamic holy book

Naiveté phase:

The Naiveté phase of the Sue and Sue White racial identity development is characterized by racial naiveté, and innocence

Naturalized citizens:

Naturalization is the process by which an immigrant can obtain citizenship in the United States after he or she meets the criteria set by the U.S. Congress

Nature of people dimension:

A reference to how different culture groups view human nature (“good, neutral, or bad”)

Nested/Embedded emotions:

Unacknowledged emotions such as anger, anxiety, defensiveness, or guilt regarding one's thoughts about race, culture, gender, and other variables of culture

Nigrescense:

Nigrescense is the process of becoming “Black” and formulating a Black identity

Noninterference:

A Native American value and outlook in life associated with living with nature and people rather than attempts to change it or others

Nonracist:

Individuals who own up to their biases, and acknowledge their past oppressive attitudes and actions

Nonracist white identity:

An identity associated with the Whites recognizing their own racial biases, and an internal commitment to eradicating prejudice and commitment

Nonverbal communication:

Nonverbal communication includes such things as body language, vocal tone, or vocal inflection

Nonverbals as triggers to bias:

Nonverbal behaviors that may trigger racist stereotypes and fears in the individual

Nuclear families:

A reference to the family unit composed of only the husband, wife, and biological children

Oia'i'o:

The Native Hawaiian healing ritual of Ho'oponopono elicits ‘oia'i'o or (truth telling), sanctioned by the gods, and makes compliance among participants a serious matter

One Drop rule:

Describes the racist practice of classifying individuals as African American even if they possess minimal African American blood in their heritage

Orthodox Judaism:

Jews who follow strictly all Jewish rules and traditions of Judaism

Overt sexism:

Blatant unequal and unfair treatment of women

Pani:

Following the closing prayer of the Native Hawaiian healing ritual of Ho'oponopono, the family participates in pani, the termination ritual in which food is offered to the gods and to the participants

Paralanguage:

The study of how vocal cues such as loudness of voice, pauses, silences, hesitations, rate of speech, and inflection affect communication

Patriarchal roles:

A division of roles where males are given greater status, prestige and influence in the family and society

Personalismo:

A Latino/a cultural orientation whereby people relationships are more valued over institutional obligations and responsibilities

Playing it cool:

A survival mechanism to appear serene while concealing one's true feelings of anger and frustration toward oppressors

Playing the dozens:

A form of verbal provocation and impromptu speaking

Post - traumatic stress disorder (PTSD):

A mental health condition that often accompanies someone who has been subjected to trauma or terror in which the individual thought he or she would die or that another individual would or did die

Poverty:

A condition in which individuals possess chronic inadequate financial resources and occupy the bottom - most rungs of society

Preencounter:

The first stage of the Cross black identity development model characterized by anti - Black attitudes and a positive White orientation

Prejudice:

An erroneous preconceived judgment about another person based on one's group membership

Progressive Judaism:

These are individuals of Reform Judaism, which advocates the freedom of individuals to make choices about which traditions to follow

Proxemics:

The study of how sociodemographic identities affect the use of conversing distances and their meanings

Pule ho'opau:

The closing prayer of the Native Hawaiian ho'oponopono healing ritual

Pule weke:

The opening prayer of the Native Hawaiian healing ritual of Ho'oponopono

Queer:

An umbrella term that encompasses many categories of sexual minorities and reclaimed by activists to remove its' stigma

Qur'an:

The *Quran* is the Islamic holy book and it is considered to be the literal word of God

R/CID model:

A racial/cultural development model that attempts to integrate the racial/cultural development of groups of color

Rabbi:

A religious leader of the Jewish faith

Race salience:

The degree to which race is an important and integral part of a person's approach to life

Racial awakening:

An individual's understanding of themselves as racial/cultural beings and how it impacts their perception of the world and relationships with others

Racial identity:

The identity one forms as a member of a racial or ethnic group

Racial identity invalidation:

Others denial of a person's racial identity that creates a significant racial stressor, especially for people of multiracial descent

Racial/ethnic ambiguity:

Racial/ethnic ambiguity occurs when people are not easily able to distinguish the monoracial category of the multiracial individual from phenotypic characteristics

Racial/Ethnic identity:

The identity one forms as a member of a racial or ethnic group

Racial socialization:

The process by which parents of color inform and educate their children about the realities of racism in society

Racism:

Blatant and overt acts of discrimination that are epitomized by White supremacy, that denies people of color their equal rights and opportunities, and can include having hate crimes perpetuated against

Ramadan:

An annual event of Muslims that involve fasting during daylight hours throughout the holy month of Ramadan—a time for inner reflection, devotion to God, and spiritual renewal

Reform Judaism:

Reform Judaism advocates the freedom of individuals to make choices about which traditions to follow

Refugees:

In contrast to other immigrants who voluntary left their country of origin, refugees are individuals who flee their country of origin in order to escape persecution or oppression

Rehabilitation approach:

The rehabilitation approach has historically been a drive to remediate the individuals with disabilities and “make them as normal as possible”

Relational dimension:

A reference to cultural group relations and whether they are more collateral or individualistic in orientation

Religious discrimination:

Discrimination against individuals of certain religious affiliations, usually non - Christians

Reservation:

A legally designated place under the U.S. Bureau of Indian Affairs, upon which a Native American people reside

Resistance and immersion:

Under the Racial/Cultural Identity Development model (R/CID), the primary orientation of these individuals is they tend to endorse minority‐held views completely and to reject the dominant values of society and culture

Resistance and immersion phase:

In the Sue and Sue White identity development model, the White person begins to question and challenge his or her own racism and begins to become aware of the existence or racism in society

Respecto:

Respecto is the act of showing respect

Scientific empiricism:

Western value placed on empiricism which involves objective, rational, linear thinking as the means to define and solve problems

Scientific racism:

Racist attitudes and beliefs expressed under the guise of science and scientific findings

Self‐disclosure:

In counseling, the value and desire for clients to talk about the most intimate aspects of their life and to share it with the counselor

Self‐reflection:

Self‐reflection entails truthfully taking stock of one's emotions, beliefs, values, thoughts, and actions and how those impact the self and others

Sexism:

Unequal and unfair treatment of women that is embedded in our culture and often perceived as normal appropriate behaviors

Sexual harassment:

Verbal or physical conduct of a sexual nature, sometimes with explicit or implicit expectations that a woman or a man submit to sexual requests

Sexual orientation:

The term that describes how one identifies in terms of which gender he or she has an affectional and/or sexual attraction

Shaman:

The name given to many healers in different cultures who are believed to possess special powers to cure troubled individuals through their ability to communicate with the spirit world via divination skills

Sharing:

A cultural value of Native Americans in which honor and respect are gained by sharing and giving, in contrast with the dominant culture where status is gained by the accumulation of material goods

Shiite:

Shiites compose 10% of the Muslim population worldwide

Simpatico:

The relational style displayed by many Latinos—a style emphasizing social harmony and a gracious, hospitable, and personable atmosphere

Skills:

Specific expertise and ability to effectively utilize therapies and knowledge to help clients from cultures different from the therapist

Social class:

Refers to where one falls on the socioeconomic spectrum and are usually classified as upper, middle, and lower class

Social class privilege:

This describes the social, economic and cultural privileges afforded to the upper class population that does not apply to those of other classes

Social justice:

Active engagement and action in working toward equal access and opportunity for all people and in fighting injustice in all its forms

Social justice counseling:

Counseling that operates from an active philosophy and approach to producing conditions that allow for equal access and opportunity

Social stratification theory:

A description of a hierarchical system that not only positions poverty and economic characteristics of groups in our society, but involves sociopolitical relationships as well

Socially marginalized groups:

These are groups that are excluded from the dominant social order and are often linked to culture and social status

Somatic complaints:

Within the meaning of this term, bodily or physical symptoms are means by which Asian clients may express their emotional distress

Spirituality:

The life force that resides within individuals which makes them inherently worthy, and connects them to other living creatures

Stereotype threat:

When an individual of a marginalized group fear inadvertently confirming a mistaken notion (stereotype) about their group

Stereotypes:

Stereotypes are inflexible generalizations based on limited or inaccurate information that can create biases and discriminatory treatment towards marginalized groups in our society

Stereotyping:

A common but inaccurate belief and perception about a cultural group

Strong Black woman:

A term that refers to African American women's pride in racial identity, self reliance and capability in handling life challenges

Subtle sexism:

Unequal and unfair treatment of women that is embedded in our culture and often perceived as normal appropriate behaviors

Sunni:

Sunnis are the largest group of Muslims, accounting for about 90% of Muslims

Survivor's guilt:

The guilt associated with surviving atrocities in their country of origin and the necessity of leaving other family members behind

Sweat lodge:

A form of healing and purification that involves rituals filled with American Indian cultural and spiritual symbolism and meaning that takes place in a sweat lodge

Sweat lodge ceremony:

A form of healing and purification that involves rituals filled with American Indian cultural and spiritual symbolism and meaning that takes place in a sweat lodge

Synagogue:

A place of worship for individuals who follow traditional Judaism

Therapeutic alliance:

Refers to the importance of the interpersonal bond such as collaboration, empathy, warmth, and genuineness which are all factors known to be critical for effective multicultural counseling

Therapeutic bond:

The strength of the working relationship between client and therapist

Therapeutic style:

The helping style of the therapist as influenced by their theoretical orientation, race, gender and other variables

Thùôc Nam:

Among the Vietnamese, Thùôc Nam, or traditional medicine, involves using natural fruits, herbs, plants, animals, and massage to heal the body

Time dimension:

How different societies, cultures, and people view time can be divided into being past, present or future oriented

Transgender:

The term describes individuals whose gender identification is inconsistent with their assigned gender

Transphobia:

Prejudice against transgender individuals

Tribe:

An indigenous social grouping and unit connected by heritage, history, and culture and important for individual and group identity

Trustworthiness:

The degree to which people perceive the communicator as motivated to make valid or invalid assertions

Uncle Tom Syndrome:

A survival mechanism used by people of color to appear docile, nonassertive, and happygo - lucky

Undocumented immigrants:

This is the less stigmatized term for individuals who are foreign born and have immigrated to a country without following the host country's laws

Unintentional racism:

Racism and unconscious bias that is invisible to those who perpetuate it

Universal level of identity:

Identity that acknowledges people have a universal level of identity, are similar to one another, originate from the same species, and share qualities that make them human

Universal–diversity orientation:

The therapist's orientation that balances the universal and diversity perspective

Universal shamanic tradition:

Refers to the centuries - old recognition of healers (shamans) such as those called witches, witch doctors, wizards, medicine men or women, sorcerers, and magic men or women

Verbal communication:

Spoken or written language and communication in which the content of what is said is important

Victim blaming:

Explanations that attribute blame to marginalized group members for their status in life when the cause is due to external barriers such as bias and discrimination

Victimization:

The experience of becoming a victim of a negative act such as of crime, discrimination, or another aversive event

Vision quest:

A rite of passage among many Native American nations and is often used to reestablish connections between the mind, body, and spirit and to seek spiritual guidance

Western healing:

Interventions based upon Western European science and empiricism

White fragility:

The inability for many Whites to tolerate racial stress and discomfort when racial topics, issues or activities are brought to their attention

White privilege:

The unearned advantages and privileges that accrue to people of light - colored skin (usually White European descent)

White racial identity development:

The process and accompanying stages or phases by which Whites achieve various racial identities

White racial identity development descriptive model:

The White Racial Identity Model developed by Sue and Sue

White supremacy:

A belief that individuals of White European descent are superior to people of color

Whiteness:

A reference to the light skin tone of European Americans and the surrounding assumptions and norms associated with it used to judge all other groups

Who's more oppressed game:

When one uses his or her own group's oppression to negate, diminish, and invalidate that of another socially devalued group

Worldview:

Worldviews are composed of people's attitudes, values, and beliefs that affect how people think, define events, make decisions, and behave

YAVIS syndrome:

An acronym meant to indicate counselor preference for clients who are young, attractive, verbal, intelligent, and successful (YAVIS)

Yom Kippur:

Yom Kippur, the Day of Atonement, is a major holy day of the Jewish religion set aside to atone for sins during the past year

Index

A

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V

W

Y

Z

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Table of Contents