Chapter 7

CULTURE, CONTEXT, AND ETHICS IN PSYCHOTHERAPY AND COUNSELING

In the last few decades, the United States (US) and Canada have become more multiracial, multiethnic, and multilingual. As of 2019, 40% of the US population was Black Indigenous and People of Color (BIPOC) including: 18.5% Latinxs, 13.4% African American, 5.6% Asian American, and 1.3% American Indians (U.S. Bureau of the Census, 2019). Approximately 20% of the US population or 40 million are immigrants (Pew Research Center, 2020). In Canada, 22.3% of the total population in 2016 identified as People of Color and 21.9% of the population as immigrant. The largest ethnic minority community in Canada was composed of people of South Asian descent (5.6%), followed by Chinese (4.6%), First Nations (4.4%), and people who identify as Black (3.5%; Statistics Canada, 2016).

In the field of mental health, several foundational publications (see Comas-Díaz, 2012; Helms & Cook, 1999; Sue et al., 2019; Vasquez, 2007; White & Henderson, 2008) and professional guidelines (see American Psychological Association [APA], 2017b, 2019c; Canadian Psychological Association [CPA], 2017b) underscore the importance of ethnicity and culture in the therapeutic process. These important documents aim to assist therapists in providing culturally responsive services to individuals and communities. Culture, defined as the "complex constellation of [learned] mores, values, customs, traditions, and practices that guide and influence people's cognitive, affective, and behavioral response to life circumstances" (Parham et al., 1999, p. 14) is an important

aspect of the work that we do as therapists. Culture shapes how clients: (a) narrate and make sense of their presenting problems, describe the causes, signs, and symptoms of their problems; (b) discuss what they believe heals or prevents the problems from getting worse; and (c) envision their relationship with healthcare providers including their therapist (Adames & Chavez-Dueñas, 2017; Gallardo et al., 2012; Kleinman et al., 1978; Vasquez, 2007). Culture always shapes how therapists view problems and issues, as well as what we consider to be healthy and unhealthy processes and functional and dysfunctional coping strategies (Vasquez & Johnson, in press). Culture is always in the therapeutic space, even when we fail to honor its presence and significance.

The concept of culture is sometimes misleadingly used interchangeably with race. However, the consensus among scientists, including social scientists, is that both concepts are distinct, albeit closely related (see Alvarez et al., 2016; Chavez-Dueñas et al., 2019; Helms & Cook, 1999). Specifically, race describes how individuals are grouped according to their shared phenotype (e.g., skin-color, eye-color, hair texture) and the social, educational, health, and political implications of this method of grouping (e.g., choosing to divide people up according to the color of their skin; see Bonilla-Silva, 2014; Carter & Pieterse, 2005; Chavez-Dueñas et al., 2014; Gannon, 2016; Helms & Cook, 1999; Ifekwunigwe et al., 2017; Jones, 1997). Said differently, race is a social construct and not a biological one. However, this social construct has real life and social consequences such as its impact on health and access to opportunities. The role of race, racism, colorism, and other forms of oppression (e.g., anti-Semitism, sexism, heterosexism) in ethics will be discussed in Chapter 23. In this chapter we focus on culture and its implications for our work as therapists—we provide some steps to recognize and overcome barriers to ethical practice in the context of different cultures.

CULTURE HAS ALWAYS BEEN A PART OF HEALING

Psychotherapy as a healing practice has existed for centuries in different cultures. However, the current practice of psychotherapy is often rooted in a Western philosophy with origins in Europe and the United States. Wampold (2001) explains that

> The idea of sitting in a room with the healer, confiding in the healer, responding to questions, and following the implicit or explicit ritualistic expectations of the psychotherapeutic protocol, whether it is expressing one's feelings, monitoring one's thoughts, forming a contingency contract, or looking at the rapidly moving hands of the therapist, would be an absurdity in 99% of the societies past or present. On the other hand, participating in some healing practice is universal. As a healing practice, psychotherapy shares commonalities with medicine, but also with laying-on-of-hands, theriac, and shaman rituals. Psychotherapy is not universal; it has existed, in widely different forms, in some (but not all) Western cultures for about 100 years (p. 79).

There is also evidence that the Indigenous people of the Americas were using talk as a form of treatment for mental illness centuries before colonization. Padilla (1984) describes how the Aztecs had a well-developed system of public health that included healing services for mental health-related concerns where conversation was used to heal and care for others. He also wrote that

> In essence it was believed that the *tonalpouhqui* [healer] had the knowledge and more authority to assist the patient by means of lengthy conversations designed to liberate them [from their ailments]. The personal characteristics and language of the *tonalpouhqui* were the major determinants for a successful outcome...The *tonalpouhqui* possessed concepts of ego formation and catharsis, as well as techniques of dream interpretation and psychotherapy similar to those developed later by Freud and Jung (p. 7).

These two passages exemplify the ways in which distinct cultural groups around the world used dialogue and other methods to connect and build relationship to address the problems of living. However, the common ways in which psychotherapy is currently practiced are not culturally universal. Consider current counseling practices prevalent in the US, Canada, and many other Western countries: 45 to 55-minute sessions, once a week, often taking place in an office setting or using a Zoom connection, typically between two people. Few would argue that these practices are universal or free of cultural influence. To a great extent, they reflect Western standards and values. If so, how do we form healing relationships with clients of other cultures for whom such practices are a barrier? What do we need to learn about ourselves, the groups we belong to, and other cultures in order to communicate and work more effectively with those from other cultures? The following sections provide some ways to address these complex, arduous, but crucial questions.

CULTURAL COMPETENCE

Psychotherapists are like all people. We too are shaped and influenced by many factors including our cultural heritage and our multiple social group memberships (e.g., race, ethnicity, gender, sexual orientation, religion, ability status). Subsequently, we navigate the world with a set of attitudes and ideologies that shape how we see ourselves and others. Indeed, you and I are "cultural beings," all of our interactions are cross-cultural, and all of our life experiences are perceived and shaped from within our own cultural stance—the mantra and bedrock of cross-cultural and multicultural practice. As psychotherapists, our culture provides a rich context for becoming more aware of how our mores, values, customs, and traditions influence our own professional practice, ethical views, and reasoning. Ronald Francis (2009) wrote:

> One of the singular merits of ethical considerations in a cross-cultural context is the way in which it forces us to confront our own values, to develop them, and to defend them. Cross-cultural comparisons afford a marvelous opportunity to examine the bases of our ethical codes in a manner which does not invite the heat more commonly attending intercultural value debates. Ethics is essentially about human values. Since not all values are shared, we are compelled to consider the issues we have in common; and those on which we divide. For instance, what may seem self-evident in one culture may be ethically repugnant to another. Ethics affords an opportunity to discuss and resolve these human values in a non-threatening frame of reference (pp. 182–193).

Ethical assessment and intervention also depend on our ability to understand culture beyond the surface level and popular culture (see Chapter 20). When considering the role of culture in psychotherapy, scholars have discussed and illustrated ways to examine and understand culture at the deep structural level, address how it impacts the psychotherapeutic process, and plan how to best integrate it into our practice (see Adames & Chavez-Dueñas, 2017; Gallardo et al., 2012; Parham et al., 1999; Vasquez, 2007). Five domains of culture at the deep structural level introduced and described by Ani (1994) include: *ontology* (nature of reality); *axiology* (value system); *cosmology* (relationship to the divine); *epistemology* (system of knowing and believing what is the truth); and *praxis* (systems of human interaction). Conversely, examples of surface level culture include food, holidays, celebrations, clothing, visual and performing arts, sports, dancing, language, and the like. The model in Figure 7.1 illustrates culture at both the deep and surface levels, with questions to guide us to explore, unpack, and understand culture in nuanced ways.

Our professional responsibility to consider and integrate our clients' culture in therapy begins with a realistic appraisal of our own multicultural training and competence. When we hear of the word "competence" we often envision an individual who is a content expert, or perhaps someone who has reached the pinnacle in their career—we may also think of a group of people who know what to do in any situation—this is not competence. Instead, we invite you to think of competence as a process through which someone gains sufficient knowledge, judgment, and skills to carry out a task without doing harm. According to scholar practitioners, cultural competence involves three aspects: (a) developing awareness of one's own cultural values, traditions, and biases; (b) learning about the cultural values, traditions and worldviews of others; and (c) developing a set of culturally informed interpersonal skills (Mio et al., 2012; Sue et al., 2019; Vasquez, 2007). Accordingly, cultural competence is a continuing, life-long process of learning and relearning about ourselves and others as complex and layered cultural beings. In turn, this process strengthens our therapeutic alliance, increases the effectiveness

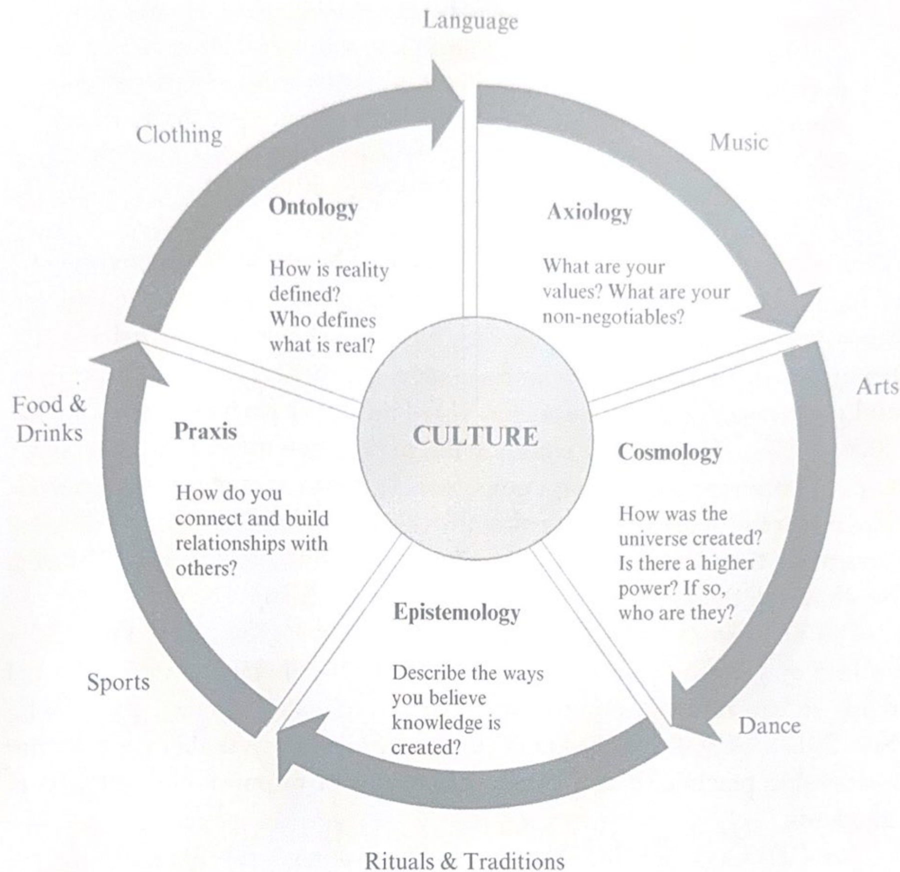

Figure 7.1. The Deep and Surface Levels of Culture Model.

Note: The model aims to assist you in thinking about you own assumptions of how you conceptualize culture in your life and in your practice. The model includes two layers: (a) outer layer depicting culture at the surface; and (b) inner layer illustrating the five domains of deep culture. The domains of deep culture influence each other in non-linear but dynamic ways. Each domain includes question(s) for individuals and groups to consider when exploring their culture, which is continuously shaped by context and history. The model can also be used with clients to explicitly introduce and explore culture in therapy—therapists can compare their responses to that of their clients and assess areas where their deep cultures overlap and diverge, which can help inform the therapeutic process.

Source: Pope, Vasquez, Chavez-Dueñas, & Adames (2021).

of treatment, and deepens our ethical awareness and sense of personal ethical responsibility (see Arredondo et al., 1996; Casas et al., 2016; Fouad & Arredondo, 2007; Vasquez, 2007, 2009).

The Impact of Cultural Competence on Treatment

Our cultural competence influences the experience that clients have in therapy. For instance, Smith and Trimble (2016) conducted a meta-analysis focused on therapists' cultural competence and its connection to clients' experiences in treatment. They concluded that

> Diverse clients tend to see therapist multicultural competence as highly related to, yet distinct from, other positive counselor attributes. In addition, culturally diverse clients are moderately more likely to prematurely discontinue treatment when their therapists do not demonstrate multicultural competence. Client outcomes improve when their therapists are able to competently attend to and value the varying experiences of culturally diverse clients (p. 64).

More recent decades have seen an increase in scholarship describing and centering the role of culture in treatment outcomes. For instance, the *evidence-based practice movement* in psychology frames evidence as the "best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, Presidential Task Force on Evidence-Based Practice, 2006, p. 273). This expansive description of evidence underscores the pivotal role of culture in psychotherapy outcomes. To illustrate, meta-analyses provide support for the effectiveness of culturally adapting psychotherapies for different groups (see Benish et al., 2011; Bernal & Domenech Rodríguez, 2012; Griner & Smith, 2006; Smith & Trimble, 2016; Zane et al., 2016).

The abundance of evidence supports the need to consider the client's culture and our own cultural competence in the therapeutic process—not doing so can result in unintentional harm to clients (Vasquez, 2009, 2012; Sue, 2019). Thus, the inclusion of cultural factors in psychotherapy is not just a desirable practice, it is a fundamental ethical responsibility outlined in standards.

The CPA Code of Ethics Standard II.10 encourages psychologists to:

> "evaluate how their own experiences, attitudes, culture, beliefs, values, individual differences, specific training, external pressures, personal needs, and historical, economic, and political context might influence their interactions with and perceptions of others, and integrate this awareness into their efforts to benefit and not harm others" (2017b, p. 19). Standard IV.15 requires that psychologists "acquire an adequate knowledge of the culture, social structure, history, customs, and laws or policies of organizations, communities, and peoples before beginning any major work there, obtaining guidance from appropriate members of the organization, community, or people as needed" (p. 33).

APA Ethics Code Standard 2.01b, Boundaries of Competence, states:

> Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to

> ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies (2017b, p. 5).

Several psychological associations in the US have published documents that articulate and augment our ethical responsibilities within different cultural worldviews. Pope, Chavez-Dueñas, and Adames (in press) report that:

> members representing the four Ethnic Minority Psychological Associations (EMPAs) in the United States including the *Asian American Psychological Association* (AAPA), *Association of Black Psychologists* (ABPsi), the *National Latinx Psychological Association* (NLPA), and the *Society of Indian Psychologists* (SIP) met with the APA Ethics Committee at the 2011 annual APA convention. During this meeting the EMPAs and APA agreed to review whether the ethics code addresses issues of culture adequately, appropriately, and knowledgeably. Specifically, the EMPAs shared their thoughts on how the ethical code both "assists or hinders their work as Psychologists of Color" with the goal of broadening knowledge on "how culture intersects with ethical dilemmas" (APA, 2012a, para. 15). Several EMPAs have developed and published their own set of ethical commentaries. (see SIP, 2014), guidelines (see NLPA, 2018), or standards (see ABPsi, n.d.).

CULTURAL COMPETENCE AND PROFESSIONAL GUIDELINES

A focus on the role of culture in psychotherapy as practiced and regulated by state or provincial licensing laws is a relatively recent phenomenon. Historically, the field of mental health has been slow at recognizing the significance of culture in psychological science, practice, and ethics (see Hall, 1997; Guthrie, 2004; Pickren & Burchett, 2014; Sue et al., 2019; Vasquez, 2007, 2012). The first mention of culture as a factor in therapy took place at the Vail Conference of 1973 (Korman, 1974). Sixteen years later, in 1990, the APA published its first guidelines that addressed culture titled, *The Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* (APA, 1990). That same decade, the CPA approved and published their *Guidelines for Non-Discriminatory Practice*. Since then, both APA and CPA guidelines have been revised. In 2003, the new APA guidelines were published with a new title, *The Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change* (see APA, 2003) and in 2017 they were revised once again (see APA, 2017b). The CPA guidelines were updated in 2001 and in 2017.

The 2017b version of the APA Multicultural Guidelines more broadly addresses the importance of attending to various identities and

> encourage psychologists to consider how knowledge and understanding of identity develops from and is disseminated within professional psychological practice. Endemic to this understanding is an approach that incorporates developmental and contextual antecedents of identity and how they can be acknowledged, addressed and embraced to engender more effective models of professional engagement (APA, 2017b, p. 6).

Similarly, the 2017 CPA Guidelines for Non-Discriminatory Practice

> promote non-discriminatory care in therapeutic work with clients, as well as to provide guidelines for evaluating the extent to which one's work falls within the parameters of non-discriminatory practice. As our society and culture become more diverse, and as we become more aware of specific diversities, it is important that psychologists gain an awareness of the need for non-discriminatory practice. As the need arises, guidelines can be developed for use of specific diversities (CPA, 2017b, p. 1).

The APA Guidelines on Race and Ethnicity in Psychology (2019c) more specifically focus on race and ethnicity

> and describe how clinicians, educators and researchers can develop racial and ethnocultural responsiveness and discuss the importance of understanding bias and recognizing the influence of race and ethnicity in society (APA, 2019c).

These guidelines encourage psychologists to understand and consider the role of culture in practice, research, consultation, and education. Unfortunately, we have a long way to go in the field of mental health to move beyond just highly encouraging people to consider the role of culture in assessment and interventions to requiring the integration of culture as a standard in practice.

BUILDING CULTURAL COMPETENCE

Building cultural competence in clinical practice often begins with effective training. Many programs in psychology and related fields historically have not provided adequate training on how to effectively integrate cultural knowledge into assessment and therapy. Adames et al. (2013) posit that

> While psychology as a discipline maintains that diversity and multiculturalism training is important, some departments do not adequately address it as a central topic, emphasize its importance by making it a requisite, or provide a sound framework for effectively addressing diversity and multiculturalism (p. 3).

To what degree is culture and diversity respected, valued, welcomed, and its potential, approached in positive and creative ways? To what extent is it approached in ways that divide, isolate, set people against each other? For instance, several studies support how conversations about culture, ethnicity, and race provoke and exacerbate uncomfortable feelings including defensiveness, anxiety, anger, helplessness, blame, and invalidation (Bell, 2003; Helms & Cook, 1999; Sue et al., 2011; Utsey et al., 2005). Other scholars posit that when culture is addressed it is at the cost of Students of Color. Franklin (2009), for example, wrote:

> Ethnic minority students often felt trapped between, if not victimized by, the roles of cultural educator and student. However, students as cultural brokers in class are often educators without a portfolio in the eyes of professors and fellow classmates. Challenging psychological information being presented that did not accurately represent our experiences could bring … a label as an impudent student. Parenthetically, it was not uncommon to have our personal insights as members of the community also challenged or dismissed by professors or researchers who had no experience with our communities other than their readings in psychology. This was infuriating to many colleagues and students, given their lived experiences … These in class and work experiences were frustrating, intimidating, humiliating, and discouraging to students and subsequently early career professionals in particular. This circumstance continues to contribute to the attrition of Students of Color in training programs and later becomes a deterrent to participation in organized psychology (p. 419; see also Kaduvettoor et al., 2009).

When we neglect how our own worldviews and cultural values influence the ways in which we navigate the world and interact with others—or when we fail to understand and appreciate the role of culture in our clients' lives and in the work that we do as therapists—we end up straying from the appropriate and helpful to the useless or even oppressive. We cannot operate from a one-size-fits-all approach to training and psychotherapy by applying frameworks and interventions grounded solely in the experiences of the dominant group (Burkard & Knox, 2004; Gómez, 2015; Sue, 2015). The road toward cultural competence, or the ability to develop interventions that are culturally responsive begins by looking inward toward the self and outward toward others.

Looking Inward

We encounter people who practice different cultures and who differ from us in many ways as we go about our lives. We learn about cultural diversity in our studies, we work on developing ethical awareness in approaching it in our clinical work, but often we forget that we also carry our own private—and

sometimes not so private—views and feelings about specific cultures, races, religions, and so on. Most readers would have no trouble naming areas in the world in which people are fighting each other in part because of religion, culture, ethnicity, and similar factors. Most could name groups in their own countries that view members of another group with suspicion, unease, resentment, disdain, or hate.

It is impossible for us as therapists to be completely free of the prejudices that afflict the rest of humanity; after all, we are socialized in societies that have long histories of racism, colorism, nativism, ethnocentrism, and many other forms of othering (Chavez-Dueñas et al., 2019). Life is remarkable in so many ways, but not that one. For any of us, various cultural, racial, ethnic, political, religious, and other groups—or topics related to these groups—may evoke an intense emotional response. The response may be subtle or powerful. We may be ashamed of it or embrace it as important. We may be reluctant to mention it to certain people. We may view it as not politically correct or—a more forbidding barrier for many of us—as not *emotionally correct* (Pope, Sonne et al., 2006).

These psychological reactions may block or diminish our cultural competence to work with specific groups or certain topics. Thus, it is vital to assess not only our intellectual competence but also what Pope and Brown (1996) termed *emotional competence* for therapy. We invite each of us to take a moment now to ask ourselves the following set of questions:

- Do you have positive or negative feelings toward most or virtually all members of any particular social groups based on their cultural traditions, values, and practices? Does a person's skin color ever affect the way you view them or interact with them? How about a person's religion (e.g., Muslim, Southern Baptist, Catholic, Mexicayotl, Hasidic Judaism)? Social class (e.g., those people known as the super-rich; those people who are poor and homeless)?
- If so, how if at all do you think it affects your clinical work?
- Would you feel comfortable hiring, supervising, or accepting as a client, or working with a member of that group?
- Would you feel comfortable sharing these feelings with your graduate school faculty, internship supervisors, employer, or colleagues?
- Have you shared these feelings with your graduate school faculty, internship supervisors, employer, or colleagues?
- Would you be okay sharing your thoughts publicly? Posting them on public social media accounts?
- How well do you believe your graduate program, internship, and continuing education courses have dealt with these issues? What improvements could you suggest?

- How well do you believe the profession has dealt with these issues? What improvements could you suggest?
- Do you believe the profession is paying too much, too little, or just about the right amount of attention to these topics?
- How do your own cultural values inform and shape the way you interact with clients?
- How do they impact your assessment and diagnosis of clients of cultures different from your own?
- How do your cultural values impact or inform your interventions?
- Do you ever consider how the client's understanding, description, and expression of symptoms may impact treatment? If so, how do you integrate this information into your work?

Becoming aware of the ways we may fail to recognize and respect a group that is different from our own challenges all of us. It is easy to recognize in theory, the influence of our own culture and context, but it often escapes our notice in practice. A remarkable book, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* (Fadiman, 1997), illustrates the potential costs of overlooking the influence of culture and context on everyone involved. The book describes the efforts of a California hospital staff and a Laotian refugee family to help a Hmong child whose American doctors had diagnosed with epilepsy. Everyone involved had the best of intentions and worked hard to help the girl, but a lack of awareness of cultural differences had tragic effects. The book quotes medical anthropologist Arthur Kleinman:

> As powerful an influence as the culture of the Hmong patient and her family is on this case, the culture of biomedicine is equally powerful. If you can't see that your own culture has its own set of interests, emotions, and biases, how can you expect to deal successfully with someone else's culture? (p. 261).

Looking Outward

Several models have been created to help us operate from a culturally responsive stance (see Adames & Chavez-Dueñas, 2017 *CREAR-CE Model*; Park-Taylor et al., 2009 *Multicultural Competency Training Model*). A well-established framework is White and Henderson's (2008) multicultural competency building model which includes an actionable plan to develop and maintain cultural competency throughout our mental health careers and beyond. This model is divided into four levels including: (1) *conceptual/theoretical/intellectual* which underscores the importance of learning about our client's culture at the deep structural level obtained by reading textbooks and journals, attending lectures and courses, and watching movies/

documentaries; (2) engaging in *challenging cross-cultural dialogues* that provide the opportunity for emotional grow through active participation in difficult dialogues around individual differences; (3) *behavioral engagement* which emphasizes the importance of immersing ourselves in the context/community of the people we serve; and (4) *building practical skills that enhance the therapeutic relationship* which focuses on developing healing approaches that are tailored to the unique and complex needs of our clients (also see Adames et al., 2016; Henderson et al., 2014). According to White and Henderson, when we engage in activities at each of the four levels, we end up developing and deepening our cultural competency and improving the psychological services we provide.

SCENARIOS FOR DISCUSSION

You share a suite of offices with several other therapists. The name of each therapist is on the door to that therapist's office. One morning you find that the door to one of the offices has been broken in and the office vandalized. The name on the door was Jewish. Swastikas along with epithets have been spray-painted on the walls, desk, floor, and bookshelves. You have no evidence but believe the vandal may have been one of your patients—someone who has expressed strong anti-Semitic views during therapy sessions, embraces the view that the Holocaust is fiction, and has described fantasies of vandalizing synagogues. But if you were to ask him during the next therapy session whether he had anything to do with vandalizing your colleague's office, he would deny it.

- How do you feel?
- What would you like to do?
- What do you think you would actually do?
- Would you mention your suspicion that your client may have vandalized your colleague's office to the colleague, the police, or anyone else? If so, how do you address issues of client privacy and confidentiality?
- Would you mention your suspicion to your client? If so, how?
- How, if at all, would you address your client's anti-Semitism in therapy?

You are a Latino psychotherapist who speaks Spanish only moderately well. Your policy is to try to refer all those who speak only Spanish to fluent Spanish speakers, but you will see

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Spanish speakers who also speak English if they wish. A South American client who speaks fluent English and Spanish sees you because you are the only Latino available on her HMO list. At the first session, she insists that you should be ashamed for not speaking better Spanish and that you therefore have no culture.

- How do you feel?
- What are your thoughts and feelings about this client?
- How would you respond to this client?
- Under what conditions would you continue to see or decline to see this client?

You have been leading a therapy group at a large mental health facility. As one of the sessions begins, a group member interrupts you and says, "I want to ask you about something. Have you noticed how none of the doctors here are People of Color but almost all the cleaning crew are? Why do you work in a system like that? Don't you think that has any effects on us patients?"

- How do you feel?
- What are the possible replies you consider?
- What do you think you would say?
- What effects, if any, might such a system have on clients?

You work in a large office building. As your therapy client, a person of the Sikh faith, is getting ready to leave your office, the police show up at the door, handcuff him, and say they are taking him to the station for questioning. When they leave, the accountant across the hall comes over and says that someone saw your client in the lobby, thought he was acting suspiciously, and called the police to report someone who seemed up to no good.

- How do you feel?
- What do you consider doing?
- What would you like to do?
- What do you think you would do?
- How, if at all, might this affect the therapy?
- How, if at all, would you chart this?

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A married couple comes to you for counseling. Both believe that men are the natural leaders in a marriage and that a woman's rightful place is to be obedient to her husband. However, they often have what they describe as "slips," when he seems to look to her for guidance or when she finds it hard to accept his decisions. They are seeking marital counseling to help them eliminate these "slips."

- How do you feel?
- What are your thoughts and feelings about the wife?
- What are your thoughts and feelings about the husband?
- What are your thoughts and feelings about the marital relationship that they value and have chosen for themselves?
- How do you think you would respond?

You work as a counselor in a high school where the majority students are African American and Latinx. You see clients in a small space right next to the principal's office. Most of your clients have been referred to you for "acting out" behaviors—they are often described by their White teachers as "lazy, unmotivated, and trouble-makers." In therapy your clients often talk about how the school is "not for them." They often discuss feeling not smart and that the teachers don't like them. During one of your sessions with a client who is crying while sharing a traumatic event, a teacher barges into your office and blurts out, "gosh, why do these kids have to be so loud, can you keep them quiet for once?"

- How do you feel?
- How would you respond to the teacher in that moment?
- What would you do when the teacher leaves?
- What would you say to your client?
- What would you do when your client leaves?
- What are your thoughts about what happened?
- What are your reactions to what happened?

You work with a geriatric population that is composed predominately of first-generation immigrants from Asia and Latin America. One of your Mexican clients, an 80 year-old woman comes to your session looking very serious. She begins her session by sharing that she wants to talk to you about what

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happened last night. She described having a conversation with her dead mother who came to give her a message. The message was that the mother was "not resting in peace" because your client was separated from her abusive husband. Your client states that her mother wants her to forgive her husband from whom she has been separated for over a decade. You have been working with this client for two years now to help her cope with the traumatic experience of living with a husband who abused her for decades.

- How do you feel?
- What are your thoughts? How are you making sense of the case?
- What would you say to your client?
- How would you chart this?
- What would you do?

You are a therapist at an agency with a policy that says that if a client misses two appointments without calling, the therapy automatically terminates. A client who is a single mother, uses public transportation, has no telephone, and is often distressed by a babysitter who does not show up, misses her appointment for the second time. Your supervisor insists that you terminate by letter, given the long waiting list of potential clients.

- What feelings do you experience?
- What are your assumptions about the client's not showing up? In what way, if any, might her diagnosis be relevant?
- What do you think and feel about the relevance of the policy for clients such as this one?
- What are your options in responding to your supervisor? To the agency policy? To the client?
- Which options do you believe you would choose in deciding how to respond to your supervisor, the policy, and the client?