1 CULTURALLY RESPONSIVE STRENGTHS-BASED THERAPY

The Journey

- ***"What lies behind us and what lies before us are tiny matters compared to what lies within us."*** —Henry S. Haskins and Nock, 1940.
- ***"We developed a multi-faceted prejudice habit-breaking intervention to produce long-term reductions in implicit race bias. The intervention is based on the premise that implicit bias is like a habit that can be reduced through a combination of awareness of implicit bias, concern about the effects of that bias, and the application of strategies to reduce bias."*** —Patricia Devine, Devine, et al, 2012.
- ***"It's not what you look at that matters, it's what you see."*** —Henry David Thoreau, 2012.

CHAPTER OBJECTIVES

1. Contextualize the multicultural movement in the helping professions.
2. List and define several key concepts in cultural counseling.
3. Explain the role of neuroscience in understanding the cognitive processes that lead to conscious and unconscious racial, ethnic, cultural, and gender bias.
4. Evaluate whether there is a new paradigm of implicit and explicit racial bias that will influence multicultural competence and training.
5. Describe the relationship among neuroscience, racial bias, and cultural strengths as an emerging framework for culturally responsive counseling/psychotherapy.
6. Utilize the clinical skills of cultural awareness, cultural humility, and cultural empathy.
7. Understand how your own cultural background and family experiences have influenced your cultural worldview and outlook.

INTRODUCTION: THE JOURNEY TO BECOMING A CULTURALLY RESPONSIVE STRENGTHS-BASED THERAPIST

All life is a journey. From the day we're born, we each embark on a journey called life. There are over 7.3 billion people in the world, yet no two journeys are exactly alike. Our life journeys are fueled by our families, friends, beliefs, values, struggles, challenges, injustices, and dreams. This book is designed to take you, the reader, on a journey where you will encounter yourself as a cultural human being, and where you will come face-to-face with who you are culturally. By taking this journey, you will better position yourself to counsel or provide therapy to those who are culturally different from you. Once you begin, you will realize that cultural competence in counseling others is a lifelong journey.

The journey toward gaining cultural competence begins with our awareness of culture and the impact it has on our own lives as well as the lives of others. Centuries ago, Socrates said that the unexamined life is not worth living. One of the critical factors we must examine is our

culture and the effect it has had, not only on our own lives but also on the lives of those whom we seek to counsel. For instance, I have become a richer person as I have considered my many influences and the varied tapestry that constitutes my life. I am who I am because I was dipped in different cultural waters, with different people having various skin colors, hair textures, languages, values, and geographic places of origin. Each day I live out my tripartite level of being—that is, I know on a deep level three facts: I am like all other people (universal level of experience), I am like some other people (cultural and ethnic level of being), and I am like no other person in the world (unique individual level of experience). This book places an emphasis upon culture, cultural strengths, and human strengths. Culture encompasses virtually all that we believe, value, and do. We are first and foremost cultural beings.

THE PROFOUND INFLUENCE OF CULTURE

Culture is the force that humanizes each one of us; it plays a key role in determining who we are; what we think; what we eat; the music that we listen to; what we believe about men, women, and the family; and how we respond to our environment. Culture is probably one of the most powerful forces in the world—far more powerful than guns or airplanes carrying bombs. In fact, culture is what exists long after the bombing is over. Each person is born into a culture that shapes and influences how he or she views the world—what researchers have called a **worldview** (Cheung, van de Vijver, & Leong, 2011; Jones-Smith, 2014; McAuliffe & Associates, 2013; Sue & Sue, 2013). Culture has assumed a pivotal role in making me who I am and in making you who you are.

The influence of culture is so profound that it affects us even before our actual birth. From the time of one's birth (and possibly even during stages of development in the womb), the brain is organized to prefer or to lean toward the culture of the mother. A mother's womb is a child's first cultural experience. In the womb, a baby is exposed to cultural food; sounds of living, including music; and the ebb and flow of culture as the mother experiences it. Even the birth process is influenced by the culture of the people who attend to the mother. Certain cultural responses are made to signal the birth of a child (Rosenberg & Trevathan, 2003).

Culture may be defined as the sum of intergenerationally transmitted lifestyles, behavior patterns, and products of a people that involve their language, music, art, artifacts, beliefs, values, history, eating preferences, customs, and social rules (Harper & McFadden, 2003). People learn their cultures through a process of enculturation; that is, they learn skills needed to function in a particular society. The family and the community are the major transmitters of culture.

The cultural rules each ethnic group adopts are not universally or consistently obeyed; yet, all members recognize them, and individuals usually live by limiting the range within patterns of communication, beliefs, and social behavior found in cultures. Each culture produces (a) shared ways of behaving among group members, (b) a basic motivational structure for behavior, and (c) psychological needs within its members. Culture is an inevitable silent partner in counseling. Counseling is a culture-specific human invention. Each form of counseling reflects the culture that produces it. Culture guides our behavior and provides the framework for observing and identifying problems. Culture also teaches people problem-solving behaviors.

Studies have revealed that culture influences the meaning that individuals give to their symptoms and to the cause and implications of the personal difficulties they experience in life (Andrade, 2017; Gopalakrishnan & Babacan, 2015; Huang & Zane, 2016). For example, in Italian and Jewish families, members may use emotional expressiveness to share personal suffering, while those from Scandinavian, Asian, and American Indian backgrounds may be inclined to withdraw and not discuss their feelings. The Euro American worldview that dominates counseling subscribes to the values of rugged individualism, competition, and individuals' mastery over nature (Katz, 1985).

Cultural Reflections

What is the cultural relevance of your name?

What values, beliefs, and attitudes do you subscribe to that are consistent with the dominant culture?

OUR BRAINS ARE CULTURALLY CONNECTED

Culture's profound influence has been shown in recent studies that demonstrate that culture affects one's biology in that it organizes one's brain rather than the other way around. For instance, a study by Zhu, Zhang, Fan, and Han (2007) found that American brains function differently when they consider traits of themselves versus traits of others, while Chinese brains function the same whether considering their own traits or the traits of others. This study supports behavioral studies that have reported that people from collectivist cultures, such as China, think of themselves as being connected to others in the community, while Americans adhere to a strong sense of individuality.

Culture shapes a person's biology, including his or her perceptual field and reward system. For instance, one study used functional magnetic resonance imaging (fMRI) to measure brain activity in American and Japanese study participants while viewing silhouettes of people in both dominant and submissive poses (Freeman, Rule, Adams, & Ambady, 2009). The researchers theorized that they would be able to see the cultural distinction between American and Japanese participants in the manner the brain responds to visual input. When Americans viewed dominant silhouettes, the reward circuitry fired in the brain's limbic system; however, there was no such firing when they viewed submissive silhouettes. The opposite effect was observed among Japanese participants. The researchers concluded that the brain's response reflects the values of the **dominant culture**, even when viewing the same stimulus. Counselors and therapists need to become aware that culture affects the reward systems in our brains.

How we learn is another brain activity, and, it too, is based on a person's cultural frame of reference. When the brain encounters information during therapy, it is searching for and making connections to what is personally relevant and meaningful. As such, culture affects what one gives attention to during therapy. Culturally relevant therapy helps clients to make connections in the brain, and it promotes the process of therapeutic alliance, therapy engagement, and neuroplasticity (Jones-Smith, 2014).

AFFIRMING EACH PERSON'S IMPORTANCE

This book affirms the importance of each person and every ethnic and cultural background—White Americans, African Americans, Asian Americans, Latino Americans, and members of other ethnic minority groups—as well as males and females, members of the LGBTQ community, the disabled, the young, and the old. Each person is important because together we form the one and only race in this world, and that is the human race. We are all part of our individual families, as well as the family of human beings.

Some students find it difficult to untangle the various strands of their cultural identity. They say, "I have different cultural groups in my family, and I'm not really attached to any specific cultural group. On my mother's side, I'm Italian and Irish, and on my father's side, there is a German background. We don't celebrate any of these cultures at home. I guess I am just an American. I have an American culture—whatever that means." This book helps students to untangle their cultural history and to come to terms with what it means to say, "I have an American culture." What does it really mean to be a White American, an African American, a Latino/Hispanic American, an Asian American, an American Indian, a Muslim or Arab American, a member of the LGBTQ community, a person with a disability, a new immigrant or a refugee, an older person, and so forth? Can we really walk in another person's shoes? Or, are we predisposed not to want to walk in another person's shoes because doing so is uncomfortable? For counselors and therapists, it is important to bring such thoughts to the surface and deal constructively with them so that we can sincerely focus on the client's strengths within the context of cultural and other characteristics that make a person who he or she is.

THE INTEGRATION OF CULTURALLY RESPONSIVE AND STRENGTHS-BASED THERAPY

Most members of the helping professions—counseling, psychology, and social work—have called for culturally responsive ways of working with people from diverse cultural backgrounds (Hoshmand, 2006; Pedersen, Lonner, Draguns, Trimble, & Scharrón del Rio, 2016; Ponterotto, Casas, Suzuki, & Alexander, 2010; Ridley, 2005; Saleebey, 2002). This book integrates two approaches to psychotherapy: (1) culturally responsive therapy and (2) strengths-based therapy (Saleebey, 2008; Seligman, 1998; Smith, 2006). **Culturally responsive therapy** traces its roots to the multicultural movement during the early 1970s, whereas **strengths-based therapy** is founded on concepts from the strengths perspective in social work, as well as from positive psychology (Jones-Smith, 2014).

Culturally Responsive Therapy: A Beginning Definition

Culturally responsive therapy refers to a counseling relationship in which a client and a therapist are of different ethnicities, cultures, races, and backgrounds and the therapist (1) evidences awareness of the significance of both his and the client's cultural stories, (2) has specific knowledge of the client's culture, and (3) uses culturally appropriate clinical skills in working with the client. The culturally responsive therapist sees clients' descriptions of their life stories as different ways of constructing meaning out of their life experiences. Culturally responsive therapy can be conducted using a variety of theoretical approaches, such as cognitive behavior therapy, person-centered therapy, or psychodynamic therapy. In contrast, culturally responsive strengths-based therapy (CR-SBT) uses a human strengths framework to conduct therapy, and it is the major theoretical framework presented in this book. CR-SBT should be designed to help people answer the question: How can I use my strengths to achieve my goals, to find happiness in life, and to feel a sense of purpose? This theoretical approach is based on the premise that what we focus on in life and in therapy materializes in our lives. Emphasizing a person's strengths provides a positive source of motivation to deal with his or her life issues. An important theme is that therapy should create a strengths-building environment for clients. Case studies using CR-SBT are provided in each of the chapters that discuss specific culturally diverse groups.

Organization of Chapter 1

Chapter 1 is organized in three basic parts. Part 1 provides a brief history and overview of the multicultural movement in counseling and psychology. It examines multicultural competencies, ethics and multiculturalism, evidence-based multicultural research, and the social justice movement. Part 2 explores cultural competence and the cultural competence continuum. It contains several awareness skill development exercises. Part 3 deals with barriers to a counselor's cultural competence. Included in this part of the chapter are discussions of implicit and explicit racial and gender/sexual orientation bias.

BRIEF HISTORY AND OVERVIEW OF THE MULTICULTURAL MOVEMENT

Multiculturalism can be defined as a school of thought or philosophy that recognizes and values the various contributions of multiple cultures to a nation's life (Anderson & Middleton, 2018). The prevailing view is that because all cultures make valuable contributions to the society, there is no one standard cultural norm. In the context of counseling and therapy, multiculturalism refers to clinicians' efforts to integrate and embrace the cultural differences of their clients, while also acknowledging the influence of their own culture on how they perceive and respond to

clients (Ratts & Pedersen, 2015). More specifically, multiculturalism is defined as the recognition and inclusion of relevant cultural factors, such as client and counselor worldviews, ethnicity/race, gender, **sexual orientation**, religion, and **social justice**, during the process of providing counseling services, and it has become a global movement. The doctrine of multiculturalism is built on **cultural relativism**, the perspective that behavior in one culture should not be judged by the standards of another. Cultural relativism posits that all cultures have equal intrinsic value, are equally entitled to respect, and should be appreciated for their differences.

The **multicultural counseling** movement can be traced to several factors, including the global trend in which large numbers of people of color migrate from their native lands to Europe and the United States (Gallardo, 2012; Ridley, Mollen, & Shannon, 2011). As a consequence of many civil wars within countries, as well as wars between countries—World War II, the Korean War, the Vietnam War, and much later the Gulf Coast, Iraq, and Afghanistan Wars—most countries in the world are multicultural in terms of religion, culture, and/or color/race. For instance, Iceland has an African and an Asian population. Most of what was previously predominantly White Christian Europe now has significant African, Asian, and Middle Eastern populations and many adherents of religions other than Christianity. At the same time, many countries in the developing world have multiple traditional cultures. India, for example, has 23 official languages and more than 1,000 other languages spoken by various ethnic groups within the country. According to some researchers, this worldwide multicultural phenomenon is leading to a paradigm shift across many different academic disciplines (Gallardo, 2012; Ridley et al., 2011).

This is no less true in the fields of counseling and psychology. Both clients and therapists have come to recognize that culture is often a "silent intruder" in the therapeutic relationship. Clients' cultural beliefs about the causes and solutions for their mental health issues affect what they believe to constitute appropriate treatment for the issues they bring to therapy (Anderson & Middleton, 2018). Traditional therapeutic approaches to assessment might be inappropriate and even harmful when applied to culturally diverse clients. Counselors and therapists can no longer ethically treat clients without understanding the cultural influences in the therapeutic relationship. Multicultural counseling is considered socially constructive because it acknowledges each culture's perspective within the therapeutic process (Anderson & Middleton, 2018).

The multicultural counseling movement has experienced three phases. Phase 1 focused primarily on ethnic/racial minority groups. Phase 2 broadened the scope of multiculturalism to include other groups, such as gays, lesbians, women, individuals with disabilities, and so forth. This broadening of the field of multiculturalism prompted Paul Pedersen (1991) to describe multiculturalism as a fourth force in counseling. Phase 3, which is the current phase, has focused on multicultural counseling competencies and on providing evidence-based multicultural research (Harris, 2012). The three phases of the multicultural movement are described in more detail below.

Phase 1 can in some respects be traced to the civil rights movement of the 1960s and the women's movement of the 1970s. Harper (2003) has labeled the 1960s as the pioneering years of the multicultural movement in counseling. The first phase of the multicultural movement was inspired primarily by researchers of color who asserted that the theories of counseling and psychotherapy were Eurocentric and lacked consideration of their ethnocultural groups' life circumstances and cultural values (Helms, 1989, 1990; Smith, 1985, 1991; Sue, 1972).

The 1970s brought about a number of new courses on counseling ethnic minorities, as well as an increase in the number of published articles on ethnicity and culture. This era also marked the beginning of research on ethnic/racial identity development with William Cross's (1971) model of Black identity development. During the 1970s, the dominant terminology used to describe members of ethnic minority groups was "culturally different"; counseling culturally different clients was referred to as "cross-cultural counseling."

Phase 2 took place during the 1980s. It was characterized by a push for inclusiveness for other cultural groups, including women, LGBTQ individuals, people with disabilities, and others. In his authoritative account of the multicultural movement, Frederick Harper (2003) wrote:

> The early 1980s marked an increasing use of culture-characterizing terms as an attempt to be more inclusive of special populations, gender, and various identity groups in addition to non-White ethnic minorities. The interest in cross-cultural counseling got a push from Pedersen and colleagues' revised edition of *Counseling Across Cultures* (Pedersen, Draguns, Lonner, & Trimble, 1981) and a special issue of *The Counseling Psychologist* on "Cross-Cultural Counseling" (Elsie Jones-Smith & Melba Vasquez, 1985). (p. 8)

Phase 3, the current phase, began in the 1990s. It emphasizes multicultural competencies together with evidenced-based research. The Association for Multicultural Counseling and Development (AMCD) approved 31 multicultural competencies in 1991. In addition to these multicultural competencies, researchers began to focus on the development and testing of cultural assessment inventories and multicultural competence instruments (Ibrahim & Owen, 1994; Ponterotto, Casas, Suzuki, & Alexander, 2010). The 1990s also witnessed a burgeoning of textbooks on culture and diversity. According to Harper (2003),

> This increasing interest in and prevalence of books on the topic of "culture and diversity" was apparently influenced by (1) the increasing number of required "culture and diversity" courses in counselor preparation programs throughout the country, (2) multicultural counseling requirements of credentialing groups for counseling program accreditation and counselor certification, and (3) the developing professional demands for multicultural competence, including AMCD's 31 competencies for multicultural counselors that were approved in 1991 (Sue, Arredondo, & McDavis, 1992). (p. 9)

In addition, the third phase of the multicultural movement has involved efforts to respond to evidence-based studies. Initially, discussions of evidence-based practice focused on providing evidence for the treatment efficacy for specific disorders. The essential question being asked was: What kind of psychological treatment works best for specific mental disorders? The multicultural movement has continued to develop and change, suggesting in some respects that all theories of psychotherapy should be examined for multicultural contributions and limitations (Helms & Richardson, 1997).

MASTERING THE MULTICULTURAL COUNSELING COMPETENCIES

In April 1991, the AMCD approved a paper outlining the need and rationale for a multicultural perspective in counseling. Subsequently, this professional association proposed 31 **multicultural competencies**. These competencies were outlined in three broad categories: (1) counselor awareness of his or her own cultural values and beliefs, (2) counselor awareness of clients' worldviews, and (3) counselor learning of appropriate intervention strategies. Within each of these three categories, the AMCD further delineated attitudes and beliefs, knowledge, and skills (Arredondo et al., 1996).

Moreover, the American Counseling Association took an early stance on endorsing multicultural competencies (Arredondo et al., 1996; Sue et al., 1992). This professional organization has also adopted social justice advocacy competencies (Lewis, Arnold, House, & Toporek, 2003). Both of these professional organizations continue to have a profound influence on the way mental health professionals conceptualize their roles with regard to clients from diverse backgrounds. They challenge therapists to analyze carefully how best to respond to clients from cultural backgrounds that differ from their backgrounds.

Since the 1990s, a number of professional organizations and accrediting bodies have published or endorsed what they consider culturally responsive clinical practice. In 2003, the American Psychological Association (APA) published the *Guidelines on Multicultural Education,*

Training, Research, Practice, and Organizational Change for Psychologists as a policy statement. The policy contained six guidelines:

> ***Guideline 1*:** "Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves" (p. 382).
>
> ***Guideline 2*:** "Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness to, knowledge of, and understanding about ethnically and racially different individuals" (p. 385).
>
> ***Guideline 3*:** As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education" (p. 386).
>
> ***Guideline 4*:** Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds" (p. 388).
>
> ***Guideline 5*:** "Psychologists are encouraged to apply culturally appropriate skills in clinical and other applied psychological practices" (p. 390).
>
> ***Guideline 6*:** "Psychologists are encouraged to use organizational change processes to support culturally informed organization (policy) development and practices" (p. 393).

Also in 2003, the AMCD published an updated version of its Multicultural Counseling Competencies (Roysircar, Arredondo, Fuertes, Ponterotto, & Toporek, 2003). In 2016, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) included the centrality of "social and cultural diversity" in its curriculum standards for counseling programs.

Not all counseling or mental health professionals are in favor of the multicultural competencies. Weinrach and Thomas (2004) and Thomas and Weinrach (2004) criticized the multicultural competencies on the grounds that they focused primarily on four ethnic groups: African, Asian, Hispanic, and American Indian. They expressed concern that definitions of *multiculturalism* and *diversity*, as well as other terms used throughout the competencies, were imprecise and contradictory. In addition, these researchers maintained that the competencies seemed to stereotype clients by suggesting that those who were members of a given group should be treated as examples of that group rather than as individuals.

For the most part, however, objections to the multicultural guidelines have gone by the wayside. The APA has made it clear that one must abide by the guidelines to provide good clinical practice and that failure to do so might result in ethical actions being taken against a psychologist.

The basic competencies for culturally responsive counseling can be grouped into three broad categories: (1) awareness, (2) attitudes, and (3) skills (Sue et al., 1992). Culturally responsive counselors have:

- ***Awareness of their own cultural values and biases.*** They must be aware of the impact of their culture on their values, choices, manners, and privileges. They should understand the processes involving discrimination and stereotyping and exhibit a desire to seek additional training where diversity issues are concerned. They are aware of how their own cultural background, experiences, values, and biases affect the counseling relationship and service delivery. They are comfortable with the cultural and other differences that exist between themselves and their clients.

Cultural Reflections

How valuable do you think the multicultural competencies and standards are for your own practice and for the clinical practice of others?

Should counselor trainees be evaluated on their ability to enact the multicultural guidelines?

- ***Knowledge of their clients' worldviews.*** They must demonstrate a reasonable level of multicultural literacy or knowledge of different ethnic and cultural groups' worldviews involving such areas as race, ethnicity, class, gender, sexual orientation, disability, and religion. They have specific knowledge about their clients' cultural membership group.
- ***Competence in implementing clinical intervention strategies that are culturally appropriate for their clients.*** They are capable of using both individual and system intervention techniques for the benefit of their clients.

ETHICAL ISSUES AND MULTICULTURALISM

Counselors face a number of ethical issues when working with culturally different clients. Increasingly, multicultural counseling standards, ethical codes, guidelines, and competencies now pervade the counseling and helping profession. Currently, CACREP requires that counseling programs include "social and cultural issues" in their curricula. To meet CACREP's

MULTICULTURAL COUNSELING COMPETENCIES: COUNSELORS' AWARENESS OF THEIR ASSUMPTIONS, VALUES, ATTITUDES, AND BIASES

Awareness Competencies

Culturally competent counselors:

1. Move from being culturally unaware to being aware of and sensitive to their cultural heritage, and to being respectful of the cultural differences of their clients.
2. Are aware of their own cultural values and how such values may enter the counseling relationship with culturally diverse clients.
3. Are comfortable with race, gender, sexual orientation, beliefs, and other cultural differences that exist between themselves and their clients.
4. Are aware of cultural issues that may suggest referral of clients to members of their own cultural group or other counselors in general.
5. Are aware of their own racist, sexist, heterosexist, and other intolerant attitudes and how these may intrude in the counseling relationship.

Knowledge Competencies

Culturally competent counselors:

1. Are knowledgeable and informed about a variety of culturally diverse groups, especially those groups with which they work.
2. Are knowledgeable about the sociopolitical system in their country, and understand how oppression, racism, discrimination, and stereotyping affect their clients' psychological, political, and economic functioning.
3. Possess specific knowledge related to the generic characteristics of counseling and psychotherapy.
4. Are knowledgeable about how institutional barriers may hinder or thwart culturally diverse clients from using mental health services.

Cultural Competence Skills

Culturally competent counselors:

1. Are comfortable using a wide variety of verbal and nonverbal counseling responses.
2. Communicate accurately and appropriately with their clients.
3. Use institutional intervention skills to help their clients become more effective.
4. Understand and anticipate the effect of their counseling styles and limitations on culturally diverse clients.
5. Are not restricted by conventional counseling methods in that they use helping roles that are characterized by an active systemic and social justice focus.

Source: Adapted from 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.

requirement, counselor training programs disperse multicultural perspectives throughout their counseling program and offer separate coursework in multicultural counseling.

Professional associations have also played significant roles in the movement toward multiculturalism. The American Counseling Association (2005) presents diversity as a central issue in the Preamble to its *Code of Ethics*: "Association members recognize diversity and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts" (p. 3). The ACA *Code of Ethics* also states that mental health counselors "will actively attempt to understand the diverse cultural backgrounds of the clients with whom they work" (p. 4).

The American Psychological Association has recently updated its multicultural guidelines to "Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality" (2017). APA's 2017 multicultural guidelines differ from the earlier ones cited in this chapter in that they emphasize intersectionality, lifelong development of an **ethnic identity**, and strengths-based therapy for culturally diverse clients. These guidelines will expire as APA policy in 10 years (2027). The following paraphrases APA's 10 new multicultural guidelines:

***Guideline 1*:** Psychologists understand the fluid nature of cultural, racial, ethnic, and individual identity of people and that one's identity undergoes a process of intersectionality, meaning that it is affected by a multiplicity of social, political, and ecological environments.

***Guideline 2*:** Psychologists recognize that people are cultural beings and that their cultural backgrounds influence their perceptions and interactions with clients. They endeavor to move beyond their own stereotypes and prejudices of individuals from different cultures.

***Guideline 3*:** Psychologists understand the significance of language and communication and how their own language affects their relationships with clients and others.

***Guideline 4*:** Psychologists take an ecological perspective when working with clients in that they take into consideration the impact of social and physical environments on the lives of their clients and students.

***Guideline 5*:** Psychologists understand the historical and current implications of power, privilege, and oppression on the lives of their clients and on the communities from which they come. They address as best they can institutional barriers, disproportionalities, and disparities of law enforcement and mental health delivery systems, as well as other systems to promote human justice and access to equitable mental health services.

***Guideline 6*:** Psychologists endeavor to promote culturally responsive interventions within and across systems in the areas of prevention, early intervention, and recovery.

***Guideline 7*:** Psychologists examine and explore the profession's assumptions about human behavior and mental health on both a national and an international level to assess cultural bias and misconceptions about individuals from different cultures.

***Guideline 8*:** Psychologists understand that cultural, racial, or ethnic identity is a lifelong process that evolves as people age and interact with others and their environment.

***Guideline 9*:** Psychologists endeavor to conduct culturally responsive research, teaching, assessment, diagnosis, and consultation and they respond to the first four levels of the multicultural guidelines.

***Guideline 10*:** Psychologists seek to take a strengths-based approach when working with clients, families, groups, communities, and organizations that endeavor to build resilience and to mitigate or decrease trauma within the sociocultural context.

CASE VIGNETTE 1.1

JIM HUANG: AN UNINTENDED ETHICAL VIOLATION

Dr. Becker was surprised to hear that one of his students, Jim Huang, had filed a complaint against him with the dean of arts and sciences. Dr. Becker had received several outstanding teaching awards within the university, and the complaint now facing him threatened his very academic reputation, as well as his chairman position in the counseling psychology department. The student complaint alleged that Dr. Becker had lowered Jim Huang's grade in the counseling seminar because he refused to share personal information about his upbringing and his family. Jim said he felt pressured to self-disclose in order to get along with the other students in his class, who were all White. The students complained that they had revealed personal information about themselves while Jim sat silently listening. They did not feel as if he wanted to be in the class, and they challenged whether he should even be in the master's level counseling psychology program. The class was a required one that Dr. Becker had taught for the past seven years, and it was required for completion of the master's level counseling psychology degree.

The student said he had indicated to Dr. Becker that his cultural background made him hesitant about revealing personal information about himself, his upbringing, and his family. He indicated that his clients would not require him to reveal such information and that he intended to work in a Veterans Administration hospital with elderly clients who suffered from depression, dementia, and/or the late stages of alcoholism. He filed the complaint because Dr. Becker said that it would be disruptive to the class if he did not self-disclose as did the other students.

The complaint was forwarded to an ethics committee within the school of arts and sciences. The committee ruled in favor of the student, but noted that the ethical infraction was not intentional. The ethics committee held that there was insufficient notice or warning to the student that a high degree of self-disclosure would be required in the course. The description of the seminar in the course catalog and the professor's own course syllabus did not mention that students would be required to disclose personal information about themselves in front of the class. If the requirement of high student self-disclosure had been mentioned in either of these documents, the committee would have ruled in favor of Dr. Becker.

The ethics committee held that Jim Huang be required to write a paper or provide evidence of his mastery of the subject matter for the course. The committee also held that the counseling psychology department had a heavy emphasis on multiculturalism and that it should have been sensitive to the student's cultural background. The course was heavily directed toward White American students instead of students from culturally diverse backgrounds.

Discussion Questions

1. To what extent should all students within a counseling psychology program be required to self-disclose as part of the course requirement?
2. Do you find it contradictory that the counseling program emphasized multiculturalism, all the while requiring students to respond in a manner that reflected White American response patterns?
3. To what extent should the professor modify his course so that it is responsive to the needs of different cultures?
4. Do many counseling courses reflect the value orientations of White American culture?
5. If you were on the ethics committee, how would you have voted, and why?
6. Do you think that Jim should have filed the complaint against Dr. Becker? Explain.

APA maintains that psychologists have an ethical obligation to develop cross-cultural competencies when working with clients who are culturally different from themselves. The counselor's role is to help clients to deal with life challenges that are consistent with the clients' worldviews.

It is unethical for clinicians to provide therapeutic services to culturally diverse clients when they are not competent to work with such clients (Fouad et al., 2009; Gallardo, Johnson, Parham, & Carter, 2009; Herlihy & Corey, 2015).

Ethical practice requires that clinicians develop multicultural competencies in testing and assessment. Diagnosis using the *DSM-5* (American Psychiatric Association, 2013) may present major ethical problems when working with some culturally diverse clients if clinicians do

not have the requisite multicultural competencies. Corey, Corey, and Callahan (2011) maintain that a comprehensive code of ethics needs to respect the values of all cultures. They point out that "when counselors are overly self-conscious about their ability to work with diverse client populations, they may become too analytical about what they say and do during counseling. Counselors who are afraid to face the differences between themselves and their clients, who refuse to accept the reality of these differences, who perceive such differences as problematic or are uncomfortable with working out these differences are likely to fail" (p. 136).

THE EVIDENCE-BASED MOVEMENT IN MULTICULTURAL COUNSELING

A major criticism of multicultural counseling approaches is that they are not evidence-based. Gradually, however, evidence-based practice (EBP) has been broadened to include "understanding the influence of individual and cultural differences on treatment" and the need to take into account client "characteristics, culture, and preferences in assessment, treatment plans and therapeutic outcome" (American Psychological Association, Presidential Task Force on Evidence-Based Practice, 2006). In an article asserting that EBPs with ethnic minorities had come of age, Morales and Norcross (2010) stated, "Multiculturalism without strong research risks becoming an empty political value, and EBT [evidence-based training] without cultural sensitivity risks irrelevancy" (p. 283).

Despite these concerns, studies of mental health treatment efficacy with members of ethnic minority groups have provided evidence that EBPs may be successful within diverse populations (National Alliance on Mental Illness [NAMI], 2008). A study by Miranda et al. (2005) reported that evidence-based care may translate to both African American and Latino populations as effectively as it does to White American populations. Kohn, Oden, Munoz, Robinson, and Leavitt (2002) found that EBPs that used culture-specific issues and concerns during the delivery of cognitive behavioral therapy for African American women with depression showed greater decreases in symptoms than did similar women who were treated with the culturally unadapted cognitive behavioral therapy. Significant data are not yet available for the effect of EBPs with Asian American or American Indian populations.

A critical challenge in EBP studies is the adequate sampling of ethnic/racial populations; however, this situation appears to be improving. Higa and Chorpita (2007) gathered information from 26 efficacy trials of cognitive behavioral therapy, and deemed this EBP to be a "best support" treatment of anxious or avoidant behavior problems among Asian, African American, Caucasian, Hindu, Latino, Indonesian Dutch, and multiethnic youth populations (NAMI, 2008).

This book adopts the view that multicultural counseling will continue to change over the years, that it will become more evidence-based, and that it will combine its emphasis with other theoretical approaches, such as cognitive behavioral theory (Comas-Díaz, 2006; Garrett et al., 2011; Geva & Weiner, 2015).

BEGINNING THE CULTURAL COMPETENCY JOURNEY

Cultural competence refers to a clinician's ability to demonstrate cultural awareness, knowledge, and skills in working therapeutically, effectively, with a client (Sue, Zane, Nagayama, Hall, & Berger, 2009). Culturally competent clinicians are aware of their own cultural identities, assumptions, and biases toward other cultural groups. To achieve cultural competence in clinical practice, clinicians should begin by exploring their own cultural heritage, and examining how it influences their perceptions of normality, abnormality, mental health, and the therapy process (Kirmayer, 2012).

What is the significance of a counselor's cultural competence for working with clients? Therapists who are aware of their own cultural heritage are more inclined to explore how culture affects their client–counselor relationship (Sue et al., 2009). Lack of cultural awareness may lead to therapists' discounting or underestimating the influence of their own cultural beliefs, values, and attitudes on their diagnostic impressions of clients (Tseng & Streltzer, 2004). When counselors lack cultural awareness, they are inclined to use their own cultural experiences as a template to judge clients and to evaluate their presenting problems. In addition, they may be oblivious to the cultural uniqueness of their clients, as well as how their clients' cultural background interacts with their presenting problem (Anderson & Middleton, 2018; Geva & Weiner, 2015).

Culturally competent counselors and therapists identify culturally specific and universal domains of helping. They do not view the Eurocentric healing standards as normative in evaluating their culturally diverse clients, and they do not use inappropriately the Eurocentric approach to therapy on their culturally diverse clients because such actions may result in the cultural oppression of their clients (Kirmayer, 2012). They understand that different cultures may have different standards for what constitutes mental health and healing practices. While some clients might respond best to culturally specific strategies, others do better when the emphasis is on universal issues of human functioning (Velez, Moradi, & DeBlaere, 2015). Moreover, culturally competent counselors and therapists familiarize themselves with the multicultural competencies that have been developed for their respective profession.

LEVELS OF COUNSELOR COMPETENCY DEVELOPMENT

Assuming that a clinician's cultural identity and cultural competence develop over a period of time, what might be some common stages through which individuals pass? T. Cross, Bazron, Dennis, and Isaacs (1989) have identified six stages that a person experiences as he or she moves toward gaining cultural competence. Although their model was originally designed for organizations, it has also been used for clinicians who work with individual clients.

1. **Cultural Destructiveness:** This is the lowest level of cultural competency, and is characterized by policies and practices that are destructive to cultures and individuals. One extreme example of the cultural destructiveness continuum is cultural genocide, or the purposeful destruction of a culture.
2. **Cultural Incapacity:** Although a therapist might not purposely act to be culturally destructive, he or she may lack the ability to help culturally diverse clients. The therapist delivers counseling service from an extremely biased perspective. He or she may believe in the racial superiority of the dominant group in society and may assume a paternal attitude toward "lesser races." The therapist operates within a biased therapy system, with a paternal attitude toward other groups. He or she may fear other groups and cultures or participate in discriminatory practices, thereby lowering expectations or devaluing such groups.
3. **Cultural Blindness:** Therapists and agencies operate with the express purpose of being unbiased; they may even post on their doors a philosophy of such. Culturally blind therapists and agencies are characterized by the belief that counseling approaches used by the dominant culture are universal and without bias. Although the cultural blindness philosophy appears to be a well-intentioned philosophy, in actuality it represents a Eurocentric and ethnocentric approach.
4. **Cultural Pre-competence:** This approach is characterized by acceptance and respect for cultural difference, and by continual self-assessment regarding culture. The therapist

might make a variety of cultural adaptations to therapy models in order to better serve the needs of culturally diverse clients. The agency makes a deliberate attempt to hire unbiased employees, and agencies may actively seek advice and consultation from the culturally diverse communities representing the clients their agency serves. The therapist understands his or her own weaknesses in working with people from other cultures, and may engage in culturally responsive training.

5. **Cultural Competence:** The therapist and agency accepts and respects cultural differences. The therapist has acquired culturally relevant intervention skills and adopts a policy of being open and sensitive to other cultures. The therapist actively engages in expanding his or her cultural knowledge.
6. **Cultural Proficiency:** The therapist holds a wide range of cultures in high esteem. He or she obtains training of new counseling approaches for working with culturally diverse clients. He or she becomes an advocate for cultural competency at the individual and agency level.

CLINICAL SKILL DEVELOPMENT: CULTURAL AWARENESS AND KNOWLEDGE

To achieve cultural competence, a counselor should have reached a level of proficiency with regard to (1) cultural awareness and (2) cultural knowledge. The clinical skill of cultural awareness is examined, and a chart is provided for this skill (Table 1.1).

Therapist **cultural awareness** is crucial for effective counseling. Counselors who are aware of their own cultural backgrounds tend to acknowledge and explore how culture affects their client–counselor relationships. A counselor who is culturally aware does not ignore effects of obvious issues involving race, gender, and culture on the therapeutic relationship. Cultural awareness works to prevent clinicians from using their own culture as the template from which they view clients' culture. With cultural awareness, clinicians are more in tune with how their own beliefs, experiences, and biases affect their definitions of what constitutes normal and abnormal behavior. Because of its critical role during therapy, cultural awareness is the first step toward becoming a culturally competent counselor.

Cultural Reflections

Cultural awareness means understanding what you feel about members of cultural groups who are different from you.

What are the values of the cultural group that has had the most influence on your life?

How does your family view itself as similar to or different from other cultural groups?

Cultural Congruence and Cultural Incongruence

The culturally responsive therapist is aware of the client's degree of cultural congruence, cultural knowledge, and self-knowledge. **Cultural congruence** is defined as a positive relationship between an individual's cultural identity and his or her behavior and lifestyle. Conversely, **cultural incongruence** refers to the inconsistencies between how a person lives and his or her cultural identification. Individuals who display a high degree of cultural incongruence may be predisposed to or vulnerable to mild, moderate, or severe mental disturbance (Parham, 2012). For instance, Julio is a second-generation Mexican American who feels a sense of cultural incongruence because he does not subscribe to the Latino cultural value of machismo. A middle- or upper-class African American might feel a sense of cultural incongruence if he or she does not subscribe to the values of African American culture or if he or she "speaks like a White person." A White American who grew up in a predominantly Black or Latino neighborhood and feels close associations with one of those cultures might also feel a lack of cultural congruence.

Table 1.1 lists the components of the clinical skill of cultural awareness in greater detail.

TABLE 1.1 ■ Components of the Clinical Skill of Cultural Awareness

Component 1: The clinician has taken steps to learn about his or her own culture. Before entering into a counseling relationship, the clinician must become aware of his or her cultural and historical background. A person who recognizes the different influences on his or her cultural background is better able to recognize the different influences in a client's background.
Component 2: The clinician understands his or her own personal worldview and is aware of how his or her cultural background might affect the clinical relationship.
Component 3: The clinician appreciates his or her multiple identities and comprehends his or her cultural identity and the stage of cultural identity he or she is in. Most people have identities related to gender, age, religion, ethnicity, socioeconomic status, professional status, and so forth.
Component 4: The clinician has cognitive and emotional knowledge about his or her implicit and explicit biases toward members of a group that is culturally different from his or her own.
Component 5: The clinician understands, appreciates, and is respectful of the culture and worldviews of his or her clients and understands the cultural identity stage that his or her client is in.
Component 6: The clinician recognizes the limits of his or her cultural competency in working with culturally diverse clients. Cultural awareness requires a lifelong commitment to self-evaluation.

Tables 1.2 and 1.3 provide class exercises that can be used to examine Component 1 (understanding the influence of our culture) and Component 2 (comprehending our worldviews). Other class discussion questions and exercises are provided at the end of this chapter.

TABLE 1.2 ■ Culturally Responsive Clinical Skill Development, Component 1: Understanding the Impact of Your Own Culture

This exercise is designed to get students and participants thinking about the influence of their own cultural, ethnic/racial, gender/sexual orientation, and religious background on their lives. Participants are asked to respond to the following questions (15–20 minutes) and to then discuss their answers or responses in groups of four or five. The group can decide to choose a person to serve as a recorder for the group so that a record can be made of the similarities and differences noted among the participants.

1. Where were you born, and during what year were you born?
2. Where did you grow up?
3. Where did your parents, grandparents, and great grandparents grow up?
4. In your family, what cultural events did you celebrate?
5. What is your earliest memory of being a member of a cultural group?
6. Is that a pleasant or an unhappy memory?
7. Do you eat any foods associated with your cultural group? What influence has your cultural group had on the type of music you listen to or the way that you dress?
8. Is there one cultural, ethnic/racial, gender/sexual orientation, or religious group toward which you feel bias? What is the source of your bias—family, cultural group, mainline society, or another factor?
9. Do you feel you were a member of a privileged group within the society or country in which you grew up?
10. What factors made you a member of a privileged group? Was it your race/ethnicity, gender/sexual orientation, religion, and so forth?

11. What impact has your cultural group, ethnic/racial group, gender/sexual orientation group, or socioeconomic group had on your life?
12. If a magic wand could be waved and you could change your cultural or racial group, of what group would you choose to be a member? Explain your answer.
13. If you had to select one major influence that your dominant cultural, ethnic/racial, religious, or gender/sexual orientation group had on your present life, what would that influence be?
14. How comfortable are you working with people who are culturally different from you?

TABLE 1.3 ■ Culturally Responsive Clinical Skill Development, Component 2: Understanding Your Worldview

Our perceptions of our clients are shaped by our own individual worldviews. We learn our worldviews through the process of socialization from childhood to adulthood. Culture has a major influence on our worldviews, and most of the time, our worldviews are perceived as "the way things are" or "the way that things should be." Our worldviews oftentimes go unquestioned because they are "silent intruders" into our relationships with others. To get at our worldviews, we have to examine the beliefs and social values that sustain them. For instance, in Western society (including Europe and the United States), one commonly accepted worldview is that the individual should be the captain of his or her soul, which is in direct contrast to the view that the group is the most important. People who are blind to their own worldviews will not be able to discern the differences in values between various cultures.

There are different aspects of worldview. For instance, worldview may deal with time, space, territoriality, relationships, and spirituality. For instance, in the United States and Europe in general, time is viewed as something that has to be mastered; it is a commodity, and people must adhere to strict time, especially being on time. The following is a short exercise to help you become clearer about your worldview.

Class Activity 1

In small groups of three to five people, answer individually on a blank sheet of paper the following questions. Then discuss the individual group members' responses to the following questions or situations:

- How do you view time? To what extent do you agree with the statement, "Time is money"? Or do you tend to believe that time is a process and that the needs of people may interfere with keeping to a set time?
- To what degree do you tend to form relationships quickly and end them quickly? Are there many people located inside your circle or just a few people?
- Do you believe that how things get done depends on relationships with people and attention to the group process, or do you adhere to the belief that things get done by following procedures and paying attention to detail?
- To what extent is your identity rooted in yourself and your accomplishments? Or is it rooted in various groups, such as your family or your work group?

Class Activity 2

Take a few minutes to write down five important beliefs you have about yourself, people, and the world in general. Next, rank order your beliefs from most to least important to you. Which beliefs are most important to you? How do your beliefs shape your view of yourself and others? In small groups of three to five people, discuss and compare your core beliefs about life and people.

According to Tervalon and Murray-Garcia (1998) cultural self-awareness requires a lifelong commitment to self-evaluation and assessment. How committed do you feel to taking a lifelong journey of cultural self-awareness? As it stands right now, how aware are you of your own cultural background? Before beginning a client–counselor relationship, a counselor must become aware

of his or her cultural background. As a counselor recognizes the different influences on his or her cultural background, he or she will be more capable of responding sensitively to the client.

Culturally Competent Awareness Checklist for Mental Health Workers

Before working with a culturally diverse client, the mental health worker completes the Culturally Competent Awareness Checklist (Table 1.4). The checklist is not exhaustive, but it does outline important areas to take into consideration when working with culturally diverse clients.

TABLE 1.4 ■ Culturally Competent Awareness Checklist for Mental Health Workers

1. _____I am aware of the impact of culture on my client's presenting counseling problem.
2. _____I am aware of the *family roles* that are dominant in my client's culture, and I understand how those family roles may differ both within his or her culture and across cultures.
3. I am aware that my client's culture can affect his or her *child-rearing practices*, including:
   - A. _____Discipline
   - B. _____Relationships with parents, siblings, and other family members
   - C. _____Expectations for academic achievement and job success
   - D. _____Communication style with parents, siblings, and other family members
   - E. _____Educational decisions
   - F. _____Career choices
   - G. _____Dating others
4. I am aware of the impact of culture on my client's *life activities*, involving:
   - A. _____Attitudes toward mental health and mental health services
   - B. _____Religious-faith-based practices
   - C. _____Views on gender roles
   - D. _____Outlook on alternative medicine
   - E. _____Marriage, divorce, etc.
   - F. _____Customs or superstitions
   - G. _____Jobs and employment
   - H. _____Perception of time
   - I. _____Views on wellness
   - J. _____Views on disabilities
5. I am aware of how my client's cultural norms may influence *communication* with me and others, including:
   - A. _____Eye contact
   - B. _____Interpersonal space relationships
   - C. _____Comfort with silence
   - D. _____Asking and responding to questions
   - E. _____Considerations for appropriate topics of conversation
   - F. _____Greeting others
   - G. _____Alternative communication methods for sharing information (i.e., storytelling)
   - H. _____Interruptions
   - I. _____Use of gestures
   - J. _____Use of humor

Source: © Jones-Smith, 2015.

MAJOR BARRIERS TO CULTURALLY COMPETENT COUNSELING

This section reviews barriers to a counselor's development of cultural competence. Five major barriers to cultural competence include (1) inappropriate use of Eurocentric theories of psychotherapy and Western cultural values, (2) cultural encapsulation of the counselor, (3) monoculturalism, (4) cultural oppression with regard to lack of consideration of a client's worldview, and (5) implicit and explicit counselor and client ethnic/racial, gender, sexual orientation, and disability and age biases. Let's examine these barriers.

The Inappropriate Use of Eurocentric Psychotherapy Theories

Because theories of psychotherapy are usually influenced by the cultural background of the theorist, most current theories need to be expanded in terms of multicultural issues. A major issue is: Do we need to separate multicultural theories for psychotherapy, or can the current major theoretical schools simply be modified to include multicultural perspectives? Multicultural counseling will continue to change over the years, and it will combine its emphasis with other theoretical approaches, such as cognitive behavioral theory and relational theory.

Historically, psychologists and other mental health professionals have used **Eurocentric counseling theories** to formulate their thinking about client issues. Yet, each of the Western theoretical formulations is value laden. How could they be otherwise? Whatever theory a person constructs is influenced by his or her cultural framework. Multiculturalists contend that traditional counseling theories fail to consider the ways in which culturally diverse persons construct their own meanings of mental health, psychological stress, and appropriate coping strategies (Ponterotto et al., 2010). They argue that no theory, however objective it appears on the surface, is value free. In evaluating each theoretical approach for psychotherapy, it is important to know something about the zeitgeist that was prevalent during the theorist's lifetime.

Despite the criticism against Eurocentric counseling theories, many of these theories have made good contributions to psychotherapy. For instance, the behavioral contributions of B. F. Skinner and the cognitive behavioral school of Albert Ellis and Aaron Beck have relevance to most cultures (Jones-Smith, 2014). Every ethnic and cultural group establishes culturally relevant cognitions or thoughts that influence individuals' behavior. Likewise, most cultures use the principle of reinforcement to ensure that individuals' behavior will conform to that group's norms or values. Counselors and therapists must become aware of the dominant cultural cognitions within each ethnic group.

Even though there are benefits to adopting a cognitive behavioral framework, mental health professionals must examine how a Western perspective may hold certain cultural biases. For instance, most Western counseling theories assume that people are capable of change and that they should pick themselves up by their own bootstraps. Such theories maintain that the self is more important than the community, that an individual should have an internal locus of control rather than an external (group) locus of control, and that an individual's spirituality should be de-emphasized in therapy. People who come from cultures that emphasize the importance of the group over the individual may find it offensive to stress the importance of the self. They may not value self-disclosure, especially when such disclosure deals with revealing family secrets.

Moreover, the therapeutic process is laden with certain beliefs, such as the value of talk therapy—the belief that establishing a relationship with another person skilled in psychological principles and intervention strategies can help that person deal with deep-seated personal issues. Counseling students frequently value client characteristics and behaviors that involve clients making their own choices rather than those of their parents, being open and self-revealing, and gaining independence from their families and other groups.

Eurocentric counseling interventions may not work with clients from Eastern, Asian, and African cultures. Does this mean that only Asians should counsel other Asians, or only African Americans should treat other members of their ethnic group? Research shows that one does not have to be a member of the client's ethnic group to counsel a client. However,

CASE VIGNETTE 1.2

ERICA AND THERAPIST CULTURAL ENCAPSULATION

Erica sat in her office reflecting on her morning counseling session with Latisha. She was frustrated because she never seemed to get anywhere with her. She realized that deep down inside she felt a sense of anger toward Latisha, an African American woman in her late twenties. Latisha was poor, barely getting by financially, and she had two kids from two different relationships. Neither father was supporting the kids. Latisha had been forced off welfare by her caseworker because she had been on welfare too long. She shared a home with her mother, and the two of them struggled to pay the rent and utility bills. Sometimes the water, lights, and gas were turned off, even in the dead of winter.

Latisha's financial and housing problems seemed to exacerbate her struggle with depression, and vice versa. Depression had left her feeling so drained that she was unable to seek new employment. Her kids were having behavior problems in school, and she lacked the energy to address this with their teachers. Nothing was working for her; everything was working against her.

As a therapist, Erica felt overwhelmed by Latisha's problems. And if she were honest with herself, she felt angry at Latisha for not doing something more positive with her life. Latisha fit so many negative stereotypes.

Then, for a brief moment, Erica thought about her own life growing up in a middle-class White suburb. She could not imagine herself being in the same situation as Latisha, and found herself thinking that she probably would not have been able to survive half of what Latisha had survived. But still, a part of her blamed Latisha. She wished she could give her a magic pill that would end her depression so that she would not have to be confronted with a seemingly hopeless counseling situation. "I'm just glad that I'm White," Erica said to herself, "because I don't think I could make it as a Black person."

Discussion Questions

1. Have you ever worked with a client whose financial and personal circumstances seemed overwhelming to you and the client? How should a therapist deal with his or her own feelings of being glad not to be in the position of a troubled client?
2. Do you believe that Erica had established a therapeutic alliance with Latisha? Explain your answer.
3. What might be a beginning point that would establish a more productive therapeutic relationship between Erica and Latisha? The theme that the therapist seemed to embrace is "I'm glad that your life is not my life."
4. There are many aspects of Latisha's situation that might benefit from strengths-based therapy. Instead of focusing on the overwhelming negatives in Latisha's life, the therapist might consider Latisha's strengths. After all, Latisha did exhibit some measure of strength in getting up and coming to therapy.
5. What other strengths do you see in Latisha's life that might serve as a source of motivation for her? Latisha deserves credit for taking care of her children, however limited that might be. She was employed previously, so she has to have an employable skill.
6. One aspect of strengths-based therapy is helping clients to let go of past failed relationships and past financial and economic failures and to focus on changing just one thing—however small that might be.
7. How might the therapist help Latisha to set meaningful goals for her life and a reasonable plan to change her situation?
8. What steps could be useful in helping Latisha to deal more constructively with her depression? Medication? Exercise?

client-perceived similarity does have an influence on the rapidity with which one can establish a therapeutic alliance (Sue & Sue, 2013).

Cultural Encapsulation: Barrier to Cultural Competence

The journey toward becoming a culturally competent counselor can be thwarted if the clinician is culturally isolated and lacks knowledge of other ethnic groups. ***Cultural encapsulation*** is a term Gilbert Wrenn (1962) used to describe a culturally unaware counselor. The term suggests that a counselor has a lack of understanding of a client's culture and the influence of both the client's and counselor's culture on the therapeutic relationship. The culturally encapsulated counselor sees a client primarily through his or her own cultural lenses instead of those of the client. Each one of us is culturally encapsulated. Learning to see the world of another person through his or her cultural lenses is a process.

Monocultural Clinical Orientation

The term ***monocultural*** means having familiarity with only one culture or sharing a common culture to the exclusion of others. Sometimes therapists/counselors who are monocultural may apply their culture's values and norms to all clients, regardless of their cultural backgrounds.

Therapists/counselors who use a monocultural approach when working with a client from a different culture may encounter problems with diagnosis (over- or underdiagnosing disorders), assessment, interpretation of symptoms, and chosen treatment methods (Gallardo, Yeh, Trimble, & Parham, 2012). A monocultural orientation may function as a barrier to culturally competent counseling.

The Cultural Barriers of Race and Ethnocentrism

In order to build culturally competent therapeutic relationships, a counselor needs to recognize, confront, and overcome the biases that he or she holds, whether conscious or unconscious. These include biases related to race and ethnicity, gender, and sexual orientation, among others. The first issue involves how people in general feel about the topic of race. What is race? Are there really five races in the world, or is there only one race—the human race?

It is important that therapists/counselors understand what may potentially constitute barriers to counseling an individual who is culturally diverse from the counselor. Although there are a number of factors that may impact a culturally diverse counseling relationship, this section identifies differences in race, ethnic group membership, ethnocentrism, cultural encapsulation, and monocultural clinical orientation as major factors that have the potentiality of affecting a counseling relationship adversely.

Race: A Social Construction

Throughout history and the world, **race** has assumed a prominent role in people's minds. This book takes the perspective that race is primarily a social construction created by the Western world (Helms, Jernigan, & Mascher, 2005; Monk, Winslade, & Sinclair, 2008).

How did the concept of race develop? During the 15th and 16th centuries, British and European colonizers proposed that because people in the countries they colonized looked different from them and lacked some of the technological developments they possessed, these people were inferior to them and, therefore, not of the same race as them (Huntington, 2004). They promoted the idea that there are biological differences among groups of people that can be used to put them into various racial categories (Monk et al., 2008; Smedley & Smedley, 2005). Skin color has been the primary biological marker to place people into "racial" groups.

The term *race* was first used in the English language about 300 years ago (Smedley & Smedley, 2005). Meaning "breed" or "lineage," the term *race* can be traced to the French language. Race was associated with observable physical markers such as skin color, facial and bodily features, and hair type. The early colonizers placed meaning into these physical markers. Tracing the history of the social construction of race in the world, Smedley and Smedley (2005) stated:

> While colonists were creating the folk idea of race, naturalists in Europe were engaged in efforts to establish classifications of human groups in the 18th century. They had to rely on colonists' descriptions of indigenous peoples for the most part, and their categories were replete with subjective comments about their appearances and behaviors. Ethnic chauvinism and a well-developed notion of the "savage" or "primitives" dictated that they classify native peoples as inferior forms of humans. Although there were earlier attempts to categorize all human groups, then known, Linnaeus and Blumenbach introduced classifications of the varieties of humankind that later became the established names for the races of the world (Smedley, 2005). (p. 21)

CASE VIGNETTE 1.3

RACE AS A SOCIAL CONSTRUCTION

Dr. Hunt was an associate professor consulting in the area of multicultural counseling. As one of the panelists at a forum at a major university, he presented the idea of ***race as a social construction*** and that there were not five distinct races—Whites, Blacks, Asians, American Indians, and Latinos. One of the doctoral students attending the panel discussion stood up and angrily challenged Dr. Hunt's assertion that there were not five major races in this country. "How could you make such a stupid statement that there are not five different races, that there is only one race, and then that there are ethnic groups with various physical features? The U.S. Census categorizes people into different races! Is the Census wrong and you're right?"

Dr. Hunt responded, "I can understand your feelings. All your life, you have been taught that there are five races, and now here I come telling you that what you have been taught is just not true. Can you tell me what the biological differences are that form the basis of each of the five races? What is the race of a person whose mother is American Indian and White and whose father is Asian American and African American? Does this person have four races within her, and does the existence of four different races within her function to form a new race?"

The student shot back, "I don't believe you. I'm out of here!" He grabbed his backpack and left.

Discussion Questions

1. Most psychological research divides people into different racial groups. Should this practice be stopped, or should it continue?
2. As a participant in a forum, what might Dr. Hunt have done to better prepare the forum's moderator, the other panelists, and the audience for the assertion he was going to make?
3. Class Exercise: Discussions about race in the United States can evoke strong feelings. Form two groups in your class, one arguing in favor of five races and the other arguing in favor of there being only one race, the human race. Each group is asked to support its arguments with scientific facts gathered from current periodicals and books.
4. Reading/Discussion Exercise: Read the article by Helms, Jernigan, and Mascher (2005), "The Meaning of Race in Psychology and How to Change It: A Methodological Perspective," in *American Psychologist, 60*(1), 27–36. Discuss the relative merits of the methodology advocated in this article. In the years since 2005, to what extent have you seen this methodology implemented?

This notion, referred to by today's scholars as **racialized science**, is based on an imprecise and distorted understanding of human differences and an agenda to empower White colonizers (Allen, 1994, 1997; Smedley & Smedley, 2005). Race is neither a biological nor an anthropological reality (see the American Anthropological Association's "AAA Statement on Race," 1998). There is no scientific evidence to support the view that there are sufficient different biological markers to form different races. As Shih, Pittinsky, and Trahan (2007) stated, "Racial categories are arbitrary, subjective, and ultimately meaningless in any biological sense. In other words, multiracial individuals come to the realization that race is a social construction" (p. 125).

There is only one race, and that is the human race—with people who have different variations in physical appearances, but all having the same biological features such as a heart, head, and so forth. Yet, the concept of race persists today and is used to stereotype people into artificial categories, often classifying people into inferior and superior groups.

Ethnic Group

Whereas the concept of race lacks a valid scientific basis, an ethnic group is based on two factors: genetic antecedents and cultural traditions. An **ethnic group** is a group of people who share a common history and culture, can be identified by similar physical features and values, and identify themselves as members of that group through social interactions (Smith, 1991). Further, a person becomes related to the ethnic group through emotional and symbolic ties. An ethnic

group can be defined in terms of self-identification (Smith, 1991). From this viewpoint, an ethnic group may be described as a process of self and other ascription (Smith, 1991).

Ethnocentrism and Cultural Relativism

Ethnocentrism may be defined as the belief that one's worldview is correct and is inherently superior to the worldviews of others. William G. Sumner coined the term after observing people's tendency to differentiate between their own in-group and others. Sumner (1906) defined ethnocentrism as "the technical name for the view of things in which one's own group is at the center of everything, and all others are scaled and rated with reference to it" (p. 16). According to him, ethnocentrism leads to beliefs about one's own group's superiority and contempt for non–group members. For instance, in U.S. history, the European colonization involved enculturating indigenous people (American Indians) with the ethnocentric view that European cultures were superior.

Ethnocentrism is the inclination of people to use their own cultural standards to judge the behavior and beliefs of people from different cultures. The ethnocentric perspective judges one's own cultural beliefs as morally correct, and the beliefs of others as morally questionable. Most people are ethnocentric to some degree, in part because it is human nature to believe that our cultural beliefs are the correct ones. Despite this observation, ethnocentrism prevents us from becoming culturally competent and responsive to those who have different cultural beliefs, traditions, and social practices. (See Table 1.5.)

Cultural relativism is the opposite of ethnocentrism and follows the idea that behavior in one culture should not be judged by the standards of another culture. According to Kottak and Kozaitis (2002), cultural relativism seeks to be objective and sensitive to different cultures without ignoring basic stands of human justice and morality. To eliminate ethnocentrism, one must first acknowledge that he or she is ethnocentric.

Currently, in the United States, White middle-class values and worldviews are often presented as socially desirable, and these worldviews are used to judge other cultural and ethnic groups. As Neil Altman (2012) stated: "One aspect of Whiteness in the American context is that the culture associated with being a White American is considered the standard or the baseline from which other people diverge, as opposed to being one culture among many" (p. 183). Ethnocentrism provides an invisible barrier to those who are not members of the dominant group (Ponterotto, Utsey, & Pedersen, 2006). When it comes to counseling and therapy, from the ethnocentric Euro American perspective, pathology is usually viewed as located within the

TABLE 1.5 ■ Culturally Responsive Clinical Skill Development: Are You Ethnocentric?

Ethnocentric thinking goes beyond having pride in one's country. Ethnocentric thinking takes place when a person believes that his or her country does everything right, while the rest of the world does things the wrong way. One can have pride in one's own country while still believing that other countries also do things well, even though they may do things differently. Ethnocentric thinking is characterized by an unwillingness to consider different cultural points of view or by a reluctance to acknowledge the strengths of other cultures.

Some American examples of ethnocentrism are:

- People who speak differently from me have an accent, but I don't have an accent.
- People from such-and-such a place tend to always be . . .
- I was brought up with certain manners, and people who do not act with these manners are rude.
- Being proud of my heritage means I must not tolerate criticism of any aspect of my heritage.
- My religion is the one true religion; all others are erroneous.

individual rather than within the environment or the sociopolitical system in which the individual lives (Harper & McFadden, 2003).

NEUROSCIENCE, THE BRAIN, AND THE INVISIBLE NEURAL BARRIER OF ETHNIC/RACIAL BIAS

Racial and ethnic prejudices constitute a major barrier to culturally responsive counseling and psychotherapy. A major goal in this section is to acknowledge that all of us have **prejudices**—some of which we recognize because they are in our immediate awareness and still others that are not known or unconscious. Hopefully, this section will provide the foundation for honest discussion of prejudices, where they come from, and how they operate in each one of our lives. Are we more alike or different—deep down inside? What do we really share with each other as human beings?

Recent developments in neuroscience are beginning to provide critical information about how ethnic/racial bias is formed in the brain. Such research has even begun to locate the brain network that supports prejudice. This book maintains we must begin to look toward neuroscience for answers for dealing with ethnic/racial bias. The section begins with a brief description of the neural basis for ethnic/racial bias followed by what some researchers are labeling as the new paradigm for cultural diversity—the **paradigm of implicit and explicit racial bias** (Olson & Fazio, 2004; Phelps et al., 2000).

Neural Prejudice Networks in the Human Brain

Research on the neural basis of prejudice has emphasized neural brain structures that mediate emotion and motivation, such as the amygdala, insula, striatum, and regions of orbital and ventromedial frontal cortices. These structures can be conceptualized as the core neural brain network for the experience and expression of prejudice (Amodio, 2014; Amodio, Harmon-Jones, & Devine, 2003; Olson & Fazio, 2004; Phelps et al., 2000).

Neuroscientist David Amodio (Amodio, 2008, 2014; Amodio & Devine, 2006; Amodio & Ratner, 2011) has conducted critical research on neural functioning and the neural basis of prejudice. The neuroscience of prejudice investigates how our brains function to create and maintain human bias and prejudice against those who are different from us. Racial and ethnic prejudice is not just located in our thoughts and attitudes. Racism lives deep inside the very neural substrates of our brains (Amodio, 2014; Olson & Fazio, 2004; Phelps et al., 2000). According to Amodio (2014), prejudice "stems from a mechanism of survival, built on cognitive systems that 'structure' the physical world" (p. 670). The human brain has evolved to sustain survival and prosperity, and our brains respond to those who are different from us as threats to our survival and prosperity. A survival belief might be "We don't want immigrants coming to the United States because they threaten our jobs and well-being."

Racial prejudice is all about our views of what is necessary for our survival. The American Civil War was fought, in part, because Southern White male farmers saw the ending of slavery as a threat to their financial and economic survival. The Confederate flag has been used as a symbol of White superiority and as a reminder to African Americans about a war for slavery that Southern Whites lost. The Confederate flag produces neural reactions in the amygdala for both Whites and African Americans. Like the Confederate flag, the symbols of racism in each culture and country are deeply embedded in several neural substrates of the human brain. The **amygdala** processes social category cues, including racial groups in terms of their potential threat or reward. The primary role of the amygdala is to signal threat. Amygdala activation reflects an immediate or an implied threat response to racial out-group members. The amygdala is able to respond very rapidly to immediate threats because it receives direct (or nearly direct) afferents from all sensory organs into its lateral nucleus (Amodio, 2014; Amodio et al., 2003;

Phelps et al., 2000). Researchers interested in the neural substrate of implicit prejudice first looked to this brain structure when measuring prejudice.

Contained within the amygdala is the central nucleus (CeA), which has been implicated in Pavlovian (classical) fear conditioning in both rats and humans. Signals coming from the CeA activate hypothalamic and brain stem structures to bring about arousal, attention, freezing, and preparation for fight or flight—a fear response (Arkes & Tetlock, 2004; Banaji & Greenwald, 2013).

The **striatum** mediates approach-related instrumental responses. The insula conducts visceral and subjective emotional responses toward social in-groups or out-groups. The **orbitofrontal cortex (OFC)** mediates affect-driven judgments of social out-group members and may be characterized by reduced activity in the ventral **medial prefrontal cortex (mPFC)**, a region of the brain involved in empathy and mentalizing (Amodio, 2014).

Chapter 3 of this book provides more details about the neuroscience of bias and cultural competency.

Implicit and Explicit Bias: A New Paradigm for Cultural Diversity

Most people do not perceive themselves as prejudiced or racist. Typically, Americans say they think it is wrong to be prejudiced against members of other cultural groups. However, when people participate in psychological experiments designed to reveal unconscious attitudes, many of them are found to hold racial biases. For instance, Amodio and colleagues (2003) found that White participants would indicate on a questionnaire that they were positive in their attitudes toward Black people, but when given a behavioral measure of how they responded to pictures of Black people compared with White people, the results indicated otherwise. Amodio was basing his work on the earlier work of Anthony Greenwald and colleagues, who invented Project Implicit (see https://implicit.harvard.edu/implicit/).

Greenwald and colleagues (Banaji & Greenwald, 2013) designed a test that required the participant to sort categories of pictures and words. In the Black–White race attitude test, participants are asked to sort pictures of White and Black people's faces, and positive and negative words, by pressing one of two keys on a computer keyboard. The difference in time a participant needs to respond is the measure of implicit bias.

Explicit bias might be defined as bias of which one is aware—your conscious cognitions about your prejudices (Amodio & Devine, 2006). You know that you dislike members of a particular racial, religious, or gender-related group. You might even hurl racial or gender epithets at the targeted group—especially when you feel safe around others who share your prejudice.

Implicit bias is activated involuntarily. Implicit bias lives deep in a person's subconscious—that is, it usually lies outside a person's conscious awareness, thereby making it very difficult to change. Implicit bias differs from known or explicit biases in that individuals may choose to conceal explicit biases for the purpose of social or political correctness. We are all probably a little bit racist, even when we feel that we are not. A person says, "I am not a racist. I have some Asian or Black or Latino friends." Implicit bias takes place when, despite our best nonprejudiced intentions and without our awareness, racial stereotypes and negative racial assumptions seep silently and unobtrusively into our minds, thereby affecting our behaviors, decisions, and evaluations.

Implicit bias stems from the "messages, attitudes, and stereotypes we pick up from the world we live in," and research over time and from different countries shows that it tends to line up with general social hierarchies (Desmond-Harris, 2016).

More than 30 years of neurology and cognitive psychology studies have shown that implicit bias influences the way we see and treat others, even when we believe we are being fair to the other person (Banaji, Hardin, & Rothman, 1993; Devine, 1989; Dovidio & Gaertner, 1986). This may occur when prejudiced and stereotyped impressions of others are activated into memory and made part of judgment and activity by the brain structures involved in the neural prejudiced network (Amodio, 2014; Amodio & Devine, 2006). A form of racial prejudice focuses on

clearly defined social categories associated with identifiable physical characteristics. Americans have deep historical roots, such that Whites may view African Americans as threatening, thereby requiring vigilant attention (e.g., being watched when they go shopping). Studies have found that participants with strong implicit bias against African Americans were anxious about appearing biased (Ofan, Rubin, & Amodio, 2014).

Studies have found that implicit racial bias takes place at the medical doctor's office when White medical doctors treat African American medical patients. In a study by Alexander R. Green and colleagues (2007), 220 medical resident doctors took an implicit association test to detect unconscious racial bias, and they also read a medical history of a patient (either Black or White) experiencing chest pains, with clinical details suggesting a possible heart attack. The results showed that implicit bias affected their medical decision making regarding Black patients. Specifically, White medical residents were less likely to prescribe thrombolysis, a drug treatment to reduce blood clots and prevent heart attacks, for Black patients than for White patients. Put succinctly, White medical resident doctors were less likely to administer a potentially life-saving treatment to Black patients.

The negative effects of implicit bias of White medical doctors can be even more far-reaching. Reviews of a substantial body of research have found that, at the same time as racial and ethnic minority patients often do not receive appropriate and necessary care, doctors are also more likely to recommend and perform unnecessary surgeries on racial and ethnic minority patients than on their White counterparts (Dovidio & Fiske, 2012; Kressin & Groeneveld, 2015). Implicit biases have been found to influence judges' decisions in criminal cases. According to the Kirwan Institute for the Study of Race and Ethnicity at The Ohio State University (2015), "Researchers found that when controlling for numerous factors (e.g., seriousness of the primary offense, number of prior offenses, etc.), individuals with the most prominent Afrocentric features received longer sentences than" those with less prominent African features.

Cultural Reflections

To what extent are you aware of your implicit racial, ethnic, religious, or gender biases?

Key Points About Implicit Biases

- Implicit bias research is critical in understanding why some counselor trainees might feel angry, defensive, or reluctant to take a multicultural counseling course.
    - Implicit bias of students can affect a number of factors and situations, including the negative or positive evaluation of teachers and college instructors, misdiagnosing of mental illness by therapists/counselors, and clinicians' use of inappropriate psychological treatment procedures. Everyone has implicit biases, even those people who think they do not have them. Even people who take oaths that mandate impartiality, such as judges, have implicit biases. Implicit associations that we maintain are not necessarily in alignment with our declared beliefs. For example, a person may say that he is not prejudiced against African Americans, but he may participate in a rally or march with known members of groups like the Ku Klux Klan or other White nationalist organizations.
- We usually are inclined to hold implicit biases that favor our own in-group; however, research has shown that we can also hold implicit biases against our in-group. Many ethnic or racial groups have derogatory words that they use to describe themselves or members of their own group.
- Implicit biases can change. However, a person just can't sit down and engage in introspection about his or her biases, or simply decide not to let implicit biases affect his or her attitudes and actions (Kirwan Institute, 2015).
- We can unlearn implicit biases through a variety of de-biasing techniques (Kirwan Institute, 2015).

Reducing Your Implicit Biases

As a counselor or therapist, it is important to employ constructive techniques to reduce your implicit biases. When assessing the behavior or performance of a person from a stigmatized group, you should make an effort to focus on concrete positive and negative factors and your memory of what actually happened, instead of relying on overall gut feelings. Pay attention when you have uneasy feelings that your responses, decisions, or behaviors might have been caused by bias or stereotypes, and make an intention to think positive thoughts when encountering members of stigmatized groups.

Another approach is to make a deliberate effort to think about members of stereotyped groups as individuals rather than as members of a specific racial, ethnic, or cultural group. Helping professionals should pay special attention to their physical feelings when they encounter members of a stigmatized group and determine if their clients' group membership has anything to do with the treatment plans used during therapy. Studies on implicit bias make it imperative that counseling programs introduce students to cultural neuroscience and the brain.

Implicit Bias: Prejudice Against Immigrants and Refugees

Helping professionals, like other people in various situations, may exhibit implicit bias toward immigrants and refugees who have migrated to their country. According to research findings by Efren Perez (2010), many Americans have a negative bias against Latino immigrants, and such bias deeply influences their outlook on policy proposals for immigration reform. In an original survey experiment, he used the implicit association test to assess people's implicit attitudes toward Latino immigrants and discovered that participants had a negative impression of Latino immigrants that influenced their immigration policy judgments, even when they were explicitly directed to focus on non-Hispanic immigrants.

Perez's research findings also showed that many White Americans make little distinction between Latino immigrants and Latinos born in the United States. In addition to highlighting the implicit bias many have against Latino immigrants, Perez's findings give insight into why there is such intense opposition among many voters in the United States to enacting any type of immigration reform. Implicit bias affects virtually all immigrants to the United States and to other countries because they are inclined to be met with resistance from members of the host country.

SUMMARY OF KEY POINTS

Within the past three decades, the field of multicultural counseling and psychotherapy has grown by leaps and bounds. Part of this phenomenal growth can be attributed to the fact that technology has helped to produce a global society that has within it the capacity to put individuals in contact with each other from diverse parts of the world within seconds. The world has begun to take note of the significance of culture on human lives. Counselors and therapists need to become aware of the impact of culture not only on their own lives but also on the lives of their clients. All counseling takes place within a multicultural and sociopolitical context. Counselors can function to liberate or to oppress their clients.

All counseling should be culturally responsive, regardless of whether one is using a psychodynamic, cognitive behavioral, humanistic-existential, or social constructivist theoretical framework. Culturally responsive strengths-based therapy (CR-SBT) maintains that in conducting counseling or therapy, the emphasis should be on clients' strengths and not on their weaknesses or problems, for only the clients' strengths can be used to solve their presenting problems.

It is clinical malpractice to be unaware of the cultural influences on our lives and the lives of our clients. Successful treatment of a client takes place when counselors and therapists consider the cultural variables that impact the client's presenting problem. It is unethical for psychologists to work with clients for whom they lack the cultural training to provide adequate services.

Current counseling reflects a Eurocentric perspective that espouses an individualistic and egocentric worldview. For

the most part, the Eurocentric perspective fails to consider the role of social and cultural contexts of diverse clients; therefore, without a culturally diverse focus, Eurocentric-oriented counseling can do harm to people of culture and to LGBTQ clients.

The paradigm of implicit and explicit bias holds great promise for multicultural education and culturally responsive counseling. Understanding how bias is formed in the brain and how it is sustained should become part of each clinician's cultural competence journey. Clinicians should become aware of their own implicit biases so that they do not interfere with culturally responsive treatment. Implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. The following is a summary of some key findings on implicit bias that might be helpful to the practitioner:

- Implicit biases are activated in the brain (usually in the amygdala) involuntarily, unconsciously, and without one's awareness or intentional control (see, e.g., Greenwald & Krieger, 2006; Faigman et al., 2012; Nier, 2005; Rudman, 2004).
- Implicit biases are pervasive among all people, regardless of their gender, ethnicity, race, or culture (Kang & Lane, 2010; Nosek et al., 2007). Everyone is susceptible to them, even people who believe themselves to be impartial or objective, such as judges. Implicit biases have even been documented in children (Baron & Banaji, 2006; Newheiser & Olson, 2012; Rutland, Cameron, Bennett, & Ferrell, 2005).
- Because implicit associations arise outside of conscious awareness, these associations do not necessarily align with individuals' openly held beliefs or even reflect stances one would explicitly endorse (Graham & Lowery, 2004; Nosek, Banaji, & Greenwald, 2002a, 2002b).
- Studies have found that most Americans, regardless of race, display a pro-White/anti-Black bias on the implicit association test (Dovidio, Kawakami, & Gaertner, 2002; Greenwald, Poehlman, Uhlmann, & Banaji, 2009; McConnell & Liebold, 2009; Nosek et al., 2002a, 2002b).
- Once an implicit association is activated in the brain, it is difficult to inhibit the association (Dasgupta, 2013). Attempts to repress and to suppress automatic implicit associations are ineffective, and such attempts may actually amplify them by making them hyper-accessible (Galinsky & Moskowitz, 2000, 2007).
- An important way to engage in implicit bias cleansing is to openly acknowledge biases and then directly challenge or refute them.
- Our implicit biases can be changed by intentionally developing new cognitive and people associations (Blair, 2002; Dasgupta, 2013).

DISCUSSION QUESTIONS

Questions for Discussion: Cultural Assumptions

1. Identify an example of a culturally biased assumption in the counseling or psychotherapy literature.
2. Is the assumption you identified relevant for your membership in an ethnic, racial, or cultural group?

Culturally Responsive Exercise 1: Significant Events in One's Life and Culture

Each person experiences and interprets the events in his or her life differently. This exercise helps to identify if there are global events that are significant to everyone in the group or if different cultures have different significant life events.

Procedure

- Divide the students into groups of four or five.
- Each group should have participants of different ethnicities, races, or cultures.
- Give each student a blank sheet of paper.
- The participants are to indicate on the paper a timeline (past, present, or future), marking in each time period three events that are very significant to them.
- Among the three significant events they list, there should be at least one event that is not personal (i.e., fall of the Berlin Wall).

Group Presentation

- Each group should spend time comparing the similarities and differences within and between the people representing different cultures, ethnicities, or races.
- One person in each group is selected to report to the other groups what similarities and differences they found in their timeline of significant events.

Culturally Responsive Exercise 2: Cultural Life History

Students are asked to examine their lives primarily in terms of their cultural life history. The goal of this exercise is to help them delineate the dominant themes in their cultural life story.

Procedures

- Divide students into groups of three to five people.
- Ask them to write on a sheet of paper the dominant themes in their cultural life histories.
- Discuss in the groups the different cultural themes students identified.
- Do different students in the class come up with different or similar themes based on their cultural life histories?
- Discuss the similarities and differences in the dominant cultural themes students listed.

KEY TERMS

Amygdala: Part of the brain's limbic system that is responsible for memory and emotions, especially fear. It is often referred to as the seat of the "fight or flight" response. It controls the way people respond to others, especially those who are ethnically or culturally different or similar from them.

Cultural awareness: Being conscious of one's own cultural background and worldview, especially in relationship to other cultures and group identities.

Cultural competence: A clinician or therapist's ability to provide services to clients that take into consideration the client's cultural beliefs, cultural worldviews, and behaviors. The culturally competent counselor values diversity, has undergone cultural self-assessment, and knows how to adapt clinical services to reflect an understanding and appreciation of a client's culture.

Cultural congruence: A positive relationship between an individual's cultural identity and his or her behavior and lifestyle.

Cultural encapsulation: A term developed by Gilbert Wrenn to reflect the idea that therapists/counselors live in cultural cocoons in which they are unaware of the culture of others. The term is used to describe a person with a limited or myopic worldview.

Cultural incongruence: A dissonant relationship between a person's cultural identity and his or her behavior and lifestyle.

Cultural relativism: The perspective that holds that behavior in one culture should not be judged by the standards of another. This doctrine maintains that all cultures are equal, have intrinsic value, are equally entitled to respect, and should be appreciated for their differences.

Culturally responsive therapy: A counseling relationship in which a client and a therapist are of different ethnicities, cultures, races, and backgrounds and the therapist (1) evidences awareness of the significance of both his and the client's cultural stories, (2) has specific knowledge of the client's culture, and (3) uses culturally appropriate clinical skills in working with the client.

Culture: An ethnic group's organized body of beliefs and rules about the ways in which persons should communicate with one another, think about themselves, and behave toward each other and objects in their environment.

Dominant culture: The values and customs of the major group in a society that sets the standard for cultural correctness.

Ethnic group: A group of people who share a common history and culture, can be identified by similar physical features and values, and identify themselves as being a member of that group through social interactions.

Ethnic identity: Awareness of one's membership in a particular cultural or ethnic group.

Ethnocentrism: An ethnic group or a person's belief that an ethnic group's ways are right or superior in terms of cultural beliefs compared to other ethnic or cultural groups. An individual displays a strong preference for his or her ethnic group and strong dislike and devaluing of other ethnic groups.

Eurocentric counseling theories: Refers to White American culture or White, Western, European cultural values and ways of conceptualizing reality. The term is often used in reference to counseling theories because they were created primarily by White males of Euro American backgrounds. In general, the term means that which is oriented toward White Western culture. Most counseling theories are Eurocentric in that they are built on the value system of White Western Hemisphere culture.

Explicit bias: Those biases and prejudices of which people are aware and may even acknowledge.

Implicit bias: Biases that are activated involuntarily and without a person's awareness or intentional control. Implicit bias lives deep in a person's subconscious—that is, it usually lies outside a person's conscious awareness, thereby making it very difficult to change.

Medial prefrontal cortex (mPFC): The human brain consists of a network of specific brain areas called the social brain. The medial prefrontal cortex is part of the adult social brain, which is responsible for social recognition and moral judgment. The prefrontal cortex can be divided into two sections: the medial prefrontal cortex (mPFC) and the lateral PFC. The mPFC has connections with the amygdala, which is important in emotional processing. Individuals with mPFC lesions have severely impaired social behavior.

Monocultural: Focus on one ethnic or cultural group, especially viewing the world through the lenses of one cultural perspective, without taking into consideration other cultural views.

Multicultural competencies: A set of culturally appropriate guidelines (promulgated by the American Psychological Association and the American Counseling Association) or competencies for individuals working with culturally diverse groups.

Multicultural counseling: Counseling in which the therapist and client come from different cultural, ethnic, and gender backgrounds. Because no two people come from the exact same background (due to differences in their experiences), all counseling is, in some respects, multicultural.

Multiculturalism: A school of thought or a philosophy that recognizes and values the various contributions of multiple cultures to a nation's life. It is a philosophy and doctrine that holds that several different cultures (rather than one national culture) can coexist peacefully and equitably in a single country.

Orbitofrontal cortex (OFC): The orbitofrontal cortex is part of the prefrontal cortex that sits just about the eye sockets, sometimes referred to as the orbits. It is located in the front of the brain and has extensive connections with the limbic system structures that deal with emotion and memory. The orbitofrontal cortex plays a role in higher-order cognition such as decision making. Areas of the brain involving the prefrontal cortex are believed to be critical in thought and human reasoning. Both impulse control and response inhibition are commonly associated with the OFC.

Paradigm of implicit and explicit racial bias: The principle that we all have biases, both explicit and implicit.

Prejudice: A preconceived devaluing of a group because of its assumed behaviors, capabilities, or attributes.

Race: A term frequently used to refer to major subdivisions of the human family characterized by hair texture, color of skin and eyes, stature, and other bodily proportions and physical characteristics.

Race as a social construction: The understanding that there is only one race within the world: the human race; that the concept of race lacks a biological or genetic basis.

Racialized science: The notion, promulgated by 18th- and 19th-century British and European scientists, that observable physical markers such as skin color, facial and bodily features, and hair type were a valid means of categorizing humans into separate races.

Sexual orientation: The way in which a person views and expresses the sexual component of his or her being; a person's habitual sexual attraction to and sexual activities with a person of the same sex, the opposite sex, or some combination thereof.

Social justice: A goal of democratic societies that commits to equitable access to societal institutions, resources, opportunities, and services. Social justice counseling is counseling designed to foster social justice and equal opportunities for all.

Strengths-based therapy (SBT): A psychotherapeutic approach that uses clients' strengths as an integral part of the therapeutic process. The therapist assesses clients' strengths and uses the focus on strengths to motivate and instill hope in them. Therapist emphasis on clients' strengths in therapy increases client cooperation and acceptance of therapy, while preventing and mitigating the presenting problem that brought them to therapy and promoting and maximizing human growth potential. Strengths-based therapy was developed by Elsie Jones-Smith during the late 1990s and the early part of 2000 (see *Strengths-Based Therapy: Connecting Theory, Practice, and Skills*, 2014).

Striatum: Involved in voluntary motor control. It is important in movement planning and in understanding rewards in social situations.

Worldview: A frame of reference and beliefs that an individual holds about life. It includes the individual's assumptions, understandings, interpretations, and beliefs about his or her relationship to the people, institutions, and phenomena within his or her environment.

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